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Keeping the Door Open or Keeping the Door Shut?
How and Why Adolescents Terminate from Mental Health Treatment

by

Diane Mirabito

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare. The City University of New York.

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Abstract

Keeping the Door Open or Keeping the Door Shut?
How and Why Adolescents Terminate from Mental Health Treatment
by
Diane Mirabito

Advisor: Professor Irwin Epstein

This study examines patterns of termination from mental health treatment among primarily low-income, minority adolescents at an outpatient, mental health center in New York City. The research design combines quantitative and qualitative methods, utilizing existing information from 100 closed client records and original data from interviews with 14 adolescents who terminated treatment. The analysis focuses on how and why adolescents with "acknowledged" and "unacknowledged" terminations discontinue treatment and the similarities and differences between these terminations. Quantitative findings report clinical and non-clinical correlates of acknowledged and unacknowledged terminations. Qualitative findings present an analysis of adolescents' experience of treatment, reasons for termination, and their retrospective assessment of treatment.

"Unacknowledged" terminations occurred almost twice as frequently (66%) as "acknowledged" terminations (34%). Among the "acknowledged" cases, termination was "addressed" by a clinical process (1-5 sessions), in only 19% of the cases. "Acknowledged" terminations occurred more frequently among Caucasian and Asian adolescents, self and school referred; diagnosed with depression, school, and conduct problems; who received more treatment sessions with multiple modalities over a longer

period of time. "Unacknowledged" terminations occurred more frequently among Hispanic, African-American, and Biracial adolescents, referred by parents; diagnosed with family problems; who acknowledged a problem at intake; and were motivated for treatment. Statistically significant relationships were found between acknowledged terminations and adolescents'/parents' desire to terminate; clinician/placement initiated terminations; participation in group and psychiatric services; and clinical disengagement at termination.

Contrary to conventional theory concerning treatment termination, adolescents who terminated without a "clinical process", reported considerably more engagement in and satisfaction with treatment than those who had clinically addressed terminations. In "unacknowledged/unaddressed cases, reasons for termination included positive progress toward developmental tasks, resolution of problems, and "natural" interruptions of treatment. In "acknowledged/addressed" cases, termination was frequently initiated by the clinician because adolescents were disengaged from and/or dissatisfied with treatment.

Recommendations for practice include: reconceptualization of termination from a developmental perspective utilizing an "open-door" approach to treatment; diverse and flexible treatment approaches and collaborative treatment planning to engage adolescents in treatment; and implementation of "exit interviews" to structure termination and provide therapeutic closure.

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CHAPTER I

INTRODUCTION

Background/Overview

In comparison to other phases of psychotherapeutic social work, the process of termination has traditionally been an unexamined area of practice. Historically, the psychoanalytically-oriented literature in social work (DeWald,1964; Levinson, 1977; Shapiro, 1980) and related disciplines (Ortmeyer, 1978; Ward, 1984) has focused on the theoretical meaning of termination and there have been few systematic attempts to study termination as it occurs in clinical practice (Kramer, 1986). Webb (1985) contends that the topic of termination has not been ignored in the literature, however, she points out that the complexity of the termination process eludes application in practice. A more consistent view found throughout the literature, however, is that termination is a phase of social work practice that needs further attention and conceptualization (Bolen, 1972; Fortune, Pearlingi, & Rochelle, 1992; Fox, Nelson, & Bolman, 1969; Levinson, 1977; Webb, 1985).

Termination has typically been conceptualized as a phase of treatment that involves a range of reactions and feelings on the part of the practitioner and the client. These reactions vary depending on the circumstances surrounding the termination, how it is initiated, and whether it is planned or unplanned. From a theoretical perspective, common reactions described in the literature include, sadness, grief, anger, and mourning (Fortune et al., 1992; Levinson, 1977; Quintana, 1993). In contrast to these common

descriptions of termination, research (Fortune, 1987; Fortune et al., 1992; Kramer, 1986; Quintana, 1993) has indicated that both clinicians and clients report more positive than negative experiences with the termination process.

While relatively little attention has been paid to the process of termination with adults, less is known about termination with adolescents. Several authors (Bolen, 1972; Ekstein, 1983; Mishne, 1986; Novick, 1990) have described the challenges and demands inherent in the termination process that are unique to the developmental phase of adolescence. Others (Baruch, Gerber, Fearon, 1998; Blotcky & Friedman, 1984; Holmes, 1983; Novick, Benson, & Rembar, 1981; Suzuki, 1989; Viale-Val, Rosenthal, Curtiss, & Marohn, 1984) have documented the problem of "premature" or "unplanned" termination with adolescents.

Significance of the Study

In light of the increasing use of time-limited and short-term treatment approaches dictated by the pressures of managed care mandates, the topic of termination is particularly relevant and timely. Moreover, the study of termination with adolescents is of special interest and significance since separation-individuation and dependence-independence, central themes in the termination process, are also the essential tasks of adolescent development (Meeks, 1971; Mishne, 1986). This dissertation focuses on the termination

process in psychotherapeutic social work with economically disadvantaged, inner-city, minority youth.

Current estimates indicate that 30% of the nation's youth under age eighteen are racial and ethnic minorities (Gibbs & Huang, 1991; Jessor, 1993; Spencer & Dornbush, 1990). As of 1988, it was estimated that one in five adolescents lived in families below the poverty level. When the proportion of poor adolescents in 1988 is examined by race and ethnicity, 11% were White, 41% were Hispanic, and 44% were Black (Dryfoos, 1990; Jessor, 1993).

In her conceptualization of a hierarchy of risk behaviors for adolescents, Dryfoos (1990) classifies over 25% of all adolescents as either at high or very high risk. Adolescents in these groups engage in multiple, co-occurring risk behaviors, including the use of drugs and alcohol, engagement in unprotected sex, school dropout, truancy, and school failure. Given the stressors associated with poverty, normative adolescent risk factors are exacerbated for inner-city youth, frequently resulting in significantly increased risk behaviors. Consequently, an even higher percentage of poor, minority, inner-city adolescents are in the high to very high risk categories (Dryfoos, 1990).

Despite the development of new research in the field of adolescent development (Petersen, 1988; Petersen & Hamburg, 1986; Takanishi, 1993; Zaslow & Takanishi, 1993), there has been a notable absence of attention to poor and minority youth (Feldman

& Elliot, 1990; Jessor, 1992; 1993; Takanishi, 1993). Accordingly, Bui & Takeuchi (1992) note that our knowledge of minority youth with emotional and behavioral problems is extremely limited. Since the population of minority youth is rapidly increasing, these gaps in theory and research raise considerable concern.

Purpose and Goals of the Study

Because there have been few theoretical and empirical examinations of how adolescents terminate from mental health services, our understanding of the termination process with adolescents is quite limited. Therefore, the overall purpose of the dissertation is to gain an understanding of how, when, and why urban, inner-city adolescents terminate from mental health services.

My interest in the topic of termination has developed out of a combination of extensive practice experience with adolescents; an ongoing interest in how adolescents utilize mental health services; prior research that I conducted with colleagues on the use of a short-term treatment model with adolescents; and a pilot study that I conducted on clinicians' views of the termination process with adolescents (Mirabito, 1993). The dissertation builds on knowledge gleaned from the pilot study by exploring the process of termination from mental health services with adolescents, in more depth, through the use of available clinical information, as well as from the perspective of adolescents who utilized mental health services.

The dissertation addresses the following research questions:

1) What are the patterns of termination from mental health services with adolescents?
2) Is termination from mental health services with adolescents "acknowledged" (acknowledged and/or discussed) or "unacknowledged" (unacknowledged and not discussed)?
3) What variables are associated with acknowledged and unacknowledged terminations?
4) What are the reasons for acknowledged and unacknowledged terminations?
5) What are the similarities and differences between acknowledged and unacknowledged terminations?
6) How do adolescents experience the termination process in acknowledged and unacknowledged terminations?

Overview of the Study

The research design will combine quantitative methods and a qualitative, grounded theory approach to explore the phenomenon of both acknowledged and unacknowledged terminations at an Adolescent Center located within a large urban medical center. Quantitative data, pertaining to: demographic and referral information; psychosocial assessment and risk factors; utilization and type of services; and the termination of services was obtained from client records. Qualitative data pertaining to the adolescents' perceptions and experiences of the termination process was obtained from in-depth interviews with adolescents. Both quantitative and qualitative findings and the relevance of these findings for the enhancement and development of practice, program development, and research will be described.

PILOT STUDY: CLINICIANS' VIEWS OF THE TERMINATION PROCESS

Overview

In April 1993, a pilot study (Mirabito, 1993) that explored clinicians' perceptions and views of the termination process with adolescents was conducted by the investigator as an assignment for a qualitative research class. Findings obtained from this pilot study provided a foundation upon which this dissertation is based and an impetus for further study of the termination process with adolescents. Findings as well as key concepts derived from this early study were further explored in the dissertation.

Description of Study Design

In an effort to learn more about termination with adolescents, as a pilot study, I interviewed social workers at an Adolescent Center about their perceptions of the termination process. At the Adolescent Center, social workers provided both short and longer-term (six months and longer) individual, family, and group treatment to adolescents, aged 12-21, who had a wide range of emotional, personal, family, and school problems. The majority of the adolescents were African-American and Hispanic, from primarily poor and "working poor" families.

A nine-question interview guide (Appendix A) was administered to a sample of nine social workers (8 MSW's and 1 BA) in order to collect qualitative data. The interviews focused on the clinicians' experiences with the process of termination from mental health

services with adolescents. Interview questions included: the clinicians' views of how and why termination with adolescents occurred; how clinicians decided when to terminate treatment; clinicians' and adolescents' reactions to and feelings about the termination process; reasons for and factors contributing to dropout from treatment; and the ways in which termination was utilized in daily practice within the mental health program at the clinic.

Overview of the Findings

Using a grounded theory approach (Patton, 1990; Strauss & Corbin, 1990), data analysis yielded themes and categories that described the termination process with adolescents, from the clinician's perspective. The pilot study suggested that while clinicians believed the termination process was important, for a variety of reasons, they spent little time and attention thinking about it or planning for it. The most striking finding in this study was that, in the vast majority of cases, staff indicated that termination was most often unplanned, unannounced, and unilateral. In other words, treatment ended when clients stopped coming. The experience of termination did differ somewhat depending on whether adolescents had been seen for a few sessions or for an extended period of time. However, in cases of both short and longer-term treatment (six months to several years), adolescents frequently discontinued mental health services without discussing their intention to do so with the clinician or going through a clinical process of termination or closure.

In contrast to the high frequency of unplanned terminations, planned terminations were reported infrequently by clinicians in this study. Generally, a termination process occurred only when a planned short-term treatment model was utilized or when situational factors for either the client, (such as aging out of the program, going away to college, or moving), or the therapist, (such as maternity leave, completion of training for social work interns or staff members terminating their employment at the clinic), forced or dictated termination. When a termination process did take place, staff reported that it was often very brief (one or two sessions) or in some cases, occurred over the telephone.

Although the "outcomes" with regard to termination were quite predictable, the process of "unplanned" or "unacknowledged" termination as experienced and described by the staff in this study appeared multifaceted, multi determined, and complex. This phenomenon resulted from a complicated interplay of factors related to the adolescents, the way clinicians conducted treatment, and organizational aspects of the program and the agency. These factors interacted in an interrelated way and were identified by the clinicians as the reasons for unacknowledged terminations, or dropout, from treatment. The factors that contributed to the occurrence of "unplanned "or "unacknowledged" terminations that related to the adolescents, the clinicians, and the agency/program, included the following:

Adolescents

1. Developmental/Emotional Factors
2. Situational/Environmental Factors
3. Adolescents' Preference for Problem-Focused, Time-Limited Treatment

Staff

1. Lack of Engagement of Adolescent Clients
2. Lack of Clinical Analysis and Management of Cases
3. Discrepancies between Staffs' and Adolescents' Goals for Treatment

Agency/Program

1. Lack of Limitations Regarding Program Entrance
2. Agency Environment
3. Lack of Program Structures for Treatment Planning and Case Review

In addition to the foregoing factors that contributed to the frequent occurrence of "unacknowledged" terminations, staff reported that they generally did not actively initiate the termination process. The reasons that they did not initiate the termination process included:

1. Reluctance to Expose Practice Limitations
2. Orientation and Preference for Longer-term Treatment
3. Countertransference/Personal Feelings about Client Disengagement

Lessons from the Pilot Study

Many of the ideas from the pilot study contributed to the development of this dissertation. Specifically, the findings derived from the pilot study suggested new variables that were utilized in the dissertation to provide more specific information about factors that impact on the termination process. These included variables such as, gender, age, ethnicity, type of problem, and type of therapeutic treatment. In addition, since the dissertation studied cases with varied lengths of treatment, it was possible to learn more definitive information about termination at different stages of treatment. Most importantly, while the pilot study explored only the clinicians' views of the termination process, the

dissertation will expand upon available knowledge about the termination process by providing the adolescents' views and perceptions of termination, a perspective that has thus far been unexplored in previous research. The addition of the adolescents' perspective and experience of the termination process will provide important information about how low-income, minority adolescents view their own mental health needs and available services.

CHAPTER II

LITERATURE REVIEW

Introduction

The literature review will be divided into two sections: "Termination: Theory and Research" and "Termination with Adolescents: Theory and Research." The first section will include a brief overview of theoretical approaches to termination, the factors that impact on the termination process, and a review of empirical studies of termination with adults. The second section will include a review of theoretical approaches to both planned and unplanned termination with adolescents as well as a review of empirical studies of unplanned termination with children and adolescents. Selected findings from the pilot study pertaining to the clinicians' perspectives on termination from treatment with adolescents will be provided as they relate to the theoretical and empirical literature. Throughout the review, concepts derived from the theoretical and empirical literature that are relevant to the dissertation study as well as limitations and gaps in the research will be identified and addressed.

I. TERMINATION: THEORY AND RESEARCH

Theoretical Approaches to Termination

Overview

Termination has typically been conceptualized in the literature as a time of separation and detachment in which a planned and conscious closure or ending of the therapeutic relationship occurs. During the termination phase of treatment the client and practitioner

may engage in a variety of activities, including: the review and recapitulation of the themes and motifs of treatment; the processing of feelings and reactions about the work done together and the therapeutic relationship; re-experiencing of previous endings or losses; evaluation of the work accomplished in treatment; bringing closure to the therapeutic relationship; and planning for the client's future (Levinson, 1977; Shapiro, 1980; Ward 1984). The extent to which these activities occur depends on a variety of factors including, the setting in which services are provided, the length and type of treatment, the theoretical orientation and skill of the clinician, and psychological attributes of the client. Although in practice there are many variations in how termination occurs, there is general agreement in the literature that the way in which the therapeutic relationship is brought to a close has a major influence on the degree to which gains made in treatment are maintained and further growth is made following treatment (DeWald, 1964; Levinson, 1977; Quintana, 1993; Shapiro, 1980; Ward, 1984). Moreover, poorly managed termination is believed to have deleterious effects on the client including, the potential to destroy positive client outcome (Quintana, 1993).

Termination as Loss

Throughout the literature, loss, mourning, and grief have been central and recurrent themes that have been used to describe the termination process for both clients and practitioners (DeWald, 1964; Fox et al., 1969; Levinson, 1977; Ortmeyer, 1978; Shapiro, 1980; Ward, 1984). This theme is so prevalent that several authors (Levinson, 1977; McRoy et al., 1986; Shapiro, 1980) believe that the inadequate attention termination has

received in the literature, in training programs, and in clinical practice, is explained by the tendency for practitioners to avoid their own and their clients' painful feelings associated with the termination process. In fact, Martin & Schurtman (quoted in Quintana, 1993) contend that research on the termination process has been severely restricted and limited because of the prevalence of this "termination anxiety".

In keeping with the "termination as loss" framework, Levinson (1977) outlines a variety of factors that can influence the reactions of clients to the termination process. These factors provide a good summary of some of the concepts that have shaped widely held views of the termination process. According to Levinson:

1. The greater the degree of involvement of the patient in the treatment and emotionally with the therapist, the more intense will be the nature of the reactions to termination. Conversely, the more the patient has avoided or minimized his emotional investment in the therapy and the therapist, the less aware of and intense will be his reactions to termination.

2. Reactions to termination will vary with the degree of success and satisfaction with the treatment.

3. The greater the degree of transference involvement and wished-for gratification or fulfillment of child-like wishes, the more intense will be the nature of the patient's reaction to termination.

4. Patients who have sustained earlier losses of significant persons in their lives will re-experience, as termination approaches, the arousal of affects and conflicts from those earlier periods.

5. Whether the patient has experienced key losses or not, his reactions to termination will be influenced by the level at which he has achieved mastery of the early separation-individuation crisis.

6. The patient's reaction to termination may be more intense and complicated when the termination is initiated by the therapist's departure from the setting, particularly if the termination is before the natural course of treatment has been completed.

7. Termination may occur at either difficult or propitious moments in the patient's life. Thus, the state of the patient's life and his life situation can influence, for better or worse, his reaction to termination.

8. Whether the termination is individually or institutionally determined, the nature of the patient's response will be affected by the knowledge, skills, experience, and willingness of the therapist to remain sensitively observant, empathic, and skillfully responsive to the patient and his security operations.

Termination as Crisis

Although termination is often conceptualized as a time of loss and mourning, other, more positive descriptions of the termination process are found in the literature. The functional school of social work devoted special attention to both the beginning and ending phases of treatment. The functionalists viewed endings as "crucial building blocks to personal growth," containing "the seeds of new beginnings" (Shapiro, 1980). Webb (1985) points out that while most of the social work literature has focused on the loss and threat components of termination, the challenging and growth-producing aspects of termination have been largely ignored. In her description of termination as a crisis, Webb (1985) indicates that as in any crisis, termination includes the simultaneous occurrence of grief and anxiety, coupled with challenge and the mobilization of energy.

Termination as Interruption

DeWald (1964) and others (Palumbo, 1982; Sanville, 1982) recommend that termination be conceptualized as an interruption rather than an ending. DeWald (1964) made important distinctions about the differences in the way termination should be handled in insight-oriented and supportive psychotherapy approaches. According to DeWald (1964), in insight-oriented psychotherapy, the termination process should include the interpretation of dynamic issues related to the transference and resistance, with the goal of the client completing a separation from the therapist. In contrast, in supportive psychotherapy, rather than terminating the therapeutic relationship, emphasis is placed on the therapist's continuing interest in and availability to the client. DeWald believes that some clients in supportive psychotherapy may never be in a position to formally terminate therapy since a continuing therapeutic relationship may be essential for ongoing support and maintenance. Thus, termination is seen as an interruption of the therapeutic relationship and therapeutic interventions are designed to allow for an ongoing and "unresolved" relationship with the therapist. This approach allows the client to make immediate and brief use of the relationship at future times of need. Hollis (1980), who described this type of "intermittent" or "episodic" treatment said:

> . . . Although it is true that much treatment having personality development as its aim, as well as some other types of social work, require extended contact over a long period, many other types need only short or intermittent contacts of varying intensity over a period of years (p. 4).

In a similar vein, for clients who benefit from supportive psychotherapy, Palumbo (1982) proposes a redefinition of the concept of termination as an interruption, with the

anticipation that the client may return in the future for continued work on ongoing problems. In his view, the focus of termination is not the grief and mourning associated with a loss, but rather, feelings of relief and pride in the goals that have been accomplished in treatment. Sanville (1982) advises that every "pulling away" by the client should not be interpreted as "resistance." In her view of termination, she discusses the importance of respecting the client's self-determination and "inner measures about timing" (p.124). Thus, rather than focusing on the anxiety and apprehension related to ending, she emphasizes the potential "hopefulness" about any interruption in the therapeutic process.

The concept of termination as interruption is potentially useful in understanding the way in which adolescents often leave mental health services. This concept will be further discussed in the section of the literature review pertaining to termination with adolescents.

EMPIRICAL STUDIES OF TERMINATION

Overview of the Research

Despite the significance attached to termination as an important phase in the treatment process (DeWald, 1964; Fox et al., 1969; Levinson, 1977; Ortmeyer, 1978; Ward, 1984; Webb, 1985), Quintana (1993) notes that research on termination has accumulated very slowly. In 1986, Kramer (1986) indicated that almost no information about termination was based on research findings. A notable exception was Mallucio's (1979) examination

of the termination process as part of his larger study (*Learning from Clients*) comparing clients' and social workers' perceptions of the process and outcome of treatment. Fortune (1987) has noted that most descriptions of termination are drawn from the literature which is primarily theoretical and anecdotal. Marx and Gelso (1987) indicated that neither quantitative nor basic descriptive data concerning client behavior during termination or client reactions to the termination process were available. Others (Fortune, 1987; Levinson, 1977; Mallucio, 1979) have cited that even less information is available about clinicians' reactions to termination and the client-worker relationship during the termination phase (Fortune, 1987; Mallucio, 1979).

In a review of the literature, nine empirical studies of termination were found (Cochran & Stamler, 1989; Fortune, 1985, 1987; Fortune et al., 1991; 1992; Kramer, 1986; Mallucio, 1979; Marx & Gelso, 1987; Quintana & Holahan, 1992). Of these, six studies (Fortune, 1985; 1987; Fortune et al., 1991; 1992; Kramer, 1986; Quintana & Holahan, 1992) utilized practitioner reports of termination, and two of these studies (Cochran & Stamler, 1989; Marx & Gelso, 1987) utilized client reports of termination. Mallucio's research (1979) was the only study located that utilized both client and practitioner reports of the termination process. All of the clients in these studies are adults with the exception of two studies (Cochran & Stamler, 1989; Marx & Gelso, 1987) which include university students, some of whom are 18-21 years old.

RESEARCH FINDINGS

How Termination is Handled by Practitioners

Several studies (Fortune, 1985; Fortune et al., 1991; Kramer, 1986) have shown that practitioners seldom plan for the termination process. These findings are consistent with the findings cited earlier from the pilot study conducted on termination with adolescents. Through in-depth interviews with twenty social workers (M.S.W.'s) in private practice, Kramer (1986) found that many practitioners do not have an explicitly formulated plan for ending treatment. The practitioners in this study indicated that there was often no discussion at the outset of the relationship or at any time in the course of treatment about who should initiate termination and how it should be handled. The social workers interviewed generally believed that clients should initiate termination and waited for clients to introduce the topic of termination before considering it themselves. Consequently, Kramer found that it was usually clients who first introduced the subject of termination. Kramer's findings indicate that this lack of planning for the termination process adversely affected clients and added to the complexity of ending treatment. In addition, he found that practitioners' countertransferential reactions, such as unconscious emotional or economic dependency on clients, at times interfered with, confused, and prolonged treatment. In conclusion, Kramer recommends that practitioners become more sensitive to cues that clients give indicating that they are considering termination.

Fortune (1985) notes that although planning for the end of social treatment is as critical to successful outcome as adequate diagnosis, it rarely receives the same attention. In a

survey of fifty-nine social workers (M.S.W.'s), Fortune reported that most practitioners use intuition, rather than systematic criteria, to determine the length and termination of treatment. Practitioners in this study reported that they often continued time-limited treatment past the originally planned time limit. In open-ended treatment, when criteria for termination were used, the most common criteria cited by practitioners were: attainment of goals; clients' improved behavior; and improved intrapsychic functioning. Criteria that were rarely used included: behavioral cues indicating a desire to terminate (such as, canceled or missed appointments); the assessment that further benefit was unlikely; or lack of progress. A limitation in the methodology of this study was that practitioners were interviewed about their general practices regarding termination rather than reporting on actual cases. Fortune believes that the considerable diversity reported by practitioners in planning for termination reflected the lack of more specific, empirical knowledge available about termination.

In a subsequent study of sixty-nine social workers, Fortune et al. (1991) again explored criteria for termination. In this study the methodology was improved by interviewing practitioners about the termination process in specific (recently terminated) cases. As in the previous study (Fortune, 1985), Fortune et al. found that the criteria practitioners frequently used to determine readiness for termination included: achievement of goals; clients' improved behavior; and improved intrapsychic functioning. In this study, however, an additional and important finding was that successful outcome of the case was the most important criterion for termination. Other important criteria included the

client's desire to terminate and changes in issues brought to treatment. Findings indicated that most terminations occurred as a result of a mutual agreement between the practitioner and the client, however, preparation for termination did not occur until just before treatment ended.

In a study of 85 practitioners from 31 counseling centers, Quintana & Holahan (1992) compared the termination process in cases of both successful and unsuccessful counseling. Like Fortune et al. (1991), Quintana and Holahan (1992) found that the practitioners' assessment of the outcome of treatment (as either successful or unsuccessful) was a critical variable that had significant impact on the way in which termination was handled. In successful cases, the end of counseling was more likely to occur as a result of a mutual decision reached together by the counselor and the client than to be determined by external (situational) factors. In addition, the termination process was described as a significant event which included the processing of clients' past losses and the review of clients' feelings about ending. In contrast, in the unsuccessful cases, counselors less frequently reviewed the course of counseling or clients' affective reactions to the termination process and they reported less activity bringing closure to the client-counselor relationship. The findings of this study parallel the theoretical notion offered by Levinson (1977) that reactions to termination vary with the degree of success and satisfaction associated with treatment.

Practitioner and Client Reactions to Termination

A question of considerable controversy in the research on termination has been whether or not clients experience termination as a significant loss. As discussed earlier, although termination is frequently described as a significant loss for the client in the social work literature (Levinson, 1977; Webb, 1985), newer theoretical conceptualizations have emphasized the challenging and growth producing aspects of termination and have noted positive reactions to termination, such as the mobilization of energy, pride, and accomplishment (Palumbo, 1982 ; Webb, 1985). Several empirical studies of termination (Fortune, 1987; Fortune et al., 1992; Marx & Gelso, 1987; Quintana & Holahan, 1992) challenge the "loss metaphor" that has been used to conceptualize clients' experience of termination for the past forty years (Quintana, 1993). These studies refute the concept of termination as a crisis that includes loss and mourning for both clients and practitioners and offer alternate conceptualizations of termination which emphasize the challenging and growth-producing aspects of termination. For example, based on the findings of the study conducted by Quintana & Holahan (1992), Quintana (1993) suggests that the difficulties with the termination process that are frequently described in the literature are related more to the lack of success of the services provided than to clients' intense reactions related to loss and mourning.

In two studies surveying social workers about the termination process, Fortune (1987; Fortune et al., 1992) found that both clients and practitioners experience more positive than negative reactions to the termination process. In these studies, social workers

reported that the most common reactions to the termination process their clients experienced were the evaluation of progress and success in treatment. In contrast to common depictions in the literature of anger, regression, anxiety, loss, denial, and the re-experiencing of previous losses, Fortune (1987; Fortune et al., 1992) found that these negative reactions were expressed infrequently. Instead, frequently expressed feelings included, pride, excitement, self-accomplishment, and independence.

Similarly, in descriptions of their own reactions to termination, practitioners most frequently reported pride in their clients' success and with their own skill. The least frequently reported reactions of practitioners were: doubt about their therapeutic skill; disappointment with their clients; relief; and the re-experiencing of their own previous losses. Fortune indicates that an unexpected finding was that few practitioner or client characteristics were related to termination reactions. It is interesting, however not surprising, that practitioners experienced more pride with successful cases and less doubt in cases with voluntary clients.

In a study of 72 counseling clients, Marx and Gelso (1987) gathered descriptive data on client-reported affective reactions and behaviors associated with termination. Like Fortune (1987; Fortune et al., 1992), Marx and Gelso (1987) found that in contrast to the "clinical lore" (Marx & Gelso, 1987) that emphasizes termination as a painful loss, clients frequently reported positive feelings about ending counseling. These findings were similar to those reported by Quintana & Holahan (1992), in their study comparing

termination in successful and unsuccessful cases. Findings from this study indicated that practitioners reported that their clients expressed more positive than negative reactions to the termination process.

Marx and Gelso reported that clients found it important for counselors to help them explore their feelings about ending treatment, and in their study, this process frequently occurred. The three themes that were most prominent in the termination process, and are consistent with the theoretical literature on termination, were, "looking back, looking ahead, and saying goodbye" (Marx and Gelso, 1987). Although this study is an important addition to knowledge about termination and a notable exception because it explores the clients' perspective, the researchers advise that the results should not be generalized to other populations and settings since reactions to termination are significantly impacted by a variety of variables, such as, type of treatment, setting, developmental stage, and the circumstances of ending.

Planned vs. Unplanned Terminations

Few studies have explored differences in planned and unplanned terminations (Cochran & Stamler, 1989; Mallucio, 1979). In the only study that compares practitioner and client experiences of termination, through in-depth interviews with clients and practitioners, Mallucio (1979) found substantial differences in planned and unplanned terminations. By comparing the perceptions of clients and practitioners to the termination process,

Mallucio also found notable differences in the ways in which the termination process was experienced by clients and staff.

In cases of planned terminations, Mallucio found that clients and practitioners frequently differed in their perception of how termination was initiated. While clients typically indicated that they initiated the decision to end treatment, practitioners frequently perceived the decision to be a mutual one. In most of the cases of planned terminations, clients and practitioners concurred in the decision to terminate, planned the termination in a gradual way, reviewed their work together, and actively discussed the ending of treatment. Generally, practitioners used the termination process to highlight clients' strengths, review changes in their functioning, and reinforce their gains and coping capacities.

In the cases of unplanned terminations, a common theme was that both clients and practitioners felt that they were not getting anywhere. Frequently, there was not a formal ending of treatment since clients dropped out of treatment before this occurred. Mallucio reports that clients were often dissatisfied with the help they received and frustrated by their lack of progress. Practitioners expressed similar views of dissatisfaction and were often frustrated with their clients' failure to continue in treatment. In all of the cases of unplanned terminations, Mallucio found that there was a lack of openness, clarity, and agreement between the client and practitioner regarding the expectations and goals of treatment as evidenced by the lack of a clear and congruent treatment contract.

In a study of university students focusing on the clients' perspective of termination, Cochran and Stamler (1989) compared clients who completed at least one counseling session and initiated their own termination with clients who mutually agreed to terminate with their counselors. Through follow-up questionnaires to 119 clients, they explored satisfaction among the two groups as well as client-reported reasons for termination. Cochran & Stamler found that the clients who terminated their counseling without discussing their decision to end with their counselor (25%) perceived their counseling experience less positively and reported different reasons for terminating than those who experienced a termination that was planned and mutually agreed upon with their counselors (75%).

The two major differences between the two groups in reasons given for termination were, "having met the goals for counseling," and "thinking that the counselor did not have the skills to be of help." Proportionally more "mutual terminators" indicated that they had terminated because they had met their goals for counseling, and proportionally more "nonmutual terminators" terminated because they did not think their counselors had the skills to help them.

II. TERMINATION WITH ADOLESCENTS: THEORY AND RESEARCH

Theoretical Approaches to Termination with Adolescents

Developmental Issues

Adolescents have typically been viewed as a difficult population to engage in mental health services. Their ambivalence toward treatment, related to the developmental tasks of identity formation and strivings for independence, autonomy, and separation from adults, has always challenged professionals. Adolescents often "act out" conflicts and feel compelled to resist help. In addition, the present, concrete, and action orientation of adolescents has often impeded the process of insight development and the goals of character change that are characteristic of traditional, long-term, open-ended approaches to treatment.

The literature on termination with adolescents outlines the ways in which the developmental tasks that are unique to the period of adolescence impact on the termination process. These developmental factors have significant implications for the ways in which adolescents both engage in and terminate from psychotherapy. The issues of separation, individuation, dependence, and independence that are inherent in the termination process parallel some of the central developmental challenges of adolescence. As DeWald (1964) points out, the dynamic conflict in the termination phase is in some ways analogous to the normal developmental stage of adolescence. Just as the adolescent struggles for emancipation, separation, independence, and autonomy, these are the same themes that generally occur in the termination phase with all clients. Likewise, both the

adolescent and the terminating client experience the "regressive tug of dependency, attachment to old objects, uncertainty about his ability, and anxiety about the experiences ahead of him" (p.274).

As a result of their developmental struggle for autonomy and independence, adolescents frequently come to treatment at someone else's request (parent, teacher, doctor) and often do not view their symptoms as problematic. Consequently, they generally do not enter treatment with the overt acceptance that it is something that they want or need (Miller, 1990). For example, in a study exploring adolescents' responses to psychotherapy, Taylor, Adelman, & Kaser-Boyd (1985) found that the majority of the adolescents studied manifested some form of reluctance or dissatisfaction with their experience in psychotherapy.

Both Blos and Mahler (cited in Ekstein, 1983; Meeks, 1971; Weiss, 1991; Widseth & Webb, 1992) regard adolescence as the "second" phase of separation-individuation in the cycle of development. From their perspective, adolescents, like toddlers, experience the same process of alternating between "rapproachment," or "togetherness," and separation from their parent(s). In beginning treatment, the adolescent experiences the conflict of separation and attachment with the therapist in the same way that it is experienced with the parent. Ekstein (1983) describes the dilemma of the adolescent in treatment in this way:

> The adolescent must develop a new attachment to the therapist at the same time he is supposed to cope with the task of separation, of creating some form of independence, of developing adult autonomy and the capacity for self-maintenance (p.127).

Since the treatment process in general, as well as the process of termination from treatment, is significantly different with adolescents than with adults, Mishne (1986) advises that the principles of termination with adults should not be superimposed on the adolescent. Moreover, since separation is a primary task of normal adolescent development, several authors indicate that proper management and handling of the termination phase is critical (Meeks, 1971; Mishne, 1986; Novick, 1976; Novick & Novick, 1991). Ekstein describes the difference of work with adolescents and adults as:

> The adolescent comes to us not only with illness, emotional distress, and symptoms but also with a developmental problem. The patient and therapist must cope with the growing up process as well as the illness (p. 162).

From a psychodynamic perspective, Miller (1990) points out that while termination with adults includes separation, mourning, and giving up a love object, termination with adolescents does not necessarily include all of these aspects. Instead, the adolescent may continue to retain the internal image of the therapist. Consequently, when the adolescent leaves psychotherapy, he/she may not mourn and may not be giving up a love object. Miller (1990) also makes helpful distinctions about the termination process in the early, middle, and late stages of adolescence. For early adolescents (age 12-15), who are struggling with the turbulence of puberty and are making initial steps toward autonomy, termination is related not only to the cessation of symptomatic behavior but also to the

level of homeostatic interaction between the adolescent and his/her family. For middle adolescents (age 16-18), since the awareness that successful psychotherapy could imply the loss of a dependent child, parents may be more conflicted about the need for therapy than with early adolescents. With late adolescents (age 19-21), termination is much more related to the capacity of the adolescent to handle the "real world" since the nature of parental support has typically changed at this stage.

