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Reducing the Premature Termination of Children from Psychotherapy through Research Based Program Evaluation

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REDUCING THE PREMATURE TERMINATION OF CHILDREN FROM PSYCHOTHERAPY THROUGH RESEARCH BASED PROGRAM EVALUATION

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This study attempts to understand premature termination from psychotherapy by children. It attempts to supply recommendations for two different mental health settings to reduce premature termination from their programs. The programs were the Center for Applied Psychology at Indiana University of Pennsylvania (CAP) and the Community Guidance Center (CGC), both located in Indiana, Pennsylvania.

Premature termination is a serious problem in the delivery of services across populations. Estimated rates of premature termination approach 60% (Kazdin, 1998). Much of the research has been conducted on adult populations with substantially less research conducted on children (Pekarik & Stephenson, 1988). This is in contrast to epidemiological data that finds prevalence rates of mental illness in children to run at 16% (Benway et al., 2003). Of those children determined to need mental health services, 70% do not receive appropriate services. The problem of premature termination exacerbates the dilemma of providing services to children. Much research attests to the efficacy of therapy for children, thus, a better understanding of how to facilitate treatment compliance, including attendance, throughout the proscribed course of therapy, is needed

(Benway et al., 2003, Kovacs & Lohr, 1995). However, much of the literature on children is emergent and contradictory (Snell-Johns, Mendez, & Smith, 2004). A thorough review of the current literature was conducted to support the hypotheses developed in this study.

Client files were reviewed to ascertain if therapists followed on-site procedures. Site policies were examined to determine their efficacy in addressing premature termination. Chi-Square analysis was conducted upon two data sets from the CGC to determine if recently enacted policy changes had an effect upon premature termination rates. Results indicated that student-therapists at the CAP were far less likely to follow on-site procedures than therapists at the CGC. Research based recommendations were created in an effort to aid these mental health providers reduce the rate of premature termination from psychotherapy by children and their families.

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CHAPTER 1

STATEMENT OF PURPOSE

A continuing and serious problem for mental health practitioners in the delivery of service to children and their families is the high rate of attrition from therapy (Kazdin, 1998). Kazdin (1998) reports rates of attrition among children who have commenced outpatient treatment to run between 40% and 60% and identifies this as a significant barrier in the delivery of treatment. To date, the research on attrition from therapy has been most predominantly conducted upon adult subjects in attempts to understand the phenomena of attrition in that population (Wierzbicki & Pekarik, 1993). The causes of premature termination from therapy in children and solutions to this problem are extremely under investigated areas of research. As the limited research that has been addressed to the problem of attrition in children consistently shows high rates of attrition from psychotherapy, further investigation into possible explanations for how this can be reduced are warranted (Benway, Hamrin, & McMahon, 2003; Kazdin, 1998).

In attrition research, the client who does not show up for a scheduled appointment or fails to make contact to cancel that appointment is often referred to as a 'no show' (Tuso, Murtishaw & Tadros, 1999). Research reports no show rates as high as 39% across populations (McKay, McCadam, & Gonzales, 1996). Some clients do more than attend therapy sporadically, they stop attending therapy altogether. The client who unilaterally discontinues therapy against the advice of the mental health provider is often referred to as a 'dropout' and this phenomenon of premature termination from therapy among children and their families is the focus of this investigation.

Some researchers (Armbruster & Kazdin, 1994) make no distinction between the two categories, no show as opposed to dropout, in their studies while other researchers (Kazdin et al., 1997) investigate the two as separate phenomena. A further area of research on attendance patterns of clients attempts to describe those clients who make initial contact with a mental health provider but fail to attend the intake session that they have scheduled (Benway et al., 2003). This group of clients does not easily lend itself to investigation as a result of the limited mental health contact and even less research has been conducted or published on this group (Benway et al., 2003).

It is difficult to compare and contrast research results from studies on attrition. Investigators employ differing definitions and differing methodologies to conduct their research. It is important to remember that much of the research on therapy attrition has been done with adults, the results of which must be cautiously extrapolated to the study of attrition among children (Pekarik & Stephenson, 1988). Careful reading of the literature is required.

Concerns about the high rate of attrition from psychotherapy are fed by an awareness of the incidence of mental illness for children. It is estimated that the prevalence rate for mental illness in children in the United States runs at 16% (Benway et al., 2003). However, it is further put forth that 70% of those children in need of mental health services are not receiving such services (United States Congress Office of Technology Assessment, 1986). If the child lives in a rural setting the problem may be further exacerbated due to increased difficulty in accessing the needed services because of such factors as long distances to service sites or simply that the services are nonexistent in that rural area (Campbell, 2002). A rather substantial body of research evidence has been

developed that attests to the efficacy of psychotherapy for children (Kovacs & Lohr, 1995; Weisz, Donenberg, Han, & Weiss, 1995). Therefore, while statistics point out that the need is great, those children and adolescents who would benefit from participation in psychotherapy appear unable or unwilling to access those services. Thus, any research avenue that might lead to facilitating participation in psychotherapy by children may prove valuable.

Clients may not show up for appointments or prematurely discontinue treatment for a variety of reasons. Much research has been conducted to address the problem of patient non-compliance as evidenced by poor attendance (Armbruster & Kazdin, 1994; Aubrey et al., 2003; Garcia & Weisz, 2002). However, the issue becomes more complex when attempting to describe the phenomenon of non-attendance when children are the clients. One must remain cognizant of the key difference between a child in psychotherapy and an adult in psychotherapy when premature termination occurs: parents typically are the ones who make the decision to discontinue for the child (Pekarik & Stephenson, 1988). This lack of independence from the significant others in a child's life who make decisions concerning accessing mental health services for the child illustrates the necessity to include an understanding of family factors that influence therapy attendance.

Parents report multiple reasons for discontinuance of treatment for their children. These difficulties are many and varied. Some examples are: (1) accessing transportation; (2) obtaining childcare; (3) experiencing feelings that therapy will not prove helpful; and (4) believing that the therapist is ineffective or uncaring (Armbruster & Kazdin, 1994; Staudt, 2003).

Another reason cited by Koroloff, Elliott, Koren, and Friesen (1994) is the child's refusal of treatment. Little research has been conducted that seeks to understand the child's response to participation in and often subsequent withdrawal from outpatient psychotherapy. Under consideration in this work will be children whose ages range from between 1 to 18 years of age. A new consideration in this area of research is the recent change in the way in which consent to treatment is conceptualized for children aged 14 through 18. Act 147 became effective on January 22, 2005 in Pennsylvania (Juvenile Law Center, 2005). Act 147 allows for the adolescent to consent to treatment at his or her own discretion but furthermore gives precedence to parental consent which can override the adolescent's wish to participate, or not, in outpatient treatment (Juvenile Law Center, 2005). Therefore, it becomes prudent to consider whether or not the adolescent who prematurely discontinues treatment began the treatment process at his or her own discretion or at the insistence of parent(s) or legal guardian(s) or even the courts.

Investigators report that research concerning the mental health issues of children and adolescents has recently shown growth but still caution that it is too often overlooked by researchers and there is much work to be done (Kazdin, 1993; Snell-Johns, Mendez, & Smith, 2004). The area of attendance noncompliance under consideration in this research project is that of the outpatient psychotherapy client aged 1 through 18 who "drops out" of therapy prematurely. 'Dropping out' or premature termination, for the purposes of this study, will mean those children and their families who contact a mental health provider with the intent to receive services but do not complete therapy either by not making any further contact or unilaterally discontinuing services. The primary population studied will be clients who participate in outpatient mental health services offered in rural settings.

The Community Guidance Center (CGC) of Indiana, Pennsylvania and the Center for Applied Psychology (CAP) at the Indiana University of Pennsylvania were the two mental health care providers specifically evaluated in this study. Based upon practices that are grounded in the current body of research in this area, hypotheses were generated and recommendations were made to address the issue of premature termination in their respective programs.

Research that contributes to a greater understanding of the area of premature termination of outpatient psychotherapy by children and their families were reviewed. Those topics included the nature of the problem of premature termination from outpatient psychotherapy by children and their families and the factors that are currently identified as contributing to this problem. Research cited supported the efficacy of outpatient psychotherapy for children and will delineate the dearth of opportunities for children to access this area of mental health services, particularly in a rural setting. Attention was paid to evidence that contributes to an understanding of the barriers that families and children must overcome to successfully complete a course of psychotherapy. It was hoped that such information will prompt the development of engagement techniques specific to this population and the creation of proactive strategies that will negate factors disruptive to the successful completion of therapy.

CHAPTER 2

REVIEW OF RELEVANT LITERATURE

Differing Definitions of Terms in Premature Termination Research

Usage affects results and interpretations. Different investigators offer different definitions of the construct of premature termination or 'dropping out' of treatment. Armbruster and Kazdin (1994) report that the problem of inconsistent use of terms in this area of research, as to what constitutes the definition of a dropout, greatly contributes to difficulty in assessing results across findings. Wierzbicki and Pekarik (1993) found in their meta-analysis of dropout research that the way in which dropout was defined by the researcher affected the dropout rates that were reported. When dropout was defined as non-attendance at a session, the rate was lower than when the determination of what constituted dropout was left to the therapist or when the number of sessions a client attended was used as a cut off point (Wierzbicki & Pekarik, 1993). Benway et al. (2003) point out that some children do not even make it to their first appointment and that very little research has been conducted that addresses this population in the dropout research. A further complication is the blanket inclusion by some researchers of children aged from as young as 3 upwards through children aged 18 in their studies (Gould, 1985; McClure et al., 1996). The inclusion of such broad ranges of ages creates a heterogeneous mix of developmental stages, reading levels, and cognitive stages that may blur clear results.

The wide range of definitions, differing methodologies, and disparate subject groups used by researchers makes imperative a careful reading of the literature and makes comparisons across studies and subsequent conclusions difficult.

Examples of definitions. As mentioned above, no standard definitions for what constitutes a dropout have been agreed upon by researchers. Venable and Thompson (1998) posit that dropout occurs when parents discontinue treatment for the child before ten sessions are completed or therapeutic goals are met. Kazdin, Holland, and Crowley (1997) broadly consider a dropout to be any child who unilaterally discontinues psychotherapy as the result of parents deciding to terminate before the mental health provider would advise it. Howard, Kopta, Krause, and Orlinsky (1986) comment that, as the effect of treatment seems to be related to the length of treatment duration, the actual number of visits provides a more reliable dependent variable for research rather than the categorical dropping out or not.

Weisz et al. (1987) define a dropout as a child who has no contact with the mental health provider after the initial intake session and define a 'completer' as a child who attends at least five psychotherapy sessions and does not terminate against the advice of the mental health provider. The issue may be further confounded because what constitutes dropout status is often a determination made at the individual therapist's discretion (Pekarik, 1991). When researchers cannot come to agreement about the meaning of terms that are commonly used in that area of research, it limits the usefulness of the collective data by making it difficult to meaningfully compare across studies.

Use and Nonuse of Psychotherapy by Children

Efficacy of psychotherapy for children. Concerning the efficacy of psychotherapy, a substantial body of research has consistently shown that children benefit from participating in psychotherapy (Baer & Nietzel, 1991; Casey & Berman, 1985; Shadish, Montgomery, Wilson, Wilson, Bright, & Okwuma 1993; Weisz et al., 1995; Weisz &

Weiss, 1993). Meta-analyses and reviews of therapy with children have led to the consensus that therapy is better than no treatment (Kovacs, 1995). Researchers have reported consistent findings with meta-analysis of psychotherapy where the data have produced positive effect sizes in the medium to large range (Casey & Berman, 1985; Weisz et al., 1995). Casey and Berman (1985) report that most psychotherapies used with children and adolescents can be called effective because the children and adolescents improve more with psychotherapeutic treatment than without it. A report from the Surgeon General (1999, Treatment Strategies, para. 5) points out that psychotherapy, while effective for most children, is also vitally important for those children for whom other therapeutic options are limited. For example, in cases where the child cannot tolerate medications or; where there exists no research on the medication and so its use is not a viable option. The value of psychotherapy also becomes clear in instances where parents may feel strongly about the use of medications and refuse permission for drugs to be used as part of their child's care.

Children who receive early psychological intervention appropriate to their needs are far more likely to decrease harmful behaviors, overcome delays in development and surmount negative emotional issues (Eyberg, 1992). Childhood problems can be entrenched and persistent: 74% of 21-year-olds with psychological problems reported prior mental health difficulties as children and these are the sorts of untreated individuals who may very well face a future that has a high probability of including time spent in jail (US Public Health Service, 2000). The National Institute of Mental Health (1981) estimates that approximately 25% of those seeking mental health services from

community mental health sites are under the age of 18, making clear the need to reach this population.

Child use of mental health services differs from other populations. Use of mental health services by children differs from that of adults. In general, use of mental health services increases up until middle age is reached and then shows a decline. This pattern has been referred to as an inverted "U" and it contrasts with usage in medical services where use of services shows a decline during middle-age and assumes an upright "U" shape (Scheffler & Miller, 1991). The inverted "U" pattern seems to indicate that mental health difficulties that develop in youth increase through adolescence and then continue into adulthood before abating.

Pottick, Hansell, and Gaboda (1994) conducted epidemiological research covering the time-span from 1986 through 1994. The data revealed that 1 out of every 50 children in the United States entered into some type of mental health service. Approximately half of those who used mental health services were adolescents aged 13 through 17. This represented a rate of 1 in every 30 adolescents. While elementary aged children were more likely to use services than preschool aged children, adolescents used services at a rate 6.7 times higher than preschoolers. Pottick et al. (1994) also found that while only 5% of youth received residential care, adolescents overwhelmingly comprised the largest percent of those in residential care at 75.5%.

It is clear that very young children participate in mental health services far less than adolescents. Adolescents using mental health services also stay in service for shorter time periods as they drop out more quickly than younger children (Bui & Takeuchi, 1992). Gender differences appear in the pattern of use of mental health services by adolescents

as contrasted with that of adults. Freidman, Katz-Levy, Manderscheid, and Sondheimer (1996) report that males in the youth population represent from between 60% to 79% of usage of mental health services. This pattern reverses in adulthood when women are the more likely to use mental health services (Freidman et al., 1996).

