BRIDGING THE RESEARCH-PRACTICE GAP IN CHILD AND ADOLESCENT PSYCHOTHERAPY: A SURVEY OF NEW ZEALAND PRACTITIONERS.

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ABSTRACT

The conditions and characteristics of child and adolescent psychotherapy in clinical practice are known to differ from those found in research settings. This is a concern for psychologists who aim to provide evidence-based practice within the scientist-practitioner model. In partial replication of a previous North American survey (Kazdin, Siegel & Bass, 1990), this study drew on New Zealand mental health practitioners' experience in order to identify clinically relevant future research directions. Two hundred and three mental health practitioners from a variety of professional backgrounds reported on their assessment and treatment practices, perception of typical outcomes, beliefs about factors affecting outcome, and adherence to aspects of the scientist-practitioner model. Apart from the types of therapies used, the conditions and characteristics of practice reported here differed from those typically found in research. A number of research imperatives were identified including issues related to: developing clinically representative outcome studies; transporting empirically supported therapies to the clinic setting; and continuing the search for common factors to guide practice. The need to continually review and critique the research underlying empirical support for therapies was highlighted, as were the possible pitfalls of failing to do so.

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Introduction

Foreword

Children and adolescents suffering mental health problems pose a special challenge to professionals, requiring prompt, specialised assessment and assistance (Kazdin, 1994). The presence of disorder during the developmental years from birth to young adulthood can interfere with normative maturation and impact the individual in mutliple functional domains, with consequences for later life (Kantor, 1995; Kazdin, 1997; Simeonsson & Rosenthal, 1992; Weisz & Weersing, 1999).

The rate of mental illness in New Zealand children increases steadily until age 18 years (Disley, 1997) and is proportionally high compared to other demographic groups (Mental Health Commission, 1998). There is evidence that the rate of mental health problems in this population is increasing both in New Zealand and internationally (Burns, Hoagwood & Mrazek, 1999; Fergusson, Horwood & Lynskey, 1997; Pfeiffer & Strzelecki,1990).

Early, appropriate therapeutic intervention may reduce the severity and development of further problems (Fergusson, Horwood & Lynskey, 1997; Fergusson, & Lynskey, 1998; Feehan, McGee & Stanton, 1993). Despite the increasing prevalence rates, significant risks, and wide-reaching functional implications that are associated with early-life psychological disturbance, progress in understanding problems and treatments for children and adolescents lags behind parallel developments in the adult arena (Hoagwood, Hibbs, Brent & Jensen, 1995; Kazdin, Siegel & Bass, 1990). Although considerable advancement has been made in the last decade (Kazdin & Weisz, 1998), this discrepancy remains apparent in the lack of evidence supporting the effectiveness of therapies in ecologically valid settings and in the limited range of questions and therapies that are studied (Hoagwood et al, 1995; Kazdin, 1994; Kazdin, 1997). In short, although outcome research provides general support for the use of psychosocial treatments with children and adolescents (Casey & Berman, 1985), it generally fails to address the depth and breadth of the real life problems and possible solutions that are found in practice.

In 1990, Kazdin, Siegel and Bass (1990) surveyed over 1000 psychologists and psychiatrists in North America to determine priorities for research on psychotherapy with children and adolescents. They found that on the whole, psychotherapy as it occurs in clinical practice had infrequently been studied empirically. They also identified a number

of research imperatives to address this limitation. Although outcome research with this population has continued to develop, the problem of questionable external validity persists (Kazdin & Weisz, 1998). There has been no follow up survey of practitioners.

No similar investigation whether by survey or through the use of current data-stores, as is now typical in North America (Norcross, personal communication, August, 2001), has ever taken place in New Zealand. Of the few similar New Zealand-based therapist practitioner surveys available, none pertain specifically to the treatment of children and adolescents and most include the activities of just one or two professional groups (e.g. Kazantzis & Deane, 1998; Patchett-Anderson & Ronan, 2002). Consequently, we can claim neither knowledge of the general nature of therapy with children and adolescents in this country, nor of the extent to which psychotherapeutic practices are empirically supported or considered effective.

To this end, the current study surveyed a wide range of mental health professionals regarding their professional activities; assessment and treatment practices; perception of treatment outcomes; and beliefs about factors affecting outcome. In addition, they were asked to report on their adherence to various aspects of the scientist-practitioner model. The survey partially replicated and extended Kazdin, Siegel and Basss' (1990) survey and aimed to build on information derived through two previous New Zealand surveys (Kazantzis & Deane, 1998; Patchett-Anderson & Ronan, 2002). The sample used here was extended to include many different professional groups to obtain a more thorough picture of the nature of therapy as practised with children and adolescents in New Zealand. It is hoped that the findings will help to serve the overriding goal of this study: to reduce the gap between research and practice in the area of child and adolescent psychotherapy.

The following review outlines a number of issues relevant to the gap between psychotherapy research and practice with children and adolescents. These are presented in the following order and include: an overview of diagnostic, assessment and treatment considerations for children and adolescents suffering mental health problems; an outline of prevalence rates for major mental health problems in this population; a review of major developments and findings in child and adolescent psychotherapy outcome research to date; a description of the gap between research and practice in this area; and finally, an

introduction to the scientist-practitioner model including possible remedies for improving science-practice integration.

For brevity, except where a distinction between the two groups is required, children and adolescents will be referred to collectively as children. In this context, as is consistent with previous similar surveys (Kazdin, Siegel & Bass, 1990; Silver & Silver, 1983), the term children refers to individuals from birth to age 17 years old. However, throughout the text, reference may be made to prevalence rates concerning children up to the age of 18 years as this is the cut off age for youth as cited in the New Zealand Public Mental Health literature (e.g. Ellis & Collings, 1997; Mental Health Commission, 1998).

Special considerations in the assessment and treatment of children and adolescents suffering mental health problems are now reviewed.

CHAPTER ONE

Special Considerations in Child and Adolescent Mental Health

From birth to death, each individual participates in a complex interplay involving self, the environment and the process of maturation. At no time in this lifelong process are these influences more dynamic than during the child and adolescent years. The distinction of typical from atypical, and the design and implementation of developmentally appropriate therapeutic strategies, can be a formidable task for all mental heatlh professionals (Adams & Cassidy, 1993: Adams, Luscher & Bernat, 2001; Garfield, 2001, Kantor, 1995; Simeonsson & Rosenthall, 1992). Certain features can make this more problematic in youth. These are now discussed.

First, the self-referral process is almost always absent where children are concerned (Campbell, 1998; Farmer & Burns, 1997; Horwood & Fergusson,1998). Instead, parents, caregivers, teachers and youth justice services are primary sources of referral (Campbell, 1998; Horwood & Fergusson, 1998; Kendall & Morris, 1991).

A second difference is that the assessment and treatment of children targets a wider area of reference (Weisz & Weersing, 1999). For example, consultation with a range of significant others is imperative (Achenbach, McConaughy & Howell,1987). Treatment may target one or more individuals, not necessarily including the child (Bird, Gould, & Staghezza, 1992; Jouriles, Mehta, McDonald & Francis, 1997). Of course, there are inherent problems with this approach. Although a full discussion falls beyond the scope of this paper (e.g. Achenbach, 1995; Achenbach et al, 1987; Kolko & Kazdin, 1993), the different individuals involved with a child will inevitably vary in their perception of what constitutes acceptable or unacceptable behaviour (Campbell, 1998; Costello & Angold, 1995). Low to moderate and non-convergent correlations between cross-informants are a common finding (Achenbach et al, 1987; Epkins, 1996; Jouriles et al, 1997). Although guidelines for the comparison of cross informant data do exist, the clinician is by necessity afforded considerable interpretative latitude in formulating each case (Achenbach, 1998).

Given that there is no 'gold standard' by which to interpret data from multiple informants and contexts, the clinician is faced with a difficult task (Bird et al, 1992; McGee et al, 1995). Furthermore, each clinician brings to this task a peculiar set of influences which

may vary according to his or her experience, theoretical orientation, age, type of training, and clinical ability (Bird et al, 1992).

Related to the need for multiple informants, assessment and treatment must extend beyond the individual child (Weisz & Weersing, 1999). Childrens' behaviour cannot be seen in isolation from their ecology. For example, a variety of childhood contextual factors, including parental separation, association with antisocial peers, low levels of family support, high levels of coercion, low socioeconomic status and cumulative disadvantage have been found to increase the likelihood of later dysfunction (Feehan, McGee, Williams & Nada-Raja, 1995; Feehan, Stanton, McGee & Silva, 1994; Fergusson, Lynskey & Horwood, 1996; McGee et al, 1995). Likewise, contextual and developmental variables may differentially combine with, among other things, gender (McGee, Williams & Feehan, 1992) and disorder type (Fergusson, Lynskey & Horwood, 1997; Rutter, 1984) to moderate mental health outcomes and impact the child in a variety of functional domains (Frick & Silverthorne, 2001; Kazdin & Marciano, 1998).

A further challenge important in child assessment is the need to account for and distinguish between normal and maladaptive developmental trajectories. Similar behaviours in different children, or in the same child at different ages, may represent health in some but maladjustment in others (Simeonsson & Rosenthal, 1992; Weisz & Weersing, 1999). Likewise, the same behaviour manifest in two different contexts may vary in meaning (Achenbach, 1998; Weisz & Weersing. 1999).

While accurate prediction of future pathology is not always possible even where the dysfunction is severe (Costello, Angold & Keeler, 1999; Loeber, 1996), early problem identification has the potential to facilitate prevention of later pathology and complication in some circumstances (Feehan, McGee & Williams, 1993; Harrington et al, 1994). For example, in an ongoing New Zealand longitudinal study, Feehan and colleagues found that various pre-adolescent child and contextual variables predicted disorder at age 15 (Feehan, McGee & Williams, 1993; Feehan et al, 1995). Such findings indicate the potential for identifying at-risk individuals early in life (Fergusson, & Lynskey, 1998; Horwood & Fergusson, 1998).

Identifying children at-risk is no simple task and not merely a matter of diagnosis (Kazdin & Weisz, 1998). Consideration of two points may help to summarise this issue. First,

whether or not children are classified as being 'disordered' depends on the degree to which they meet a cut off point for 'caseness' in the empirical method, or a predetermined number of diagnostic criteria in the clinical system (Achenbach, 1995, 1998; American Psychiatric Association, *Diagnostic and statistical manual of mental disorders (4th ed.)*, 1994; Costello & Angold, 1995; Garfield, 2001). However, the full extent to which an individual is functionally impaired is not routinely considered in either appproach (Costello et al,1999; Frick & Silverthorn, 2001). This is noteworthy in light of a recent study replicating earlier findings that young children who do not exceed diagnostic criteria but who demonstrate functional impairment, are similarly prone to becoming clinically impaired during adolescence as are those who exceed classification thresholds (Costello et al, 1999). In some instances, even in the absence of overt functional impairment, a child that approaches (but does not exceed) a diagnostic threshold, may be equally at risk (Costello et al, 1999). These findings converge with those from other studies that highlight the negative implications of functional impairment even in the absence of diagnosis (Angold, Costello, Farmer, Burns & Erkanli, 1999; Gotlib, Lewinsohn & Seeley, 1995).

Classification is further complicated by high rates of comorbidity and blurred distinctions between childhood disorders (Hinden, Compas, Howell & Achenbach, 1997; Kazdin & Marciano, 1998; Mental Health Commission, 1998). For example, anxiety and depression, which are frequently comorbid, also overlap to some degree in symptomatology (Anderson & McGee,1994; Brady, 1998; Hinden et al, 1997; Maubach, 1999). This is true for children more so than for adults and can lead to diagnostic confusion (Frick & Silverthorn, 2001; Werry, 1992).

An implication of this discussion is that each child is bound within a unique context from which extrication of meaning can be difficult and confounded. Despite a growing body of research, albeit predominantly in controlled settings, the assessment and treatment of child psychopathology remains an inexact science. Consequently, the lifetime risks associated with early childhood disorder render the systematic pursuit of knowledge in this area to be a critical endeavour.

To provide a context, prevalence rates and typical trajectories of childhood disorders are now outlined.

Prevalence of Child and Adolescent Mental Health Problems

The following outline of prevalence in child psychopathology is presented against the background of diagnostic reliability and validity problems described in the previous section.

Based on a collection of international studies, overall prevalence rates for child psychopathology are estimated to lie in the range of 9-21% for preschoolers, 9-22% for school age children and 18-22% for adolescents (Frick & Silverthorn, 2001). These figures differ according to sex, age, type of disorder and, as implied earlier, according to the assessment approach that is used (Costello, 1999). Also of note is the finding that significantly more children meet the diagnostic criteria for a clinical diagnosis in the population than there are children receiving treatment in mental health services (Costello & Angold, 1995).

After respiratory disease and intellectual disability, mental illness is listed by Newacheck & Halfon (1998, 1999) as the most disabling childhood condition. In turn, four of the world's most disabling adult diseases: unipolar depression; schizophrenia; bipolar disorder; and obsessive-complusive disorder, are known to frequently originate during these formative years (Christie et al, 1988; Murray & Lopez, 1996). The immediate and life-time implications of these and other serious emotional disorders are extensive and debilitating (Costello, 1999; Murray & Lopez, 1996).

New Zealand Child and Adolescent Mental Health

In New Zealand, youth aged 15-19 years have a higher proportional rate of mental health problems than any other group (Mental Health Commission, 1998). Although constituting only 7% of the population, they acount for a relatively high 11.9% of those requiring treatment for mental illness. Of the 23% of the population who are children from 0-14 years of age, 14.2% of them have a mental illness that requires intervention (Mental Health Commission, 1998).

The Dunedin Multidisciplinary Health and Development Study (DMHDS) has achieved much in explicating age and gender based prevalence rates of disorder for children and youth in New Zealand. Based on a cohort of Dunedin-born participants, this longitudinal

study is limited in that the sample does not represent all demographic groups within New Zealand. Results may therefore fail to accurately reflect prevalence rates, particularly where Maori and Pacific People are concerned (McGee et al, 1995). Findings are highlighted below.

Mental Health During the Preschool Years

A recent DMHDS study reports that 22.5% of children aged between 2.5 and 5 years have behavioural problems (Pavuluri, Luk, Clarkson & McGee, 1995). At age 3 years, 11% of this sample were identified as exhibiting hyperactive or shy-inhibited behaviours, or were described by parents as being difficult to manage. No gender differences were found. By the age of 15 years, 75% of these children met the criteria for a mental disorder during at least one follow-up contact and demonstrated ongoing cognitive and academic difficulties (McGee et al, 1995). These findings are consistent with the assumption that, although typically referred for treatment at age 7-9 years, the onset of attention deficit disorder (ADD) and other difficulties tends to occur in early childhood or infancy, often before the age of 4 years (McGee et al, 1992). Preschool hyperactivity was associated with both internalising and externalising problems in later adolescent years. Inhibition and withdrawal predicted future internalising disorders, although this relationship was true only for girls (Caspi, Henry, McGee, Moffitt & Silva, 1995; McGee et al, 1995).

Mental Health During the School Years

Significant behavioural differences across age and sex are frequently reported for children of school age (McGee & Feehan, 1991; McGee et al, 1995; Rutter, 1984). Differing informant views shed doubt on the reliability of prevalence data in this population (Costello, 1999). Applying the criteria of either consensus between multiple informants or consistency over time by one source, McGee and colleagues (1995) report that 23% of boys and 12% of girls aged 5-9 years in the Dunedin sample presented with problematic mental health. In turn, 39% of these children continued to exhibit diagnosable problems during the pre-adolescent and adolescent phases.

At preadolescence (11-13 years of age), boys were twice as likely to present with a mental illness (Anderson, Williams, McGee & Silva, 1987). There was evidence of continuity between pre-adolescence and adolescence for boys and girls with externalising and internalising behaviours respectively (McGee, Feehan, Williams & Anderson, 1992).

Interestingly, internalising 11 year old boys frequently re-presented at age 15 with an externalising disorder (McGee & Williams, 1988).

Available data pertaining to the continuity of disorders during the pre-adolescent to adolescent phase is complex. However, four generalisations regarding findings from the Dunedin sample are possible. First, girls were more likely to present with a diagnosable disorder at the age of 15. Second, the rate of mental illness among girls increased during adolescence (McGee et al, 1995). Third, 56% of those identified with a disorder at age 15 had presented with a mental health problem at a previous developmental stage (McGee et al, 1995). Finally, the presence of a mental health problem during childhood was predictive of mental illness in boys at age 15 years (McGee et al, 1992).

Given these findings, it is of particular concern to note the lack of service access in New Zealand. Although the Ministry of Health aims to provide service access for 3% of children from 0 - 19 years, access rates in 1998 were only 0.7% (Mental Health Commission, 1998). In addition, although a wide range of treatment approaches are in use (Fergusson, Horwood & Lynskey, 1997), there is relatively little published data concerning the nature and effects of treatment available for children and young persons in New Zealand.

Major developments and findings in child and adolescent psychotherapy outcome literature are now reviewed.

CHAPTER TWO

Review of Child and Adolescent Psychotherapy Outcome Literature

In tracing the recent history of child psychotherapy research, evidence of the age-old tension between science and humanity abounds. From the somatogenesis of Hippocrates then Kraeplen, to the demonology of the dark ages and psychogenesis of Mesmer, humankind has searched for ways to first explain, then treat mental illness (Davison & Neale,1997; Freedheim, 1992). Through the marriage of empiricism and philosophy, psychology was born, underpinned by a continual struggle between the oft-opposing forces of science and humanity (Riger, 1992). It is with this struggle as backdrop that the following review of psychotherapy research with children and adolescents is undertaken.

The trend toward evidence-based practice is first discussed. This is followed by an overview of findings from empirical studies to date. In particular, the finding that behaviourally-based therapies produce the best results with children and adolescents, is highlighted. Methodological and conceptual developments which underlie research-practice tensions are introduced here for fuller discussion in a later chapter.

The Emphasis on Evidence-Based Practice

In their review of child psychotherapy research since 1963, Barrnett and colleagues (Barrnett, Docherty & Frommelt, 1991) describe research as having taken place along two independent pathways: through anecdotal description of therapeutic interventions and through controlled treatment-outcome studies. In recent decades, societal and fiscal forces have played a significant role in propelling forward the empirical line of inquiry. With well over 230 psychotherapies in existence (Kazdin, 1994), it is not surprising that funding agencies have demanded evidence supporting the relative efficacy of treatments (Burns, Hoagwood & Mrazek, 1999; Goldfried, 2000; Hoagwood et al, 1995).

Empirical validation of psychological therapies is not therefore merely an academic pursuit. It is critically important to the future of psychology. That evidence be scientifically bound is necessary, not simply to satisfy political, academic and fiscal expectation, but to ensure accountability and evidence-based practice among clinicians (King & Ollendick,

1998). Indeed, the scientist-practitioner model is a foundational concept in the history of clinical psychology (Davison, 1998; Evans, 2000) and the development of psychology in general (Belar & Perry, 1992). As discussed below, the degree to which this ideal is manifest in reality is the subject of ongoing debate. Therefore, in view of the importance of science to the continuing development of practice, it is the empirical line of inquiry that is reviewed here.

Early Psychotherapy Reviews

The field of psychotherapy for children and adolescents has undergone considerable development over the last half century (Freedheim, 1992; Parry-Jones, 2001). Initially considered a mere extension of adult psychology (Barrett, Hampe & Miller, 1978), the child and adolescent mental health arena has grown and emerged as a discrete and specialised domain (Davids 1975; Kendall & Morris, 1991; Parry-Jones, 2001).

Attention was first drawn to the then small body of child outcome literature in 1957 when, following in Eysenck's footsteps, Levitt compiled two reviews of first 18, then 22 psychotherapy outcome studies (Levitt, 1957, 1963). Findings suggested that psychotherapy, when compared with no treatment at all, had a generally negligible if not negative effect on improvement rates across disorders in this population. The reviews generated considerable debate and brought a number of methodological issues to the fore (Kazdin, 1994).

Subsequent empirical developments remained slow in comparison to those of adult therapy outcome investigation in which more definite conclusions as to the general efficacy of psychotherapy were being proposed (Barrett et al, 1978; Smith, & Glass, 1977). The extent to which findings based on reviews of studies with adult populations could be extended to children and adolescents, was indeterminable (Casey & Berman, 1985).

Reviews by Heinecke and Strassman (1975), Wright and colleagues (Wright, Moelis & Pollack, 1976) and Tramontana (1980) followed, progressively highlighting areas for improvement. In particular, design issues such as the need for increased control through the use of explicit inclusion and exclusion criteria, careful baseline and outcome monitoring, and prudent selection of candidates, were discussed. In the context of these

limitations, however, general claims as to the overall efficacy of psychotherapy with children and adolescents were beginning to be made (Tramontana, 1980; Wright et al,1976).

Parallel investigations with an emphasis on process issues were concurrently taking place. For example, Heinecke and Strassman (1975) questioned the utility of pursuing the general question of psychotherapy effectiveness, proposing instead a more specific focus on the impact of process variables on outcome. In 1978 a review led by Barrett (Barrett et al, 1978) explicitly rejected the generic question of efficacy. They revisited the question initially posed by Paul (1967) as to "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" (p. 111), highlighting this as a more appropriate point of inquiry. This emphasis was further supported byTramontana in his 1980 review of the previous decade's adolescent therapy outcome literature (Tramontana, 1980). Research comparing the disorder-specific effects of various treatments had already begun (Goldfried & Wolfe, 1998). However, support for an even more idiosyncratic approach, accounting for the specific influences of therapist, treatment and client variables was accumulating.

The subsequent years were marked by a number of significant, complementary advancements. First, the introduction and refinement of the clinical trial for evaluating psychological therapies and second, the use of statistical techniques through meta-analysis, to facilitate large-scale reviews of outcome studies. A third, related development (discussed more in a later section) was the establishment of the American Psychology Association Task Force on Effective Psychosocial Interventions (Task Force, 1995). This formalised a route for generating and critically reviewing empirically supported interventions for individuals across the lifespan. Finally, resources such as the Cochrane collaboration reviews were established to disseminate knowledge of empirically tested therapies to practitioners in the field.

Later Psychotherapy Reviews

Casey and Berman (1985) were the first to apply meta-analysis to the evaluation of child therapy outcome studies. They found psychotherapy in general to be more beneficial than no treatment at all, producing effect sizes comparable to those found in adult therapy outcome studies. However, unlike conclusions based on results from adult research

(Wampold, Mondin, Moody, Stich, Benson & Ahn, 1997), they also found that behavioural therapies produced greater effect sizes than non-behavioural. This finding was qualified by the use of outcome measures similar in nature to activities required within the treatment itself (Kolko, Brent, Baugher, Bridge & Birmaher, 2000; Weisz, Weiss, Alicke & Klotz, 1987). Nevertheless, two succeeding meta-analyses using improved methodology, produced progressively rigorous support (Weisz et al, 1987; Weisz, Weiss, Han, Granger & Morton, 1995). A subsequent string of meta-analytic and qualitative reviews provided further evidence both in terms of the general efficacy of psychotherapy (Hoag & Burlingame, 1997; Kazdin, 1997; Prout & Prout, 1998) as well as the superiority of behavioural over non-behavioural treatments (Prout & Prout, 1998; Weiss & Weisz, 1990; Weiss & Weisz, 1995a; Weisz & Weiss, 1995b; Weisz, Weiss et al, 1995). These findings were not without rebuttal (e.g. Shirk & Russell, 1992), including concerns over the quality of non-behavioural studies reviewed in meta-analyses.

Meta-analysis is limited by the methodological quality of outcome studies included for analysis (Crits-Christoph, 1997; Kazdin & Weisz, 1998; Pearsall, 1997; Shadish & Sweeney, 1991). Studies included in meta-analyses such as those previously listed have been criticised on these grounds (Shirk & Russell, 1992; Weiss & Weisz, 1990). In the case of non-behavioural treatments, both the quantity and quality of available studies are problematic (Barrnett, 1991). For example, Weisz and colleagues (1987, 1995) noted a dearth of controlled non-behavioural studies available for review. Only 10% of studies included in their 1995 meta-analysis had used non-behavioural treatments.

Further, a review of the non-behavioural / non-cognitive-behavioural child therapy outcome literature by Barrnett and colleagues (1991) lamented the abundance of methodological flaws in their sample of 43 outcome studies (Barrnett et al, 1991). They concluded that child non-behavioural therapy outcome research at that time remained inferior both to parallel developments in the adult arena as well as to parallel behavioural investigations in child psychotherapy research. They were unable, on the basis of available evidence, to make definite conclusions as to the efficacy of non-behavioural child psychotherapy.

Similar concerns were reported in a subsequent review of non-behavioural studies conducted by Shirk and Russell (1992). In addition, these authors posed investigator allegiance as a potential contributor to the possibly erroneous effect sizes underlying the

superior behavioural therapy effects (Robinson, Berman & Neimeyer, 1990). Considerable debate followed these reports (Shirk & Russell. 1992; Weisz, Weiss et al, 1995; Pearsall, 1997), with further calls for improved methodological quality in all studies and the inclusion of only superior studies in meta-analytic reviews (Shirk & Russell, 1992, 1995; Weiss, Catron, Harris & Phung, 1999; Weiss & Weisz, 1995b). Although the evidence lies in their favour, whether or not behavioural treatments are more effective than their non-behavioural counterparts remains the subject of ongoing debate. This is discussed further in a later chapter.

Based on the medical model, introduction of the randomised clinical trial in the 1980's marked to some, the methodological gold standard in scientific psychological inquiry, elevating standardisation in psychotherapy outcome research to a level not previously seen (Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999; Persons & Silberschatz, 1998). This new methodological rigour required the use of categorical, for example *DSM-IV* (1994), diagnoses to clearly define and target problems; the random assignment of participants to treatment groups; the use of treatment manuals and therapist adherence monitoring to implement theoretically pure therapies; and the use of fixed treatment time limits (Goldfried & Wolfe, 1998). Such techniques have markedly improved the internal validity of treatment-outcome studies (Kazdin, 1997).

However, along with these developments, the long-standing debate over external validity and the widening gap between psychotherapy research and practice with children and adolescents was re-ignited. This is now discussed.

CHAPTER THREE

The Research-Practice Gap

Despite the numerous significant advances made since Levitt's first critical review, the utility of current knowledge as a basis for determining the best treatment for a given client with a particular problem in a specific set of circumstances, cannot be assumed (Kazdin, 1997; Kazdin & Weisz, 1998). Indeed, whether or not research findings have any validity or utility for the therapist and client facing real-world problems, is a much pondered question. For example, the generalisability of findings is questioned on the basis that controlled outcome studies are frequently unrepresentative of therapy as it occurs in clinical practice. This argument refers to characteristics such as the types of clients, therapists, treatments and conditions that are used in research. It extends also to the focus on the treatment modality that occurs to the exclusion of other important process and outcome variables, in many outcome studies. In addition, the utility of findings based on group averages for therapists facing the complexities of idiosyncratic case management is a further point of contention. Finally, the degree to which knowledge is communicated reciprocally between the research and practice communities appears inadequate. These manifestations of the research-practice gap are discussed below.

1. The Ecological Validity of Research FIndings

Many argue that the clients, therapists, treatments, and parameters of treatment-outcome studies differ so substantially from those found in clinical practice as to render their findings useless as a guide for treatment (Goldfried & Wolfe, 1998; Kazdin, Bass, Ayers & Rodgers, 1990; Kazdin & Weisz, 1998; Persons & Silberschatz, 1998; Weisz, Donenberg, Han & Weiss,1995b).

Clients versus Research Participants

Although certain participant characteristics such as age, sex and the range of disorders often reflect those that typically occur in practice, other diffferences outweigh the similarities (Weisz, Donenberg, Han & Kauneckis, 1995a; Weisz et al,1995b). For example, whereas clients are typically referred to or actively seek a particular treatment, research participants tend to be randomly assigned (Weisz et al, 1995b). Study participants often differ from their clinical counterparts (Persons & Silberschatz, 1998),

with the former being selected for homogeneity on a single diagnosis, and the latter frequently presenting with multiple comorbid conditions and more severe pathology (Kazdin, Bass et al, 1990; Kendall & Southam-Gerow, 1995; Weisz et al, 1995a; 1995b). Client expectancy may also differ between the two settings with study participants having sought or been recruited to a specialised research setting and consequently holding greater hope of recovery (Kendall & Southam-Gerow, 1995).

Clinic versus Research Interventions

The types of treatment and their delivery also differ between research and practice. In research, treatment interventions are highly structured, manualised and time-limited, usually taking place over a period of 8-10 weeks (Kazdin, Bass et al, 1990). On the other hand, clinic-based interventions tend to be flexible, continuing for anywhere up to 55 weeks or until the client no longer requires therapy (Kazdin, Siegel & Bass, 1990; Silver & Silver, 1983). In research, therapies are usually pure-form and are frequently cognitive or behavioural in orientation (Kazdin, Siegel & Bass, 1990; Kazdin, Bass et al, 1990). While these two modalities are often used in practice, research fails to represent the wider range of approaches such as family, psychodynamic and eclectic therapies that are commonly subscribed to by clinicians (Crits-Christoph, 1997; Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Silver & Silver, 1983; Tuma & Pratt, 1982) Further, group treatment approaches typically used in research are rare in practice where individual or family psychotherapy is more usual (Kazdin, Siegel & Bass,1990; Koocher & Pedulla, 1977). Similarly, consultation with parents and teachers is common in clinical practice, but until more recently, absent in most child and adolescent therapy outcome studies (Kazdin, Bass et al, 1990).