How Adolescents Terminate from Treatment

As a result of the developmental issues just described, the greater tendency for adolescents to "interrupt" rather than end or terminate treatment is a common theme found in the literature on termination with adolescents (Ekstein, 1983; Meeks, 1971; Mishne, 1986; Novick, 1976). In this regard, Ekstein (1983) says that "it is seldom that psychotherapists describe their treatment of adolescent cases in terms of the kind of end which gives the feeling of completion, of having reached the goal of treatment--the cure, the end point of the process (p. 125)." In his description of the process of "interruption," Ekstein says:

> Interruptions are a kind of termination, not really agreed on by both the therapist and adolescent because they have reached a goal, but a termination by withdrawal on the part of the adolescent who often breaks up the treatment, does not want to come any longer, and fights against the therapist in the same way he rebels at home and school (p.130).

Several authors describe adolescents engaging in a fluid process in which there is a pattern of interrupting and reentering treatment. Meeks (1971) notes that it is usually

necessary for the adolescent to actually experiment with physically leaving therapy, returning briefly, and going away again. Meeks believes that as a result of the expected continuation of developmental struggles, it is important for adolescents to know of the therapist's availability to help clarify or resolve new problems in their development. As Meeks says, adolescents need to "visit home briefly," therefore he believes that an "open door" policy for the treatment of adolescents is necessary.

Similarly, Widseth & Webb (1992) believe that as a result of the ongoing process of separation-individuation described earlier, adolescents frequently experience an "in and out" pattern in their use of psychotherapy. Widseth & Webb (1992) say that while, "adolescents are fascinated with exploration of the internal world, they also have a fluctuating capacity to stay with the exploration" (p.63). In describing the ways in which college students use psychotherapy, Widseth & Webb (1992) use the image of the "refueling toddler" who returns periodically to the parent for brief holding or touching. Moreover, they believe that this "in and out" pattern, described as "exploration/rest," is characteristic of normal adolescent development. Several other authors (Miller, 1990; Mishne, 1986; Novick, 1976) concur in this view and recommend a treatment approach for adolescents that utilizes "episodic" cycles of treatment.

Similar to the concept of "interruption," Novick (1976; 1990) indicates that most adolescents terminate treatment prematurely, either by provoking the therapist to force an ending or by surprising the therapist with a "unilateral termination plan." In order to

handle the conflict that adolescents experience in beginning psychotherapy, Novick (1976; 1990) believes that many adolescents develop a "unilateral termination plan" at the very beginning of treatment or soon after treatment has started and announce their departure from therapy rather suddenly. According to Novick, this plan, which is generally kept secret from the therapist, is an "escape hatch" used to control and limit the treatment, especially the quality and intensity of the transference.

Practice Principles: How and When to Terminate

Due to the evolving nature of development for children and adolescents, Beiser (1993) indicates that it is difficult to clearly identify when psychotherapy should end. Weiss (1991) suggests that since the child or adolescent's development is incomplete, psychotherapy should stop, rather than end, with the therapist remaining involved with the child and parent as an educator and parent surrogate throughout the child's development.

Meeks (1971) points out the importance of having reasonable guidelines or "checkpoints" for termination that relate to normal developmental behavior. Novick (1976), however, indicates that the primary criterion for termination, "restoration to the path of progressive development," is easier to define in childhood and adulthood than in adolescence which is normally characterized by flux and uncertainty. Meeks (1971) says that, ideally, handling termination with adolescents, "will depend on the therapist's ability to mobilize his or her

concern for the patient, to get inside the youngster's head, and to think and feel developmentally with the adolescent at his or her own level" (p.185).

As discussed, termination frequently occurs when the adolescent develops a wish for autonomy and insists that therapy is no longer needed. Several authors (Meeks, 1971; Miller, 1990; Novick, 1976; 1990; Weiss, 1991) emphasize the importance of the adolescent choosing when to terminate treatment. Miller (1990) believes that, "as soon as the adolescent is no longer functioning in destructive ways and no longer needs to have tension held by the therapist, the adolescent can decide when to leave treatment" (p. 87).

Novick (1976) also believes that it is important for adolescents to choose when to leave treatment. In addition, he emphasizes the importance of the adolescent experiencing the leaving process as one in which he/she actively leaves rather than being left. Therefore, Novick recommends that the adolescent both initiate the topic of termination and set a date for the end of treatment. He further recommends that termination should not take place during holidays or times when the therapist is not present because he believes it is important for the adolescent to retain the image of the continued existence and working of the therapist.

Similarly, Meeks (1971) advocates that the adolescent choose when to terminate since he/she may experience a therapist's suggestion to terminate as a personal rejection. He notes that the adolescent may respond to the suggestion to terminate either by "bolting"

prematurely from therapy without working through the leave-taking process or by increasing symptoms in an effort to maintain the therapeutic relationship. He believes that not only do adolescents need to "reject" adults but that they also find it very difficult to tolerate adults rejecting them. According to Meeks (1971), at the termination of therapy, "the adolescent should reject the therapeutic situation but not the therapist" (p.185). Likewise, the therapist, should not reject the adolescent by telling him/her that treatment is no longer needed. At the same time, however, Meeks points out that it is important for the therapist to introduce the idea of termination as soon as the adolescent is emotionally ready because the adolescent will not suggest termination in a direct manner.

Although the therapist or parents may not agree with the adolescent's assessment about the readiness to terminate, there is general agreement (Besier, 1993; Blotcky and Freidman, 1984; Miller, 1990) that it is typically better not to try to keep the adolescent in treatment, unless there is some real danger in stopping. Blotcky and Friedman (1984) recommend having at least one final session with the adolescent and/or the parent(s) so that the therapist can directly communicate the belief that there is much unfinished business, without attacking the adolescent's character, imposing a sense of guilt, or destroying a positive relationship. They emphasize that keeping the termination a positive experience is important so that the adolescent will be more likely to seek further therapy, if needed, in the future. Mishne (1986), however, points out that the adolescent's impulsive decision to conclude therapy may be due to a transference response in the treatment relationship. With seriously disturbed adolescents who wish to

terminate. Mishne (1986) notes the importance of informing parents of the need for further treatment.

Countertransference

Countertransference reactions on the part of the clinician are frequently cited in the literature as having a significant impact on the termination process in general, and especially with adolescents. Weiss (1991) defines countertransference reactions as those reactions the clinician has that interfere with the "orderly" termination of treatment. Regarding termination, Webb (1985) says that, . . . "The social work dictum 'start where the client is' often does not operate effectively regarding the timing of termination, since the worker's own feelings may cloud his or her judgement" (p.331). Meeks (1971) notes that as a result of the intensity of emotion and the rawness of expression that are characteristic of adolescents, there is an increased likelihood of strong personal responses from the clinician. Moreover, countertransference reactions to adolescents are often intense and seem more likely to lead to acting out than do countertransference reactions toward adult clients (Meeks, 1971; Miller, 1990).

The tendencies for clinicians to both "hold on to" some adolescents, and "get rid of" others, are common in the treatment of adolescents, and can interfere with the termination process. Several authors discuss the common tendency for clinicians to keep the adolescent in treatment longer than may be necessary. Novick (1990) says that the overprotective impulse to help the adolescent deal with unfinished developmental issues

can delay starting a termination process. Mishne (1986) indicates that the adolescent's ego strengths are frequently underestimated by protective clinicians who want to continue to support and guide the adolescent through the painful maturation process.

Meeks (1971) notes that successful psychotherapy contracts with adolescents tend to be unnecessarily prolonged because of the clinician's "anxious desire to ward off or delay necessary developmental struggles" (p.177). Meeks points out that for practical reasons, clinicians often have some reluctance to terminate successful cases that provide both comfort and pleasure for the clinician. As Meeks says, "small wonder that the therapist is tempted to hold onto his comfortable and cooperative youngster past the time when the adolescent really needs him" (p. 183). Meeks indicates, however, that the frequency of the clinician's countertransferential desires to " hang on" may be part of the reason that "many adolescents seem slightly guilty and apologetic about the appropriate wish to terminate and handle their own affairs" (p. 183), by leaving treatment without a discussion with the clinician. Finally, Beiser (1993) indicates that the clinician may have a negative attitude toward the parent(s) and attempt to keep the adolescent in therapy as a way of rescuing him/her from a "bad" parent.

In a similar vein, Ekstein (1983) points out that attachment and separation are problems not only for the adolescent but for the therapist as well. He says:

> Termination is not only the patient's problem, but ours as well. This is doubly true in the treatment of adolescents. We cope with our own problems of letting go--the uncertainness of the outcome and the uncertainty of the adolescent's future, makes it hard for us to let go. With adolescents, we clear

> the way for further development, but we cannot predict where it is going to lead (p.130).

In addition, Ekstein says that the therapist often faces the danger of behaving like a parent and holding onto the adolescent who he/she thinks is not ready to separate since the therapeutic work is not yet finished. Ekstein recommends that in working with adolescents, clinicians must learn to withstand the uncertainty that accompanies their uncompleted development. He says:

> Can we be psychotherapists who are willing to let the adolescent go but in such a way that our concern for him, our interest in him, is now internalized in him so that he can return after a good experience? (p. 129).

In addition to the clinician's reactions of "over attachment" that can delay termination, other negative reactions on the part of the clinician can interfere with the termination process or cause a premature termination. Reactions such as, the clinician's hostile feelings or the fear of erotic urges toward the adolescent (Meeks, 1971), dislike of the adolescent (Mishne, 1986), or an adolescent's angry rejection of treatment (Miller, 1990), can cause the clinician to inadvertently encourage a premature termination.

Unplanned Termination

The ubiquitous phenomenon of unplanned termination, or "dropout," from outpatient mental health treatment has been well documented in the literature (Littlepage, Kosloski, Schnelle, McNees, & Gendrich, 1976; Sweet & Noones, 1989). Various terms have been used to describe unplanned termination, including, "nonagreed" (Novick et al., 1981),

"premature" (Blotcky & Friedman, 1984), and "early" (Ibid). A variety of studies examining trends pertaining to "dropout" from treatment have led to an increased recognition that practitioners and clients differ substantially in their views of the desired duration of treatment (Littlepage et al., 1976). Numerous studies reporting on the average length of treatment in both public and private settings with adults (Garfield, 1978; Koss, 1979; Viale-Val et al., 1984) and children (Dulcan,1984) have shown that the average length of treatment (as indicated by the number of kept appointments) is between four and twelve sessions. These studies have challenged the assumption that early "dropout" from treatment represents failure, by establishing that, in fact, a majority of clients may expect and prefer a shorter duration of treatment. Sweet & Noones (1989) suggest that dropout from treatment does not imply treatment failure. Moreover, they indicate that clients who drop out of therapy do not evaluate their success any differently than those who experience a termination process.

A review of the literature indicates that unplanned termination with adolescents is multifaceted, multi determined, and complex. As Blotcky & Friedman (1984) say:

> Early termination is a multi determined phenomenon that involves a number of factors working independently or conjointly to produce the decision to stop treatment (p. 305).

In the literature, the primary reasons for unplanned or "premature" termination focus on factors related to: adolescent development; parents; situational factors; and the clinician's management of treatment, including, discrepant expectations and goals for treatment between the adolescent (and/or family) and the clinician.

Similarly, findings from the pilot study (Mirabito, 1993) on termination from treatment with adolescents indicated that unplanned termination resulted from a complicated interplay of factors related to the adolescents, the staff, and the agency/program. Factors contributing to unplanned terminations both from the literature and the pilot study (selected findings) will be examined in order to understand some of the reasons that unplanned terminations occur.

Developmental Issues

Unplanned termination is believed to result from developmental factors that are particular to adolescents. Beiser (1993) indicates that adolescents may experience discomfort with issues brought up in psychotherapy, fear the intimacy of the therapeutic relationship, or engage in power struggles with the therapist. Moreover, she points out that since adolescents detach from important adults as part of normal development, they may not be able to experience an intimate relationship with the therapist without viewing it as a threat or regression. Blotcky & Friedman (1984) believe that adolescents often externalize and project internal distress and cope with psychic pain through acting out behaviors, such as anger, irritability, provocative behavior, and running away. Thus, becoming aware of powerful feelings in treatment can be especially difficult and termination can be seen as an action-oriented attempt to deny internal pain.

In the Adolescent Center pilot study (Mirabito, 1993), staff indicated that as a result of the need to balance closeness and dependence with separation and independence, many

adolescents are threatened, frightened, and ambivalent about developing a close therapeutic relationship. Developing a close relationship with the clinician and then leaving the relationship can be both emotionally taxing and difficult for adolescents. The normal tensions adolescents experience between dependence and independence can become activated by the therapeutic relationship and can lead to difficulties becoming engaged in treatment and result in a tendency to leave treatment abruptly. The following statements by different staff members illustrate these themes:

> Developmentally they're moving toward independence and autonomy and this therapeutic relationship is a dependent relationship. Developmentally they do what they have to do--and they do it abruptly. They tend to outgrow the relationship--they move on and they don't look back.
>
> Developmentally they have not matured sufficiently to be held accountable for putting closure on the therapeutic relationship and to take responsibility for treatment. It's very normal for them to walk away from treatment because they are not sufficiently committed because of their age and level of development.

In addition to the ambivalence and fear inherent in a close relationship, dealing with difficult issues in treatment can be painful. Staff indicated that for some adolescents, the fear of rejection because of previous losses can make it difficult to become engaged in treatment. Moreover, as indicated by the staff in these comments, many adolescents feel overwhelmed by the feelings elicited in treatment and leave precipitously:

> It's very painful and overwhelming to talk about these issues. If the issues become too painful or too difficult, they split. This is consistent with adolescent development.
>
> For some adolescents, they think I'll leave you before you leave me. If they sense some kind of pulling back from you, these kids are so fragile. If you're not available kids take it as a rejection that we have to move him on. It's too

painful to get close to someone because it repeats what they have experienced in the past.

Parents' Attitudes Toward Termination

Beiser (1993) points out that parents may withdraw a child or adolescent from treatment if they feel threatened by or resentful of the adolescent's attachment to the therapist or disagree with the goals and priorities for treatment. She further believes that those adolescents who seek help without parents, and those who are seen with the permission of the parent but without parental involvement in the evaluation or treatment process, often terminate their treatment prematurely. Beiser (1993) believes that by including the parents early in the treatment, there is a greater likelihood that a "proper" termination process can occur. Miller (1990) notes that unplanned termination can occur when parents precipitously withdraw an adolescent from treatment because they cannot tolerate the growth that an adolescent may have made in treatment. Similarly, Blotcky & Friedman (1984) maintain that frequently parents, or influences within the family system as a whole, undermine the adolescent's treatment.

Situational Factors

Blotcky & Friedman (1984) cite a variety of situational factors for the client or therapist that may result in an unplanned or premature termination. These can include, changes in the family's income or financial constraints for the family, changes in the adolescent's schedule or life situation, or a change in the therapist's work. In the pilot study (Mirabito, 1993), staff reported that adolescents often left treatment as a result of multiple

environmental problems and pressures in their lives. Moreover, in many of these cases, parents were not involved in treatment sufficiently to support the adolescent's continued involvement. Without family support and commitment to treatment, the level of distress in their lives led to unplanned and precipitous terminations. Staff members described these experiences with unplanned terminations:

> Very often there isn't a real decision to end treatment but life circumstances like moving, getting a job, having a change in their schedule seem to dictate the treatment course. Their lives are such that therapy as a priority is not very high. That they can manage day to day is a big deal.

> When the therapeutic relationship ends its not so much about treatment not moving or something not happening therapeutically, but rather something happening outside of here. When chaos hits, they will leave. They can't afford the luxury of this one stable relationship

Clinicians' Management of Treatment

Blotcky & Friedman (1984) point out that difficulties in the relationship between the clinician and the adolescent that are not recognized and managed can lead to early termination from treatment. As mentioned earlier, Miller (1990) believes that premature termination can occur because the therapist's countertransference may be such that, in inappropriate ways, the adolescent is encouraged to leave. Blotcky & Friedman (1984) say that premature termination can be the result of strict adherence to a particular treatment approach and the exclusion of other intervention modalities (such as family or group therapy) which may result in conflicts and issues being left unaddressed and unresolved. Beiser (1993) indicates that the use of techniques that are too uncomfortable for the adolescent or family to tolerate, such as, exploration of early stages of development, can contribute to early or unplanned terminations.

Discrepancies between Clinicians' and Adolescents' Views and Goals of Treatment

A commonly cited reason for unplanned termination are discrepancies in the expectations and goals of treatment between the client and practitioner (Blotcky & Friedman, 1984; Kagle, 1987; Mallucio, 1979; Strean, 1986). Beiser (1993) notes that as a result of "over ambition," or "characterologic perfectionism," the clinician often identifies more issues that they believe should be resolved before terminating than the adolescent does. In this regard, Blotcky & Friedman (1984) indicate that, "Careful consideration of the adolescent's expectations are needed so that problematic mismatches between the patient and therapist can be avoided."

In the pilot study (Mirabito, 1993), staff agreed that adolescents often view treatment in a concrete, problem-focused, and crisis-oriented way. Consequently, they believed that adolescents are frequently interested in problem-solving, symptom relief, and immediate attention. According to the staff, when their problem or crisis is solved, adolescents usually move on. This theme is reflected in the following statements made by staff:

> Their approach to treatment is problem-focused. As soon as they develop ego strengths and are doing better, there is less of a problem focus. They have other things in their lives and they move on--on their own.
>
> They come in a crisis and when the crisis is abated, they leave. The whole idea of coming in when they are not feeling the pain is foreign to them.
>
> They don't understand the process of treatment and maybe that is why they don't come back. They didn't want to come and talk about their feelings.

In contrast to their perception that adolescents are seeking problem-focused, crisis-oriented services, staff described a clear preference for and belief in insight-oriented, longer-term treatment. Staff agreed that there was often a lack of consistency and mutuality between their goals and their clients and they believed that this was a common reason for premature terminations. The following descriptions illustrate the ongoing tension between these conflicting goals:

> A lot of kids see what we're doing here very differently than we do. There's a gap between what therapists and adolescents want out of treatment. There isn't sufficient clarity about why they are here. We don't make things specific enough. We always see more, but you have to balance that with where adolescents are developmentally.
>
> I create goals that are beyond their reach. We deliver treatment through an adult lens. Experience is showing me that if they need more they will be back.
>
> We have expectations of these patients that are not realistic. We're coming from different places--we could very easily have different agendas and different wishes for the outcome.

EMPIRICAL STUDIES OF UNPLANNED TERMINATION

Overview of Studies with Children and Adolescents

A variety of studies have examined the phenomenon of unplanned termination from outpatient treatment with adults (Littlepage et al., 1976). In comparison with the large volume of studies with adults, only 1-2% of attrition studies focus on children and adolescents (Armbruster & Kazdin, 1994). Although studies with children and adolescents are scarce, some authors (Blotcky & Friedman, 1984; Novick,1990; Novick et al., 1981) believe that unplanned termination is as common with adolescents as with

adults. In a review of literature on premature termination with children and adolescents, Novick et al. (1981) indicate that attrition rates from outpatient mental health treatment range from 28 to 71%. In summarizing the findings from these studies, they indicate that:

> The incidence of nonagreed termination is extremely high; the problem is persistent over time, and high dropout rates are characteristic of all types of psychiatric and mental health services, including private practice among highly skilled practitioners (p. 835).

Both Sirles (1990) and Armbruster & Kazdin (1994) note that studies of treatment with children and adolescents are quite different from those of adults in ways that directly affect attrition and the factors with which treatment continuation and termination are associated. They indicate that since children and adolescents generally do not seek treatment for themselves nor report problems that they wish to have resolved, motivation for coming to and remaining in treatment often depends largely on others, including, parents, teachers, and referral agents. Consequently, attrition is more complex to study because of the need to consider variables related to both children and parents. This issue applies more to children since adolescents can more easily continue treatment without parental involvement.

Limitations of the Studies

Armbruster & Kazdin (1994) indicate that the findings from attrition studies with children and adolescents have been contradictory and inconclusive. Two significant problems with these studies have been cited. First, the extreme variability in the operational definition of dropout (continuers and completers) across studies has resulted

in "definitional chaos" (Armbruster & Kazdin, 1994) and has made generalizations problematic (Armbruster & Kazdin, 1994; Sirles, 1990). Second, the variables studied, such as demographic variables and diagnosis, have been measured differently in each study and data sources and collection techniques have varied across studies. Consequently, the lack of standardized measures and instruments has inhibited communication among investigators and has limited a more conclusive profile of clients and families who dropout from treatment (Armbruster & Kazdin, 1994).

In addition to the problems in the methodologies of these studies, other limitations of the research on dropout from treatment have been noted. Sirles (1990) notes that more is known about dropout in the beginning phase of treatment than in the later stages of the treatment process. Laufer (1992) points out that the research has concentrated primarily on identifying aspects of intervention that might facilitate prediction of continuation or termination from treatment and less attention has been paid to the clients' perceptions of aspects of the treatment process. Similarly, Armbruster & Kazdin (1994) cite the need to pay greater attention to what children and parents say about dropout and they recommend formal evaluations of youth, parents, and families regarding dropout. They maintain that most dropout studies take a "clinic centric" perspective in which there is an assumption that dropout from treatment represents failure and that clients who dropout assess the services they received negatively. Thus, they recommend further examination of the match between the services offered and the client (and/or family) as well as the differences between clients' and clinicians' goals and expectations of treatment.

Empirical Studies of Adolescents

Three studies were found that pertain to dropout from treatment with adolescents, (Baruch et al., 1998; Suzuki,1989; Viale-Val et al., 1984). Viale-Val et al. (1984) and Suzuki (1989) both note that despite the common belief that adolescents are more likely to dropout of psychotherapy than adults or children, no evaluations have been done to compare the rates of dropout among the three groups. Although recent studies that have argued against the myth of "adolescent turmoil" (Offer, 1975; Offer, Ostrov, & Howard, 1989), stereotypic views of adolescents as universally "troubled" and unresponsive to psychotherapy still prevail. Viale-Val et al. (1984) note that no research has systematically focused on why adolescents dropout of treatment, how frequently dropout occurs, and what information might be useful in predicting and preventing premature termination.

In a retrospective study of 102 adolescents who received individual, psychoanalytically oriented psychotherapy in an outpatient clinic, Viale-Val et al. (1984) utilized clinic records to explore the rate of unplanned termination from treatment and to identify variables that differentiated "terminators" from "remainers." The majority of the sample (80%) were ethnic minorities (70% black, 10% "other," 20% white), 95% of the families were in the lower socio-economic classes, and the age range of the adolescents was 13-18 years old, with a mean age of 15.3.

The researchers defined treatment dropout as "unilateral termination" by the patient regardless of the number of treatment sessions attended. The four categories of patients they described included: no show; pretreatment dropouts (1-3 sessions); treatment dropouts (4-16 sessions); and remainers (those who terminated treatment by mutual agreement with the therapist and those who were still in treatment).

The findings indicated that 48% of the patients dropped out before they were accepted for therapy, either by not attending the initial appointment (22.5%), or by dropping out during the initial assessment, 1-3 sessions (25.5%). About one-quarter (26.5%) of the patients terminated unilaterally after attending between four to sixteen sessions. 14.7% of the patients were "remainers," those who terminated by mutual consent with the clinician or were still in treatment. Therefore, almost 75% of patients initially accepted for treatment terminated unilaterally prior to the 17th session (almost 50% of these included patients who came for 0-3 sessions; about 25% came between 4-16 sessions). The range of sessions attended was 1-80; the median number of sessions attended was nine.

Different sets of variables were associated with dropout at different phases of treatment. Although several variables were associated with dropout from the initial appointment and the assessment stage (0-3 sessions), in the intermediate phase (4-16 sessions), most of the patient variables were not predictive of either terminating or remaining. The authors conclude that the results of their study confirm the clinical observation that a majority of adolescents in long-term psychoanalytic treatment terminate against the recommendations

of their therapists. However, they emphasize that their results indicate that adolescents do not show a higher rate of premature termination than the rates reported for adults in public or private settings.

In a study similar to Viale-Val et al. (1984), Suzuki (1989) studied 105 adolescents in an outpatient setting specializing in psychoanalytic psychotherapy. The adolescents in the study ranged in age from 14-22 years old, with a mean age of 18. The majority of the treatment contracts were open-ended, two-thirds of the adolescents were seen once weekly and one-third were seen 2-3 times per week. Data was collected through questionnaires to the therapists regarding the length of stay in treatment and the reasons for termination.

The findings from this study were similar to those of Viale-Val et al. (1984). Approximately 50% of the adolescents dropped out before being accepted for treatment (17% did not attend the intake appointment; 25% dropped out during the assessment stage; 8% were referred out). It should be noted that the authors do not specify how long the assessment stage is in this study. 20% of the adolescents terminated treatment unilaterally; 13.3% terminated by mutual consent (of these 9.5 % terminated according to a prearranged time-limited contract, and 3.8% by mutual consent with the therapist); and 17.1% were still in treatment. The author notes that if only those who received treatment (post assessment) are considered, 55% had more than 24 sessions.

Although the adolescents in this study were older than those in the study by Viale-Val et al. (1984), the results of the two studies are similar, there was a high dropout rate at the assessment stage and a tendency to terminate treatment unilaterally at later stages. Suzuki, like Viale-Val et al., maintains that in both studies adolescents did not show higher rates of premature termination than reported dropout rates of adult patients in public or private settings.

Although in these two studies similar rates of dropout are reported with adults and adolescents, Suzuki (1989) believes that there is a general perception that adolescents drop out of treatment more frequently because of the strong feelings unilateral termination by adolescents evokes in clinicians. Like the concept of the "unilateral termination plan" suggested by Novick (1976), Suzuki explains unilateral termination as the adolescent's attempt to separate and become independent from the therapist, much like the process of separation from parents. Thus, Suzuki concludes that the strong countertransferential feelings evoked in therapists by unilateral termination with adolescents leads to an overemphasis on their tendency to dropout of treatment.

In a more recent retrospective study of 134 adolescents in a community-based psychotherapy service in London, England, Baruch et al. (1998) investigated the attributes which differentiate adolescents who remain in psychoanalytic psychotherapy from those who dropout. The investigators explored a variety of variables, including age, ethnic background, referral type, living situation, diagnosis, and type of therapy received

(supportive vs. interpretive psychoanalytic psychotherapy), to determine whether they affected length of time before unilateral termination by the patient.

The majority of the sample, (79.1%), were white, while the remaining 20.9% were from ethnic minorities: 71.6% of the patients resided in an area of high social and economic deprivation; and the age range of the adolescents was 12-24, with a mean age of 18.72. Almost half, (46.3%) of the adolescents had a principal diagnosis of depressive mood disorder. Diagnoses of the remainder included, a neurotic, stress-related or somatoform disorder (22.4%); adolescent or adult personality disorder (13.4%); hyperkinetic or conduct disorder (9.9%); syndromes with physiological symptoms (6%); and other disorders (3%).

The researchers defined dropout as a "unilateral decision made by the young person without the agreement of the therapist" (p.236). Adolescents were assigned to one of three groups defined by the amount of psychotherapy sessions attended prior to dropout. The "early termination" group terminated before the sixth session, "late termination" was defined as unilateral termination after the fifth session and before the twenty-first. "Continuers" in treatment were those adolescents who remained in treatment after twenty sessions. The findings indicated that 30.6% were early drop-outs, 29.1% were late drop-outs, and 40.3% were continuers. The mean number of sessions attended for early drop-outs was 3, for late drop-outs, 11.87, and for continuers, 38.

Baruch et al. (1998) found that the independent variables which led to continuation in treatment were age and referral source. Consistent with their hypotheses, the investigators found that older, self referred adolescents with "internalizing"(depression and anxiety) problems were more likely to remain in treatment. Dropouts were younger, had greater externalizing problems, school problems, diagnoses of hyperkinetic or conduct disorder, and were referred by others. The continuers were more likely to be self-referred and to be treated by supportive (in contrast to interpretive) psychotherapy techniques.

One of the strongest factors associated with attrition, even when controlling for age, was therapeutic approach. Adolescents were more likely to continue in treatment if they received a supportive therapeutic approach as opposed to an interpretive one. Based on this finding, Baruch et al. identified the need to train adolescent psychotherapists in supportive therapeutic approaches. He also concluded that there is a great need to investigate how to keep younger, conduct disordered patients in therapy.

Summary

In summary, a variety of theoretical approaches to planned and unplanned termination with adults and adolescents have been reviewed in this chapter. Several gaps and limitations in research on termination have been noted. First, the vast majority of research on termination has been undertaken from the perspective of the practitioner.

Mallucio's (1979) study provides an important model for this dissertation study as an exploration of the client's perspective.

In addition, the topic of unplanned termination has received little attention and will be further explored in this study. The dissertation study will address some of the gaps and limitations identified in the studies of unplanned termination. As noted, most of the research on unplanned termination is on the beginning stages of treatment. The dissertation study will explore unplanned termination from varying lengths (short and longer-term) of treatment. Finally, as indicated by this review of research on termination, descriptive studies pertaining to the termination process with adolescents do not exist. This study will address these significant gaps in the existing research on termination. In addition, by including the pilot study of the clinicians' views of the termination process, there will be an opportunity to compare these findings with the adolescents' views.

The next chapter will describe the combination of quantitative and qualitative methodologies that will be utilized to examine the termination process.

CHAPTER III

METHODOLOGY

Rationale/Goals of the Study

As discussed in the literature review, since few empirical studies have been undertaken on termination in general, and even fewer of these with adolescents, very limited information is available about the termination process in psychotherapeutic treatment. In light of these gaps in research, the overall purpose of this dissertation study is to learn more about the termination process with adolescents in order to inform and enhance practice and mental health program development for adolescents.

Setting

The setting for this dissertation study was within a mental health program at a large, multi-service adolescent center located within a major urban medical center. The Adolescent Center is a primary care clinic in a large northeastern city that provides interdisciplinary, comprehensive, confidential, and easily accessed medical, family planning, mental health, and health education services to adolescents, aged 12-22, throughout the urban area. The Adolescent Center operates it's primary clinic near the large medical center, as well as at two school-based health clinics located in neighborhood high schools. Since it's inception in 1968, the Adolescent Center has grown to become one of the largest health centers for adolescents in the United States and is nationally renowned as a model of excellence in providing high quality, comprehensive, holistic, and accessible health care to adolescents.

The mission of the Adolescent Center is to enhance disease prevention and promote health and mental health for adolescents, a population classified at high health risk by the U.S. Congress, Office of Technology Assessment (cited in Dougherty, 1993). Experimentation and risk-taking which is normative in adolescence, combined with the rapidly changing and frequently tumultuous nature of the adolescent period of development, places adolescents at particularly high risk for a variety of serious health and mental health problems.

The Adolescent Center provides comprehensive services for a broad range of health and mental health problems, including: teenage pregnancy; sexually transmitted diseases; substance abuse; HIV and AIDS; school and family problems; physical, emotional, and sexual abuse; suicidality and depression; and the impact of violence and poverty. Comprehensive services holistically address the biopsychosocial nature of adolescent health problems and are provided by a broad range of health care professionals, including: physicians; nurses; social workers; psychiatrists; psychologists; and health educators. Services are provided in an "adolescent appropriate" and culturally sensitive manner. "Adolescent appropriate" services have a goal of ensuring that adolescents develop a sense of "ownership" of their health and mental health needs so that they are able to become good consumers of medical services as adults. In order to maximize the accessibility of services to all adolescents, and particularly to inner-city adolescents, who are often underserved, underinsured or uninsured, the majority of the services provided

by the Adolescent Center are free. While family and other support systems are involved when appropriate, adolescents are able to receive confidential services when needed.

Since 1970, the mental health program been housed at the Adolescent Center. The goal of the mental health program is the prevention of adolescent substance and alcohol abuse and related risk behaviors, through the delivery of free, high quality, mental health and prevention services to adolescents, and their families, who are at high risk for substance and alcohol abuse. While the mental health program serves an ethnically and socioeconomically diverse population from the large urban area, the majority of program participants are African-American and Hispanic adolescents from poor, "working poor," or working-class families who live in poor, inner-city neighborhoods that have the most severe health status problems in the city (HSA, 1993).

The mental health services at the Adolescent Center help adolescents cope with and make decisions about the normative challenges of adolescence, such as, peer pressure, dating relationships, school, the development of life goals, and the gradual separation from their families. In addition to handling the normative struggles of the adolescent passage, as a result of the additional stressors of poverty and violence, many of the program participants are exposed to economically depressed and dangerous neighborhoods, schools, and communities, where they face the availability of drugs and other risk factors in their families and/or within their communities. As a result of these and other stressors, many of the program participants also struggle with school failure, significant family

difficulties, substance use/abuse of their own or within their families, and depression or other serious emotional problems, all of which require more intensive counseling efforts.

The mental health and prevention services are provided at the Adolescent Center, two high-school satellite clinics, and within several junior-high schools. Referrals for mental health services come from a wide range of sources, including, health care providers at the Adolescent Center and within the large Medical Center, schools, community agencies, courts, group homes, adolescents themselves, and their parents and/or other family caretakers.

Counseling/treatment services begin with an intake/evaluation process, typically one to three sessions, in which the presenting problem/request for service is evaluated and a treatment intervention plan is developed. Parents are typically included in the evaluation process, however, if requested and deemed appropriate by a clinician, adolescents can receive mental health services without parental knowledge or involvement. Frequently, the participation of parents and/or other family members in counseling is encouraged in order to maximize the effectiveness of services.

Mental health and prevention services include: individual, group, and family therapy; the use of psychotropic medication; and referrals to appropriate community agencies and services. Many of the adolescents and families served by the mental health program receive weekly services, however, the length, frequency, and intensity of the services

provided varies depending on the nature of the problem. As a result of the grant that supports the mental health program, adolescents and their families can receive comprehensive counseling services without a fee for as long as the services are deemed necessary and appropriate, or until the adolescent "ages out" of the mental health program, at age twenty two. The mental health program is staffed by approximately twenty Masters level (M.S.W.) social workers, two psychologists, and two psychiatrists, all of whom have a range of experience providing psychotherapeutic services to adolescents.

OVERVIEW OF THE RESEARCH DESIGN

Operational Definitions

Several terms are used throughout the literature on termination to describe types of termination. The term "planned" termination has been used (Cochran and Stamler, 1989 Mallucio, 1979) to denote a termination process that included a discussion between the client and clinician about the decision to terminate services. Terms such as, "unplanned" (Mallucio, 1979), "unilateral" (Viale-Val et al., 1984), and "premature" (Blotcky & Friedman, 1984) termination, as well as, "dropout" (Sweet & Noones, 1989) have been used to denote terminations in which there is neither an acknowledgment by the client about the decision to discontinue services nor a discussion between the client and the clinician about the discontinuation of services.