Therefore, while epidemiological data indicates that the need for services increases during adolescence, particularly for males, the adolescent is far less likely to remain a participant in those needed services.

Reported rates are affected by the parameters of the individual study. The dropout rates reported on children suffer from similar issues as does the problem of defining the nomenclature used in dropout research. It is difficult to compare studies that include children of differing ages based upon different conceptualizations of what dropout is. There is also a paucity of studies that investigate the issue of dropout amongst children. Baekeland and Lundwall's review in 1975 revealed that only five articles out of 362 in the then current literature on dropout addressed children. Nearly 20 years later, Wierzbicki and Pekarik (1993) conducted a meta-analysis that provided an overview of 125 studies of premature termination of psychotherapy. Of these studies, only 16 were child studies. However, the mean rate of noncompletion (dropout) of psychotherapy reported from those 16 studies was 46.81%. Different researchers may compute different rates from different starting points but they all appear to report uniformly high dropout rates. For example, Kazdin et al. (1993) reported a rate of 38.5%, while, in slightly later studies, Armbruster and Fallon (1994) gave a rate of 45% and Kazdin and Muzurick (1994) gave a slightly higher rate of 47.5%. These studies were all based on data from child guidance clinics. However, Pekarik (1991) cited results from the National Institute

for Mental Health that reviewed client initiated termination in both private and public mental health settings. These results were a combination of adult and child clients and indicated that approximately 50% of those clients had terminated treatment by the fifth visit while 80% of those clients left treatment against the advice of the mental health provider by the tenth visit.

The investigations reviewed above differ in client populations and definitions of dropout. Nonetheless, the results uniformly show high rates of dropout across the studies.

Psychotherapy needs are often unmet. Unfortunately, children are often unable to avail themselves of the benefits of psychotherapy due to a variety of obstacles. The effects can be far reaching. The Great Smokey Mountain Study of Youth (Costello et al., 1996) is a continuing, longitudinal study that collects data on the mental health status and needs of rural and urban children aged 9, 11, and 13 from different areas in North Carolina. One of the conclusions drawn from these data was that the majority of the 1015 children sampled who had mental health care issues requiring mental health services were not receiving those services, including those children who were deemed seriously disturbed (Burns et al., 1995). The data further revealed that only 40% of the children had received any kind of mental health services in the three months that preceded the sampling (Burns et al., 1995). In the course of a single year, approximately 1.5 million children in the United States receive psychological evaluations (Magrab & Wohlford, 1990, as cited in MacNaughton et al, 2001). Statistics such as these prompt government officials to label the state of health care for children as a public crisis and warn that service needs are unmet and remain at the same levels as 20 years ago. (US Public Health Service, 2000). Costello et al. (2003) found a similar pattern in the most recent figures

generated by the Great Smokey Mountains Study. The highest rates of disorders were found among 9-and 10-years-olds, the lowest for 12-year-olds and then a slow rise in prevalence into adolescence (Costello et al., 2003).

Research such as the Great Smoky Mountain Study of Youth (Costello et al., 1996), demonstrates clearly the gap between need for mental health services for youth and use of such services. While statistics point out that the need is great, those children who would benefit from participation in psychotherapy appear unable or unwilling to access those services. Therefore, any research avenue that might lead to facilitating participation in psychotherapy by children may prove valuable.

While it appears clear that many researchers are in agreement as to the efficacy of psychotherapy for children and adolescents, there is far less agreement as to how much therapy is needed to provide beneficial results. This is a particularly salient area of interest in the field of attrition research as it speaks to how the psychotherapy course of treatment that is cut short through dropout may or may not have provided beneficial rewards for the child.

Issues Concerning Treatment Dosage

Opinions differ on optimum number of sessions. Lowry and Ross (1997) conducted an interesting survey of 234 American Psychological Association psychologists who were members of Division 29 (Psychotherapy). While this study referred to an adult population, it serves to illustrate the lack of consensus among therapists regarding what is the optimal number of therapy sessions for clients. The psychologists were asked to respond to a questionnaire that asked how many 50 minute sessions of psychotherapy would be necessary to restore a normal level of functioning to (adult) clients. While the

responses indicated that the psychologists recognized that different disorders would require a differing number of sessions, the aggregate number of sessions deemed advisable (sans the use of medication) was between 30 to 50 sessions. The type of therapy employed caused a considerable discrepancy in the number of sessions estimated to be needed. It was judged that psychodynamic therapy would require between 41 to 52 sessions while cognitive behavioral therapy or eclectic therapy might only need between 23 to 29 sessions (Lowry & Ross, 1997). This study serves to show the large gap between the doses of psychotherapy that psychologists would prefer to administer as contrasted with what it is typical for managed care to allow.

Haas and Cummings (1991) report that managed care companies would prefer to have therapy sessions limited in number to between 10 or 20 sessions. Poynter (1994) concurs that 10 sessions is generally the number of sessions endorsed by current standards of managed care. As Lowry and Ross (1997) point out, it is a question of ethical behavior for psychologists to not stint on therapy sessions but rather, to provide the amount necessary to meet the client's needs. Furthermore, many researchers believe that progress in psychotherapy by the client is positively correlated to length of treatment (Orlinsky & Howard, 1986).

Howard et al. (1986) found supportive evidence that adult clients showed the greatest improvement in the first eight sessions. Pekarik's (1986) observations seem supportive of this as he found that when termination occurred after only two or three visits there seemed to be little improvement. Koss and Butcher (1986), however, seem to argue that an extended course of treatment does not translate to ever increasing treatment gains. The National Institute of Mental Health (1981) reported that across public and private mental

health venues half of the clients terminate by their fifth visit while 80% are gone by the tenth visit. Thus, while many therapists push for at least 11 visits, if not many more, it is not clear at what point during therapy that the best, fastest, most enduring, etc., treatment gains are made. Now that managed care companies are able to impose limitations upon treatment durations it becomes increasingly important to obtain knowledge about how best to invest in the treatment sessions that are available (Pekarik, 1991). Kazdin and Wassell (1999) state that the greatest benefits for practical application and for clinical research would accrue from assessment of the treatment course conducted throughout in an intentional and standardized manner.

Minimal contact may prove beneficial. There is evidence in the adult based literature that it takes only one to a very few sessions to benefit from psychotherapy (Howard et al., 1993). Silverman and Beech (1979) questioned whether or not dropouts from therapy should even be considered drop outs especially if the term is applied pejoratively and indicative of failure. In their study, they surveyed via telephone 47 adult clients who had attended a single session at a community mental health center. Silverman and Beech's questions covered client satisfaction, attributions of problem resolutions, expectations of the client and an assessment of the impact of the services received. They found that 70% were satisfied with the services and 79% reported that their problem had been resolved with 49% of those attributing that to their contact with the mental health clinic. The majority felt their expectations had been fulfilled and the contact with the clinic had contributed to their improvement. This study suggests that even minimal contact with a mental health provider can prove beneficial to the client. Klein, Stone, Hicks, and Pritchard (2003) posit that what may be happening when clients terminate after only

approximately three sessions is that the client has actually improved. Three sessions may be enough for immediate symptom relief or the resolution of a crisis situation or the implementation of an effective medication regimen. Klein et al. (2003) caution that this phenomenon may be "surprising" to clinicians and, that it is a very valuable but "under appreciated clinical observation" (p. 91).

When the contact between client and mental health provider is exceptionally fleeting, it becomes very difficult to discern the impact the service provider may have upon the client. Very few studies address the issue of families that schedule initial appointments but never show up for that first session. Benway et al. (2003) found a very limited number of studies that examined this phenomenon and urge research that scrutinizes mental health clinic characteristics that could potentially influence the decision to not attend first sessions. A few studies have been conducted that gathered information from families about why they did not show up for the first appointment. Lowman et al. (1984) followed up with families who did not attend their initial appointment and found that 29% gave the reason that the problem issue had improved. Kourany et al. (1990) sampled 111 children who did not show up for their first appointment at a community child psychiatry clinic and found that the second most often reason given was that the problem issue had improved. Benway et al. (2003) found that the single consistent variable that influenced a family not showing up for the initial appointment was a longer wait time.

The literature on how much treatment is necessary and sufficient runs the gamut from as little as contact made during an intake session to those who would continue indefinitely. The limited research that has been conducted on those families who only

minimally engage in mental health services reveals that several factors may contribute to the brief contact. Clearly, further research is needed to address this distinct population.

Therapy duration and children. Kazdin and Wassell (1999) repeat the theme of a 'dose and effect' relationship for psychotherapy when conducted with children. In this study, measures of improvement showed a consistent and strong association with fully concluded therapy whether the outcome measures were completed by parents or therapists. It is important to note that a significant number of those children who completed therapy were rated improved as contrasted with those children who prematurely terminated therapy. However, the relationship is not so simplistic. Kazdin and Wassell point out that some of the children who completed therapy did not improve while some of the children who dropped out did show improvement. They conclude that some children will make much improvement early on in treatment but others will not show hoped for improvement even upon completion.

Pekarik (1991) offers a slightly different view on the duration of therapy by children. He posits that rather than using a 'yes/no' format or 'completer/drop out' to classify clients, that the dependent and continuous variable of number of sessions provides more information for study, particularly in understanding the dose and effect relationship. This would also help to eliminate the definitional discrepancies as to what constitutes a dropout. Kazdin and Wassell's (1999) formula for studying treatment attendance is to record the number of times a family cancelled a session, did not show up for a session or were 20 or more minutes late for a session and then divide these figures by the number of weeks that the family had been in session. If one conceptualizes the course of treatment as occurring in phases, then assessment of the benefit of treatment

done throughout the course of treatment would allow one to obtain a better understanding of the rate at which and what phase in which improvement occurs. Littell et al. (2001) agree that a linear conceptualization of the dose/benefit relationship is too simplistic. While it is generally agreed that participation in treatment is better than nonparticipation, the amount of positive change is not perfectly correlated with the amount of sessions. If the severity of the presenting complaint is low, a ceiling effect will quickly be encountered. Saltzer et al. (1999) agree that a greater level of severity of the initial reason for coming to treatment will allow for longer treatment duration and greater room for improvement.

Clients and therapists have differing perspectives. As discussed above, providers differ on how many therapy sessions are optimal. On the other hand, clients may report improvement resulting from minimal contact or very few sessions. To continue this line of reasoning further suggests that clients may, as Armbruster and Kazdin (1994) propose, be making reasonable decisions when they determine to discontinue treatment. They coin the phrase of "clinic-centrism" (1994, p. 96) to illustrate the limited point of view that mental health practitioners possess about the family's abilities for self determination concerning when treatment has 'run its course'. In order to increase understanding of how much treatment is enough treatment, Armbruster and Kazdin call for further research that accounts for parent and child perspectives concerning the reasoning that results in the decision to drop out and what subsequently happens to these children in terms of where else they may seek out help or the ultimate disposition of their mental health problems. Pekarik (1985) states that the lack of agreement between clients and therapists surrounding optimum treatment length, and what the treatment should address, may

explain a great deal of why clients leave therapy early. He bluntly states that clients expect therapy to last a much shorter duration than therapists do. Furthermore, he questions why therapists maintain the expectation that clients should be willing to increase the number of sessions that they are willing to attend to the 10 to 40 session range that therapists typically expect. Pekarik (1985) cites research (Ciarlo, 1979; Garfield, 1978; Koss, 1979) demonstrating that client expectations for treatment length and the actual number of sessions that they attend show consistency. Most community mental health clients and private practice clients terminate from therapy by the tenth visit with the median number of visits hovering between five and six (Pekarik, 1985). Apparently, clients match their expectations about treatment length with consistent behavior. A serious difficulty with the divergence of beliefs about treatment duration between clients and therapists is revealed when one considers the typical manner in which treatment is delivered. When a therapist adopts the stance that treatment will continue over a longer time period, he or she may pace the treatment itinerary by his or her own time frame. Therefore, those precious initial sessions may be devoted to gathering history and conducting assessment rather than conducting actual therapy (Pekarik, 1978). In contrast, the client whose predisposition is towards a much shorter length of treatment may be expecting immediate symptom or crisis relief. When this is not forthcoming, client dissatisfaction may increase the likelihood of early withdrawal from treatment (Pekarik, 1978). The client's desire for immediate relief as opposed to fundamental personality or behavioral changes is at direct odds with the way in which most therapists perceive the course of therapy should run. Clients may prematurely

terminate before the therapist actually begins psychotherapeutic treatment (Pekarik, 1978).

Research indicates that minimal contact between the mental health services provider and child may prove beneficial. However, further evidence exists that suggests that an optimal number of sessions may exist but has yet to be determined by researchers. Families may often feel that they know when enough therapy has been successfully completed and discontinue services at their own discretion. Further research is warranted to determine at what point therapy can appropriately be terminated.

Barriers and Risk Factors Associated with Premature Termination

The effect of the rural setting. For children who reside in rural areas, a number of unique barriers to accessing service are encountered as a result of where they live. The United States Census Bureau (2002) defines a rural area as one in which fewer than 500 people live in a square mile. Fox, Merwin, and Blank (1995) reported that one-quarter of the United States population resides in rural areas. Of the 3075 counties in the United States, 55% do not have psychologists, psychiatrists, or social workers who are practicing and all of those counties are classified as rural (APA, 2000). The rural setting inherently provides especial impedance to access of mental health services for children. Because of distances involved, parents must overcome transportation issues in traveling to mental health providers (Campbell, Gordon & Chandler, 2002). These geographic barriers may also contribute to a sense of social isolation that may reduce one's motivation to even seek out services or to continue on in treatment until it is deemed completed (Campbell et al., 2002).

It is twice as likely that a child in an urban setting will receive a diagnosis as it is likely for a child in the rural setting (Cohen & Hesselbart, 1993). Not only do rural areas have greater difficulty in attracting professionals with expertise in the mental health field but these areas are also less likely to offer the children who live there as many specialized services as their urban counterparts (Cohen & Hesselbart,1993). A further obstacle to obtaining the appropriate treatment from appropriate professionals may also include a greater difficulty with use of insurance (DeLeon et al., 1989).