Clinic versus Research Therapists

Along with clients and treatments, the characteristics of therapists also vary between research and practice. Research therapists often receive intensive preliminary training, with their interventions then closely monitored for treatment integrity (Addis, 1997; Kendall & Southam-Gerow, 1995). Neither of of these practices is typical in a clinical setting. Furthermore, exposure to the research environment and shelter from the time and fiscal restraints of the practice setting may engender motivation and enthusiasm beyond that which is realistic in the latter context (Kendall & Southam-Gerow, 1995).

Wholisitc versus Unidimensional Outcome Assessment

The research participant's progress and outcome in therapy is typically monitored through standardised pre and post treatment assessment regimes (Kendall et al, 1999): a practice not necessarily adhered to in clinical work (Kendall & Southam-Gerow, 1995). For better or worse, clinical judgement often takes precedence over scientific markers in practice (Beutler, 2000a), especially where the two diverge (Garb, 1998). However, when formal clinical assessment does take place, it differs from what occurs in the majority of outcome studies. For example, Kazdin and colleagues found that of 223 studies taken from over 19 years of articles, only 12.6% attempted to measure clinically significant therapeutic change (Kazdin, Bass et al, 1990). They further noted that data was typically derived from either an independent observer or from the child him or herself. Parents and teachers, the most commonly consulted informants in clinical practice, were conferred with in less than 30% of studies (Kazdin, Bass et al, 1990).

The goals of outcome evaluation in research also appear to differ from those of the practising clinician, with the latter seeking evidence of overall functional improvement and the former, a reduction in symptoms (Hoagwood, Jensen, Petti & Burns, 1996; Kendall & Morris, 1991;Persons & Silberschatz, 1998; Silverman, 1996). This is particularly relevant given the controversy discussed earlier, over diagnostic thresholds for disorders in the child and adolescent population (Hinden et al, 1997; Kazdin & Weisz, 1998). When viewed in isolation, symptoms represent just one dimension of a child's psychological well-being, yet researchers frequently focus on such singular parameters of interest when assessing outcome (Phillips, Hargis, Kramer, Lensing, Taylor, Burns & Robbins, 2000).

Finally, outcome studies rarely assess longer term client progress following termination of treatment (Chambless & Hollon,1998). Although the extent to which follow-up occurs in practice appears largely unknown, information regarding long term and sleeper effects could prove invaluable to practising therapists (Chambless & Hollon, 1998; Kazdin, 1994).

2. Group-Derived, Treatment - Focused Research Findings

"There are no main effects, only interactions." (Horvath, 1989, cited in Hubble, Duncan & Miller,1999).

The Focus in Research on Treatment as the Primary Outcome Predictor

A second contributor to the so-called gap between research and practice lies in the tendency within child and adolescent treatment-outcome research to focus on treatment as the primary outcome predictor (Kazdin, 1994; Kazdin, 1997; Kazdin, Bass et al, 1990). This trend opposes the natural inclination of the practising clinician for whom a variety of other client, contextual, family, social and therapist factors hold similar if not increased weight (Kazdin, Siegel & Bass, 1990; March & Curry, 1998). Such a focus denies both clinician and researcher of complex answers to complex clinical questions (Beutler, Williams & Wakefield, 1993; March & Curry, 1998), such as "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" (Paul, 1967, p. 111). Recent trends, such as manualisation , have further cemented technique as the core ingredient in therapeutic change (Silverman, 1996). However, not all evidence supports an hypothesis in which treatment is the primary outcome predictor (Garfield, 1998; Norcross, 1995).

First, despite its considerable advantages, the RCT approach to outcome research lacks the sensitivity to detect differential effects of treatment on clients (Addis & Jacobson, 1996). The large within-subject differences that are frequently found within a single study, along with the effect of averaging results across randomly assigned participants, render conclusions misleading with respect to individual treatment response (Addis & Jacobson, 1996; Beutler, Engle, Mohr, Daldrup, Bergan, Meredith, & Merry, 1991). The designs common to many RCTs provide no guarantee that it is the effect of treatment as opposed to for example, the impact of differences between therapists, that is being measured (King, 1998; Shapiro et al, 1995).

Second, when asked to report the influence of a variety of different client, therapist and treatment variables on outcome, practitioners tend to rate treatment as one of the least influential (Kazdin, Siegel & Bass, 1990).

Finally, in a break down of factors influencing therapeutic change, Lambert (Asay & Lambert, 1999) estimates that technique contributes to no more than 15% of the overall therapeutic effect, whereas extratherapeutic factors and client variables, the therapeutic relationship, and placebo effects, are attributed 40, 30 and 15 percent, respectively. These components are frequently referred to as common or non-specific factors which can occur regardless of therapeutic method, to effect or impede therapeutic change (Hubble et al, 1999).

The incongruity between the centrality of treatment in research versus practice is further amplified when dealing with children whose developmental dynamism underscores increased heterogeneity in their population (Kazdin & Weisz, 1998). Thus, explicating meaning from group-derived, treatment-focused research findings poses a significant challenge to researchers and therapists alike. However, increasing attention is being paid to specific client by treatment interactions as well as to non-treatment related outcome predictors.

Disorder-Specific Treatment Interventions

The global question of psychotherapy effectiveness has, in the last few decades, been surpassed by the quest to identify specific treatments for specific problems (Chambless & Ollendick, 2001). Propelled by the criterion of treatment specificity as outlined by the Task Force for empirically supported therapies (Task Force, 1995), a large number of studies supporting treatment-specific effects have emerged (Kazdin & Weisz, 1998). For example, RCTs meeting requirements as set out in Chambless and Hollon's 1998 system (Chambless & Hollon, 1998), have demonstrated cognitive behavioural therapy (CBT) to be effective in treating childhood anxiety. Likewise, although receiving less attention in research, children and adolescents with depression have been found to benefit from coping skills training (CST). Third, a number of methods including CBT, parent management training (PMT), multisystemic therapy (MST), problem solving skills training (PSST) and functional and structural family therapy have received empirical support for their part in reducing aggression and antisocial behaviours in children with conduct and disruptive disorders (Chambless & Ollendrick, 2001; Kazdin & Weisz, 1998). Finally, problems ranging from distress due to medical procedures, through to elimination disorders, pervasive developmental disorders and a variety of somatic concerns such as recurrent headaches and abdominal pain, have all been shown to benefit from specific cognitive behavioural and behavioural interventions (Chambless & Ollendick, 2001;

Kazdin & Weisz, 1998). Biofeedback, self-hypnosis and thermal biofeedback have also gained empirical support for their beneficial effects on somatic complaints (Chambless & Ollendick, 2001).

Non-Treatment Related Outcome Predictors

The shift in emphasis from investigating global to disorder specific effects in psychotherapy, although not wholeheartedly supported (Garfield, 1998), is viewed by many as progressive (Asay & Lambert,1999). This is especially so in the child and adolescent outcome literature where a stronger case against the equality of all therapies, exists (Weisz, Weiss et al, 1995). However, treatment by disorder relationships are but one of the numerous possible interactions that may occur between intervention and outcome in therapy (Norcross & Rossi, 1994). The additional role that other client, therapist and contextual factors play in moderating treatment outcome , whilst not a new concept (Rosenzweig, 1936), is increasingly acknowledged (Hubble et al, 1999). Many experts are calling for a move away from the use of diagnoses as the uniform inclusion criterion and from the use of manuals as the standard for treatment administration. Neither of these representations is congruent with the idiosyncratic case management required in clinical practice (Beutler, 1997) nor with much of psychotherapy theory (Arkowitz, 1992; Persons, 1991).

Despite growing interest, research investigating systematic interaction effects among client, therapist, contextual, treatment and process variables has been slow to develop (Addis & Jacobson, 1996; Hayes, Castonguay & Goldfried, 1996). Historically, research in this area has typically been retrospective, non-theoretically based and has failed to adequately tease apart the myriad of possible treatment by client by therapist by context interactions (Beutler et al, 1991; Dance & Neufeld, 1988; Greencavage & Norcross, 1990; Hayes et al, 1996; Norcross & Rossi, 1994). Further, the bulk of research has focused on effects with adult populations. However, as both quality and quantity of research in the area accrue (March & Curry, 1998), a number of notable findings and directions for future research are emerging. These are presented below.

Therapist Influences on Outcome

Among the qualities that therapists bring to their practice, the effects on outcome of variables such as experience level, personality, age, gender, theoretical orientation, professional training, expectations for improvement, psychological mindedness, level of

directiveness, flexibility, self-disclosure, and the ability to demonstrate warmth, empathy and genuineness, have been subject to investigation (Bergin & Garfield, 1994; Berman & Norton, 1985; Jennings & Skovholt, 1999; Morris & Nicholson, 1993). In addition, specific therapist interventions such as the effects of exploratory versus information gathering assessment techniques (Gaston & Ring, 1992; Kivlighan, 1990), the use of biological interventions (Blatt, Sanislow, Zuroff & Pilkonis, 1996) and the use of transference interpretations (Jacobs & Warner, 1981) have been scrutinised. However, few of these studies have specifically addressed child populations.

In many cases, such characteristics have been found to beneficially impact outcome. For example, therapists who are psychologically minded, who avoid the use of biological interventions and who expect longer outpatient response to treatment, may be particularly effective in the treatment of depression (Blatt et al, 1996).

In other instances findings have proved less fruitful. For example, few studies have consistently found significant differences in outcome across levels of therapist experience (Christensen & Jacobson, 1994). However, some indirect relationships have been found. For example, investigations into high versus low therapist directiveness (Beutler et al, 1991) have shown possible interactions with specific client characteristics such as emotional experiencing, ego strength and pretreatment motivation (Shoham-Salomon & Hannah, 1991; Wiser & Goldfried, 1998). However, as will be discussed in the context of client factors below, this line of research has been hampered by methodological limitations (Dance & Neufeld, 1988).

At the heart of the common factors debate lies the issue of therapist theoretical orientation. There endures among many therapists a powerful drive to claim allegiance to a particular theoretical paradigm or technique (Asay & Lambert, 1999; Wogan & Norcross, 1985). More recently however, underpinned by support for the common factors approach, increasing allegiance to theoretical integration and technical eclecticism has emerged (Greencavage & Norcross, 1990; Norcross, 1996).

As alluded to earlier, progress in identifying and integrating common factors has been slow and not well organised (Patterson, 1989). In an atttempt to draw findings from research on therapist factors together, Greencavage and Norcross (1990) reviewed 50 studies from 1936-1989. They found that 24% of authors believed "...beneficial therapist

qualities..." (Greencavage & Norcross, 1990, p. 374), such as therapist ability to cultivate hope and to demonstrate warmth, positive regard, acceptance and empathy, to be common across all psychotherapies. Other studies have identified attributes that are consistently associated with good outcomes such as therapist emotional health; belief in the working alliance; ability to draw on accumulated experience; voracious learning; and the tendency to value cognitive complexity (e.g. Goldfried, Raue & Castonguay, 1998; Jennings & Skovholt, 1999).

However, the so-called 'therapist as hero' dogma has lead at times to a skewed perspective (Bachelor, 1995). For example, client insight has been operationalised as 'provision of insight' by the therapist in some research settings (Tallman & Bohart, 1999). While specific conditions and interventions may aid in facilitating growth, it is the client him or her self who must actually 'do' the work (Bohart & Tallman, 1999). In fact, evidence suggests that the more therapists access and rely on a client's own resources, the more likely it is that positive change will occur (Bergin & Garfield, 1994).

Notable here is the finding that therapeutic progress can take place without the assistance of a professional therapist (Christensen & Jacobson, 1994; Gould & Clum, 1993). Spontaneous recovery is known to occur in a significant proportion of individuals (Tallman & Bohart, 1999). In addition, many studies have found that in certain conditions, the effects of paraprofessional and self-help techniques such as bibliotherapy and talking with a friend, are comparable to or greater than those gained through professional intervention (Berman & Norton, 1985; Christensen & Jacobson, 1994; Gould & Clum, 1993). Results such as these shed doubt on the essential role of the psychotherapist. Indeed, evidence supports the possibility that change is both initiated and maintained by the client (Lawson, 1994), a prospect that centralises the client, as opposed to the therapist and his or her approach, as a core ingredient in outcome research. Again, few of these findings address exclusively child or adolescent populations.

Client Influences on Outcome

With the exception of client disorder, the client appears to have been understudied as an active component in treatment (Greencavage & Norcross, 1990). Studies investigating client-related child and adolescent outcome predictors are often based on inpatient samples only (Blotcky, Dimperio & Gossett, 1984; King, Hovey, Brand & Ghaziuddin, 1997; Pfeiffer, Strzelecki, 1990; Phillips et al, 2000).

However, in their review of studies published between 1970 and 1999, Phillips and colleagues (Phillips et al, 2000) reported a surge of research investigating adolescent outcome predictors over the past decade. They found client diagnosis, comorbidity, gender, age at intake, previous treatment and cognitive ability to be variously related to outcome. Contrary to some expert opinion, duration of illness was not found to predict outcome. On the other hand, some factors commonly believed to influence treatment success such as a client history of sexual or physical abuse, had not been studied at all.

A number of other reviews and studies have found an additional array of client factors to be correlated with treatment outcome across a variety of age groups and disorders. These include variables such as social impairment, pretreatment level of disturbance, level of motivation, initial and ongoing expectation for improvement, openness to the therapy process, capacity to relate, active involvement, ego strength, psychological mindedness, focality, clarity of goals, intelligence, reading achievement, academic or school functioning, and response to trial treatment (Jones, Cumming & Horowitz, 1988; Jayson, Wood, Kroll, Fraser & Harrington, 1998; Kazdin & Crowley, 1997; Lambert & Anderson, 1996; Lawson,1994; March & Curry, 1998; Piper, Joyce, Azim & McCallum, 1998; White, Moffitt & Silva, 1989).

However, the method and designs used in this area of research are frequently flawed (Phillips et al, 2000). First, many factors considered by clinicians as crucial to outcome, such as a history of abuse, are not represented in the studies reviewed. Second, relationships between outcome predictors and specific disorders are rarely examined. Finally, predictor - outcome relationships are commonly measured in a single domain, leaving the effects on other outcome indicators largely unexplored.

In addition to their individual influences, client and therapist may also interact in ways that impact outcome . Although its exact role remains unclear, the therapeutic relationship, now generally referred to as the therapeutic alliance, has consistently emerged as one of the most crucial outcome predictors in psychotherapy (Barber,Connolly, Crits-Christoph, Gladis & Siqueland, 2000; Hilliard, Henry & Strupp, 2000; Horvath, 1994; Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins & Pilkonis, 1996). Not surprisingly, it may be the client's and not the therapist's perception of the quality of this relationship that best predicts treatment success (Krupnick et al, 1996; Luborsky, 1994).

Therapeutic Alliance: Influence on Outcome

Research into the therapeutic alliance with children has lagged behind that of adult psychotherapy (Morris & Nicholson, 1993). However, both clinicians and researchers attribute considerable import to the client-therapist relationship in effecting therapeutic change (Bachelor & Horvath, 1999; Morris & Nicholson, 1993; Quinn, Dotson & Jordan, 1997). Research in this area has progressed from investigating global alliance effects to looking at more specific influences of pretreatment variables on the alliance (e.g. Mallinckrodt, Gantt & Coble, 1995; Paivio & Bahr, 1998) and finally, to exploring increasingly more complex networks of relationships between alliance and outcome (Hilliard et al, 2000; Horvath & Luborsky, 1993).

The success of the alliance depends not only on the individual characteristics that therapist and client bring to therapy but also on compatibility between the two (Beutler, Machado, & Allstetter-Neufeldt, 1994; Shoham-Salomon & Hannah, 1991). Factors researched in this regard include demographic variables such as therapist-client similarity in gender, age, ethnicity and socioeconomic situation (Beutler et al, 1994; Hill, 1975). Neither similarity in age nor gender have consistently been found to significantly influence outcome (Bachelor & Horvath, 1999; Luborsky, 1983). Similarly, studies investigating likeness in socioeconomic situation have elicited mixed results (Garfield, 1994). On the other hand, shared cultural values, common goals and complementarity between therapist and client have been shown in some studies to impact treatment success (Bachelor & Horvath, 1999; Beutler et al, 1994; Bordin, 1994).

In addition, the client brings to therapy a number of other attributes which may have some influence on development of the therapeutic relationship. These include such characteristics as: the ability to trust others and form positive, intimate relationships outside of therapy; the ability to collaborate, self-explore and engage in therapy; level of openness or defensiveness and hostility; quality of emotional experiencing; willingness to participate in the therapetuic relationship; level of social adjustment; overall psychological distress; and personality type (Bachelor & Horvath, 1999; Gelso & Carter, 1994; Horvath & Luborsky, 1993; Kokotovic & Tracey, 1990; Muran, Segal, Samstag & Crawford, 1994; Paivio & Bahr, 1998).

Therapist characteristics that may influence the alliance include: the use of various types of interventions (Gaston & Ring, 1992; Kivlighan, 1990); capacity to embody the Rogerian

principles of empathy, warmth and genuine acceptance (Beutler et al, 1994; Lafferty, Beutler & Crago, 1989; Peschken & Johnson, 1997); and the ability to match personal attitude and style to each client's individual needs (Beutler et al, 1991).

Contextual Influences on Outcome

In view of the relationship between contextual factors and the development of mental health problems in children (e.g. Beardslee & Podorefsky, 1988; Erickson, 1998; Farrell & White, 1998; Feehan, McGee, Stanton & Silva, 1991; Fendrich, Warner, Weissman, 1990; Forehand, Miller, Dutra & Chance, 1997; Greenberger, Chen, Tally & Dong, 2000; Holmes, Yu & Frentz, 1999; Rey, Walter, Plapp & Denshire, 2000) it seems likely that psychosocial, family and environmental factors may also impact a client's ability to change through therapy. Nevertheless, there appears to be a relative dearth of research specifically aimed at identifying contextual influences on therapy outcome in this population (Phillips et al, 2000).

In the studies reviewed by Phillips and colleagues (2000), treatment outcomes were found to correlate variously with family structure, family functioning, problematic parent-child relationships and family members' psychological and social functioning (Emslie, Rush, Weinberg, Kowatch, Carmody & Mayes, 1998; Goodyer, Herbert, Tamplin, Secher & Pearson, 1997; King, Hovey, Brand & Ghaziuddin, 1997; Parmelee, Cohen, Nemil, Best, Cassell & Dyson, 1995). However, other environmental factors strongly believed or shown to influence the development of problem behaviours in youth such as poverty, residential instability, community violence, exposure to domestic violence and physical and sexual abuse (Durbin, Klein,& Schwartz, 2000; Erickson, 1998; Lanktree & Briere, 1995) were either not studied or yielded indeterminate results (Farrell & Bruce, 1997; McCauley, Myers, Mitchell, Calderon, Schloredt & Treder, 1993; Phillips et al, 2000).

Other studies have identified quality of peer relationships and level of social support as possible outcome predictors (Goodyer, Germany, Gowrusankur & Altham, 1991; Kokotovic & Tracey, 1990). Similarly, maternal pathology has been found to differentially predict outcome across disorder and treatment type (e.g. Brent et al, 1998). Some factors may have an indirect effect on outcome such as the impact of a child's behavioural problems on a family's ability to help-seek and to continue in treatment (Farmer & Burns, 1997; Kazdin, Holland & Crowley, 1997).

Treatment Influences on Outcome

Although technique has traditionally claimed 'centre stage' in research as the primary predictor of outcome, the range and breadth of research in this area is increasingly focused on a narrow set of therapies.

In recent child and adolescent psychotherapy reviews, Kazdin (1994; Kazdin & Marciano, 1998; Kazdin & Weisz, 1998) advocates that a greater range and combination of therapies be rigorously studied so that the empirical basis for therapy development might be widened. That the onus of such inquiry should fall on the champions of less validated therapies is a frequent proposal (Kendall, 1998). Indeed, were research an isolated individual pursuit, separable from its relationship to practice, this might be a viable suggestion. However, the responsibility to investigate and validate all therapies commonly used in practice, arguably lies with all who share a concern for child mental health (Roth Fonagy, Parry, Target & Woods, 1996). This issue is discussed further in a later chapter.

3. The Relationship Between Researcher and Therapist Practitioner

Research-practice comparisons such as those presented earlier beg the question: what, if anything, do practising psychotherapists stand to learn from controlled therapy outcome studies? Fuelled by the manifold disparities between research and practice, many respond that experimental research offers nothing to the clinician, speaking only to other researchers (Goldfried & Wolfe, 1996). This sentiment is supported by the common finding in research that clinicians generally remain uninfluenced by science, are uninterested in research (Goldfried & Wolfe, 1996; Weisz et al 1995b) and in some academic opinions, that they may lack the expertise to decipher scientific reports (Kendall & Southam-Gerow, 1995). Although such beliefs may be held by researchers, contrary findings suggest that practitioners do in fact seek and use scientific information, albeit different in quality from the type of knowledge most valued by researchers (Beutler et al, 1995; Beutler, Williams Wakefield & Entwistle, 1995; Kazdin, Siegel & Bass, 1990).

While researchers bemoan the practitioner's apparent disinterest in their science, practitioners likewise lament the researchers lack of attention to their art. Although clinicians may report that they read scientific journals (Goldfried, 2000; Kazdin, Siegel & Bass, 1990) or follow the progress of large scale research projects such as those undertaken by the United States National Institute of Mental Health (NIMH) (Beutler et al,

1995), the extent to which they use this information to influence their practice may be minimal (Beutler, 2000b; Mussell, Crosby, Crow, Knopke, Peterson, Wonderlich & Mitchell, 1997; Norcross, 2000). In fact, the degree to which psychologists and other health professionals have the capacity, the resources or even the desire to implement empirically supported therapies in practice, remains unclear (Beutler, 2000b; Kendall, 1998).

Certainly, the issues and questions that concern practitioners are not readily addressed through the primary research modes of today. As examples, a clinician wishes to know how to: treat clients with numerous problems and underlying personality disorders; resolve clinical conflicts; tailor treatment to the needs of particular individuals, and to learn how or why certain interventions work (Beutler et al, 1993; Goldfried, 2000; Goldfried & Wolfe, 1996; Persons & Silberschatz, 1998). Indeed, the primary question addressed through RCTS being, 'which treatments work best in controlled, manipulated environments', is the one with least direct relevance to the practising clinician (Goldfried & Wolfe, 1996; Persons & Silberschatz, 1998).

Thus, it seems that in a discipline so ostensibly grounded in the scientist-practitioner model, the rift between research and practice is, ironically, well ingrained. Clinicians see themselves as the 'insiders', and view researchers as the distrusted 'outsiders' (Greenberg, 1994) with a mutual scepticism existing between the two (Beutler et al 1995). The development of a pragmatic working relationship between these two, at times, independent enterprises has thus far been unattainable in psychology (Davison, 1998; Goldfried, 2000; Norcross, 2000).

The following introduction to the scientist-practitioner model addresses the complexity of this issue as well as some possible solutions.

CHAPTER FOUR

The Scientist-Practitioner Model: Dream or Reality

"In many respects, our dilemma may be thought of as reflecting a conflict between a wish and a fear: Our wish is that therapy interventions be based on psychotherapy research: our fear, however is that they might." (Goldfried & Wolfe, 1996, p. 1007).

The tension between science and practice is age-old and universal, with psychology being just one of many disciplines challenged by the need to 'bridge the gap' (Beutler, et al, 1995; Kenny, 1997; Sobell, 1996). In psychology, the Boulder model forms the basis of the scientist practitioner ideal, setting the guidelines for evidence-based practice (Belar & Perry, 1992; Evans, 2000).

In therapy, the principles of the scientist-practitioner prototype underpin practices such as: implementing and informing clients about evidence-based treatment options; providing (individually formulated) treatments that are empirically supported; and modelling the therapy process on the principles of experimental design (Addis, 2000; Belar & Perry, 1992). Yet few of these practices are achievable in the absence of a progressive interactive working relationship between the researcher and the clinician.

Science and practice do not share mutual goals. While scientific endeavour aims to develop knowledge through the generation of laws that govern and explain behaviour, practice moves in the opposite direction, attempting to apply these generalities to specific individuals (Kenny, 1997). Indeed, science and practice may be inherently cleaved: a status that arguably cannot and should not be altered given their essentially divergent design (Beutler et al, 1993; John, 1998).

Despite barriers to achieving the Boulder model, few argue against a place for science in the discipline of applied psychology (Persons & Silberschatz, 1998). In fact, there has been a proliferation of literature acknowledging the need and heralding a desire to bridge this gap (Goldfried & Wolfe, 1998). Effort is being made to move bridging efforts toward some sort of reality. Of particular note in this regard has been the establishment of the Task Force on Promotion and Dissemination of Psychological Procedures (Davison, 1998; Task Force, 1995).

The Task Force on Promotion and Dissemination of Psychological Procedures

In brief, this task force was established with the goal of generating recommendations for the identification and dissemination of empirically supported psychotherapies. In recent years there has been growth in the number and variety of treatments, many of these being used without knowledge of their effects (Beutler, 2000; Kazdin & Weisz, 1998). The task force was intended to design a means of identifying evidence-based interventions so that treatments could be administered with confidence and accountability (Goldfried, 2000). It placed psychologists as the "... primary scientists in the psychotherapy field." to fend off the challenge from parallel biomedical initiatives (Task Force, 1995, p. 3). However, the task force establishment has not been without controversy (Beutler, 1998; Goldfried, 2000; Kazdin, 1996, 1998; Silverman,1996). Whilst a full discussion extends beyond the scope of this paper, some pertinent issues are outlined below.

Throughout its development, the task force has declared the process of identifying empirically supported therapies to be evolutionary, dynamic and infinite in nature (Task Force; 1995; Chambless & Ollendick, 2001). Even so, many criticise its recommendations for being overly restrictive, fearing that those therapies not appearing on the 'list' will be neglected despite strong clinical beliefs supporting their effectiveness (Beutler, 2000b; Crits-Chrisoph, Frank, Chambless, Brody & Karp, 1995; Kazdin, Siegel & Bass, 1990). In a similar vein, others accuse the task force of advocating cognitive and behaviourally based therapies over others that are less amenable to manualisation and straight forward scientific analysis (Crits-Christoph et al, 1995;Task Force, 1995).

Certainly, it is apparent that psychotherapy research has applied the greatest force of its investigatory efforts to those therapies most responsive to investigation using empirical methods (Pearsall, 1997). In particular, the outcome of treatments involving behavioural and cognitive behavioural therapies have been thoroughly investigated, whereas other forms of psychotherapy have been neglected in research (Barrnett et al, 1991). This is ironic given evidence cited earlier, that many non-behavioural therapies are in fact the therapies most frequently used in practice (Crits-Christoph et al, 1995; Kazdin, Siegel & Bass, 1990) and that behavioural therapies may be effective for only a small group of contained and uncomplicated psychological problems (Asay & Lambert, 1999; Barnnett et al, 1991). Because of the difficulties involved in studying psychological change (Crits-Christoph et al, 1995), a vicious circle may have developed whereby only a small group of therapies are adequately investigated and validated (Crits-Christoph, 1997). The

remaining therapies are left unstudied and consequently lacking in support and validation (Roth et al, 1996). In turn, they may receive less emphasis in psychological training institutions and as a consequence, become further marginalised (Crits-Christoph et al, 1995; Kazdin, 1994).

Further complicating this dilemma is the issue of investigator allegiance. For example, in their review of psychotherapies for the treatment of adult depression, Robinson and colleagues found that the apparent superiority of cognitive over other therapies disappeared after controlling for investigator allegiance (Robinson et al, 1990). This effect may also be at work within child therapy outcome research in which all therapies have not been found to be equal (Weisz, Weiss et al, 1995). Thus, with certain therapies continually studied, validated and replicated, it is perhaps inevitable that those less easily applied to this process will remain unattractive to the researcher. The relationship between investigator allegiance and outcome may therefore reflect a circular rather than a linear association, with investigator allegiance both causing as well as resulting from available findings (Weisz, Weiss et al, 1995).

Another pertinent issue here is that the extent to which validated therapies are adequately disseminated (through manuals and training) and effectively utilised in practice, is largely unknown (Beutler et al, 1993; Crits-Christoph et al, 1995).

Thus, the cleft between research and practice in psychology remains. Recent proposals for addressing this gap are now discussed.

CHAPTER FIVE

Resolutions to the Practice-Research Dilemma: Bridging the Gap

In recent years, a number of possible solutions to closing the gap between research and practice have been offered. Among these are: Beutler's proposal to develop empirically informed overarching principles to guide change in therapy (Beutler, 2000a, 2000b; Norcross, 2000); recommendations for the use of idiographic, theory-driven outcome studies (Person, 1991); the use of alternative forms of outcome research; continuation and expansion of the search for common factors to guide practice (Ogles et al, 1999); transportation of empirically supported therapies into the clinic setting (Kazdin, 2000); and the development of clinically-representative therapy outcome studies (Chambless & Hollon, 1998; Kazdin & Weisz, 1998 . To succeed, any of these would involve improved collaboration between researcher and practitioner (Beutler et al, 1993; Goldfried & Wolfe, 1996; Hoagwood et al, 1995; Sobell, 1996).

The transport of empirically supported therapies to the clinic setting and the development of clinically representative outcome studies are now discussed.

1. Informing the Practitioner: Transporting Empirically Supported Findings to the Clinic

Differential Findings Between Clinic and Research Based Studies.