Acknowledged and Unacknowledged Terminations

For the purpose of this study, termination is defined as the discontinuation of mental health/counseling services. The terms "acknowledged" and "unacknowledged" have been used to define the way in which services are terminated. "Acknowledged" terminations are operationally defined as those cases in which there is an acknowledgment and/or a discussion between the clinician and the adolescent (and/or parent) about the discontinuation of mental health services. Acknowledged terminations were initiated by either the client (adolescent and/or parent) or the clinician and occurred either in person (in session), through telephone conversations, or by letter. In acknowledged terminations, a process of "closure" can be reached by an acknowledgment and/or a discussion between the adolescent and the clinician about the discontinuation of mental health services.

"Unacknowledged"terminations are operationally defined as those cases in which there was neither an acknowledgment nor a discussion between the clinician and the adolescent (and/or parent) about the discontinuation of mental health services. In unacknowledged terminations, "closure" can not be reached because the adolescent (and/or parent) did not notify the clinician nor discuss with him/her the decision to discontinue mental health services.

Administrative Definition of Termination

In order to understand the way in which cases at the Adolescent Center are terminated, it is important to describe the definition of termination utilized by the funding source for mental health/counseling services at the Adolescent Center. The funding source stipulates that a case must be terminated or closed if there has not been a clinic visit for one full month. For example, if the last clinic visit took place in the month of January, the case would remain open through the month of February and it would have to be closed (terminated) at the end of February. If a client requests additional services after a case has been closed, the case can be reopened or "readmitted" to the mental health program, if the clinician establishes that there is a need for continued services. The mental health records reviewed in this study included both single admissions, cases that were admitted and closed one time, and "readmissions," cases that were opened, closed, and readmitted one or more times for additional services.

CHOICE OF METHODOLOGY: QUANTITATIVE AND QUALITATIVE METHODS

Quantitative Methodology

In order to explore the research questions posed in this dissertation study, the research design utilized both quantitative methods and a qualitative, grounded theory approach. Strauss & Corbin (1990) suggest that the nature of the research questions that are being posed dictate the choice of the methodology. In this study, a quantitative approach that utilized available clinical information obtained from existing client records of the mental health program at the Adolescent Center (Epstein, Zilberfein, and Synder, 1997) was

chosen to explore why, when, and how adolescents terminated from mental health services. The objectives of the quantitative design were:

1) To provide descriptive data about the background characteristics, risk factors, type of mental health services received, and patterns of termination from mental health services, for a sample of adolescents, and

2) To explore the relationships between the type of termination (acknowledged or unacknowledged) and a variety of independent variables.

In this portion of the study, the type of termination, that is, whether termination was acknowledged or unacknowledged, was the dependent variable. The independent variables included, the patterns and process of termination; demographic variables; referral information; presenting problem; diagnosis; parental involvement in treatment; past mental health services; motivation for treatment; psychosocial risk factors; patterns of admission and termination; modality and length of treatment; outreach efforts; and treatment outcomes. A bivariate analysis was conducted to explore the relationships between the dependent variable and these independent variables. The findings include both descriptive and analytic data that was obtained from the univariate and bivariate analyses.

Qualitative Methodology

Since very little is known about how adolescents understand and perceive the process and dynamics of termination, a qualitative, grounded theory approach was utilized in conjunction with the quantitative methodology. The purpose of the qualitative portion was to provide an in-depth account, inductively derived from the subjective experience of

the adolescents themselves, about their understanding, perceptions, and views of the termination process. As Patton (1990) indicates, "Qualitative methods permit the evaluation researcher to study selected issues in depth and detail" (p. 165) . According to Strauss and Corbin (1990), "Qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet known" (p. 19). Strauss and Corbin (1990) explain that a grounded theory is one that, " . . . is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon" (p. 23).

In a discussion of how quantitative and qualitative methods can be used together, Epstein (1988) points out that:

> Quantitative methods are best suited in trying to establish cause-effect relationships between variables or to describe relatively straightforward characteristics such as demographic variables. Qualitative methods lend themselves to the description of complex social processes and the rendering of the subjective impressions of these processes by people involved in them. As a result, qualitative methods are ideal for identifying new concepts and for hypothesis formulation (p. 196).

The qualitative data obtained from the interviews with adolescents were able to capture, in greater depth, information that could not be collected from the client records. In addition, the qualitative data, comprised of the adolescents' viewpoints regarding termination, were utilized to enrich, explicate, and illustrate the quantitative data, which was the clinicians' account of the termination process as reported in the client records.

As Strauss and Corbin (1990) indicate:

> ". . . qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods" (p. 19).

QUANTITATIVE DESIGN

The Use of Available Data

The exploratory pilot study completed earlier (Mirabito, 1993) provided a beginning understanding about clinicians' views regarding how and why adolescents terminate from mental health services. The findings from this study were helpful in generating new questions about termination with adolescents that were further explored in this dissertation. Specifically, they revealed the need for a quantitative design that would provide systematic data from specific cases of adolescents who terminated from mental health services in order to obtain information about the services they received and their patterns of termination from these services.

A retrospective study, utilizing available clinical data from the records of terminated mental health cases at the mental health program was chosen as the method to obtain quantitative data. Epstein, Zilberfein, and Snyder (1997) indicate that the utilization and analysis of information that is routinely available in medical and social service settings can be a viable alternative to the use of randomized, controlled trials. They present a compelling rationale for utilization of available agency data by pointing out that,

> In comparison with studies based on original data generation, available information studies are likely to raise fewer ethical problems, are faster and less costly to complete, are less disruptive to existing staff and patient care routines, and make use of compliance and outcome indicators that are likely to be more agency and practice relevant (page 225).

For these reasons, using available data from the closed client records of the mental health program was chosen as an effective, efficient, and pragmatic method of data collection.

Initial Review of Records

An initial review of closed records from the mental health program was conducted in order to determine which client records were appropriate for the study, what information about the termination process was available in the records, and how consistently the information was recorded. Through the process of reviewing the records, it became clear that many of the school-based cases included time-limited group services with a prearranged termination point. Since all of these cases had acknowledged terminations because the services were planned at the outset to be time-limited, they were excluded from the study. The exclusion of these cases left a considerably smaller pool of school-based cases, consequently, a decision was made to focus the study only on cases from the Adolescent Center.

The initial review of records was guided by relevant concepts about termination that were obtained from the literature review and the pilot study of termination (Mirabito, 1993). The initial variables used in the pilot review of records, included: age; sex; ethnicity; location of services (school or clinic); referral source; diagnosis; modality; number of

sessions; number of admissions to the mental health program (one or multiple admissions); outreach efforts; type of mental health services (time-limited or open-ended); type of termination (e.g., planned or unplanned, with closure or "dropout"); reasons for termination (e.g., worker left agency, client moved); and achievement of treatment goals.

In addition, I wrote a brief summary of each case that included specific information that was relevant to the termination process, such as, the client's engagement in the treatment process, and how and why the client terminated services. In an effort to obtain as much information as possible about the way services were terminated and the circumstances at the time of termination, in reading each record, I focused particular attention on a thorough review of documentation from the last sessions attended by the client and any outreach efforts that were made by the clinician. For example, I paid close attention to whether a discussion regarding termination took place, and if so, whether this discussion occurred in a therapy session or by telephone. A list of variables that were relevant to specific aspects of the termination process, specifically, how and why termination occurred, was developed from the information contained in these case summaries.

Thus, the initial review of records revealed what information was available in the existing documents in the client records (psychosocial intake/assessment database, progress notes, treatment updates, termination forms) in order to develop a preliminary inventory of this information. The initial review of records was also used to determine what information

would need to be excluded from the study because it was not available in the records. For example, although I wanted to explore the relationship between the way the treatment contract was developed and how termination occurred, this information could not be included in the study because the records did not routinely document how the treatment contract was developed.

Development of the Research Instrument

Guided by this pilot review of the client records, an original research instrument, the "Inventory of Variables"(Appendix B), was designed to retrieve and record available data from the client records. The "Inventory of Variables" included salient concepts pertaining to the termination process that were gleaned from a combination of, the literature review of termination, "practice wisdom" that resulted from my extensive practice experience with adolescents, the pilot study of termination, and the pilot review of client records. Some of the central questions that shaped the selection and development of variables pertaining to termination that were gleaned from the literature and the pilot study included: How were services ended? Do adolescents drop out or discuss their intention to end services? Who initiates the ending, the adolescent, the parent, or the clinician? What are the reasons for discontinuing services? Are there signs or signals that predict when adolescents will discontinue mental health services? If, so, what are these signs or signals for the discontinuation of services?

The process of developing the inventory of variables required numerous revisions as efforts were made to include information relevant to the termination process that could be easily obtained from the records, easily coded, and as close to the record as possible. The process of coding each of the variables required breaking down each variable into it's component parts. Numerous revisions were made so that each variable was as simple, straightforward, and behaviorally specific as possible in order to make the definition of each variable consistent and clear. Operational definitions were developed for all of the variables in order to insure that each one was simple, easy to code, mutually exclusive, and exhaustive. Once the variables were coded, a code book was developed so that the variables could be accurately and consistently coded.

This process of identifying, coding, and revising the variables led to the development of the final version of the "Inventory of Variables" (Appendix B), which was used to extract clinical data from the client records. The Inventory of Variables consisted of eight categories of variables that described, the sample population (e.g. demographics, assessment, and psychosocial risk factors), the type of mental health services they received, the process of how and why they terminated from mental health services, and the outcome/status of the services at termination. These categories included the following:

1) **Demographic Characteristics:** gender; ethnicity; age at termination; grade; borough; parental employment; family composition

2) **Modality/Length of Treatment**: individual, family, group, and/or psychiatric services; single or multiple admissions; total length (sessions and months) of services

3) **Referral Information**: referral source; reason for admission (presenting problem); reaction to the referral; motivation for services

4) **Assessment Information:** confidentiality of services; parental involvement in assessment; past mental health services; diagnosis

5) **Psychosocial Risk Factors:** absence/loss of parent; additional losses of significant others; behavioral risk factors (sexual activity, alcohol and drug use/abuse, school problems, truancy, school dropout) and parental/familial risk factors (history of physical/sexual abuse and neglect, parental alcohol and drug abuse)

6) **Termination of Treatment:** who initiated termination; type of termination, whether acknowledged or unacknowledged, for how long it was acknowledged/discussed; whether it was acknowledged/discussed in session, by telephone, or by letter; the reasons for and circumstances of termination; and feelings about/reactions to termination

7) **Outreach Efforts/Results of Outreach at Termination:** outreach efforts by telephone and letter; whether contact was made with the adolescent and/or family; results of the outreach efforts.

8) **Outcomes at Termination:** status of the case at the last session (researcher's assessment); status of the case at case closing (clinician's assessment)

Validity of the Research Instrument

In describing content validity, Bostwick and Kyte (1988) indicate that,

> Personal judgements of the social worker (alone or with others) determine how a concept is to be defined, how the universe of items is to be identified, and how the sample of representative items from that universe is to be drawn. Thus, the general content validity of any instrument rests to a large extent on the skill and judgment of the person who constructs it (p.114).

As described by these authors, the investigator established content validity for the research instrument, the "Inventory of Variables," by drawing on "practice-wisdom" derived from her extensive practice experience with adolescents and verified through a

review of the literature pertaining to termination with adolescents (Meeks, 1971; 1990; Miller, 1990; Mishne, 1986). In addition, the "Inventory of Variables" was reviewed and revised by members of a research committee comprised of clinicians who had extensive experience providing clinical services to adolescents and in utilizing the agency forms at the Adolescent Center.

Reliability of the Research Instrument

Before extracting data from the client records, the reliability of the "Inventory of Variables" was established in order to insure that the variables were coded accurately and consistently. In order to establish both intrarater and interrater reliability, ten randomly chosen charts were recoded by both the researcher and a colleague. The colleague, (an MSW) who was a member of the research committee and had extensive experience providing mental health services to adolescents at the Adolescent Center, coded the records after she was given the codebook and specific instructions for coding.

A reliability coefficient of .80, or higher, was obtained in all except fifteen of the variables when the records were recoded by myself and my colleague. Inconsistent ratings were found in six variables that were coded by both, two variables that were coded by myself, and seven variables that were coded by my colleague.

Variables with a reliability coefficient of less than .80 were revised. Specifically, the instructions in the code book were revised for several variables because there was not

enough clarity both about how the terms were defined and where in the records the information could be obtained. For example, in variable 46, "Other significant losses," and variable 47, "Number of losses," the definition of loss was revised in the codebook to include the loss of a parent, grandparent, relative, or friend, and the codebook specified that the information could be obtained from the genogram and/or the psychosocial assessment/data base. Similarly, the codebook was revised to indicate that variables 66, "COA (Child of Alcoholic)," and 67, "COSA (Child of Substance Abuser)," could be obtained in the genogram and/or the psychosocial assessment/database, and 69, ("Termination Discussed"), 72, ("Termination First Discussed"), and 76, ("Type of Termination"), could be obtained from a careful review of the last sessions preceding the final sessions recorded in the record.

Three variables, "Motivation" (37), "Result of Outreach" (83), and "Clinician assessed further services needed" (101) were revised because they were not sufficiently clear and specific and one variable, "client attending regularly" (102), was deleted because it was not possible to accurately measure "regular" attendance to sessions. The three variables were revised as follows:

#37. MOTIVATION

ORIGINAL	**REVISED**
1) Unmotivated	1) States willingness to try treatment
2) Ambivalent	2) States motivation/interest in treatment
3) Motivated	3) States unwillingness/does not want treatment
4) Not Available	4) Statement of motivation is not available
5) Other_____	

#83. RESULT OF OUTREACH

ORIGINAL

1) Termination occurred over telephone
2) Client returned to terminate in session
3) Client returned to continue treatment sessions
4) Client agreed to return and did not follow through
5) No contact made with client
6) Outcome not available from chart
7) Other _____

REVISED

1) Termination discussed over telephone
2) Client returned to terminate in session
3) Client returned to continue treatment sessions
4) Client agreed to return and did not follow through
5) Outreach not necessary because case was terminated
6) Outreach desirable but not done
7) No response to outreach recorded in the chart (outcome of outreach not available in record)
8) Other _____

#101. CLINICIAN ASSESSED FURTHER SERVICES NECESSARY

ORIGINAL
Clinician assessed further services needed.

REVISED
Clinician expected client to return. Follow-up plan made at last session.

DATA ANALYSIS

Quantitative Data

SPSS was used to facilitate analysis of the quantitative data. The investigator set up each variable from the "Inventory of Variables" in SPSS so that data could be entered. A

graduate research student was hired to enter all the data contained on the "Inventory of Variable" protocols for the one hundred cases. After the initial frequencies were obtained, many of the variables were collapsed and recoded in order to have an adequate distribution of cases for cross tabulations of the variables.

Frequencies of all the variables and cross-tabulations of the relationships between the dependent variable, whether termination was acknowledged or not, and the independent variables were obtained. Findings with a chi square level of .05, or lower, were reported as statistically significant. Findings with a chi square level between .06 and .08 were reported as "noteworthy."

Profile of the Sample

All records that were closed during the one year period, from January 1996 to December 1996, were included in the sample. Records that were inadequately documented were excluded, leaving a total sample of one hundred records. Data were extracted by thoroughly reviewing each record and recording data from the records onto the "Inventory of Variables." Data collection took place from December 1997 to August 1998.

The sample of 100 adolescents who were the subjects of this study (displayed in figure 1 on page 73) received mental health services at the Adolescent Center and terminated their services between January to December 1996. The sample included 37 males and 63

females. The majority of the sample, 87%, were minorities, while only 13% were Caucasian. The largest minority group was Hispanic, 39%, followed by African American/Caribbean, 29%; Biracial, 10%, and Asian, 9%. At the time they terminated from mental health services, the mean age of the sample was 15.96 years, including 28% young (12-14 years) adolescents, 51% middle (15-17 years) adolescents, and 21% older (18-22 years) adolescents. All of the adolescents except for 2% were attending school, with 21% in junior high school (6th-8th grades), 68% in high school (9th-12th grades and GED), and 11% in college.

An almost equal number of adolescents lived in single-parent families, 44%, as those who lived with two (biological and/or step/common-law) parents, 41%. A relatively small number, 15%, of the adolescents lived in other family constellations, including with extended family members and friends. Seventy-six percent of the adolescents lived in families in which the custodial parent was employed while only 4% lived in families supported by Public Assistance. It should be noted that the sample utilized for this study was drawn from the section of the Adolescent Center's mental health program designated for adolescents who are not eligible for Medicaid while those who receive Medicaid are registered in a different section of the program. Almost three-quarters (70%) of the referrals for mental health services came from schools (39%) and parents (31%). The majority of the sample, 81%, lived in areas closest to the Adolescent Center; while the remainder lived in outlying areas.

Figure 1 Profile of the Quantitative Sample (N=100)

Demographic Variable	Percentage
GENDER	
Male	37
Female	63
ETHNICITY	
Caucasian	13
African-Amer/ Caribbean	29
Hispanic	39
Asian	9
Biracial	10
AGE/TERMINATION	
12-14	28
15-17	51
18-22	21
FAMILY COMPOSITION	
Single Parent	44
Two Parents	41
Other Relative	13
Non Relative /Friend	2
PARENTAL EMPLOYMENT	
Parent Employed	76
Parent Unemployed	24
REFERRAL SOURCE	
Parent	31
School	39
AC/Medical Center	9
Community Facilities	11
Self	10
Friends	2
RESIDENCE	
Closest to AC	81
Further from AC	19

QUALITATIVE DESIGN

Development of the Interview Guide

An interview guide including thirteen questions (Appendix C), was developed by the investigator, as the research instrument that was utilized to obtain qualitative data about the subjective meaning and experience of termination from interviews with the adolescents who terminated from mental health services. The interview guide was developed by drawing on themes pertaining to the beginning, middle, and ending phases of treatment. These themes were gleaned from a variety of sources, including, the investigator's practice wisdom derived from her clinical work with adolescents, the pilot study about clinicians' perceptions of the termination process at the Adolescent Center, and relevant theoretical and empirical literature on "planned" and "unplanned" termination and treatment "dropout." The interview guide included exploration, with the adolescents, of the following areas:

- How and why the referral for mental health/counseling services was made
- The response to the initial referral and the plan for mental health/counseling services
- Expectations and goals of mental health/counseling services
- The overall experience of mental health/counseling services
- Perceptions about how and why services were discontinued
- Perceptions and feelings about the process of discontinuing services
- Reactions, feelings, and meanings about the discontinuation of services
- Perceptions about the outcome of services

The interview guide was designed to ask a general question about each of these areas with a series of "probes" (Lofland & Lofland, 1984) that were used to ask more specific questions about each area, in order to gain further understanding and clarification. The interview guide was reviewed by members of the dissertation committee (I. Epstein, M. Mailick, F. Vigilante) as well as the research committee at the Adolescent Center and it was revised based on feedback from both committees.

Next, the interview guide was piloted with two adolescents in order to determine whether the content, sequencing, and language used in the questions would be relevant to and understood by adolescents. Valuable information was derived from these pilot interviews. For example, in one of the pilot interviews, one adolescent commented on her perception of the language used in the interview guide. Regarding use of the word, "termination," she said, "Termination was used when I got fired. It has the feeling of finality." Moreover, she added:

> The focus on the leaving part, you shouldn't stress leaving but put more stress on what it was like. The focus should be more on the experience. The question about leaving almost makes you feel bad. To be asked about leaving, it feels incomplete. It makes me sad.

These comments illustrated the importance of utilizing adolescents' language in the interviews. Since the word "termination" clearly held different meanings for clinicians than it did for adolescents, this word was not used in the interview guide. Instead of asking about their experience of "termination," the adolescents were asked how they experienced both receiving and "stopping" counseling/mental health services. The pilot

interviews also clarified the importance of exploring the adolescents' reactions and feelings about participating in and stopping services. The revisions that were made as a result of feedback from the pilot interviews led to the interview guide that was used for the in-depth interviews with the adolescents (Appendix C). One of the pilot interviews was included in the sample.

Selection of the Sample

Patton (1990) recommends that the sampling strategy for qualitative research should be selected to "fit the purpose of the study, the resources available, the questions being asked, and the constraints being faced" (p. 181 and 183). Since the purpose of the qualitative design was to learn about how adolescents experience both acknowledged and unacknowledged terminations and to identify the similarities and differences between these types of termination, the sample included adolescents who experienced both acknowledged and unacknowledged terminations.

Purposeful sampling was the sampling strategy that was utilized. According to Patton (1990), the aim of purposeful sampling is to select "information rich cases" (p.169), those cases that will provide the most information possible in order to maximize the understanding of the phenomenon being studied. The case summaries containing information relevant to the termination of services that were obtained from the client records were used to identify the two types of termination, "acknowledged" and "unacknowledged". Cases that were "acknowledged" included those cases in which

termination was acknowledged by a process of discussion between the adolescent and the clinician and closure was achieved. "Unacknowledged" cases were those cases in which the adolescent unilaterally discontinued his/her services without notice, acknowledgment, discussion, or agreement with the clinician about this decision and without closure of the therapeutic experience.

Forty adolescents who represented these types of termination were chosen to be contacted by letter and telephone for in-depth interviews. Cases that were chosen for interviews were those that provided maximum information and best exemplified each type of termination. In addition, in order to obtain a broad representation of cases served by the clinic, cases with a varied range of age, gender, referral source, and length of treatment were chosen.

Enlisting Participation

The adolescents chosen for interviews were contacted first by letter (Appendix D) and then with a follow-up telephone call in order to inform them about the purpose and parameters of the study and to inquire about their interest in participating in an interview. Almost one-half (19) of the adolescents chosen for interviews could not be reached by telephone. Of these nineteen cases, in eight cases telephones were disconnected; in six cases parents and family members indicated that the adolescents were either not in the area or their whereabouts were not known; and in five cases messages were left but not returned. Of the remaining twenty-one cases, there was a range of responses to the

telephone calls, including respondents who immediately agreed to come for an interview, those who agreed to come for an interview after some explanation and clarification of the study, and four respondents who declined participation because they lacked either the time and/or interest. Sixteen adolescents agreed to be interviewed. Of those who agreed to interviews. thirteen adolescents kept their appointments and were interviewed.

It should be noted that I provided treatment to three of the adolescents who were interviewed. These three cases included adolescents with both acknowledged and unacknowledged terminations. One of these interviews was a pilot interview. Patterns that emerged in these interviews were consistent with those from the other cases. Thus, it did not appear that my prior involvement with these adolescents as a clinician affected their responses in the interviews.

The initial plan to provide movie passes as an incentive to participate in the study was changed to a monetary incentive because it was anticipated that this would be a more effective means of engaging adolescents in the study. Thus, an incentive of $15.00 and transportation to and from the Adolescent Center was provided to the adolescents who participated in the study. This revision in the original proposal was submitted to the Institutional Review Board at the Medical Center when the original research proposal was renewed.

Description of the Qualitative Sample

The sample for the qualitative interviews included fourteen adolescents, thirteen of whom were obtained in the manner described and one who participated in a pilot interview. The sample included interviews with nine adolescents with acknowledged terminations and five adolescents with unacknowledged terminations. The acknowledged terminations were divided into two categories, "acknowledged with a process" (**Acknowledged/P**, six cases) and "acknowledged without a process" (**Acknowledged/WP**, three cases). Terminations that were acknowledged with a process were those in which there was a face-to-face discussion in one or more therapy sessions about the termination of services. Terminations that were acknowledged without a process included those in which either the client or clinician simply acknowledged that services would be discontinued, however no face-to-face discussion regarding the termination occurred. The three cases of terminations that were acknowledged without a process included: two by telephone, one with an adolescent and one with a parent who advised that they would no longer be coming for services because of work and other commitments; and one case in which the clinician terminated the case because of the client's poor attendance. The background characteristics of the sample included the following:

	Acknowledged/P (With a process)	Acknowledged/WP (Without a Process)	Unacknowledged
Gender	4 Females 2 Males	2 Females 1 Male	2 Females 3 Males
Age Range	12-16	16-20	13-22
Ethnicity	3 Hispanic 1 African-American 1 Biracial 1 Asian	1 Hispanic 1 African-American 1 Biracial	2 Hispanic 2 African-Americans 1 Biracial
Total Sessions (Range)	7-37	9-54	16-40
Total Months (Range)	2-17 Months	4-30 Months	5-19 Months
Admission Status	3 Readmit 3 Admit	2 Readmit 1 Admit	3 Readmit 2 Admit

Enlisting Staff Participation

Before the interviewing process was initiated, the mental health staff at the Adolescent Center were informed about the purpose and scheduling of the interviews. I informed social work staff about the study through discussion at a mental health staff meeting and by a written memo that summarized the procedures for the study (Appendix E). Staff were informed that while the content of the interviews was confidential, they would be given aggregate data about adolescents' reactions, perspectives, and viewpoints about mental health services and the termination of services at the conclusion of the study in an effort to improve and further develop mental health services at the Adolescent Center.

Staff were advised that the content of interviews would not be confidential if an adolescent was at risk of harm due to suicidal or homicidal ideations and/or gestures or reports of current physical or sexual abuse. In addition, staff were informed that if an adolescent requested either to contact the social worker who provided his/her counseling/ mental health services, or obtain additional mental health or medical services at the Adolescent Center, the investigator would provide the information and/or assistance requested.

Protection of Human Subjects/Implementation of the Interviews

Prior to conducting the interviews, the research protocol was submitted for approval to both the Institutional Review Board at the Medical Center and the Committee on the Protection of Human Subjects from Research Risks Institutional Review Board at the City University of New York, Hunter College School of Social Work.

Individual, "focused"(Merton, quoted in Mallucio, 1979), in-depth interviews, ranging from one and one-quarter to two hours, were conducted in my office at the Adolescent Center in July and August, 1998. The purpose of the interviews was to obtain an in-depth understanding about how adolescents experienced both receiving and leaving mental health services. An inductive, exploratory approach provided an opportunity to obtain the adolescents' accounts of their experience, in their own language and terms (Lofland & Lofland, 1984) in order to elicit the meanings, expectations, and understanding that adolescents had of both receiving and leaving mental health services. A key element in

conducting the interviews was my engagement with the respondents by establishing rapport, helping them feel at ease, and conveying interest in their experience, ideas, and views.

Before each interview began, all the participants were clearly and honestly informed about the voluntary nature of participation in the study and the ways in which confidentiality would be assured. An introduction (Appendix F), developed according to suggestions by Lofland & Lofland (1984), was read to the participants to explain the purpose of the study and the expectations of participants in the interviews. Each adolescent was informed about his/her choice to refuse to answer any question, that participation in the study was completely voluntary, and that participation in the study would not have any effect on obtaining current or future services at the Adolescent Center. The adolescents were informed that their responses in the interviews and their identity would be kept confidential except under specific circumstances of actual or potential risk and harm, including suicidal or homicidal intentions and/or gestures or abuse/neglect. No incidents occurred in the study that required a violation of confidentiality.

I informed each participant about my interest in tape recording the interviews and requested the participants' permission to do so. I also informed the participants that I would be taking notes during the interview, "for the purpose of staying on top of what is going on in the interview" (Lofland & Lofland, p. 61). Two of the adolescents indicated

that they did not want to have their interviews tape recorded. In these cases, I took extensive notes instead of tape-recording the interviews. All questions were answered and discussed before the interviews began as well as throughout the interview process and each adolescent was asked to sign the informed consent form.

DATA ANALYSIS

Qualitative Data

Of the fourteen interviews that were conducted, ten and a half interviews were tape recorded. The interviews that were not tape-recorded included, the two cases in which adolescents chose not to be tape-recorded: one case in which the tape recorder did not work throughout the interview; another case in which the tape recorder did not work during the second half of the interview; and the pilot interview that was subsequently included in the sample. Of the ten and a half interviews that were tape recorded, I transcribed six and a half interviews. An assistant was hired to transcribe four interviews and to type the interviews that I transcribed.

The typed transcriptions as well as interview notes were reviewed for on-going analysis (Lofland & Lofland, 1984). An inductive analysis of the content of interviews was done to obtain knowledge about the ways in which adolescents understand, perceive, experience, and handle the process of leaving mental health services. An understanding of the meaning of termination for adolescents and the factors which influence the process

of leaving services was derived from analysis of the general themes and patterns which emerged from the interviews.

The analysis of the data obtained from interviews was guided by the principles and methods for coding data outlined by Strauss & Corbin (1990). Through the procedures of "open coding," "axial coding," and "selective coding" (Strauss & Corbin, 1990), data was coded into categories, refined, and recoded. Recoding of categories and subcategories was done as the preliminary "story line" and an "analytic story line" (Strauss & Corbin, 1990) emerged.

Strauss and Corbin (1990) emphasize the importance of data collection (interviewing), data analysis, and the development of theory as a simultaneous, interactive, and ongoing process. Consequently, through the process of data analysis, concepts and the relationships among them were generated and provisionally tested.

Limitations of the Study

While client records provided an easily accessible and rich source of data for this study, not surprisingly, there was variation and some unevenness in the manner in which information was documented in the records. In order to obtain consistent, reliable data, it was important to pilot the research instrument (the "inventory of variables") to insure that the operational definitions of the variables were sufficiently concise. Some of the findings were influenced by the variations in the way clinicians documented their

interventions. For example, the inconsistent recording of the presence and outcome of outreach efforts made it difficult to ascertain how outreach influenced the termination process.

A limitation of the qualitative design of this study is its small sample size. As recommended by Patton (1990), the sample size was consistent with the purpose and goals of the study as well as the resources and time available. In addition, Patton indicates that, "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information-richness of the cases selected and the observational/analytical capabilities of the researcher than with sample size" (p. 185). The small size of the qualitative sample permitted the investigator to engage in thorough, detailed interviews which provided rich illustrations of the quantitative data.

Despite the small size of the qualitative sample, a point of theoretical "saturation" (Strauss, 1987; Strauss & Corbin, 1998) was reached in the process of data analysis. As Strauss & Corbin explain, "theoretical saturation" is defined as, "The point in category development at which no new properties, dimensions, or relationships emerge during analysis" (p.143). Thus, as the analysis progressed, since few new categories emerged, it was clear that enough data had been gathered to fully develop the core categories. The findings therefore represent beginning hypotheses and point to possibilities for further research.

Given the small size of the sample and the sampling strategy utilized, the findings that are reported cannot be generalized to other populations or settings. Instead, the data can be extrapolated in order to apply it in a meaningful way to other practice contexts. Patton (1990) explains the concept of extrapolation in this way:

> Extrapolations are modest speculations on the likely applicability of findings to other situations under similar, but not identical, conditions. Extrapolations are logical, thoughtful, and problem oriented rather than statistical and probabilistic. Extrapolations can be particularly useful when based on information-rich samples and designs. . . Users of evaluations will usually expect evaluators to thoughtfully extrapolate from their findings in the sense of pointing out lessons learned and potential applications to future efforts (p. 489)

It is possible that the investigator/interviewer's position as a social worker at the Adolescent Center may have influenced the adolescents' responses in the interviews. Specifically, adolescents may have offered "socially desirable" responses because of the interviewer's association with the clinic as well as the clinicians who provided the services that were being evaluated. In addition, my professional experience with and knowledge base about adolescents was both a strength and limitation. As Strauss and Corbin (1990) indicate, "theoretical sensitivity" derived from the literature and professional experience can provide insight to draw upon in research but "can also block you from seeing things that have become routine or obvious" (p. 47). Therefore, throughout the study, it was important to remain open to new insights and discoveries.

In the next chapter, findings from the quantitative data analysis, using available data from client records, will be provided. The quantitative findings will provide a detailed profile

of both acknowledged and unacknowledged terminations. In addition, the relationships between type of termination (acknowledged or unacknowledged) and a variety of variables will be examined.

CHAPTER IV

ACKNOWLEDGED AND UNACKNOWLEDGED TERMINATIONS: THE QUANTITATIVE FINDINGS

Goals and Operational Definitions

The primary objectives of the quantitative portion of this study are first, to describe how adolescents terminated from mental health services and second, to describe the relationships between the type of termination and various independent variables pertaining to the sample of adolescents and the type of mental health services they received.

As discussed in Chapter III, the dependent variable in this study was the type of termination, or the way in which termination occurred, which is defined as "acknowledged" or "unacknowledged." The independent variables included: termination variables; demographics; referral information; presenting problem and diagnosis; parental involvement in treatment; past mental health services; motivation; psychosocial risk factors; modality and length of treatment; outreach efforts; and treatment outcomes.

"Acknowledged" terminations are defined as those cases in which there was an acknowledgment and/or a discussion between the clinician and the adolescent (and/or parent) about the termination or discontinuation of mental health services. Acknowledged terminations were initiated by either the client (adolescent and/or parent) or the clinician and occurred in several ways, including, in person (in session), through

telephone conversations, and/or by letter. In acknowledged terminations, a process of "closure" was achieved by either an acknowledgment by the adolescent or clinician and/or a discussion between the adolescent and the clinician about the discontinuation of mental health services.

"Unacknowledged" terminations are defined as those cases in which there was neither an acknowledgment nor a discussion between the clinician and the adolescent (and/or parent) about the discontinuation of mental health services. In unacknowledged terminations, "closure" was not reached because the adolescent (and/or parent) did not notify or discuss with the clinician his/her decision to discontinue mental health services.

Overview of the Findings

The quantitative findings presented in this chapter include both a univariate analysis of all of the variables in the study, and a bivariate analysis of the relationships between the dependent variable, the type of termination (acknowledged or unacknowledged), and the independent variables. The analysis and discussion of the findings has been organized in the following sections, including: the Termination Process; Profile of the Adolescents; Assessment Information; Psychosocial Risk Factors; Utilization of Mental Health Services; Modality and Length of Services; Outreach Efforts and Outcome Measures.

In each section, findings from both the univariate and bivariate analyses will be presented and discussed. The first section, The Termination Process, describes the termination

process of the one hundred cases in the sample, the unacknowledged terminations, and a more detailed description of the acknowledged terminations, including, how termination occurred and was initiated, and whether the clinician and the client agreed or disagreed about the decision to terminate.

The remainder of the findings include the univariate and bivariate analyses of all the variables in the study. Sections II, III, and IV presents the univariate and bivariate analyses of: demographics; referral information; presenting problem; diagnosis; parental knowledge of and involvement in treatment; past mental health services; motivation for treatment; and psychosocial risk factors. Sections V and VI presents an analysis of the patterns of admission and termination from mental health services, the modalities and length of treatment, and the total length of treatment (months and sessions). The last two sections, VII and VIII, present an analysis of outreach efforts and outcome measures.