The societal norms and customs of rural society may also contribute to a reluctance to take advantage of mental health services. There may be an awareness of the increased possibility of dual relationships in the rural setting and the fear of threats to confidentiality surrounding the use of mental health services for one's child (Fox et al., 1995). Small communities may foster the belief that use of mental health services indicates weakness and attach stigma to those that do participate in mental health services, thereby discouraging those that could benefit from services from seeking them out (Fox et al., 1995). Rural communities may also have a system of personal beliefs in the autonomy of the individual with an emphasis on self reliance or may, conversely, believe that the community should 'take care of its own' and not rely upon an outside source (Fox et al., 1995).

Because of the lack of professionals, such as psychologists and psychiatrists available to provide specialized mental health services, parents in rural settings may turn to sources for help that lie outside the conventional mental health systems that are more readily available in urban settings (Burns et al., 1995). Parents may contact the primary care physician for help with their child's mental health issues. Burns et al. state that another

source may be the educational system that is in place in the rural community that may, unfortunately, be ill equipped to respond to the need. Oftentimes in rural settings, these sorts of services are used in combinations that may also include the welfare and court systems. Unless carefully orchestrated, this may result in a patchwork mélange of assistance from individuals not specifically trained in the field of children's mental health (Burns et al., 1995; MacNaughton & Rodrigue, 2001).

Children in a rural setting may find it more difficult to access appropriate mental health services than their urban counterpart which contributes to therapy drop out. An understanding of the manner in which parents access and use mental health services for their children is critical to assessing areas of need and may prompt organizational changes in the way agencies and professionals cooperatively structure their care for children both interagency and intra-agency (Burns et al., 1995; MacNaughton & Rodrigue, 2001). The efficacy of psychotherapy is a moot point when access to services proves unavailable or too difficult to encourage children and their families to persevere in their treatment.

Family factors that influence obtaining services. As detailed above, living in a rural setting can impede a child's access to mental health services. However, there exist many other obstacles to a child obtaining the treatment that he or she needs and many of these stem from the nature and characteristics of the family to which the child belongs. Kazdin and Weisz (1998) remind us that there are unique challenges that arise when attempting to conduct research about therapy attrition with children. Children typically have little control over when, how and if they are to attend therapy as they are dependent upon the direction of their parents or guardians. Variables that affect the family *in toto* by default

then affect the child. The mental health of the child is inextricably linked with the mental health of the remainder of the family (Cornah, 2002).

The difficulties in operationalizing definitions and controlling for the heterogeneity of samples also colors the research on what factors can be predictive of a family dropping out of treatment prematurely (Staudt, 2003). Researchers have compiled extensive lists of variables that impede a family from fully participating in a course of psychotherapy for their child. Dadds and McHugh (1992) start their list with the level of family functioning, specifically, such things as the health of the marriage and the mental health of the parents, living conditions, stressful life occurrences and ethnicity. They also include in their list factors on the more macro level that influence the family such as, culture and socioeconomic status. Staudt (2003) elaborates upon similar factors and describes stress for a family as possibly being caused by alcohol or drug addictions, loss of members due to death or arrest and artifacts of poverty such as illiteracy and violence within or towards the family. Koroloff et al. (1994) adds to these by pointing out those logistical considerations such as, difficulties securing transportation or child care, and time demands that may be hard for families to overcome. Koroloff et al. continues by pointing out that families may have trouble developing a liking for the therapist and the services that are offered or accepting the diagnosis or they may not believe that the treatment will have positive results. Finally, the child may simply refuse to attend therapy (Koroloff et al., 1994).

Kazdin and Wassell (1999) agree with most of the above list. In their study, children were considered to have dropped out of treatment if the decision had been unilaterally made by the parent or guardian after the child had attended at least one session. To be

considered a ‘completer’, the child needed to have finished the proscribed course of treatment and termination was mutually agreed upon by therapist and parent. Kazdin and Wassell found that the discerning characteristics between dropouts and completers proved to be socioeconomic disadvantages and trying living conditions for the dropouts. The children who dropped out showed greater levels of impairment. These families had more problems attending treatment regularly. Kazdin and Wassell found evidence that the parents of the children who dropped out had significantly more psychopathology or stresses in their lives. In similar research, Venable and Thompson (1998) investigated the influence of a caretaker’s psychological characteristics and the child’s drop out rate. They administered The Symptom Checklist-90-R (SCL-90-R) (Derogatis, 1983) to 85 caregivers of children aged between 3 and 18. The SCL-90-R is a 90 item, self-report measure that indicates psychological distress and has nine subdivisions that include four factors (general hostility, depression, anxiety, and paranoia) of interest to Venable and Thompson. They concluded that when a caregiver presents with hostility, that caregiver will be more likely to remove the child from therapy prematurely.

MacNaughton and Rodrigue (2001) questioned 93 parents of clinic-referred children aged 4 through 12 and found as part of their investigation that overall adherence to treatment recommendations was influenced by variables that included difficulties in securing child care and procuring transportation, financial hardship and delays in obtaining insurance approval, strains upon available time, and lack of confidence that the suggested treatment would prove to be helpful.

Snell-Johns et al. (2004) suggests that researchers not consider the variables that pose a risk to a family’s ability to meet treatment demands as occurring singly, such as, low

socioeconomic status, parental psychopathology, a rural setting, etc. It is far more likely for these barriers to occur in a "constellation" (Snell-Johns et al., 2004, p. 20) that supplies its own synergy for compounding the negative effects. The effects of barriers to treatment are interactive and cumulative. Kazdin and Mazurick (1994) agree that it appears that no single attribute or variable appears to be solely responsible for dropping out of treatment but rather it is an accumulation of elements that increase the probability that a family will not complete treatment.

Many researchers have sought out defining characteristics of the families who drop out in hope of developing good predictors of who may be at most risk. Weisz et al (1987) conducted a study that attempted to delineate the characteristics of children who dropout prematurely from therapy from those who stay. This study contributes to the literature by finding results that indicate that there is little to distinguish the children who drop out of therapy from those who remain. In this study, dropouts were those who never appeared for the first therapy session after intake at any of the nine public mental health clinics that were used. The clinics were a mix of urban and rural settings and the 304 children involved ranged in age from 6 through 17 years old. The results indicated that the groups could not be significantly distinguished by demographics, by the characteristics of the therapists, by the extent and nature of the child's mental health problems, or by the parents' perceptions of the efficacy of the clinic. The researchers cautiously suggest that the implications are that those who would wish to conduct clinic based research might be able to consider those who drop out as control groups in their studies (Weisz et al., 1987). Pina, Silverman, Weems, Kurtines, and Goldman, (2003) agree that differences between children who complete therapy and those who discontinue

prematurely are often difficult to ascertain. They studied 137 children aged 6 through 16 years old who were being treated for phobic and anxiety disorders with cognitive and behavioral exposure based treatment. They found no significant differences in demographic characteristics or in pretreatment scores on measures of anxiety and fear. Pina et al. (2003) point out that research conducted in community based mental health services has typically not produced significant differences between those that complete therapy and those that drop out while research conducted in the more controlled environment of university based clinics have also only been able to show a very few differences.

Child refusal of treatment. Another reason cited by Koroloff et al. (1994) for premature psychotherapy termination is the child's refusal of treatment. Little research has been conducted that seeks to understand the child's response to participation in and often subsequent withdrawal from outpatient psychotherapy. Recent changes in Pennsylvania in the way in which consent to treatment is conceptualized for children aged 14 through 18 became effective on January 22, 2005 when Act 147 became law (Juvenile Law Center, 2005). Act 147 allows for the adolescent to consent to treatment at his or her own discretion but furthermore gives precedence to parental consent which can override the adolescent's wish to participate, or not, in outpatient treatment (Juvenile Law Center, 2005). Therefore, it becomes prudent to consider whether or not the adolescent who prematurely discontinues treatment began the treatment process at his or her own discretion or at the insistence of the parent or legal guardian or even the courts.

The normally developing adolescent is in the unique position of having attained cognitive abilities that begin to approach that of adulthood and would conceivably allow

him or her to thoughtfully consider premature termination from outpatient therapy as an option in a considered manner. The adolescent at this developmental stage is appropriately seeking independence and personal autonomy (Ribner, 2000). However, in matters such as interface with mental health services, the adolescent must often defer to parental wishes. The adolescent's perspective on the psychotherapeutic experience may differ markedly from that of the adult's.

While the need for services is clear, complexities arise that prevent children from receiving those services. Some of the barriers to treatment compliance, as evidenced by lack of treatment completion, include: logistical issues, such as, arranging transportation and child care; beliefs that the services would not prove helpful and were too time consuming; disagreements about the actual diagnosis or treatment; aversion to the therapist or services that are offered; and refusal by the child to continue treatment (Koroloff, Elliott, Koren, & Friesen, 1994, as cited in Staudt, 2003). Furthermore, the decision to discontinue treatment is qualitatively different for children than for adults as the child is typically not the one to make that determination. Rather, parents make the decision for the child not only to initiate treatment but may also unilaterally decide when to terminate treatment (Pekarik & Stephenson, 1988).

The value of comparing adult and child research results. Pekarik and Stephenson (1988) point out the benefits of critically comparing the results of dropout research from adult and child studies. They proceeded on the premise that the predictors of dropout would differ from adults to children based upon the inability of children to self determine the parameters of treatment for themselves.

Therefore, they reasoned that factors such as client and therapist attitudes and therapist's style might have less impact upon a child's continuance as compared to an adult's. However, factors that would influence both the adults in a family and the children in that family, such as, socioeconomic status, parental expectations about the treatment for their child and practical considerations like transportation could be reasonably expected to still exert a substantial influence upon whether or not the child would continue in therapy. While the study conducted by Pekarik and Stephenson used 118 adults and 212 children, it is interesting to note that for some aspects of the study the children were divided by ages into groups: preschool (ages 3 to 5), grade school (ages 6 to 12) and adolescent (ages 13 to 17). For preschoolers, dropouts were more likely to come from larger families, for those in grade school, completers were more likely to come from a higher social class, but, for adolescents no single variable was found, although the experience of the therapist, while not statistically significant, did appear to contribute to continuation in treatment.

Through the use of multiple regression analysis, the two variables of referral source and therapist experience were found to be related to adult continuance of therapy while none were found for children. When univariate analysis was applied, adults who dropped out could be distinguished from their adult counterparts who continued therapy on all three of the variables that were focused upon in the study: therapist, treatment and demographics. Children were only distinguished by two variables that were associated with lower social class as indicators of premature termination. Pekarik and Stephenson (1988) concluded that children are influenced by differing variables than adults when it comes to premature termination of therapy. This most likely is a result of a child's

powerlessness to unilaterally discontinue treatment if they are displeased with their therapist or the treatment. Furthermore, a child typically has little impact upon or ability to readily control his or her socioeconomic status. Thus, Pekarik and Stephenson ask researchers on therapy dropout to bear in mind the need to focus on variables that are more distinct to children rather than to attempt to extrapolate from adult dropout research.

Wierzbicki and Pekarik (1993) in their meta-analysis repeat the caution to examine risk factors for dropping out as different for adults versus children. They, furthermore, add that less complex variables, such as, demographics show weaker relationships to dropout than more complex variables. These would include consideration of the client's psychological state, expectations, and relationship with the therapist. The investigators urge that future research more fully consider these variables. Mohl, Silverman, Weems, Kurtines, and Goldman (1991) agree that while socioeconomic status consistently inversely correlates with dropout rates, they chose to study how the interaction between clients who were screened for services and the screening therapist would affect the subsequent dropout rate for 96 adults at university medical center. They found a correlational effect that when clients liked the interviewers and saw them as courteous, yet vigorous in treatment approach, dropout rates were lower.

Researchers have studied various influences that tend to increase dropout for adults as compared to children. As children have little power to change the demographics of their family, those variables that affect the family as a whole also work to increase dropout for the children. Furthermore, while adults may discontinue therapy because of interpersonal concerns with the therapist, children are seldom given the opportunity to make that decision.

Expectancy as an influencing variable. Another parental variable that appears to affect children's continued participation in therapy is what the parent's expectations towards therapy is (Nock, Phil, & Kazdin, 2001). Nock et al. (2001) define expectancies as "…anticipatory beliefs that clients bring to treatment and can encompass beliefs about the procedures, outcomes, therapists, or any other facet of the intervention and its delivery" (p. 155). The study included 405 children aged 2 through 15 who were attending a university based clinic for treatment of oppositional and antisocial behaviors.

Through the use of multiple regression analysis, two variables emerged. The results indicated that parents whose expectations were either very high or very low for therapy attended more sessions and were less likely to terminate their child's therapy prematurely. The researchers hypothesized that this curvilinear effect might be explained if parents with high expectations viewed any improvement in their child as an expected result of therapy while those with low expectations would have their positive expectations of the results increased by any observable improvement in their child thereby increasing motivation to continue on in therapy (Nock et al., 2001). This expectancy factor provided incremental variance over and above the typically explored variables of demographics and logistical considerations that often contribute to premature termination. MacNaughton and Rodrigue (2001) found that parental beliefs about anticipated barriers to treatment also had a significant effect upon child attendance. The apprehension of barriers to treatment by parents served as a significant predictor of treatment compliance, including attendance. MacNaughton and Rodrigue recommend that a cooperative examination and discussion of a parent's concerns about what the

parent expects to arise as obstacles to treatment compliance should become a standard follow up to the initial evaluation of the child.

Kerkorian, McKay, and Bannon (2006) conceptualized barriers as occurring in two categories. Structural barriers are of a more logistical nature, such as, difficulties with transportation or insufficient time to attend therapy. The second category consists of attitudes surrounding the therapy experience. It is important for parents to feel respected and understood throughout every phase of contact with a mental health agency. Kerkorian et al. (2006) include in this category such things as helping parents to understand the utility of a particular treatment plan and encouraging their assistance in developing the treatment plan. When mental health providers are responsive and respectful to parents' concerns and empower them by providing them with a clear understanding of what to expect from treatment, parents are less likely to withdraw their children from therapy (Kerkorian et al., 2006).