In view of information presented earleir, it may come as no surprise that naturalistic outcome studies consistently render significantly smaller effect sizes than studies such as RCTs that are performed in controlled, research conditions (Weisz et al, 1995a, 1995b). This pattern holds fast even when randomisation is used (Weiss et al, 1999) and sleeper and curvilinear effects are controlled for (Weiss, Catron & Harris, 2000). For example, a comparative review found that clinic-based studies produced a mean treatment effect size (ES) of .01, as opposed to an ES of .77 in laboratory-based settings (Weisz et al,1995a). Using an empirical retrospective analysis method, these authors attempted to identify what might account for such a significant discrepancy (Weisz et al, 1995a; Weisz et al, 1995b). Their initial analysis covered 10 possible factors including: the predominant use of behavioural over non-behavioural treatments; the use of analogue (e.g. less severely disturbed) participants; the use of stress free settings that, unlike the clinic context, are conducive to therapy effectiveness; the use of stringently trained therapists and treatment

integrity monitoring; the use of in-session structure; the use of strict time limits; and the unitary problem focus and use of specialised treatments that are typically found in research settings. They also looked at the impact of methodologically flawed clinic-based studies. Of these potential influences, three emerged as the most likely contributors to the superior ESs found in laboratory when compared to clinic-based treatment-outcome studies. These were: the use of specific, problem-focused treatments; adherence to highly structured in-session plans; and the predominant use of behavioural and cognitive-behavioural therapies in research based studies. Identifying factors such as these, for transportation from the lab to the clinical setting, is one proposed means of informing the clinician and bridging the gap between research and practice.

That research studies rarely represent the exact conditions of practice even the staunchest advocates of experimental control do not deny (Persons & Silberschatz, 1998). However, this may not mean that research can have no bearing on practice (Chambless & Hollon, 1998). When a treatment or parameter of practice, such as those identified in Weisz and colleagues work (Weisz et al, 1995a, 1995b) is shown to have a positive impact on outcome, it may then be possible to successfully adapt it for use in a clinical setting (Hoagwood et al, 1995; Weisz et al, 1995a, 1995b). Although this process may not be simple, requiring further research and modification in some instances, the possibilities are being considered with what appears to be increasing optimism by many (Kendall, 1998; Kendall, 2000; Kendall & Southam-Gerow, 1995; Persons & Silberschatz, 1998; Shadish et al, 1997).

Dissemination through Manuals

The use of manual-based therapies for the dissemination of empirical findings to the clinic, although lauded by many researchers is often criticised by practitioners (Addis, 1997; Addis & Krasnow, 2000; Luborsky & DeRubeis, 1984; Persons, 1991; Wilson, 1996). Manuals represent an approach to psychotherapy based on a world view that departs considerably from that of many therapists. Clinical practice, no matter how solidly based in evidence, inevitably involves some degree of clinical judgement, flexibility and perhaps even intuition (Addis, 1997; Beutler, 2000a, 2000b; Kenny, 1997). This is the case even in medicine where the objects of inquiry are considered to be more defined and measurable (Kenny, 1997). Yet it is precisely this, the *art* of psychotherapy, that adherents to manualised treatment protocols are accused of quashing (Goldfried & Wolfe, 1996, 1998). It is further argued that strict adherence to treatment manuals may interfere

with other important process-related therapist activities such as acceptance, warmth and the therapeutic alliance (Henry, Strupp, Butler, Schacht & Binder, 1993; Lambert & Bergin, 1994). Idiosyncratic case management places client variability at the heart of successful therapy (Anderson & Strupp, 1996): a notion not readily supported by manualised therapy (Calhoun, Moras, Pilkonis & Rehn, 1998; Kendall & Southam-Gerow, 1995).

Steps to include findings from process research as well as improved integration of common factors in manuals, have been suggested as means of improving their clinical utility (Addis, 1997; Goldfried and Wolfe, 1998).

Dissemination through Journals

Empirical findings are most often disseminated through psychological journals. However, surveys suggest that although many clinicians believe empirical findings to be important, they frequently solicit such information from sources other than scientific reports. These include popular books, workshops and supervision (Beutler et al, 1993). That scientific journals may be inaccessible to clinicians has been acknowledged (Beutler et al, 1993; Beutler et al, 1995; Goldfried & Wolfe, 1996; Sobell, 1996). Attempts have been made to address this obstacle. For example, the journal 'In Session' is designed to be jargon - free and to provide practice-related information directly to clinicians (Goldfried & Wolfe, 1996, 1998). Others have suggested alternative means of disseminating information. For example, Sobell (1996) advocates using business models to 'market' research findings. All proposals require effective collaborative communication between clinicians and researchers.

Dissemination through Training

As mentioned earlier, the little that is known about training in empirically validated therapies indicates that on the whole, clinical and doctoral psychology programmes neither emphasise nor train their graduates to administer them (Crits-Christoph et al, 1995). However, this may not be the case in New Zealand where studies indicate that most clinical psychologists report being trained in and practice cognitive and behavioural modalities (Kazantzis & Deane, 1998; Patchett-Anderson & Ronan, 2002).

2. Informing the Researcher: Developing Clinically representative Outcome Studies

Another possible means of bridging the research-practice gap is in the design of clinicially representative and naturalistic research studies (Chambless & Hollon, 1998; Kazdin & Weisz, 1998). Projects such as these would aid in identifying possible weaknesses in clinical practice as well as determining the degree to which empirically supported therapies might be transportable (Chambless & Hollon, 1998; Shadish, Matt, Navarro & Phillips, 2000). External and internal validity need not be mutually exclusive (Persons & Silberschatz, 1998) and studies are emerging as a testament to this possibility (e.g. Kendall, 1994; Kazdin & Weisz, 1998). However, it is clear that researchers need to look to practice to inform their work (Beutler et al, 1993). More and enhanced empirical data, extending beyond the role of technique in the practice of psychotherapy, is required in order to facilitate this process (Shadish et al, 1997).

The current study aimed to provide empirically derived, clinically-relevant data with which to fuel four possible solutions to the research-practice gap: the continuation of the search for common or non-specific factors to guide practice; the integration of science with practice through the scientist-practitioner model; the transport of empirically supported findings to the clinic; and the development of clinically representative outcome studies. These goals are now discussed.

The Current Study

This review outlined a number of issues pertinent to the gap between psychotherapy research and practice with children and adolescents. These included: special assessment and treatment considerations; international and New Zealand disorder prevalence rates; progress in and limitations of the empirical child psychotherapy outcome research to date; and the problem of questionable external validity with respect to the questions asked, and conditions and characteristics studied through treatment-outcome studies.

With these points as background, the fundamental thesis was introduced: that the discrepancy that persists between psychotherapy research and practice with children and adolescents threatens evidence-based practice, a guiding principle in psychology. Recent resurgence in concern over this dilemma has inspired a variety of solutions. These include: the search for common factors to guide practice; transport of empirically-supported therapies to the clinic setting; and development of clinically representative outcome studies. In addition, institutions such as the Task Force on Effective Psychosocial Interventions have been established to facilitate the goals of the scientist-practitioner.

In order to move forward with these initiatives, the current lack in available data describing the 'real-life' practice of child psychotherapy in New Zealand needs to be addressed. The primary goal of this study therefore, was to establish a broad descriptive picture of the nature and types of therapeutic practices used with children and adolescents in New Zealand. A comprehensive overview including: therapist and client profiles; assessment and treatment practices; practitioners' beliefs about typical outcomes, and factors affecting outcome, was sought. In addition, aspects of practitioners' practices with respect to integrating science with practice, were surveyed With a view to lessening the gap between research and practice, it was hoped that current findings might provide clinically informed data from which to identify future research directions.

To this end, the following study goals were set.

Study Goals

1. Generally describe the demographic, professional and clinical (including clientele) characteristics of mental health practitioners providing therapeutic intervention to children and adolescents in New Zealand.

2. Describe the assessment modalities, therapeutic approaches, techniques and treatment characteristics / parameters used by practitioners.

3. Identify practitioners' beliefs about the impact of a range of treatment techniques and other factors on therapeutic change for children and adolescents.

4. Assess the extent to which the conditions and characteristics of psychotherapy as practiced with children and adolescents in New Zealand differ from those typically found in research.

5. Assess the extent to which psychologists adhere to aspects of the Scientist-practitioner model.

6. Identify clinically informed areas for future research

CHAPTER SIX

Method

Study Design

A mail survey design was chosen as the optimal method to support the aims of the present study. Inquiries were amenable in most cases to closed-ended questions, which are considered ideal for use in questionnaires (Mangione, 1995). A common limitation of the survey method, being the potentially cursory nature of the information obtained, was less of a concern in this context, where the goals of investigation were primarily descriptive and broad in character.

Surveys are deemed appropriate for use when research participants are likely to be personally or professionally invested in the topic of investigation (Mangione, 1995). In this case, where the nature of respondents' professional practice was ostensibly under scrutiny, the mailed questionnaire provided a tangible guarantee of anonymity and confidentiality (Mangione, 1995). Further, the mail survey facilitates elicitation of a large amount of information from a geographically wide range of respondents in a relatively short period of time and within a limited budget (Mangione, 1995). All were important considerations in the present context.

As with all research design options there are limitations to the mail survey method. For example, response rates are often low, producing data that lends weight to tentative conclusions only (Leavitt, 1991; Yammarino, Skinner, & Childers, 1991). Second, there is considerable scope for misunderstanding and misinterpretation of questions (Leavitt, 1991; Mangione, 1995). This was a concern in the current study where responses from a wide range of practitioners with potentially diverse world-views were being sought. Third, although mail surveys ensure a sense of privacy and are therefore likely to elicit relatively honest responses, it is always possible that participants may sense a particular stance or bias on behalf of the researcher and construct their responses accordingly (Coolican, 1999). Further, if a respondent perceives the researcher's disposition to be incompatible with his or her own, that individual may decline to participate altogether (Coolican, 1999). Although effort was made to minimise this effect, it is likely that aspects of the researcher's own training background were reflected in the questionnaire. A final disadvantage of this method is the inability of the researcher to follow up responses

through in-depth questioning. This process was not possible within the primary goals and limited time to carry out this master's thesis.

Given the broad overall aim of this study, the wide range and number of targeted participants, and the limitations of a master's thesis, the mail survey was deemed the best methodological option.

Participants

The study targeted a wide range of mental health workers from a variety of professional backgrounds. All practitioners working in any capacity with children and adolescents suffering mental health problems (not only those specialising in this area) were sought for inclusion. Practitioners working with children in physical health-related psychology settings (e.g. oncology pain management) were not targeted. A total of 1223 questionnaires were sent out. The overall response rate was 40%. Approximately 200 were returned uncompleted with explanations such as the recipient did not work with children or adolescents, had retired, or was no longer at that address. The number of completed questionnaires returned totalled 203 (N = 203), amounting to a completed survey response rate of 20%. A description of responses is presented in Table 1. Registered nurses and social workers are combined under a single classification labelled 'others', due to low response rates from these two groups.

Table 1.

Response Profile

	Questionnaires					
Contact Source	Number Sent (adjusted*)	Number Returned	Percent Returned		***Professional*** Affiliation	Number of Responses
NZACAP	27	9	33		Psychologists	97
NZAP	164	18	11		Counsellors	33
Miscellaneous	160	27	17		Psychotherapists	36
Psychologists (reg)	237	40	17		Psychiatrists	17
Government Dept.	160	75	47		Other	20
NZCCP	122	11	9			
RANZCP	32	8	25			
NZAC	110	15	14			
TOTAL	**1012**	**203**	**20**			

Note:

- NZACAP = New Zealand (N.Z.) Association of Child and Adolescent Psychotherapists; NZAP = N.Z. Association of Psychotherapists; NZCCP = N.Z. College of Clinical Psychologists; RANZCP = Royal Australian and N.Z. College of Psychiatrists; NZAC = N.Z. Association of Counsellors; Other = social workers and registered nurses.; Government Dept = Practitioners of all designations procured through government services; Miscellaneous = Practitioners advertising in yellow pages, not identified by any qualification or professional designation.
- * = Numbers adjusted to account for retirement and incorrect addresses

A description of practitioners' demographic and professional characteristics is presented in the results section. Owing to the unique nature of this sample, demographic representation of the wider New Zealand practitioner population was difficult to determine. In terms of gender, age and ethnicity, psychologists were similar to those responding to comparable recent surveys (Kazantzis & Deane, 1998; Patchett-Anderson & Ronan, 2002) and to data held by the Ministry of Health (Health Workforce Advisory Committee, 2001). In terms of gender, responding counsellors were similar to the wider population of counsellors in New Zealand, including those working outside of the mental health field (Health Workforce Advisory Committee, 2001). Demographic data for other professional groups was unobtainable.

Instrument: The Child and Adolescent Psychosocial Intervention Survey Questiionnaire

The 12 page questionnaire was developed specifically for use in this study. Questions were presented under four broad headings: clinician profile; client profile; assessment and outcome evaluation; and treatment (see Appendix A).

Question Content

1.0 Clinician and 2.0 Client Profile

As described earlier, a primary goal of the present study was to examine client and therapist variables. Consequently, the survey was designed to obtain a detailed and meaningful description of these factors.

Clinician Profile (1.1 - 1.2)

Respondents were asked to describe themselves and their practice in terms of their demographic characteristics, years of experience, professional affiliation, theoretical orientation, qualifications, professional activities, work environment, hours worked per week and use of training and educational resources. These categories and sub-headings were created based on information found in reports from a large number of previous practitioner surveys (Byrne & Reinhart, 1990; Garfield & Kurtz, 1975; Garrett & Davis, 1995; Kazdin, Siegel & Bass, 1990; Norcross, Karg & Prochaska, 1997; Norcross & Prochaska, 1982; Norcross & Wogan, 1983; Orlinsky et al, 1999; Prochaska & Norcross, 1983; Watkins, Campbell & McGregor, 1991). Each category was then adapted

to optimise relevance to the wide range of targeted recipients, as well as to the unique cultural context of New Zealand.

Demographic and Professional Profile (1.1.2; 1.1.3; 1.1.4; 1.1.6)

In this section, practitioners were asked to report their age (1.1.3), gender (1.1.4), ethnicity (1.1.5), years of experience (1.1.2), and qualifications (1.1.6).

Issues regarding both the validity of demographic constructs (Beutler, 1997) as well as the importance of consistency in the use of demographic terms in psychological research (Beutler, Brown, Crothers, Booker & Seabrook, 1996) were considered throughout this section. A balance in meeting both of these objectives was sought.

Where possible and practicable, questions were adjusted to elicit a maximally meaningful response. For example, the question of clinician ethnicity was posed in an open-ended format so as to encourage a free response with respect to what is increasingly recognised as a dynamic and highly personal construct (Beutler et al, 1996). However, in other instances, questions were worded for the sake of replicability and practicality. For example, the construct "experience" is frequently operationalised as "years of practice" in psychological research. The shortcomings of this operationalisation in accurately reflecting a clinician's level of experience were tolerated here, as elsewhere, to facilitate consistency and replication (Beutler et al, 1996). Limitations such as these are difficult to address in a mail survey and would be better addressed through follow up, in-depth studies.

Professional Affiliation (1.1.1)

Respondents were asked to indicate their professional affiliation by ticking one or more of 11 options. The question was designed to be inclusive of a wide range of practice backgrounds. Along with the common professional classifications, additional categories such as 'other', pastoral, whanau and community worker, were included. It was hoped that from this list, each respondent would find a label that fit comfortably with his or her own professional self-view.

Theoretical Orientation (1.1.7; 1.2.2)

The goal in this section was to describe the theoretical influences that underlie clinicians' work with children and adolescents. The first question, 1.1.7, simply asked respondents to report their theoretical orientation. This question was designed to elicit a quick 'off the

cuff' reply and in response to feed back from the pilot study, made allowance for the possibility that some practitioners might not perceive themselves as adhering to any particular orientation.

The second question, 1.2.2, asked respondents to rate nine theoretical paradigms according to their relative influence on their practice. Prior to construction of this question, a number of clinicians were interviewed about their own theoretical orientation. It became clear through this process that the relationship between paradigm and practice might not necessarily be linear in nature. Four practitioners were interviewed including a counsellor; psychotherapist, nurse, and a clinical psychologist. None claimed to use a theoretically 'pure' approach to practice and most described a pattern of practice whereby they associated different paradigmatic influences with specific techniques or areas of their practice. For example, one practitioner described a tendency to use gestalt approaches in the 'here and now' and psychodynamic principles for interpersonal issues.

A question on theoretical orientation needed to somehow reflect this complexity while still working within the constraints of the survey context. Prior surveys have used similar formats, employing 'percent of time' as the rating scale descriptor (e.g. Kazantzis & Deane, 1998). A possible limitation to this method is that the time spent practising in a specific paradigm may in fact reflect the time spent working with various different types of clients or some other confounding variable. Again, a thorough investigation of this phenomenon would most likely require in-depth process analysis at a qualitative level (Jensen, Bergin & Greaves, 1990). However, Question 1.2.2 was considered a good starting point, with the use of a rating scale that specified relative influence on none, a few, some, most and all areas of practice. The descriptors on this rating scale were chosen to reflect the notion that paradigms may influence practitioners in a dimensional as opposed to a categorical sense.

An additional concern pertained to the categories chosen for inclusion in this question. An initial culling produced a list of over 20 major and subsidiary orientations. Given the wide range of intended respondents, an extensive list was deemed appropriate. However, in the interests of space and response time, the list was reduced to nine major headings considered to subsume the subsidiary paradigms. To supplement this list, an 'other' option was provided, with the instruction that the words eclectic or integrated were not to be used in the response. As previously discussed, practitioners across a range of

professional affiliations frequently identify themselves as eclectic (Jensen et al, 1990; Kazantzis & Deane, 1998). Thus, it was intended that through analysis of the combined responses from Questions 1.1.7 and 1.2.1, both the constitutive elements of each practitioner's orientation as well as the relationship between their stated orientation and the actual paradigms that influence their practice, might be elicited. Identification of patterns such as these is likely to further our understanding of the therapist as a variable in the treatment-outcome process as well as help clarify the picture of practice in New Zealand.

Professional Activities & Work Environment (1.1.8; 1.1.9; 1.2.0)

Questions 1.1.8 , 1.1.9 and 1.2.0 pertained to hours of work, work environment and professional activities respectively. Again, these questions were based on similar items in previous surveys and were adapted through the consultative process outlined later, to ensure relevance and inclusiveness in the context of New Zealand mental health practice.

Training and Educational Resources (1.2.1)

The current study aimed to address two aspects of practitioner adherence to the scientist-practitioner model. First, the degree to which research findings influence clinicians' choices with respect to their selection of treatments and second, the extent to and means by which research findings are disseminated and utilised by practitioners.

Question 1.2.1 addressed the latter of these two queries. Respondents were asked to rate the extent to which a variety of training and educational resources influence their practice. In addition, they were encouraged to list some of the journals that they regularly read, thus providing concrete information with which both to verify and further detail their rated responses. Response categories were compiled from previous surveys and adjusted to suit the context. Again, the consultative process was fruitful in eliciting resources deemed relevant to New Zealand practitioners.

2.0. Client Profile (2.1 - 2.2)

Client profile questions were divided into two sections: caseload and characteristics (including source of referral). Again, major content areas in this section were adapted from those addressed by Kazdin and colleagues (1990).

Client Caseload (2.1.1 - 2.1.3)

In Questions 2.1.1, 2.1.2, and 2.1.3 respondents were asked to report their total current client caseload as well as both the total number of clients and the number of children and adolescents seen over the past 12 months.

Nature of Treatment Received by Clients (2.1.4)

Clinicians were asked to indicate the percent of clients receiving solely pharmacotherapy, solely psychosocial therapy and those receiving a combination of both. This question required respondents where possible to include knowledge of interventions administered not only by themselves, but by other health professionals as well. This provided a preliminary picture of the nature of interventions experienced by children and adolescents in New Zealand, to be further developed in later sections.

Question 2.1.4 served the secondary purpose of providing a lead-in to the second exclusionary instruction. Clinicians providing drug therapy alone were asked not to respond to any questions beyond that point.

Client Characteristics and Source of Referral (2.2.1 -2.2.3)

Respondents were asked to report on the ethnic identity (2.2.1) and sex (2.2.2) of their clients. Unlike the question of clinician ethnicity, where a subjective response was considered most accurate, Question 2.2.2 used a closed format style. This was appropriate given that clinicians can only respond from an objective perspective with respect to their clients' ethnicity.

The source of referral question (2.2.3) required respondents to indicate the percent of clients referred from each of a list of 10 referral options.

3.0 Assessment and Outcome Evaluation

Assessment (3.1.1 - 3.1.2)

Despite its integral role in both treatment and outcome evaluation, assessment approaches have rarely been examined in previous practitioner surveys of this type (see Kazdin, Siegel & Bass, 1990; Silver & Silver, 1983). Where assessment is addressed, it is often operationalised in terms of techniques and therefore elicits information pertaining to the frequency with which various psychometric tools are used in practice. A previous New

Zealand practitioner survey has provided a comprehensive description of test usage in this country (Patchett-Anderson & Ronan, 2002).

Given the centrality of assessment to the therapeutic process, the current study aimed to build on information derived through Patchett-Anderson and Ronan's (2002) study so as to develop an understanding of the types of assessment 'approaches' that underpin the use of psychometric and other tools. That is, a broader view of assessment practices was sought.

Two questions were constructed to optimise elicitation of data on this topic. In Question 3.1.1, a list of 14 assessment models, including 'none' and 'other' was presented. Respondents were asked to identify the systems they regularly use to define or describe clients' presenting problems. If necessary, more than one option could be endorsed.

The categories for inclusion in Question 3.1.1 were generated as follows. First, a number of general child and adolescent treatment and assessment textbooks were consulted. From these books and through discussion with colleagues and clinicians, leads to additional alternative assessment approaches were drawn. In combination, these resources produced a list of 20 assessment models, which in turn were reduced to 12 through an elimination process similar to that utilised in Question 1.2.2.

A second aim in this section was to determine the manner and extent to which clinicians monitor progress throughout and following an intervention. A review of literature and feedback through the consultative process indicated that in practice, progress and outcome assessment is often inadequate. This question was therefore deemed likely to induce a socially desirable response if a range of appropriate response alternatives were provided. Given this and in view of the diverse range of approaches likely to be represented in the sample, an open-ended question was used. The disadvantages of open-ended questions are frequently outlined throughout the survey literature (Mangione, 1995; Suskie, 1996). Responses depend on each participant's interpretation of the question. In addition, the resulting data is subject to further interpretation through coding and analysis by the researcher. However, Question 3.1.2 arguably allowed a more valid overview of assessment approaches than it would have, had it been presented in closed format. The free-response format was restrained to some extent by the request that respondents reply in the form of a list.

Outcome Evaluation (3.1.3)

Question 3.1.3 was designed to fulfill two content requirements. First, to determine the type of clients seen by each clinician and second, to ascertain the general outcome patterns commonly associated with each type of client presentation. A number of issues were considered.

Preceding surveys have used a variety of approaches to elicit clients' presenting problems. For example, Kazdin and colleagues (1990) asked practitioners to identify the five clinical problems most commonly seen in their practice. A limitation of this method is that a large number of client 'types' are not represented. An alternative approach is the use of broad, inclusive categories. Again, this method is deficient in that a large amount of important information is lost. Given the recent emphasis on treatment-specificity, prescriptive matching and on increasing the range of disorders studied (Goldfried & Wolfe, 1998; Kazdin, 1994), maximal specificity was deemed important.

An extensive list of client problem categories was therefore developed by searching through well-known texts and recent articles on child and adolescent psychopathology (e.g. Carr, 1999; Erickson, 1982; Ollendick & Hersen, 1998). An index of more than 100 documented problems and disorders including those falling under both diagnostic and non-diagnostic categories was initially compiled. In consultation with clinicians and colleagues, any significant overlap between major and minor categories was then eliminated. The resultant list of 32 classifications also allowed clinicians to add 'other' unlisted problems. Although the list was incomplete, it did provide an index of relatively specific presenting problems within the constraints of the questionnaire context. Where possible, to maintain some degree of standardisation, *DSM-IV* (1994) categories were used.

Respondents were asked to estimate and rate from zero to four, the extent to which therapeutic change typically occurred for clients with a range of different complaints. The rating descriptors differed from those used in Kazdin and colleagues' (1990) survey in which respondents were asked to rate their 'effectiveness' in treating a variety of disorders. Clinician 'effectiveness' is an entirely subjective marker. By asking for an estimation of 'overall level of therapeutic change', this author aimed to elicit a more objective response, hopefully based on systematic assessment findings. This method

also acknowledged the possibility that change might occur independently of the clinician and in the context of other influencing factors.

Factors that Influence Therapy Outcome (3.2.1)

Question 3.2.1 was an adaptation and extension of the question originally posed by Kazdin and colleagues (1990) regarding practitioners' opinions about outcome predictors. All 25 of the former questionnaire's variables were included in the current inquiry. A literature search of texts and articles printed following the release of Kazdin and colleagues' 1990 survey elicited a further 80 variables. Through feedback during the piloting and consultative processes, the list was eventually reduced to 67 items in total. Concerns regarding the length of this question were discussed with pilot study participants. It was agreed that the 67-item list represented a threshold index from which further elimination would considerably alter and compromise the nature and purpose of the question.

4.0. Treatment (4.1 - 4.3)

The final section dealt with issues directly related to treatment and treatment selection. This segment consisted of three questions.

Treatment Modalities / Techniques (4.1.1)

In Question 4.1.1, practitioners were asked to tick all of the treatment interventions that they use in their practice. A limitation of this method is that it did not provide information that directly linked treatment usage to specific clients or client problems. Again, in the present study where an important goal was to develop the foundations for future research into prescriptive matching, this type of data would have been valuable. However, obtaining this type of detail proved difficult within the constraints of the questionnaire format.

Steps were taken to procure a list of response options that were inclusive of the wide range of therapies potentially in use in New Zealand. The categories were derived through extensive literature searches. Therapeutic modalities falling under three broad categories including: empirically supported therapies; behavioural or cognitive-based therapies; and non-behavioural therapies, were identified. Duplications between categories were eliminated. In addition, a variety of clinical sources were consulted to identify commonly

accepted practices within each professional group. By providing a list that included even marginalised therapies, it was hoped that the effects of social desirability response biases might be minimised.

Treatment Parameters (4.2.1 -4.2.6)

Question 4.2 asked clinicians to describe the characteristics of their treatment practices along a variety of parameters including: the typical duration of a course of therapy; the typical number of sessions per course; the percent of clients whose parents attend one or more therapy session; the percent of clients who receive follow up assessment; and the percent of clients who fail to complete a full course of therapy. Three of these questions were adaptations of similar inquiries in Kazdin and colleagues' (1990) survey. The remaining two questions, 4.2.5 and 4.2.6 were included as the result of discussions with clinicians and in view of previous findings regarding the relationship between premature treatment termination, follow-up practices, and therapy outcome (Kazdin, 1994; Kazdin, 1997; Mufson & Fairbanks, 1996; Pearsall, 1997).

Treatment Selection (4.3.1)

The final question addressed the second scientist-practitioner issue: the degree to which research findings influence clinicians' treatment selection decisions. Respondents were asked to rate the relative influence of various treatment characteristics on their selection of a treatment modality. Response items included in this question fell under three categories. First, items one to three ('empirical support for use with a specific problem', ' some empirical support', and 'accompaniment by a manual') were treatment characteristics reported to be associated with positive outcomes. Second, items four and five ('compatibility with own paradigm' and 'congruence with proposed etiology') were noted in the integrative therapy literature to be factors that commonly influence treatment choice (Beutler, Consoli & Williams, 1995; Goldfried & Norcross, 1995; Hollanders & McLeod, 1999). Finally, items six and seven ('used successfully in the past' and 'recommended by another professional') were identified through the consultative process as factors likely in reality, to influence the treatment selection process.

Procedure

Ethics approval was sought and obtained from Massey University Human Ethics Committee.

Sampling Process

An extensive sampling process was implemented in order to meet the study goal of reaching New Zealand mental health workers from a wide range of professional backgrounds. To the author's knowledge, no New Zealand based survey has previously targeted a population of this nature. Thus, in the absence of a single list including all population members, a variety of sampling strategies were employed. Three primary procedures were used. These are outlined below.

1. Identification of Professional Groups Likely Involved in Psychotherapy with Children and Adolescents

Those professions likely to include practitioners involved in psychosocial therapy with children and adolescents were first identified. Therapists involved in physical health-related interventions such as pain management were not targeted. The professional bodies of counsellors, psychiatrists, social workers, school counsellors, psychologists, nurses and psychotherapists, were approached. Where possible, publicly available membership lists were obtained. In cases where organisations were unwilling or unable to release members' names, alternative means of contact were negotiated. General medical practitioners were not approached for inclusion in the study on the basis that their involvement with this population is typically diagnostic or pharmacological in nature. The various means used to identify and reach each different respondent group are outlined here.

Counsellors (n = 117)

The New Zealand Association of Counsellors (NZAC) does not hold a list of members whose names can be publicly released. Therefore, branch representatives were contacted and asked to provide lists of members advertising services in each local region. From eight representatives, three responded in time to be included in the sample. The

lists from these regions were included in full to form a cluster sample of the NZAC membership.

Clinical Psychologists (n = 127)

The New Zealand College of Clinical Psychologists (NZCCP) provided a list of 117 members willing to have their names released for research purposes. This list was then supplemented with 10 additional NZCCP members identified through collateral directories.

New Zealand Registered Psychologists (n = 272)

The New Zealand Psychological Society declined an invitation to have their members take part in this study. Alternative means for contacting psychologists working in health-related fields were therefore undertaken. On request, a directory of New Zealand registered psychologists was provided by the New Zealand Registrations Board. The directory did not catalogue the occupational designation (e.g. industrial or educational) of each registration, so practitioners that were likely not involved in the mental health services of interest (e.g. identified through addresses and business titles) were eliminated. To aid this process, a list of all psychologists advertising relevant services in the yellow pages was compiled and merged with the list of registered psychologists. Any psychologists appearing in both lists were immediately identifiable as working in the area of mental health.