The tables that are provided in each section display frequencies for each variable as well as the bivariate analysis of the relationship between the dependent variable, whether termination was acknowledged or not, and each independent variable. In each table, percentages of the total number of cases in the sample, and percentages of acknowledged terminations are displayed. Descriptions of the salient aspects of each bivariate relationship are provided. Findings with a chi square level of significance of .05, or lower, were reported as statistically significant and elaborated. Findings with a chi square level of between .06 and .08, were treated as "noteworthy" and suggestive. The

Fisher's Exact test was used instead of the chi square statistic when one or more cells contained an expected value of less than five.

I. THE TERMINATION PROCESS

Overview of the Termination Process for the Entire Sample (N=100)

Type of Termination

As described in Table 1, of the one hundred cases in the sample, termination was acknowledged in only thirty-four percent of the cases, and unacknowledged in almost twice as many cases (66%). In the acknowledged cases, an acknowledgment and/or discussion took place about the plan to terminate services between the adolescent and/or parent and the clinician in a therapy session and/or by telephone or letter. In the unacknowledged cases, the adolescent and/or parent discontinued mental health services unilaterally, without any acknowledgment of or discussion with the clinician about this decision.

Table 1 Termination from Mental Health Services (N=100)

Type of Termination	Percentage
Acknowledged	**34**
Unacknowledged	**66**

Initiation of Termination

As displayed in table 2, in the majority of the one hundred cases in the sample (84%), termination was initiated by the adolescent. The high percentage of adolescent initiated

terminations in this study is consistent with the findings from other studies (Fortune, 1985; Fortune et al., 1991; Kramer, 1986) which have established that clinicians rarely plan for the termination process. For example, through interviews with twenty private practitioners, Kramer (1986) reported that clinicians typically did not discuss with clients either at the beginning or during the process of treatment, how termination should be initiated or handled. Moreover, Kramer found that clinicians believed the client should initiate termination, and generally waited for clients to initiate termination rather than initiate it themselves. Kramer concluded from this study that clinicians' lack of planning for termination adversely effected clients and recommended that clinicians take a more proactive approach and initiate discussion about termination when clients provide overt and covert cues indicating a readiness to terminate.

The belief that adolescents should initiate termination is further supported by others (Meeks, 1971; Miller, 1990; Novick, 1976; 1990; Weiss, 1991) who emphasize the critical role adolescents have in choosing when to terminate treatment. These authors believe that adolescents should experience control over the process of leaving psychotherapy by taking responsibility to initiate the topic of termination and set the date for ending. Since a normative developmental task for adolescents is to "reject" adults, Meeks (1971) believes adolescents should be active in initiating termination from psychotherapy. He further suggests that adolescents might experience the clinician's suggestion to terminate as a personal rejection and prematurely "bolt" from psychotherapy.

Although termination was initiated by adolescents in the majority of the cases, a statistically significant relationship (x2=6.89, df=1, p=.009) was found between social worker, parent, or placement initiated terminations and acknowledged terminations. As indicated in Table 2, the percentage of acknowledged terminations was two times higher when termination was not initiated by the adolescent, but instead, when it was initiated either by the clinician, when the parent (in addition to the adolescent) was also involved in the decision to terminate, or as a result of placement in a psychiatric or residential facility.

Table 2 **How Termination Was Initiated by Acknowledged Terminations (N=100)**

		Acknowledged Terminations	
Initiation of Termination	**Percentage Total Cases**	**Percentage**	**LS**
Adolescent	84	28.6	.009
Non-Adolescent	16	62.5	

Key:

*Non-Adolescent= Clinician (6), Parent (5), Placement (5)

Tables 3, 4, and 5 describe client behaviors, situational factors, and interruptions that occurred at the termination of mental health services. These data were obtained from a review and analysis of the final therapy sessions that were attended and documented in the client records. While this information does not explain why termination occurred, it provides an understanding of circumstances and events that coincided with and may have contributed to the termination of services.

Client Behaviors at the Time of Termination

In approximately three-quarters (76%) of the cases, adolescents either canceled or failed to attend scheduled appointments prior to the termination of services. When outreach and follow-up was conducted to determine why the appointment was not kept and/or to re-engage the adolescent in therapy, approximately one-third (34%) of the adolescents who rescheduled an appointment, again failed to attend this appointment, and subsequently failed to participate in services. In contrast to these adolescents who indicated an interest in returning for services, in one-quarter (25%) of the cases, adolescents expressed a desire to discontinue (stop) services, either in a therapy session or by telephone.

As indicated in table 3, acknowledged terminations occurred in over three-quarters of the cases (80.8%) in which the adolescent and/or parent expressed a desire to discontinue services. The relationship between an expressed desire by the adolescent and/or the parent to discontinue services and acknowledged terminations was statistically significant ($x2=34.24$, $df=1$, $p=.000$). In the next chapter, qualitative findings from the interviews with adolescents provide further insight and clarification about why some adolescents directly expressed their desire to discontinue services to the clinician while others simply left treatment without expressing a desire to do so.

Table 3 **Client Behaviors at the Time of Termination by Acknowledged Terminations (N=100)**

Client Behavior		Acknowledged Terminations	
	Percentage Total Cases	Percentage	LS
Client Failed/Canceled Sessions	76	26.3	.004
Client Rescheduled/No Follow up	34	26.5	.254
Adolescent Expressed Desire to Stop	25	80.0	.000
Parent Expressed Desire to Stop	9	88.9	.001**
Adolescent and/or Parent Desire to Stop	26	80.8	.000

Key:
**Fisher's Exact Test of Significance
Percentages do not equal 100 because there may be multiple client behaviors for each case.

Situational Factors at the Time of Termination

In fourteen percent of the cases, situational factors (see "combined situational factors" in table 4), including, scheduling problems, moving, going to college, and/or "aging-out" of the mental health program, coincided with the termination of services. In addition, in 8% of the cases, termination occurred because adolescents were referred to other services, including outpatient, inpatient, and residential treatment. When cases that terminated because of situational factors are combined with cases that were referred to other facilities, there was a statistically significant relationship (Fisher's Exact, p=.000, df=1) between cases terminated for situational and/or referral reasons and acknowledged

terminations. As indicated in table 4, termination was acknowledged in two-thirds (66.7%) of these cases.

Table 4 Situational Factors at the Time of Termination by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Situational Factors	**Percentage Total Cases**	**Percentage**	**LS**
Referred Out & Combined Situational Factors	21	66.7	.000
Combined Situational Factors	14	57.1	.068**
Referred Out	8	87.5	.002**
Schedule Problem	7	42.9	.687
Moving	4	75.0	.113
Going to College	4	75.0	.113
"Aged Out" of Program	3	33.3	1.00

Key:
Combined Situational Factors = Schedule Problem, Moving, Going to College, "Aged Out"
**Fisher's Exact Test of Significance
Percentages do not equal 100 since situational factors do not apply in all cases.

Interruptions at the Time of Termination

As indicated in table 5, in over one-third (37%) of the cases, the termination of treatment coincided with the end of the school year or summer vacation, a time when adolescents are typically less available for mental health services due to their involvement in other activities, such as, employment, summer school, and family vacations. Moreover, many adolescents associate attendance to psychotherapy appointments with the structure and time frame of the school year and consequently are less motivated for and interested in

therapy during the summer months. In addition, in 17 of the cases, termination coincided with the clinician's vacation or extended absence (personal, sick, or maternity leave).

Thus, when these interruptions are combined, in fifty-four cases, termination occurred when there was an interruption or break in the provision of services. These findings suggest that adolescents rely on routine and structure in order to comply with treatment and that when these routines and/or structures are interrupted, more than one-half (54%) of the adolescents in this study terminated their treatment.

Table 5 Interruptions at the Time of Termination by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Interruptions	**Percentage Total Cases**	**Percentage**	**LS**
End School and/or Summer Vacation	37	29.7	.489
Clinician Vacation/Absence	17	29.4	.661

The Unacknowledged Terminations (N=66)

Unacknowledged terminations are described most frequently in the literature as "dropouts" (Sweet & Noones, 1989; Littlepage et al., 1976). Other terms used to describe unacknowledged terminations include: "nonagreed," (Novick et al., 1981), "premature," (Blotcky & Friedman, 1984) and "early" (Ibid). Several studies of treatment dropout

(Dulcan, 1984; Garfield, 1978; Koss, 1979; Sweet & Noones, 1989; Viale-Val et al., 1984) have challenged the assumption that early "dropout" from treatment represents failure. For example, Sweet & Nones (1989) indicate that clients who drop out of therapy do not evaluate their success any differently than those who experience a termination process.

As discussed earlier, experts on adolescent development (Ekstein, 1983; Meeks, 1971; Mishne, 1986; Novick, 1976) describe unilateral termination as normative for adolescents. For example, Ekstein (1983) notes a common pattern for adolescents that he calls, "interruption" from treatment. According to Ekstein (1983),

> Interruptions are a kind of termination, not really agreed on by both the therapist and adolescent because they have reached a goal, but a termination by withdrawal on the part of the adolescent who often breaks up the treatment, does not want to come any longer, and fights against the therapist in the same way he rebels at home and school (p.130).

Similarly, Novick (1976) believes that all adolescents develop a "unilateral termination plan" at the beginning of treatment in order to master the normal developmental conflict that they experience regarding the state of dependence that is an inherent component of the psychotherapy process. Thus, he believes that most adolescents terminate treatment prematurely, either by leaving treatment without telling the therapist, provoking the therapist to end treatment, or surprising the therapist with a "unilateral termination plan". The rate of unacknowledged terminations (66%), found in this study is consistent with the range of treatment dropout reported in other studies with children and adolescents. For example, in a review of literature on premature termination with children and

adolescents. Novick et al (1981) indicate that dropout rates from outpatient mental health treatment with children and adolescents range from 28-71%. In a discussion of the findings from these studies, they conclude that:

> The incidence of non-agreed termination is extremely high; the problem is persistent over time, and high dropout rates are characteristic of all types of psychiatric and mental health services, including private practice among highly skilled practitioners (p. 835).

Three other studies found in the literature that pertained exclusively to adolescents reported slightly lower rates of dropout (unacknowledged terminations) than this study: Viale-Val et al. (1984) reported a dropout rate of 52% (25.5% terminated unilaterally after one-three sessions and 26.5% after four-sixteen sessions), Suzuki (1989) reported a dropout rate of 53% (the number of sessions before unilateral termination is unspecified), and Baruch, Gerber, & Fearon (1998) reported a rate of 59.7% (30.6% terminated unilaterally after one-five sessions and 29.1% after six to twenty-one sessions). The size and demographic characteristics of the samples in these studies were similar to the sample utilized in this study except that the study by Baruch et al. (1998), conducted in London, was comprised of primarily impoverished, white adolescents (80%). A notable difference between the samples in these two studies and this study was that in the other studies all the cases in the sample were not terminated cases (some of the cases that were studied were "remainers," i.e. still engaged in treatment).

THE ACKNOWLEDGED TERMINATIONS (N=34)

How Termination Was Acknowledged

In this study, thirty-four percent of the terminations were acknowledged. These acknowledged terminations occurred in several ways, including, in person, in the context of a therapy session(s), by telephone and/or by letter, or both in a therapy session and by telephone. As indicated in table 6, among the one hundred cases in the sample, termination was acknowledged in one or more therapy sessions in 19% of the cases, or 55.9%, of the acknowledged cases. In the remaining 15% of the entire sample, or 44.1% of the acknowledged cases, termination was acknowledged only by telephone. In nine of the cases, or 26.4% of the cases with acknowledged terminations, termination was acknowledged both in a therapy session and by telephone. In the majority of these cases, the telephone conversations took place between clinicians and parents, discussing the adolescent's plan to terminate services.

Since clinical training in Social Work typically prepares clinicians to view termination as a distinct phase in the treatment process, it is striking that only 55.9% percent of the cases with acknowledged terminations occurred in the context of a therapy session. It is of equal interest that in almost one-half (44.1%) of the cases with acknowledged terminations, the termination occurred only by telephone instead of in person. Both of these findings suggest that there are great discrepancies between long-held theoretical beliefs about how termination should ideally occur (Levinson, 1977) and what actually occurs in clinical practice. Moreover, these patterns of termination provide support for

the reconceptualization and revision of existing theory about termination with adolescents.

Table 6 How Termination was Acknowledged (N=34)

How Termination Was Acknowledged	Percentage Total Cases	Percentage Acknowledged Cases
In Session	19	55.9
By telephone only	15	44.1

How Acknowledged Terminations Were Initiated

As indicated in table 7, among the thirty-four cases of acknowledged terminations, adolescents initiated termination in eighteen cases, or 52.9% of the acknowledged cases. In the remaining sixteen cases, termination was initiated by the clinician, the adolescent and the parent together, and as a result of placement in a psychiatric hospital or residential treatment facility. The reasons that clinicians initiated termination included the following: the adolescent and/or the parent did not agree with the treatment recommendation(s) made by the clinician, psychiatrist and/or administrator (2 cases); the adolescent had inconsistent attendance and/or tardiness to sessions (2 cases); a social work intern completed her training and the adolescent declined the offer to transfer to another worker for continued treatment (1 case); and the adolescent "aged out" of the program (1 case).

Table 7 **How Terminations were Initiated in Acknowledged Cases (N=34)**

How Termination Was Initiated	N	Percentage Acknowledged Cases
Adolescent	18	52.9
Clinician	6	17.7
Adolescent & Parent	5	14.7
Placement	5	14.7

Agreement Regarding Termination

In the thirty-four cases with acknowledged terminations, the investigator assessed whether the client and clinician agreed or disagreed about the decision to terminate treatment. As displayed in table 8, in nineteen of the cases, or 55.8% of the acknowledged cases, the client and the clinician agreed on the plan to terminate treatment. In the remaining fifteen of the cases, almost one-half (44.2%) of the acknowledged cases, the client and the clinician disagreed about the plan to terminate treatment. In eleven of these cases, or 32.4% of the acknowledged cases, the clinician objected to the adolescent's plan to terminate, while in four cases (11.8%), the adolescent disagreed with the clinician's plan to terminate.

It is important to note that in approximately one-third (32.4%) of the cases with acknowledged terminations, clinicians terminated treatment even though they did not agree with the adolescent's decision to terminate. This finding is supported by several authors (Beiser, 1993; Blotcky & Friedman, 1984; Miller, 1990) who recommend that

even when clinicians do not agree with an adolescent's decision to terminate treatment, they should respect the adolescent's wish to terminate and, in some cases, advise the adolescent and parent about the need for and availability of future mental health services. As indicated by Mishne (1986), the clinician's view that the adolescent is not ready to terminate may reflect tendencies to both underestimate the adolescent's coping capacities and to be overprotective in their desire to help the adolescent deal with unfinished developmental issues (Novick, 1990). Moreover, Meeks (1971) points out that this tendency for the clinician to "hold on to" adolescents in treatment may contribute to the reason that "many adolescents seem slightly guilty and apologetic about the appropriate wish to terminate and handle their own affairs" (p.183) by leaving treatment without having a discussion with the clinician about their decision to do so.

This pattern was also evident in the pilot study of termination in which staff viewed adolescents as seeking problem-focused, shorter-term services, in contrast to their own preference for and belief in insight-oriented, longer-term treatment (Mirabito, 1993).

Table 8 Agreement about Termination in Acknowledged Cases (N=34)

Agreement About Termination	N	Percentage Acknowledged Cases
Agreement Between Adolescent & Clinician	19	55.8
Disagreement/Adolescent Initiates and Clinician Disagrees	11	32.4
Disagreement/Clinician Initiates and Adolescent Disagrees	4	11.8

Terminations Acknowledged in Session (N=19)

Among the thirty-four cases with acknowledged terminations, termination was acknowledged in one or more therapy sessions in nineteen cases, or 55.9% of the acknowledged cases (Table 6). As displayed in table 9, the number of sessions in which termination was acknowledged ranged from one to five sessions. In nine cases, or almost one-half (47.4%) of the cases acknowledged in session, termination was acknowledged in only one session. In the remaining ten cases, or 52.6% of the cases acknowledged in session, termination was acknowledged in two to five sessions. There was a statistically significant relationship (tau-c=.196, p=.009) between the number of sessions devoted to termination and the total number of treatment sessions attended.

In all but one of the cases in which termination was acknowledged in only one session (eight of the nine cases), termination was first acknowledged in the last session. (In the one exception to these cases, the adolescent raised termination before the last session because he was told that he was going to be placed in a residential facility. Subsequently, he was abruptly placed and did not have an opportunity to return to treatment to terminate). In the remaining eleven of the cases, or 57.9% of the cases acknowledged in session, the period of time between when termination was first raised and the final session, ranged from two to twelve sessions.

These findings indicate that in clinical practice with adolescents, if termination is acknowledged, it is frequently a brief process of acknowledgment. The findings are

consistent with those obtained from the pilot study (Mirabito, 1993) that reported clinicians' perceptions that termination with adolescents was often brief or even occurred over the telephone (Mirabito, 1993). Moreover, at least in this clinical context, the findings challenge the traditional theoretical model of termination as a distinct phase of the treatment process (Levinson, 1977).

Table 9 Terminations Acknowledged in Session (N=19)

Number of Sessions Acknowledged	**Percentage Total Cases**	**Percentage Acknowledged Cases**
One	9	47.4
Two to Five	10	52.6
When First Acknowledged	**Percentage Total Cases**	**Percentage Acknowledged Cases**
Last Session	8	42.1
Before Last Session*	11	57.9

***Two-twelve sessions**

II. PROFILE OF THE ADOLESCENTS

Demographic Variables

The relationships between demographic variables (gender, ethnicity, age, grade, family composition, parental employment, and residence) and type of termination (acknowledged or unacknowledged) were explored in order to establish whether these demographic factors impacted on how adolescents terminated from treatment.

As indicated in table 10, there were few differences in the percentages of acknowledged terminations among males and females and adolescents who lived in families with different constellations and parental employment patterns. Baruch et al. (1998), who studied an older adolescent population with a mean age of 18, found that younger adolescents (defined as 12-21 years old) were more likely to dropout of treatment than older (defined as 21-24 years old) adolescents. Contrary to the prediction that older adolescents would have a higher percentage of acknowledged terminations because they are more mature and more likely to be motivated for treatment, in this study, younger adolescents had a higher percentage of acknowledged terminations than older adolescents.

Table 10 illustrates that the percentages of acknowledged terminations were higher as the educational level of the adolescents increased. While there were fewer adolescents in college than in junior high or high school, adolescents who were in college had considerably higher percentages of acknowledged terminations than those who were in

junior high school. This finding is likely to be a result of the fact that when college-age adolescents "age-out" of the mental health program at age 22, they must terminate from services. This mandate to terminate services results in a higher likelihood that either the adolescent or the clinician will raise the issue of termination. There was a lower percentage of acknowledged terminations among adolescents who lived closest to the Adolescent Center as compared with those who lived further away from the Adolescent Center. While the reason(s) for this difference need further exploration, this finding suggests that, in this study, when adolescents had to travel a greater distance to obtain mental health services, an acknowledgment of and/or a discussion about termination occurred more frequently.

The most noteworthy differences in the percentages of acknowledged terminations occurred among the various ethnic groups. Although the majority of the adolescents in the sample were Hispanic, African-American, and Biracial, the percentage of acknowledged terminations was considerably higher for Caucasian and Asian adolescents than for Hispanic, African-American, and Biracial adolescents. In fact, when the Caucasian and Asian adolescents were combined, there was a statistically significant relationship ($x2=5.306$, $df=1$, $p=.021$) between Caucasian and Asian adolescents and acknowledged terminations.

The striking differences in the percentages of acknowledged terminations among ethnic groups suggests that different cultural beliefs and mores influence the ways in which

various ethnic groups utilize and terminate from mental health services. These findings indicate a need for further exploration about the reasons that various ethnic groups are more likely to have acknowledged terminations. For example, it would be important to find out whether adolescents from certain ethnic groups are more or less likely to discuss their intention to terminate with the clinician. It is possible that adolescents from different ethnic groups may be more or less likely to initiate a discussion of termination as a result of their cultural customs regarding the ways in which they communicate with adults in authority roles (e.g. clinician). Another cultural difference that may impact on the likelihood of adolescents initiating and/or discussing termination is the level of comfort they experience with therapy and the therapeutic relationship. Similarly, the ways in which clinicians handle termination may be affected by their own and the adolescent's ethnicity. Specifically, the likelihood that clinicians will engage in a discussion of termination may be affected by their attitudes and values toward the ways adolescents from different ethnic groups utilize treatment.

Almost two-thirds (seven) of the eleven clinicians who provided mental health services in this study were non-white. Of the non-white clinicians, four were Hispanic (all were bilingual, three were "white" Hispanic and one was "black" Hispanic), two were African-American, and one was Asian-American. The remaining four clinicians were Caucasian. Since the match between clinician and client was not identified in this study, it was not possible to determine whether there was a relationship between the clinician's and client's ethnicity and whether or not termination was acknowledged. Since there

were notable differences in the percentages of acknowledged terminations among various ethnic groups in this study, it would be useful to further explore the factors that contribute to these differences in future research endeavors.

Table 10 Demographic Variables by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
DEMOGRAPHIC VARIABLE	**Percentage Total Cases**	**Percentage**	**LS**
GENDER			
Male	37	32.4	.80
Female	63	34.9	
ETHNICITY			
Hispanic	39	25.6	.18
African/Caribbean-American	29	31.0	
Bi-Racial	10	30.0	
Asian	9	44.4	
Caucasian	13	61.5	
AGE (AT TERMINATION)			
Younger (12-16)	65	36.9	.40
Older (17-22)	35	28.6	
GRADE			
6-9	38	26.3	.39
10-GED	51	37.3	
College	11	45.5	
FAMILY COMPOSITION			
Single Parent	44	34.1	.99
Two Parents	41	34.1	
Relative/Friends	15	33.3	
PARENTAL EMPLOYMENT			
Parent Employed	76	34.2	.93
Parent Not Employed	24	33.3	
RESIDENCE			
Closest to AC	81	32.1	.40
Further from AC	19	42.1	

REFERRAL INFORMATION

Referral Source

As displayed in table 11, the majority of referrals for mental health services came from schools, 39%, and parents, 31%, while the remainder came from community facilities (agencies, hospitals, courts), the Adolescent Center and the Medical Center, adolescents (self-referrals), and their friends.

The high percentage of referrals from schools reflects the ongoing collaboration that the Adolescent Center has historically maintained with numerous schools throughout the city. It is interesting that a relatively small percentage of referrals came from health care providers within the Adolescent Center (7%) and the Medical Center (2%). It is likely that few referrals came from the primary care medical clinic at the Adolescent Center because two social workers provide crisis intervention, assessment, and some longer-term therapy to adolescents who use the primary care medical clinics, resulting in fewer referrals for mental health services to the mental health program. The lower rate of acknowledged terminations from referrals within the Adolescent Center is not surprising, and may reflect the fact that adolescents referred for mental health services from medical providers at the clinic frequently accept the referral primarily to comply with and/or please the medical provider even though they themselves do not identify or recognize a problem(s) for treatment. In addition, the rate of acknowledged terminations may be low because when adolescents who are medical patients at the Adolescent Center discontinue mental health services, they may not recognize a need to "formally" terminate from

mental health services since they continue to obtain medical services at the clinic. These findings suggest that further collaboration between the adolescent and his/her medical and mental health providers may increase the adolescent's acceptance of a mental health referral as a method of handling problem(s) which may result in more effective utilization of mental health services.

As an independent and self-contained multi-service clinic located in the community, the Adolescent Center functions autonomously from the larger Medical Center. Consequently, the very small number of referrals from the Medical Center is not surprising since the focus of the Adolescent Center's collaborative and linkage efforts are primarily with community-based facilities (schools and community agencies) rather than with professionals from within the Medical Center. However, the low number of referrals from within the hospital and Medical Center suggests that the adolescent-specific expertise of the mental health staff at the Adolescent Center may be underutilized within the larger hospital and Medical Center.

As indicated in table 11, adolescents who were self-referred or referred by friends, (50%) and those who were referred from schools (41%) had the highest percentages of acknowledged terminations, while adolescents who were referred by their parents had the lowest percentage of acknowledged terminations (22.6%). There are several clinical and organizational factors that may contribute to the differences in the rate of acknowledged terminations among these referral sources. The higher rate of acknowledged terminations

from schools, (41%), may occur because of collaborative relationships between clinic and school staff who may both actively track and monitor compliance and progress with treatment. As a result of these collaborative relationships, there may be more opportunities to bring closure, when indicated, to cases referred from schools, resulting in more acknowledged terminations.

While self-referrals (8%) and referrals from friends (2%) comprised only 10% of the referrals for mental health services, these referral sources had the highest percentage of acknowledged terminations. These adolescents may be more self-directed about their need and desire for mental health services than other adolescents. In addition, they may also be more informed about how to utilize and terminate from mental health services. In future research efforts, it would be useful to further explore whether and why self-referred adolescents have a higher rate of acknowledged terminations.

Table 11 Referral Source by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Referral Source	**Percentage Total Cases**	**Percentage**	**LS**
School	39	41.0	.26
Parent	31	22.6	
Community Facilities	11	27.3	
AC and Medical Center	9	33.3	
Self/Friends	10	50.0	

Key
Community Facilities: Agencies (4); Hospitals (4); Courts and Probation (3)
AC--Adolescent Center (7); Hospital and Medical Center (2)
Self (8) Friends (2)

Reaction to the Referral

Although the adolescents typically came for mental health services at the request of a concerned adult rather than as a result of their own initiative and frequently they attributed the cause of the presenting problem to someone else (e.g. parent or teacher), the majority of adolescents in this study, (87%), acknowledged the presence of a problem at the time of intake. The small number of adolescents who did not acknowledge a problem at the time of intake (12%), included those who did not know that they were coming for psychotherapy (e.g. were brought for mental health services by a parent who told them they were going to a medical appointment), were uncertain about what the problem was, and/or denied the presence of a problem.

It is both interesting and surprising that the percentage of acknowledged terminations was higher among adolescents who did not acknowledge a problem (41.7%) at the time of intake than among those who did acknowledge a problem (33.3%). Although one might expect adolescents who do not acknowledge a problem to be more likely to simply drop out of therapy, in this study, when adolescents did not acknowledge a problem or identify a need for mental health services, they acknowledged and/or discussed a plan to terminate services more frequently than adolescents who did acknowledge a problem. Since the number of adolescents who did not acknowledge a problem at the time of intake is small

(12), the relationship between non-acknowledgment of a problem at intake and whether termination is acknowledged needs to be further studied with a larger sample in order to explore the strength of this relationship.

Table 12 Reaction to the Referral by Acknowledged Terminations (N=99)

		Acknowledged Terminations	
Reaction to Referral	**Percentage Total Cases**	**Percentage**	**LS**
Problem(s) Acknowledged	87.8	33.3	.74
Problem(s) Not Acknowledged	12.2	41.7	

Presenting Problem

The presenting problem was obtained from the clinician's assessment of the adolescent's problem(s) at the time of admission for mental health services recorded on the "admission form" for the mental health program. On this form, clinicians are able to identify from one to three problems if substance abuse is present, and one or two problems if substance abuse is not present.

As indicated in table 13, in approximately three-quarters of the cases (76%), clinicians identified two or three problems at the time of admission. This finding is consistent with the "problem behavior theory" developed by Jessor (1993). Jessor uses this theory to describe the "covariance" or "co-occurrence" of adolescent problems, indicating that

most adolescents possess "clusters" or "packages" (Jessor, 1993) of problems rather than one single problem.

The lowest rate of acknowledged terminations (29.2%) were in cases in which clinicians noted only one presenting problem at the time of admission for mental health services (29.2%). Theoretically, these adolescents would be considered to be the least at risk because the clinician recorded only one presenting problem at the time of admission. It is also possible that they discontinued treatment without a termination process more frequently than those adolescents with two or three problems because they did not view themselves as in need of mental health services.

Table 14 displays the presenting problems for the one hundred cases. As indicated in this table, the most frequent presenting problems were family problems (68%), depression and anxiety (43%), and school problems (37%). School problems, particularly academic problems, which comprised the majority of the school problems, had the highest percentage (48%) of acknowledged terminations. Although it was not statistically significant, there was a noteworthy relationship between academic problems and acknowledged terminations ($x2= 2.911$, $df=1$, $p=.088$).

As discussed earlier, several factors may contribute to the high percentage of acknowledged terminations among adolescents with school, specifically, academic problems. First, in cases referred for academic problems, termination may be

acknowledged more frequently because progress (or lack of progress) may be easily measured and therefore closure may be more likely in these cases. Alternatively, since adolescents who are referred by school personnel may not view themselves as in need of mental health services, they may express the desire to terminate, resulting in a high percentage of acknowledged terminations. Finally, as discussed earlier, the higher number of acknowledged terminations among adolescents with school problems may suggest that collaboration between clinicians and school staff provides opportunities for the closure of services to occur, resulting in a higher number of acknowledged terminations. In addition, in these cases, termination may occur more frequently because treatment is structured around the "natural" ending of the school year.

While adolescents with school problems had the highest percentages of acknowledged terminations, adolescents with conduct problems had the lowest percentage (10%) of acknowledged terminations. Despite the " mandate" to obtain mental health services (by courts and/or probation) that is common among these cases, a mandate may not be effective in helping these adolescents obtain services since they dropped out of services more frequently than adolescents with other presenting problems. This finding is consistent with other studies (Baruch et al., 1998; Kazdin, 1993) that have found adolescents who present with conduct problems are likely to have unacknowledged terminations.

Table 13 **Number of Presenting Problems by Acknowledged Terminations (N=100)**

		Acknowledged Terminations
Problems at Admission	**Percentage Total Cases**	**Percentage**
One	24	29.2
Two	70	35.7
Three	6	33.3

Table 14 **Presenting Problem by Acknowledged Terminations (N=100)**

		Acknowledged Terminations	
Presenting Problem	**Percentage Total Cases**	**Percentage**	**LS**
Family Problems	68	36.8	.395
Depression/Anxiety	43	32.6	.791
School Problems	37	40.5	.290
Academic Problems	25	48.0	.088
Other Problems	16	31.3	.799
Conduct Problems	10	10.0	.158
Substance Abuse	8	25.0	.713

Key

The total percentage of presenting problems does not equal 100% because there can be multiple problems for each case.

Definition of Presenting Problems:

Depression/Anxiety: Depression (38); Anxiety (5)
School Problems: Academic Problems (25);Truancy (7); Maladaptive Behavior (7)
Other Problems: Sexual Abuse/Rape (7); Eating Disorder (4); Psychiatric (3); Abortion (1); Abusive Relationship (1)
Conduct Problems: Community Conduct Problems, including court and probation involvement

Diagnosis

All cases in the mental health program are assigned diagnoses according to classification in the Diagnostic and Statistical Manual of Mental Disorders, [DSMIV] (American Psychiatric Association, 1994). Axis one diagnoses are assigned based on symptoms of the primary clinical disorder that is the focus of clinical attention in treatment. Axis two diagnoses include disorders that are longstanding behavior patterns which are typically recognized by others as problematic, however may not be recognized as such by the client. Both axis one and two diagnoses are assigned when specific diagnostic criteria are present (definitive diagnosis) or a "deferred" diagnosis is given when there is the possibility that criteria may be fulfilled upon further assessment in the future.

Axis one and two diagnoses were obtained from the clinician's assessment of diagnosis at the completion of the psychosocial assessment. As with the presenting problems, more than one diagnosis was reported on axis one, consequently, the axis one diagnoses displayed in table 15 represent the multiple diagnoses for the one hundred cases in the sample. The axis two diagnoses include both definitive and "deferred" diagnoses. "Rule-out" diagnoses on axis one and two were not included in the data analysis.

As indicated in table 15, the most frequent diagnosis reported was depression (43%). There was a noteworthy relationship, approaching statistical significance, between adolescents diagnosed with dysthymia and major depression and acknowledged

terminations (x2=2.891, df=1, p=.062). Adolescents with these diagnoses were among those with the highest percentages of acknowledged terminations (44.2%).

In contrast, adolescents who had diagnoses of parent-child and family problems had the lowest rate of acknowledged terminations (19%). This finding is consistent with the finding reported earlier which indicated that the lowest percentage of acknowledged terminations were among adolescents referred by parents/family members. It is important to further explore and understand why cases with parent-child and family diagnoses and those referred by parents/family members have lower acknowledged terminations in order to obtain a better understanding of how to work effectively with adolescents who have family problems and those who are referred for mental health services by their parents.

It is somewhat surprising that adolescents with conduct disorders and oppositional defiant disorders had the highest rates of acknowledged terminations (47.1%) since they are typically considered difficult to treat because they generally do not believe that they have a problem. Similarly, it is interesting and surprising that adolescents with axis two (definitive and deferred) diagnoses had higher percentages (38.1%) of acknowledged terminations than adolescents who did not have an axis two diagnosis (31%) since they are typically considered to be more difficult to treat because they have serious, long-standing problems that are imbedded in their character structures.

As indicated earlier, this study has not determined whether the acknowledged terminations in these cases (conduct problems and axis two diagnoses) are indicative of completed and successful treatment or of treatment that was discontinued prematurely because the adolescent did not want mental health services. Qualitative data from interviews with adolescents which will be presented in the next chapter will provide further clarification about the reasons for acknowledged terminations. In addition, these findings point to the need for further exploration of the relationships between various diagnoses and whether termination is acknowledged or unacknowledged.

Table 15 Diagnosis by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Diagnosis	**Percentage Total Cases***	**Percentage**	**LS**
Axis One			
Depression	43	44.2	.062
Other Diagnoses	27	29.6	.575
Parent Child/Family	21	19.0	.104
Conduct	17	47.1	.212
Adjustment Disorder	16	31.3	.562
Axis Two			
Yes & Deferred*	42	38.1	.462
No	58	31.0	

Key:
*Axis One diagnoses do not equal 100% because there may be more than one diagnosis for each case.
Definition of Diagnoses:
Depression: Dysthymia (41); Major Depression (2)
Other Diagnoses: PTSD (3); Anxiety Disorders (6); Substance Abuse (8); Eating, Learning, Psychotic, Relational Disorders (6); V Codes (4)
Parent Child/Family: Parent/Child Conflict (16); Bereavement (4); Physical Abuse of Child (1)
Conduct: Conduct Disorder (4), Oppositional Defiant Disorder (13)

***Axis Two Diagnoses:** "Yes" (10) ; "Deferred" (32)

III. ASSESSMENT INFORMATION

Parental Knowledge of and Involvement in Treatment

As indicated in Table 16, in the vast majority of cases (95%), adolescents received mental health services with the knowledge of a parent(s)/guardian and they requested confidential services, that is, without parental knowledge/consent, in very few cases. Although there was a higher percentage of acknowledged terminations in the cases that were not confidential (34.7%, non-confidential; 20%, confidential) since there were so few confidential cases, meaningful comparisons between confidential and non-confidential cases cannot be made.

