INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600

UMI®

A Validity Study of the Youth-Outcome Questionnaire and the Ohio Scales

By

Marc A. Gironda, M.S.Ed.

A Doctoral Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology in the Department of Psychology at Pace University

New York

2000

UMI Number: 9975586

UMI®

UMI Microform9975586

Bell & Howell Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

PSY.D. PROJECT FINAL APPROVAL FORM

NAME: MARC A. GIRONDA

TITLE OF PROJECT: A VALIDITY STUDY OF THE YOUTH OUTCOME QUESTIONNAIRE AND THE OHIO SCALES

DOCTORAL PROJECT COMMITTEE:

PROJECT ADVISOR: JACK L. HERMAN, PH.D.
PROFESSOR, PACE UNIVERSITY

PROJECT CONSULTANT: ALBERT F. MELINO, PH.D.
ASSOCIATE PROFESSOR, PACE UNIVERSITY

FINAL APPROVAL OF COMPLETED PROJECT:

I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Clinical Child Psychology.

Jack L. Herman — Project Advisor's Signature

4/28/00 — Date

Albert F. Melino — Project Consultant's Signature

5/18/00 — Date

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

Completion of this doctoral project would not have been possible without the assistance of my advisor, Dr. Jack Herman, and consultant, Dr. Albert Melino. I am grateful for all of the time, support, and guidance with which they provided me throughout the research process.

I would like to acknowledge the assistance of Mr. Stephen Salbod, whose wit, knowledge and empathetic understanding of the doctoral project process was invaluable to me.

My father, Dr. Ronald Gironda, has always been a source of inspiration and guidance for me. I am eternally grateful to him for his many pearls of wisdom along the way. My mother, Diane Gironda, is a woman of both strength

and compassion, and has shown me unconditional love for as long as I can remember.

Finally, I dedicate this work, along with all that I do, to my wife, Lori Gironda. She is the love of my life, and somehow put up with me throughout the arduous process of completing this project. Without her support, nothing I have achieved thus far would have been possible.

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

The Youth-Outcome Questionnaire (Y-OQ) and the Ohio Scales (OS) were developed to track the course of child psychotherapy across time. They are unique instruments to the psychological test battery, as they were designed not to diagnose mental illness or elaborate on a patient's psychological state of mind. Instead, they purport to be *sensitive to change*; that is, both the Y-OQ and OS are specifically designed to measure the behavioral "change" that occurs in a child as the result of psychotherapy.

Both the Y-OQ and the OS attempt to capture change over time. However, the OS, at face value, appears to be a superior instrument to the Y-OQ. This occurs for several reasons. First, the OS is shorter. Second, the OS allows for multiple raters. Third, the OS is simpler to score. And fourth, the OS allows for evaluation of a patient's strengths in addition to pathology. A validity study between these two instruments is indicated. Should

satisfactory validity be established between the two instruments, an argument might exist to replace the Y-OQ with OS for the reasons stated above.

The purpose of this study was to execute an investigation of validity between the two instruments. Fifty-eight pairs of children and parents were recruited. Participants completed the scales at intake and again three months into treatment. Internal consistency estimates for both instruments were calculated and found to be very high for both measures. Correlations between the scales at both points in time, and between the changes detected between the two points in time, were calculated to establish overall validity. Further analysis investigated correlations between the subscales of the instruments. All results revealed high degrees of internal consistency and evidence of concurrent and construct validity between the two measures.

The identification of a satisfactory instrument to measure the effectiveness of psychotherapy is critical in today's managed-care climate. Such instruments are especially critical to school-clinical child psychologists, who are often bound by extreme budget restraints, and accordingly require instruments to address these restraints and to substantiate the efficacy of their work. This study demonstrates that the OS, while a new instrument, holds much promise as a both a clinically useful and psychometrically intact instrument for both mental health treatment providers and the institutions in which they work.

CHAPTER I. INTRODUCTION

The practice of psychotherapy is constantly changing. From the "talking cure" first proposed by Breuer and Freud to the short-term (even one session) interventions of today, psychotherapists of all orientations attempt to achieve a common goal: relieve their clients of a psychological "problem". By relieving their clients of their "problem", it is assumed that the client is "better". However, a question remains. That is, how does one know that a client is truly "better"? Is it because the client simply reports relief? Or perhaps it is because in the therapist's judgment the client has made progress? The answer to either question is debatable and variable.

The medical model presumes that people become well based on tangible, often visually determined evidence. If, for example, one breaks his leg and after eight weeks a x-ray proves it has mended, the individual is considered

healed. A patient with a high fever who begins a course of antibiotics to counter infection will show improvement based on a thermometer reading. There is very little guesswork on the part of the physician, and a comfortable reliance remains on scientific instruments such as x-rays and thermometers.

Unfortunately, mental health does not possess equivalent precise measures of change that are available in medicine. There is no radiation procedure (such as a x-ray) to assess the presence and severity of depression, or a probe (such as a thermometer) that can accurately depict level of anxiety. Instead, the field of psychometrics has attempted, with varying degrees of success, to fill the role for mental health that radiology and laboratory studies fill for traditional medicine.