Psychotherapists (n = 182)

The New Zealand Association of Psychotherapists (NZAP) provided a membership list that included 182 New Zealand based members who had given their permission to be contacted.

Child and Adolescent Psychotherapists (NZACAP) (n = 41)

The New Zealand Association of Child and Adolescent Psychotherapists (NZACAP) provided a list of affiliated practitioners, including 28 full and 15 associate members.

Psychiatrists (n = 35)

The New Zealand and Australian Royal College of Psychiatrists (NZARCP) would not release a list of its membership. Instead, they distributed the survey on the researcher's behalf. In this case, all 35 specialised child psychiatrists were included.

School Counsellors

A list of contacts for all secondary schools in New Zealand was obtained from the Ministry of Education. Unfortunately, the list included addresses but not names of counsellors. Further, many of the addresses found on the school index overlapped with those on the NZAC directory. Given the difficulty in accurately determining overlap between these two groups, a decision was made not to use the list of school counsellor contacts.

Social Workers & Nurses

Complete and detailed lists of social workers and nurses working in the area of mental health proved difficult to obtain. Only 10 nurses and 15 social workers were identified through advertisements in the yellow page directories. National registration lists do not indicate occupational designation. Thus a further sampling procedure, described in section two below, was undertaken to elicit potential participants from these two professional groups.

Supplementing Sample Lists

To supplement samples of the professional groups outlined above, all therapists advertising counselling, psychological or psycho-therapeutic services of any type in the yellow pages were extracted and sorted into professional categories. For example, counsellors that fell into any of the three clustered regions were added to the counsellor list, and registered psychologists who did not appear on the register supplied by the qualifications' board were appended to the psychologist list. This process of supplementation was undertaken with each of the professional groups. Final numbers are reflected in the n of each participant group.

2. Recruitment of Participants in Government & Community Organisations

Government / Community Organisations (n = 261)

Feedback from clinicians suggested that many social workers and nurses worked within major private, community, hospital, trust and government organisations. Managers of these organisations were approached to invite their staff into the study. Psychologists, psychotherapists, psychiatrists and counsellors working in these areas but not identified through other means, were procured through this method. A letter outlining the nature and goals of the study was sent to 95 managers or coordinators of major organisations including: The James Family Trust; Relationship Services; Special Education Services; Child and Adolescent (and Family) Mental Health Services; and Child Youth and Family

Services. The letter requested recruitment of any and all staff involved in psychosocial interventions with children and adolescents into the study. Managers were encouraged where possible to forward the name, designation and address of each practitioner to enable cross checking of contact lists. At the time of distribution, 60 managers had responded, providing a further 156 contacts. Approximately 70% of these responses included contact names and addresses, with the remaining 30% to be distributed by the services themselves.

3. Recruitment of Practitioners not Affiliated with any Particular Professional Group

Miscellaneous Practitioners (n = 188)

A final sampling method was implemented in order to capture those practitioners not holding formal qualifications but who publicly advertise regular services to children and adolescents. To achieve this, all individuals promoting their services in the absence of any profession or qualification indicator were extracted from the yellow page directories. These were cross-checked with all other contact lists. The final index of 188 practitioners was included in the overall sample as a "miscellaneous" group. It was expected that representatives from a variety of different professional groups would likely exist within this sample and identify their affiliation in response to the questionnaire.

Eliminating Overlap in Contact Lists

Extensive cross checking was undertaken to minimise where possible any overlap between practitioner lists. The entire sample was sorted by surname, address and region with any overlaps eliminated. Despite this process, it is possible that some duplication occurred and a small number of practitioners may have received more than one questionnaire. This is most likely to have occurred in either of two sampling scenarios. First, where questionnaires were distributed by organisations or managers on behalf of the researcher and second, where a questionnaire was unwittingly sent to a clinic as well as to a practitioner (identified from a different register) who happened to work in that clinic. However, only organisations whose addresses did not appear elsewhere in the final sample list were included. The importance of reaching a representative sample was considered to outweigh both the inconvenience to clinicians and the increased cost associated with duplication in a minority of cases.

Eliminating Practitioners Not Likely to Work with Children and Adolescents

In order to obtain as complete a picture as possible, and in spite of the extra cost involved, all clinicians (not only those identifying themselves as child and adolescent specialists) were sampled as described. Even practitioners seeing a minority of child or adolescent clients were asked to respond. Only those practitioners advertising services that specifically eliminated children or adolescents, such as marriage counsellors, were excluded from the initial mail out. On receipt of the questionnaire package, further provision was made to exclude those clinicians who *never* treated children or adolescents. Exclusion instructions were clearly outlined in both the information sheet and the questionnaire itself (see Appendix A and B).

A limitation of this method was the inability to distinguish between true non-responders and those practitioners who were actively eliminated from the sample due to their lack of involvement with child and adolescent clients. However, the design did enable the specified goal of reaching a wide range of practitioners to be met.

Questionnaires were colour-coded according to contact source to enable response rates per contact list to be determined.

Final Sample

The initial plan had been to randomly sample all appropriate professional groups. However, incomplete contact lists precluded this option. The decision to invite all available contacts for inclusion in the sample was based on the following premises.

First, rates of response to previous similar New Zealand-based studies fall into the range of 30-50 % (Kazantzis & Deane, 1998; Mickleson, 1999; Patchett-Anderson & Ronan, 2002). A number of considerations such as the length of the questionnaire and a recent glut of surveys targeted at both psychologists and psychiatrists further suggested the likelihood of a low response rate. Second, a preliminary power survey to determine a sample size adequate for use with multivariate analyses yielded an approximate requirement of N = 300 participants (Cohen, 1988; Lipsey, 1990). Based on a possible response rate of 30%, a total sample size of 1000 participants was required. Given the possibility of numbers lost through overlap and likely attrition due to exclusionary criteria, it was deemed appropriate to retain all contacts within each group. Assuming proportionally representative responses from each subsidiary group, the resulting data

would provide an adequate foundation from which to make some exploratory conclusions regarding the practice of a wide range of mental health workers working with children and adolescents in New Zealand.

Questionnaire Development

The 'Child and Adolescent Psychosocial Intervention Survey' was developed specifically for use in this study. Conceptually, the questionnaire was designed to partially replicate a previous practitioner survey by Kazdin, Siegel and Bass (1990) as well as to build on information derived from two recent New Zealand based practitioner surveys (Kazantzis & Deane,1998; Patchett-Anderson & Ronan, 2002). Questions were designed to elicit information falling into seven areas including: i) the professional and personal characteristics of clinicians; ii) the demographic and source-of-referral patterns of child and adolescent clients; iii) practitioner approaches to assessment and outcome evaluation including typical outcomes across a variety of client problems; iv) the perceived influence of client, therapist, family, treatment and community variables on outcome; v) types of psychosocial interventions used by practitioners including the typical parameters applied to those treatments; vi) the priority placed on various treatment characteristics in treatment selection; and vii) practitioners' use of ongoing professional development resources and their level of commitment to the scientist-practitioner model. All content areas were considered pertinent to the overall study goal of developing a clinically informed foundation for future research into psychosocial interventions with children and adolescents in New Zealand. As described earlier, content domains were presented in questionnaire form under four broad headings entitled: Clinician Profile; Client Profile; Assessment and Outcome Evaluation; and Treatment. These are discussed in detail below.

Consultation and Development

Once the question domains were established and put in questionnaire form, a comprehensive piloting process was carried out. This process continued over a period of months and occurred simultaneously alongside ongoing development of the questionnaire. Thus, feedback to the author was continual and facilitated progressive discussion and incorporation of ideas in an accumulative fashion. A range of practitioners and experts (n = 10) were consulted throughout this process, including those specifically affiliated with professional groups as well as practitioners who held no formal

qualifications, but who had extensive experience in the field. In addition, fellow students (n = 4) and researchers (n = 3) were consulted for their opinions and feed back. Where possible, previous similar questionnaires were obtained to inform question construction and structure. These included survey questionnaire forms obtained from Norcross and Prochaska (1982), as well as New Zealand authors such as Kazantzis and Deane (1998), Mickelson (1999) and Patchett-Anderson and Ronan (2002). Despite repeated attempts, it was not possible to obtain a copy of Kazdin and colleagues' (1990) questionnaire form.

Pilot Study

As a final stage in the consultation process, 10 practitioners were invited to complete the questionnaire and to provide formal feedback with respect to the following components:

- The time taken to complete the questionnaire
- Whether or not questions / instructions were easy to understand and if not - why not.
- Whether or not any language might be considered offensive or inappropriate and if so, why and how to adjust it.
- Whether or not there were any obvious omissions or oversights in the content of the questionnaire.
- Any other feedback

Of the 10 piloted practitioners, seven returned completed questionnaires, two provided extensive verbal feed back and one failed to respond. The sample included two clinical psychologists, one child and adolescent psychotherapist, one experienced counsellor and member of NZAC, one nurse, one assistant psychologist, one social worker, one child and adolescent mental health manager, one community worker and one pastoral worker. No psychiatrists were included in the pilot study, despite repeated invitations. Within this group, both Maori and Pakeha, but no other ethnicities, were represented.

One final procedure was used to supplement the consultative processes. Three individuals of different educational backgrounds, with no experience in the mental health arena were consulted for their feedback on the questionnaire and cover letters. In particular, they were asked to comment as to the clarity of each question and whether or not they understood the instructions. Finally, a language expert was asked to comment on clarity, spelling and grammar.

Supervision

Throughout this process, steady contact between the author and her supervisor was maintained. This ensured close guidance and provided the foundation from which to develop ideas whilst still underpinning the research process with primary goals as determined from the outset.

Feedback derived through each of these sources was incorporated into the questionnaire. In many instances, mutually exclusive opinions emerged. For example, there was some disagreement over whether respondents should be asked to report numbers in terms of percentages or raw figures, with approximately 50% of pilot participants preferring one method over the other. A variety of different response options were therefore developed and trialed, eliciting consistently divergent opinions. Discussions between the author and her supervisor to determine the most appropriate method in the context of each question ensued. The final outcome included a mix of both response options, based on question content and the split of opinion during the pilot phase.

Appealing to a Diverse Audience

A further point of consideration was the expected diversity of the intended audience. With this in mind, care was taken to use language and response categories that would be optimally relevant and meaningful to a wide range of practitioners. In an attempt to foster tolerance among respondents, the difficulty in adequately appealing to such a wide range of different paradigms was explicitly discussed in a covering letter described later (see Appendix C). Respondents were encouraged to overlook ostensible differences in professional language or world-view and if desired, to detail their preferred terminology or perspective. They were also given 'permission' to omit questions by writing the words 'not applicable' when they could not make sense of or find meaning in the question asked.

However, given the researcher's own background and training, a western-academic bias was likely reflected in the questionnaire style. For example, Question 3.1.3 may have proved problematic for some practitioners. The response options in this question included labels based in many instances on *DSM-IV* (1994) categories that reflect to some degree, a 'pathology' - based orientation to mental health. This question explicitly stated that a 'categorical system' had been used thereby acknowledging that alternative systems of problem-definition do exist. Nevertheless it is possible that response options

were viewed as inappropriate by some. Although considerable effort was taken to avoid this effect, it is accepted as an inevitable limitation of the study.

Questionnaire Structure

A number of structural considerations were also considered in developing the questionnaire. Relevant issues included the general clarity of presentation, logical progression of questions and sections, and the effects of possible interactions between questions, for example priming or other effects.

General Presentation

A primary aim of presentation was to produce a questionnaire that was visually appealing and easy to read while at the same time, minimal in length. This goal was considered throughout the composition of the questionnaire and was frequently balanced against other study objectives.

Logical Sequence of Sections and Questions

In line with expert recommendation, questions were sequenced from simple to complex, non-threatening to more threatening and from those purely factual and descriptive in nature, to those requiring considerable thought on the respondent's part (Suskie, 1996). The sections progressed logically from clinician and client profile, through issues concerning assessment, progress and outcome evaluation, to the final section on treatment - related issues.

Interrelated Questions

Given the descriptive, non-experimental nature of this study, priming-effects were not a concern. In only one instance did the order of questions have implications for the validity of the elicited response. As outlined earlier, Questions 1.1.7 and 1.2.2 were designed to elicit independent responses regarding theoretical orientation. Had these two questions been presented consecutively, they may have induced a consistency response bias (Weisberg et al, 1996).

Engaging the Respondent

The first page of any questionnaire has a crucial role to play. After the cover letter, this section provides what may be the final opportunity to gain the recipient's attention (Mangione, 1995). Among other things, the degree to which this is achieved may then

influence the manner and commitment with which the respondent completes (or does not complete) the remainder of the form (Suskie, 1996).

Participants in the pilot study provided substantial feedback with respect to the order of questions in section one. Based on these discussions, the four objectives to be achieved in page one were: to clarify / reiterate instructions regarding who was targeted by the survey; to establish a non-threatening tone; to achieve a bi-culturally appropriate introductory tone; and to engage each respondent by providing clear and easy-to-answer questions. The question of professional affiliation was positioned first so as to allay any concerns on behalf of the respondent that he or she either did not qualify to participate or that he or she would be "different' to most other respondents.

Discussion during the consultative process suggested the importance for Maori of being asked personal identification questions, for example, age and gender, early in the piece. Ideally, these questions would have been foremost. However, this was balanced against the need to identify unambiguously, the range of targeted practitioners immediately at the outset.

Finally, Question 1.1.2 (years of experience) was positioned to follow logically from question.1.1.1 (professional affiliation). Question 1.1.6. (qualifications), being the most potentially threatening question in this section, was placed at the end of the page and worded to allow for the possibility that a respondent may not hold any formal qualification.

Response Formats

As discussed above, all but 3 of the 31 questions were closed-ended. This was in line with recommendations for maximising validity and rate of return (Childers & Skinner, 1996; Mangione, 1995). As is also outlined earlier, response category options, where available, were as exhaustive and clinically relevant as possible (Mangione, 1995).

In four of the questions, participants were asked to rate different aspects of their clinical experience from zero to four. Although controversial, it is generally agreed that well-designed rating scales produce interval-level data (Mangione, 1995). As much as practicable, care was taken to ensure that each scale complied with commonly accepted standards for this level of data. In each instance, a 5-point Likert scale was used. This allowed for a conceptually evenly spaced range of response options. To optimise the

theoretical equi-distance between points, all scales were labelled with dichotomous extremes, a balanced mid-point, and were presented in the questionnaire as horizontal scales with equal distance between each indicator. In addition, the 5-point scale enabled adequate response sensitivity without overloading the respondent with a potentially confusing array of options.

Distribution

In September 2001, a total of N = 1223 mental health practitioners were sent a survey package inviting their voluntary participation in the current study, 'Psychosocial Interventions with Children and Adolescents in New Zealand: A Survey of New Zealand Mental Health Practitioners.'

Survey Packages

First Posting

Each initial survey package contained the following items:

- The 'Child and Adolescent Psychosocial Intervention Survey' (see Appendix A)
- An information sheet written in accordance with guidelines set out by the Massey University Human Ethics Committee, outlining the study purpose, intended participants and the rights of all respondents (see Appendix B)
- A second cover letter, providing instructions and incentive for completing the questionnaire (see Appendix C)
- A pre-paid, return addressed envelope.

Second Posting

Two weeks following the initial survey distribution, a second package was sent to all respondents. This included the following items:

- A letter thanking those who had completed and returned their forms along with a gentle reminder to those that hadn't. (see Appendix D)
- A personal identification (ID) form including a 'consent to participate in future research' option (see Appendix E)
- A pre-paid, return-addressed envelope

Anonymity and Confidentiality

Anonymity and confidentiality were guaranteed. No identifying information was requested in the first mail out. The follow up letter invited each participant to complete a personal identification form *only* if they wished to be sent a personal copy of results and/or to participate in subsequent related research. There was no attempt, nor indeed was it possible, to pair questionnaires with corresponding identifying information.

Response Incentive Techniques

Because mail surveys are known to elicit lower response rates than a variety of other methods (Weisberg, Krosnick & Bowen, 1996), a number of recommended techniques were used to maximise their return.

Covering Letters: Official and Appealing

First, as detailed above, each questionnaire was accompanied by two covering letters appealing to participants on a number of levels. Both letters were written on university letter-head thereby indicating affiliation with and sanction by a recognised and respected organisation (Childers & Skinner, 1996; Suskie, 1996). The letters appealed to each practitioner's sense of professional obligation and importance (Childers & Skinner, 1996; Church, 1993) by acknowledging their role as experts in treating children and adolescents. The value of their experience and the relevance of their opinions with respect to the gap that exists between psychotherapy research and practice were emphasised. They were asked to 'make use of this survey' to inform future research as well as ultimately to benefit themselves and the clients with whom they work (see Appendix C).

Immediate Reward

Along with the long-term benefits to themselves and their clients, a second, more tangible and immediate reward was afforded through the offer of a personal copy of findings to each clinician. In order to receive a copy of results, a respondent was required to complete and return the identification form that was included in the second posting. It was clear by the separation of the questionnaire and ID form that no attempt to match questionnaires with identifying information was either desirable or possible. Both the prospect of reward and the reassurance of anonymity are known methods for improving response rates (Childers & Skinner 1996; Yammarino, Skinner & Childers, 1991).

Reminders and Ease of Response

Two further incentive methods were employed to increase the likelihood of response: the inclusion of return-addressed, pre-franked envelopes in each mailing; and the use of a follow up reminder and thank you letter. These techniques have collectively been shown to increase survey response rates by up to 10% (Weisberg, Krosnick & Bowen,1996; Yammarino, et al, 1991). In ideal circumstances, a second copy of the questionnaire is included in the follow-up posting (Yammarino et al, 1991). However, budget did not permit use of this method here. Instead, instructions were provided in the second posting, enabling those practitioners who wished to respond but who had misplaced their original form, to source a second copy.

The Questionnaire: Length and Style

Care was also taken to ensure that the questionnaire itself, including each individual item, was written in such a way as to encourage response. Questionnaires of four pages or less, correlate strongly with high return rates (Yammarino et al, 1991). However, a high response rate, whilst desirable, does not outweigh the need to elicit quality information (Suskie, 1996). At each point during item construction, the risk to rate of return was balanced against the importance of the desired information in the context of the broad, descriptive goals of the study. As recommended in the literature, questions were kept short, relevant to the topic, non-technical and as easy to answer as possible (Mangione, 1995).

Data Analysis

Data Preparation

Because information about a wide range of practitioner activities, many of which were applicable to relatively few respondents, was sought, many of the items showed low base rates of affirmative responses. To improve interpretability and suitability for statistical analysis, some aggregation of individual items into composite items was therefore required. This was achieved using either logical combination of subcategories or factor analysis. Despite efforts to improve base rates, there remain some categories within which numbers are low or the aggregation less than ideal.

Data Limitations

It should be noted that response rates for psychiatrists and 'others' failed to reach the conventionally accepted criterion of n = 30 for comparison with other sample groups. Between group differences should therefore be cautiously interpreted with respect to these two groups.

Data Analysis Techniques

For normally distributed data, statistical differences were determined using one-way analysis of variance (ANOVA) and t tests. In most instances, however, data was non-normally distributed and not amenable to transformation. Non-parametric tests were therefore employed. The Kruskall Wallis non-parametric test was used to determine significant between group differences with ordinal or non-normal continuous data. Chi-square tests were used to identify reliable differences with frequency data and the Friedman test was used to explore significant within-subject differences using ordinal data.

CHAPTER SEVEN

Results

This study aimed to describe the clinical practice (including clientele) of mental health practitioners working with children and adolescents, elicit practitioners' opinions as to the effectiveness of a range of psychosocial interventions and outcome predictors and to evaluate the extent to which psychologists adhere to aspects of the scientist-practitioner model. As such, the research goals were primarily descriptive. However, statistical comparisons were undertaken to identify reliably divergent opinions and activities between professional groups, thus yielding a more complete picture of practice patterns. Additional analyses were employed to explore or reduce data and to further clarify relationships between a range of variables.

Data Presentation

Some general guidelines have been used for presentation of data. In general, median values are used to present non-normally distributed data and mean values, to present normally distributed data. In addition, to facilitate comparison with other studies, means are sometimes provided for non-normally distributed data pertaining to the total sample. There are some exceptions to these guidelines. For example, where medians are predominantly zero in value, the mean, and range are provided.

Clinician Profile

Demographic and Professional Characteristics

The demographic and professional characteristics of survey respondents are presented in Tables 2 and 3.

Table 2.

Demographic and Professional Characteristics of Respondents

Characteristic	Total Sample N=201-203		Psycholog. n = 97		Counsel. n = 33		Psychoth. n = 35-36		Psychiat. n = 16-17		Others n = 18-20	
	%		%		%		%		%		%	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Age	46.0	10.0	43.0^{b}	10.7	48.1^{ab}	8.1	50.1^{a}	10.5	44.4^{ab}	8.6	45.7^{ab}	8.9
Experience	13.3	8.9	12.6	8.8	10.7	6.3	15.4	10.6	13.6	8.3	16.0	8.0

Note:

- Groups with different superscripts are significantly different at $p<.05$ level.

Age

Participants ranged from 24 to 72 years of age, with an average age of 46 years. Statistical analyses using a one-way ANOVA, with profession as the grouping variable indicated a significant difference in age between professional groups [$F(4,196) = 3.704$, $p = .006$]. Post hoc comparisons using the Tukey test showed that psychologists were significantly younger than psychotherapists. No other significant differences were found ($p > .05$).

Table 3.

Demographic and Professional Characteristics of Respondents (continued)

	Total Sample N=201-203	Psycholog. n = 97	Counsel. n = 33	Psychoth. n = 35-36	Psychiat. n = 16-17	Others n = 18-20
	%	%	%	%	%	%
Gender						
Male	35	39	24	25	53	30
Female	66	61	76	75	47	70
Ethnicity						
Pakeha NZEuro	91	97	97	94	82	80
Maori	5	3	3	3	12	15
Other	4	5	0	3	6	5
Highest Qualification						
Doctorate	9	16	0	6	-	5
MA/PG Dip.	58	80	36	11	-	25
Degree	9	2	18	17	-	25
Diploma	14	1	0	0	-	5
Other	1	1	0	0	-	5
Nil	1	0	0	0	-	5
Psychiat. Flw.	6	-	-	-	100	-

Note:

- NZ Euro = New Zealand European; MA = Master of Arts; PG Dip = Post Graduate Diploma; Psychiat. Flw. = Psychiatric Fellowship
- Groups with different superscripts are significantly different at $p<.05$ level.

Gender

Most survey participants were female (n = 133), with chi-square analysis demonstrating no overall difference in gender balance between professional groups ($p > .05$).

Ethnicity

The majority of respondents described themselves as New Zealand-European or Pakeha. Ten identified themselves as Maori. For the purposes of analysis, the remaining eight participants, identifying themselves as South American and European, were categorised together as 'others'. Chi-square analysis indicated no significant overall difference in the ethnic composition of different professional groups ($p > .05$).

Highest Qualification

A majority of survey respondents had received some sort of tertiary training. Eighty-two percent (n = 166) indicated qualification at a university-level with 73% (n = 148) claiming to hold either a post-graduate diploma, masters, doctoral or medical degree. Psychiatrists' responses reflected the standard qualifications expected for their profession.

Experience

On average, respondents reported having worked in their indicated profession for around 13 years, with experience levels ranging from 1 to 40 years. A one-way ANOVA with profession as the between-subjects factor, indicated no significant differences in years of experience ($p > .05$).

Theoretical Orientation

Respondents were asked to describe their theoretical orientation. Although only 45% (n = 91) used the words eclectic or integrative, 81% (n = 164) listed two or more theoretically distinct stances in their response. The 40 (20%) remaining participants reported a theoretically pure orientation, with 27 (13%) of these describing themselves as cognitive-behavioural; 6 (3%) as psychodynamic; 5 (2.5%) as narrative; 1(.5%) as systemic; and 1 (.5%) as client centred in orientation. Overall, 45% (n = 91) of practitioners included the words cognitive or behavioural in their response, with the remaining 55% (n = 112) listing a variety of non-behavioural orientations including family, narrative, systems, solutions-focused, social constructivist, psychodynamic, psychoanalytic, gestalt and transactional analysis.

Using a 5-point Likert scale, participants were also asked to rate the extent to which each of nine theoretical paradigms influenced their practice. Table 4 presents their responses. On average, respondents reported being most influenced by cognitive-behavioural and least by constructivist and medical paradigms. Ten to 25% (n = 20-51) of respondents reported psychodynamic, constructivist and ecological paradigms to have absolutely no influence on their practice. A large majority of respondents indicated that all other paradigms influenced at least a 'few' areas of practice.

See Table 4 over page...

Table 4.

Influence of Theoretical Paradigm on Practice (rated 0-4)

	Total Sample (N = 190-203)		Psychol (n = 91-97)	Counsel. (n = 27-33)	Psychoth. (n = 36)	Psychiat. (n = 14-17)	Others (n = 18-20)
Paradigm	0-4 rating		*% Respondents Indicating Influence in Most / All Areas of Practice*				
	M	**SD**	**%**	**%**	**%**	**%**	**%**	**%**
Behavioural	2.3	.92	43	**61**^{a}	26^{bc}	29^{bc}	25^{b}	7^{c}
Cognitive	2.5	.99	48	**70**^{a}	28^{bc}	29^{bc}	31^{b}	14^{c}
Cog-behav.	2.7	.95	**59**	**82**^{a}	43^{b}	31^{b}	44^{b}	26^{b}
Psychodynamic	2.0	1.3	41	18^{b}	44^{b}	**94**^{a}	47^{b}	35^{bc}
Humanistic	2.1	1.2	41	28^{bc}	**55**^{a}	**77**^{a}	31^{bc}	35^{ac}
Ecological	2.0	1.3	35	38	36	31	25	38
Family Systems	2.7	.93	**58**	**53**	**62**	**66**	**65**	**52**
Constructivist	1.4	1.2	20	17	25	42	25	39
Medical Model	1.6	.93	16	10^{b}	0^{c}	10^{b}	**69**^{a}	28^{b}

Note:

- 0 = does not influence practice; 1 = influences very few areas; 2 = influences some areas ; 3 = influences most areas ; 4- = influences all areas of practice.
- Percentages greater than 50% are presented in **bold.**
- Groups with different superscripts are significantly different at p<.05 level.

Kruskal-Wallis analysis with profession as the grouping variable, indicated significant differences between professional groups on the cognitive [X^2 (4, n=203) = 42.7, p = .000]; behavioural [X^2 (4, n = 203) = 38.0, p = .000]; cognitive-behavioural [X^2(4, n = 203) = 52.1, p = .000]; psychodynamic [X^2(4, n = 203) = 65.3,p = .000]; humanistic [X^2(4, n = 203), = 9.4, p = .052]; and medical [X^2(4, n = 203) = 36.7, p = .000] paradigms. In particular, psychologists were more influenced by the cognitive, behavioural and cognitive-behavioural paradigms than any other group. Psychotherapists were more influenced by the psychodynamic paradigm; psychotherapists and counsellors more so by the humanistic paradigm; and psychiatrists more by the medical paradigm when compared to other professional groups.

Professional Activities and Work Environment

The proportion of time respondents reported spending in various settings performing a range of professional activities is presented in Table 5.

See Table 5 over page...

Table 5.

Professional Activities and Work Settings

	% Hours Spent Working in Various Settings and Activities																	
	Total Sample N = 199 - 201		Psychologists n = 95 - 96			Counsellors n = 32 - 33			Psychotherapists n = 34 - 35			Psychiatrists n = 16			Others n = 20		
	M	SD	M	SD	R	M	SD	R	M	SD	R	M	SD	R	M	SD	R
Work Setting																		
Inpatient	2.5	8.1	3.3	13.6	0-100	0.0	0.0	0-0	.11	.68	0-4	3.1	8.5	0-27	6.6	22.7	0-100
Outpatient	8.5	17.1	10.2^{a}	18.5	0-50	$.75^{b}$	4.4	0-25	7.7^{a}	17.7	0-50	14.7^{a}	20.4	0-50	9.1^{a}	17.2	0-50
Private	28.4	39.0	19.9^{b}	33.9	0-55	47.8^{a}	43.0	0-100	42.6^{a}	42.8	0-100	15.5^{b}	32.7	0-100	23.3^{b}	38.3	0-100
Community	27.9	40.8	25.4	39.5	0-100	32.8	42.6	0-100	28.0	40.4	0-100	26.3	42.3	0-100	32.3	46.2	0-100
School	7.5	23.0	27.0	11.1	0-100	10.2	29.4	0-100	1.4	8.5	0-50	0.0	0.0	0-0	2.6	8.6	0-32
Research	2.2	8.1	1.9^{b}	7.2	0-44	$.16^{b}$	.91	0-5	2.7^{b}	10.7	0-50	8.7^{a}	14.5	0-44	$.75^{b}$	3.4	0-15
Other	8.5	22.5	12.1	27.8	0-100	3.5	10.9	0-47	2.7	9.7	0-40	12.2	26.8	0-100	6.6	16.9	0-56
Professional Activities																		
Therapy	39.6	27.0	29.5^{c}	22.3	0-79	65.1^{a}	24.5	0-100	52.0^{b}	26.7	0-100	**28.9^{c}**	18.3	0-60	34.0^{c}	23.5	0-75
Assessment	13.0	12.1	16.3^{a}	11.1	0-44	6.2^{b}	10.9	0-50	6.8^{bc}	7.5	0-27	19.2^{a}	13.4	0-50	13.8^{bc}	8.2	0-50
Teaching	3.7	**4.2**	3.8^{b}	4.0	0-20	3.2^{b}	3.6	0-14	2.7^{b}	2.9	0-13	7.6^{a}	6.4	1-21	3.3^{b}	4.4	0-19
Supervision	5.0	**5.2**	4.0^{b}	3.4	0-16	6.4^{a}	6.5	0-31	6.7^{a}	7.3	1-35	5.2^{ab}	4.2	0-13	4.2^{b}	5.7	0-19
Research	3.6	10.6	4.3^{ac}	12.6	0-91	4.9^{ac}	11.0	0-42	$.98^{bc}$	2.7	0-13	6.7^{a}	12.1	0-43	$.22^{bc}$	1.0	0-4
Admin.	10.8	7.5	11.8	6.8	0-38	10.6	8.5	0-50	10.0	7.0	0-31	7.6	5.7	0-20	4.2	2.6	1-25
Other	3.8	9.1	3.1	8.1	0-43	2.2	5.8	0-25	6.3	13.1	0-60	1.7	4.1	0-13	6.9	11.9	0-35
Working Hours (Hours Per Week)																		
	35	11.2	39	9.5		27	12.2		31	12.0		40	12.5		37	9.7	

Note:

- Teaching = inservice, consultation and teaching; Supervision = both receiving and providing supervision; Administration = report writing and administrative tasks; Assessment = diagnosis & assessment; Community Setting = Community/clinic + university clinic; Research Setting = non-university research setting + university setting
- Groups with different superscripts are significantly different at $p<.05$ level.