Although a parent(s) and/or guardian participated in at least one of the initial intake/evaluation sessions in over three quarters of the cases (78%), there was a slightly higher percentage of acknowledged terminations (36.4%) in those cases in which a parent/guardian was not involved in the assessment/evaluation process. Beiser (1993) believes that adolescents who seek help without parents, and those who are seen with the

permission of the parent but without parental involvement in the evaluation process, frequently terminate their treatment prematurely. Similarly, Miller (1990) and Blotcky & Friedman (1984) both indicate that the absence of parental involvement in the evaluation process can lead to unacknowledged terminations. Since there was only a small difference in the percentages of addressed terminations in cases with (33.3%) or without (36.4%) parental involvement in the evaluation stage, these theoretical notions were not supported in this study.

Table 16 Parental Knowledge of and Involvement in Treatment by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Parental Knowledge	**Percentage Total Cases**	**Percentage**	**LS**
Not Confidential	95	34.7	.659
Confidential	5	20.0	
Parental Involvement			
Parent Not Involved	22	36.4	.791
Parent Involved	78	33.3	

Past Mental Health Services

Forty-six percent of the adolescents received either outpatient, inpatient, or school-based mental health or counseling services prior to their admission for mental heath services at the Adolescent Center. As indicated in Table 17, adolescents who received previous

mental health services had a higher percentage (39.1%) of acknowledged terminations than those who did not receive mental health services (29.6%) prior to their treatment at the Adolescent Center. This finding suggests the possibility that adolescents who have had prior experience with psychotherapy/counseling may be more prepared and knowledgeable about what to expect from the experience of treatment as well as the process of termination from treatment. Thus, a prior successful experience with therapy may allow them to more effectively utilize current mental health services. Alternatively, if an adolescent experienced a prior psychotherapy/counseling experience as negative or not helpful, he/she may anticipate that the current experience will again not be helpful, and prematurely terminate from treatment.

While fewer adolescents had received inpatient and school-based services than those who had received outpatient services prior to coming for mental health services at the Adolescent Center, those who received prior inpatient and school-based services had higher percentages of acknowledged terminations than those who received outpatient mental health services.

Table 17 **Past Mental Health Services by Acknowledged Terminations (N=100)**

History of Previous Services	Percentage Total Cases	Acknowledged Terminations Percentage	LS
Previous Services	46	39.1	.318
No Previous Services	54	29.6	
Type of Previous Services			
School	16	50.0	.140
Outpatient	33	39.4	.424
Inpatient	12	50.0	.329

Motivation for Treatment

Motivation for treatment was obtained from the clinician's assessment, at the completion of the initial intake/evaluation process (1-3 sessions), of the adolescent's motivation and/or willingness to engage in treatment. Despite the common belief that adolescents frequently come for mental health services under duress and are not motivated for such services, in the majority (88.1%) of the cases, clinicians assessed adolescents to be either motivated for and/or interested in treatment (53.6%), or at least, "willing to try it" (34.5%). In contrast to the high percentage of adolescents who expressed some motivation for treatment, in only 11.9% of the cases, adolescents were not motivated for treatment.

Although few adolescents were unmotivated for treatment, it is both interesting and surprising that the percentage of acknowledged terminations was more than two times higher with unmotivated adolescents than with adolescents who were assessed by the

clinician as either motivated or "willing to try" treatment. This resulted in a statistically significant relationship ($x2=4.052$, $df=2$, $p=.044$) between adolescents who were not motivated for treatment and acknowledged terminations. As discussed earlier in relation to the adolescent's acknowledgment of a problem, this finding indicates that, in this study, acknowledged terminations occurred more frequently when adolescents were clear and vocal about their lack of motivation for treatment and their desire to discontinue mental health services (this finding is consistent with qualitative data and will be further discussed in Chapter V). Moreover, these findings indicate that, in this clinical context, adolescents who did not acknowledge a problem and those who directly expressed a lack of motivation for treatment, had higher percentages of acknowledged terminations than those who were able to acknowledge a problem and appeared to be motivated for treatment. In addition, it is possible that acknowledged terminations occur more frequently when adolescents do not acknowledge a problem and are not motivated for treatment because clinicians may be more likely to address and/or initiate termination as a result of the potential challenges, difficulties, and lack of gratification that are frequently associated with providing psychotherapy to unmotivated adolescents. As Mishne (1986) indicates, a clinician's dislike of the adolescent or an adolescent's angry rejection of treatment (Miller, 1990) can cause the clinician to inadvertently encourage a premature termination.

Table 18 Motivation for Treatment by Acknowledged Terminations (N=84)

Motivation	Percentage Total Cases	Acknowledged Terminations Percentage	LS
Motivated	88.1	28.4	.044
Not Motivated	11.9	60.0	

Key

Motivated=Motivated/Interested (45 cases, 53.6%) and "Willing to Try Treatment" (29 cases, 34.5%)

IV. PSYCHOSOCIAL RISK FACTORS

In order to explore the impact of psychosocial risk factors on the way termination occurred, three measures of psychosocial risk were obtained from the client records. These included, the absence and/or loss of a parent(s) and/or extended family member(s), adolescent behavioral risk factors, and parental/familial risk factors. Adolescent behavioral risk factors were defined as risk behaviors that adolescents engaged in while parental/familial risk factors were defined as risks that resulted from parental behaviors.

History of Absence/Loss of Parents and Significant Others

Historically, loss, mourning, and grief have been central and recurrent themes used throughout the literature to describe the termination process (Levinson, 1977; Shapiro, 1980; DeWald, 1964; Ward, 1984; Ortmeyer, 1978; Fox et al, 1969). As part of the "termination as loss" framework described by these authors, a commonly held belief, both

in the literature and in practice, has been that during the termination process, clients will re-experience feelings related to past losses of significant persons in their lives. In order to explore the relationship between past losses and the way in which termination occurred, specifically whether termination was acknowledged or unacknowledged, information pertaining to the absence and/or loss of parents and significant others was obtained.

As indicated in table 19, almost three-quarters (72%), of the adolescents served had experienced the absence or loss of at least one parent. The most common reasons for the absence/loss were either abandonment, separation, or divorce, resulting from parental conflict, drug and alcohol addiction/abuse, incarceration, psychiatric hospitalization, and/or relocation. Parental loss resulted from death or other circumstances in a relatively small percentage (14%) of cases. In addition to the absence or loss of a parent(s), approximately two-thirds (66%) of the adolescents had experienced one to five losses of other significant people in their lives, including grandparents, aunts, uncles, and/or cousins, and in a few cases, friends.

The percentage of acknowledged terminations was somewhat higher for adolescents who had not experienced the absence/loss of a parent (39.3%) than for those who experienced parental absence/loss (31.9%). Adolescents who experienced losses in addition to their parents (33.3%) and those who had two or more losses (31.4%) both had only slightly lower percentages of acknowledged terminations than adolescents who did not have additional losses (35.3%) or who had one additional loss (35.5%).

These findings indicate that loss was a prominent theme in the lives of the adolescents in this study as evidenced by the high rate of absence/loss of parents and significant others in their lives. Although loss and mourning are central and recurrent themes that have been used to describe the termination process throughout the literature (Levinson, 1977; Shapiro, 1980; DeWald, 1964; Ward, 1984; Ortmeyer, 1978; Fox et al, 1969), in this study, the presence of loss did not appear to significantly influence whether termination was acknowledged or unacknowledged.

Table 19 **History of Loss by Acknowledged Terminations (N=100)**

		Acknowledged Terminations	
Parent Absence/loss	**Percentage Total Cases**	**Percentage**	**LS**
Yes	72	31.9	.487
No	28	39.3	
Additional Losses			
Yes	66	33.3	.845
No	34	35.3	
Number of Other Losses			
One	31	35.5	.727
Two to Five	35	31.4	

Adolescent Behavioral Risk Factors

Since experimentation and risk-taking are behaviors that are expected in the course of normal adolescent development (Dryfoos, 1990; Mishne, 1986; Steiner & Yalom, 1996), it is not surprising that over three-quarters of the adolescents in this study (77%), had engaged in one or more risk behaviors (Table 22). As indicated in table 20, the most prevalent risk behaviors included, school problems [(61%)--academic problems, truancy, and/or school dropout], sexual activity (38%), and substance (alcohol and/or drug) use/abuse (32%). The high rate of school problems is consistent with the finding that the highest number of referrals for mental health services came from schools. It is possible that the rates of sexual activity (38%) alcohol, (21%) and drug use (29%) are under reported, particularly in short-term cases, since adolescents may withhold information about their involvement in these risk behaviors in the beginning of treatment and discuss their involvement in these activities at a later point in the treatment process. The percentages of acknowledged terminations among adolescents with these risk behaviors were fairly similar.

Table 20 Adolescent Behavioral Risk Factors by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Behavioral Risk Factor	**Percentage* Total Cases**	**Percentage**	**LS**
Sexually Active	38	34.2	.972
Alcohol Use	21	33.3	.942
Drug Use	29	37.9	.596
School Risk*	61	37.7	.328
Truant	23	43.5	.274
Dropout	5	0	.163
Substance Risk*	32	34.4	.956

Key:
School Risk: Academic Problems; Truancy; Dropout
Substance Risk: Drug and/or Alcohol Use
*Total equals more than 100% because each case may have multiple risk factors.

Parental/Familial Risk Factors

As indicated in table 21, parental alcohol and/or drug abuse was the most prevalent parental/familial risk factor (36%). Given the strong links that have been established between the presence of current and/or past parental substance abuse and the potential for adolescents' use/abuse of alcohol/drugs (Steiner & Yalom, 1996; Mishne, 1986), it is striking that the rates of parental (36%) and adolescent (32%) use/abuse of alcohol and drugs are quite similar. Approximately one-quarter of the adolescents (26%) had a history of physical and/or sexual abuse perpetrated by either a parent(s), extended family member, or a person outside of the family. Adolescents who are children of substance abusing parents (COSA, 53.8%) and those who have a history of sexual abuse (46.7%) had the highest rates of acknowledged terminations.

Table 21 Parental/Familial Risk Factors by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Parental/Familial Risk	**Percentage Total Cases***	**Percentage**	**LS**
Abuse/Neglect	11	27.3	.745
Sexual Abuse	15	46.7	.261
COA (Child of Alcoholic)	28	32.1	.807
COSA (Child of Substance Abuser)	13	53.8	.124
Combined Parental Substance Risk	36	36.1	.738
Combined Abuse Risk	24	33.3	.937

* Total equals more than 100% because each case may have multiple risk factors.

Total Risk Factors

As described earlier, since there is considerable overlap between risk/problem behaviors (Dryfoos, 1990; Jessor, 1992; Kazdin, 1993), adolescents who are at risk typically exhibit a number of risk (problem) behaviors rather than just one. Dryfoos (1990) believes that adolescents who are involved in one of four risk behaviors, including early sexual involvement, school failure, delinquency, and substance abuse are likely to be involved in one or more of the other risk behaviors.

When the findings pertaining to adolescent risks are analyzed in the context of Dryfoos's "hierarchy of risks" (displayed in table 22), there was only a small difference in the percentage of acknowledged terminations between adolescents with no risks (30.4%) and those with one or more risks (35.1%).

Table 22 Total Risk Factors by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Total Adolescent Behavioral Risk Factors	**Percentage Total Cases**	**Percentage**	**LS**
No Risks	23	30.4	.681
1 or More Risks	77	35.1	

V. UTILIZATION OF MENTAL HEALTH SERVICES

Patterns of Admission and Termination

As indicated in table 23, the highest number of cases (46%) were admitted to the mental health program between the months of January through April while the highest number of cases (51%) were terminated from the program between the months of May through August. These patterns of admission and termination coincide with time periods that are known to be the busiest (January-April) and slowest (May-August) periods of operation for the mental health program. Specifically, the first third of the year, January through April, is when the highest number of school referrals are made because school problems are generally identified by this time in the school year. Conversely, the period of May through August coinciding with the end of the school year and the summer months, is typically the slowest time of the year for mental health services. During this period, adolescents are typically less available and motivated for therapy since they associate it with the structure and time frame of the school year and they are involved in other activities, such as, employment, summer school, and family vacations. It is possible that these are factors that contribute to the lower percentages of acknowledged terminations among cases that were both admitted (25.9%) and terminated (31.4%) during the Spring and Summer months, May through August.

Table 23 **Patterns of Admission and Termination by Acknowledged Terminations (N=100)**

		Acknowledged Terminations	
Month/Admission	**Percentage Total Cases**	**Percentage**	**LS**
January-April	46	32.6	.344
May-August	27	25.9	
September-December	27	44.4	

		Acknowledged Terminations	
Month/Termination	**Percentage Total Cases**	**Percentage**	**LS**
January-April	31	38.7	.792
May-August	51	31.4	
September-December	18	33.3	

Readmissions

As described earlier, according to the guidelines of the mental health program, cases must be "administratively" closed (terminated) when there has not been a face-to-face counseling session with the adolescent and/or family member for one month. If the adolescent and/or parent requests services after the case has been "administratively" closed, the case can be reassessed for "readmission" to the mental health program.

Among the one hundred adolescents in the sample, 59% had one admission and 41% had multiple admissions for mental health services (table 24). Cases with multiple admissions were "readmitted" from one to five times (table 25). As indicated in table 25, the majority

of the readmitted cases were readmitted once, 70.7%, while 29.3% of readmitted cases were readmitted two to five times. In approximately three-quarters of the readmitted cases 75.6%, the same clinician provided services, while in the remaining one-quarter, 24.4%, of the readmitted cases, two clinicians provided services

Several authors (Ekstein, 1983; Meeks, 1971; Mishne, 1986; Novick, 1976) describe the tendency, as exemplified by the high rate of readmissions, for adolescents to "interrupt" and re-enter treatment. This "in and out" (Widseth & Webb, 1992) pattern in the way that adolescents utilize psychotherapy is consistent with the normative struggles that they grapple with as they experience the dichotomous developmental tasks of dependence/independence and separation/individuation.

There was only a slightly higher percentage of acknowledged terminations among the readmitted cases (36.6%) as compared to those cases that were admitted only once (32.2%). As displayed in table 25, among the readmitted cases, the percentages of acknowledged terminations were considerably higher among cases that were admitted two to five times (50%) and those that had two clinicians (50%) as compared to those admitted once (31%) who had one clinician (32.4%). These findings suggest that, in this study, a flexible model of treatment that permitted adolescents to come for multiple "cycles" of treatment resulted in a higher rate of acknowledged terminations. The high percentage of cases that were readmitted for treatment (41%) and the fact that cases readmitted multiple times had a higher rate of acknowledged terminations (50%), both are indications that this type of service, characterized by Hollis (1980) as "intermittent" or "episodic" treatment, is

a common, and potentially useful way for adolescents to utilize mental health services. In this model of treatment, "termination" is not viewed as a final "ending," but rather as an "interruption" (DeWald, 1964; Palumbo, 1982; Sanville, 1982), allowing the client "to make immediate and brief use of the relationship at future times of need" (Hollis, 1980, p.4).

Table 24 **Number of Admissions by Acknowledged Terminations (N=100)**

		Acknowledged Terminations	
Admissions	**Percentage Total Cases**	**Percentage**	**LS**
Admitted Once	59	32.2	.649
Readmitted	41	36.6	

Table 25 **Readmissions by Acknowledged Terminations (N=41)**

		Acknowledged Terminations	
Number of Readmits	**Percentage Readmits**	**Percentage**	**LS**
One	70.7	31.0	.300
Two to Five	29.3	50.0	

Key:
Readmitted: two times (8), three times (3), five times (1)

		Acknowledged Terminations	
Number of Clinicians	**Percentage Readmits**	**Percentage**	**LS**
One	75.6	32.3	.453
Two	24.4	50.0	

VI. MODALITY AND LENGTH OF TREATMENT

Adolescents received a combination of individual, family, and group treatment provided by MSW level social workers (table 26). In addition, consultation visits with the clinic psychiatrist were arranged, as needed, in order to further evaluate mental health needs and/or to administer and monitor psychotropic medication(s).

Individual Sessions

All one hundred adolescents in the sample received individual counseling sessions. The mean number of individual sessions was 11.99, with a range of 96 sessions. The median number of individual sessions was 7, indicating that 50% of the adolescents attended one to seven sessions and 50% attended eight to ninety-six sessions. As indicated in table 26, the highest percentage of acknowledged terminations were in cases with 5-10 individual sessions (41.7%), while the percentage of acknowledged terminations was slightly lower (36.4%) among the longest-term cases (11-96 sessions).

Family Sessions

Family sessions which included both conjoint sessions with an adolescent and parent(s)/other family member(s) and sessions with a parent(s)/family member(s) alone were held in eighty-one percent of the cases in the sample. In over-half of the cases, 54%, a parent/guardian was involved in one to three sessions. The mean number of family sessions was 2.87, with a range of 19 sessions. The median number of family sessions was two, indicating that 50% of the cases included 0-2 family sessions and 50% of the cases included three to nineteen family sessions.

In light of the widely held belief that parental involvement is a critical component of effective treatment with adolescents, it is interesting to note that, in this study, (see table 26) the percentage of acknowledged terminations was highest when no family sessions were held (36.8%) and was lowest (29.6%) when the highest number of family sessions (4-19 sessions) were held. While parental involvement may indeed be a critical component of effective treatment with adolescents, in this study, parental involvement was not a factor that contributed to termination being acknowledged. This finding suggests the need for and value of further exploration regarding the ways in which parental involvement effects treatment with adolescents.

Group Services

Only 5% of the one hundred adolescents in the sample participated in one of two groups that were operating at the clinic during the time of this study. These included a problem-solving/support group for adolescent girls and a health/exercise group for weight reduction and the improvement of cardiovascular health. All of the adolescents who participated in either of these groups also received individual, family, and/or psychiatric mental health services at the Adolescent Center. The mean number of group sessions was .96, with a range of 36 sessions.

All of the adolescents who participated in groups had acknowledged terminations, resulting in a statistically significant relationship between participation in a group and acknowledged terminations (Fisher's Exact, p=.004, df=1). Since the number of adolescents who participated in groups was so small, the relationship between group

participation and acknowledged termination needs to be further studied with a larger sample of group participants in order to further explore the strength of this relationship.

Several factors may contribute to the high rate of acknowledged terminations associated with participation in groups. First, since the adolescents who participated in groups also received other mental health services (individual, family, and psychiatry), they were likely to have had a therapeutic relationship with more than one clinician with whom they could potentially discuss plans to terminate. In addition, since adolescents who participate in groups frequently develop a bond with and commitment to their peers in the group (Malekoff, 1997), they may be more likely to address termination with their peers rather than leave the group without an explanation or discussion. Moreover, when an adolescent is planning to terminate from a group, the clinician often engages the adolescent in a discussion of termination in order to provide closure both for the individual member who is terminating as well as for the remaining members of the group.

Psychiatric Services

Psychiatric services included sessions with the psychiatrist for the purpose of an evaluation and/or to assess for or monitor psychotropic medication. Approximately one-fifth (19%) of the adolescents received psychiatric services. Almost two-thirds (63%) of those who received psychiatric services were seen for an evaluation (1-2 sessions) only, while slightly more than one-third (37%) received ongoing psychiatric services (4-39 sessions).

There was also a statistically significant relationship between the utilization of psychiatric services and acknowledged terminations ($x2=5.96$, $df=1$, $p=.015$). As indicated in table 26, the percentage of acknowledged terminations among adolescents who had one or more visits with a psychiatrist was twice as high (57.9%) as it was for those who did not receive any psychiatric services. (28.4%). This finding may be explained by the fact that adolescents who receive psychiatric services typically have more serious emotional disturbances, are at greater risk, and may require additional services, such as psychiatric hospitalization and/or placement, all of which could increase the likelihood that termination would be discussed. In addition, as discussed regarding adolescents who received group services, adolescents who received psychiatric services had a therapeutic relationship with more than one professional which may be a factor that contributes to termination being acknowledged.

Table 26 Modality/Length of Treatment by Acknowledged Terminations (N=100)

Modality/Length	Percentage Total Cases	Acknowledged Terminations Percentage	LS
Individual Sessions			
1-4	31	22.6	.243
5-10	36	41.7	
11-96	33	36.4	
Family Sessions			
None	19	36.8	.847
1-3	54	35.2	
4-19	27	29.6	
Group Sessions			
None	95	30.5	.004*
1-36	5	100.0	
Psychiatry			
None	81	28.4	.015
1-39	19	57.9	

* Fisher's Exact Test of Significance

Multiple Modalities

As indicated in Table 27, the majority (85%) of the adolescents in this study received two or more types of mental health services (individual, family, group, and/or psychiatric) at the Adolescent Center, while only fifteen percent of them received just one service. Of those who received two or more types of services, approximately two-thirds (67%) of the

adolescents received two types of mental health services and eighteen percent received three or four types of services.

Although it was not statistically significant, there appeared to be a strong and noteworthy relationship between the number of services adolescents received and acknowledged terminations. As indicated in table 27, adolescents who received three or four types of mental health services had higher percentages of acknowledged terminations (62.5% and 100%) than those who received one (33.3%) or two (25.4%) services.

Table 27 **Number of Services by Acknowledged Terminations (N=100)**

		Acknowledged Terminations	
Number of Services	**Percentage Total Cases**	**Percentage**	**LS**
1	15	33.3	
2	67	25.4	.008
3	16	62.5	
4	2	100.0	

LENGTH OF TREATMENT

Total Number of Sessions

The total number of sessions attended included the total number of individual, family, group, and psychiatry sessions (table 28). The mean number of sessions attended was 17.1, with a range of 138 sessions. The median number of sessions attended was 9,

indicating that in 50% of the cases the total number of sessions attended was 1-9 and in 50% of the cases the total number of sessions attended was 10-138.

While the number of adolescents who came for short (1-6 sessions), longer (7-13 sessions), and longest-term (14-138 sessions) treatment was relatively equal, the percentage of acknowledged terminations was highest (39.4%) in the cases with 7-13 sessions cases and lowest (25%) in the shortest-term (1-6 sessions) cases (see table 28). In other empirical studies that explored rates of dropout from treatment with adolescents (Baruch et al., 1998, Suzuki, 1989; Viale-Val et al., 1984), the highest dropout rates were also in the earliest (referred to as "assessment stage" in these studies) stages of treatment.

Total Number of Months

The total number of months, or total length of mental health services, included the total number of months from the month the case was opened to the month the case was closed. Since readmitted cases could be opened and closed several times, the total number of months included the total time span from the first time the case was admitted to the last time that it was closed (including time periods that no services were provided).

The mean number of months that services were provided was 9.46 months, with a range of 57 months, or 4.7 years. The median number of months of services was 5, indicating that in 50% of the cases the total length of services ranged from 1-5 months and in 50% of the cases the total length of services ranged from 6-57 months.

As indicated in Table 28 , cases that were seen over the longest period of time (greatest number of months), had the highest percentages (40%) of acknowledged terminations. Specifically, in the cases in which adolescents received services for 8-57 months (8 months to 4.7 years), the percentages of acknowledged terminations were almost twice as high (40%) as those who received services for 1-2 months (22.6%).

Table 28 Total Length of Treatment by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Total Number of Sessions	**Percentage Total Cases**	**Percentage**	**LS**
1-6	32	25.0	.420
7-13	33	39.4	
14-138	35	37.1	
Total Number of Months	**Percentage Total Cases**	**Percentage**	**LS**
1-2	31	22.6	.268
3-7	34	38.2	
8-57	35	40.0	

Total Number of Sessions and Total Number of Months

When the total number of sessions and the total number of months of services are examined together, the highest percentage (39.4%) of acknowledged terminations occurred in cases in which adolescents received 7-13 therapy sessions over a period of 8-57 months (40%). Adolescents who had the highest percentage of acknowledged terminations received a relatively short number of sessions (7-13 sessions) that took place

over an extended period of time (8-57 months). Thus, they did not come for services weekly, but instead they received varied intervals or "episodes" of services over time. This pattern of service utilization is described by Hollis (1980), who believes that many clients, ." . . need only short or intermittent contacts of varying intensity over a period of years" (p.4). Likewise, as discussed earlier, these findings are consistent with the tendency for adolescents to "interrupt" rather than end or terminate from treatment that has been described by several authors (Ekstein, 1983; Meeks, 1971; Mishne, 1986; Novick, 1976) and observed by many clinicians. These findings suggest that an "open-door" approach to services in which adolescents can come in and out of treatment during the years of their adolescence may be an important factor that contributes to termination being acknowledged.

VII. OUTREACH EFFORTS

Scope and Methods of Outreach

Outreach efforts are done to explore the adolescent's intention to continue and/or terminate services, and to either schedule a follow-up appointment or terminate the case. Since the administrative termination form used in the mental health program requires the clinician to document three outreach efforts (by telephone and/or letter) in order to close a case, in the vast majority of the cases, (86%), one or more outreach efforts, were documented in the records (see table 29). Among the remaining fourteen cases in which outreach was not documented, in ten cases, outreach was not required because termination was completed in the last counseling session, and in four cases there was no documentation of outreach. In the majority of the cases, 84%, outreach was done by

telephone; in 50% of the cases outreach was done by mail; and in 5% of the cases outreach was done by other methods, including, through the school counselor, at medical visits at the Adolescent Center, or by fax.

There was a statistically significant relationship between outreach being done and termination being acknowledged (Fisher's Exact, p=.004, df=1). Since there was a considerably higher percentage of acknowledged terminations (71.4%) when no outreach occurred, this finding seems to indicate that outreach was not associated with acknowledging termination. It may be that termination was already acknowledged and outreach was not necessary. In addition, this finding seems to indicate that outreach efforts were often not effective in arriving at closure/termination in cases.

Table 29 Patterns of Outreach by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
Outreach Variable	**Percentage Total Cases**	**Percentage**	**LS**
Outreach Done			
Yes	86	27.9	.004
No	14	71.4	
Method of Outreach			
Telephone	84	28.6	.018
Letter	50	18.0	.001

Results of Outreach Efforts

As indicated in table 30, given the high number of cases in which the records do not document the results of outreach (43.8%), it is difficult to assess the relationship between outreach and whether termination was acknowledged or unacknowledged. In almost one-third of the cases in the sample (30.4%), as a result of outreach, the adolescent agreed to return and did not follow through with scheduled appointments. In one-quarter (25.8%) of cases, termination was discussed by telephone with either the adolescent and/or the parent. In some of these cases, the decision to terminate services had also been discussed in the counseling session and was further acknowledged and/or discussed by telephone. In only one case, following outreach, a social work intern terminated with an adolescent at the clinic during a medical visit.

Table 30 Result of Outreach Efforts (N=89)*

Outcome Variable	Percentage
Client Agreed to Return and Did Not	30.4
Termination Occurred by Telephone	25.8
Response and/or Outcome Not Recorded	43.8

*Eleven cases are not included in the analysis of "Result of Outreach". These include: Ten cases in which outreach was not necessary because the case was terminated; one case in which the adolescent returned to terminate in session as a result of the outreach.

As indicated in table 31, in forty-eight percent of the cases an adolescent and/or parent was reached to discuss plans regarding the continuation or termination of treatment. When a parent was reached by telephone and a discussion took place, there was a higher

percentage of acknowledged terminations (55.2%) than when a telephone discussion took place with an adolescent (39.3%). In fact, there was a statistically significant relationship between having a parental telephone discussion and acknowledged terminations (x=8.159, df=1, p=.004).

Table 31 Discussion via Outreach by Acknowledged Terminations (N=100)

		Acknowledged Terminations	
	Percentage Total Cases	**Percentage**	**LS**
With Adolescent	28	39.3	.487
With Parent	29	55.2	.004
With Adolescent and/or Parent	48	47.9	.005

VIII. OUTCOME MEASURES

Clinicians' Rating of Improvement

The measure of outcome obtained from the client records was the clinician's evaluation of client improvement on a "termination" form that was a replication of the "admission" form. On this form, the clinician rated the status of the presenting problem at the termination of services. As indicated in table 32, the status of the case at termination (Improved or Unimproved) was almost equally distributed for depression/anxiety, school problems, and academic problems. There was a slightly higher number of improved cases when family problems were the presenting problem and significantly fewer number of improved cases when the presenting problem was a conduct problem. The latter finding is

consistent with other findings reported earlier, specifically, that conduct problems are typically considered to be difficult to treat with a poor prognosis often expected.

Table 32 Outcome of the Presenting Problems at Termination (N=100)

		Outcome at Termination	
Presenting Problems	**Percentage Total Cases***	**Improved Percentage**	**Unimproved Percentage**
Family Problems	68	55.9	44.1
Depression/Anxiety	43	48.8	51.2
School Problems	37	48.6	51.4
Academic Problems	24	50.0	50.0
Conduct Problems	6	16.7	83.3
Substance Abuse	7	42.9	57.1

* Total equals more than 100% because there may be multiple problems in each case.

Independent Rating of Client Engagement

A measure of client engagement at the termination of treatment was developed by the investigator in order to explore the relationship between the client's level of engagement in treatment at the last session and how termination occurred (acknowledged or unacknowledged). Clients that were rated as "engaged" in treatment were defined as those who appeared to be involved in the session and the treatment process as demonstrated by discussion of and/or efforts to resolve problems. Clients that were rated as "disengaged" presented as and/or discussed ambivalence, disinterest, and/or resistance to treatment. The following vignettes are examples from the records of adolescents who were rated as "disengaged" from treatment:

> Patient presents as guarded, stating that she is coming because of her mother. She does not know if she will have time when school starts, yet she agreed to another appointment.
>
> Patient remains ambivalent about the need for treatment and feels that since he is going to school and talking to people there are not problems to be dealt with in treatment. The patient is going away for the summer and therefore is unable to come to treatment. The patient fears counseling means being labeled.
>
> Patient stated she had come just to get her parents off her back and to be able to get what she wants from them. She remained silent and withdrawn, shrugging her shoulders.
>
> Social worker recommended at least one family session to obtain a better perspective on the relationship with the client's's father. The client is adamantly against the idea and threatens not to return to counseling.

As illustrated in Table 33, the percentage of acknowledged terminations was almost twice as high (58.3%) among adolescents who were disengaged in the last session as compared to those who were engaged (28.6%). This was a statistically significant relationship ($x2=6.857$, $df=1$, $p=.009$). This was a surprising relationship since clinicians typically associate termination being acknowledged and/or discussed in cases in which clients are engaged, rather than disengaged, in the treatment process. Moreover, it does not support previous research (Cochran & Stamler, 1989; Mallucio, 1979) in which planned and discussed (acknowledged) terminations have been associated with successful client engagement while unplanned and unacknowledged terminations have been associated with a lack of engagement.

Table 33 **Level of Engagement at Last Session by Acknowledged Terminations (N=94)**

		Acknowledged Terminations	
Level of Engagement	**Percentage Total Cases**	**Percentage**	**LS**
Engaged at Last Session	74.4	28.6	.009
Disengaged at Last Session	25.6	58.3	

IX. SUMMARY OF THE QUANTITATIVE FINDINGS

The Termination Process

The findings from the quantitative portion of this study indicate that termination was unacknowledged in approximately two-thirds of the cases (66%) and acknowledged in approximately one-third (34%) of the cases. The rate of unacknowledged terminations, referred to throughout the literature as treatment "dropout," is within the range reported in other studies of treatment dropout with adolescents (Baruch et al., 1998; Suzuki, 1989; Viale-Val et al., 1984). As described in other studies, unacknowledged, or "unilateral" (Novick, 1976; 1990), terminations were initiated by adolescents without the agreement of the clinician.

The findings provide information about both clinical and non-clinical antecedents to termination that can be utilized by clinicians to anticipate and plan for the termination process. Specifically, in approximately three-quarters (76%) of the cases, adolescents canceled or failed scheduled appointments prior to discontinuing mental health services, while in only 25% of the cases they expressed a desire to discontinue services. Of those who canceled or failed scheduled appointments, 34% rescheduled their appointments and subsequently did not attend the scheduled appointments. In over one-half (54%) of the cases, the termination of mental health services coincided with an interruption or break in the schedule, resulting from the end of the school year and/or summer vacation in 37% of the cases, and from the clinician's vacation and/or absence in 17% of the cases.

In contrast to the traditional theoretical view of termination as a distinct phase in the treatment process, the findings from this study are consistent with those from the pilot study (Mirabito, 1993) and revealed that when termination occurred, it was typically a brief process that occurred almost as frequently by telephone as it did in the context of a therapy session. When termination was acknowledged, it was acknowledged and/or discussed in person, in the context of one or more therapy sessions, in slightly more than one-half, 55.9%, of the cases. In the remaining 44.1% of the acknowledged cases, the discussion and/or acknowledgment of termination occurred only by telephone.

In almost one-half, 47.4%, of the acknowledged cases, termination was discussed in only one session, usually the last. In the remaining 52.6% of the acknowledged cases, a discussion of termination, ranging from two to five sessions took place. Termination was initiated by adolescents in 52.9% of the acknowledged cases and the adolescent and clinician agreed about the decision to terminate in 55.8% of the acknowledged cases.

The highest frequencies of acknowledged terminations occurred among cases in which: termination was initiated by the clinician, the adolescent and the parent, or as a result of placement; the adolescent and/or parent expressed a desire to discontinue services; or termination occurred because of either situational factors or a referral to another facility. There were statistically significant relationships between these types of cases and acknowledged terminations.

The highest percentages of acknowledged terminations, or the lowest dropout rate, occurred among adolescents who: were Caucasian (61.5%) and Asian (44.4%); were referred from schools (41%) and self-referred (50%); presented with school (40.5%), particularly, academic (48%), problems; were diagnosed as depressed (44.2%), with conduct problems (47.1%), and with axis two disorders (38.1%); did not acknowledge a problem at intake (41.7%) and were not motivated for treatment (60%); had a history of having received previous mental health services (39.1%); and had not experienced the absence and/or loss of a parent (39.3%).

In contrast, the lowest percentages of acknowledged terminations, or the highest dropout rate, occurred among adolescents who: were Hispanic (25.6%), African-American (31%), and Biracial (30%); were referred by their parents (22.6%); presented with conduct (10%) and substance problems (25%); had diagnoses of parent-child conflicts and other family problems (19%); acknowledged a problem at intake (33.3%) and were motivated for treatment (28.4%); had not received prior mental health services (29.6%); and had experienced the absence and/or loss of a parent (31.9%).

Type of Mental Health Services Received

The majority of the adolescents in this study (85%) received two or more types of mental health services (individual, family, group, and/or psychiatric), while only fifteen percent received just one service. Several differences in the percentages of acknowledged terminations were noted between individual, family, and group treatment modalities. Specifically, among the cases with individual sessions, the highest percentage of

acknowledged terminations (41.7%) was in cases with 5-10 sessions while the lowest percentage of acknowledged terminations (22.6%), or the highest dropout rate, was in the shortest-term cases (1-4 sessions). Among the cases with family sessions, the percentage of acknowledged terminations was highest (36.8%) when no family sessions were held and was slightly lower as more family sessions were held.