Kazdin, Holland, and Crowley (1997) confirmed in their research many of the more typically found obstacles that are found as circumventing attendance. These included low socioeconomic status, young mothers, and single parent families. However, they also found that the mere perception of barriers was related to premature termination. These included the belief that treatment was not relevant for their child and the belief that they had a poor relationship with the therapist. Even higher risk families, such as those with a history of antisocial behavior and children with high levels of psychopathology were less likely to terminate if the perception of barriers to treatment were not present.

Parental expectancies exert an influence over treatment compliance and can contribute to dropout. Therapists should be sensitive to this and attempt to openly communicate with

the parent in an attempt to clarify parental expectancies in an effort to forestall premature termination.

Early attrition as a predictor. Aubrey, Self, and Halstead (2003) presented research that studied the relationship between nonattendance early in the course of therapy and its relationship with later attrition. This study was conducted with adult outpatient therapy clients and showed that missing any of the first three therapy sessions either by canceling or 'no showing' was highly predictive of later dropping out. Approximately sixty five percent of those who did so later unilaterally dropped out of therapy, while those clients who attended all of the first three sessions showed a dropout rate of 21.1%. These results suggest that sporadic early attendance should serve as a helpful 'red flag' for the therapist and that if proactive steps are quickly enacted, attrition might be forestalled.

Another phenomenon of premature termination consists of the client who makes initial contact with a mental health provider but then fails to attend the intake session. Clearly, this type of client presents great logistical difficulties in any attempt to perform research on them because of the transitory nature of the contact. Staudt (2003) found no show rates at initial appointments to range from 6.8% to 26.6%. A study done by McKay, McAdam, and Gonzales (1996) revealed that 39% of the children who were scheduled for an intake appointment at an outpatient clinic serving primarily families who had a low socioeconomic status and minority status did not show up for this initial appointment. Kluger and Karas (1983) assigned 141 adult clients who called a community mental health center for services to one of three groups. The first group was given an orientation statement at the time of scheduling their first appointment. The statement was to inform the clients about what to expect to occur at their first visit. The second group, in addition

to receiving the orientation statement, also received a reminder telephone call within 2 hours of their scheduled appointment. The third group received only a prompting telephone call, again within 4 hours of their appointment. The fourth group was a control group that received no intervention of any kind. When compared to the control group, the first group who received an orientation statement and telephone prompt had a lower rate of nonattendance. Kluger and Karas (1983) deemed this a cost effective and time effective intervention strategy. Furthermore, it is significant to note that this intervention takes advantage of minimal contact with the client as the intervention is conducted as part of the first contact. Hochstadt and Trybula (1980) conducted a similar study in which clients were divided into one of four groups: the first was called one day before their appointment; the second was called three days before; the third group was sent a letter to arrive three days before their appointment that stated the time and date of the appointment and the name of their intake worker; and the fourth group was a control group that received no kind of notice. The first group showed the most significant improvement in attendance, however, all of the other groups all showed significantly better attendance rates than did the control group. Kourany et al. (1990) conducted a similar study with 111 subjects. Those who received any kind of contact demonstrated better attendance thereby concluding that any type of contact that can be made with the client will produce better results that no contact at all. Howard, Kopta, Krause, and Orlinsky's (1986) research found that 14% of the clients that they contacted who had failed to attend an initial therapy appointment claimed that they experienced improvement and that the mere scheduling experience had some curative effect for them. Benway et al. (2003) state that no single answer as to why clients fail to attend a first

appointment may be adequate but that they have found that simple forgetfulness may be a primary reason.

The effects of waiting for service. Most of the research conducted in this area is once again primarily based upon adult subjects. Linden, Stone, and Shertzer (1965) define the length of delay for treatment as the number of days between the intake session and the first therapy session.

Freund, Russell, and Schweitzer (1991) found no relationship between the length of time between the intake sessions and the first therapy session and premature termination. Freund et al. (1991) studied 64 clients at a community mental health setting who were seen by 32 PhD candidacy practicum students. They were unable to find any association between length of delay and the clients' reported reasons for not returning to treatment after having attended the intake interview session. It should be noted that these clients were given forewarning that there would be a potential wait time. A further noteworthy result is that more that one-half of the clients who did not return cited the agency's requirement to agree to videotaping of sessions as the reason that they did not return for their initial appointment.

One of the few studies that targeted child subjects was research conducted by Weisz et al. (1987). They examined children aged 6 through 17. One hundred sixty-six children completed the intake process but did not continue on to attend therapy. A second group of 133 children completed the intake process and went on to complete an average of 13 therapy sessions. The two groups were compared across a variety of measures: demographics; Child Behavior Check List scores (Achenbach & Edelbrock, 1983); Child Depression Inventory scores (Kovacs & Beck, 1977); the age and sex of the therapist;

and on parental perceptions of both the clinical setting and on the child. Weisz et al. were unable to find any significant or reliable group differences based on these comparisons.

After a review of the literature, Snell-Johns et al. (2004) concluded that, although a longer wait time has long been hypothesized to negatively influence drop out rates, not enough well constructed and satisfactorily conducted studies have been published to bear out this hypothesis, despite its seeming face validity. One of the few recent studies to attempt more rigorous standards was conducted by Reitzel, Strellrecht, Gordon, Lima, Wingate, Brown, Wolfe, Zenoz, and Joiner (2006). Reitzel et al. (2006) made an effort to differentiate between two types of nonattendance in regards to wait time. They defined one type of nonattendance as clients who contacted a community mental health center but never showed up for the initial intake appointment. The second type of nonattendance was defined as those who showed up for the intake appointment and began treatment but who subsequently prematurely terminated from treatment. The results demonstrated that less important than the actual number of days of wait time was the timely assignment of a therapist. When clients were informed that they had been assigned to a therapist, even though they had not had an actual appointment for the first session of therapy set up, they were more likely to attend the intake session. Clients that experienced a wait of 15 days until therapist assignment were significantly more likely to not attend the intake session than those clients who only experienced a wait time of 9.5 days until they were assigned a therapist. This predictive relationship did not hold true for those who would later prematurely terminate. Reitzel et al. (2006) controlled for symptom severity as measured by the Global Assessment of Functioning and this did not influence the results. Furthermore, this study did not find a moderating relationship between other patient

variables, such as, ethnicity, gender, a personality disorder diagnosis, or age. The 22% dropout rate in this study was less that the 30% dropout rate typically reported in the literature.

The literature on the effect of wait time on premature termination continues to offer conflictual data. This may be the result of heterogeneity of methods, samples and definitions.

Costs of premature termination. Finally, when premature termination occurs, its effects can reach beyond the negative outcome upon the child and family. Premature termination costs mental health providers in time and money and is disruptive to the ability of the provider to schedule efficiently and to provide quality care (Weisz et al., 1987; Ulmer & Troxler, 2004). Pekarik (1985) points out that those clients who "no show" are typically not charged any fee. Benway et al. (2003) caution that, particularly when resources are limited in the provision of services for children, premature termination from therapy can severely tax not only the physical resources of the mental health care provider but also have a cumulative and negative effect upon the morale of the individual therapist. This may serve to increase personnel costs as lowered job satisfaction may contribute to increased staff turnover (Pekarik, 1985).

The available literature points to a variety of factors that contribute to the decision to prematurely discontinue therapy. With prevalence rate estimates that range from 16% (Benway et al., 2003) to 22% (Costello et al., 1996), the literature on the epidemiology of mental disorders in children clearly demonstrates the need for services. There exists a general consensus in the field that psychotherapy is beneficial for children. However, a constellation of barriers appears to prevent 70% of those identified children from

receiving needed services (US Congress Office of Technology Assessment, 1986). Unfortunately, research has delivered inconsistent results about treatment barriers likely due to the use of dissimilar samples, differing methodologies and, as previously mentioned, differences in the operationalization of key concepts (Armbruster & Kazdin, 1994). More research is needed to develop a clearer understanding of the influence of these factors.

Facilitating Factors for Therapy Continuance

Preparing clients for therapy. Some researchers have suggested that the use of specific preparatory techniques with clients can reduce the possibility of premature termination. Walitzer, Dermen, and Connors (1999) posit that these techniques function in several different ways. Role induction requires the sharing of information that educates the client about the psychotherapeutic process and should be one of the first steps. This is of particular importance for clients who have no experience with therapy. Included should be the underlying principles of psychotherapy and sharing the expectation of positive outcomes from the therapy process. Walitzer et al. (1999) believe that it is important for the client and therapist to have a common understanding of the work that will be required. For example, the nature of homework assignments, the need for the client to take a dynamic stance in session, and how long therapy is expected to last. Furthermore, client attrition may be avoided if the client is informed that he or she may encounter some negative experiences associated with forward movement in therapy, such as, the experience of strong emotions and uncomfortable feedback commentary from the therapist.

Walitzer et al. (1999) continue by saying that *pretraining* of a client may be either vicarious or experiential. The provision of examples of actual therapy to clients allows them to vicariously sample the therapeutic experience. Research suggests that this technique contributes to higher attendance rates but does not differentially affect drop out rates. For example, Shuman and Shapiro (2002) believe that the use of videotape instruction can provide much information, such as: avoiding parental misunderstandings by providing a fundamental understanding of therapy; an understanding of the use of 'play' in therapy; the importance of active parental participation and, persistence in completing the entire course of therapy. However, when they provided 149 parents of children between the ages of three and 10 with this opportunity, it did not reduce the rate of premature termination. Only a small body of research suggests that when clients are given the opportunity to actually practice therapy behaviors treatment attendance improves.

Day and Reznikoff (1980) used videotape modeling to prepare families for therapy. Boys aged seven years, 11 months through 12 years, 11 months and their parents were shown a videotape designed to disabuse them of incorrect expectations related to premature termination. The results indicated that while the number of cancelled appointments was decreased, there was no effect upon the overall rate of premature termination.

Wennin and King (1995) required parents to attend a free orientation at a child psychiatric clinic. This requirement served to reduce the number of families on the waiting list thereby allowing more access to services to those who were motivated to participate in the orientation meeting. However, while this technique helped to increase

attendance at intake and initial appointments, it did not appear to continue to affect subsequent attendance.

Motivational interviewing is a technique of engagement that has support in the research (Miller & Rollnick, 1991; Ogrodniczik et al., 2005; Walitzer, et al., 1999). This preparatory technique is intended to increase an individual's willingness to pursue a specific stratagem of change (Ogrodniczik et al., 2005). Miller and Rollnick (1991) developed this method and organized it using the acronym "FRAMES":

- Feedback of information obtained from various types of assessment is provided to the client
- Responsibility is couched in terms of personal accountability by the client
- Advice about ways to change in order to meet treatment goals is given by the therapist to the client
- Menus of change strategies are introduced and jointly examined by therapist and client
- Empathy from the therapist to the client is a key element
- Self-efficacy is encouraged and facilitated in the client

Though used extensively in the substance abuse field, this style of engagement can be readily applied to other kinds of therapy (Walitzer et al., 1999).

The therapeutic relationship. The importance of the therapeutic relationship in the practice of psychotherapy with any population of clients has been repeatedly demonstrated through a large body of research (Epperson, Bushway, & Aram, 1983; Garcia & Weisz, 2002; Pekarik, 1988; Tolan, Ryan, & Jaffe, 1988). The nature of this relationship may have a direct influence upon not only the quality of treatment but also

whether or not the client will remain a willing participant for the full course of treatment. Its importance in working with children and their families is a relatively new area of research emphasis that some researchers have begun to examine in conjunction with its effect upon premature termination.

Garcia and Weisz (2002) interviewed parents after their children had ended outpatient psychotherapy prematurely. They used a measure adapted from the work of Gould, Shaffer and Kaplan (1985). Garcia and Weisz entitled their measure, "Reasons for Ending Treatment Questionnaire" (Garcia & Weisz, 2002, p. 1). They examined the results through factor analysis in an effort to discern if the therapeutic relationship might account for a significant amount of the variance that would help explain the instances of premature termination. The results of the statistical analysis revealed that the factor they identified as 'Problems with the Therapeutic Relationship' did account for the largest percentage of variance. These 'problems' included such issues as: the therapist was not perceived as doing the right things or talking about the right problems; parents did not believe that the therapist was talking enough with family members or helping the child; it was felt that the therapist did not seem to understand the pertinent issues; parents thought that the therapist failed to explain the child's treatment clearly to them; and, the child or parent simply did not like the therapist. Garcia and Weisz concluded, based upon the results of their study, that 'Problems with the Therapeutic Relationship' and 'Money Problems' were the only two factors that they uncovered that were predictive of premature termination.

Epperson et al. (1983) and Pekarik (1988) supply more supporting evidence that speaks to the importance of clear communication as an important element of the

therapeutic alliance. They concluded that when clients feel that the therapist does not have an understanding of the client's problems as the client conceptualizes them the rate of premature termination increases threefold. This predictive relationship is far stronger than any based upon the more simplistic demographic details that have been more commonly studied (Epperson et al., 1983). Lazare et al. (1975) suggest that as early as the second and third sessions, therapists should be asking clients if they believe that therapy is meeting their goals and if the process is contributing towards a greater understanding of the presenting problems. Lazare et al. (1975) believe that a continuous monitoring process will assure that the client feels understood and that the therapy is proceeding in the desired direction.

Research by Tolan, Ryan, and Jaffe (1988) also seems to highlight the importance of developing a strong therapeutic relationship. They studied 505 contacts by adolescents aged 13 through 17 at an outpatient clinic. Those adolescents who saw the same mental health professional throughout the entire process of psychotherapy attended an average of 24.8 sessions. This is in juxtaposition to those adolescents who saw more than one professional and whose subsequent attendance was a far less number of sessions, averaging only 7.6.