Working Hours

On average, psychiatrists, psychologists and 'others' (nurses and social workers) reported spending the most hours at work per week, and psychotherapists and counsellors, the least.

Work Environment

On average, respondents reported spending the largest amount of their time working in private practice and the community, with the least amount of time in research and in-patient settings.

Kruskal Wallis analysis with profession as the grouping variable indicated significant differences between professional groups in the hours spent in outpatient [X^2 (4, n = 198) = 12.2 p = .016]; private [X^2 (4, n = 198) = 21.2 p = .000]; and research [X^2(4, n = 198) = 16.0, p = .003] settings. Counsellors and psychotherapists spent proportionally more time in private practice, and psychiatrists more in research settings than any other group. Psychologists spent no more time in research settings than counsellors, psychotherapists or 'others' (nurses and social workers). The proportion of time spent in other localities, including in-patient, community, school and 'other' settings, did not vary significantly between professional groups ($p > .05$).

Professional Activities

Also presented in Table 5 is the proportion of work time that practitioners reportedly spent involved in a range of different professional activities. On average, respondents reported spending the largest proportion of their time doing therapy, followed by diagnosis and administration. Kruskal Wallis analysis with profession as the grouping variable showed that professional groups varied significantly in the amount of time spent involved in therapy [X^2(4, n = 198) = 48.8, p = .000]; diagnosis [X^2(4, n = 199) = 39.4, p = .000]; teaching [X^2(4, n = 197) = 13.7, p =.008]; supervision [X^2(4, n = 196) = 10.5, p = .033]; and research [X^2(4, n = 198) = 12.4, p = .015]. Professionals did not vary in the amount of time spent in administration or 'other' activities ($p > .05$).

Psychiatrists spent proportionally more time teaching than any other group and were relatively more involved in diagnosis, assessment and research when compared to all but psychologists. Psychologists spent significantly more time in diagnosis and assessment than psychotherapists and counsellors. Counsellors and psychotherapists spent significantly more time in therapy than most other groups.

Psychologists reported spending a similar amount of time in research when compared to all except 'others'. Only a third (n = 29) of psychologists reported participating in any research at all. A significantly larger proportion of psychiatrists did research when compared to other groups.

Training and Educational Resources

Influence of Training and Educational Resources

Table 6 shows the relative influence of various training and educational resources on therapist practice. Answers were recorded on a 5-point Likert scale.

Table 6.

Influence of Educational Resources on Practice (rated from 0-4)

	Influence on Practice: Rated 0-4											
Resource	Total Sample (n=188-201)		Psycholog. (n = 92-96)		Counsel. (n = 29-33)		Psychoth. (n = 34-36)		Psychiat. (n = 17)		Others (n = 17-20)	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Colleagues	3.0	.52	3.1	.52	2.9	.54	3.1	.44	2.8	.62	3.1	.49
Workshops etc.	2.9	.59	2.9	.52	3.0	.61	2.9	.67	2.7	.49	2.9	.79
Professional Books	2.9	.67	2.9^{b}	.69	2.9^{bc}	.63	3.2^{bc}	.65	2.8^{a}	.75	2.9^{bc}	.59
Conferences	2.3	.75	2.2	.74	2.4	.63	2.5	.79	2.6	.83	2.3	.86
Profes. Journals	2.7	.77	2.8	.70	2.4	.75	2.6	.86	3.2	.67	2.7	.82
Specialist Training	3.2	.69	3.2	.70	3.2	.72	3.2	.69	3.0	.79	3.2	.53
Media Articles	1.3	.68	1.2^{b}	.64	1.4^{ab}	.78	1.5^{a}	.56	1.0^{b}	.63	1.2^{ab}	.83

Note:

- Ratings 0-4: 0 = Never influences my practice; 1 = Rarely influences my practice; 2 = Sometimes influences my practice; 3 = Often influences my practice; 4 = Always influences my practice
- Colleagues = 'discussion with colleagues' + supervision; Conferences = conferences + meetings with professional body; Profes. Journals = professional journals; Workshops etc = workshops and presentations.
- Groups with different superscripts are significantly different at p<.05 level.

On average, respondents reported 'specialist training' and 'discussion with colleagues' (including supervision) as having the most influence on their practice. 'Media articles' were reported to be least influential.

Kruskal-Wallis analysis with profession as the grouping variable indicated that professional groups varied significantly in the degree to which they were influenced by media articles [$X^2(4, n = 188) = 11.0, p = .028$] and professional journals [$X^2(4, n = 198) = 15.7, p = .003$]. Specifically, psychiatrists reported being significantly more influenced by professional journals than any other group and psychologists more so than counsellors. Psychotherapists were significantly more influenced by 'media articles' than were either

psychologists or psychiatrists (but not more so than counsellors or 'others'). The relative influence of other resources did not vary by profession ($p > .05$).

Client Profile

Therapist-Reported Client Characteristics

Respondents were asked to report on the quantity, demographic characteristics and referral sources of their clients. These data are presented in Table 7.

Current and Annual Case Load

Overall, respondents reported seeing more children than adults throughout the previous 12 month period [t (182) = 13.213, p = .000]. Adolescents aged 12 -17 years constituted the largest and children aged 0-5 years, the smallest proportion of the total number of children seen by these practitioners.

Most practitioners (94%, n = 169) reported treating one or more adolescents during the previous 12-month period. Proportionally fewer therapists reported treating one or more 0-5 (45%, n = 84) or 6-11 year olds (73%, n = 136) per year.

Kruskal-Wallis analysis with profession as the grouping variable indicated significant differences in the types and numbers of clients seen by different professional groups. Professions did not vary significantly in the number of clients on their 'current caseload' ($p > .05$). However, both the total number of clients [X^2 (4, n = 183) = 13.27, p = .012] and the proportion of children [X^2 (4, n = 184) = 16.03, p = .003] and adults [X^2 (4, n = 203) = 17.64, p = .001] treated over the past 12 months varied between groups. Psychiatrists, counsellors and 'others' (nurses and social workers) tended to see more clients in total per annum than either psychologists or psychotherapists. However, when compared to other groups, 'others', psychologists and psychiatrists reported treating a significantly greater proportion of children and adolescents whereas psychotherapists and counsellors reported seeing a greater proportion of adults.

See Table 7 over page...

Table 7.

Client Characteristics

	Total Sample (n = 183-194)			Psychologists (n = 87-89)		Counsellors (n = 30-32)		Psychotherapist (n = 31-34).		Psychiatrists (n = 17)		Others (n = 17-20)	
	M	**SD**	**Range**	**Med**	**Range**	**Med**	**Range**	**Med**	**Range**	**Med**	**Range**	**Med**	**Range**
Case Load (frequencies)													
Current Case Load	28.8	29.5	0-300	20	0-75	25	5-300	22	1-59	40	6-200	24.0	6-66
Total Clients per annum	89.3	82.1	6-560	60	6-500	75^{a}	24- 560	58^{ce}	6-300	100^{a}	12 -400	100^{ade}	11-240
Age (% of total case load in previous year)													
Tot. chldrn ages 0-5	6.8	11.3	0-100	9.1^{ac}	0-100	0.0^{bc}	0-20	0.0^{b}	0-28	6.0^{a}	0-30	2.2^{a}	0-58
Tot childrn Ages 6-11	24.5	26.4	0-100	13.5	0-92	4.5	0-66	1.4	0-100	37.5	0-76	25.3	0-85
Tot adolscnts. Ages 12-17	27.8	38.3	0-100	20.0^{ac}	0-100	12.0^{bc}	0-100	10.0^{b}	0-100	30.0^{a}	3-93	30.0^{ac}	0-98
Tot. chldrn & Adlscnts.	58.8	69.3	1-100	100.0^{a}	0-100	26.7^{b}	2-100	18.6^{b}	0-100	100.0	0-100	100.0^{a}	0-100
Tot adults (> age 17 yrs)	40.1	42.0	0-100	0.0^{b}	0-100	73.3^{a}	0-98	81.6^{a}	0-91	0.0^{b}	0-86	0.0^{b}	0-94
Client Ethnicity (% of total child and adolescent cases in previous year)													
Pakeha / NZ European	76.3	25.0	0-100	84.8	0-100	87.0	0-100	85.0	2-100	85.0	0-100	80.0	0-100
Maori	16.1	20.2	0-100	10.0	0-100	10.0	0-100	6.0	0-63	10.0	0-100	10.0	0-80
Other*	1.9	3.5	0-24	0.0	0-13	0.0	0-1	0.3	0-17	1.7	0-24	0.3	0-17
Client Gender (% of total child and adolescent cases in previous year)													
	M	**SD**	**Range**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
Male	50.1	28.6	0-100	55.2	26.8	44.9	28.3	32.2	62.1	61.9	20.1	59.3	40.8
Female	48.4	28.5	0-100	43.2	26.4	55.1	28.3	29.4	32.1	38.1	20.1	27.6	27.8

Note:

- Other = South American and Europeans`
- Groups with different superscripts are significantly different at p<.05 level.

Current and Annual Case Load Continued...

Some differences in the proportion of 12-17 year olds [X^2 (4, n = 181) = 11.14, p = .025] and 0 - 5 year olds [X^2 (4, n = 189, p = .004] seen by practitioners also emerged. Psychiatrists, counsellors and psychologists treated the highest proportion of 12-17 year olds, with psychotherapists seeing significantly less in this age group when compared to all except counsellors. The same pattern emerged for the 0-5 year age group. Professions did not vary in the proportion of 6-11 year olds that they saw each year (p> .05).

Client Ethnicity

Most practitioners reported having seen predominantly NZ European / Pakeha clients with 16 % (n = 29) having worked solely with this population over the previous 12 months. Twenty three percent (n = 41) had not seen any Maori clients during the previous year. Only 36 % (n = 66) of practitioners reported having treated one or more Pacific People and 26 % (n = 47), one or more Asian clients during the preceding 12 month period. Kruskal Wallis analysis with profession as the grouping variable indicated no significant differences between professional groups (p> .05).

Client Gender

Practitioners tended to see a mixture of both boys and girls with only 8 % (n = 15) and 4% (n = 8) reportedly having treated either girls or boys exclusively throughout the previous year. Comparisons using t tests showed no significant differences in the proportion of boys and girls seen by different professional groups (p> .05).

Client Source of Referral

Overall, the most common sources of referral were parents or caregivers (M = 27.4, SD=30.6), members of the medical profession (M = 24.7, SD = 30.1) and schools (M =17.9, SD = 27.8).

Client Presenting Problem

Therapists were asked to estimate the range of different childhood problems presented to them over the previous 12 months. For ease of presentation, the original list of 32 individual problems was reduced to 12 logically-derived super-ordinate categories. These are presented in Appendix F. Results by super-ordinate category are presented in Table 8. On average, the client problems reported to be most common were family conflict and

externalising disorders. Eating, elimination and 'miscellaneous' (schizophrenic, spiritual and neuropsychological) difficulties were least common.

Table 8.

Client Presentation

Problem Type	% Clients Reportedly Seen With Each Problem Type											
	Total Sample		Psychologist		Counsellors		Psychoth.		Psychiatrists		Others	
	Med	R	Med	R	Med	R	Med	R	Med	R	Med	R
Externalising	7.0	0-66	7.0^{b}	0-67	8.3^{b}	0-57	3.3^{b}	0-67	22.8^{a}	3-47	0.7^{b}	0-37
Depressive	3.7	0-33	3.3	0-33	3.3	0-18	5.8	0-33	7.5	2-23	4.1	0-33
Anxious	6.0	0-40	6.0	0-40	8.0	0-27	5.8	0-28	17.5	0-26	2.5	0-26
Developmental	1.5	0-77	3.3^{ab}	0-77	0.0^{b}	0-17	0.0^{b}	0-12	8.0^{a}	0-21	1.5^{b}	0-10
Abuse	4.2	2.2	2.0^{b}	0-44	10.0^{ab}	0-42	11.0^{a}	0-73	10.0^{ab}	0-72	4.5^{ab}	0-40
Eating	0.0	0-50	0.0	0-50	0.0	0-5	0.0	0-50	1.0	0-13	0.0	0-5
Elimination	0.0	0-20	0.0	0-20	0.0	0-7	0.0	0-15	0.75	0-15	0.0	0-8
Addiction	0.0	0-75	0.0^{b}	0-75	0.0^{c}	0-48	0.0^{bc}	0-40	5.0^{a}	0-15	2.0^{b}	0-17
Family Conflict	5.0	0-100	2.0	0-88	10.0	0-93	8.8	0-00	18.3	0-85	16.5	0-85
Crises	3.0	0-100	5.0^{b}	0-100	0.0^{b}	0-13	0.0^{b}	0-40	10.5^{a}	0-25	3.0^{b}	0-25
Miscellaneous	0.0	0-35	0.0	0-35	0.0	0-21	0.0	0-25	0.9	0-8	3.0	0-8
'Other'	0.0	0-100	0.0	0-100	0.0	0-85	0.0	0-100	0.0	0-11	0.0	0-18

Note:

- Med = Median; R = Range
- 'Miscellaneous = schizophrenia, spiritual and neuropscyhological problems; Other = unspecified disorders not presented in the questionnaire
- Groups with different superscripts are significantly different at p<.05 level.

Kruskal-Wallis analysis with profession as the grouping variable indicated significant differences in the proportion of clients reported to have presented with addiction [X^2 (4, n = 168) = 24.8, p = .000]; externalising disorders [X^2(4, n = 167) = 14.5, p = .006]; developmental difficulties [X^2(4, n = 166) = 23.9, p = .000]; a history of abuse [X^2(4, n = 165) = 12.9, p = .012]; and crises [X^2(4, n = 167) = 15.0, p = .005]. These are presented in Table 8. When compared to most other groups, psychiatrists saw the greatest proportion of clients presenting with externalising disorders, crises and addiction; psychiatrists and psychologists, the greatest proportion of clients with developmental difficulties; and psychologists, the smallest proportion of clients suffering from abuse.

Treatment

Nature of Treatments Used

Practitioners were asked to estimate the proportion of their child and adolescent clients who, over the previous 12 months, had received from any source, exclusively psychosocial or pharmacological therapies, or a combination of both. Results are presented in Table 9. Overall, respondents reported that the majority of their clients had received solely psychosocial interventions. One quarter had received a combination of both and very few had received solely drug therapy.

Table 9.

Nature of Treatment Interventions

	% Clients Reportedly Receiving Each Intervention Type												
Type of Intervention	Total Sample (N = 189)			Psycholog. (n = 88-89)		Counsell. (n = 31)		Psychoth. (n = 35)		Psychiat (n = 16).		Others (n = 19)	
	M	SD	R	Med	R	Med	R	Med	R	Med	R	Med	R
Psychosocial (only)	63.3	37.6	0-100	80^{b}	0-100	96^{a}	0-100	85^{ab}	0-100	30^{c}	0-100	56^{bc}	0-100
Pharmacological (only)	2.6	11.1	0-90	0^{c}	0-60	0^{bc}	0-15	0^{bc}	0-5	5^{ab}	0-30	0^{a}	0-90
Combination	24.0	30.0	0-100	20^{b}	0-100	0^{c}	0-50	5^{bc}	0-100	67^{a}	0-100	25^{b}	0-100

Note:

- Combination = both pharmaological and psychosocial therapies
- Groups with different superscripts are significantly different at $p<.05$ level.

Kruskal-Wallis analysis with profession as the grouping variable indicated that the proportion of clients receiving psychosocial only [X^2 (4, n = 189) = 19.2, p = .001]; pharmacological only [X^2 (4, n = 189) = 19.8, p = .001]; or a combination of both therapies [X^2 (4, n = 189) = 34.6, p = .000], differed significantly between professional groups. Clients seen by counsellors were more likely than all but psychotherapists to receive solely psychosocial therapies. Clients seen by psychiatrists were less likely than those seen by all but 'others' (social workers and nurses) to do so. Clients seen by 'others' were more likely to receive drug therapy alone than those seen by all other groups except psychiatrists. Clients seen by psychiatrists were more likely than those seen by psychologists to do so. Clients seen by psychiatrists were significantly more likely than those seen by any other professional, to receive a combination of therapies. Those seen by counsellors were the least likely.

Practitioner Utilisation of Techniques

Respondents were asked to indicate from a list of 40 psychosocial techniques, the therapeutic approaches that they use in their own practice. On average, practitioners reported using a total of 12 (M = 12.0, SD = 4.8) of the 40 technique options. Fifty percent (n = 90) used between 11 and 24 different treatment techniques. The percent using each technique are presented in Appendix G. The majority of practitioners reported using cognitive behavioural (81%, n = 149) and family therapies (72%, n = 132). Over half used parent-management training (58%, n = 102), behavioural therapy (64%, n = 107), parental therapy relevant to the child's problem (56%, n = 103) and narrative therapy (56%, n = 103). Past life regression (1%, n = 2), biofeedback (3%, n = 6), rhetorical (.5%, n = 1) and discursive (.5%, n = 1) therapies were utilised by very few practitioners. No respondents reported using either hermeneutic or rebirthing techniques.

Patterns of Treatment Usage

To explore patterns of treatment usage among therapists (and for ease of presentation), a factor analysis using oblique (promax) rotation was undertaken. Variables falling below the 5% usage threshold were excluded from the analysis.

The resultant factor solution explained at least half of the variance of each of the 33 variables. Sixty-one percent of the total variance was explained by 11 factors, suggesting some consistent patterns of treatment usage. The rotated component pattern matrix is presented in Appendix H.

Factor constituents are presented in Table 10. Some factors are immediately recognisable as theoretically meaningful. For example, object-relations therapy, brief psychodynamic therapy, psychodynamic therapy, sand-tray therapy, attachment therapy and play therapy all load significantly onto the first factor, suggesting an overall psychoanalytic / psychodynamic theme. Other factors are less readily definable, particularly those with low eigenvalues.

See Table 10 over page...

Table 10.

Treatment Factor Constituents

Factor Theme	Factor Constituents	Eigen Value
Factor 1: Psychodynamic	Object Relations Therapy Brief Dynamic Therapy Sand Therapy Attachment Therapy Psychodynamic Therapy Play Therapy	3.88
Factor 2: Client-centred / Dynamic	Dream Therapy Interactional Drawing Therapy Client Centred Therapy Experiential Therapy *Dialectical behaviour Therapy*	3.53
Factor 3: Systemic / Wholistic	Multisystemic Therapy **Psychoeducation** *Multimodal Therapy* **Systems Therapy** *Family Therapy* *Respite Care*	2.37
Factor 4: Family Focus	**Family Therapy** Parent Therapy Marital Therapy	1.72
Factor 5: Cognitive - Challenging	**Dialectical Behavioral T.** Interpersonal Therapy Rational Emotive Therapy *Cognitive Therapy*	1.63
Factor 6: Cognitive-Behavioral - Role-play	**Cognitive-Behavioural T.** **Psychodrama** *Psychoeducation* *Parent Management Training*	1.44
Factor 7: Cognitive-Behavioral - Retraining	Behavioral Therapy **Cognitive Therapy** *Health Camp*	1.32
Factor 8: Contextual	**Respite Care** **Health Camp** Ecological	**1.18**
Factor 9: Instructional	**Parent-management Training** Bibliotherapy Life Skills Training *Cognitive-Behavioural Therapy* *Psychodrama*	**1.13**
Factor 10: Life Stories and Systems	Narrative *Systems Therapy* **Multi-modal Therapy**	1.07
Factor 11: Part & Whole	Gestalt Therapy Group Therapy	1.02

Note:

- Variables are considered practically significant (Hair, Anderson, Tatham & Black, 1998) and are listed with a factor if their loading on that factor is > / = .300.
- Where one variable loads significantly onto more than one factor, the higher correlate is indicated in **bold** and the lower in *italics*.

Patterns of treatment usage are presented in Table 11. A majority of practitioners used treatments with a systemic-wholistic, cognitive-behavioural-role-play, instructional, family focus, cognitive-behavioural-retraining and life-stories / systems theme.

Table 11.

Patterns of Treatment Usage Among Professional Groups

	% Respondents Reportedly Using Each Treatment Group					
Factor	Total Sample (N = 183)	Psychol. (n = 85)	Counsell. (n = 30)	Psychoth. (n = 33)	Psychiat. (n = 16)	Others (n = 19)
1: Psychodynamic	63.9	51.8^{b}	66.7^{b}	90.9^{a}	68.8^{b}	63.2^{b}
2: Client-C - Dynamic	57.6	44.2^{bc}	83.3^{a}	75.8^{a}	18.8^{c}	78.9^{ac}
3: Systemic / Wholistic	91.3	91.8	86.7	90.9	93.8	94.7
4: Family Focus	82.0	74.1^{bd}	80.0^{cd}	87.9^{cd}	100^{ac}	94.7^{cd}
5: Cognitive-Challenging	60.1	74.1^{ae}	46.7^{bd}	42.4^{cd}	62.5^{de}	47.4^{de}
6: C-B-Role-play	89.1	95.3^{ae}	80.0^{bd}	75.8^{cd}	93.8^{de}	94.7^{de}
7: C-B-Retraining	73.2	89.4^{bc}	60.0^{ade}	$48.5.^{ad}$	87.5^{ce}	52.6^{ad}
8: Contextual	61.2	64.7	50.0	51.5	81.3	63.2
9: Instructional	89.1	94.1	80.0	81.8	87.5	94.7
10: Life Stories / Systems	71.0	71.8	76.7	69.7	62.5	68.4
11: Part & Whole	38.0	36.5	40.0	42.4	43.8	36.8

Note:

- Client-C = client centred; C-B = cognitive-behavioural
- Groups with different superscripts are significantly different at p<.05 level.

The Relationship between Professional Group Membership and Treatment Usage

To determine the extent to which various techniques are used by different professional groups, a discriminant analysis with profession as the grouping variable and 33 techniques as the independent variables, was performed. Of the 40 techniques included in the questionnaire, 33 were reportedly used by at least 5% of respondents. Variables falling below this 5% threshold were not included in the analysis.

The derived functions correctly predicted professional group membership for 71% of all cases [$f_{unctions\ 1\text{-}4}$: X^2 (132, n = 180) = 267.31, p = .000], suggesting some consistency in treatment usage among professional groups.

Chi-Square analyses identified significant differences between professional groups on a number of factors including psychodynamic [X^2 (4, n=183)= 16.14, p = .003]; client-centred [X^2 (4, n=184) = 32.36, p = .000]; family focus [X^2 (4, n=183) = 10.02, p = .04]; cognitive -challenging [X^2 (4, n=184) = 14.85, p = .005]; cognitive-behavioural-role-play [X^2

(4, n=183) = 12.91, p = .012, s]; and cognitive-behavioural-retraining [X^2 (4, n=183) = 30.11, p = .000] factors.

Factor one, which appeared to represent psychodynamic and related techniques, was more likely to be used by psychotherapists than by other professionals. Factor two appeared to represent therapies with a client-centred /dynamic theme and was used most frequently by counsellors, 'others' (social workers and nurses) and psychotherapists. There was little variation between groups in the use of factor four, which appeared to represent therapies with a family focus. However, psychologists reported using these techniques less than most, and significantly less than psychiatrists. Factors five and six which appeared to represent cognitive-challenging and cognitive-behavioral-role-play themes respectively, were used significantly more by psychologists than by counsellors and psychotherapists. Similarly, with the exception of psychiatrists, psychologists reported the use of factor seven, representing a cognitive-behavioural-retraining theme, significantly more than any other professional group.

To summarise, except for psychiatrists, psychologists showed a tendency toward using behaviourally-based therapies such as those described in the cognitive-challenging, cognitive-behavioural-role-play, and cognitive-behavioural-retraining factors, significantly more than most other groups. Psychiatrists also used these techniques relatively frequently. Psychotherapists and counsellors were more inclined to use therapies with a psychodynamic and client-centred / dynamic theme. Psychiatrists reported a stronger family focus than other groups.

Treatment Characteristics

Respondents were asked to report on a variety of treatment characteristics. On average, practitioners reported administering 15 sessions over a period of 22 weeks. Half of all respondents reported administering therapy over a 13 week period (Median = 13, Range = 1-104). Seventeen percent of clients reportedly terminated therapy prematurely. On average, over half of all children and adolescents were seen together with a parent or caregiver for at least one session during the course of therapy. An attempt to follow progress at completion of therapy was generally undertaken in approximately one third of all cases. These responses are summarised in Table 12.

See Table 12 over page...

Table 12.

Treatment Characteristics

	Total Sample (n=147 -173)			Psycholog. (n=71 - 80)		Counsel. (n=25 - 29)		Psychoth. (n=25 - 32)		Psychiat. (n=9 - 5)		Others (n=16 - 18)	
	M	**SD**	**Range**	**Med.**	**Range**	**Med**	**Range**	**Med**	**Range**	**Med**	**Range**	**Med**	**Range**
Therapy Length (frequencies)													
Typical duration in weeks	21.8	18.8	1-104	16.0[bc]	3-102	13.0[b]	4-80	26.0[ac]	1-104	26.0[a]	13-104	10.5[b]	2-52
Typical no. of sessions in all	14.8	19.1	0-200	10.0	0-60	10.0	1-40	10.0	1-75	9.0	6-200	10.0	3-52
Parents Seen with Clients (%)													
Children seen with parents (>/= 1 session)	68.6	40.6	0-100	98.0	0-100	80.0	0-100	80.0	0-100	100	0-100	100.0	0-100
Adolescents seen with parents (>/= 1 session)	62.9	37.9	0-100	80.0	0-100	40.0	0-100	75.0	0-100	90	25-100	80.0	0-100
Premature Termination and Follow-up (%)													
'Drop-out' rate	16.8	17.8	0-100	10.0	0-100	10.0	0-50	15.0	0-80	13.5	3-80	15.0	0-60
Cases 'followed-up' (or attempted to)	38.5	37.5	0-100	25.0	0-100	36.5	0-100	15.0	0-100	25.0	0-100	20.0	0-100

Note:

- Groups with different superscripts are significantly different at p<.05 level.

Treatment Characteristics Continued...

Kruskal-Wallis analysis with profession as the grouping variable indicated that the typical duration of therapy differed significantly between professional groups [X^2 (4, n=147) = 9.72, p = .045]. In particular, psychiatrists tended to administer therapy for a significantly longer period (M = 35.7, SD=29.8) than psychologists (M=20.5, SD = 16.3), counsellors or 'others'. Professional groups did not vary on any of the other treatment characteristics (P> .05).

Treatment Selection Criteria

To determine the relative importance that members of the different professional groups placed on each of the seven selection criteria, a Friedman's non-parametric test was used. Significant differences were found between the treatment characteristic variables within each of the groups including: the total sample [X^2 (6, n = 163) = 323.87, p = .000]; psychologists [X^2 (6, n = 79) = 174.769, p = .000]; counsellors [X^2 (6, n = 28) = 76.61, p =.000]; psychotherapists [X^2 (6, n = 28) = .71.21, p = .000]; psychiatrists [X^2 (6, n = 11) = 17.10, p = .009]; and 'others' (social workers and nurses) [X^2 (6, n = 17) = 35.37, p =.000]. Results are presented in Table 13.

Table 13.

Treatment Selection Priorities

	Mean Rank (1-7)					
Selection Criteria (Treatment Characteristic)	Total Sample (N = 169-75)	Psychol. (n = 80-83)	Counsel. (n = 28-30)	Psychoth. (n = 29-32)	Psychiat. (n = 13-16)	Others (n = 17)
	2.99 **(1)**	2.33 $(1)^{a}$	4.16 $(5)^{b}$	4.02 $(4)^{bc}$	2.50 $(1)^{a}$	2.76 $(1)^{ac}$
Previous success with this treatment	3.08 **(2)**	3.17 (2)	2.50 (1=)	2.86 (3)	4.14 (4)	3.29 (3)
Compatible with own paradigm	3.16 **(3)**	3.42 $(3)^{bc}$	2.50 $(1=)^{a}$	2.75 $(1)^{a}$	4.23 $(5)^{bc}$	3.00 $(2)^{ac}$
Congruent with proposed etiology	3.35 **(4)**	3.49 (4)	3.21 (3)	2.82 (2)	3.41 (3)	3.71 (4)
Empirical Support (general)	4.52 **(5)**	4.39 $(5)^{b}$	5.02 $(6)^{b}$	4.66 $(6)^{b}$	3.32 $(2)^{a}$	4.88 $(6)^{b}$
Recommended by other professional	4.54 **(6)**	4.93 $(6)^{ac}$	4.07 $(4)^{b}$	4.29 $(5)^{ab}$	4.50 $(6)^{c}$	3.97 $(5)^{b}$
Accompanied by a manual	6.36 **(7)**	6.27 (7)	6.54 (7)	6.61 (7)	5.91 (7)	6.38 (7)

Note:

- 1 = characteristic considered most important when selecting a treatment; 7 = considered least important
- Groups with different superscripts are significantly different at p<.05 level.

