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Therapists' Own Childhood Problems as Predictors of Their Effectiveness in Child Psychotherapy

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Explored a previously untested possibility, namely, that therapists who faced numerous problems in childhood may be especially effective in helping their young clients cope with problems. Forty therapists filled in the Child Behavior Checklist (CBCL) for themselves as children; we then assessed outcomes for their child clients via pretherapy and posttherapy CBCLs completed by the children's parents. Number of childhood problems reported by the therapists was positively related to improvement in their child clients' externalizing problems. Perhaps predictors of child therapy effects can be found in therapists' own childhood histories.

Over the past three decades, researchers have explored the impact of various therapist characteristics on psychotherapy outcomes (see, e.g., Parloff, Waskow, & Wolfe, 1978). Most of the research, however, has dealt with adult therapy; the little that has focused on children and adolescents (herein referred to collectively as children) has been inconclusive. For example, tests of whether more experienced (or more fully trained) therapists are more effective have not shown main effects of experience or training (see Berman & Norton, 1985, regarding mixed age groups of clients; see Weisz, Weiss, Alicke, & Klotz, 1987, regarding children only).

Might therapists' theoretical orientations predict their effectiveness? Research has not been very supportive of this idea. Two meta-analyses of child therapy effects, in which entire studies were the units of analysis, reached conflicting conclusions as to whether behavioral and nonbehavioral approaches differed in their effects (Casey & Berman, 1985; Weisz et al., 1987), and a recent study of individual child clients found that the youngsters' improvement during therapy was unrelated to the theoretical models on which their therapists relied (Weisz, 1986).

In the present study, we explored a possibility that has received little attention to date, namely, that a therapist's ability to empathize with young clients and to foster effective coping may be related to the therapist's own personal history, even in childhood. It is possible that a history of having faced problems in childhood may better equip therapists with insight into ways of helping their young clients deal with problems. Therapists who themselves had to cope with numerous problems as children, but who overcame them to such an extent that they are now clinicians, may be especially able to appreciate what troubled children are going through and may be especially able to help such children resolve their problems.

As an initial inquiry into the impact of therapists' childhood problems, we asked child therapists to complete the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) for themselves as children, reporting which of its 118 behavioral and emotional problems they had shown. We collected pretherapy and posttherapy CBCL parent reports on their child clients to assess improvement. Then we assessed relations between children's adjusted pretherapy–posttherapy differences and therapists' childhood problems. Following up on previous studies (already mentioned here), we also included a check on whether ther-

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apist experience or theoretical orientation predicted outcomes in this sample.

Method

Participants

Therapist sample. The sample was drawn from seven public mental health clinics—three in cities and four in rural areas of North Carolina. This helped ensure that the findings would not reflect idiosyncratic characteristics of one particular clinic or area. From an initial pool of 76 therapists, 57 (75%) completed our measures. Of these 57, 15 had treated children for whom we did not have a complete set of measures (to be discussed), and 2 returned incomplete questionnaires. The remaining 40 were included in the study. The 21 men and 19 women ranged from 29 to 61 years of age, with a mean of 36 years (*SD* = 6.84 years); 36 were White, 2 were Black, 1 was Asian, and 1 did not report race; 18 were psychologists, 12 were social workers, 5 were psychiatrists, and 5 had had other professional training (e.g., psychiatric nursing). Years of experience as therapists ranged from 2 to 21 years, with a mean of 7.65 years (*SD* = 3.97 years).

Child sample. Because therapists conducted therapy with more than one child, we randomly selected a single child client for each therapist as a participant in this study (all therapists were blind to these selections). The 40 children included 21 boys and 19 girls. They ranged in age from 6 to 16 years, with a mean of 11.0 years (*SD* = 2.71 years); 25 were White, 14 were Black, and 1 was a Native American. Hollingshead (1975) socioeconomic status (SES) ratings of parent occupation ranged from 1 to 9 (9 = highest SES), with a mean of 4 (*SD* = 2.03).

As is common in outpatient child clinics, the children were referred for a variety of problems, and many received no formal *DSM–III* (American Psychiatric Association, 1980) diagnosis. Of the 40 youngsters, 10 received no diagnosis (or diagnosis deferred); 12 were diagnosed with adjustment disorders, 4 with conduct disorders, 4 with various anxiety disorders, 2 with attention deficit disorder, and one each with several other *DSM–III* categories. Because a primary goal was to understand factors related to change in children during *naturally occurring* therapy, no attempt was made to influence the number or content of therapy sessions. Consequently, over the sample of 40 children, the number of sessions varied considerably (from 1 to 28), with a mean of 7.43 (*SD* = 6.87) and a median of 4.