Mohl et al. (1991) conducted a study with 80 adult subjects who were seeking psychotherapy at a university center. The focus of this study was to ascertain if statistical differences could be found among the four different clinicians who conducted screening interviews in respect to a client's subsequent participation in therapy. The researchers employed the Helping Alliance Scale (Luborsky et al., 1980) and the Osgood Semantic Differential (Osgood, Suci, & Tannebaum , 1975). Prospective clients were asked to

complete these measures at the end of the screening interview. The Helping Alliance Scale, as the name implies, allows for client commentary on such things as whether the client felt understood and had gained a new understanding from the interview. The Osgood Semantic Differential assesses the three dimensions of evaluation, activity and potency. The results demonstrated a correlative effect between how the client felt that he or she was treated and perceived and how the client perceived the interviewer. Those who continued on in therapy felt "…that they had gained more understanding, had been helped more, liked the screener more, were liked better, were treated with greater respect, and were more satisfied…" (Mohl et al., 1991, p. 479). They also viewed their interviewer as "more active". This study also serves to point out the importance of client/provider interaction from the first meeting.

Some variables may act as facilitators that move the parent along in the process of obtaining and using mental health services for their child, once it has been determined that mental health services are needed either through the assignment of a diagnosis by a professional or the resolution of the parent and child. Logan and King (2001), for instance, found that previous service use history, the child's willingness to cooperate with therapy, and having sufficient time and money resources could positively influence the family's move towards participation in therapy. Kazdin et al. (1997) found that the experience of a fewer total number of barriers would serve the family as a protective element in forestalling premature termination from treatment. Use of engagement techniques and the development of a strong therapeutic alliance are other examples of factors important to recognize as salient in combating premature termination.

What Current Research Suggests to Combat the Problem of Premature Termination

Logistical considerations. Current research provides evidence that many factors influence whether or not a child will prematurely terminate from therapy. These range from the individual characteristics of the child and family to community factors to influences from the world at large (Snell-Johns et al., 2004). Furthermore, it is clear that these influences merge and converge to synergistically work against or in favor of increasing the chances that a child will remain in therapy. Concomitantly, researchers have attempted to provide solutions to negative dynamics and enhance positive influences upon the decision to remain in therapy. Snell-Johns et al. (2004) define these strategies as "…methods used to enhance or adapt programs and curricula so that they are accessible and appropriate for families who are typically underserved" (p. 4).

Even for children and families that enter into therapy fully intending to successfully conclude it, practical considerations often interfere with those plans. Transportation difficulties may arise that prevent bringing the child to therapy. Partly in response to this, treatment programs have been created that are intended to deliver services in the home. Examples of these types of programs are many but they all have in common that therapy is primarily conducted outside of the traditional mental health care setting. Multisystemic Therapy (MST) provides a successful example of these types of programs (Henggler et al., 1996). When examined for rates of premature termination, MST showed a 98% completion rate over the course of 130 days of a treatment protocol (Henggler et al., 1994). The subjects in this particular study were low socioeconomic status delinquent youths who were also considered substance abusers. While this high rate of completion is very encouraging, these programs may often be expensive to mount and maintain, prompting the need for further research to better specify the components of the *modus*

operandi that account for the highest contribution towards reducing premature termination.

A different approach to therapy in the home is the use of self directed materials. There are examples of the successful use of these types of materials with specific populations residing in a rural setting where transportation issues may be worse than in a suburban or urban setting. For example, Kacir and Gordon (1999) have created the Parenting Adolescents Wisely (PAW) program. The material is presented through the use of a 3 hour videodisk that affords parents the opportunity to access the interactive materials at their leisure and when needed, not based upon therapist availability. Approximately half of the parent participants took advantage of this opportunity. While conclusive research of this program's efficacy is ongoing, nevertheless, this program shows promise as a way to overcome access barriers (Snell-Johns et al., 2004). Connell et al. (1997) presented evidence for the use of self directed materials for children aged 2 through 6 years old. Therapist contact was limited to once weekly phone consultations. Families were given reading materials that allowed them to self select goals and to self monitor progress. Although the small sample size of this study (n = 12) is a clear limitation, it is encouraging that all 12 families completed the 10 week program with significant improvement in disruptive behaviors and parental satisfaction. A similar study was conducted by Webster-Stratton et al. (1988) (as cited by Snell-Johns et al., 2004). Children aged 3 through 8, with conduct disorder diagnoses, showed significant behavioral improvement when their families participated in a self directed video taped course. A high rate of participation compliance was demonstrated as 92% of the families completed the entire course of treatment. The use of self directed materials such as these

allows beneficial therapeutic materials to be used by families with minimal therapist participation in a flexible and cost efficient manner.

Addressing parental needs. Some researchers have examined the effect of the parental presence upon the therapy situation (Hodges, 2004; Nevas & Farber, 2001; Prinz & Miler, 1994). Nevas and Farber (2001) believe this a much overlooked area of investigation. Parents' influence upon the course of treatment begins immediately. At intake, it is they who provide the child's history along with information about the child's peer and sibling relationships and school behaviors. Furthermore, it is they who will provide feedback to the therapist about the child as the course of therapy proceeds (Nevas & Farber, 2001). Inclusion of the parent in a positive, considerate and affirming manner has the potential to increase the effectiveness of therapy with the child. Care should be taken to cultivate a strong parent/therapist alliance from the beginning of treatment. Parents should immediately be told that they will be asked to contribute to therapy on a regular basis. This will not only allow the parent to share information with the therapist but will also allow the therapist to share encouragement with the parent. Nevas and Farber (2001) recommend initiating parents into the process of their child's therapy by providing them with information about treatment goals and about how therapy will be conducted. Hawley and Weisz (2003) found that this is often not the case. In the cases that they studied, nearly three-quarters of the client-families began treatment without benefit of a clear consensus from the involved parties, i.e., child, family and therapist, on a main objective for treatment. Hodges (2004) advocates the inclusion of parents from the very beginning stages of therapy in an intentional manner. The fallout from failure to do so can contribute to the parents' decision to prematurely discontinue treatment. Garcia

and Weisz (2002) reported that in one-third of the cases they investigated, parents said they removed their child from treatment early because they believed that the therapist was not talking about the most important issue. Kazdin et al. (1997) found that the most robust predictor of premature termination was the client's belief that treatment was ineffective and irrelevant. From the beginning, conversations with children and families should assess the confluence of client and therapist stances on the character of the problem and how it should be tackled (Ogrodniczuk, Joyce & Piper, 2005).

A discussion of what barriers might preclude completion of the course of therapy should also occur very early on. MacNaughton and Rodrigue (2001) recommend that standard procedure include attention to what parents believe will present as obstacles in order to forestall this significant contributor to premature termination.

Parents who are under stress (for example, psychological, financial or related to the care of a child with a serious emotional disorder) may require even more from a therapist in order to insure continuation of services for the child. Andra and Thomas (1998) studied a group of 74 children aged 24 to 72 months of age along with a control group. The emotionally disturbed children attended a daily therapy group at an outpatient treatment facility. Parents attended individual therapy sessions on a biweekly basis. A lower rate of attendance for parents was significantly associated with lower socioeconomic status. In response to findings such as these, Prinz and Miller (1994) developed an approach to therapy that they call Enhanced Family Treatment (EFT). In this protocol, therapists consistently included discussions of stressors and barriers to treatment with the parents. In their study in support of EFT, 147 families were randomly assigned to either the EFT group or a group that received standard family treatment. The

children in these families were aged 4 through 9 years and displayed aggressive behaviors. Therapists were directed to address an assortment of barriers that ranged from individual issues upwards through ecosystemic levels. This simple practice demonstrated a dropout rate of 29.6% for the EFT group as contrasted to a rate of 46.7% for the comparison group.

Summary of the Literature

Researchers have made it clear through epidemiological studies that the rates of mental illness among children in the United States warrant concern and attention from those who provide mental health services (Benway et al., 2003; Kazdin, 1998; United States Congress Office of Technology Assessment, 1986). Unfortunately, the literature also points out that children may often have difficulty in accessing the mental health services that they need. The list of variables that are barriers to attaining effective and appropriate treatment is long and, according to researchers, far from complete at this point in time. Because of these many variables, children who begin psychotherapy may find it difficult or impossible to continue treatment. Dropping out of treatment, or prematurely terminating treatment, may occur as much as 40% of the time and represents a rampant problem for mental health providers. Children often have little say in whether or not they continue or dropout of therapy. The recommendations in the literature regarding the reduction of the phenomenon of premature termination should be considered for practical application in treatment settings.

Contact with clients is considered essential to facilitating attendance (Tolan, Ryan, and Jaffe, 1988). At the two sites examined in this study, CGC and CAP, clients are contacted when they have two 'no shows'. "Intent to discharge" letters are then sent as

prompts to encourage clients to resume attendance. This is a standardized procedure at both sites intended to reduce premature termination. Where formalized procedures for dealing with premature termination are few, any policy such as this should be examined. This study attempted to determine if therapists from both mental health settings followed internal protocol in sending "intent to discharge letters" when their clients compiled two missed appointments that were considered 'no shows'. It was hypothesized that therapists at both sites would have followed protocol in their efforts to reduce premature termination. The study also attempted to determine if a significant change in the ‘no show’ rate at the CGC occurred when new policies to address this issue were instituted. It was hypothesized that a significant reduction in the no show rate would be demonstrated between the data set that represented attendance before the policy changes and the data set that represented attendance after the policy changes.

CHAPTER 3

METHODS

Participants

Record review was conducted upon children aged 1 through 18 who attended outpatient psychotherapy at one of the two clinics located in the rural town of Indiana, Pennsylvania. The two clinics accessed in this study were the Center for Applied Psychology at Indiana University of Pennsylvania and the Community Guidance Center. Participants were included in the study when they were considered to have prematurely terminated from therapy. Premature termination as used in this study means those children and their families who contacted one of these two mental health providers with the intent to receive services but did not complete therapy either by not making any further contact or by unilaterally discontinuing services. All diagnoses were included.

Charts from the CAP that date from August 31, 2006 through August 31, 2007 were used. Charts from the CGC that date from July 31, 2005 through July 31, 2004 were examined. Henceforth, this data will be referred to as CGCControl. Charts from the CGC that date from August 31, 2006 through August 31, 2007 were examined. Henceforth, this data will be referred to as CGCTreatment.

The Indiana University of Pennsylvania Department of Psychology has a Clinical Psychology Doctor of Psychology program that has an in-house training facility called the Center for Applied Psychology (CAP). The CAP is intended to provide a setting for students of the clinical psychology doctoral program to gain introductory and advanced experience and professional expertise in the field. The CAP accomplishes this while also serving the community at large by providing a variety of psychological services, such as,

psychotherapy, educational presentations, consultations, and ongoing research projects (ww.iup.edu, retrieved 8/15/06). At the time of this investigation the CAP offered four different clinics for differing populations to receive clinical services. They are: the Intake Clinic; the Stress and Habits Disorders Clinic, sometimes referred to as the Adult Treatment Clinic; and the Family and Child Treatment Clinic. Of interest to this study are the Intake Clinic and the Family and Child Treatment Clinic.

The Intake Clinic conducts interviews of those interested in receiving services at the CAP. During the intake interview, information is gathered that will aid the clinician in developing a diagnosis and treatment plan. Based upon the information gathered, the prospective client is given a recommendation to the appropriate clinic or triaged to another more appropriate facility.

The Family and Child Treatment Clinic (FCTC) can provide family therapy, individual outpatient therapy for the child, or specialized group therapies for children. When a child is referred for outpatient psychotherapy to the FCTC, a therapist is assigned and it becomes his or her responsibility to call the client to schedule and confirm the appointment. The FCTC typically holds sessions one day a week with the hours of operation from 2:00 PM until 9:00 PM. Clients may contact their therapist by leaving messages with the CAP secretary who then posts them on a bulletin board for therapists to retrieve. Alternatively, all clients are to be given the CAP telephone number and instructions for leaving a voice mail message for the therapist. Therapy sessions are typically one hour long and fees are determined through a sliding fee scale.

The Community Guidance Center (CGC) of Indiana County is the local Community Mental Health Center which has served the community since 1959. The Center offers a

full range of Outpatient Services, Partial Hospitalization Services for adults and children, and comprehensive community based services including Family Based, Behavioral Health Rehabilitation Services, Adult and Child Case Management Services and Psychiatric Rehabilitation. Hours are from 8:00 AM to 8:30 PM Monday through Thursday and from 8:00 AM to 5:00 PM on Fridays, with after hours crisis intervention offered in select programs and a 24-hour crisis on-call telephone service.

The CGC employs a same day intake process wherein callers are triaged by a centralized intake service on an emergent, urgent or routine level. Clients are seen on a walk-in basis as necessary. Clients may be assigned directly to a clinician for the opening intake or seen directly by an intake worker, based upon clinical triage. The client can be scheduled immediately, or at their convenience for the initial session.

The CGC has undergone policy changes in the past two years that address the way in which outpatient clients are scheduled and the way in which occurrences of premature termination are handled. The CGC has adopted a centralized scheduling system that allows for better tracking of client cancellations and no shows. The CGC currently employs a response to those occurrences that provides for a letter to be sent to the client by administrative personnel when two 'no shows' occur. The letter informs the client that he or she will be required to attend a Psychotherapy Education Group (PEG) session before a return to regular therapy sessions can occur. PEG is a one hour group session the purpose of which is to educate clients on the importance of regular therapy attendance. Failure to attend PEG results in the closing of the case.

Measures

A questionnaire consisting of a checklist of items was developed to insure that adequate and consistent information gathering would occur across both settings (see Appendix A). The questionnaire is designed to include the following: general client information; standard intake procedures; standard policies to address attendance issues; and chart review to determine adherence to policy, and whether clients returned to therapy after receiving letters informing of the intent to discharge. Information was gathered through interview of personnel, policy review, and archival chart review. At no time was there any contact with the individual client or the parents of the client in gathering any of the above listed information.

Procedures

Approval for the participation of the CAP was obtained by permission of the current CAP director, Dr. Kimberely Husenits (See Appendix B). Approval for the participation of the CGC was obtained via the review and consent of the Research and Outcomes Committee at CGC (See Appendix C).