As a group, respondents prioritised 'empirical support for use with a specific problem' as the most important treatment selection criteria. 'Paradigm compatibility', 'congruence with a proposed etiology' and whether or not one could claim 'previous success with the treatment', were also granted relatively high rank. 'Accompaniment by a manual' was deemed least relevant to treatment selection.

Psychologists, psychiatrists and 'others' all reported 'empirical support for use with a specific problem' to be the most important criteria for treatment selection. Counsellors and psychotherapists ranked 'paradigm compatibility', 'congruence with a proposed etiology' and ' previous success with a treatment' as characteristics most relevant to treatment selection. All professional groups reported 'accompaniment by a manual' to be the least important consideration. Similarly, both 'general empirical support' and 'recommendation by another professional' were ranked as relatively low selection priorities by all professional groups.

Kruskal Wallis analysis with profession as the grouping variable indicated significant differences between professional groups in the degree to which they prioritised 'empirical support for use with a specific problem' [X^2 (4, n = 175) = 31.43, p = .000,]; 'general empirical support' [X^2 (4, n = 169) = 14.31, p = .006]; 'compatibility with own paradigm' [X^2 (4, n = 173) = 16.4, p = .002]; and 'recommendation by another professional' [X^2 (4, n = 170) = 12.58, p = .014]. In particular, psychiatrists and psychologists valued treatments that were empirically validated for use with a specific problem more than most other professions. Psychotherapists and counsellors prioritised this the least. Psychiatrists placed the most importance on treatments that have some general empirical support. Counsellors and psychotherapists prioritised 'paradigm compatibility' more highly than did psychologists or psychiatrists. Finally, 'others' (social workers and nurses) and counsellors placed more weight on recommendations from other professionals than did psychologists or psychiatrists.

To summarise, counsellors and psychotherapists shared similar views as to the relative importance of various treatment characteristics. The same can be said for psychotherapists and others, and to a lesser extent, psychologists and psychiatrists.

Assessment

Respondents were asked to indicate from a list of 14 options, the assessment models that they used to describe and define their clients' problems. On average, practitioners reported using 4 (M=4.3, SD = 1.9) of the 13 assessment options. Eighty-three percent (n = 155) used between 3 and 10 approaches. The percent using each model are presented in Table 14. The majority of respondents reported using diagnostic, developmental, family systems and cognitive-behavioural assessment models.

Table 14.

Therapist Utilisation of Various Assessment Approaches

	% Respondents Reportedly Using Each Approach					
Assessment Model	Total Sample (n=188)	Psychol. (n=89)	Counsell. (n=30)	Psychoth. (n=33)	Psychiat. (n=17)	Others (n=19)
Diagnosis	**72**	**80^{b}**	27^{c}	**73^{b}**	**100^{a}**	**79^{b}**
Functional Analysis	46	**71^{a}**	23^{b}	18^{b}	35^{b}	26^{b}
Ecological	26	35^{a}	17^{ab}	9^{b}	18^{ab}	32^{a}
Process-driven	12	8	10	21	6	21
Developmental	**65**	**63**	**63**	**82**	**59**	**58**
Family Systems	**67**	**60**	**73**	**73**	**77**	**74**
Cognitive-Behavioural	**59**	**74^{a}**	**53^{b}**	39^{b}	**53^{ab}**	37^{b}
Whanau-Hapu-Iwi	8	6	13	3	12	16
Community-based	6	7	0	6	6	1
Personality-based	14	8	13	27	24	16
Psychometric	35	**57^{a}**	3^{b}	12^{b}	41^{a}	11^{b}
Whanaunga-tanga	7	8	10	3	6	11
None	0.5	0	3	0	0	0
Other	7	2	10	15	0	16

Note:

- Percentages greater than 50% are presented in **bold.**
- Groups with different superscripts are significantly different at p<.05 level.

Relationship between Professional Group Membership and the Use of Assessment Models

To determine the extent to which different assessment models are used by different professional groups, a discriminant functional analysis with profession as the grouping variable and the 12 assessment models as the independent variables was performed. The derived functions correctly predicted professional group membership for only 57% of all cases [functions 1-4 = X^2 (48, n = 187) = 166.5, p = .000]. However, group membership was accurately predicted for 72% (n =29) of counsellors and 65% of psychologists, suggesting some consistency in assessment usage within these two groups. The functions predicted membership for less than half of members in the remaining three groups. Overall, these results suggest that there may be less within-group consistency in the use of assessment modalities than there is in their use of treatment techniques.

Kruskal Wallis analysis with profession as the grouping variable indicated significant differences between professional groups in the use of diagnosis [X^2 (4, n = 188) = 39.9, p = .000]; functional analysis [X^2 (4, n = 188) = 42.0, p = .000]; ecological [X^2 (4, n = 188) = 10.8, p = .028]; cognitive-behavioural [X^2 (4, n = 188) = 18.1, p = .001]; and psychometric [X^2 (4, n = 187) = 44.9, p = .000] assessment models. Diagnosis was used significantly more by psychiatrists and significantly less by counsellors than by any other group. Psychologists used functional analysis more than all other groups and the cognitive-behavioural model more than all but psychiatrists. Psychologists and psychiatrists used psychometric approaches significantly more often than all other groups. These differences must be interpreted in light of the relatively weak relationship between assessment usage and professional group membership as found in the discriminant analysis.

To explore patterns of assessment usage among therapists, a factor analysis with oblique (promax) rotation was undertaken. Neither the 'no-assessment' nor the 'other' categories were included in the analysis.

The resultant factor solution explained over half of the variance for each of 9 assessment variables and more than one third for each of the remaining three. Sixty-two percent of the total variance was explained by five factors, suggesting some consistent patterns of assessment usage. The rotated component matrix is presented in Appendix I. Factor constituents are presented in Table 15.

See Table 15 over page...

Table 15.

Assessment Factor Constituents

Factor Theme	Factor Constituents	Eigen Value
Factor 1: Hierarchical Assessment Model	Developmental Family Systems **Diagnosis** *Process Driven*	1.75
Factor 2: Clinical Assessment Model	**Cognitive Behavioural** Psychometric *Diagnosis* *Functional Analysis*	1.55
Factor 3: Relational Assessment Model	Whanau-Hapu-Iwi Whanaungatanga	1.33
Factor 4: Contextual Assessment Model	Community-based **Process Driven** Ecological **Functional Analysis** Diagnosis (-ve)	1.11
Factor 5: Personality Formulation Assessment Model	Personality-based *Cognitive Behavioural*	1.02

Note:

- Variables are considered practically significant (Hair et al, 1998) and are listed with a factor if their loading on that factor is > / = .300.
- Where one variable loads significantly onto more than one factor, the higher correlate is indicated in **bold** and the lower in *italics.*
- -ve = negative correlate.

Outcome

Therapist Perception of Outcome

Therapists were asked to estimate the global level of therapeutic change that typically occurred for clients experiencing a variety of problems. For ease of presentation, the original 32 problems were condensed into 12 logically-derived super-ordinate categories (see Appendix F).

Table 16 presents the frequency with which practitioners reported a marked change or complete recovery across the 12 problem categories. Overall, therapists reported most optimism about the effects of treatment with clients suffering from depressive, anxious, social, eliminative, abusive and critical problems. They were less optimistic about outcome when it came to the treatment of eating, addictive, developmental and miscellaneous (spiritual, psychotic and neuropsychological) disorders.

Table 16.

Therapist Perception of Outcome Across Problem Types

	% Respondents Perceiving a Marked Change or Complete Recovery					
Problem Type	Total Sample (N=150-70)	Psychol. (n=74--81)	Counsel. (n = 24-28)	Psychoth. (n=32-33)	Psychiat. (n=12-14)	Others (n=16-17)
Externalising	**59**	**57**	**52**	**78**	**67**	42
Depressive	**74**	**70**	**60**	**86**	**83**	**75**
Anxious	**74**	**76**	**50**	**83**	**73**	**82**
Social Relations	**66**	**61**	**70**	**83**	43	**69**
Developmental	28	27	33	46	10	30
Abusive	**61**	43^{b}	$\mathbf{81}^{a}$	$\mathbf{83}^{a}$	22^{b}	$\mathbf{64}^{ab}$
Eating	41	42	25	**71**	30	40
Elimination	**61**	**57**	**67**	**71**	38	**100**
Addiction	33	37	**68**	17	10	**57**
Family conflict	**57**	47^{c}	$\mathbf{76}^{ab}$	$\mathbf{90}^{a}$	0^{d}	40^{c}
Crises	**78**	**75**	**67**	**93**	**80**	**78**
Miscellaneous	35	18^{b}	33^{ab}	$\mathbf{67}^{ab}$	25^{b}	$\mathbf{86}^{a}$

Note:

- Percentages refer to the proportion of therapists reportedly *treating each disorder* (i.e not a proportion of the total sample)
- Percentages greater than 50% are presented in **bold.**
- Groups with different superscripts are significantly different at p<.05 level.

Significant differences between groups were explored using chi-square analysis. Professional groups differed in their experience of outcome when working with children suffering from abuse (X^2 (4, n =100) = 19.11, p = .001), family relationship problems, (X^2 (4, n = 99) = 25.04, p = .000), and miscellaneous difficulties (X^2 (4, n = 43) = 12.35, p = .015). In particular, psychotherapists and counsellors reported the most and psychiatrists the least success when dealing with family relational problems. Similarly, psychotherapists and counsellors claimed to make more therapeutic progress with abused children than most other groups.

Relationship between Therapist Perceived Outcome (per problem type) and Treatment

To identify any relationships between therapist perception of outcome and treatment type, chi square analyses were performed using the 12 broad problem categories and each of the 40 treatment techniques. Positive relationships were identified through examination of frequency data. Table 17 presents all positive relationships that reached significance at a p< .05 level. Remaining non-significant (p>.05) relationships are not presented.

Table 17.

Technique X Perceived Outcome (per problem type)

	Specific Techniques Showing Significant Relationships Between Use and Outcome				
Problem Type	Brief Psycho-Dynamic	Family Therapy	Psycho-Education	Narrative Therapy	Sand Therapy
	Chi Values and Significance				
Internalising	9.04	-	-	-	-
p (n =107)	(.003)	-	-	-	-
Anxious	5.44	4.44	-	-	-
p (n = 114)	(.012)	(.04)	-	-	-
Social Relational	-	-	7.12	-	-
p (n = 105)	-	-	(.008)	-	-
Abuse	-	-	-	6.71	-
p (n = 99)	-	-	-	(.009)	-
Family Conflict	6.92	-	-	-	8.64
p (n = 99)	(.009)	-	-	-	(.003)

Note:

- Only relationships reaching significance at p<.05 are presented.

A significant majority of therapists using brief psychodynamic therapy reported a marked change or complete recovery in clients presenting with depressive disorders, anxious disorders and family conflict. Similar success was reported for clients with social problems by practitioners using psychoeducation; for clients in crises, by practitioners using respite care; for clients with anxiety disorders by practitioners using family therapy; and for clients suffering abuse, by practitioners using narrative therapy. However, the sensitivity of these

results may be limited by the relatively consistent pattern of optimism reported by most clinicians about their treatment methods.

These relationships suggest that although practitioners using these techniques reported significantly better outcomes than those not using them, therapists using other techniques may also experience relatively good outcomes with these disorders.

Relationship between Therapist Perceived Outcome (per problem type) and Treatment Characteristics

To identify any relationships between therapist perception of outcome and various treatment characteristics, a Spearman's correlation was performed between each of the 12 outcome (per problem type) categories and the six treatment parameters. To account for the possibility of type one error (due to multiple comparisons in this analysis), a more conservative significance criteria was calculated using Bonferroni adjusted p [p = (.05 / 12) = .004]. Correlations overall ranged from .003 to.435. Table 18 presents all correlations that reached significance at a p< .05 level. Remaining non-significant (p>.05) relationships are not presented.

Table 18.

Treatment Characteristics X Perceived Outcome (per problem type)

	Treatment Characteristics Showing Significant Relationships with Outcome				
Problem Type	Typical Number of Sessions	% Children Seen with Parents	% Adolesc. Seen with Parents	% Drop Out	% Follow-up / Attempted Follow-up
	Chi Values and Significance				
Externalising	-	.261	-	-	-
P (two-tailed)	-	.006	-	-	-
Depressive	-	-	-	-.300	-
P (two-tailed)	-	-	-	**.002**	-
Anxious	-	.381	.261	-.201	-
P (two-tailed)	-	**.000**	.007	. 038	-
Abusive	-	-	-	-.202	-
P (two-tailed)	-	-	-	.038	-
Addictive	-	-	-	-	.343
P (two-tailed)	-	-	-	-	.023
Miscellaneous	.435	-	-	-	-
P (two-tailed)	.008	-	-	-	-

Note:

- Only relationships reaching significance at p<.05 are presented.
- **bold** = significant at Bonferri adjusted level [p = (.05 / 12) = .004]

Only two associations emerged that reached the Bonferroni adjusted $p < .004$ level. First, therapist perception of outcome when treating anxiety disorders in 0-11 year olds was positively correlated with the inclusion of parents in at least one treatment session. Second, therapists who reported a high percentage of clients dropping out of treatment had less optimism about treatment success with depressed clients. Neither therapy duration, typical number of sessions, proportion of adolescent clients seen with parents, nor the proportion of clients followed up post treatment, were found to be associated with outcome ($p>.05$).

Outcome Predictors

Therapist Beliefs about Factors Affecting Outcome

Respondents were asked to rate a number of variables according to their likely impact on therapy effectiveness. The variables were derived from eight broad theoretical categories: (i) therapist-client match; (ii) client characteristics; (iii) therapist characteristics; (iv) in-session variables; (v) parent and family characteristics; (vi) network/community variables; (vii) treatment variables; and (viii) third party influences. Appendix J presents the percent of respondents who rated each of the original 67 sub-ordinate variables to be either very likely or most likely to influence outcome. A large majority of participants (over 80%) rated quality of therapist alliance (88%, n = 154), therapist overall experience (83, n = 143) and therapist degree of flexibility (86%, n = 147) as very important. Complexity of comorbid problems (87%, n = 144), motivation for change (88%, n = 150) and ability to apply in-session progress to every-day-life (81%, n = 132) were the client characteristics rated most likely to affect outcome. Of the family and parent variables, parental mental illness (80%, n = 139) and family stress (90%, n = 157) were most frequently rated as strong outcome predictors. Many other variables were believed to be either very much or most likely to impact outcome by over half (51% - 79%, n = 85-134) of respondents. Twenty-four percent (n = 43) of practitioners indicated their belief that other variables not specified in the questionnaire had some impact on outcome.

To meaningfully summarise this information, factor analyses using oblique (promax) rotations, were performed for each broad theoretical category. As this was undertaken for presentation purposes only, the statistical details are not presented here. In most instances, variables from each broad theoretical division fell into two or more theoretically meaningful subcategories. However, the therapist variables, with the exception of three characteristics (therapist directiveness, theoretical orientation and availability) fell convincingly onto a single factor. The resultant 14 factors and their constituents are presented in Table 19.

See Table 19 over page...

Table 19.

Outcome Predictor Factor Constituents

Factor Theme	Factor Constituents	
1. Therapist-Client Match-Stable Similarity	• Similarity in age • Similarity in sex	• Cultural similarity • Similarity in SES
2. Therapist-Client Match - Alliance	• Quality of therapeutic alliance • Congruence in interpersonal style	• Agreement in role expectation • Freedom to express negativity
3. Client-Response to Problem & Treatment	• Motivation for change • Expectation for improvement • History of abuse • Level of acculturation • Beliefs about problem	• Level of self awareness • Emotional response to treatment • Ability to generalise from in-session • Level of distress
4. Client-Stable Traits	• Developmental stage • Age • Gender	• Academic ability • Verbal skills
5. Client-Clinical Profile	• Severity of dysfunction • Duration of dysfunction	• Complexity of co-morbidity • Diagnosis
6. Therapist	• Qualifications • Overall experience • Experience with specific problem • Demonstration of warmth • Flexibility • Sense of accountability in achieving change	• Ability to integrate skills • Expectation for change • Attendance in own therapy • Quality of professional supervision
7. In-Session	• Use of structure • Use of homework • Use of a manual	• Use of relapse-prevention methods
8. Treatment-Type and Characteristics	• Treatment type • Number of sessions attended • Promptness of intervention	• Duration of sessions • Use of follow-up / booster sessions
9. Treatment-Focus	• Adherence to time limit • Focus by end of session	
10. Community	• Level of social support • Involvement with deviant peers • Quality of school environment	• Availability of cultural support • Negative neighbourhood influences
11. Family -Structure	• Socio-economic situation • Two versus one parent family	
12. Family / Parental - Stress	• Parental co-operation • Parental mental illness	• Stable home life • Family conflict / stress
13. Family/Parental-Engagement	• Parental hope of improvement • Quality of parent-therapist alliance	• Parental perception of barriers to treatment
14. Third Party	• Source of funding • Degree of co-operation between agencies	

Note:

- Three therapist variables (theoretical orientation; directiveness and availability) failed to load onto the single therapist factor and are therefore not represented here

Table 20 presents the percent of professionals who rated each outcome predictor factor as being either very much or most likely to impact outcome. 'Client clinical profile' and 'therapist' factors were reportedly seen as the most influential. These were closely followed by the 'client-response to problem and treatment', 'family / parental stress', 'therapist-client match-alliance', 'treatment-type and characteristics', and 'community' factors. Therapists placed relatively little importance on the influence of therapist-client-stable similarities', 'treatment focus', 'family-structure' and 'client-stable-traits'.

Table 20.

Therapist Beliefs About Outcome Predictors

	% Respondents Rating Factors Very Much or Most Likely to Impact Outcome					
Outcome Predictor Factors	Total (N=170-80)	Psychol. (n=79-84)	Counsell. (n=28-29)	Psychoth. (n=30-33)	Psychiat. (n=15-16)	Others (n=18)
Therapist-Client Match - Stable Similarity	23	18	28	25	20	33
Therapist-Client Match - Alliance	**93**	**89**	**100**	**100**	**87**	**89**
Client -Response to Problem & Treatment	**94**	**96**	**89**	**93**	**100**	**89**
Client - Stable Traits	62	59	61	68	60	67
Client - Clinical Profile	**99**	**99**	**100**	**100**	**100**	**94**
Therapist	**99**	**99**	**100**	**100**	**100**	**94**
In-Session	71	75	71	57	73	72
Treatment - Type and Characteristics	**91**	**90**	**82**	**94**	**100**	**94**
Treatment - Focus	38	28[b]	46[a]	57[a]	27[ab]	44[ab]
Community	**90**	**85**	**97**	**94**	**94**	**94**
Family -Structure	26	23	32	33	20	22
Family / Parent - Stress	**94**	**91**	**93**	**100**	**100**	**94**
Family /Parent - Engagement	**81**	74	79	**94**	**100**	78
Third party	70	61[b]	75[ab]	**90**[a]	67[ab]	72[ab]

Note:

- Three therapist variables (theoretical orientation; directiveness and availability) failed to load onto the single therapist factor and are therefore not represented here
- Percentages greater than 80% are presented in **bold.**

Kruskal Wallis analysis with profession as the grouping variable indicated significant differences between professional groups for the 'third party' (e.g. funding source) [X^2 (4, n = 170) = 9.90, p = .042] and 'treatment focus' [X^2(4, n = 171) = 11.26, p = .024] factors. When compared to other professional groups, psychotherapists and counsellors rated treatment factor two, representing 'adherence to a time limit' and 'focus by the end of the first session' as significantly more likely to influence outcome. Professional groups did not vary significantly in their beliefs about other outcome predictor factors including: family structure; family / parent-stress; family / parent-engagement; therapist-client-match-stable similarity; therapist-client-match-alliance; client-response to problem and treatment; client-stable traits; client-clinical profile; in-session; therapist; treatment-type / characteristics; or community factors (p> .05).

CHAPTER TEN

Discussion

The purpose of this study was to describe patterns of child and adolescent psychotherapy in New Zealand, to assess the extent to which these differ from the characteristics of treatment-outcome research, and to identify clinically relevant areas for future research. Specifically, patterns of practice including: assessment and treatment, therapist perceived outcomes; therapist beliefs about factors affecting outcome; and psychologists' adherence to aspects of the scientist-practitioner model, were sought. Practitioners from a wide variety of professional backgrounds were surveyed to enable a thorough picture of childrens' experience of psychotherapy in New Zealand to emerge.

Findings are presented as follows. First, practice patterns are compared with those found in Kazdin and colleagues' (1990) survey and to results from earlier New Zealand and North American practitioner surveys. Second, the gap between research and practice in New Zealand and psychologist adherence to the scientist-practitioner model is assessed. This is followed by a brief outline of limitations. Finally, future directions with respect to: developing clinically representative outcome studies; transporting empirically-supported therapies to the clinic setting; continuing the search for common factors, and integrating science with practice, are discussed.

Major Finding

Apart from the types of treatments used, the main finding from this study concurs with that from Kazdin, Siegel and Bass's (1990) survey in that the conditions and characteristics of child and adolescent psychotherapy practice differ from those found in research. Results also share some similarities with those from previous practitioner surveys (Kazantzis & Deane, 1998; Koocher & Pedulla, 1977; Patchett-Anderson & Ronan; 2002; Tuma & Pratt, 1982; Silver & Silver, 1983).

Main Findings

Main findings are first summarised below and then discussed in relation to the primary study questions.

- As was found in Kazdin and colleagues' (1990) survey, the clients, therapists and treatment characteristics reported by this sample of psychotherapy practitioners were unlike those typically used in treatment-outcome research.

- As suggested in previous surveys (Kazantzis & Deane, 1998; Kazdin, Siegel & Bass, 1990; Patchett-Anderson & Ronan, 2002; Tuma & Pratt, 1982), there was evidence here to suggest that most therapists adopted an eclectic approach to practice. This differs from the pure-form approach typically used in treatment-outcome research.

- As was found in Kazdin and colleagues' (1990) survey, therapists in this sample believed that a large number of non-treatment related variables were extremely likely to impact therapeutic change. This was particularly so with respect to client, therapist and family variables. However, in contrast to Kazdin and colleagues' (1990) findings, and more in line with research priorities, this sample also rated treatment characteristics, including the type of treatment used, as having an important impact on outcome. Despite this, relatively few treatments were found to be associated with therapist perceived excellent outcomes.

- In contrast to previous surveys (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Tuma & Pratt, 1982), findings indicated that some of the treatments used by this sample were consistent with those typically studied in research, although this varied between professional groups. On the other hand, therapies rarely studied in research were also frequently used by practitioners in this sample and in some cases, associated with good reported outcomes.

- Although not addressed in previous studies, findings here indicated a more contextual approach to assessment than is typically used in research.

Review of Findings in Relation to Study Goals

Findings are now presented in relation to the primary study questions. Comparisons with previous surveys are limited by sample differences. Samples from comparable surveys included either counsellors, psychologists or psychiatrists, or a combination of both psychologists and psychiatrists whereas the present sample included at least four distinct professional groups. In addition, methods used and questions asked vary between surveys.

1. General Description of the demographic, professional and clinical (including their clients) characteristics of mental health practitioners providing psychosocial intervention to children and adolescents in New Zealand.

Respondents were predominantly New-Zealand-European, female and aged in their mid-forties.

As with this sample, North American respondents were predominantly Caucasian and in their mid-forties (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Tuma & Pratt, 1982; Silver & Silver, 1983). However, in contrast to the current sample, the majority of North American respondents were male (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Tuma & Pratt, 1982).

All practitioners in the present sample were currently involved in the psychosocial treatment of children and adolescents although they varied considerably in experience level. Most held university qualifications, many at a post-graduate level. The degree to which New Zealand practitioners had undergone specialist training for their work with children and adolescents was not able to be determined by their qualifications, although very few indicated holding qualifications of this nature. In addition, specialisation through qualification is not the norm in New Zealand except with psychiatrists. This may contrast with practitioners from North American samples in which up to 25% of participants in one study (Tuma & Pratt, 1982) had received specialist pediatric mental health qualifications. Practitioners in the current sample reported that on average, 40% of their clients were adult. However, this varied significantly between professional groups. Psychologists, psychiatrists and others (nurses and social workers) saw a greater proportion of children than adults (in some cases 100%). Psychotherapists and counsellors saw proportionally more adults than children suggesting less specialisation within these two groups.

Practitioners reported treating predominantly New-Zealand European / Pakeha clients with an equal mix of boys and girls. As is consistent with known prevalence rates (Ministry of Health, 1997), adolescents aged 12 to 17 years formed the highest proportion of clients seen. Children were most often referred for treatment by parents or caregivers, medical professionals and schools. In descending order of frequency, the most common problems seen were family conflict, externalising disorders, abuse and anxiety disorders. Least commonly seen were eliminative, eating, addiction and 'other' (schizophrenia, neuropsychological and spiritual) problems. This contrasts somewhat with known prevalence rates for conditions. In descending order of frequency, mood disorders, anxiety disorders, substance abuse and conduct disorders are the most prevalent problems in NZ at age 18 years (Ministry of health, 1997).

As was the case here, clients seen by North American clinicians were also predominantly Caucasian. However, practitioners reported seeing more boys than girls (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977;Tuma & Pratt, 1982; Silver & Silver, 1983). Except for depression, personality disorders and adjustment disorder (which was not explicitly categorised in the current study), clients presented with a comparable range of problems (Kazdin, Siegel & Bass, 1990; Tuma & Pratt, 1982; Silver & Silver, 1983). Although a large number of New Zealand children were reported to experience problematic family conflict, this 'diagnosis' was not investigated in the North American surveys.

2. Describe the assessment modalities, therapeutic approaches, treatment techniques and treatment characteristics / parameters used by practitioners.

Nature of Treatment

According to participants in the current study, most of their clients were receiving purely psychosocial interventions, with about one-quarter receiving a combination of both pharmacotherapy and psychotherapy. This differed between professional groups with clients seen by counsellors and psychotherapists less likely to receive combination treatments than those seen by psychiatrists, psychologists and others. This likely reflects the differential emphasis placed by professional groups (and associated institutions) on the medical model. Clients seen by psychotherapists and counsellors may be disadvantaged in view of findings in support of combination therapies with specific problems (e.g. Bacaltchuk, Hay & Trefiglio, 2002).

Theoretical Orientation

There was evidence to suggest that most therapists had an eclectic approach to practice, although this was more apparent in their theoretical orientation than in their use of specific techniques. For present purposes, respondents who described themselves as practising from two or more theoretically distinct stances were said to be using a theoretically eclectic approach. The majority of practitioners fell into this category. A minority reported using a theoretically pure stance. For both eclectic and pure-form practitioners, cognitive-behavioural was the most frequently endorsed paradigm. However, more than half of practitioners claimed to practice from an entirely non-behavioural orientation, contradicting the finding to be discussed later, that more than half of practitioners use cognitive-behavioural techniques.

The majority of practitioners indicated that a mixture of up to four different paradigms influenced at least some areas of their practice, lending further support to the initial suggestion of eclectic practice among therapists here. Practitioners reported being most influenced by cognitive-behavioural and family systems orientations. Professional groups varied in expected ways with psychotherapists most influenced by psychodynamic, counsellors by humanistic, psychiatrists by family systems, and psychologists by cognitive and behavioural orientations.

These findings conform on the whole with those from two previous New Zealand studies (Kazantzis & Deane, 1998; Patchett-Anderson & Ronan, 2002), in which a large number of psychologists were shown to practice from an eclectic or cognitive-behavioural stance. Although comparisons are limited by sampling and methodological differences between the studies, these consistent findings may reflect the predominant cognitive-behavioural focus that has characterised training for psychologists in New Zealand over the past 20 years (Kazantzis & Deane, 1998).

North American survey results also indicate a predominant eclectic theoretical orientation among psychiatrists and psychologists, with family systems also reported to be very influential (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Tuma & Pratt, 1982). However, behavioural and psychodynamic influences were found to be more popular in the North American studies. This comparison was also noted by Kazantzis and Deane (1998) and conforms with findings from this study. Here, only psychotherapists reported being strongly influenced by psychodynamic theory or to frequently use associated

techniques. The behavioural paradigm had less influence on psychologists and psychiatrists here than in North American samples, which is surprising given the a-fore mentioned behavioural and cognitive-behavioural training focus in New Zealand.

Technique Usage

Overall, therapists reported using an average of 12 different treatment types in their practice, supporting a picture of technical eclecticism. However, practitioners did tend to use paradigmatically similar treatment techniques that appeared to vary according to professional group. Interventions used by the majority of the sample included cognitive-behavioural therapy, family therapy, behavioural therapy, parent-management training, narrative therapy and parental therapy relevant to a child's problems. As mentioned earlier, this finding contradicted the indication by over half of practitioners that they practice from an entirely non-behavioural stance.

The use of paradigmatically similar techniques may indicate a form of 'narrow-band' eclecticism as described by Hollanders and McLeod (1999). On the other hand, taken together with the discrepancy between reported orientation and technique usage, this finding suggests the possibility that practitioners are less technically than they are theoretically eclectic. This possibility supports a distinction often made in the integrative literature, between technical and theoretical (sometimes called formulative) forms of eclecticism (Arkowitz, 1989; Beutler et al, 1995; Jensen et al, 1990; Lampropoulos, 2001). Although not directly comparable, findings from one North American study (Koocher & Pedulla, 1977) suggested a similar picture in that practitioners' (psychologists and psychiatrists) claims of eclectic orientation were not reflected in the relatively narrow range of techniques that they considered effective in practice.