While only five percent of the adolescents in the sample participated in groups, all of the adolescents who participated in groups had acknowledged terminations. Nineteen percent of adolescents received psychiatric services and had rates of acknowledged termination two times higher (57.9%) than those who did not receive psychiatric services (28.4%). The relationships between participation in both group and psychiatric services and acknowledged terminations were statistically significant.

Adolescents who received multiple treatment modalities had a higher percentage of acknowledged terminations than adolescents who received only one mental health service. Although it was not a statistically significant relationship, there appeared to be a direct and noteworthy relationship between the number of services adolescents received and acknowledged terminations. Adolescents who received three (62.5%) or four (100%) types of mental health services had a higher percentage of acknowledged terminations than those who received one (33.3%) or two (25.4%) services.

Consistent with findings from other studies of treatment dropout with adolescents (Baruch et al., 1998; Suzuki, 1989, Viale-Val et al., 1984), the percentage of acknowledged

terminations was highest (39.4%; 37.1%) in cases with more treatment sessions (7-13; 14-138 sessions) and lowest (25%) in short-term (1-6 sessions) cases. In addition, cases with the highest percentages of acknowledged terminations were those that had the longest length of services. Specifically, adolescents who received services for 8-57 months (8 months to 4.7 years) had percentages of acknowledged terminations that were almost twice as high (40%) as those who received services for 1-2 months (22.6%).

Outreach Efforts and Outcome of Services

There was a statistically significant relationship between outreach being done and termination being acknowledged (Fisher's Exact, p=.004, df=1). Surprisingly, there were significantly fewer acknowledged terminations, 27.9%, when outreach occurred as compared with 71.4% acknowledged terminations, when no outreach occurred. Thus, the presence of outreach efforts, was inversely correlated with acknowledged terminations. Given the high number of cases in which the records do not document the results of outreach, it is difficult to assess the relationship between outreach and whether termination was acknowledged or unacknowledged. The percentage of acknowledged terminations was much higher in the cases that did not record outreach as compared to those in which outreach efforts were documented. Finally, there was a statistically significant relationship between disengagement from treatment at the time of termination and the likelihood that termination would be acknowledged.

In the next chapter, the qualitative analysis of interviews with fourteen adolescents with both acknowledged and unacknowledged terminations will be presented. The qualitative

findings will provide the adolescents' views and experience of the treatment process and the termination from treatment. Moreover, the adolescents' perspectives will provide further understanding of the quantitative findings as well as an in-depth account of their own experience of treatment.

CHAPTER V

ADOLESCENTS' PERCEPTIONS AND EVALUATION OF THE THERAPEUTIC PROCESS: THE QUALITATIVE FINDINGS

Introduction

The qualitative data discussed in this chapter are drawn from transcripts of interviews with fourteen adolescents who discontinued treatment at the Adolescent Center in 1996. The adolescents chosen for interviews were a sub-sample drawn from the sample of quantitative cases of adolescents who had both "unacknowledged" and "acknowledged" terminations from treatment (as discussed in Chapters III and IV).

As described in Chapter III, in this study, termination was defined as the discontinuation of mental health services. In the prior chapter, the terms "acknowledged" and "unacknowledged" were used to describe in quantitative terms the way in which services were terminated. "Acknowledged" terminations were operationally defined as cases in which there was either an acknowledgment and/or a discussion between the clinician and the adolescent (or parent) about the discontinuation of mental health services. "Unacknowledged" terminations were operationally defined as cases in which there was neither an acknowledgment or a discussion between the clinician and the adolescent about the discontinuation of services.

As indicated by the quantitative findings, "acknowledged" terminations occurred in two ways, either through a discussion between the clinician and adolescent in one or more

therapy sessions, or through a telephone conversation between the clinician and adolescent (or parent). In almost one-half (44.1%) of the cases with "acknowledged" terminations, termination occurred only by telephone, without an opportunity to discuss or process the termination of treatment. In the remaining 55.9% of the cases with "acknowledged" terminations, termination occurred in the context of one or more therapy sessions.

Based on the quantitative findings, three types of termination that most aptly captured the patterns of termination in this study were identified. These included terminations that were: "acknowledged with a clinical process," "acknowledged without a clinical process" and "unacknowledged." Cases that were "acknowledged with a clinical process" included those cases in which termination was acknowledged by a process of discussion between the adolescent and the clinician in one or more therapy sessions; cases that were "acknowledged without a clinical process" were those cases in which either the client or clinician simply acknowledged that services would be discontinued, however no face to face discussion regarding the termination occurred (e.g. termination was acknowledged by telephone only); and "unacknowledged" terminations included those cases in which the adolescent unilaterally discontinued services without an acknowledgment or discussion with the clinician. A purposeful sampling strategy was utilized to select cases with each of these three types of termination in order to provide maximum understanding of the termination process with adolescents via qualitative interviews.

Through analysis of the qualitative interview data, striking similarities in the adolescents' experiences of the process of treatment and the termination from treatment were found among cases in which termination was "acknowledged without a clinical process" and those in which termination was "unacknowledged." This surprising and significant finding that emerged inductively from the qualitative data analysis provided a clearer understanding about adolescents' experience of termination and further informed the methodology for qualitative data analysis. Based on this finding, adolescents with two types of terminations, "unacknowledged" and "acknowledged without a clinical process," were combined and analyzed as a single group. Since there was no opportunity to "address" termination in either of these two types of cases, they are referred to in this chapter as "unaddressed" terminations. In cases in which termination was "acknowledged with a clinical process," termination was "addressed" through a face-to-face discussion between the clinician and adolescent in one or more therapy sessions, and are referred to as the "addressed" terminations.

Thus, the qualitative findings include the analysis of two types of terminations, the "addressed" (six cases) which include cases in which termination was discussed in one or more therapy sessions, and the "unaddressed" (eight cases) which include cases in which termination was not discussed in the context of a therapy session (the "unacknowledged" and the "acknowledged without a clinical process". The "unaddressed" terminations include five adolescents with "unacknowledged" terminations and three adolescents with terminations that were "acknowledged without a clinical process." Cases with

terminations that were "acknowledged without a clinical process" (three cases) included those in which the clinician was aware that the client would not be returning to treatment, however a discussion of termination did not occur in the context of a therapy session(s). In two of the three cases that were "acknowledged without a clinical process," the termination was acknowledged only through a telephone conversation (in one case with the adolescent, in the other with the parent), and in one case the clinician terminated the case because of the adolescent's consistently poor attendance.

The primary objectives of the qualitative portion of this study are first, to describe how adolescents with both unaddressed and addressed terminations experienced the processes of engagement in and termination from treatment; second, to describe the reasons for termination among unaddressed and addressed terminations; and third, to describe the similarities and differences between the experiences of adolescents with unaddressed and addressed terminations. In order to achieve these objectives, findings for each type of termination, "unaddressed" and "addressed," and the similarities and differences between them, will be presented in the following sections:

1) Beginnings: How and Why the Adolescents Came for Treatment?
2) The Experience of Treatment:
   How the Adolescents Experienced the Treatment Process?
3) The Termination from Treatment:
   How and Why the Adolescents Terminated Treatment?
4) Evaluation of the Treatment Experience:
   How the Adolescents Evaluated Treatment?

DESCRIPTION OF THE SAMPLE

The following summaries briefly describe the fourteen adolescents who comprised the sample from which the qualitative data was analyzed. The description of each adolescent includes: age at termination, ethnicity, gender, total number of sessions, treatment modalities, total length of treatment, and presenting problem.

ADOLESCENTS WITH UNADDRESSED TERMINATIONS

U=Unacknowledged AWP=Acknowledged without a Process

A: 18 year-old African-American male, attended 16 sessions (9 individual, 7 family) over a sixteen month period, presented with difficulties related to past sexual molestation by a cousin and difficulties in his relationship with his mother. **(U)**

B: 16 year-old African-Caribbean American male, attended 9 sessions (7 individual, 2 family) over a four month period, presented with problems of frequent marijuana use and academic failure in school. **(AWP)**

C: 20 year-old Hispanic female, attended 25 sessions (23 individual, 2 family) over a 14 month period, presented with problems of depression, sleeplessness, and academic failure. **(AWP)**

D: 16 year-old Hispanic male, attended 24 sessions (22 individual, 2 family) over an 11 month period, presented with depression, social isolation, and academic failure. **(U)**

E: 22 year-old Biracial (Hispanic/African-American) female, attended 33 sessions (28 individual, 5 psychiatric) over a 19 month period, presented with depression and bulimia. **(U)**

F: 13 year-old Hispanic female, attended 23 sessions (19 individual, 4 family) over a 5 month period, presented with a suicide gesture related to difficulties in her relationship with her mother. **(U)**

G: 14 year-old African-American male attended 40 sessions (30 individual, 10 family) over a 13 month period, presented with academic, family problems. **(U)**

H: 18 year-old Biracial (African-American and Hispanic) female, attended 54 sessions (10 individual, 9 family, 35 group) over a two and a half year period, presented with academic and family problems. **(AWP)**

ADOLESCENTS WITH ADDRESSED TERMINATIONS

I: 16 year-old Chinese/American male, attended 7 sessions (5 individual, 2 family) over a two month period, presented with academic difficulties related to the impending divorce of his parents.

J: 15 year-old Biracial (Caucasian and African-American) female, attended 37 sessions (20 individual, 16 family, 1 psychiatric) over a 16 month period, presented with depression, truancy, and auditory hallucinations.

K: 14 year-old African-American female, attended 19 sessions (15 individual, 4 family) over a 7 month period, presented with acting-out behavior at home and conflicts with her mother.

L: 12 year-old Hispanic (Mexican) female, attended 8 sessions (2 individual, 6 family) over a three month period, presented with anxiety attacks and peer problems.

M: 14 year-old Hispanic male, attended 28 sessions (5 individual, 19 family, 4 psychiatric) over a 1 year period, presented with academic failure.

N: 14 year-old Hispanic female, attended 29 sessions (19 individual, 10 family) over a 17 month period, presented with difficulties related to a recent rape and family problems.

I. BEGINNINGS: HOW AND WHY THE ADOLESCENTS CAME FOR TREATMENT?

Encouragement and Mandate of Parents and Concerned Adults

All except one of the fourteen adolescents who were interviewed sought mental health services at the request of a concerned adult, such as a parent, guidance counselor, or doctor who was either worried about them, or in some cases, bothered by their behavior, and recommended that they obtain mental health services. Since adolescents typically do not recognize treatment as something that they want or need (Miller, 1990) and often manifest some form of reluctance to engage in treatment (Taylor et al., 1985), it is not surprising that adolescents with both unaddressed and addressed terminations were initially reluctant to engage in treatment. Thus, it was both the encouragement and the mandate of concerned adults that helped all of the adolescents get to the first appointment and view treatment as potentially helpful.

For adolescents with both unaddressed and addressed terminations, the early engagement process was a critical factor for the way in which they experienced the treatment process. The adolescents with unaddressed terminations were generally receptive to the encouragement of concerned adults. As the adolescents with unaddressed terminations explained how and why they came for treatment, the influence of parents, guidance counselors, doctors, and other concerned adults emerged as a primary influence in the decision to seek help:

> My high school guidance counselor said it would help me to deal with my relationship with my mom and the situation (*sexual molestation*). **(A)**

> I came here because I wasn't doing so well in school--my grades weren't good and my attendance was bad. My guidance counselor hooked me up with the program. She thought it would be good for me. **(B)**

> I was always tired and really I had no energy. I had real problems sleeping. Yeah, the teachers, and basically one of them, my counselor referred me to another one, who referred me to another one, who had information about here. And he felt I would benefit from it because he believed that it was some sort of emotional thing, or behavioral thing, or something going on at home, or my personal life. Basically stressed. A lot of issues were stressing me,'cause, if your stressed a lot, then your sleeping patterns change, and they get all messed up, so he referred me here. **(C)**

> To see what's wrong. To see what I'm doing wrong. Grades, because of the way I react everybody's telling me, the resource teacher from High School was like telling me I had like tunnel vision and I'm trying to figure it out to this day that people telling me I should really go to counseling to make sure I'm still sane not insane. Always by myself, always locked in my room, basically 24 hrs a day, I don't know, depression, or let me put it this way, king of depression, that's about it. **(D)**

Even when adolescents were independently interested in and motivated to pursue treatment, adults played an important role in the process of obtaining services. For example, E., who was self-referred and self-motivated, still benefitted from her doctor's encouragement to seek treatment:

> I think, I mean I needed something and I guess *(Dr.)* just kind of encouraged it. I mean she opened up the door for me to really have this opportunity, so I took it. Whether I was desperate to have some kind of help, and you know, and I always like talking to someone. It's always helped and I was like, you can't lose anymore than I have, so it was fine to talk to somebody new, and luckily it just worked out well. **(E)**

In contrast to the general receptiveness to the referral among adolescents with unaddressed terminations, overall, the adolescents with addressed terminations responded

to the referral for mental health services less favorably. From the beginning, four of the six adolescents with addressed terminations clearly indicated that they only came for treatment because of the insistence of concerned adults or to appease them. However, they indicated little or no motivation for treatment themselves. As several adolescents with addressed terminations described how and why they came for treatment, it was evident as well that although they cooperated with the referral source, they did not view the problem in the same way, nor did they experience a need for treatment. The involuntary quality of their involvement is illustrated in their descriptions of how and why they came for treatment:

> It's because I was doing badly in school, that's why my guidance counselor made me come. Plus I was having a family situation at home and she thought that was affecting me in school and she wanted me to seek help for that. At the time, like during the family situation and when I was doing badly in school, I didn't really connect the two because I didn't really feel that they were connected, but I guess maybe on a subconscious level they were. I really didn't want to come but she insisted so she referred me to a social worker here. **(I)**

> My guidance counselor and my grandmother agreed and I didn't want to go... I just came because my grandmother wanted me to go. I just didn't want to go but I did because of my grandmother. I feel bad for my grandmother because she has to take care of me and my sister because my mother messed up and I do it just to please her. **(J)**

Parental Involvement

Parents were often responsible for helping adolescents obtain treatment by "mandating" it. The way in which parents communicated this mandate to the adolescents clearly impacted upon their initial receptiveness to treatment. For example, F., who was initially not motivated to seek services, described how her mother insisted that she try therapy:

> I didn't want to go but she kept on telling me that you have to go, it's going to help you, you're going to be a different person later. **(F)**

In contrast, G. was brought to the first appointment by his mother without any preparation or knowledge about the fact that she was bringing him for treatment. Not surprisingly, this clearly had a negative impact on his initial engagement in treatment:

> At first I didn't really like it, coming, not the first session but I didn't like the fact of coming before I even got here. My mother just brought me here one day without even telling me. She didn't tell me where I was going so I was mad about that. **(G)**

Similarly K., was brought to the Adolescent Center without any knowledge about coming because her mother had no other way to gain her cooperation for treatment:

> My mother called, I didn't know she called but she called. She thought that I needed help. She didn't even tell me at first, all she did was tell me I had an appointment, to come one morning and I just came and that's when I found out it was counseling. Because if she had probably told me in the beginning what it was before I came, I wouldn't have come. **(K)**

Not surprisingly, she goes on to describe that she did not want to come for treatment:

> I just didn't want to come, I just don't like to be forced to do things. If anyone tries to force me, I just go the opposite way. **(K)**

Expectations of Treatment

Five of the eight adolescents with unaddressed terminations and four of the six adolescents with addressed terminations had prior mental health experiences. While many of the adolescents with both unaddressed and addressed terminations had predictable reservations and displayed doubt about engaging in treatment, the reasons for

these cautions and concerns about treatment differed. Three of the eight adolescents with unaddressed terminations had reservations about treatment because they had prior negative mental health experiences. In contrast, three of the six adolescents with addressed terminations expressed reservations about treatment because they did not identify a need for it and they had other methods of handling their problems.

The Influence of Prior Mental Health Experiences

Three of the eight adolescents with unaddressed terminations described prior treatment experiences that they did not find helpful, which left them uncertain, skeptical, and cynical about what this new treatment experience would be like. Despite these initial concerns about treatment, all these adolescents engaged in treatment at the Adolescent Center and found it helpful. E., a twenty year-old girl described her prior treatment experience in this way:

> I was placed with this woman, a social worker, and I had a horrible experience with her. We just didn't connect very well. I think by the end I had lost a lot of faith in the patient-doctor relationship. She got too personal I think, like some of the statements I had made. I didn't feel comfortable at all talking to her anymore, and I didn't feel that she was going to be helpful. And you know after that first experience, I was like it really doesn't work, and I was still bulimic, and I wasn't dealing with any of the issues and I mean it didn't seem like it really worked. I was very skeptical about coming in to see a counselor that anything would ever happen with another one. **(E)**

Based on this prior experience, she explained that she did not initially intend to invest herself much in treatment or gain much from it. She described what she thought treatment at the Adolescent Center would be like:

> Well, to just be really crass, I thought it would be a joke. You know I would talk to somebody, and they would hear me out. Like oh everything will be ok, and then I would just go back, and do whatever I want. Like I didn't think anything of it. It would just be an opportunity for somebody to pay attention to me, for just an hour, or whatever, however long. You know affirmation, and I would feel good about myself, and walk out, and that would be fine. In a way it was like a haven, I wouldn't have to think about the external world, and the attention would be totally on me. But then you know once you get outside, you know, life as usual. **(E)**

In a similar way, two boys with unaddressed terminations described prior treatment experiences which left them skeptical and doubtful about engaging in treatment at the Adolescent Center. D., who was fifteen when he came to the Adolescent Center, described his past experience with a psychiatrist and how this influenced his expectations of coming to treatment:

> I started going there for a little while, I started talking about my problem and everything and a psychiatrist down there started falling asleep, like nodding off. So I started talking to my father about that and he got a little pissed off about that and my mother decided to bring me over here and after that I started talking to (*clinician*). So I expected to be talking to a counselor and the counselor starts nodding off like he needed coffee or someone would be sleeping while I was talking about it. **(D)**

Although G. was uncertain what treatment at the Adolescent Center would be like, based on his past experience with counseling, he didn't know if it would be helpful:

> I don't really know what I expected it to be, I just did it. I just knew that I had to start coming or whatever because my mother told me. I don't really know what I expected out of it. I had gone to counseling at the center with the volunteers. They were working on their college thesis or whatever and they didn't help me any because after they came they would leave the next year so they didn't help me, I would just have another one every year. **(G)**

In contrast to those who had previous mental health experiences, the three adolescents with unaddressed terminations who had no prior mental health experiences and therefore, no frame of reference for the experience of treatment, were positive and optimistic about how treatment might help them. F., who was fourteen years old when she came to the Adolescent Center, explained what she thought it would be like to come for treatment:

> Just talking openly about what you felt, how you thought things should be, if you had a problem and you needed to talk about it, you knew that person would be near. Well, I felt I couldn't talk to my mother, so I would talk to my counselor about it or to my grandmother. **(F)**

Similarly, A., a seventeen year-old boy said:

> I thought that the services would help me, that I would overcome it. I was expecting being able to talk about the molestation so I could get over it. **(A)**

In contrast to the generally positive expectations of adolescents with unaddressed terminations, only two of the six adolescents with addressed terminations came to treatment with positive expectations. The remainder approached the treatment experience with either neutral, guarded, or negative expectations. For example, L, a twelve year-old girl who came to treatment with positive expectations, described her initial receptiveness to and trust in the treatment process in much the same way as those who had unaddressed terminations:

> I felt fine because I was free to say all that I felt inside because honestly I can't talk to my parents. I don't feel that trustful with them, I don't know why but I can't trust them. My parents. I can't talk to them. I can't...I knew I would talk to someone who would keep my secrets, even though I didn't know that person. **(L)**

In a similar way, N., who came to treatment because she had been raped and she had difficulties with her parents, described positive expectations of treatment:

> To get over what happened and to have a better relationship with my parents. **(N)**

Other Methods of Handling Problems

Two of the six adolescents with addressed terminations expressed uncertainty that treatment could help them, while two others clearly believed it would not help. From the beginning of the experience, they indicated that they did not believe in the therapeutic process. Some reported that they did not believe that talking about problems would be helpful and they indicated that they had other methods of handling their problems. For example, I., a sixteen year-old Chinese-American boy explained that he did not believe talking to a stranger about his problems would be helpful. In addition, he preferred an action-oriented approach to the problem that would provide him with a concrete solution:

> I told her, I'm not the kind of person that likes to seek social help or counseling and that I felt bad because if I was in counseling, if I was seeking counseling, someone else that needs it more desperately might not be able to because I was taking up the time. I didn't want any counseling because I know I'm the kind of person, like when I say things, like I want something to result after that. I feel that if I come to counseling and I say something, nothing really happens. Like I'm not the kind of person that needs to unburden themself to talk to someone about his problems, so if I talk to you I expect something to be done...And, well, if I do, I prefer to unburden myself to a close friend rather than someone I don't know. **(I)**

Coming for treatment because of school problems related to his parents' impending divorce, he explained how the values and customs of his culture, specifically, privacy and obedience, conflicted with the goals and methods of mental health treatment.

Consequently, he found it difficult to consider treatment as a viable mechanism to solve his problems. He explained his dilemma in this way:

> As a Chinese, and especially as the stereotypical Chinese family, is that the child respects their elders, and children are supposed to be seen not heard, they're not supposed to question their parents. And uh, they're supposed to obey their parents at all times. And Chinese people aren't very emotional. So, I guess that those influences affected how my personality developed. In China, it's like, the things that happen in the family stay in the family. It doesn't go around. **(I)**

J., a fourteen year-old girl who had been in and out of counseling since kindergarten expressed a similar view. Based on her prior experiences in counseling, she did not think treatment would be helpful to her. As she explained, rather than "talking," which was not helpful to her, she had other methods of handling her problems that she found more effective:

> I expected it to be like every other time and it was just like every other time, the same exact thing the same questions, the same things, except this time I didn't have toys to play with. I didn't tell the counselor that I didn't want to come. I continued to not want to come the whole entire time everywhere. I went to, I don't know how many different people, I got tired, I didn't want to talk about it. I handled it in my own way, I didn't feel I needed it. It didn't seem to help me at all, I helped myself in different ways, like writing and music. **(J)**

Similarly, M. a fourteen year-old boy did not view treatment as a useful method of solving his problems. While he was cooperative, he did not expect that "just talking" would help, nor did he feel the need to do so:

> I thought it would be someone to talk to other than my mother and father. I didn't think it was going to help me just by talking to someone. I didn't think I would need it at that time. **(M)**

Expectations for the Time Frame of Treatment

Although all the adolescents received open-ended treatment without time limits, they were asked about their expectations regarding the length of treatment to explore whether a time-limited treatment structure would have effected their engagement in or termination from treatment. While Norman (1980) believes that adolescents can be more easily engaged in time-limited treatment, only one of the fourteen adolescents indicated that he would have preferred time limited treatment. Only B. explained that a time-limited treatment format would have been helpful to structure treatment for him and help him complete it:

> I didn't know how long I would be coming. It would have helped because then I could look at it like a mission that I wanted to complete. I would know when it would start and when it would end, just like school. **(B)**

All of the eight adolescents with unaddressed terminations indicated that they were motivated to engage in and continue treatment because they enjoyed it and/or found it helpful. When asked if a time-limit would have helped them engage in treatment, adolescents with unaddressed terminations explained why they did not find it necessary to have a pre-arranged time-limit:

> No, basically just give me a day and a time and I'll be here. Let me put it this way, if it's something I like to do or something I like to get, I'll figure a way someway, somehow, to get it. That's how I am these past days--let's say if I want a CD, let's say a CD I saw on Chambers St., I had my eye on it for two years, I'll figure out someway, somehow to get that CD. Well if I like the counseling I started coming like you see in the chart, well I guess I started liking counseling, I liked it so I kept on coming. **(D)**

> I don't think that was an issue. I think she knew I was going to come. And I wanted it, I wasn't forced into it. It was something I knew was necessary, and partly it was because I wanted to stop doing it and figure out ways to deal with it. **(E)**

Consistent with adolescent development, some of the adolescents tended to be "present-oriented" to the here and now, rather than thinking ahead toward the future. Their view of a time-limit for treatment was influenced by their focus on the immediate, concrete problems of the moment. This was evident in the following responses about the time frame for treatment:

> I didn't have any idea I just took it, every time I came I was trying to solve something. **(G)**

> The time period was not important. As long as it took for me to gain control. It would slow it down or speed it up, I have to take it as it comes and see where I am in each meeting. Time would interfere. I feel the counselor was here for me as long as I needed her to be and the group as well. A time limit would have interfered. We took it as it came each week, we took it in stride. **(H)**

For C., who was nineteen when she first came for treatment, it was a relief to know that services were open-ended and without time-limits:

> I remember her telling me that being that it's free, and also that it's an Adolescent Center, that the services stop when you are twenty-two, you know, that's the age. Well she told me and I said OK, fine, that sounds good. 'Till I'm twenty-two, I have no problem with that. I was in no rush. **(C)**

For reasons different than the adolescents with unaddressed terminations, the adolescents with addressed terminations also did not believe that a prearranged time-limit for

treatment was a necessary or helpful method of engagement. Two of the six adolescents with addressed terminations indicated that a time-limit was not necessary because they intended to stop treatment when they chose to. J. explained her view of a time limit for treatment in this way:

> It wouldn't have been helpful because when I really didn't want to come I wouldn't. I would just stop going and I did just stop going when I wanted to. **(J)**

In a similar way, I. clearly stated that he did not want to come for treatment, and felt that a time-limit was unnecessary. Based on his prior counseling experience in school, he described his expectations of treatment:

> Time frame wise, I believed that counseling here would be more extensive because at school, you know, you have to go according to a bell schedule, and the periods, and it kind of interrupts, so yah, counseling here would be more uninterrupting, more in depth. It made no difference to me because I didn't want to come anyway. I pretty much thought it was the same thing. **(I)**

> I didn't expect anything different between in school and outside counseling. It was pretty much the same. I guess my guidance counselor expected something else. I guess she saw that in school counseling wasn't helping me so she was hoping that outside of school counseling would be more effective. Um, I just decided to come to see how it would go, and then if I didn't like it, I'd stop. I really had no idea, I was just going to get an idea. **(I)**

II. THE EXPERIENCE OF TREATMENT: HOW THE ADOLESCENTS EXPERIENCED THE TREATMENT PROCESS?

Overview

Overall, the adolescents with unaddressed terminations were more engaged in the treatment process than those with addressed terminations as evidenced by, their growing trust in the relationship with the clinician; the identification of a problem(s) to work on; the presence of clear goals and a focus for treatment; and active efforts to solve problems. While they may not have chosen to come for treatment, once there, they were able to find something of value and benefit for themselves in the experience.

By contrast, it was not surprising, based on their initial reactions to the referral and their expectations of treatment, that, in general, there was more variation in the quality of engagement in treatment among the adolescents who had addressed terminations. Of the six adolescents with addressed terminations, only one was highly engaged in treatment, three were moderately engaged, and two were either indifferent or disengaged. Moreover, two of the six who were initially engaged became frustrated with ineffective efforts to solve problems with their parents. Two others never became engaged around their own concerns and did not identify goals or a focus for work in treatment.

Receptiveness and Gradual Trust

Although it was generally not their idea to come to treatment, and some came under duress or with negative prior experiences, the adolescents with unaddressed terminations were generally receptive to treatment. They seemed to accept the idea of coming for

treatment and they typically experienced the beginning stage of treatment in a positive way. Thus, when asked how they felt about coming to treatment, the adolescents with unaddressed terminations were generally open and receptive:

> I didn't mind. I appreciated it. Cause I was in a different environment, very professional, grounded environment, stabilized environment, and the people here are very kind and courteous to me. I didn't experience any attitude. I felt rather different because I was the only one who dressed differently from all the patients, and the kids my age, they were kind of different. But I agreed with it completely, 100%. **(C)**

> I thought it was a good thing. A lot of teenagers need someone to talk to. Even though I didn't stay long when I came, I thought it was pretty good. I felt pretty good about coming. My mother knew I was coming but I was the one who thought I should come. My mother supported me because she came too. **(B)**

> Basically, I just wanted to be heard out, to be understood, to get the opinion of what I should do, or at least make me think, give me ideas on why I'm this way. Why I think I'm this way, what do I do, how should I go about to change. That's basically it. **(D)**

G. was initially angry about coming to treatment because it competed with other activities. Although he was not as enthusiastic as the others, he gradually settled into an acceptance of coming to treatment:

> At first I was mad because I was in Day Camp and I would come over here at 5:00 and I used to come over and sometimes they would be going to the park at 5:00 and I had to leave here to come. Sometimes I was mad and stuff but then I got here and it was like, whatever, it was something I had to do and I just came. **(G)**

While they expressed a range of reactions to the initial sessions with the clinician, including discomfort and annoyance, all the adolescents with unaddressed terminations

described the gradual development, usually within a few sessions, of a positive connection with the clinician and a beginning trust in the therapeutic relationship. As illustrated in their accounts of the first therapy sessions, their initial reactions of discomfort and mistrust subsided as they gradually began to trust the clinician and engage in therapy:

> It was a little odd, it took me a while to trust her. It took me a while to trust her and then after that I trusted her more than sufficient like a couple of friends of mine as well like I trusted a best friend of mine who lives in Brooklyn. She proved to me that I could trust her a lot so I started talking about everything from A to Z, so that's about it. **(D)**

> I felt uncomfortable at first cause I never met this woman in my life and then I began just talking openly about how I felt and how things were going, and then later I got used to it after three or four weeks and it was no problem. In the beginning it was difficult but then after going a few times, I loosened up and I started opening my ears so I could understand her point of view, then it was OK. **(F)**

Identification of a Problem

All of the adolescents with unaddressed terminations described a collaborative process with the clinician in which they began to explore and identify problems that pertained either to themselves or their relationships with others that they viewed as problematic and wanted to work on in treatment. Although they were not always able to define the problem, they were receptive to the idea that a problem might exist and they were willing to explore it. For example, G., a thirteen year-old boy brought to therapy by his mother because he was acting out in school initially was not certain if a problem existed and what kind of help was needed. He described how, with the help of the clinician during the first

few sessions, he was able to clarify his thoughts and feelings and identify what he viewed as the problem:

> At first I didn't really like it because I didn't think I had a problem or anything 'cause I wasn't doing anything like at that age. I didn't understand what I was doing wrong because you hide a lot of things inside of you and you don't know what it is until you talk about it. Then I think I started talking about me and my mother's relationship, how she always yells at me and stuff and how she doesn't really give me a say in things and that's what mainly became the topic every time I would come in, about how my relationship was with my mother. I think she knew that I was having serious problems with my mother because it wasn't schoolwork, 'cause I would be doing my schoolwork, I can do my schoolwork and things like that, I'm not stupid. It wasn't anything else, even though my father didn't live with me he was still there and would see me once a month. It wasn't anything with that, it was really the way my mother was treating me. **(G)**

In a similar way, D., described how he gradually identified his need to be more independent:

> It took me a couple of months to start to figure it out, like I started talking to a couple of my friends and going out more often. Don't wait for mother or father to give me some money so I could go out that kind of stuff, first do stuff by myself or with a couple of friends. Like for instance, today, I had to go for a job interview and then after that I had to go to my college, and then after that I came here I did that by myself. Right, basically being independent. **(D)**

A. described how the focus of his concerns shifted during the course of treatment:

> I think my thing was when I came into it, was trying to let other people know, being able to talk about myself, my situation (*sexual molestation*) and not my mother talking about my situation to other people. She talked to my family about it, yeah, she told people before I said anything about it. I know we talked some about it but we didn't talk too much about it. We talked about it in the beginning, then we shifted to some other things that were certainly also very prominent, like my parents. **(A)**

Goals for Treatment

In addition to being able to identify and take ownership of a problem, the adolescents with unaddressed terminations had clearer goals for therapy than those with addressed terminations. They described a collaborative process of working with the clinician to set goals for treatment. Some set specific goals, while others had broader, more general goals. However, the ways in which they described their goals for treatment reflected their ownership of their problems and a collaborative process of working on them with clinicians. For example, D. described his goal as:

> Getting my life on track-- that's basically it. To see what's wrong. To see what I'm doing wrong. She (*clinician*) had the same goals as well, trying to figure out, me and her were trying to figure out what's wrong with me. **(D)**

Similarly, other adolescents with unaddressed terminations described their goals for therapy and conveyed involvement in a collaborative process as well as ownership of the problem:

> To calm me down, I was really wild. I was answering my mother back and she wouldn't yell at me, I would yell at her. I don't know. I was pretty wild when I was younger. **(F)**

> To escape what was going on. Whether I talked to my counselor or in the group, I felt I wasn't alone. My goal was to get away from it, to work around it. I wanted things to change within the family. **(H)**

> I wanted to do better in school. That's basically it. I felt bad about messing up in school. She wanted to know what was going on with me. **(B)**

For others, broader, more general goals worked better than setting specific goals. For example, E. described how she worked with her therapist to develop a sense of therapeutic purpose that felt suited to her sense of her situation:

> We talked about the problem. I don't know if we set goals or anything in the beginning, I think it was just more like learning about who I was and my situation. You know, I don't remember specific goals. Mainly it was just my situation, it was just me. She wasn't pushing me to, you know, we've got to stop this, we've got to put an end to this which I think for me was helpful. Like she looked at me like an individual instead of like all bulimic people, we have to do this, and really worked with where I was at, and where I needed to be. I don't think she ever said well by the end of this you will be cured one hundred percent. . .Yeah, and I'm glad cause I wouldn't have been able to deal with the goal setting, 'cause, that would put more pressure on me, and I think she realized that I had a lot of pressure on me...and different expectations from all over. From my school, and my dance, and my family, and that was an unnecessary burden. **(E)**

Similarly, several of the adolescents with addressed terminations described their goals for treatment in these ways:

> My goals were to say everything that I feel that I keep inside of me and to get some kind of advice, that's it. Advice about all the things that I feel. **(L)**

> Someone I can talk to who wouldn't tell my mother everything, some privacy. To make my relationship better with my parents and to get over what happened. **(N)**

For some, goals were general and for others they were concrete and specific:

> I guess getting a lot of things off my chest that I can't tell other people, just the talking, to have someone to talk to. **(K)**

> Just to help me, not really help me, but to get suggestions on how to study, plan out my time for doing homework and stuff. Stuff like that. **(M)**