Charts from the CAP that dated from August 31, 2006 through August 31, 2007 wherein the identified patient was a child between the ages of 1 through 18 were examined to determine if they indicated that the standard policies in place for handling cases of premature termination were followed. Henceforth, this data will be referred to as CAPDATA. Specifically, it was attempted to determine if therapists sent a letter of "intent to discharge" to clients after two incidences of "no shows" as per site policy. Charts from the CGC that dated from July 31, 2005 through July 31, 2004 were examined. Henceforth, this data will be referred to as CGCControl. Charts from the CGC

that dated from August 31, 2006 through August 31, 2007 were examined. Henceforth, this data will be referred to as CGCTreatment. These two sets of charts were compared to determine how policy change affected premature termination at this site.

At no time was information that could identify individual clients used in this study. No clients or their families were contacted for any information. Charts were not removed from the premises. Information was used only in aggregate form. All reasonable precautions were taken to maintain client confidentiality.

The primary researcher interviewed the personnel at the CGC and at the CAP using the Data Collection Questionnaire as described above in the *Measures* section.

Design

The qualitative aspects of this study resulted in the creation of recommendations for each of the sites involved. These recommendations are intended to assist the sites in handling the issue of premature termination from therapy based upon what the current research indicates as efficacious to this issue.

Quantitative data collected via chart review was used to determine if clinicians followed the sites' policies for handling premature termination from therapy by clients. When a chart indicated that a child between the ages of 1 to 18 had discontinued therapy prematurely, it was further reviewed to determine if the therapist had followed site policy and sent an "intent to discharge" letter to the client.

Charts from the CGC were examined. These charts were divided into two groups based upon time frames. The first group represented charts from July 31, 2005 through July 31, 2004. The second group represented charts from August 31, 2006 through August 31, 2007. In the time period between, the CGC made policy changes designed to

reduce premature termination. Thus, the two groups were compared to determine if the policy changes affected the rate of premature termination.

Analysis

Charts were reviewed to ascertain if clinicians followed each sites' protocol for instances where clients prematurely terminated from therapy. In reviewing charts from the CAP for the time period of 2005 through 2006, 35 charts that met the criteria for the study were found. CGC charts from the time period July 2004 through July 2005 totaled 24. CGC charts from the time period August 2006 through August 2007 totaled 15.

Frequency tables provide descriptive formats for viewing data from both sites concerning the number of session, no shows, cancellations, and return to therapy. A t-test was used to compare CGCCONTROL and CGCTREATMENT in an attempt to discern whether the rate of premature termination changed when policies were implemented to address this issue. Furthermore, the data from CGCCONTROL and CGCTREATMENT were analyzed using an Independent Samples Test. The results of this analysis allowed the two groups to be combined into a third group that was designated as CGCCOMB. CGCCOMB was compared to CAPDATA using ANOVA to determine if there were statistically significant differences between no shows and cancellations between the CAP and the CGC.

CHAPTER 4

RESULTS

Chart review allowed for the determination of the number of sessions, cancellations, and no shows for both sites across all time periods. That information is presented in Appendices A through D.

When files were examined to determine if intent to discharge letters were appropriately sent, discrepancies were found between the CAP and the CGC. In all cases examined from the CGC, copies of letters of 'intent to discharge' were found indicating that therapists had followed protocol. However, files from the CAP revealed that in nearly 46 % of the cases reviewed, there was no indication in the files that a letter of intent to discharge was sent to the client.

Table 1

Intent to Discharge Letters Sent from the CAP and CGC

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
CAP				
N	16	45.7	45.7	45.7
Y	19	54.3	54.3	100.0
Total	35	100.0	100.0	
CGCCONTROL				
Y	24	100.0	100.0	100.0
CGCTREATMENT				
Y	15	100.0	100.0	100.0

Out of 74 files reviewed, in only one case did sending an 'intent to discharge' letter result in the client returning to continue therapy. The implications of this finding will be more fully discussed in the Discussion section. It should also be noted that 24 cases from CGCCONTROL met the criteria for premature termination. The total number of cases closed during that same time period was 99. Thus, those cases examined in this study represent 24% of the cases. The number of cases that met the criteria for premature termination for the CGCTREATMENT group was 15. The total number of cases that were closed in that same time frame was 104. The 15 cases examined in this study represent 14% of the cases.

Table 2

Clients Returning After Intent to Discharge Letter Sent

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
CAP				
N	35	100.0	100.0	100.0
CGCCONTROL				
Y	23	95.8	95.8	95.8
N	1	4.2	4.2	100.0
CGCTREATMENT				
N	15	100.0	100.0	100.0

The two groups from the CGC were given the designations of "Control" and "Treatment". The CGCCONTROL group represents files examined that dated from July

31, 2004 through July 31, 2005. The CGCTREATMENT group represents files examined that dated from August 31, 2006 through August 31, 2007. In the interim between these two time periods, the CGC instituted several agency changes that were designed to have an impact upon the problem of premature termination. These changes will be more fully examined in the Discussion section. The two groups were examined using a t-test.

Table 3

T-test for Comparing Treatment and Control Groups

	Group	N	Mean Number Of Sessions	Std. Deviation	Std. Error of the Mean
Sessions	CGC Control	24	7.0833	5.97762	1.22018
	CGCTX	15	6.1333	8.59291	2.21868
Cancellations	CGC Control	24	2.6250	2.72570	.55434
	CGC TX	15	1.6000	1.84391	.47610
No Shows	CGC Control	24	2.1667	1.90347	.38854
	CGC TX	15	1.6667	2.02367	.52251

The groups were further examined by using Levene's Test for Equality of Variances and a t-test for Equality of Means.

Table 4

Levene's Test for Equality of Variances

		F	Sig.
		Lower	Upper
Sessions	Equal Variances Assumed	1.401	.244
Cancellations	Equal Variances Assumed	.792	.379
No Shows	Equal Variances Assumed	.573	.454

Table 5

t-test for Equality of Means

		t	df	Sig. (2-tailed)	Mean Difference	Std Error Difference	95% Confidence Interval of the Difference	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower
Sessions	Equal Variances Assumed	.408	37	.686	.95000	2.33087	-3.77280	5.67280
	Equal Variances Not Assumed	.375	22.497	.711	.95000	2.53207	-4.29447	.19447
Cancel-lations	Equal Variances Assumed	1.285	37	.207	1.02500	.79751	-.59090	2.64090
	Equal Variances Not Assumed	1.403	36.688	.169	1.02500	.73072	-.45604	2.50604
No Shows	Equal Variances Assumed	.779	37	.441	.50000	.64176	-.80034	1.80034
	Equal Variances Not Assumed	.768	28.466	.449	.50000	.65114	-.83282	1.83282

Using an alpha level of 0.05 for all of the analysis, the Levene's test shows that equal variances can be assumed for sessions with a p-value of 0.244. This is because the p-

value is greater than the alpha level. With a p-value of 0.686, there was no significant difference between the treatment and control group with respect to number of sessions. The p-value is greater than the alpha level.

For cancellations, the Levene's test shows that equal variances can be assumed since the p-value of 0.379 is greater than the alpha level. With a p-value of 0.207, there was no significant difference between the treatment and the control group with respect to the number of cancellations. The p-value is greater than the alpha level.

For no shows, the Levene's test shows that equal variances can be assumed since the p-value of 0.454 is greater than the alpha level. With a p-value of 0.441, there was no significant difference between the treatment and the control group with respect to the number of no shows. The p-value is greater than the alpha level.

Because of the lack of statistical significance found between the groups, they were combined into the group CGCCOMB and used for comparison to the CAPDATA. ANOVA's were conducted to determine statistical differences between these two groups regarding sessions, cancellations, and no shows.

Table 6

ANOVA Between CGCCOMB and CAPDATA Comparing Sessions Attended

Sessions	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	97.907	2	48.953	1.306	.277
Within Groups	2662.310	71	37.497		
Total	2760.216	73			

With an alpha level of 0.05 and a p-value of 0.277, there was no significant difference between the number of sessions attended for CGCCOMB and CAPDATA.

Table 7

ANOVA Between CGCCOMB and CAPDATA Comparing Cancellations

Cancellations	Sum of Squares	df	Mean Square	F	Sig
Between Groups	32.692	2	16.346	3.552	.034
Within Groups	326.768	71	4.602		
Total	359.459	73			

With an alpha level of 0.05 and a p-value of 0.034, there was a significant difference between number of cancellations for the CGCCOMB and the CAPDATA since the p-value is less than the alpha level. To further support these results, a Contrast Test was conducted the results of which served to confirm the significant results of the ANOVA.

Table 8

Contrast Test Comparing Cancellations

	Contrast	Value of Contrast	Std. Error	t	df	Sig
Assume Equal Variances	1	1.9964	1.01221	1.972	71	.052
Does Not Assume Equal Variances	1	1.9964	.94983	2.102	69.192	.039

With the variances assumed to be unequal, the p-value is 0.039. This is less than the alpha level so there is a significant difference between number of cancellations and the combined CGC and CAP groups. However, because the p-value of 0.039 was close to the

alpha level of 0.05, a Mann-Whitney test was also conducted that served to support the conclusion of significant findings.

Table 9

Results of Mann-Whitney Test

	Cancellations
Mann Whitney U	445.000
Wilcoxon W	1075.000
Z	-2.677
Asymp. Sig (2 tailed)	.007

Table 10

ANOVA Between CGCCOMB and CAPDATA Comparing No Shows

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	35.716	2	17.858	6.575	.002
Within Groups	192.838	71	2.716		
Total	228.554	73			

When an ANOVA was conducted that compared no shows between the CGCOMB and the CAP, significant results were found. Since the p-value is 0.002, it is less than the alpha level so there is a significant difference.

Files were reviewed from the CAP and from the CGC. Therapists at the CGC followed protocol in every case by sending "an intent to discharge" letter whenever two instances of missed appointments were noted. In contrast, therapists at the CAP sent "intent to discharge" letters in only 46% of the cases when it would have been appropriate to do so. It is important to be noted that in only one instance did sending an "intent to discharge" letter result in the return of a client. Programming changes that were made at the CGC to address premature termination did not result in a significant reduction in premature termination.

CHAPTER 5

DISCUSSION

Steps to Reduce Premature Termination

Ogrodniczuk et al. (2005) observed that, as no solid identification of specific variables that unilaterally direct a client towards early termination has been finalized, likewise, no one strategy that will effectively apply across client populations and treatment settings can be recommended. Many strategies may apply and in combination. Furthermore, while Ogrodniczuk et al. (2005) stated that while therapists may recognize the great need for stratagems to reduce instances of premature termination they typically do not apply those types of measures in a structured manner that would produce more meaningful results. Walitzer et al. (1999) echoed this sentiment. These researchers believe that by methodically employing known techniques for reducing premature termination, therapists would enjoy the benefits of more efficacious therapy with relatively little cost in terms of time or financial investment.

Change within organizations may be accomplished in many ways. A structured method employed by both 'for profit' and 'nonprofit' organizations is through individualized program evaluation (McNamara, 2006). Program evaluation provides a basis for making decisions about change within an organization. Necessary data collection is completed and a plan created to guide the implementation of specific actions designed to meet specific goals of the organization (McNamara, 2006). McNamara stated that one does not need to be an expert to conduct a program evaluation that will be useful to the organization. He posited that the application of '20%' effort can engender '80%' of

results that will be useful and that the employment of a program evaluation conducted with even minimal effort is the better choice than to conduct none at all.

If the goal is to reduce the rate of premature termination from outpatient psychotherapy by children and their families, then actions to address this problem should proceed from what current research suggests. Furthermore, recommendations have little value unless they are applicable and attainable to the setting and are fluid enough in nature to evolve when new and useful information in attained.

This study proceeded from the hypothesis that therapists would follow on site procedures designed to reduce premature termination. Specifically, sending "intent to discharge" letters when clients presented with two 'no shows'. The results showed that therapists in training at the CAP program were less likely to follow procedure than therapists at the CGC. This may be the influence of lack of experience by therapists in training or less emphasis placed upon the logistical contingencies of therapy in favor of an emphasis on the experiential components of therapy. In any event, the overall effectiveness of "intent to discharge" letters may be called into question. There were a total of 74 "intent to discharge" letters sent from the CAP and CGC. In only one instance did a child return to therapy after receiving a letter.

In recent years, the CGC has made some fundamental shifts in policy that have addressed the problem of premature termination. One of the major shifts was the move to centralized scheduling. This type of scheduling results in the elimination of standing appointments. When a client does not show up for an appointment, the next appointment that they receive will be at the discretion of the administrative scheduler. The client will be scheduled so as to fill an open slot in the therapist's schedule rather than being given

the option of choosing an appointment time for his or her self. This system promotes a "tightening up" (Diefenbach, personal communication, September 21, 2007) of the therapist's schedule and results in fewer nonproductive hours. A second change is the promotion of continuity of care by providing opportunities for therapists to conduct their own intakes. Called "direct-to-therapist intakes" (Diefenbach, personal communication, September 21, 2007), this serves the dual purpose of helping to fill a therapist's schedule with productive work while potentially allowing for the development of the therapeutic relationship to begin from intake. Research has shown support that when clients interface with fewer mental health professionals during the process of therapy, they are more likely to continue on in services (Tolan et al., 1988). The CGC also has recommitted to enforcing their policy to respond to instances when a client no shows for sessions. When two no shows occur, the client receives a letter advising him or her that they will be required to attend a Patient Education Group (PEG) before resumption of regular therapy sessions. The PEG sessions are designed to educate clients upon the importance of consistency of attendance. As mentioned in the Results section, significant improvement in the rate of premature termination was not evidenced after these policies were implemented. The rates of premature termination at the CGC may be compared to those found in other settings. In Kazdin's (1993) study on children and attendance, he reported a premature termination rate of 38.5%. Armbruster and Fallon (1994) reported an even higher rate of 45%. In the first time frame examined at the CGC (July 31, 2005 through July 31, 2004) the rate was 24%. Cases examined at the CGC in the second time frame (August 31, 2006 through August 31, 2007) showed a rate of 14%. Clearly, the CGC demonstrates a much lower rate of premature termination when contrasted with these

representative studies. However, as pointed out throughout this study, comparison between studies is often difficult to interpret because of differing methodologies, differing ways researchers operationalize premature termination, mixed population samples, etc. Nevertheless, the lower rates found in this study in the CGC appear to indicate that the issue of premature termination from therapy may be handled in a more successful manner than at other sites. MacNaughton and Rodigue (2001) comment on the importance of further research that investigates those site specific characteristics that influence premature termination.