Procedures and Measures

CBCL for children. At the time of each child's first session with the therapist and then again 6 months later (after all children had completed therapy), the child's parent filled in the CBCL, rating the child on each of 118 problems. Norms permit conversion of summary scores based on these ratings to *T* scores reflecting a child's standing relative to others of the same sex and similar age. Of special interest here were *T* scores for internalizing problems (e.g., social withdrawal, worrying, sadness) and externalizing problems (e.g., aggression, arguing, disobedience). At the outset of therapy, the children's mean *T* scores were 69.0 (*SD* = 11.1) for internalizing problems and 69.5 (*SD* = 9.9) for externalizing problems, which placed the average child at about the 98th percentile for his or her age and sex group on both problem dimensions.

CBCL for therapists. After therapists had completed work with the children in our sample, we gave them "a request that may tax your memory, but one which we hope you will find interesting" asking them to "please complete the Child Behavior Checklist for yourself as a child, remembering, as well as you can, your own experiences throughout the period when you were 6 to 16 years old." On the CBCL, therapists reported themselves as having shown an average of 26.9 problems (*SD* = 13.2) of a possible 118. Summing their ratings of 1 and 2 (reflecting the degree to which they showed each problem) yielded a mean total problem raw score of 31.0 (*SD* = 18.7); if these CBCL scores had been obtained by children under standard conditions, they would fall about 1 *SD* above the median for nonclinic-referred youngsters in the United States.

Therapist Orientation Questionnaire (TOQ). The revised form of the TOQ (Sundland, 1977) was designed to assess theoretical perspectives. Therapists rate their agreement with statements that load on separate scales: Experiential (e.g., "Body movements and postures tell us a lot about the patient's psychopathology"), Psychodynamic-Analytic (e.g., "It is important to analyze the transference reactions of the patient"), and Cognitive-Behavioral (e.g., "The most important results of therapy are the new ideas and new ways of thinking about himself that the patient achieves").

Results

First, we computed t tests for correlated means to determine whether the 40 children improved over the 6-month period. Mean internalizing T scores improved from 68.17 at the outset of therapy to 63.5 at 6 months, $t(40) = 3.35, p < .001$. Externalizing T scores improved from 69.5 to 65.5, $t(40) = 2.39, p = .02$.

Next, we tested whether the degree of change in the children was related to their therapists' characteristics. To do this, we needed unbiased change estimates to control for initial problem levels and to gauge levels of change beyond the general improvement noted here. We computed linear regression equations for internalizing problems, then for externalizing problems, using scores at admission to predict scores at 6 months. The regression residual (i.e., the difference between the predicted and actual score for each child) was the measure of change used here.

Does Therapist Experience Predict Therapy Outcomes?

The results were initially more positive for therapists' theoretical orientations. Therapists' scores on the TOQ Cognitive-Behavioral scale were correlated with externalizing residuals, $r(40) = .32$, $p = .04$. The higher therapists scored on this scale, the worse were their young clients' outcomes.

Checking for robustness. To be confident of this finding, we needed to rule out an artifactual possibility, namely, that the findings might have resulted from individual differences in child age, sex, SES, or number of therapy sessions. To test this possibility, we structured a matched-groups comparison. We formed pairs of youngsters who were matched for age (within 3 years of one another), sex, SES (within 4 SES points of one another), number of therapy sessions (within 5 sessions of one another), and number of therapist problems (within 11 problems) but who differed in that one child had a therapist who scored above the mean on the TOQ Cognitive-Behavioral scale and the other child had a therapist who scored below the mean. The high and low cognitive-behavioral groups thus formed consisted of 12 youngsters each. To check the matching procedure, we computed dependent-groups t tests comparing the high and low therapist TOQ Cognitive-Behavioral score groups on each of the five matching variables. The tests revealed no significant difference between the groups on any matching variable. By contrast, the groups differed as expected on therapists' Cognitive-Behavioral scores, $t(20) = 7.92, p = .001$. We then compared the two groups, via dependent-groups t tests, on externalizing residual scores and found that the groups were not significantly different. Thus, the TOQ finding did not appear to be robust.