Certainly, psychometrics has provided psychologists with many instruments to diagnose "mental" problems. This fact probably stems from the referral questions for

psychological evaluations that are most often asked. That is, psychologists are asked to help in diagnosing individuals' emotional condition more often than to assess whether or not individuals have improved. If psychologists are asked the latter question, it is usually answered by comparing results on a previous diagnostic test, used as a baseline, with current results from the same instrument. Such practice is to be questioned, as it is now essential that any instrument to be used as a mental health outcome measure be evaluated for its *sensitivity to change* (Reisinger & Burlingame, 1997). The concept of sensitivity to change has been defined as, "…the demonstrated ability of a measure to track real symptomatic improvement made by patients beyond change attributable to temporal instability (Reisinger & Burlingame, p. 372, 1997)." Reisinger and Burlingame further indicate that the sensitivity to change concept is a relatively new concept to psychometrics, therefore many older instruments have not been designed nor evaluated with these important considerations in mind.

Why is it even important to measure outcome of psychological treatments and worry about a measure's sensitivity to change? The answer lies in the political and economic climate of the 1990s. It has been suggested that we have entered a climate in healthcare that demands accountability from all disciplines (Ellwood, 1988). The impact of managed care has been resounding: competition between providers is fierce, reimbursement has decreased, and financial considerations are paramount.

Challenges to the effectiveness of psychotherapy have certainly existed long before the advent of managed care. Hans Eysenck, in his classic 1952 study, disputed the previously held assumption that psychotherapy was effective to those individuals engaged in it (Sonnanburg, 1996). Eysenck's (1952) review of previous psychotherapy research concluded that psychotherapy is no more effective in the treatment of psychological disorders than an absence of treatment. Landmark studies as early as Eysenck's, up to

Seligman's (1995) *Consumer Reports* publication that concluded that most individuals *do* report positive and helpful psychotherapy experiences, have traditionally focused on psychotherapy with adults. A plethora of child psychotherapy research does exist; indeed, a recent review by Durlak, Wells, Cotten, & Johnson (1995) revealed 376 published studies alone between 1965 and 1990. Still, Kazdin (1995) has proposed that certain research domains that have been extensively studied in adults, e.g. therapist and setting influences, have not been similarly considered in child research. Therefore, research in child psychotherapy may have not yet achieved the maturation of adult psychotherapy research.

The current era of managed health care, combined with the need for expanded research in child psychotherapy, suggest a need for innovative outcome measures. Specifically, child-focused instruments that are both realistic to administer within the managed care

environment, while allowing satisfactory assessment of outcome, will be most desirable.

The development of the Youth Outcome Questionnaire (Y-OQ: Burlingame, et al., 1996) was developed in response to both Kazdin's (1995) concerns for child psychotherapy research and ramifications of the current healthcare environment. The instrument itself is quite simple, consisting of 64 questions rated on a 5-point Likert scale. The instrument is filled out by the youth's caregiver and consists of items tapping "troublesome situations, behaviors, and moods" (Burlingame et al., 1996). The authors estimate the measure takes between five and seven minutes to complete.

The Y-OQ taps six domains determined to be characteristic of childhood psychopathology: Intrapersonal Distress, Somatic, Interpersonal Relations, Critical Items, Social Problems, and Behavioral Dysfunction. In addition to scores for each of these domains, a Total Score is also

calculated. The Y-OQ has been shown to be sensitive to change in functioning, and the hope is that through examination of the six subscale scores and the total score, efficient treatment planning and simplified tracking of treatment effectiveness can be attained (Burlingame et al., 1996).

Although satisfactory data exists to confirm that the Y-OQ is psychometrically sound in terms of reliability, validity, and sensitivity to change, the validation of any instrument must be considered a continuing process (Nunnally & Bernstein, 1994). Recently, Ogles, Davis, and Lunnen (1998) developed the Ohio Scales (OS). The OS, like the Y-OQ, was constructed to facilitate tracking the effectiveness of child psychotherapeutic interventions. Several factors make the OS a unique instrument when compared with the Y-OQ. However, a fundamental difference between the two instruments exists. The Y-OQ relies only on the observations of a child's caregiver, while the OS

allows for input from both the caregiver, treatment provider, and in cases of adolescents, self-report.

Scores on the OS are collected in four primary content areas: problem severity, functioning, hopefulness, and satisfaction with services. Not all scales exist on the three different versions (caregiver-report, provider-report, self-report). The OS, like the Y-OQ, is brief, easy to administer, and appears to demonstrate satisfactory psychometric characteristics.

The purpose of the present study is to execute a concurrent validity study with both the Y-OQ and the OS. Since both instruments are quite new in a field that itself is young, such an investigation is essential. It is hypothesized that since the two measures purport to assess psychotherapy outcome, they will demonstrate concurrent validity. Further research questions will explore the relationships between the subscales on the two measures, comparisons of self-reporting versus other-reporting,

usefulness of the scales in a clinical setting, and implications for the practice of child psychotherapy. Finally, the necessity of maintaining two instruments that measure the same construct will be explored, and the possibility of one instrument being superior to another will be examined.

CHAPTER II. REVIEW OF THE LITERATURE

Interest in the effectiveness of psychotherapy began in 1952 when Hans Eysenck's review of the research demonstrated that psychotherapy was no more effective at alleviating psychological disorders than no treatment at all (Eysenck, 1952). In 1957, Levitt published a study in *Journal of Consulting Psychology* investigating utilization of psychotherapy with children. His conclusion: children treated with psychotherapy were no better off than those who received no treatment (Levitt, 1957). The 1950s also brought about the publication of B.F. Skinner's *Science and Human Behavior* (Skinner, 1953), which challenged individuals to apply the scientific method to studying human behavior. Thus, the 1950s ushered in the era of accountability for psychotherapists. No longer could one simply say therapy worked, its effectiveness needed to be proven. However, the accountability demanded by the scientific community did not similarly emanate from