The CAP currently has no policy in place to proactively deal with the problem of premature termination. The CAP currently keeps no statistics on the rate of premature termination from therapy that they experience. In the Family and Child Treatment Clinic, premature termination is regarded as a continuing problem that might be alleviated through the formal adoption of standardized policies and procedures designed specifically to address this issue (Ogrodniczuk et al., 2005).

The CAP faces issues unique to its setting as a training ground for therapists. Clearly, clinical psychology graduate students have many tasks to master as emerging clinicians. Their developing skills sets and relative inexperience may tend to preclude an emphasis upon attending to the problem of premature termination. Record review showed that nearly 47% of the charts reviewed did not include a letter of intent to discharge. The Family Clinic Guidelines do not contain any information that specifically addresses how to lower the rate of premature termination. Burgeoning therapists may require a more structured approach to thinking about how to keep their clients in therapy.

One change that the CAP has made is that therapists from the different clinics now conduct their own intakes. As it does for the CGC, this allows for consistency of service and facilitates the beginning of the therapeutic relationship. Garcia and Weisz (2002) demonstrated the importance of the *therapeutic relationship* through their research. When parents believe that they are not enjoying a therapeutic alliance of good quality, it is predictive of premature termination. New therapists should be apprised of this correlation and encouraged to confer from the very beginning of the course of therapy with the parents to define the presenting complaint and to develop the course of treatment with the parents' cooperation and understanding. Kerkorian et al. (2006) produced research that is supportive and complementary. Their research supported the findings that empowered and respected parents are more likely to maintain their child in therapy.

A poor quality therapeutic relationship was only one impediment to the successful completion of therapy. Families face many barriers to consistent attendance. Therapists should make it a point as early as the intake interview to inquire from families as to what would constitute a barrier to treatment (Kazdin, 1998). While the individual therapist or site may not be able to address such barriers as economic privation, they may be able to recommend or arrange alternative means of transportation or help the family successfully navigate insurance difficulties. Prinz and Miller (1994) provided strong evidence that when time is taken to attend to parental concerns and issues that they themselves are experiencing, their child was more likely to continue treatment. Furthermore, therapists are in an ideal position to recognize potential mental health issues in other members of the family and direct those members to appropriate care. MacNaughton and Rodrigue (2001) recommended this type of cooperative discussion about what parents expect to

arise as obstacles to treatment compliance become a standard component of the very early stage of treatment.

Another area of disagreement that often arises between client and therapist that needs to be addressed early on was the expectation of length of treatment (Nevas and Farber, 2001). Therapists routinely anticipate a longer course of treatment than clients do. Alerting families to an approximation of the number of sessions expected followed by a discussion of the rationale for such an estimate can forestall misunderstandings later.

Experienced, as well as novice, therapists may experience discouragement from high rates of premature termination (Pekarik, 1985). However, this may be particularly salient for students at the CAP for whom this experience may be new. Beginning therapists should be made aware of this phenomenon and alerted that they may not be the reason behind the noncompliance of their clients. They should be encouraged that research shows that clients report that they have gained benefits in as little as three sessions while some clients report relief at simply having spoken with someone about making an appointment (Howard et al., 1993; Silverman and Beech, 1979). Therapists should therefore consider each and every session as a potential change point.

It is also important for therapists to avoid "clinic-centrism" (Armbruster & Kadin, 1994, p. 96) through the realization the clients have lives outside of therapy that often may provide significant barriers to consistent attendance.

Both settings examined in this project are set in Indiana County, Pennsylvania. The effect of the rural setting should be acknowledged as often having a detrimental consequence upon attendance because of such things as transportation issues or the likelihood of stigma attached to mental health matters.

The obvious differences in setting characteristics between the CGC and the CAP may make it difficult for proactive approaches to premature termination to translate from one to the other. It is unrealistic to expect that a clinic that provides services one day a week as the CAP does could or should implement the same policies as a full service community mental health provider such as the CGC. However, the current research does point to techniques that can be adapted to each setting in an effort to reduce premature termination from therapy by children and their families.

The following steps would have relevance across both the CGC and the CAP and would contribute to the effectiveness of any protocol created in those settings to address premature termination.

1. In as much as logistics will allow, the number of different staff with whom clients must interact should be kept to a minimum (Tolan et al., 1988). If the therapist can conduct the intake and even make appointment reminder calls, a beneficial therapeutic relationship is formed from initial contact.
2. Reminding clients about upcoming appointments is beneficial by whatever means. Any contact is better than no contact (Kluger and Karas,1983).
3. Part of the first session, at least, should be devoted to insuring that all parties have an understanding of the fundamentals of what to expect from their unique therapy experience. A brief discussion of the type of therapy to be conducted and the rationale for choosing it and the expected timeframe for this process should be outlined. All parties should agree upon what the priority issues in treatment are (Nevas and Farber, 2001).

4. Time should be made very early in therapy for a discussion with parents and children about what obstacles they foresee that would prevent them from consistent attendance (Ogrodniczuk et al., 2005).
5. Novice therapists should be aware of the many barriers that families face in making and keeping the commitment to enable their child to maintain consistent attendance. Blame, judgmental beliefs, or characterological assumptions about why families find it difficult to attend sessions must be replaced with informed understanding (Armbruster and Kazdin, 1994).
6. Parents should be systematically included in sessions (MacNaughton and Rodrigue, 2001). This allows for ongoing collection of information as well as enhancing the therapeutic relationship. Addressing parental concerns that may initially appear unrelated to the presenting complaint has been shown to reduce premature termination. Furthermore, increased contact with other family members allows for increased opportunities to suggest that they may also find some form of mental health treatment beneficial. Inclusion of other family members can occur within the limitations of current interpretation of state laws. In Pennsylvania, this control is given to adolescents who are age 14 or over (Juvenile Law Center, 2005).

Limitations of the Study

This study primarily attempted to make sense of the literature about premature termination from therapy. Even though such research has been conducted for more than 40 years, much more research in this area is needed. Some of the literature is in direct contradiction. For example, some researchers consider premature termination to be

discontinuation before ten sessions (Venable & Thompson, 1998) while others consider premature termination to be discontinuation at any point before the mental health professional considers therapy completed (Kazdin et al., 1997). The bulk of the research has been conducted with adults (Pekarik & Stephenson, 1988). Much of the research that has been conducted with children very often mixes diagnoses and age groups thereby making generalizations difficult (Gould, 1985; McClure et al., 1996). Attempts were made to draw conclusions and make recommendations in this study only when agreement could be found among several researchers.

The population examined in this study was from a rural area. The clinics examined in this study were both sited in the same small town of Indiana, Pennsylvania. When a sample is defined by such parameters, it may preclude the generalization of results to other populations. Furthermore and in general, there may be differences in the socioeconomic status between clients at the CAP and clients at the CGC where many clients are on medical assistance.

The data used in this study provided unexpected information in that the number of cases from both sites that met the criteria for inclusion was much less than was intuitively expected. Clients left both sites for many reasons and took the time to inform their therapists of those reasons. Far fewer than expected simply stopped coming and made no attempt at further contact with the site. As a result, there was a small *n* in this study. Statistical power is related to sample size. Therefore, the ability to discern statistical significance may have been reduced in this study.

Suggestions for Future Research

Clearly the need for continued research in this area exists. Most of the research that has been conducted speaks to the effects of demographics upon attendance. For example, researchers have investigated socioeconomic factors, transportation availability, and race (Campbell, Gordon & Chandler, 2002; Cohen & Hesselbart, 1993). More research is needed that addresses 'higher order' factors that contribute to or are in defense of premature termination. Examples of this would be to continue to study the effect of the therapeutic relationship or how pre-therapy training contributes to treatment compliance. Even more importantly, is the necessity for examining the interactions of these many variables. No single variable is sufficient as a complete explanation.

Methodology issues abound in this field of research. A large area of improvement could occur if researchers were able to address the issue of the effect of the child's age and developmental stage upon premature termination. Most research reflects mixed age groups, both sexes and differing diagnoses (Gould, 1985; McClure et al., 1996). A simple beginning and a step in the right direction would be to simply have a consistent operational definition of what constitutes premature termination.

Within individual agencies, much can be done to promote research. Accumulating, collating and providing researchers with raw data would go far to facilitate the understanding of why people discontinue services.

References

Achenbach, T.M. & Edelbrock, C.S. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile.* Burlington: University of Vermont Department of Psychiatry.

American Psychological Association. (2002). *The critical need for psychologists in rural America.* Retrieved March 29, 2005 from http://www.apa.org/ppo/issues/ebsrural.html

Andra, M.L. & Thomas, A.M. (1998). The influence of parenting stress and socioeconomic disadvantage on therapy attendance among parents and their behavior disordered preschool children. *Education & Treatment of Children, 21, (2),* 195-209.

Armbruster, P., Fallon, T. (1994). Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry, 64,* 577-585.

Attkisson, C.C. & Greenfield, T.K. (1994). Client Satisfaction Questionnaire-8 and Service Satisfaction-30. In: M.A. Marish (Ed.). *Psychological testing: treatment planning and outcome assessment.* Hillsdale, NJ: Lawrence Earlbaum Associates, 1994.

Aubrey, R., Self, R., Halstead, J. (2003). Early non-attendance as a predictor of continued non-attendance and subsequent attrition from psychological help. *Clinical Psychology, 32,* 6-10.

Baekeland, F., & Lundwall, L. (1975). Dropping out of treatment: a critical review. *Psychological Bulletin, 82,* 738-783.

Benway, C.B., Hamrin, V., McMahon, T. (2003). Initial appointment nonattendance in child and family mental health clinics. *American Journal of Orthopsychiatry, 73,* 419-428.

Bickman, L. (1996). A continuum of care: more is not always better. *American Psychologist 51,* 689-701.

Bui, K. T. & Takeuchi, D. T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20,* (4), 403-417.

Burns, B. J., Costello, E, J., Angold, A. et al. (1995). Children's mental health service use across service sectors. *Health Affairs, 14,* 147-159

Campbell, C., Gordon, M., Chandler, A. (2002). Wide open spaces: meeting mental health needs in underserved rural areas. *Journal of Psychology and Christianity, 21,* (4), 325-332.

Center for Applied Psychology (2000). Retrieved August 15, 2006 from www.iup.edu

Ciarlo, J.A. (1979). Annual evaluation report for 1975 of the Northwest Denver Mental Health Center. In C. Windle (Ed.), *Reporting program evaluations: Two sample community mental health center annual reports.* Rockville, MD: U.S. Department of Health, Education and Welfare.

Cohen, P., Hesselbart, C. (1993). Demographic factors in the use of children's mental health services. *American Journal of Public Health, 83 (1),* 49-52.

Costello, E.J., Angold, A., Burns, B.J., et al. (1996). The Great Smokey Mountain study of youth: goals, design, methods, and the prevalence of DSM-III-R disorders. *The Archives of General Psychiatry, 53,* 1129-1136.

Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., & Angold, A. (2003). Prevalance and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry, 60,* 837-844.

Day, L., Reznikoff, M. (1980). Preparation of children and parents for treatment at a children's psychiatric clinic through videotaped modeling. *Journal of Consulting and Clinical Psychology, 8, (2),* 303-304.

DeLeon, P., Wakefield, M., Schultz, A., Williams, J., VandenBos, G. (1989). Rural America: unique opportunities for health care delivery and health services research. *American Psychologist, 44,* 1298-1306.

Derogatis, L. (1983). *SCL-90-R Manual II.* Towson, MD: Clinical Psychometric Research.

Epperson, D.L., Bushway, D.J. & Warman, R.E. (1983). Client self-terminations after one counseling session: Effects of problem recognition, counselor gender, and counselor experience. *Journal of Counseling Psychology, 30,*307-315.

Eyberg, S. (1992). Assessing therapy outcome with preschool children: Progress and problems. *Journal of Clinical Child Psychology, 21,* 306-311.

Fox, J., Merwin, E., Blank, M. (1995). Defacto mental health needs in the rural south. *Journal for the Poor and Underserved, 6,* 434-468.

Freund, R..D., Russell, T.T., & Schweitzer, S. (1991). Influence of length of delay between intake session and initial counseling session on client perceptions of counselors and counseling outcomes. *Journal of Counseling Psychology, 38, (1),* Retrieved March 29, 2005, from the PsycARTICLES database.

Garcia, J.A. & Weisz, J.R. (2002). When youth mental health care stops: therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70, (2),* 439-443.

Garfield, S.L. (1978). Research on client variables in psychotherapy. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed., pp. 191-232). New York: Wiley.

Gould, M.S., Shaffer, D., & Kaplan, D. (1985). The characteristics of dropouts from a child psychiatry clinic. *Journal of the American Academy of Child Psychiatry, 24,* 316-328.

Hoagwood, K., Burns, B., Kiser, L., Ringeisen, H., Schoenwald, S. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52,* 1179-1189.

Harris, P.M. (1998). Attrition revisited. *American Journal of Evaluation, 19, (30,)*

Hochstadt, N.J. & Trybula, J. (1980) *Reducing missed initial appointments in a community mental health center.* Journal of Community Psychology 8, 261-265.

Hunsley, J., Aubry, T.D., Verstervelt, C.M., Vito, D., (1999). Comparing therapist and client perspectives on reasons for psychotherapy termination. *Psychotherapy: Theory, Research, Practice, Training, 36, (4).*

Inhelder, B, & Piaget, J. (1958). *The growth of logical thinking from childhood to adolescence.* New York: Basic Books.