Predicting Change From Therapists' Childhood Problems

Focusing next on therapists' CBCL reports, we found that the more problems therapists reported for themselves as children, the more improvement their young clients showed in externalizing problems, $r(40) = .33, p = .03$.

Checking for robustness. This finding, too, was checked for robustness. We formed pairs of youngsters matched for age (within 3 years), sex, SES (within 2 SES points), and number of therapy sessions (within 5 sessions) but differing in that one child had a therapist who scored above the mean on CBCL Total Problems and the other child had a therapist who scored below the mean. The high and low therapist problem groups thus formed consisted of 14 youngsters each. To check the matching, we computed dependent-groups t tests comparing the high and low therapist problem groups on each of the four matching variables. The tests revealed no significant difference between the groups on any matching variable. By contrast, the tests revealed the expected difference between groups on therapists' total problems, $t(26) = 7.15, p < .001$. Means were 38.78 for the high therapist problem group and 18.57 for the low therapist problem group. We then compared the two groups, via dependent-groups t tests, on externalizing residuals. The original significant relationship between therapists' problems and child residual scores was significant and at a more pronounced probability level, $t(26) = 3.28$, $p < .001$. Thus the relationship between therapists' childhood problems and children's improvement in externalizing problems appears to be robust.

Type of therapists' childhood problems. This finding regarding the number of childhood problems reported by therapists raised a question as to whether the types of problems reported by therapists made a difference. To find out, we created a variable labeled $I\text{--}E$, which consisted of the number of internalizing problems minus the number of externalizing problems reported by therapists. We classified problems as internalizing or externalizing based on Achenbach and Edelbrock's (1983) principal-components analysis of

children's data. The I–E variables were not significantly correlated with children's residual scores for either internalizing or externalizing problems.

Next, we explored whether children improved more on specific problems that matched those reported by their therapists. For each of the 40 child–therapist pairs, we constructed a 2 × 2 table. In each table, every problem noted for the child at the beginning of therapy was classified as to whether it (a) was also reported by the child's therapist and (b) had an improved rating at the time of the 6-month follow-up. This made it possible to test whether the probability of improvement was higher for child problems that matched therapist problems than for child problems that did not match therapist problems. The comparison revealed no relationship. For 19 of the child–therapist pairs, the probability of improvement was higher for matching than for nonmatching problems; for 21 pairs, the pattern was reversed. So, a therapist–child match in specific problems did not increase the likelihood of improvement.

Discussion

The findings point to a hitherto ignored therapist factor that predicted improvement in children receiving psychotherapy, namely, the therapist's own history of childhood problems. Children who improved most in externalizing problems had been treated by therapists who reported high levels of problem behavior for themselves as children. This supports the possibility that therapists who themselves faced numerous problems as children may be better able to empathize with and assist the youngsters they treat than are therapists who had a more pacific, problem-free childhood.

The findings on therapists' problems predicted improvement in externalizing problems but not in internalizing problems. Yet, the relative preponderance of internalizing and externalizing therapist problems was not related to the outcomes their young clients experienced. Moreover, children were no more likely to improve on the specific problems that matched those of their therapists than on problems that did not match. This pattern of findings suggests that it may be broad, general experience in having confronted and coped with childhood problems that enhances therapist effectiveness, not experience linked to some specific type of problem.

Having offered these preliminary interpretations, we note that the study has both methodological strengths and limitations. On the positive side, the relationship identified here is not likely to have been artifactual, because our measure of therapist' childhood problems was obtained entirely independently of our measure of children's improvement. Moreover, therapists did not know which of their young clients was the focus of our study. On the other hand, because our data on therapists' childhood problems came from therapists' self-reports, it is possible that our findings actually reflect a relationship between therapists' effectiveness and their potentially inaccurate self-perceptions of what they were like as children. Such a relationship would be important in its own right, but its underlying dynamics would differ from those discussed here. To address this possibility, researchers who can sample therapists younger than those studied here might obtain childhood problem reports from the therapists' parents (parents of several of our therapists were no longer living).

On balance, the findings reported here should be regarded as preliminary indications of a possibility that warrants study in future research, namely, that predictors of child therapy effects may be found in the therapist's own childhood history.

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