Technique usage varied among professions here, with psychologists and psychiatrists tending to use more cognitive-behavioural techniques; psychotherapists more psychodynamic; and counsellors more client-centred techniques than other professional groups

In terms of the types of techniques used, current findings shared some similarities with those from the two more recent North American studies in which behavioural therapy and parental counselling were frequently used by psychologists (Tuma & Pratt, 1982), and family therapy was reported to be most effective by psychologists and psychiatrists

(Kazdin, Siegel & Bass, 1990). However, they differ from an earlier survey (Koocher & Pedulla, 1977) in which psychologists and psychiatrists reportedly believed psychoanalytic based techniques such as doll, puppet play and art therapy to be the most effective. Narrative therapy, reportedly used by most respondents in the New Zealand sample, was not included in the North American studies.

Treatment Characteristics

The number of sessions and length of therapy differed considerably between practitioners and between professional groups in the current sample. On average, therapy included 15 sessions, administered over a period of 22 weeks. Psychotherapists and psychiatrists administered therapy over the longest period of time, averaging 26 and 36 weeks respectively.

Psychotherapy in North America tended to be administered over 27 weeks (Kazdin, Siegel & Bass, 1990), a longer average period of time than was reported by practitioners in the present study. Again, this comparative finding may be a result of underlying differences in the professionals sampled. Nevertheless, when compared directly, both psychologists and psychiatrists in North America treated clients over a longer average period of time than their New Zealand counterparts (Kazdin, Siegel & Bass, 1990; Silver & Silver, 1983). This may reflect the apparent tendency by North American practitioners to use psychodynamic approaches and the longer treatment duration typically associated with these modalities.

These findings are based on a comparison of means between studies. However, median values (not available for North American findings) indicate that half of all practitioners administered therapy for a typical duration of 13 weeks, and half of all psychologists and psychiatrists, for 16 and 26 weeks respectively.

Practitioners in the current sample reported that parents or caregivers were seen at least once during therapy in an average of 67% of all child and 63% of all adolescent cases. This contrasts with findings from one North American study in which parents were included with an average of 94% (Koocher & Pedulla, 1977) of all child cases. However, current findings are similar to Kazdin and colleagues' (1990) study in which parents were included with 78% of all child and 62% of all adolescent cases. The difference between the two countries in the number of parents seen with children may be explained by sampling differences. Psychologists and psychiatrists, the sole constituents in the North

American studies, included parents in treatment of children more than psychotherapists, counsellors or others (nurses and social workers) in the present study. Follow-up was achieved or attempted in less than half of all cases here and was not reported in the North American surveys.

Assessment

The majority of participants in the current sample reported using three or more different assessment approaches to describe and define clients' presenting problems. More than half of all practitioners reported using diagnostic, developmental, family systems and cognitive-behavioural assessment models. A similar picture emerged for all professional groups although psychologists tended to use more approaches than other groups, especially counsellors. Psychologists also showed the most consistent pattern of assessment usage with many using diagnosis, functional analysis, cognitive-behavioural, developmental, family systems and psychometric approaches. Both psychiatrists and psychologists spent more time doing diagnosis and assessment than other groups, whereas psychotherapists and counsellors reported spending proportionally more time in therapy.

Previous surveys investigating assessment in this context have primarily focused on the use of techniques and procedures (Patchett-Anderson & Ronan, 2002; Tuma & Pratt, 1982) whereas the current study surveyed the use of assessment approaches.

3. Identify and evaluate a range of treatment techniques and other factors that may impact on therapeutic outcome for children and adolescents.

Relationship between Therapist-perceived Outcome (per disorder) and Treatment Type

Therapists were most optimistic about treatment success with clients experiencing depressive, abusive, anxious, social, eliminative and critical problems. Some positive relationships between specific treatment by disorder - outcome combinations emerged. Brief psychodynamic therapy, narrative therapy, family therapy, psycho-education and sand therapy were each related to therapist perceived excellent outcomes with certain disorders. However, given the large amount of possible disorder-specific treatment-outcome combinations in this data, relatively few positive relationships emerged.

It was not possible to directly compare respondents' beliefs about therapy effectiveness between the two studies. Participants in the North American studies (Kazdin, Siegel &

Bass, 1990; Koocher & Pedulla, 1977) were asked to comment on the effectiveness of various approaches, whereas those in the current study were asked to estimate the degree to which clients with a range of different presentations typically benefited from therapy. The latter approach supported two central theses of this investigation: the view of treatment as one of many possible influences on outcome; and the importance of disorder-specific treatment - outcome relationships. Despite these differences it is interesting to note that of the therapies considered most effective by practitioners in three of the North American studies (eclectic, psychodynamic, family, behavioural, parent-focused, play and cognitive therapies) (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Tuma & Pratt, 1982), only psychodynamic and family therapies emerged as being associated with the best outcomes with certain problem types in the current study. Eclectic therapy was not included as a discrete category here.

Practitioners' Opinions about Factors Affecting Outcome

Therapists generally agreed that a large number of client, therapist, alliance, treatment, family and community variables were likely to affect treatment-outcome. Therapist and client factors were seen as the most influential. Of the therapist variables listed, flexibility and experience were considered to have the greatest influence on outcome. Quality of the therapeutic alliance was also considered crucially important. Motivation to change, ability to apply in-session progress to every day life and complexity of co-morbid problems were the client factors seen to be most influential. Diagnosis, severity and duration of dysfunction were also viewed as particularly relevant to therapeutic change. In addition to these, other variables pertaining to 'client-response to problem and treatment', 'family / parent-stress', 'therapist-client-match-alliance', 'treatment-type and characteristics', and 'community' factors were also viewed as very important. Outcome predictors to do with 'therapist-client-match-stable similarities', 'client-stable traits' 'treatment focus' and 'family structure' were thought to be least relevant although there was less agreement among therapists with regard to treatment focus.

Therapist beliefs about the effect of different variables were somewhat different to those found in the one North American study that investigated outcome predictors (Kazdin, Siegel & Bass, 1990). In particular, treatment variables including 'treatment type', 'therapy duration', and 'session frequency' were considered more influential by New Zealand practitioners. Similarly, therapist experience and training were attributed more bearing by the New Zealand sample whereas parental cooperation, client motivation for change and

client level of distress were more strongly endorsed in the North American study. The samples expressed similar opinions with respect to other variables (e.g. client age, academic functioning, diagnosis, severity of dysfunction, duration of dysfunction, two- versus one parent family, stable home life, therapist age and sex).

Relationship between Therapist Perceived Outcome and Treatment Characteristics

As an adjunct to the question of therapist beliefs about outcome predictors, relationships between reported treatment characteristics and outcome were explored. Only two were found to relate to therapist-perceived positive outcome. Therapists who reportedly included a large percent of parents in treatment of 0-11 year olds also reported better outcomes when treating anxiety disorders. Therapists reporting high percentages of clients dropping out of treatment tended to report poorer outcomes with depressed clients. These findings were not directly comparable to those of Kazdin and colleagues (1990).

4. How do the conditions of psychotherapy as practiced with children and adolescents in New Zealand differ from those typically found in research?

As is supported by findings from previous New Zealand and North American studies (Kazantzis & Deane, 1998; Koocher & Pedulla, 1977; Patchett-Anderson & Ronan, 2002; Silver & Silver, 1983; Tuma & Pratt, 1977;) and was concluded by Kazdin and colleagues (1990), the current findings indicate that psychotherapy with children and adolescents in New Zealand differs on the whole from that which occurs in research.

In research, child and adolescent participants are frequently 'recruited' from schools and communities, not through clinical sources or caregivers, as was the case here. The interventions used are predominantly pure-form behavioural or cognitive-based therapies. Family therapies are occasionally used. Likewise, New Zealand practitioners reported using a predominance of cognitive-behavioural based approaches, techniques and technique combinations. However, narrative therapy, family therapy and therapies with a family and systemic / wholistic focus were also frequently used. Further, current findings suggest that New Zealand practitioners tend toward an eclectic approach to therapy. Although the exact nature of this approach is not fully understood, evidence supports the likelihood that it differs from the pure-form, manualised treatments that are typically employed in research settings.

Therapy in research usually takes place over a period of between 8 and 10 weeks, considerably shorter than the average 22 weeks reported by this sample. However, using median values, half of all practitioners administered therapy over a 16-week period indicating less of a discrepancy between research and practice than when using mean values. Half of all 'others' (nurses and social workers), counsellors and psychologists administered therapy over 11, 13 and 16 weeks respectively. Psychiatrists and psychotherapists did so for longer periods of time. In contrast to usual research practice, parents or caregivers were reportedly included in treatment for over half of all cases.

In research, assessment and outcome evaluation usually involves the administration of standardised tests or interviews to determine diagnoses, without reference to functional or other aspects of client presentation. Although diagnosis was frequently used in practice here, there is evidence that this occurs in combination with other assessment priorities. For example, many practitioners in the current study also reported using approaches of a more contextual nature including developmental, cognitive-behavioural, family systems, and functional analysis models. Less than half of all practitioners reported having attempted or achieved follow-up assessment. Similarly, long-term treatment effects are not routinely studied or reported in research.

Treatment-outcome research has tended to focus on technique as the primary outcome predictor. However, results from this study show that many other variables, especially client and therapist influences, are thought by practitioners to have an important influence on outcome. On the other hand, this sample placed more emphasis on the influence of treatment variables such as type, duration and frequency than has been found previously. Nevertheless, non-treatment-related outcome predictors are rarely studied in research, with those specifically relevant to child and adolescent psychotherapy even less frequently investigated.

Finally, with the exception of family therapy, none of the empirically supported treatments used by this sample were found to relate significantly to therapist perception of good outcomes. Thus, an hypothesis in which treatment is viewed as the primary outcome predictor is not supported here.

5. ***Determine the extent to which psychologists adhere to aspects of the scientist-practitioner model.***

Participants were asked a number of questions designed to elicit information regarding their adherence to a scientist-practitioner model. Possible indicators here included the degree to which practitioners: use empirically validated therapies; participate in research-based activities; are influenced by professional journals and books; and value and adhere to evidence-based knowledge regarding outcome predictors. In general the findings identified psychiatrists, then psychologists as most likely to practice in a manner consistent with aspects of a scientist-practitioner model.

In terms of using evidence-based therapies, the NZ sample did so more than the North American. However, this varied between professional groups with psychologists and psychiatrists using cognitive-behavioural approaches and psychiatrists using family therapies more frequently than other professions. Cognitive, behavioural and family therapies comprise the bulk of the empirically validated therapies to date (Chambless & Ollendick, 2001). Psychotherapists and counsellors tended to use therapies with less empirical validation, including those with a psychodynamic and client-centred theme. Psychodynamic psychotherapy is validated only on the basis of a "...low level of evidence..." (Chambless & Ollendick, 2001, p.691) as showing 'promise' for use with one problem type (psychophysiological disorders). Client centred therapies do not appear on the list of empirically validated therapies at this time (Chambless & Ollendick, 2001).

Through research, a variety of treatment characteristics have been found to associate with good outcomes. These include: adherence to a time limit; problem definition and focus; use of structure in session (Weisz et al, 1995); use of homework in-session (Kazantzis, Deane & Ronan, 2000); and adherence to a treatment manual (Addis & Krasnow, 2000). As a group, this sample placed relatively little weight on the influence of in-session structure, problem definition, problem focus, and the use of manuals and homework, on treatment success. Of all the professional groups, psychiatrists and psychologists felt that adherence to a time limit and problem focus bore the least impact on outcome. This is surprising given the documented evidence supporting these practices within the psychological literature (e.g. Bergin & Garfield, 1994). When selecting a treatment, all practitioners in this sample placed a low priority on the use of manualised treatments. Professional groups differed in their opinions about other treatment-selection priorities

with psychologists and psychiatrists placing the most importance on using treatments with specific or general empirical support, and counsellors and psychotherapists emphasising treatment-paradigm compatibility.

When compared to other professionals, psychiatrists spent more time in research and were the most influenced by professional journals. Psychologists were similar to other groups in terms of research involvement. Psychologists also showed a greater tendency to be influenced by professional journals and were less likely to be influenced by media articles than all other groups except psychiatrists.

Most therapists agreed that information shared during specialist training courses and discussion with colleagues (including supervision) had the most influence on their practice. The extent to which evidence-based information is currently disseminated via these sources is unknown.

Taken together, these findings suggest that of the professional groups sampled here, psychiatrists, then psychologists tend to practice in a manner that is most compatible with a scientist-practitioner model. However, this is not consistently the case. Apart from their primary treatment selection priority and the types of treatments they use, psychologists tend not to differ greatly from counsellors, psychotherapists or 'others' on the scientist-practitioner indicators investigated here. Nevertheless, the fact that psychologists use predominantly evidence-based interventions and that they do so more than counsellors, psychotherapists, 'others' and more so than psychologists surveyed in North American studies (Kazdin, Siegel & Bass, 1990; Koocher & Pedulla, 1977; Tuma & Pratt, 1982), is notable. This finding is consistent with previous New Zealand surveys (Kazantzis & Deane, 1998; Patchett-Anderson & Ronan, 2002), indicating a strong tendency among psychologists toward the use of evidence-based therapies.

Limitations

This study is limited in a number of ways. First, the practitioners sampled may not represent the greater population of mental health practitioners working with children and adolescents suffering mental health problems in New Zealand. However, where possible comparisons with relevant practitioner populations were made and proved favourable in most cases. Further, it is likely that the activities and beliefs of those working outside of

'mainstream' services, for example marae-based Maori practitioners, are not represented here. With its western academic focus and impersonal nature, the mail survey method may be less appropriate for use in certain cultural populations (Glover & Robertson, 2000; Pakeha Treaty Action, 2000).

Second, as mentioned in an earlier section, information derived through the mail survey method is subject to various response biases. Further, the results are based on 'reported', not 'observed' behaviour (Leavitt, 1991). This is especially relevant here with regard to therapists' perception of treatment-outcome success. For example, differences in perceived outcome across therapist groups may be the product of systematic professional response biases such as alternative world-views and levels of optimisim. Further research is required to clarify these findings (Hollanders & McLeod, 1999; Weisz et al, 1995). Conclusions here must be interpreted accordingly.

Third, the questionnaire itself was limited. For example, space and time constraints meant that category definition was not possible. Thus, practitioners may have misinterpreted or applied their own meaning to some items. For example, 26 % of respondents claimed to use multisystemic therapy, an approach that very few New Zealanders are currently trained in (Curtis, 2001). Similar limitations apply to questions regarding assessment. For example, the meaning and process of 'diagnosis' may vary between professionals. In addition, many questions required estimation of percentages and numbers, producing data with a probable large margin of error. Finally, although attempts were made to ensure that response categories were as inclusive as possible, it is likely that some therapist practices and opinions were not represented here. As with all research, the author operates within the bounds of his or her own experience and resources. The method and conclusions may therefore reflect that bias to some extent.

Fourth, it was not possible here to delineate findings according to practitioner characteristics such as for example, age, gender or experience, although comparisons such as these may help to clarify the therapist's role in effecting change. Similarly, findings were not delineated according to client age, developmental stage or gender. Given what is known about prevalence rates across developmental stage, age and gender, investigations of this type would likely prove useful.

Finally, any relationships that were found between therapist perceived outcome and treatment techniques or characteristics are correlational and cannot therefore be considered causal in nature.

Future Directions

The study was successful in identifying a number of areas for future research. Findings have implications for three of the possible solutions for bridging the research-practice gap. Considerations for integrating science with practice are also discussed.

1. Developing Clinically Representative Outcome Studies

Some of the treatments reportedly used by the majority of this sample (cognitive-behavioural therapy, behavioural therapy, parent management training and family therapy) have been subject to extensive (in most cases) empirical investigation and found effective for use with specified disorders (Chambless & Ollendick, 2001). However, evidence points to a need for more clinically valid research with respect to these treatments.

First, the conditions under which they have been studied generally do not reflect those typically reported by therapists in this sample. In particular, the types of clients, length of treatment, assessment approaches used and the degree of parental involvement that were described by this sample differ from those used in research. Second, respondents in Kazdin and colleagues' (1990) study reported frequent use of eclectic therapies, leading the authors to call for more investigation into the nature and effectiveness of eclectic treatments. Despite ongoing research in this area, clear definitions as to the characteristics and constituents of eclectic therapies are yet to be agreed upon (Patterson, 1989). Results here converge with previous findings (Kazantzis & Deane, 1998; Kazdin, Siegel & Bass, 1990; Patchett-Anderson & Ronan, 2002) and provide further support for a picture of psychotherapy practice whereby therapist approaches to treatment are complex and multi-leveled. It is unlikely that this complexity is reflected in outcome research in which interventions are manualised and monitored for adherence to a single treatment modality. Further research is required in order to better understand the manner in which therapists approach and administer therapeutic interventions. This would necessitate more than just a break down of the various techniques that comprise the

therapists' 'tool box'. An examination as to the manner and rationale by which treatments are combined and executed is required. Without this it is difficult to see how therapy practice can be legitimately studied in research or how empirically supported treatments can be successfully used in the field.

In short, whilst empirically validated treatments may be used frequently in practice, the extent to which they are implemented as intended and effective in clinical conditions remains unknown. More in-depth understanding of how therapies are employed within the restraints and demands of real clinical situations is required. Outcome studies better reflecting these conditions are then needed to address this limitation.

Although the tension in research between external and internal validity cannot be underestimated (Kazdin & Weisz, 1998; Persons & Silberschatz, 1998), it is clear that some movement toward the external validity end of this continuum is required. The nature and breadth of evidence sought through controlled outcome research has the potential to restrict the range of therapies sanctioned for use by the scientist-practitioner (Kendall, 1998). This possibility is supported by the finding that therapies associated with good outcomes by practitioners in this study differ from those found effective in research. Alternative methods and parameters for determining evidence-based practice may be required (John, 1998; Persons & Silberschatzx, 1998).

Findings also suggest a need for research into a number of less-studied, non-validated therapies used by many in this sample. These include narrative, sand and brief psychodynamic therapy. In addition, improving understanding as to what constitutes family therapy and 'parental therapy related to the child's problem' in the New Zealand context may be worthwhile. Both of these approaches were frequently used and in the case of family therapy, associated with good outcomes when treating anxiety disorders.

Finally, psychologists appeared to be more consistent in their approach and spend more time involved in assessment and diagnosis than other professions. This finding may reflect the experimental, hypothesis generating approach to assessment that is espoused by the scientist-practitioner model (Belar & Perry, 1992). Other professional groups may conceptualise assessment differently, using a less formal approach that occurs implicitly throughout the therapeutic process. The degree to which either of these approaches may exist and differentially impact outcome appears to be largely unresearched. Similarly,

whether or not clinicians effectively monitor progress and outcome, including long term treatment effects, remains largely unknown. Finally, it is clear from findings here that assessment in practice is qualitatively different to what is used in research, pointing again to a need for studies with improved clinical validity.

2. Transporting Empirically - Supported Therapies to the Clinic Setting

Results here support a previous finding that practitioners value information gleaned through supervision and to a lesser extent, workshops (Beutler et al, 1993). In addition to these methods, specialist training may be a particularly effective means for disseminating research findings to New Zealand practitioners.

Although manualised therapy is controversial (Anderson & Strupp, 1996; Henry et al, 1993), it has been associated with positive outcomes in some circumstance (Addis & Krosnow, 2000; Kendall & Southam-Gerow, 1995) and clearly is one means of disseminating research findings. Manualised treatments were however, given low priority and considered relatively unlikely to impact outcome by all practitioner groups in this sample. This may concern those in the scientific community who place considerable import on their use. A previous survey on psychologists' attitudes toward treatment manuals (Addis & Krosnow, 2000) found that therapists held complex opinions influenced by a variety of systemic and therapeutic factors. If researchers want to use manuals as a method of transporting therapies into the clinic, extensive collaboration with practitioners appears to be needed. An initial step would be to explore therapist attitudes toward manuals and the reasons underlying their lowly status. Further, 'marketing' manuals as one component in a stepped-care or pathways development approach may improve their credibility for practitioners. Finally, increased understanding of eclectic approaches will aid the researcher in tailoring manuals to better suit the realities of practice.

Similarly, a number of treatment characteristics that have repeatedly been associated with good outcomes in research were considered by many in this sample to have little impact. Characteristics such as 'in-session structure', which have been identified through research as accounting for discrepancies between lab and clinic based outcome effect sizes (Weisz et al, 1995), were attributed relatively little weight here. Strong contradictions such as this may indicate a need for more in-depth investigation. For example, why do therapists place

such little import on these variables? Are there systemic or therapeutic factors that make them difficult to implement in practice and can these be addressed?

3. Search for Common Factors to Guide Practice

Findings suggest a need for improved research on possible outcome predictors. Therapist and client variables were considered strong determinants of outcome by this sample and therefore warrant attention. Although research in this area is growing, studies aimed at child populations are few, their findings poorly integrated, and they often lack theoretical bases. It is likely that relationships between common factors and outcome are complex (March & Curry, 1998; Peschken & Johnson, 1997). However, controlled studies investigating theoretically derived constructs may prove fruitful in identifying such factors (Hayes et al, 1996; Kazdin, Siegel & Bass, 1990). This type of research is needed in order to redress the disproportionate attention paid to treatment effects in research (Hubble et al, 1999). Evidence supporting the mutual roles of technique and common factors in determining outcome is accumulating (Asay & Lambert, 1999; Norcross, 1997). It is time this was reflected in research.

Notably, the current sample emphasised the influence of therapist factors, whereas practitioners in Kazdin and colleagues' (1990) study emphasised the impact of client factors' in effecting therapeutic change. This may be related to New Zealand practitioners' apparently stronger affiliation for evidence-based practices, and a possible associated emphasis on therapist ability to administer techniques. Research into the reasons behind findings such as these may illuminate differential approaches to practice. In particular, the degree to which the scientist-practitioner model underlies practice for different practitioners and ultimately of course, whether or not this has any implications for treatment success.

4. Integrating Science with Practice

Finally, results discussed here call the current view in psychology of psychologists as "...the primary scientists in the psychotherapy field..." (Task Force, 1995, p. 3) into question. The question arises as to whether and how psychologists should continue to strive toward this ideal of practice. Although the current findings provide some support for the notion of the psychologist as a scientist-practitioner, much remains unknown about if and how this ideal is manifest or the extent to which it benefits clients in practice. The

tendency among psychologists to use so-called evidence-based therapies probably reflects training initiatives in New Zealand (Kazantzis & Deane, 1998). However these therapies need to be viewed in light of the limitations of the knowledge base underpinning them (King, 1998). An indisputable benefit of research lies in the "..cycle of controversy, debate and succession..." (Fowler, 1996, p.5) that fuels change and growth in the discipline. To maximise this process, it is important that clinicians and researchers resist the inclination to contract and enshrine evidenced-based practices into a narrow set of interventions. This type of reduction is neither consistent with what is known about the diversity of human behaviour nor justified on the basis of research methods and findings to date (Garfield, 1998; Kendall, 1998; King, 1998; Persons & Silberschatz, 1998).

This study has highlighted a range of areas for future research and practice development. There is a need for research that better reflects the conditions of child psychotherapy practice in New Zealand. This may require the use of alternative research methods, a shift in the type of evidence sought, and an extension to the types of questions and range of therapies investigated. In addition, for transport of treatments from research to practice, improved means of dissemination, possibly through supervision, workshops and specialist training is required. For manuals to be useful, the reasons underlying their lack of credibility in practice need to be explored and addressed. Finally, the effect of the scientist-practitioner ideal on psychologists' practice requires continual review and critique to ensure that the focus of knowledge expands not contracts, and that the purpose of research remains linked to the needs of clients and practitioners in the field.

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Appendix A: THE CHILD AND ADOLESCENT PSYCHOSOCIAL INTERVENTION SURVEY

Completion and return of this questionnaire is regarded as your consent for participation in this research.

If none of your clients in the previous year included children or adolescents, you need not complete this questionnaire. Thank you for your time.

1.0 CLINICIAN PROFILE
1.1 Professional/Personal Characteristics

1.1.1 What is your professional affiliation? You may tick more than one option.

Social Worker _____ (Please describe specialty area if any) ☐

Nurse _____ (Please describe specialty area if any) ☐

Pastoral Worker _____ (Please describe specialty area if any) ☐

Tohunga _____ (Please describe specialty area if any) ☐

Community Worker _____ (Please describe specialty area if any) ☐

Whanau Worker _____ (Please describe specialty area if any) ☐

Psychotherapist _____ (Please describe specialty area if any) ☐

Psychiatrist _____ (Please describe specialty area if any) ☐

Counsellor _____ (Please describe specialty area if any) ☐

Psychologist _____ (Please describe specialty area if any) ☐

Other _____ (Please describe specialty area if any) ☐

1.1.2 How many years have you been practising in your profession (as indicated above)? (years worked in profession) _____

1.1.3 What is your age? (age in years) _____

1.1.4 Are you male or female?

Female ☐
Male ☐

1.1.5 Please describe your ethnicity. _____

1.1.6 What qualifications (if any) do you hold? _____

1.1.7 What is your theoretical orientation (if any)? (e.g. Eclectic, Task-centred, Behavioural) _____

1.1.8 Approximately how many hours do you work per week? (hours worked per week) _____

1.1.9 Please tick the setting(s) that best describe your work environment over the past 12 months. If you indicate more than one setting, please estimate the number of hours per week spent at each setting.

- ☐ Hospital Inpatient _____ (hrs.)
- ☐ Hospital Outpatient _____ (hrs.)
- ☐ Private Setting _____ (hrs.)
- ☐ Community Clinic/Setting _____ (hrs.)
- ☐ Primary/Secondary School _____ (hrs.)
- ☐ University Clinic _____ (hrs.)
- ☐ University Setting _____ (hrs.)
- ☐ Research Setting (non university) _____ (hrs.)
- ☐ Other (please describe) _____ (hrs.)

_____

1.2.0 Please estimate the number of hours per week that you spend involved in the following professional activities.

- Therapy _____ (hrs.)
- Diagnosis and/or assessment _____ (hrs.)
- Teaching (related to your profession as outlined above) _____ (hrs.)
- Supervision (receiving) _____ (hrs.)
- Supervision (providing) _____ (hrs.)
- Research _____ (hrs.)
- Consultation _____ (hrs.)
- Administration _____ (hrs.)
- Report Writing _____ (hrs.)
- In-service Training _____ (hrs.)
- Other (please describe) _____ (hrs.)

_____

1.2.1 Please rate the following training and educational resources from 0-4 according to their relative influence on your practice.

(Please circle the appropriate rating.)	Never influence my practice	Rarely influence my practice	Sometimes influence my practice	Often influence my practice	Always influence my practice
Media Articles	0	1	2	3	4
Discussion with Colleagues	0	1	2	3	4
Workshops/Presentations	0	1	2	3	4
Professional Books	0	1	2	3	4
Supervision	0	1	2	3	4
Specialist Training Courses	0	1	2	3	4
Meetings with Professional Body	0	1	2	3	4
Conferences	0	1	2	3	4
Professional Journals	0	1	2	3	4

(Please list some of the journals that you regularly read)

_____

_____

1.2.2 Please rate the following theoretical paradigms from 0-4 according to their relative influence on your practice.

(Please circle the appropriate rating.)	Does not influence my practice	Influences very few areas of my practice	Influences some areas of my practice	Influences most areas of my practice	Influences all areas of my practice
Behavioural	0	1	2	3	4
Cognitive	0	1	2	3	4
Cognitive Behavioural	0	1	2	3	4
Psychodynamic	0	1	2	3	4
Humanistic	0	1	2	3	4
Ecological	0	1	2	3	4
Family Systems	0	1	2	3	4
Constructivist	0	1	2	3	4
Medical Model	0	1	2	3	4

Other (Please describe without using the words eclectic or integrated.)

_____

2.0 CLIENT PROFILE

2.1 Client Caseload (Please give a best estimate if actual figures are not immediately available.)

2.1.1 In total, how many clients do you currently have on your caseload? _____ (No. of clients)

2.1.2 Approximately how many clients did you treat in total over the last 12 months? _____ (No. of clients)

2.1.3 From the figure stated in 2.1.2, how many clients were children and/or adolescents?

Children (age 0-5) ..... _____ (No.)

Children (age 6-11) ..... _____ (No.)

Adolescents (age 12-17) ..... _____ (No.)

(Total no. of child/adolescent clients over last 12 months) _____

2.1.4 What percent of the children and adolescents treated by you over the last 12 months received the following types of treatment. If possible, please account for interventions that you know were administered by other practitioners as well as those offered by yourself.

Psychosocial intervention ONLY (e.g. therapy, counselling, psychotherapy) . _____ (%)

Drug therapy ONLY..... _____ (%)

A combination of drug & psychosocial therapies..... _____ (%)

If your treatment of children and adolescents DOES NOT include PSYCHOSOCIAL INTERVENTIONS of any type, you need not answer the following questions. Thank you for your participation in this study. Your contribution has been valuable and is thoroughly appreciated.

2.2 Child and Adolescent Clients: Characteristics

2.2.1 Of what ethnic identity were the children and adolescents that you treated through psychosocial intervention over the past 12 months? Please estimate as a percent from your total child and adolescent client load.

Maori	_____ (%)	Pakeha / NZ European	_____ (%)
Pacific Island	_____ (%)	Other(s) (specify)	_____ (%)
Asian	_____ (%)	_____	_____ (%)

2.2.2 What sex were the children and adolescents that you treated through psychosocial intervention over the past 12 months?