Kazdin, A., (1993). Premature termination from treatment among children referred for antisocial behavior. *Journal of Clinical Child Psychology, 31,* 415-425.

Kazdin, A., Holland, L., Crowley, M. (1997). Family experiences of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65,* 453-463.

Kazdin, A., Mazurick, J. (1994). Dropping out of child psychotherapy: distinguishing early and late dropouts over the course of treatment. *Journal of Consulting and Clinical Psychology, 62,* 1069-1074.

Kazdin, A., Mazurick, J., Bass, D. (1993). Risk for attrition in treatment of antisocial children and families. *Journal of Clinical Child Psychology, 22,* 2-16.

Kazdin, A., Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical and Child Psychology, 28,* 160-172.

Kazdin, A., Weisz, J. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology, 66,* 19-36.

Kluger, M.P. & Karras, A (1983). *Strategies for reducing missed initial appointments in a community mental health center.* Community Mental Health Journal, 19 (2), 137-143.

Koroloff, N., Elliott, D., Koren, P., Friesen, B. (1996). Connecting low-income families to mental health services: the role of the family associate. *Journal of Emotional and Behavioral Disorders, 4,* 2-11.

Koss, M.P. (1979). Length of psychotherapy for clients seen in private practice. *Journal of Consulting and Clinical Psychology, 47,* 210-212.

Kourany, R., Garber, J., Tornusciolo, G. (1990). Improving first appointment attendance rates in child psychiatry outpatient clinics. *Journal American Academy of Child and Adolescent Psychiatry, 29,* 657-660.

Kovacs, M., & Becks, A.T. (1977). An empirical-clinical approach toward a definition of childhood depression. In J.G. Schulterbrandt & A. Raskin (Eds.), *Depression in childhood: Diagnosis, treatment, and conceptual models* (pp. 1-25). New York: Raven Press.

Lazare, A., Eisenthal, s. & Wasserman, L. (1975). The customer approach to patienthood: Attending to patient requests at a walk-in clinic. *Archives of General Psychiatry, 32,* 553-558.

Lebow, J. (1982). Consumer satisfaction with mental health treatment. *Psychological Bulletin, 91, (2),* 244-259.

Linden, J.D., Stone, S.C. & Shertzer, B. (1965). Development and evaluation of an inventory for rating counseling. *Personnel and Guidance Journal, 44,* 267-276.

Logan, D. & King, C. (2001) Parental facilitation of adolescent mental health service utilization: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 8,* 319-333.

Lowry, J., Ross, M. (1997). Expectations of psychotherapy duration: how long should psychotherapy last? *Psychotherapy: Theory,Research, Practice, Training, 34,* PsychARTICLES downloaded 2/18/2005.

Luborsky, L., Mintz, A., Auerbach, P., Christoph, H., Bachrach, T. , Todd, Johnson, M., Cohen, C., O'Brien, C.P. (1980). Predicting the outcome of psychotherapy. Findings of the Penn psychotherapy project. *Archives of General Psychiatry, 34,* 471-481.

MacNaughton, K., & Rodigue, J. (2001). Predicting treatment adherence to recommendations by parents of clinic-referred children. *Journal of Consulting and Clinical Psychology, 0022-006X, April 1, 2001 (69). downloaded from PsyscARTICLES 3/29/2005.*

McClure, R., Newel, S.J. & Edwards, A. (1996). Patient characteristics affecting attendance at general outpatient clinics. *Archives of Diseases in Childhood, 74,* 121-125.

McKay, M., McCadam, K., Gonzales, J. (1996b). Addressing the barriers to mental health services for inner city children and their caretakers. *Community Mental Health 32,* 353-361.

Miller, W.R. & Rollnick, S. (1991). *Motivational Interviewing.* New York: Guilford.

Mohl, P., Silverman, W., Weems, C., Kurtines, W., Goldman Matinez, D., Ticknor, C., Huang, M., Cordell, L. (1991). Early dropouts from psychotherapy. *The Journal of Nervous and Mental Disease, (179),* 478-481.

National Institute of Mental Health. (1981). *Provisional data on federally funded community mental health centers, 1978-1979* (Report prepared by Survey and Reports Branch, Division of Biometry and Epidemiology, NIMH). Washington, DC: U.S. Government Printing Office.

Nevas, D.B. & Farber, B.A. (2001). Parents' attitudes toward their child's therapist and therapy. *Professional Psychology: Research and Practice, 32, (2).*

Nock, M., Phil, M., Kazdin, A. (2001). Parent expectancies for child therapy: assessment and relation to participation in treatment. *Journal of Child and Family Studies, 10,* (2), 155-180.

O'Brien, G., Lazebnik, R. (1998). Telephone call reminders and attendance in an adolescent clinic. *Pediatrics, 6,* E6.

Ogrodniczuk, J.S., Joyce, A.S., & Piper, W.E. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harvard Review of Psychiatry, March/April,* 57-70.

Orton, G. L. (1997). *Strategies for counseling with children and their parents.* USA: Brook/Cole Publishing Company.

Pekarik, G. (1985). Coping with dropouts. *Professional Psychology: Research and Practice,16, (1),*

Pekarik, G, Stephenson, L. (1988). Adult and child client differences in therapy dropout research. *Journal of Clinical Child Psychology, 17, (4), 316-321.*

Pina, A., Silverman, W., Weems, C., Kurtines, W., Goldman, M. (2003). A comparison of completers and noncompleters of exposure-based cognitive and behavioral treatment for phobic and anxiety disorders in youth. *Journal of Consulting and Clinical Psychology, 71, (4),* 701-705.

Ribner, N. (2000). *The first session with teenagers.* San Francisco: Jossey-Bass, Inc.

Santisteban, D., Szapocznik, J., Perez-Vidal, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology, 10,* 35-44.

Scheffler, R. M., & Miller, A. B. (1991). Differences in mental health service utilization among ethnic subpopulations. *International Journal of Law and Psychiatry, 14, (4),* 363-376.

Shapiro, T. (1995). Developmental issues in psychotherapy research. *Journal of Abnormal Child Psychology. 23, (1),* 31-44.

Sherman, R.T., & Anderson, C.T. (1987). Decreasing premature termination from psychotherapy. *Journal of Social and Clinical Psychology, 5 (3),* 298-312.

Shuman, A.L., Shapiro, J.P. (2002). The effects of preparing parents for child psychotherapy on accuracy of expectations and treatment attendance. *Community Mental Health Journal, 38, (1),* 3-16.

Snell-Johns, J., Mendez, J., Smith, B. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology, 18,* (1), 19-35.

Staudt, M. (2003). Helping children access and use services: a review. *Journal of Child & Family Studies, 12,* 49-53.

Tolan, P., Ryan, K., & Jaffe, C. (1988). Adolescent's mental health service use and provider, process, and recipient characteristics. *Journal of Clinical Child Psychology. 17, (3),* 229-236.

Tuso, P.J., Murtishaw, K., Tadros, W. (1999). The easy access program: a way to reduce patient no-show rate, decrease add-ons to primary care schedules, and improve patient satisfaction. *The Permanente Journal, 3.*

United States Public Health Service. (2000). *Report of the Surgeon General's conference on children's mental health: Developing a national action agenda. Washington, DC: Department of Health and Human Services, 2000.*

United States Census Bureau. (2002). *United States census 2000: Urban and rural classification.* Retrieved March 29, 2005. from http://www.census.gov/geo/www/ua/ua2k.html

Venable, M., Thompson, B. (1998). Caretaker psychological factors predicting premature termination of children's counseling. *Journal of Counseling & Development, 76,* 286-293.

Weisz, J., Weiss, B., Langmeyer, D. (1987). Giving up on child psychotherapy: who drops out? *Journal of Consulting and Clinical Psychology, 55,* (6), 916-918.

Weisz, J., Donenberg, G., Han, S., & Weiss, B. (1995). Bridging the gap between lab and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 688-701.

Wierzbicki, M., Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24,* (2), 90-195.

Ulmer, T. & Troxler, C. (2004). The economic cost of missed appointments and the open access system. *Community Health Scholars.* University of Florida: Gainesville, FL.

APPENDICES

Appendix A

Data Collection Questionnaire

General Client Information:

1. How many appointments did each client have?
2. How many "no shows" did each client have?
3. How many cancellations did each client have?

Standard Intake Procedures:

1. What are the standard questions asked of the prospective client at the initial contact?
2. What is the time span between the initial contact and the assignment of a therapist?

Standard Policies to Address Attendance Issues:

1. Does the site have specific and written policies in place to deal with "no shows"?
2. Does the site have specific and written policies in place to deal with premature termination?

Chart Review:

1. Based upon chart review, did therapists follow the site's protocol when a client prematurely terminated from therapy?
2. Did clients return to therapy after receipt of intent to discharge letter?

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June 29, 2006

IUP IRB

The Center for Applied Psychology (CAP) is pleased to be a participant in the dissertation project of Candace Dunn titled "An experimental study on the problem of premature termination." The CAP functions as a training clinic for students enrolled in the Psy.D. program for both clinical and research training.

Please accept this letter as approval for Candace Dunn to collect information regarding the CAP policies regarding client premature termination from our Child & Family Therapy Clinic.

Please direct any questions regarding this consent to:

Dr. Kimberely J. Husenits, Director
Center for Applied Psychology (CAP)
1020 Oakland Avenue
Uhler 238A
Indiana, PA. 15705

Phone: 724-357-7978
Email: Husenits@iup.edu

Appendix C

Community Guidance Center
793 Old Route 119 HWY North • Indiana, PA 15701 • (724) 465-5576 • 1-888-686-1991 • FAX (724) 463-3262

July 17, 2006

Beverly Goodwin, Ph.D
Professor of Psychology
IUP
Department Psychology
238A Uhler Hall
Indiana, PA 15705

Dr. Goodwin:

The purpose of this letter is to confirm that we have received and reviewed the Dissertation Proposal titled: "Reducing the Premature Termination of Children from Psychotherapy through Research Based Program Evaluation". The Utilization Review Committee of the Community Guidance Center believes that this project has significant merit and we approve utilizing consumers from the Community Guidance Center with the appropriate consents as outlined.

For the Committee,

Ralph May, Psy.D
Chief Clinical Officer

Appendix D

Table D-1

Sessions for CAP

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	1	2.9	2.9	2.9
1.00	9	25.7	25.7	28.6
2.00	5	14.3	14.3	42.9
3.00	6	17.1	17.1	60.0
4.00	1	2.9	2.9	62.9
5.00	4	11.4	11.4	74.3
6.00	1	2.9	2.9	77.1
7.00	2	5.7	5.7	82.9
8.00	1	2.9	2.9	85.7
9.00	1	2.9	2.9	88.6
10.00	1	2.9	2.9	91.4
11.00	1	2.9	2.9	94.3
14.00	1	2.9	2.9	97.1
25.00	1	2.9	2.9	100.00
TOTAL	35	100.00	100.00	

Table D-2

Cancellations for CAP

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	20	57.1	57.1	57.1
1.00	7	20.0	20.0	77.1
3.00	5	14.3	14.3	91.4
4.00	1	2.9	2.9	94.3
6.00	1	2.9	2.9	97.1
7.00	1	2.9	2.9	100.0
Total	35	100.0	100.0	

Table D-3

No Shows for CAP

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	26	74.3	74.3	74.3
1.00	2	5.7	5.7	80.0
2.00	4	11.4	11.4	91.4
4.00	3	8.6	8.6	100.0
Total	35	100.0	100.0	

Table D-4

Sessions for CGCCONTROL

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1.00	2	8.3	8.3	8.3
2.00	1	4.2	4.2	12.5
3.00	3	12.5	12.5	25.0
4.00	3	12.5	12.5	37.5
5.00	2	8.3	8.3	45.8
6.00	4	16.7	16.7	62.5
7.00	2	8.3	8.3	70.8
8.00	2	8.3	8.3	79.2
11.00	1	4.2	4.2	83.3
13.00	2	8.3	8.3	91.7
15.00	1	4.2	4.2	95.8
29.00	1	4.2	4.2	100.0
Total	24	100.0	100.0	

Table D-5

Cancellations for CGCCONTROL

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	4	16.7	16.7	16.7
1.00	5	20.8	20.8	37.5
2.00	7	29.2	29.2	66.7
3.00	2	8.3	8.3	75.0
4.00	1	4.2	4.2	79.2
5.00	3	12.5	12.5	91.7
7.00	1	4.2	4.2	95.8
12.00	1	4.2	4.2	100.0
Total	24	100.0	100.0	

Table D-6

No Shows for CGCCONTROL

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	5	20.8	20.8	20.8
1.00	6	25.0	25.0	45.8
2.00	3	12.5	12.5	58.3
3.00	5	20.8	20.8	79.2
4.00	3	12.5	12.5	91.7
6.00	1	4.2	4.2	95.8
7.00	1	4.2	4.2	100.0
Total	24	100.0	100.0	

Table D-7

Sessions for CGCTREATMENT

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
1.00	5	33.3	33.3	33.3
2.00	2	13.3	13.3	46.7
3.00	3	20.0	20.0	66.7
5.00	1	6.7	6.7	73.3
7.00	1	6.7	6.7	80.0
10.00	1	6.7	6.7	86.7
22.00	1	6.7	6.7	93.3
30.00	1	6.7	6.7	100.0
Total	15	100.0	100.0	

Table D-8

Cancellations for CGCTREATMENT

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	6	40.0	40.0	40.0
1.00	2	13.3	13.3	53.3
2.00	4	26.7	26.7	80.0
4.00	2	13.3	13.3	93.3
6.00	1	6.7	6.7	100.0
Total	15	100.0	100.0	

Table D-9

No Shows for CGCTREATMENT

Valid	Frequency	Percent	Valid Percent	Cumulative Percent
.00	8	53.3	53.3	53.3
2.00	1	6.7	6.7	60.0
3.00	3	20.0	20.0	80.0
4.00	2	13.3	13.3	93.3
6.00	1	6.7	6.7	100.0
Total	15	100.0	100.0	