In contrast to the adolescents with unaddressed terminations who were engaged in treatment, two of the six adolescents with addressed terminations expressed ambivalence and reluctance early in the treatment process. They indicated that they did not like the treatment experience and failed to find anything of value in it for themselves. They had no goals for treatment, except to cooperate with and/or appease others. As J. explained, when asked about goals for treatment:

> Just to make my grandmother happy and that's it, except to see if she'd talk to my grandmother about certain things. I don't know what they were but she always wanted me to come, real bad, to talk about my problems, she would say you must go. **(J)**

I. also had no goals for treatment:

> No, I didn't expect anything and you know, I didn't get anything. Since I didn't expect anything, I didn't have any goals. And you know, in turn, I got nothing, um, 'cause I didn't really want anything. Um, I guess a goal would just be seeing how it was. **(I)**

Working on and Solving Problems

Adolescents with unaddressed terminations described being engaged in an active process in which they were grappling and struggling with their concerns and problems. They recalled a process of problem-solving that kept them engaged, as indicated by the presence of goals and a focus for work. In the following comments about the experience of treatment, adolescents with unaddressed terminations reported that treatment was beneficial and that they continued to attend because they were gaining something for themselves. For example, G. chose to continue coming to treatment and use his therapy sessions to work on his problem with his mother:

> After awhile I had the liberty of choosing whether or not I wanted to come and so I kept coming because it helped me because that's why I kept coming and I wanted to say like every time I was coming I was trying to solve something, literally. If you really look at it, every time I was coming I was trying to solve the problem between me and my mother. Well I was coming because I was really having these problems with my mother, that's why I kept coming. **(G)**

In addition, some adolescents with unaddressed terminations reported that sessions held with their parents helped them understand their parents' perspective. A.'s description of conjoint sessions with his mother illustrates his engagement in the process of trying to communicate with her:

> Very descriptive, very real, emotional, a lot of heart to heart talks. Yeah, they were helpful. We always started out with a good topic, good questions, there was always the like heat, the heat, the heat, the meat of the problem and it always lasted the whole time and we just didn't have enough time and it ended off with a suspense, always shocking because you didn't know what the other person was thinking. Talking with my mother was more useful, to listen, because she said a lot of stuff. I didn't know she keeps things inside. I didn't know how my mother felt and she didn't know how I felt. **(A)**

Similarly, F., described a tumultuous process in which she was actively engaged in a struggle with both the clinician and her mother in her therapy sessions:

> Because she would explain to me how things had to go and I would tell her no, it's not that way cause, you know, I didn't see it as I had to listen. It was what I wanted, but it's not that way cause I had to listen to my mother and to what Ms. *(clinician)* was telling me, it was always disagreement. 'Cause she would tell me, well what do you think, and she would tell me no, it's not that way, that's not the right way, you have to see it this way. **(F)**

A Range of Engagement in the Treatment Process

In contrast to adolescents with unaddressed terminations who were generally engaged and involved in the treatment process, there was greater variability in the quality of engagement among adolescents with addressed terminations. Similar to the pattern for adolescents with unaddressed terminations, L. and K., described their enjoyment of the treatment experience. L. developed a trusting relationship with the clinician while engaged in a collaborative problem-solving process:

> I just talked to my counselor about everything. I was feeling bad and I felt comfortable with her. Oh yeah, I solved some of my problems--my friendship problems. I used to fight a lot with my friends... we were just fighting for nothing. She advised me, she was like, I forget what she said, but she helped me, but I forget now. **(L)**

Likewise, K., who initially displayed considerable resistance to treatment, described how she gradually became engaged in treatment and enjoyed it, finding it valuable to talk to someone about herself. In addition, the presence of friends who also went to counseling normalized the experience for her and provided social benefits as well:

> At first I really didn't want to come and my mother started using it against me as a punishment and things like that and so that's when I started going. And then I really started liking coming on my own cause for the first few weeks I really didn't want to come and my mother was like if you don't go, you can't go here on the weekends so I came anyway because, you know, I wanted to go where I wanted to go on the weekends. When I started really liking coming here is when I saw a lot of people I knew, my friend came here, a couple of my friends came here. She went to another counselor, we went to the same school also we started making our appointments at the same time and getting together afterwards. So I just ended up coming. But then after a while I started you know, liking it. Just the talking, conversating, I kind of like telling people about myself. Yeah because I like talking about myself, I like telling people about my life, I had a rough life, or I believe so, I did a lot of things faster than normal people. **(K)**

However, as she proceeded in the treatment process, K. described the experience with greater indifference:

> It wasn't like heavy deep conversation because we didn't have anything to talk about. The main thing I did talk about was like the problems I was having with my mother that was mainly it, and well you know, it was me just sitting there talking, you know it wasn't like exciting or boring I guess it was just in between, you know, it was just, you know, there. **(K)**

In contrast to those adolescents with unaddressed terminations who were actively solving problems and engaged in the treatment process, J. was indifferent to the treatment process. She reported how she communicated her lack of interest and disengagement from the treatment process by her silent, sullen, angry behavior:

> She knew I hated it because I just sat there really quiet. Like the time I didn't say anything or when I had an attitude and I told her I talked about these things and I don't feel like repeating it. I probably gave her a hard time. I don't feel bad about it. **(J)**

Indifference was also expressed by I., who was clear from the start that he was not interested in treatment. In his therapy sessions, he was cooperative and polite, however, he never became engaged in treatment. In contrast to those who saw a benefit in talking about their problems, he experienced no tangible, concrete results from treatment:

> Basically when I came to counseling, what we discussed was my parents divorce, and I felt I didn't want to tell her about it 'cause I didn't know her, and also that... Um... Also telling her would do nothing for me, it wouldn't speed up the divorce any. It wouldn't make my father more understanding. So it really doesn't do anything. I would say talking about it, it was really indifferent. It didn't really matter to me. If you ask me, you know, I'll tell you. But it didn't really help me that much. Emotionally, I didn't feel it did anything for me. **(I)**

III. THE TERMINATION PROCESS: HOW AND WHY THE ADOLESCENTS TERMINATED TREATMENT?

Overview

The findings in this section include a discussion of how and why the adolescents with both unaddressed and addressed terminations discontinued treatment, their reactions and feelings about the process of discontinuing treatment, and the reasons that a termination process occurred or did not occur.

Adolescents with unaddressed terminations generally either gradually or abruptly disengaged from the treatment process and eventually stopped attending, without having a discussion with the clinician about this decision. Previous research in the same setting, based on practitioners' perceptions of the termination process (Mirabito, 1993), captures the common phenomenon of unaddressed termination that occurs in the treatment of adolescents. Clinicians described unaddressed terminations as normative, unplanned, unannounced, and unilateral:

> Endings do happen, but they are not planned endings. I can recall only a few announced terminations. Very often there isn't a real decision to end treatment.
>
> It's very rare that termination is planned. Tons of kids just leave.
>
> Termination with adolescents is usually unilateral. In the two years that I've been here, I haven't had a termination in the traditional sense. Often they leave and don't say good-bye.
>
> If it isn't short-term treatment or if a clear contract isn't defined in the beginning, termination just doesn't happen.

As indicated by the quantitative findings reported in Chapter IV, termination was a brief process, ranging from one to five sessions. As described by clinicians in this setting, these terminations do not conform to the theoretical model clinicians were taught to expect (Mirabito, 1993):

> Unlike the terminations we learned about in Social Work school, some adolescents are ready to terminate in one session.
>
> Termination could be one session, part of a session, or over the telephone. It may not be a textbook termination, but I'm not sure how realistic that is in an agency.

As discussed earlier in this chapter, the majority of adolescents with unaddressed terminations reported that they were engaged and involved in treatment and found it helpful. Among those with unaddressed terminations, the most frequently reported factors that contributed to adolescents' decisions to discontinue treatment included: developmental thrusts toward separation, independence, and autonomy; improvement and/or resolution of their problems; and the interruption of treatment by situational factors. In contrast, the most frequently reported themes that emerged as reasons that adolescents with addressed terminations discontinued treatment included: a lack of engagement in treatment; a perception that treatment was not helping; and a lack of resolution of family problems.

While five of the eight adolescents who had unaddressed terminations described feelings of resolution and completion regarding the termination of treatment, three of the eight described feelings of ambivalence and regret associated with a lack of completion of

treatment. In addition, adolescents with unaddressed terminations indicated that they did not identify a need for a termination process. Alternatively, the most frequently reported feelings about termination among the adolescents who had addressed terminations were relief and satisfaction that treatment was terminated. Those who had addressed terminations reported that they discussed termination with the clinician primarily because the clinician raised it, and they felt that it was socially appropriate to do so.

How and Why The Adolescents Terminated from Treatment

DeWald (1964) points out that just as adolescents struggle for emancipation, separation, independence, and autonomy, these are the same themes that typically occur in the termination phase with all clients. The ways in which the adolescents were grappling with and mastering the normative developmental tasks of adolescence including separation, independence, and autonomy emerged as prominent themes that significantly influenced the ways they disengaged from treatment and their reasons for doing so. The degree to which these themes were central and integral to the termination process was striking, though not surprising, since these are the essential tasks of adolescent development.

While the majority of the adolescents with unaddressed terminations indicated that termination was unplanned and unexpected, there was considerable variation in how termination occurred. Some described a process of abruptly leaving without giving any notice to the clinician, while others described gradually "phasing out" of treatment. Many of the adolescents could not recall specific events in their lives at the time that they

terminated from treatment. This is illustrated by the response of C., a twenty year-old girl who was asked what was happening in her life at the time that she discontinued treatment:

> Honestly I don't remember anything life altering or major at the time. I had my minor every day pains that everyone does, but nothing staggering. **(C)**

In contrast to the adolescents with unaddressed terminations, in four of the six cases of addressed terminations, termination was initiated by the clinician. In three of these cases, the clinician initiated termination in response to either a direct request or behavioral indications from the adolescents that they no longer wanted to continue treatment. In only one case, the clinician initiated termination when agreed upon goals had been reached. Termination was initiated by adolescents in the remaining two cases. In one of these, the adolescent stated that he did not believe there was a need for treatment, and in the other the adolescent terminated because her parents prohibited her from attending treatment.

Developmental Tasks: Separation, Independence, Autonomy

Initiation of Termination: Control and Autonomy

For adolescents, who are actively struggling with the tasks of separation and independence from their parents and other adults, the therapeutic relationship represents another potentially dependent relationship from which they must separate. The findings in this study indicate that the decision about when and how to disengage from treatment was an individual one reflecting an assertion of the adolescent's independence and

autonomy. As suggested by Sanville (1982) , the adolescents had their own "inner measures about timing" (p.124) regarding when to terminate treatment. In addition, as described by Miller (1990), age and stage of development (early, middle, late adolescence) clearly influenced how the adolescents made the decision about when and how to terminate from treatment.

A common theme that emerged in the interviews was the importance for the adolescents to have control of termination, rather than having this decision imposed by a parent or the therapist. In some cases, being in control of ending therapy was clearly a way to assert one's autonomy. G., a fourteen year-old boy with an unaddressed termination, (whose mother had briefly been involved in treatment because of a concern about his safety), expressed his ambivalence about the continued need for help in his developmental struggle for autonomy and independence from his mother. Ultimately, his decision to end treatment was both an act of rebellion against his mother and a way for him to assert his autonomy and begin to separate from her. Conflict and ambivalence concerning separation and autonomy from both his mother and the clinician, a normative part of the developmental process of adolescence, was clearly reflected in his decision about whether or not he still needed help from the clinician:

> My mother told me I should still go but I just never went because it was my choice and I didn't want to go again. Also (*clinician*) said, 'is it your mother's choice for you to come or is it your choice'? If you don't feel comfortable, you don't have to come and stuff. And then I was like, I'm tired of her forcing me to do stuff that I don't want to do and I said that I wanted to come still and stuff like that but after that incident happened with my mother, I guess I said I don't want to come and stuff. I had made an appointment to see her, but then I just forgot to come because my mother

> started getting on my nerves again. And I was like, well maybe I do need to speak to someone to know how to deal with her but then I just forgot to go and then after that I never got the chance to call back again. **(G)**

E., a twenty-two year-old girl who came to treatment because she was bulimic, described the gradual process of disengagement from treatment that occurred as she developed an increasing sense of independence and autonomy. She too, described why it was important for her to be in control of ending treatment:

> I think it was because I initiated it. I think it's important that I'm in control of my life, and I think that my understanding of therapy would be that you have no control, you're going in there because you have no control, you know, and in some ways being bulimic you're out of control. And in some ways being able to have that power to start something and end it was very important. I think she knew that and for me it was very empowering, and it was like I know I'm getting ready to finish it now. It was very important that it was all my decision, and I think I wasn't at a point where I was in danger of harming myself. She felt confident enough to just give me that. I also am very clear about what I need, and I think that helped in my situation. **(E)**

Like many of the adolescents who are gradually separating from adults and becoming independent, E. benefitted from a gradual process of termination. Despite the fact that she had to terminate treatment because she was "aging-out" of services, she still wanted to be in control of when and how it ended:

> At 21, she explained to me, you know I said that at 21 it's over. She said well, actually we've been talking at the clinic that it really puts a quick end to things when you say at 21 it's all over. And she was like, we are actually going to extend it. It's actually OK for people over 21 to come, and I was like, OK, it's a relief, I can come for one more year. And I think that probably helped a lot, knowing that I could have one extra year, and I could end it, and it wasn't her. **(E)**

While the adolescents with unaddressed terminations did not report discussing termination at the beginning of treatment, three of the adolescents with addressed terminations recalled that at the beginning of treatment they were told by their clinicians that they could stop treatment whenever they wanted to. They remarked that in beginning treatment, their clinicians emphasized that the decision to continue treatment was ultimately their own. This typically occurred in cases in which there was considerable initial reluctance, ambivalence, or resistance to treatment. For example, I., who was clearly not interested in coming to treatment from the start, recalled that his clinician attempted to engage him in the beginning of treatment by giving him permission to stop at any time:

> When I came in the first session I said I really didn't want to come. And she said just try it out a few sessions and if you don't like it you can stop any time. So I agreed to that. I felt my original idea was that I didn't want to come at all, and since she said that, that kind of obliged me to continue, 'cause she said it so nicely, and so I said OK. I guess she said it because she figured that after coming for awhile I would feel more comfortable and continue the um... social help. So, that was a way to get me to stay. **(I)**

After six sessions, he raised the issue of termination, having decided that treatment was not working for him:

> I did stay for a few sessions but at the end I still decided I didn't like it...She did say that I could try it out, and if I didn't like it I could stop, and I gave it a try, and it didn't do anything, so I decided to stop...Well, I discussed it with her already, and at the end I just said I don't feel that this is helping me any, and that I believe I should discontinue coming. And that was the last session. **(I)**

K., who also displayed initial ambivalence to treatment recalled a similar discussion with her clinician:

> I think she told me in the beginning um, whenever you're ready to stop, you can stop coming or whatever. I believe that's what she said in the beginning that I could stop coming, that she's not forcing me to come that nobody's forcing me to come. She's like, it has to be on my own. **(K)**

Like others with addressed terminations, K. described engaging in a variety of behaviors to communicate her disinterest in treatment that are well known to clinicians who work with adolescents, such as missing appointments, coming to sessions late, or presenting in sessions as either silent or sullen. K. described how she communicated her lack of interest in treatment through her behavior. She explained that she lied to her mother about coming, came late, and even came to some sessions under the influence of drugs:

> I think I did that a couple of times and I got in trouble because she would call and say, no I didn't come in. I don't think I did it on purpose. I think I might have lost track of time and then this is like out of the way from where I live and like where everything else is because like everything is closer to me, my school and everything is on the West Side. In between sessions I would get out of school early and my sessions were like 4:15 or 4:30, so I didn't have anything to do between school and here, so I would go to a friend's house and dilly dally and end up coming late, or missing it, or maybe I was high or something, I don't know. **(K)**

In response to this behavior and perhaps as a result of her own frustration with the lack of progress in the case, K.'s clinician initiated a discussion about termination. As she explained, the clinician offered the option to terminate treatment and she took it:

> She brought it up the first time, she mentioned it, like she said you don't really have to come to counseling if you don't want to, you know, things like that, cause towards the end I remember I was coming in like real late, like I forgot how long the session was but I was coming in like close to when the session was over, cause you know, because I didn't really want to come

> anymore. It was like there wasn't anything to talk about, it was boring, just dead boring, so I didn't want to come so I just came real, real late so the sessions were shorter. .. I think she agreed because I think she saw too that we didn't have anything to discuss and I think the sessions were like an hour or something or forty-five minutes. And we'd have like a little bit to say for the first fifteen minutes and then stop and we'd spend a long time just looking at each other and having nothing to say. She's waiting for me to say something and I didn't have anything to talk about. **(K)**

When asked how she thought the clinician viewed the plan to terminate, K. explained:

> I guess she thought it wasn't the best thing but she wasn't going to get in my way, and that's why she offered for me to come back if I needed to talk. **(K)**

Likewise, N., who was resistant to treatment from the start, explained that she was given a choice about attending treatment by her clinician because she did not think that it was helping her. In her description of their discussion about termination, the clinician's countertransferential response of frustration and anger, described in the literature (Meeks, 1971; 1990; Miller, 1990; Mishne, 1986) as common in the treatment of adolescents, was evident:

> I don't remember, but I guess I didn't want to come anymore and she saw that and she said think about it. She brought it up to me, she brought it up. Two sessions, two different times and then she was like, well, she seemed like she was annoyed, probably was nothing but it seemed like she was mad at me, she didn't talk about it. It seemed like she was, not mad at me, just annoyed.... like if you don't want to come, she explained, how it's my choice, it's up to me this decision and stuff like that. I only went two times after that, I think she really brought it up because she saw I didn't really want to come and it didn't seem like it was helping any. **(N)**

Separation and Independence

In contrast to those who gradually separated from treatment, D's sudden disappearance from treatment illustrates another common pattern of separation from treatment. His description aptly captures the conflicts adolescents experience around the competing demands of attachment and separation that are endemic to adolescence. Both Ekstein (1983) and Novick (1976; 1990) describe the dilemma adolescents experience in treatment as they struggle with both forming an attachment to the therapist and simultaneously coping with the tasks of separation and independence.

D.'s account of his sudden departure from treatment conveys the conflict that he experienced between attachment to the clinician and the treatment process, and the normative developmental need to do things on his own, to be independent, and to use his own resources to solve his problems rather than depending on an adult for guidance:

> Let's just put it this way, I was getting a little too close and I needed to do things myself. So after that a couple of months, about twelve or eighteen months later, I started going to her. I started enjoying going there practically once a week at least. I started coming here religiously coming down here every week, I mean once a week basically and then after that I suddenly stopped. After that one day I stopped going there because I wanted to like try by myself, you know, to see how I could do everything by myself without telling anything else to anybody. So that's why like two or three months later I started having a journal, my own personal journal. I started writing stuff, feelings or anything I could think of, write, and a date, and a time, whatever, a John Hancock, my signature. After that, I've been doing that for the past couple months and these past days working, praying that thank God, I have money in the bank. Actually I have two savings accounts. **(D)**

Meeks (1971), who discussed the ways in which clinicians' countertransferential reactions impact on the termination process said, "many adolescents seem slightly guilty and apologetic about the appropriate wish to terminate and handle their own affairs" (p. 183). Accordingly, during the follow-up interview, D. was initially unable to articulate his reasons for discontinuing treatment. He seemed to be reluctant to tell the interviewer why he stopped treatment, perhaps in the same way that he did not tell his therapist:

> The only thing I can say is that I can't remember, seriously, I don't know, I can't remember why I stopped coming, not because I didn't want to or anything else, no lie, no joke, no nothing. Seriously I forgot I can't remember why I stopped coming, no joke, nothing, I don't know why I stopped coming and the chart notes say why, I don't why. **(D)**

Upon further exploration, he described how he attempted to convey his readiness to terminate:

> I probably gave a couple of signals and I didn't even notice it myself. Talking less or talking about less problems that would be it, that probably could be it. **(D)**

By the end of the interview, he was much clearer about why he discontinued treatment:

> I think it's probably to prove to everybody else I could do things by myself without any help or if I need the help, I'll go and ask for it. If I don't need the help, I'll do it myself. I think that made sense and I think you found out why I stopped coming. Probably because, maybe because I was trying to prove to everyone else I could be independent, do everything my way, like it or not. I think that probably was the reason why. It makes more sense to me then saying I can't remember, that's no answer. **(D)**

The need for clinicians to bring the discussion of separation, autonomy, and independence into treatment is highlighted by this case, since adolescents often will not

do so themselves. As illustrated above, it is critical that clinicians recognize adolescents' progress with these developmental processes, and permit them to separate and "move on."

Resolution of Problems

Recurrent themes that emerged as reasons for the adolescents with unaddressed terminations to discontinue treatment were, an improvement in their situations, individual and family problems were resolved, and they correspondingly felt no need for further treatment. As clinicians in previous research in this setting (Mirabito, 1993) observed:

> Their approach to treatment is problem-focused. As soon as they develop ego strengths and are doing better, there is less of a problem focus. They have other things in their lives and they move on--on their own.
>
> They come in a crisis and when the crisis is abated, they leave. The whole idea of coming in when they are not feeling the pain is foreign to them.

As suggested by these clinicians, in this study, the adolescents with unaddressed terminations indicated that even though they still experienced problems, they did not view the need for continued treatment. Moreover, they most frequently expressed positive feelings about the termination of treatment because they associated leaving treatment with the improvement of their immediate concerns. For example, D., a sixteen year-old boy explains why he left treatment and how he currently handles the difficulties he encounters in his life:

> Everything else was getting better for me. I was satisfied that things were going right for once. I was pretty much satisfied that everything was going correctly. Well, my life was getting a little bit better, let's put it this way, my life getting a little bit better. Basically, everything, everything you could think of, school, work, going out, my clothes, doing basically whatever the

> hell I want sometimes, not much. These past days sometimes I probably have my ups and downs which I always get myself up again. If I have bad days basically sometimes I get bad days, and just pray that thank God that I get over that day everything goes wrong. Like where I'm working now as a security guard, some days I'm in such a real bad mood, I don't really want to know about anything, no one, nobody, or if I'm tired or in a bad mood, I have to forget about it. I have to do the job first, either way, like it or hate it. **(D)**

A., who participated in both individual and family treatment, was ready to end treatment before his mother was because he felt that his problems were resolved:

> It was sort of my decision that we stop. I thought that I was finished with it. I thought, OK, I can't keep dwelling on it. It's part of my past. She wants to dwell on issues but I can't do that. She being my mother. **(A)**

Similarly, F. described how she resolved her initial problems and no longer experienced a need for treatment:

> After a while, I just gave up, I started listening to my mother and there weren't any problems. Yeah, I gave up because I wanted everything the way I wanted it but I saw that it wasn't getting nowhere so I just forgot about it. I said it wouldn't be bad to continue but then when I lost contact, I didn't go back. My mother asked me if I still wanted to go and I told her, you know, it's good to talk to someone even though there's not a problem but I didn't think that I needed it anymore. **(F)**

Although B. explained that he was ready to leave treatment because his immediate presenting problems had improved and his situation had stabilized, he also indicated that, in retrospect, he thought it would have been valuable to continue:

> When I stopped things were back to normal. Schoolwise, I was doing better, passing classes, I think it was just a phase of growing up. It wasn't better or worse, just a phase. With the path I took, coming to counseling would have changed my path in a better way because I'd be more aware of my actions in

> school. It's good to keep an update with someone asking about you, to update them about how things are going. I figured I could come back anytime. I knew I could come back, but I never did. **(B)**

Six of the eight adolescents with unaddressed terminations terminated treatment because problems were resolved, while only one of the adolescents with an addressed termination ended treatment for this reason. L. terminated brief treatment by mutual agreement with her clinician and her mother because her problems were resolved. It is noteworthy however, that during the follow-up interview, she indicated that she now had new problems and wanted to reconnect with her clinician to address them. Having had a good experience in the past, she wanted to return to work on them:

> I stopped coming because by that time the problems that I had they were resolved already, so I stopped coming. I didn't have any more problems at all, but next year and this year I started having more problems because I stopped coming. **(L)**

Problems Unresolved

In the cases of addressed terminations, the most frequent reason for termination was a lack of engagement in the treatment process that resulted from the adolescent's perception, sometimes shared by the clinician, that treatment was not helping. In several empirical studies of termination with adults (Fortune, 1985; Fortune et al., 1991; Kramer, 1986), clinicians reported that they generally waited for clients to initiate termination rather than introducing it themselves. By contrast, in this study, a critical factor that led to termination was the clinician's initiation of termination, in response to the adolescent's initial and continued lack of engagement in treatment. Specifically, in three of the six

cases of addressed terminations, clinicians initiated a discussion of termination both in the beginning of treatment, as a means of engagement, and at the end of treatment when the adolescents felt that treatment was not helping.

Empirical studies (Fortune et al., 1991; Quintana and Holahan, 1992) indicate that successful case outcome was the criterion utilized most frequently by clinicians to determine readiness for termination. In stark contrast to these findings, in several of the cases of addressed terminations in this study, termination was most often initiated by the clinician when the outcome of the case was not successful.

Unresolved Difficulties with Parents

Three of the six adolescents with addressed terminations described unsuccessful attempts to address and resolve family problems in treatment. Although they felt misunderstood by their parents, several reported that they disliked having their parents involved in treatment. While clinicians attempted to involve parents in efforts to help the adolescents, as illustrated in the following accounts, the adolescents generally felt that parental involvement was not helpful, or in some cases, made the problem worse. In these cases, termination ultimately occurred because parents were not adequately or effectively engaged in treatment.

While difficulties in her family were her primary concern, J. found the involvement of her mother and grandmother in treatment even less helpful than her own individual sessions:

> It seemed like a waste of my time, usually I came by myself, sometimes my grandmother came when there was a problem and even my mother came I think twice. I didn't like it at all with them there, it was even worse because I thought they probably were talking about me. I would rather they not be there at all, it was the social worker's idea for them to come. **(J)**

N., who initially came to treatment to resolve issues related to a rape, explained that conflicts with her mother eventually became the primary focus of her treatment:

> My relationship with my mother was getting sour, it got worse and it turned out to be the main reason for coming. **(N)**

Similarly, for N., family involvement was difficult and, from her perspective, made the problem worse:

> I went for a half hour to an hour once a week. She would give me appointments, and remind me the day before, I'd talk about what I wanted to, she'd give me advice, I'd take it or leave it, in the last five minutes, she would call in my mother to talk to her briefly. It was stressful because of my parents, but if my parents hadn't interfered like they did, it would have been better. When I got home, they would drive me crazy, bring a lot of things up, it went from bad to worse. **(N)**

She explained that eventually, as a result of a disagreement between the clinician and her mother, her parents would not allow her to continue in treatment:

> My mother kept interfering and she didn't want me to come anymore. My mother didn't want me to come because the counselor told her she was wrong about giving me space. She doesn't like to be corrected. She was telling her to leave me alone, give me some space, the more you smother somebody, the more they are going to want to leave. .. My mother got mad, forbade me to see (*clinician*). With my parents, I developed a negative attitude about counseling. **(N)**

Although she explained to the clinician that she would be discontinuing treatment, N. acknowledged that she never really discussed with her the extent of the difficulties with her parents:

> In the last session my counselor asked me why, I told her it wasn't working. ...Vaguely, I talked and I told her I wouldn't be coming anymore because my parents didn't want me to. I told her it wasn't working anymore. I felt it wasn't working, they were getting aggravated, they weren't giving me space. I never really told her why it wasn't working. I went around it. **(N)**

K. described how the clinician attempted, unsuccessfully, to act as a mediator to manage the conflicts with her mother:

> Like my mother would call her by phone, like if she found out something about me with her snooping and stuff, and say like to my counselor, to my old counselor, and say like oh, talk to her about her smoking weed and smoking cigarettes and stuff like that. She would call and tell her what I was doing and when I came in the counselor would ask me, you know, around that subject. I hated that because I don't like my mother snooping and then whether I'm doing things I'm not supposed to be if she would make it easier for me to talk to her about things then I wouldn't have to hide them. **(K)**

Engaging parents and adolescents in treatment together can be challenging. In K's case, although family treatment seemed to be needed, neither K. nor her mother wanted it:

> She said you know bring your mother in this time but then my mother would be like, like we're sitting in here and we're trying to talk it out and you know, we just started arguing and like when we leave she doesn't want to speak to me. Like when she wanted me to bring my mother in the next week and my mother was like, I don't need no stupid counseling and all of this stuff and she started being a real bitch about it. And she was the one that, and I told her that you know, the problems not with school or anything, it's with you and she was like she had an attitude and she didn't want to listen either. I guess she's the same way. Yeah, she was like I don't want to listen to the counselor, I don't have time. Back then I was young, running wild so if anyone gets an attitude with me I wouldn't let anyone, I didn't like any

> authority or anything like that, I was just hard headed I guess you could say, I didn't want to hear anything. Because (*clinician*) was like I could call her and tell her to come and we could discuss this together because that's what the problem is, she just had an attitude about it, she didn't want to speak to me or anybody you know. No, I didn't want to be anywhere near my mother I wanted to be away from her. **(K)**

While K. did not think that she had any of her own problems, she acknowledged that problems remained in her relationship with her mother. Ultimately, however, the failure to engage her and her mother together led to the termination of treatment. After unsuccessful efforts to resolve problems with her mother, K. decided that it was time to stop because she did not believe the problems could be resolved:

> Well, when I left counseling nothing really changed about me. The reason I left was that the counselor and I you know didn't see any reason for me to be coming there. Because I didn't see that I was getting anything out of it, except for just talking, just talking about things... She thought that I didn't really have any problems, most of the problems were with my mother. My mother came in, you know, see we were arguing back and forth and things and she said if I wanted to stop I could stop coming because she was like this, its not really helping anything with me or anything like that. **(K)**

While six of the adolescents with unaddressed terminations reported that they ended treatment because problems were resolved, G., who was clearly frustrated with the lack of improvement in his relationship with his mother and the slow pace of therapy, also decided it was time to discontinue treatment and try to solve the problem by himself. Having had counseling in the past, he reflected upon how, as an adolescent, he had more insight into the problem:

> I was going to counseling since I was younger and there I didn't really like it or whatever...I guess as I got older I knew what I was feeling more because you get more of a sense of what's going on as you get older... It stopped I think when I was fourteen going on fifteen or I was thirteen going on

> fourteen. I really don't remember the age but I know it was because I was getting upset about the fact that nothing was happening, it was like I was coming in for an hour and then I was going back home and the problem was still right there. It wasn't helping me because she was not in my house, that's one thing I said to her that she was not in my house and I'm the one who has to go back home and listen to her, my mother, you know was still doing the same things to me. Toward the end I was just saying that I could deal with the problem that I didn't really need to go because like I thought it was going too slow and she wasn't coming in enough, that she wasn't talking about like when she was coming in, I would say well you do this to me. She would always respond to it by something like I'm disrespectful, so I just felt that it's an adult's word over mine and I might as well just forget about it. I can deal with the problem myself and that it would go faster. **(G)**

Interruptions

Four of the eight adolescents with unaddressed terminations reported that treatment was interrupted by various life events, such as working, going on vacation, or going away to college. While they often described an intention to continue treatment, they frequently reported that they did not continue because they "lost contact" with the clinician or the relationship "died out." Three of the adolescents were ready to discontinue treatment, and the interruption provided a "natural" ending to do so. This was the case for A., who entered and left treatment several times, both individually and with his mother. His treatment discontinued when he went away to college an hour from the clinic. He explained that there was no formal termination because his mother continued to seek services sporadically for herself and for him. From his perspective, however, the work was done:

> We set up appointments. We set up an appointment in September and then it sort of died out. I felt good because I got what exactly what I wanted. We did try to talk about it but we always came back so I don't know. It ended good, like when we ended I thought that was it each time we ended. I thought that was it but there was always something new with my Mom. **(A)**

Similarly, treatment was permanently interrupted for F. by a six week vacation. Although she had planned to continue, she explained that she did not return because she changed her "attitude" and felt less of a need for treatment:

> I went to Florida with my aunt and after that I didn't go back to counseling. What happened was, I was going on vacation and I told her, first it was like twice every week that I was coming, then it came down to once, then I went on vacation and then from there we lost contact. Yeah, I told her, she knew exactly when I was coming back and she called but then being that it was summer and I wasn't home that much I never got a chance to really call back and set any appointment to come back to counseling. My mother asked me if I still wanted to go and I told her, you know, it's good to talk to someone even though there's not a problem but I didn't think that I needed it anymore. **(F)**

In contrast to those who no longer felt a need for treatment, H. regretted the fact that her treatment was interrupted by other demands in her life. Although termination from a weekly group was unplanned and unexpected because of these competing demands, she still felt a desire to continue:

> I started working full-time and going to school. I was working forty hours a week. I never felt that I outgrew it or didn't need it at the time--it was circumstantial at the time. It was unexpected to stop coming. I expected to be working less but I took on a lot more than I could handle. It was kind of like taking a break from group but I also felt like I was leaving it behind. I felt really bad because I felt like I was leaving it behind, just shutting the door. I felt bad about leaving the group behind. My counselor called me and I came in once when I had a Dr.'s appointment and I'd see one of the group members once in a while, or chatting on the phone, I called them. **(H)**

The quantitative findings discussed in Chapter IV indicated that summer was a natural interruption that frequently resulted in the termination of treatment. In G.'s case, anger about the clinician's call to his mother when he expressed suicidal ideation, combined with the natural interruption of summer vacation and employment, led to the termination of his treatment:

> I think I stopped after that incident with calling my mother, after that I was really mad about that. I probably came like three times after that and then the summer came and I think I was working at the time downtown and I didn't feel like being able to come there and then come up here. So I think I was like, oh forget it, I'm not coming anymore. It had to be when I was fourteen. I know now because you can only work at fourteen. **(G)**

Disappointment and Regret

In only two of the eight cases, adolescents with unaddressed terminations discontinued treatment because they were not motivated. While they expressed an interest in treatment and a belief that it was needed and could have been helpful to them, they lacked adequate motivation to continue. Moreover, they both expressed feelings of regret that they had not better utilized or completed treatment. For example, C., who had left and returned to treatment over a two year period, eventually terminated at age twenty after a longstanding pattern of sporadic attendance and lateness. In describing how she ended treatment, she emphasized her continued need for treatment but her inability to utilize it. Moreover, because of her embarrassment and shame about her poor attendance and lateness, she "faded out" and felt that she could not return:

> I guess the easiest way of saying it, is that it just happened. I hate using that line. I didn't want to but I did it anyway. I guess you could say, you know how they say, you are your own worst enemy. I faded out because I felt

> ashamed about coming late, and taking up her time that she didn't have... I mean it was nothing personal, nothing against her, or her services. I mean she was wonderful, I'll tell her that right now. She was a wonderful counselor, I had no problems what so ever. Basically it was like pretty much myself, I felt so ashamed of, you know, coming late all the time. Cause I knew it was for the good of me so why am I messing it up? Why am I messing up a good thing? A lot of people have to pay for their counseling. I don't have to pay or anything here. I hadn't had a problem with the area, the people, so I don't know why I was rude like that. I'm just late for practically everything.... I knew I needed it. It was my own lack of self discipline. There was no apathy. But lack of self discipline. It's what I need. ..I just felt ashamed. I felt like pretty indecisive...So I let it happen, I didn't face it, I didn't deal with it. I didn't want to deal with it, so weeks became months, months became years and that was it. **(C)**

In retrospect, she recognized that even at age twenty, she needed and would have benefitted from additional active and assertive outreach by the clinician in order to better utilize treatment:

> I know I come across as a certain type of adult which is true, but when it comes to my discipline, I'm really bad....I admit I'm a procrastinator. I mean if she was going to call me up and ask me about coming, I would have liked that too. That would have helped. I wouldn't have beat myself up over it because I didn't show. She can't make me come. I guess maybe if she had said I really want you to come, maybe that would have made me. I mean I'm not blaming anything on her what so ever. Like I said, like I realized today, I do respond to forwardness and assertiveness. I'm like wow, yeah, I like it...That's one of the reasons why I look forward to joining the marines because I know that they are going to make me a different woman. I will be structured. I will have discipline. They will drive it into me so to speak. **(C)**

Similarly, B. explained that he was interested in treatment and felt it was helpful. However, while he acknowledged that coming for treatment had been somewhat difficult for him emotionally, his lack of motivation was the primary reason that he discontinued treatment:

> I was lazy. I guess, laziness. I can't say because of lack of interest. Cause the topics were interesting when I came. I had a lot to express. It was laziness because when I was coming after school, I wanted to stay home instead of taking the detour to come here. I still was interested. The last time I came was when my mother came. Things were being expressed, and it felt pretty good. The truth was coming out. It was a little uncomfortable but it ended up well. I had an appointment to return but I didn't come. The counselor called but I lost her number and I never called her back. **(B)**

Nonetheless, he expressed regret about not completing treatment:

> I felt I didn't complete it, I didn't narrow everything down after me and my mother came, I just left. I wasn't done but I left anyway. You know I was like I should have stayed, it was not too long ago that I thought I should have stayed...I was thinking about counseling, thinking about what I was like then, thinking I should have completed it. I would feel much better--like I didn't leave things undone. When I left I thought about coming back but I had already lost contact with her, I lost her number and stuff...I think it ended sad because I didn't come back. It wasn't a happy ending. I should have come back because she arranged an appointment for me to come and I didn't come. **(B)**

Two adolescents with addressed terminations also expressed feelings of regret that they would not be able to continue to see the clinician and would not have anyone to talk to about remaining or new problems. N. regretted that her treatment ended prematurely, yet felt that because her parents did not support it, she had no other choice. She described her feelings about the termination of treatment in this way:

> I wish it didn't end but it ended and there isn't much I could do about it. I still come around. I was frustrated and very nonchalant...I wish I would of kept seeing her but it was too stressful. My parents got off my back a little. I was upset because I had no one to talk to. **(N)**

Although L. was satisfied with her experience, in retrospect, she recognized that she would miss having someone to talk to, as she did not feel that she had adequate supports in her life:

> I didn't feel sad, I just knew I was going to miss her because at the time that I had a problem I knew I would have no one to talk with. **(L)**

By contrast, M. was glad that he no longer had to come for treatment, however, he also expressed some regret because of continuing problems in his family that were never resolved:

> I felt like we didn't finish. We didn't get to accomplish the stuff. The different things. Like how everybody was towards me. And stuff like that. 'Cause like three weeks ago, my father started back on drugs, you could say. And that pulled me apart from him. And I'll do like little things to annoy him. And he will be like why are you doing this. But he never told me this. He never said, oh why are you acting like this. You know I'll be like why are you doing this. He would never tell me, I don't know little by little, he does things that pull me away from him. **(M)**

Because of unresolved family difficulties, in retrospect, M. described the value of continued contact with the clinician to keep an "update" with his and his family's continuing development:

> Um, not that I have no time free it was just that it was someone to see how I am, and up to date and stuff. Like update things that are happening. Things that are happening now and stuff, like a job and stuff, and camp and how my mother, father, and I are getting along. **(M)**

Reasons for the Absence of a Termination Process

Two themes emerged most often as reasons that adolescents with unaddressed terminations did not discuss leaving treatment with the clinician. First, four associated ending the therapeutic relationship with other losses in their lives. Accordingly, they thought it would have been difficult to say "goodbye" to the clinician, or they did not feel the need to say goodbye because they were accustomed to multiple changes in their lives.