Female	_____ (%)	Male	_____ (%)

2.2.3 Please estimate the percent of children and adolescents seen by you over the past 12 months, who were referred from each of the following sources.

Parent/Caregiver	_____ (%)	Social Worker	_____ (%)
Whanau	_____ (%)	Medical Professional	_____ (%)
Kura/Kohanga	_____ (%)	Legal Referral	_____ (%)
School	_____ (%)	Client (self)referral	_____ (%)
Community or Other Public Organisation (e.g. CCAFS, YFS)	_____ (please describe)		_____ (%)
Another Treating Professional	_____ (please describe)		_____ (%)

2.0 ASSESSMENT AND OUTCOME EVALUATION

3.1 Assessment

3.1.1 In your work with children and adolescents, what systems do you use to define or describe their presenting problems? You may tick more than one option.

Diagnosis (e.g. DSM-IV)	☐	Whanau-Hapu-Iwi Model	☐
Functional Analysis	☐	Whanaungatanga Model	☐
Ecological Model	☐	Community-based Model	☐
Process-driven Model	☐	Personality-based Model	☐
Developmental Model	☐	Psychometric Evaluation	☐
Family Systems Model	☐	None	☐
Cognitive-Behavioural Model	☐	Other (please describe)	☐
		_____	

3.1.2 Please list the client family and other factors that you typically assess in order to evaluate a client's progress and response to treatment (e.g. procedures / measures used; steps followed)

_____

_____

_____

_____

3.1.3 Please use the categorical system below to answer the following two questions.

i. Please estimate the percent of child and adolescent clients who presented to you with each of the following PRIMARY problems over the past 12 months.

ii. Please also estimate the global level of therapeutic change that typically occurred for clients presenting with each of the following primary problems.

i. Client (%)		**ii Degree of therapeutic change (0-4)**				
% of clients with problems	(Please circle the appropriate rating.)	No change	Minimal change	Moderate change	Marked change	Complete recovery
	Behavioural Problems					
____ %	Attention-deficit hyperactivity disorder	0	1	2	3	4
____ %	Conduct/aggression problems	0	1	2	3	4
____ %	Oppositional problems	0	1	2	3	4
	Emotional & Social Problems					
____ %	Depression	0	1	2	3	4
____ %	Bipolar disorder	0	1	2	3	4
____ %	Generalised anxiety disorder	0	1	2	3	4
____ %	Seasonal affective disorder	0	1	2	3	4
____ %	Post traumatic stress disorder	0	1	2	3	4
____ %	Obsessive compulsive disorder	0	1	2	3	4
____ %	Phobias	0	1	2	3	4
____ %	Problems in social relationships	0	1	2	3	4
____ %	Victim of bullying	0	1	2	3	4
	Developmental Difficulties					
____ %	Mental retardation	0	1	2	3	4
____ %	Autistic spectrum disorder	0	1	2	3	4
____ %	Learning disabilities	0	1	2	3	4
	Abuse					
____ %	Physical abuse	0	1	2	3	4
____ %	Neglect	0	1	2	3	4
____ %	Sexual abuse	0	1	2	3	4
____ %	Emotional abuse	0	1	2	3	4

Question 3.1.3 continued ...

% of clients with problem	(Please circle the appropriate rating.)	No change	Minimal change	Moderate change	Marked change	Complete recovery
	Problems with Eating					
%	Bulimia	0	1	2	3	4
%	Anorexia	0	1	2	3	4
	Elimination Problems					
%	Encopresis	0	1	2	3	4
%	Enuresis	0	1	2	3	4
	Addiction and Substance Abuse					
%	Substance use and dependence	0	1	2	3	4
%	Gambling problems	0	1	2	3	4
	Family Relationship Problems					
%	Marital issues affecting client	0	1	2	3	4
%	Family conflict	0	1	2	3	4
	Crises					
%	High suicide risk	0	1	2	3	4
%	Danger to others	0	1	2	3	4
	Psychotic Disorders					
%	Schizophrenia	0	1	2	3	4
%	**Spiritual Issues**	0	1	2	3	4
%	**Neuropsychological Problems**	0	1	2	3	4
	Other (please specify)					
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4
%	_____	0	1	2	3	4

3.2 Factors That Influence Therapy Outcome

3.2.1 Therapy effectiveness is influenced by a number of factors. Please indicate the extent to which, in your experience, each of the following variables is likely to impact the degree of therapeutic change that takes place in the children and adolescents that you treat.

(Please circle the appropriate rating.)	Not likely to impact on outcome	Minimally likely to impact on outcome	Moderately likely to impact on outcome	Very likely to impact on outcome	Most likely to impact on outcome
Therapist -Client Match & Relationship					
Quality of therapeutic alliance	0	1	2	3	4
Congruence in interpersonal styles	0	1	2	3	4
Agreement in role expectations	0	1	2	3	4
Client freedom to express negativity	0	1	2	3	4
Similarity in terms of age	0	1	2	3	4
Similarity in terms of sex	0	1	2	3	4
Similarity in terms of SES	0	1	2	3	4
Similar cultural background	0	1	2	3	4
Client Variables					
Client problem (e.g. diagnosis)	0	1	2	3	4
Developmental stage of client	0	1	2	3	4
Client age	0	1	2	3	4
Client sex	0	1	2	3	4
Client level of verbal skills	0	1	2	3	4
Client level of academic functioning	0	1	2	3	4
Severity of client dysfunction	0	1	2	3	4
Duration of client dysfunction	0	1	2	3	4
Complexity of comorbid problems	0	1	2	3	4
Client level of motivation for change	0	1	2	3	4
Client expectancy for improvement	0	1	2	3	4
Client level of distress	0	1	2	3	4
Client history of abuse	0	1	2	3	4
Client level of self awareness	0	1	2	3	4
Client emotional response to therapy	0	1	2	3	4

Question 3.2.1 Continued ...

	Not likely to impact on outcome	Minimally likely to impact on outcome	Moderately likely to impact on outcome	Very likely to impact on outcome	Most likely to impact on outcome
Client Variables Continued ...					
Client beliefs about cause of problem	0	1	2	3	4
Client ability to apply in-session progress to every day life	0	1	2	3	4
Client level of acculturation (if member of a minority group)	0	1	2	3	4
Therapist variables					
Therapist qualifications (training)	0	1	2	3	4
Therapist theoretical orientation	0	1	2	3	4
Therapist level of overall experience	0	1	2	3	4
Level of experience with a specific problem	0	1	2	3	4
Therapist demonstration of warmth / empathy	0	1	2	3	4
Therapist level of flexibility in approach	0	1	2	3	4
Therapist level of directiveness	0	1	2	3	4
Therapist ability to integrate skills	0	1	2	3	4
Therapist degree of availability to client	0	1	2	3	4
Therapist level of expectation for change	0	1	2	3	4
Therapist attendance in own therapy	0	1	2	3	4
Quality of therapist's professional supervision	0	1	2	3	4
Therapist sense of accountability for achieving positive change	0	1	2	3	4
In-Session Variables					
Use of structure in session	0	1	2	3	4
Use of homework	0	1	2	3	4
Use of a treatment manual	0	1	2	3	4
Successfully defining and focusing on problem by end of the first session	0	1	2	3	4
Parent & Family Variables					
Socioeconomic status	0	1	2	3	4
Two versus one parent family	0	1	2	3	4
Level of parental co-operation with treatment	0	1	2	3	4
Stable home life	0	1	2	3	4

Question 3.2.1 Continued ...

	Not likely to impact on outcome	Minimally likely to impact on outcome	Moderately likely to impact on outcome	Very likely to impact on outcome	Most likely to impact on outcome
Parent & family Variables Continued...					
Parental mental illness	0	1	2	3	4
Level of family stress / conflict	0	1	2	3	4
Level of parental hope for improvement	0	1	2	3	4
Quality of parent-therapist alliance	0	1	2	3	4
Parental perception of barriers to treatment	0	1	2	3	4
Network / Community variables					
Level of overall social support	0	1	2	3	4
Client involvement with deviant peers	0	1	2	3	4
Quality of school environment	0	1	2	3	4
Quality and availability of cultural support	0	1	2	3	4
Presence of negative neighbourhood influences	0	1	2	3	4
Treatment Variables					
Type of treatment used	0	1	2	3	4
Promptness of intervention	0	1	2	3	4
Treatment duration	0	1	2	3	4
Frequency of sessions	0	1	2	3	4
Number of sessions attended	0	1	2	3	4
Adherence to a time limit	0	1	2	3	4
Use of relapse prevention methods	0	1	2	3	4
Use of follow up contact / booster sessions	0	1	2	3	4
Third Party Influences					
Source of funding	0	1	2	3	4
Degree of cooperation between treating agencies	0	1	2	3	4

Please list other factors that in your opinion, may impact on therapeutic progress / change.

4.0 TREATMENT
4.1 Treatment Selection

4.1.1 Which of the following therapeutic modalities do you use in your work with children and adolescents. You may tick any number of options.

Dream Therapy	☐	Health Camps	☐
Respite Care	☐	Ecological Interventions	☐
Cognitive Behavioural Therapy	☐	Cognitive Therapy	☐
Behavioural Therapy	☐	Interpersonal Therapy	☐
Dialectical Behavioural Therapy	☐	Systems Therapy	☐
Group Therapy	☐	Family Therapy	☐
Multisystemic Therapy	☐	Attachment Therapy	☐
Object Relations-based Therapy	☐	Psychodynamic Therapy	☐
Interactional Drawing Therapy	☐	Discursive Therapy	☐
Brief Psychodynamic Therapy	☐	Experiential Therapy	☐
Client Centred Therapy	☐	Gestalt Therapy	☐
Narrative Therapy	☐	Play Therapy	☐
Hermeneutic Therapy	☐	Rational Emotive Therapy	☐
Rhetorical Therapy	☐	Life Skills Training	☐
Sand Tray Therapy	☐	Psychodrama	☐
Psychoeducation	☐	Self Help Bibliotherapy	☐
Past Life Regressional Therapy	☐	Rebirthing	☐
Parent Management Training	☐	Hypnosis	☐
Multimodal Therapy	☐	Biofeedback	☐
Marital therapy relevant to the child's problem			☐
Parental therapy relevant to the child's problem			☐

OTHER (please specify) _____

_____

_____

_____

(You are nearly finished ...)

4.2 Treatment Parameters

4.2.1 What is the typical duration of a course of therapy with the children and adolescents that you treat? (days / weeks / months) _____

4.2.2 What is the typical number of sessions or meetings? (sessions) _____

4.2.3 Please estimate the percent of children (age 0-11) who are seen with their parent/s at one or more meetings during therapy. _____ (%)

4.2.4 Please estimate the percent of adolescents (12-17) who are seen with their parent/s at one or more meetings during therapy. _____ (%)

4.2.5 Of your total child and adolescent client load, please estimate the percent of clients who prematurely drop out of a treatment programme _____ (%)

4.2.6 Please estimate the percent of clients whose post treatment progress you attempt to follow up directly in any way. _____ (%)

4.3 Treatment Selection

4.3.1 Clinicians base their treatment selection decisions on a variety of different criteria. Please rank the following treatment characteristics in order of the priority that you place on using a modality with that characteristic. 1 indicates the characteristic that you consider to be most important when selecting a treatment; 2, the next most important and so on with 7 indicating the characteristic that you least value when selecting a treatment. **(Rank in order of priority for treatment selection.)**

The intervention is empirically supported for use in treating a specific problem. ☐

The intervention has some empirical support. ☐

The intervention is accompanied by a manual. ☐

The intervention is compatible with your own paradigm. ☐

The intervention is congruent with the proposed etiology of a disorder. ☐

I have used the intervention successfully in the past. ☐

The intervention is recommended by another professional. (e.g. through supervision or at a workshop). ☐

Thank you very much for the time and energy taken to complete this survey. You have made a valuable contribution to future research into psychosocial practices with children and adolescents in New Zealand. This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/103.

Appendix B : Information Sheet (written in accordance with guidelines set out by the Massey University Human Ethics Committee)

Developing a Clinically Informed Foundation for Future Research into Psychosocial Interventions with Children and Adolescents: A Survey of New Zealand Mental Health Practitioners.

This research is relevant to all clinicians who work in any capacity, whether frequently or infrequently, with children and adolescents suffering from emotional, social, behavioural, intellectual or spiritual health problems in New Zealand.

Dear Clinician,

Tena Koe, Your are invited to participate in a nationwide survey aimed at exploring the practices of mental health practitioners who work with children and adolescents in New Zealand. Information that you provide will form the basis of a masterate research project being undertaken by myself with the supervision of Associate Professor Kevin Ronan of Massey University.

Clinicians are frequently acknowledged as experts in what they do and need, yet their voices are rarely heard. A wide range of mental health practitioners, including those from many different professional backgrounds have therefore been selected from publicly available lists and invited to participate in this project. Whether you work with children and adolescents frequently or on only the rare occasion, your input is valuable and will make an important contribution to future research in this area.

Your voluntary participation in this study will involve completing the enclosed questionnaire, a process that should take no more than 25-35 minutes of your time. Completion and return of the questionnaire (in the reply-paid envelope enclosed) will be regarded as your informed consent to participate in the study. At no time during the survey will you be required to identify yourself or any of your clients. You will remain anonymous at all times.

If you wish to receive an individual copy of survey findings, you will be able to do so by completing and returning the personal identification form that will be sent to you in 7-14 days time. Your completed questionnaire and identifying details will thereby remain separate throughout the entire process, thus ensuring your anonymity. A summary of findings may also be submitted for publication in peer review journals.

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/103. Your rights as stated in the Massey University Code of Ethical Conduct are listed below and shall be upheld at all times during and after completion of this research. You have the right:

- To decline participation
- To refuse to answer any particular questions
- To have your privacy and confidentiality protected
- To ask questions at any time
- To be given access to a summary of the findings when the study is concluded

If you require any further information, please contact me at J.J.Kibblewhite@massey.ac.nz or by writing to me at the School of Psychology, Massey University, Private Bag 11222, Palmerston North. Alternatively, you may contact Dr Ronan on (06) 3505799 ext. 2069.

We know your time is valuable. Your participation in this study will be greatly appreciated.

Sincerely,
Joanna Kibblewhite

Appendix C: Second Cover letter

Dear Clinician,

The attached questionnaire has been designed to meet the requirements of a wide variety of different mental health practitioners. Such extensive distribution has been necessary in order to meet *a central aim of this study which is to elicit the broadest possible range and variety of psychosocial interventions currently being utilised in New Zealand.* This is in line with literature reviews which reveal that a wider range of therapies are needed to be studied and validated for use in the area of child and adolescent mental health.

As you work through the questionnaire, you may therefore come across terms or concepts that are unfamiliar to you or that do not fit comfortably with your own particular professional "world view". For this reason, most sections allow space for you to include descriptions that fit better with your own approach to practice. Please make use of these. However, if you feel that a particular question really does not apply to you, please indicate this by writing "not applicable" as your response. The more accurately your answers represent you and your practice, the richer the information will be and the more it will ultimately benefit the clients with whom you work.

Please do not be put off by questions that ask for specific numbers. *We appreciate you are busy and your time is valuable. A best estimate is all that is required.*

Please make use of this survey as a means to share your knowledge and needs with other health professionals so that the gap between practice and research may be bridged and your clients better served.

Thank you for the time and energy taken to complete this questionnaire. Your efforts are very much appreciated.

Sincerely,

Joanna Kibblewhite

Appendix D: Thank-you and Reminder Follow-up Letter

Dear Survey Participants,

To those of you who have already completed and returned your questionnaire, "The Child and Adolescent Psychosocial Intervention Survey", *Thank you very much!* The information you have contributed has been received and is now being prepared for data analysis. If you would like to receive a personal copy of results, please complete the enclosed 'Personal Identification Form' and return it in the envelope provided. Remember, there will be no attempt to match your personal details with information from your completed questionnaire.

Included as part of the identification form is a section inviting your consent to be contacted for participation in future related research. The absence of your signature will be taken as a denial of consent.

Thank you again.

For those of you who intend to, but as yet have not completed the questionnaire, *thank you for considering taking part in this survey. You still have time to do so.*

If you have misplaced the questionnaire, you can obtain another by contacting Dr Ronan or myself at the following addresses. Likewise, if you have any concerns or questions, please feel free to contact either one of us.

Email: J.J.Kibblewhite@massey.ac.nz

Address: FREEPOST 86
Joanna Kibblewhite
School of Psychology
Massey University
Private bag 11 222
Palmerston North

Phone: 06 3505799 x2069
(Dr Ronan)

Appendix E: Personal Identification and Consent Form

PERSONAL IDENTIFICATION FORM
(OPTIONAL)

Yes, I would like to receive a personal copy of the summary of research findings.

Name / Organisation_____

Address _____

_____

_____

_____

Email _____

I agree / do not agree to be contacted for participation in future related research that arises as a result of findings from this survey.

Name _____

Signed _____

Date _____

PLEASE USE THE ENVELOPE PROVIDED, TO RETURN THIS FORM. THANK YOU.

APPENDIX F: Super-ordinate Problem Categories

Problem Type	Problems / Disorders
Externalising Problems	ADHD Conduct / Aggression problems Oppositional problems
Depressive	Seasonal Affective Disorder Depression Bipolar Disorder
Anxious	Generalised Anxiety Disorder Post Traumatic Stress Disorder Obsessive compulsive Disorder Phobias
Social Relationship	Social relationship problems Victim of bullying
Developmental	Mental Retardation Autistic Spectrum Disorder Learning Disabilities
Abuse	Physical Neglect Sexual Emotional
Eating	Bulimia Anorexia
Elimination	Encopresis Enuresis
Addiction / Substance Abuse	Substance use and dependence Gambling problem
Family Relationship	Marital issue affecting client Family Conflict
Crises	High suicide risk Danger to others
Miscellaneous	Schizophrenia Spiritual Issues Neuropsychological problems

APPENDIX G: Therapist Utilisation of Various Techniques

	% Respondents Reportedly Using Each Technique					
Technique	Total Sample (n=182 - 84)	Psychol. (n = 85 - 86)	Counsel. (n = 30)	Psychoth. (n = 33)	Psychiat. (n = 16)	Others (n = 19)
Dream Therapy	13	4	20	36	0	11
Respite Care	46	**52**	30	39	**69**	37
CBT	**81**	**91**	**73**	**64**	**88**	**79**
BT	**64**	**82**	47	42	**69**	42
CT	43	**64**	27	12	44	16
DBT.	15	21	3	9	19	11
Group Therapy	31	32	23	24	44	37
MST	26	27	17	15	**56**	26
ORT	19	9	7	49	38	16
IDT	31	20	**60**	45	13	26
BDT	33	15	30	**76**	44	32
Client-Centred .T	47	34	**70**	**58**	13	**79**
Narrative Therapy	**56**	**52**	**70**	**64**	38	**58**
Sand-Tray	25	15	23	**52**	19	32
Psycho-Educ.	**50**	**62**	33	46	50	26
PMT	**58**	**67**	33	42	**69**	**74**
Multimodal Therapy	19	24	7	6	**50**	16
Health camp	25	31	17	21	44	5
Psychodynamic	35	19	27	**76**	**56**	32
Experiential Therapy	8	4	23	9	0	5
Gestalt Therapy	14	8	27	30	0	0
Play .Therapy	39	28	37	**64**	44	42
RET	26	34	33	6	19	21
Psychodrama	13	7	23	24	0	16
Bibliotherapy	11	14	3	9	19	5
Hypnosis	4	4	3	3	6	5
Marital Therapy	40	33	40	49	**63**	42
Parental Therapy	**56**	48	**50**	**73**	**69**	**58**
Hermeneutic T	0	0	0	0	0	0
Rhetorical Therapy	0.5	0	0	0	6	0
Discursive .Therapy	0.5	0	3	0	0	0
Rebirthing	0	0	0	0	0	0
IPT	27	25	27	27	38	26
Systems Therapy	45	45	43	**58**	44	31
Family Therapy	**72**	**69**	**70**	**70**	**94**	**74**
Biofeedbackc	3	4	0	0	6	11
Attachment T	41	38	30	**61**	44	37
Regression	1	0	3	3	0	0
Ecological approach		29	38	33	12	31
Life Skills	35	37	23	47	31	32
'Other"	23	12	20	39	**63**	16

Note:

- CBT = cognitive-behavioural therapy; BT = behavioral therapy ; DBT = dialectical behavioural therapy; CT = cognitive therapy; MST = multi-systemic therapy; IDT = interactional drawing therapy; BDT = brief dynamic therapy; ORT = object relations therapy; IDT = interactional drawing therapy; PMT = parent management training; RET = rational emotive therapy; IPT = interpersonal therapy; regression = past life regression; T = therapy
- All frequencies over 50% are presented in **bold.**

APPENDIX H: Patterns of Treatment Usage - Factor Analysis

(Rotated Pattern Matrix)

	Treatment Components										
Treatment Modality	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
ORT	.741*	-	-	-	-	-	-	-	-	-	-
BDT	.692*	-	-	-	-	-	-	-	-	-	-
Dynamic.	.638*	-	-	-	-	-	-	-	-	-	-
Attach.	.731*	-	-	-	-	-	-	-	-	-	-
Play	.709*	-	-	-	-	-	-	-	-	-	-
Sand Tray	.671*	-	-	-	-	-	-	-	-	-	-
Dream	-	.527*		-	-	-	-	-	-	-	-
IDT	-	.534*		-	-	-	-	-	-	-	-
Experiential	-	.831*		-	-	-	-	-	-	-	-
Client Cent.		.558*		-	-	-	-	-	-	-	-
Systems		-	**.694***	-	-	-	-	-	-	.497*	-
MST		-	.761*	-	-	-	-	-	-	-	-
MMT		-	.367	-	-	-	-	-	-	**.465***	-
Family		-	.322	**.458***	-	-	-	-	-	-	-
Marital		-	-	.930*	-	-	-	-	-	-	-
Parental		-	-	.873*	-	-	-	-	-	-	-
DBT	-	.409	-	-	**.776***	-	-	-	-	-	-
RET	-	-	-	-	.730*	-	-	-	-	-	-
IPT	-	-	-	-	.517*	-	-	-	-	-	-
CT	-	-	-	-	.421	-	**.510***	-	-	-	-
BT	-	-	-	-	-	-	.908*	-	-	-	-
CBT	-	-	-	-	-	**.691***	-	-	.323	-	-
Psychodram	-	-	-	-	-	**.712***	-	-	.239	-	-
PMT	-	-	-	-	-	.343	-	-	**.465***	-	-
Psycho-edu	-	-	**.415**	-	-	.404	-	-	-	-	-
Respite	-	-	.406	-	-	-	-	**.598***	-	-	-
Health C.	-	-	-	-	-	-	.416	**.569***	-	-	-
Ecological	-	-	-	-	-	-	-	.703*	-	-	-
Narrative	-	-	-	-	-	-	-	-	-	.948*	-
Biblio	-	-	-	-	-	-	-	-	.630*	-	-
Life Skills	-	-	-	-	-	-	-	-	.817*	-	-
Gestalt	-	-	-	-	-	-	-	-	-	-	.799*
Group	-	-	-	-	-	-.406	-	-	-	-	
Psychodr.	-	-	-	-	-	712*	-	-	-	-	-

Note:

- 1 = Psychodynamic; 2 = Client-centered; 3 = Systemic / wholistic; 4 = family Focus; 5 = cognitive-challenging; 6 = cognitive-behavioural -role-play; 7 = cognitive-behavioural - retraining; 8 = contextual; 9 = instructional; 10 = life Stories & systems; 11 = whole-perspective
- Only values considered practically significant at a level of >/= 3.0 (Hair et al, 1998) are included in the table.
- Where one variable loads at a practically significant level on more than one factor, the higher value is indicated in **bold.**

APPENDIX I: Patterns of Assessment Usage
(Rotated Pattern Matrix)

Assessment Model	Components				
	1 Hierarchical	2 Clinical	3 Relational	4 Contextual	5 Personality Formulation
Family Systems	.774*	-	-	-	-
Developmental	.582*	-	-	-	-
Process Driven	.361	-	-	**.382**	-
Diagnosis	**.540***	.333	-	-.356	-
Functional Analysis	-	.403	-	**.565***	-
Psychometric	-	.729*	-	-	-
Cognitive Behavioural	-	**.802***	-	-	.331
Whanaungatanga	-	-	.879*	-	-
Whanau-Hapu-Iwi	-	-	.732*	-	-
Ecological	-	-	-	.820*	-
Community-Based	-	-	-	.405	-
Personality-Based	-	-	-	-	.934

Note:

- Only values considered practically significant at a level of >/= 3.0 (Hair et al, 1998) are included in the table.
- Where one variable loads significantly onto more than one factor, the highest correlate is indicated in **bold**

APPENDIX J: Therapist Beliefs about Outcome Predictors

	% Respondents Rating Variable Very Much or Most Likely to Impact Outcome					
Outcome Predictor Variables	Total Sample (N=132-75)	Psychol. (n=71-83)	Counsel. (n=20-29)	Psychoth (n=17-32)	Psychiat. (n=13-16)	Others (n=9-18)
Therapist-Client Match and Relationship Factors						
Therapeutic alliance (quality)	88	85	86	100	87	82
Matching inter-personal styles	49	47	44	63	15	65
Role expectation agreement	61	61	57	62	40	77
Client freedom of expression (-ve)	66	57	71	87	47	78
Similarity in age	0.6	1.3	29	9.4	0.0	12
Similarity in sex	2.9	2.6	3.6	3.1	6.7	0.0
Similarity in SES	3.8	1.4	0.0	5.9	13	11
Similar cultural background	21	17	25	22	20	27
Client Characteristics						
Client Problem (diagnosis)	65	66	56	60	87	63
Developmental Stage (client)	49	45	53	67	40	41
Client age	26	21	33	40	13	24
Client Sex	6.0	2.6	11	6.7	6.7	12
Client level of verbal skills	27	24	32	27	21	35
Client academic functioning	22	24	25	17	27	11
Severity of dysfunction	74	74	59	90	73	67
Duration of dysfunction	77	73	73	90	80	72
Complexity of comorbidity	87	89	78	87	93	81
Motivation for change	87	87	89	87	87	89
Expectancy for improvement	68	68	68	66	60	82
Level of distress	43	45	33	52	20	56
History of abuse	57	45	68	77	71	50
Level of self awareness	64	63	64	63	47	83
Emotive response to therapy	65	59	75	90	36	61
Beliefs about cause of problem	50	51	50	59	27	50

Appendix J: Therapist Beliefs about Outcome Predictors (Continued)

	% Respondents Rating Variable Very Much or Most Likely to Impact Outcome					
Outcome Predictor Variables	Total Sample (N=132-75)	Psycholog (n=71-83)	Counsel. (n=20-29)	Psychoth. (n=17-32)	Psychiat. (n=13-16)	Others (n=9-18)
Client Characteristics Continued...						
Application of in-session progress	81	84	82	79	79	67
Level of acculturation	39	33	48	44	14	59
Therapist Factors						
Qualifications	75	76	68	84	80	67
Theoretical Orientation	41	48	30	45	33	28
Overall level of experience	83	84	86	84	93	67
Experience with a specific problem	77	74	79	81	87	72
Demonstration of warmth / empathy	86	81	93	97	87	83
Degree of flexibility	86	84	86	97	80	78
Level of deirectiveness	42	43	43	43	33	44
Ability to integrate skills	77	75	75	87	64	78
Degree of availability	43	41	36	60	33	44
Expectation for improvement	56	56	61	53	60	50
Attendance in own therapy	38	21	52	70	21	50
Quality of prof. supervision	67	57	75	83	64	78
Accountability for achieving change	58	54	64	66	67	56
In-session Variables						
Use of structure	43	48	43	30	53	33
Use of homework	32	37	36	14	40	22
Use of a manual	10	12	7.1	3.6	20	12
Focus on problem by first session	30	24	46	18	29	44
Parent and Family Variables						
Socioeconomic status	19	16	21	30	13	11
Two-versus one parent family	17	16	19	17	13	22
Parentalco -operation with tx	79	74	68	91	100	83
Stable home life	72	67	79	83	67	72
Parental mental illness	80	74	86	80	93	89

Appendix J: Therapist Beliefs about Outcome Predictors (Continued)

	% Respondents Rating Variable Very Much or Most Likely to Impact Outcome					
Outcome Predictor Variables	Total Sample (N=132-75)	Psychol. (n=71-83)	Counsel. (n=20-29)	Psychoth (n=17-32)	Psychiat. (n=13-16)	Others (n=9-18)
Parent and Family variables Continued...						
Family stress / conflict	90	85	93	90	100	94
Parental hope for improvement	60	55	54	74	50	78
Quality of parent-therapist alliance	71	62	69	93	88	59
Parent perception of tx barriers	61	53	68	77	50	67
Network / Community Variables						
Overall social support to client	75	68	79	84	81	83
Involvement with Deviant peers	77	72	86	74	88	82
Quality of school environment	69	63	72	65	81	89
Quality of cultural support	63	53	79	77	56	61
Neighbourhood influences (-ve)	51	44	54	58	53	59
Treatment Variables						
Type of treatment	68	73	54	61	80	67
Promptness of intervention	66	65	54	71	60	83
Treatment duration	50	46	54	43	73	56
Frequency of sessions	47	39	50	58	47	56
No. of sessions actually attended	64	66	61	67	60	61
Adherence to time limit	19	9.2	11	57	6.7	22
Use of relapse prevention	58	62	44	57	64	56
Use of follow-up /booster sessions	58	58	52	60	79	44
Third Party						
Source of funding	44	30	61	67	27	53
Cooperation between agencies	66	58	64	87	64	67