Second, as a result of their continuing development, three adolescents did not feel the need for a termination process because they did not experience terminating treatment as an "ending." In fact, their focus was not on ending or terminating, but rather on growing and changing. Consistent with their continuing development, some wanted to maintain a continuing relationship with the clinician by "keeping the door open" for future contact.

Feelings of Loss

Levinson (1977) described the ways in which previous losses of significant persons are re-experienced at the time of termination and how these impact on the termination process. Four adolescents who had unaddressed terminations described feelings of loss and sadness associated with termination and indicated that for this reason, they did not have a termination process. Three adolescents associated these feelings of sadness and loss with previous losses in their lives, while one described general feelings of sadness saying goodbye. Interestingly, all those who described feelings of sadness or loss were females. Four girls described the difficulty they would have had saying goodbye because of the attachment they felt with the clinician. F. described why it would have been difficult for her to say goodbye to her therapist:

> Like if you had a best friend and she was going to be moving away. I guess I'd try to talk to her. It's a lot different with a counselor because you won't talk to your friends about those personal things. With a counselor you would talk about the most personal things, it's better than a friend. To say goodbye it's harder than with a best friend. Your friends come and go but when you think about it, that person was there for you. **(F)**

Moreover, she connected her feelings of sadness about saying goodbye to her therapist to the difficulty she had when her great grandmother died. In describing her dilemma about saying goodbye to her therapist, she reflected on this past loss:

> I was thinking about my great grandmother and thinking how difficult it would be. I thought it would be better not to call because I was going to feel sad, saying goodbye. I didn't really know her that well but she used to speak Spanish and I didn't know a word of Spanish and I would just go visit her with my mother and brother but then I used to see her suffer, lay in the bed, with the nurse coming over, but being that she was a part of my family, like I felt the pain for her. And I knew it right there, it would be hard to say goodbye to a person I got close to. **(F)**

While her ambivalence about the decision is evident, upon reflection, she regretted not having said goodbye to her therapist:

> I think it's better to say goodbye because you know you're saying goodbye, it's not like what I did, not calling. It's better because you know and your counselor knows that you're not going to be seeing each other again. I should have gone back. This way she would have known a little more about you know, if I was going to go to counseling or not but I never got a chance to. Uh, it would have been better, to say, you know, goodbye, thank you for helping me with life you know how I came out to be. At the time to me it was fine but what I should of done was tell her anyway because one day or another she would have said I didn't need the counseling. But I didn't because I was going to feel bad about things. I wasn't going to see her after I got close to her and spoke openly about things. It's hard to say goodbye. Let's say I called her and told her I didn't need counseling anymore. I'd feel bad if I would change my mind, I felt both ways, partly I felt everything is OK but being that I got so close to her, maybe I shouldn't call her. I was feeling sad, I probably would have cried then I'd want to just say I'm feeling sad but you get over it after awhile then all you have is the memories.... Well, yeah when you get close to a person, it's hard. **(F)**

In a similar way, E., twenty-two years old, attributed her gradual phasing out of treatment to the difficulty she had with "endings." As a result of her past associations with loss and transition, she knew that a termination process would have aroused difficult feelings

and consequently, she preferred to leave the door open. As described by Meeks (1971), it was important for her to be able to "visit home briefly," rather than give up the image of her therapist. Upon reflection, she felt that this was also understood by her therapist:

> She knew how I would cope with situations, and a long procedure of ending would not be good for me. I would not have responded very well to that because I probably would not have ended up coming any more. ... I think about all my situations. It's a pattern with me. I ended up staying five years in college, I had to prolong that ending one extra year. Even with dance. I didn't end completely, I dwindled. That last year, I used to go less, and less, and less, and then at eighteen, I stopped. I couldn't just have a cut and dry ending. It wasn't necessary for me to do that. I think it was what my needs were, and her accepting the way that I would need to deal with ending. I always had trouble with ending. That was the whole thing, now thinking back. From the beginning, part of dealing with bulimia, was putting an end to things, like I have trouble with endings. Like if you give me a long ending, it would probably have triggered a lot of things for me, 'cause, part of the way I dealt with ending was to be bulimic, and she knew that. I have a lot of trouble with that. I don't think I would have responded very well to ending with this. Keeping it open-ended, there has never been an ending in my mind. I know that she would be there. I know maybe not to speak with me for a long period of time, yeah she would probably be available to talk to. I don't think she ever really put an ending for a reason. I don't know if she does that with everybody, but for me it helped. Like for me, I don't need to call her, but I know that she is there, and we had a lot of conversations about how I had trouble with endings, and so she probably picked up on that and that is why we never had a very clearly delineated ending session. It was kept open-ended for a reason. You learn things when you reflect. **(E)**

Upon reflection, C. discovered that the way she left treatment was similar to the way she handled other relationships in her life. She noted a pattern in her life of leaving important relationships to avoid experiencing feelings of loss, linking this pattern to the loss of her father. As a result of these feelings she was never able to fully utilize treatment and needed to be in control of it ending:

> I'm really thinking, now that I'm talking this openly I'm really thinking that the reason I don't maintain long term relationships, when it comes to love, romantic love, I do that. I have noticed this. Either I will to do something subconsciously or inadvertently to screw it up so that it doesn't last, or I will consciously terminate that relationship, so I don't get hurt in the end. It is ridiculous, kind of ironic, 'cause they're gone. The fact that they are gone, whether it is my doing or theirs, I'm still hurt...Honestly I'm not too sure about that, but I felt comfortable, I bared my soul to her. I mean I know we weren't best friends or anything, but that's not the thing. I guess with anyone, regardless if it's a friend or relative, or counselor, anyone who I bare my soul to, I guess it seems at a certain time I will stop it whether I realize it or not. I'll sabotage it so that it does stop. I don't want to blame my father, but I guess it's because of his leaving. A lot of people don't realize the impact it has on a child when a parent leaves, they really don't. It comes out and shows in ways people don't even realize it can happen. Like me, I don't like... I don't view myself as the marrying type. I have no intentions of getting married and having children. I'll be damned if my husband leaves me for another woman. I'll raise hell... A lot of people leave and I had no power over it. No control. So I guess that's why I like to control when a person will leave, even when it hurts me. At least I know it happened because I did it, not because they wanted to. He left for this woman, and it was hell on all of us. I'm sure he knew it had an impact on us, but I don't realize the extent of the impact it had on us, or me particularly. Because I was his first child. I was very much a daddy's girl lets say. I was very close to him. I can't even describe how close I was to my father...I look at myself, and my relationships with guys and people in general, and I do that. I stop it before it would end on it's own or whatever. **(C)**

H. also attributed her departure from group treatment, without a termination process, to the difficulty she would have experienced saying goodbye. She didn't want to have a permanent ending, however she regretted not having said goodbye:

> I wasn't happy, not at all, but I felt that had I said goodbye to them I wouldn't have been here today. But I wasn't happy with the ending because I didn't tell them personally at the time and I felt I owed them that. I think it would of been hard to say goodbye and that's a big part of the reason that I didn't. **(H)**

In contrast to the ways in which these girls described the difficulties associated with ending, D. did not experience the leaving process as emotionally charged and explained that he did not have any feelings about leaving treatment. He described handling the termination of treatment in a matter of fact, stoical manner, much like he handled other changes and transitions in his life. Although he did not discuss leaving, he described his view of a discussion about leaving treatment in this way:

> Like an everyday normal chat, no good thing, no bad thing, no ugly thing, no nothing, like an everyday chat. Like I said, I liked coming here so I came. **(D)**

He went on to describe how he felt about leaving counseling:

> Leaving counseling was like leaving someone that I know really, like leaving someone I know and I think it didn't affect me too much at all, it took me awhile to get rid of it. It felt like, how can I say it, it felt like nothing. It felt like nothing, the reason why is that when I was in my childhood, five, six, seven, eight, I always went from one school to another. When I finished graduating, I finished graduating from one school, I know I made a couple friends there and then I went to another school. It was like nothing. It's like when I graduated and left from one school to the other it felt like nothing. I didn't know if I'd meet them again, see them again, or anything else and after that I went to a new school, made a couple friends and went to another one you know, the same basic thing. I think that's's just the way I deal with things. **(D)**

Developmental Issues: Desire to Keep the Door Open

In their descriptions about how they experienced leaving treatment, it became clear that adolescents with unaddressed terminations did not experience the need or desire for a termination process. Consistent with their developmental needs, they experienced themselves as growing and changing, rather than as ending or leaving. Thus, while clinicians may view the need for an ending or closure, the adolescents, having had a good

relationship with the clinician, wanted to maintain this relationship, rather than end it permanently. In fact, the adolescents explained that they did not want a process of "closure." Instead, they preferred to "keep the door open" in order to let the clinician know about their future development. In this regard, E. explains her way of having closure and the importance of being able to have future contact with the clinician:

> I know I wrote her a thank you letter, and I know that was my way. No that wasn't even at the end, I saw her after that but um, no I never thought of it as good bye. I don't think I would ever call her back for that, and if I called her it would be to say hello. But for help, I feel now I've been given the chance to put an end to it, and I will never need to call her for anything of that nature. **(E)**

Moreover, she explained why she felt an "open door" approach to treatment is important to adolescents, particularly for older adolescents, who are "aging out" of services:

> Saying this is always open for you, I think for any teenager, that is always a plus. It's not over. Like having teachers that are always there for you, teachers are always good to have. Knowing that you can always go back to that person. Like in math if you are struggling in math, you really had a good connection with your first year math teacher. I had one teacher who I love. She wasn't my teacher anymore, but I used to always go back to her. And that's 'cause she just left it open. It was never just like three months and then it's over. Once I get my final grade in, our relationship is over. No, I'm still good friends with her. Yeah. I mean I would have had a difficult time if it was explicitly told to me that I could no longer be serviced here. For a lot of people that's a problem. And a lot of kids are probably dealing with that, and having things end for them. Like when you are a teenager. You have to go to college, and then that ends, and at a certain point, you are dealing with a lot of emotional problems. I remember high school was very emotional for me, you don't need an extra door closed in your face. **(E)**

H., who also had a positive experience in group treatment, explained that she did not associate leaving with ending, but rather with growing and changing. She clearly did not

feel the need to end and wanted to be able to "keep the door open" as a way of keeping the good experience she had in the group with her:

> Leaving has a negative tone. It's good not to end because of returning. I felt guilty about talking about leaving. What I was doing was moving on and growing rather than leaving. Termination is used when I got fired. It has the feeling of finality... If I said goodbye, I thought I wouldn't be able to come back. It wouldn't be appropriate. I wanted to leave the door partway open so I'd always be able to come back and give updates to the group and get feedback as we grow and become our own separate people. We'd always be able to come back and be a group--sometimes I still look to them to come back and tell us how they're doing. I didn't want to say goodbye forever but to say goodbye for now. I felt like I should have given the group a better idea that I wouldn't be coming back but when leaving I thought if I said goodbye forever, I could not come back. I always want us to be able to come together, even though we changed members, gained members, lost members. There was always a sense of being together. I want to keep in touch, we're kind of close as a group. I didn't feel the need for the group to end. I wanted to keep it always with me--saying goodbye wouldn't be appropriate. I feel like we would always have the group. Saying goodbye would be like it was over so I feel like I owe the group to know what's going on with me. I always want us to be able to come together. **(H)**

Reasons for the Presence of a Termination Process

In contrast to the adolescents with unaddressed terminations, three of the six adolescents with addressed terminations thought that it was important to notify the clinician of their decision to terminate treatment because they thought it would be rude not to do so. This is in contrast to the adolescents with unaddressed terminations who did not discuss termination because of the difficulty they had saying goodbye. I. explained that his decision to notify the clinician that he would not return was influenced by his cultural background as well as other factors:

> Well, I thought it would be rude of me, if I just stopped all of a sudden, you know, hey what happened to_____. It would be rude. To just cut someone off right there. Basically to let her know I wasn't going to come anymore, that I felt it was unnecessary, and I thanked her for her time. Chinese people are supposed to be very polite. We're raised to be polite. I don't like to leave things hanging. Um, I guess like 'cause it made me so mad that people don't give you any notice and they just stop something. It makes me really mad, so I don't want to be a hypocrite. So that's why. **(I)**

Similarly, N., who continued to obtain medical services at the clinic, thought it was important to notify the clinician that she would not be coming back to treatment and to explain why:

> I told her that it wasn't working and my parents said I couldn't come anymore. I felt it was important to say I wouldn't be coming back. You just don't do it like that, plus I knew I would see her. If anything, the reason I gave her is that I felt it wasn't working. It wasn't because of her but really it was because of my parents who were stressing me out. It's not like I was only seeing her for a couple of months, it was quite awhile and I felt I should tell her, especially what was going on. There was nothing much she could've done. She offered to have my mother come and she asked if I would seek counseling somewhere else. **(N)**

Others were glad that the clinician raised termination because they thought it would have been difficult to do so themselves. As K. explained, she did not want to hurt the clinician's feelings:

> Yeah, I think that was the better way instead of just stop coming, you're supposed to always notify someone cause it messes up their scheduling and its just a courtesy. I don't think I would have ever brought it up. I think I felt that I didn't want to just say I don't want to come and I thought I was going to like hurt her feelings or something, you know, to just say, I don't want to just say, I don't want to come, it's hard. **(K)**

J. expressed similar concerns:

> If she didn't bring it up I would have eventually told her. I didn't want to come anymore. It's easier when the social worker brings it up but I know eventually I would have said something. **(J)**

Feelings of Relief

Half of the six adolescents with addressed terminations expressed relief that treatment was over and satisfaction with their decision to end treatment. For example, as J. explained, she did not need a process for termination, she just wanted to end it. Moreover, consistent with her developmental need for control and autonomy, it was important that she made the decision to terminate:

> I felt happy and relieved. It didn't really matter how we said goodbye as long as we said it. I was happy that it ended, period. That's it. Glad it ended, I didn't care how it ended as long as it did. I felt like I was making a good decision. **(J)**

I. also felt that he was making a good decision to terminate treatment and expressed satisfaction that his desire to terminate was respected by the clinician:

> Um, it was good, I was pretty satisfied because, like if I told her I wanted to stop she would understand. She didn't like disagree with me or like try to change my mind, she supported me. . . . She supported me in that, and I thought that was good. **(I)**

K. indicated that her situation did not change significantly as a result of treatment. She described feelings of ambivalence, relief, and regret when treatment was over. K. described her feeling about ending treatment in this way:

I guess I was happy, I had a lot more time on my hands but after I stopped I think that things were the same. **(K)**

IV. EVALUATION OF THE TREATMENT EXPERIENCE: HOW THE ADOLESCENTS EVALUATED TREATMENT?

Overview

Findings from two empirical studies (Cochran & Stamler, 1989; Mallucio, 1979) that explored clients' satisfaction with treatment found that clients with unaddressed terminations reported considerably less satisfaction than those who planned and discussed termination. Specifically, Mallucio (1979) found that clients (adults) who did not discuss termination were dissatisfied with the help they received and frustrated with their lack of progress in treatment. Similarly, Cochran & Stamler (1989) reported that clients (older adolescents and adults) felt that their counselors did not have the skills to help them.

A striking and surprising finding in this study, that all of the adolescents with unaddressed terminations reported that they were satisfied with their treatment experience, contradicts previous research. Even the few adolescents with unaddressed terminations who reported some disappointment or regret about treatment, still expressed some level of satisfaction with their treatment experience.

In contrast, for adolescents with addressed terminations, there was a considerable range in the way in which they evaluated their experience in treatment. In general, they reported considerably less satisfaction than those with unaddressed terminations. Of the six adolescents with addressed terminations, only one was extremely positive; one was extremely negative; and the remaining four expressed a combination of satisfaction, dissatisfaction, and indifference. These findings also differ from clinicians' common

assumptions that a termination process is associated with successful, completed treatment, and that unaddressed termination, or "dropout," is associated with the failure of treatment (Sweet & Noones, 1989).

Both strengths and limitations of treatment will be discussed. Strengths and the most helpful aspects of treatment included, improved ability to manage emotions, improved communication and/or relationships with parents, behavioral changes, someone to listen, and the relationship with the clinician. Limitations and the least helpful aspects of treatment included the routine of treatment, the time and effort it required, and the lack of effective parental involvement and family therapy.

Positive and Helpful Aspects of Treatment

Improved Ability to Manage and Handle Emotions

Half of the eight adolescents with unaddressed terminations reported that the experience of treatment helped them learn how to identify, process, and handle their feelings more effectively. In contrast, this was reported infrequently by the adolescents with addressed terminations. In the following accounts, the adolescents with unaddressed terminations described how treatment helped them express and manage their feelings:

> The experience was worthwhile. It was heart wrenching and what I mean by heart wrenching, it really made you feel everything, helped you to deal with your emotions. **(A)**

> Letting out a lot of perhaps repressed anger, or repressed emotions or whatever they were, yeah. What ever may have been bugging me in other words, at that time. At that age, whatever was going on at that time. It taught me how to think about it, and how to handle it, and react to it. What ever

> might have been going on at the time. Whether it was one thing, or several things. I can handle situations better than before in all aspects. That was unexpected. **(D)**
>
> I felt it was a good experience, being able to express myself and it keeps you focused, up to date. **(B)**

While the treatment experience did not improve his relationship with his mother, G., reported that it did help him identify and express his feelings. Specifically, he learned alternative ways of handling his feelings and was able to more directly discuss his feelings and concerns rather than acting them out:

> It helped me a lot, grow up, and express my feelings and stuff. I guess I got more than what I wanted. Not really the situation with my mother and stuff like that. I guess I'm growing up anyway and I'm not doing nothing bad, that I know that I'm a good person so I don't worry about that. It helped me to be able to talk more, how do I put it, I guess it helped me to sit down with someone and say why I'm upset because before I couldn't even say so I would just do something stupid and get in more trouble. I guess like, if I'm upset, later on I'll go do whatever they tell me to do and then later on I try to talk with my mother or grandmother, like why did you say that to me, or if I see it getting out of line, I'll just leave. **(G)**

Improved Communication/Relationships with Parents

Adolescents with both unaddressed and addressed terminations reported that the treatment experience helped them to better handle their feelings about their parents and communicate with them more effectively. A., who came for treatment both individually and with his mother, felt that the experience helped him, not only resolve his feelings about a past experience of sexual molestation, but also to identity and improve the difficulties he had with his parents:

> I think we settled, I think we settled the molestation and I think we really hit the nail with my parents. Emotionally, they both distract me emotionally. **(A)**

While H. did not like family counseling, she explained that it helped her communicate more effectively with her mother as well as gain a better understanding of her mother's problems:

> I was satisfied with counseling. It changed a lot of things for me. I realize that things change in due time for the better. I never liked the family counseling. Every time my mother was in here I wanted to strangle my mother but at the time it was unavoidable. I wouldn't have talked to her outside of this office. It was also very helpful to talk to my mother's psychiatrist about her illness. **(H)**

F., who only came to treatment because of her mother's mandate to do so, reflected on the changes that she felt she made in her "attitude," her relationship with her mother, and in school:

> It was better for me. Who knows where I would be if I didn't go to counseling. I thank my mother. It helped to change the way I was, my attitude toward things. I changed from a little snob because I changed my attitude a lot. My mother was on one side of the rope and I was on the other...I'm a different person now. . .Yeah, because after counseling my grades went to a 90.2 average, I was on the Honor Society, my school took me out to dinner, they gave me three Yankee tickets and I got a certificate from the Board of Education. **(F)**

Two adolescents with addressed terminations who generally did not find treatment helpful, acknowledged that having their parents/grandparents involved in treatment was <u>one</u> aspect of the experience that they found useful:

> Um the best thing... I think the best thing about counseling was that me and my Mom got to talk more, uh, we saw more how each other felt because we would be in the sessions together. **(I)**

> What I wanted changed was to help my grandmother understand things I wanted to do or little teenage things but also some things that were really important to me that my grandmother wouldn't understand like being in music, to be a DJ because that's the only thing I wanted to do, that's a start to being a music writer or producer. Sometimes my grandmother would listen more to other people, she would get little things from other people and then put it together. I usually do things to please my grandmother. I talked to the social worker about how I felt about my mother and the family situation and stuff like that. **(J)**

Behavioral Changes

While six of the eight adolescents with unaddressed terminations expressed satisfaction with treatment because it helped them improve problematic behaviors and reach their goals. most of those with addressed terminations reported less satisfaction with behavioral changes and problem resolution. Adolescents with unaddressed terminations gave the following accounts of changes they made as a result of treatment. D., who came to treatment because he was depressed and his academic performance had declined, speaks proudly of the improvements he made in school. in social relationships, and in separating from his mother and becoming more independent:

> I was satisfied and happy that it helped me a lot. I benefitted a lot. My grades started coming up bit by bit, slowly but pacingly, my grades started coming up...I started going out more often, buying more clothes more often, going out with friends and by myself, and basically trying to do without no assistance from my mother. **(D)**

When asked if she had reached her goals for treatment, E., who came to treatment because she was bulimic explained:

> Two years without being bulimic, yes. Definitely. **(E)**

She goes on to describe what she learned about herself from her experience in treatment and how this helped her change her behavior:

> I really feel that I'm more in tune with who I am. I don't internalize it so much, so that it's easier to deal with being hard on myself. And I think it's just accepting OK, I'm just like this, and I do push myself a lot, sometimes you do not perform the best, and that's OK not to be the best. I've learned what people I want around me, and it ends up there are very little people because the other people who were around me, made me feel more stressed, and I have to then deal with the bulimia. So I just learned how to assess myself, and what kind of people and things I want to do with myself which has helped a lot. And I don't care so much what other people think which is one other thing which is a thing which encouraged me to throw up. Caring so much about what other people thought about me. **(E)**

H. came for individual, family, and group therapy. She reported reaching her goals. In talking about how she did this, she identified her participation in a group as particularly helpful:

> Yes, they were reached. I got the most I could out of the group. I didn't expect to bond to the group the way I did, but I feel close to them. I definitely didn't expect that...Talking helps a lot more than you think it does. Talking to someone else, it helps you through whatever you're going through. **(H)**

In contrast to adolescents who had unaddressed terminations, only one of the adolescents with an addressed termination reported positive behavioral changes and was very satisfied with her experience in treatment. Hence, L. came for eight sessions both

individually and with her mother, with presenting concerns of sadness related to the recent death of a cousin, academic problems, and difficulties with friends. As she explained, she had no complaints about her experience in treatment:

> Everything was good, nothing was bad. I was satisfied with it. Everything was fine. I feel different. I didn't have any more problems. I didn't think anymore about my cousin and I didn't care anything about my friend if she wanted to do anything or if she called me, like that. **(L)**

Others with addressed terminations reported that treatment produced considerably less behavioral change and felt that it resulted in either little or no change. For example, I. explained:

> I felt that the counseling didn't really solve anything. **(I)**

Others evaluated their treatment experiences in these ways:

> I'd say neutral . Alright...We talked about different things when I came. I stopped being lazy. I was studying and stuff, and made like a time schedule of things. It wasn't just eat, watch a lot of TV. I started my homework and stuff. **(M)**

> Somewhat helpful, I guess. I don't know. The same. I guess maybe I think more about things. **(K)**

Someone to Listen and Talk Freely To

Many of the adolescents reported that what they liked most about the treatment experience was the opportunity to talk freely with someone who listened to them. This theme was particularly strong among the adolescents with unaddressed terminations, who reported that they enjoyed talking and emphasized how important it was to have someone listen to them. Illustrated in the following accounts, "just talking" freely, with or without

a purpose, and having someone listen to them in a non-judgmental way, was something that several of the adolescents with unaddressed terminations described as absent in their lives. Consequently, they found this aspect of the treatment experience extremely important:

> Coming here, talking a bit uh, talking about how was my day, see what's up basically, a nice little chat, a nice little chat first to figure out what's wrong, how are you doing, what's wrong with this picture, what happened today, what happened yesterday, that's it. Yeah, what happened yesterday, what happened last Friday, anything, it could be something about sports, I don't care, anything, and she didn't care either, anything, just start talking. If something's wrong just spit it out, it's not going to kill you or anything, let's say if a friend of mine has a little trouble at home or mental problems or something, I'll give them the address and the same person as well. **(D)**

> Having someone to talk to, having someone to listen to you for forty-five minutes if all you do is talk. At first it was funny, 'cause I would find those quiet periods when she wouldn't talk, then I realized that she was giving me space to talk. In the rest of the world you really don't get a chance to communicate your feelings. No one really cares when they ask you how you are feeling. She was very honest about that. You know, really how are you doing. She wanted to hear the long story not the short story. And that was very reassuring. And it was nice to come to a place where you felt safe, and you didn't have to have pretensions at all. And very supportive, and it was your time. It was nice. You never felt like what you were saying was going to be criticized, or questioned, which is what I got from friends. It was just questions. **(E)**

Although he thought counseling did not help him identify his problems, B. emphasized how important it was to have someone listen to him:

> I was using marijuana and alcohol. I knew that was a problem, the counseling didn't make me realize that. But it did make me feel good. Talking about things, sometimes there are a lot of things I want to talk about and I'm not able to talk with a lot of people. At times I want to express things and I'm not able to express them. Here you're on a one to one with the person and they want to see what you're about. Not really everyone listens

> usually. Usually people are talking to me and I'm listening to them. Here, somebody is asking me how I feel and what's going on with me. **(B)**

Others described how important it was to talk freely and to have someone listen to them:

> It was comfortable, it was open, personal, pretty much that. I could say what I wanted, how much I wanted, in any way I wanted. What I wanted to say, how I wanted to say it, talk her ear off. It was really comfortable and in a neutral setting. I really just poured my heart out to her. I just told her everything. Like yesterday I had a bad dream, or this guy is a jerk, or whatever. Or anything that would be troubling, that would be on my mind that was really troubling. I don't know, anything that would just piss me off. Like if something had just happened to me, like the day before counseling, or I had a counseling session that day, that really, really set me off, and what I did about it. She would ask me what happened, why, maybe I should have handled it better basically. **(C)**

> She didn't disrespect me or anything, she would just listen, she didn't even give any real input unless I would say something where I was looking for an answer. She would just listen to me. I liked that because I could get out all my feelings. **(G)**

> The best thing was being able to talk as freely as I wanted. **(A)**

> Being able to talk to someone like as if I was keeping everything inside and then letting it out once I got here. **(F)**

Although adolescents with addressed terminations were not as enthusiastic as those with unaddressed terminations, they also reported that the aspect of the treatment experience they liked most was having someone with whom they could talk freely. They described the best aspects of treatment in these ways:

> I guess just talking and stuff. **(K)**

> I guess just having someone who you know she's going to be there for you, you know, someone to talk to and not worrying that it will go back to your mother. **(N)**

> The best thing was having someone to talk to. **(L)**
>
> To have the chance to talk to somebody. **(M)**

One of the adolescents with an addressed termination explained that she did not find the aspect of talking to someone helpful. J., who came for treatment at her grandmother's insistence and never found anything of value in it for herself, specifically explained that instead of talking, she preferred other non-verbal and creative ways of expressing herself and handling her problems. Unfortunately, the clinician was not able to capitalize on these modes of expression in order to help her. J. described her experience of treatment in this way:

> It was nothing to me. It was like hell, I hated it, it was a bad experience... I didn't like it at all, I felt that it was a waste of time... It never helped, maybe it's just me, maybe it helped some people but for me it just didn't because I had other ways of dealing with my problems, for me to write it on paper, or listen to music, write a poem, write in a diary, that would help me. I don't like to think about it. I face it and then throw it away. I didn't talk with my counselor about doing these things. I would write short stories. I even started writing a book about a teenage girl. I never talked to my counselor. I just started that recently but I always used to write short stories and I'm an art major and I'm working on a painting now. I like dealing with it myself. I haven't convinced my grandmother that she can deal with it herself, my grandmother, she doesn't understand, especially the music part. **(J)**

Relationship with the Clinician

While adolescents with both unaddressed and addressed terminations reported that having someone to talk to was one of the best aspects of the treatment experience, the adolescents with unaddressed terminations focused on the quality of the relationship with the clinician, as a factor that contributed to their satisfaction with treatment. For

example, E. highlights the relationship with her clinician as the best aspect of treatment. She described the supportive, empathic, individualized, and accessible attention that she experienced in this relationship:

> I had a fantastic experience here. I think I was lucky also. I had a great therapist also. I don't know if they're all like that, or if she is like that with everybody. She was great with me. I mean if she does the same thing with me that she does with other patients, she would be great, 'cause she would be taking each person who stepped in her door as that person and not as all drug addicts, or all alcoholics, like what you learn in school to catagorize... Like she looked at me like an individual instead of like all bulimic people, we have to do this, and really worked with where I was at, and where I needed to be...It was great. It was um, especially comparing it with the other experience, very supportive, and we definitely built a very trusting relationship. I feel like I could have talked about anything, and I wouldn't have been judged at all. Very accessible. I felt we connected very well which was important for me. She really laid out a good foundation for me to grow. And guided me into changing. I didn't realize it then. **(E)**

Though E. valued highly the relationship she had with her clinician, she appropriately credits herself for the changes that she made and described how the relationship with the clinician helped her to do so:

> I think it really changed my view of therapy, and therapists to a more positive light, because before I didn't have any trust in their ability, and I didn't think that anyone else could change who you were and how you did things. It showed me that therapists couldn't change who you were. In the end it wasn't (*clinician*) who changed me, but having been able to talk to somebody who supported you, and really understood where you were coming from even if she hadn't experienced what you did. It helped me overcome my situation, and my emotions, which was what I needed... You know really it's just all about me, and if I want to put into it. It's not about this lady or whoever I'm seeing whose going to put an end to it. It's really just about I owe it to myself. Like, I really need to wage this war and not anybody else. Somebody else can really just give me strategies, but in the end it was me who really had to put an end to this. You know, whether it was praying or whatever, but I had to. It wasn't going to be any external force. And that's

> kind of how I just, you know partly just put an end to it, and just really dealt with it... It's not about saying, like giving you these psychological terms...It's more like in your language, this is how you feel, you're really kind of defining for yourself, yourself in the end so that it's easier to deal with so that it's not someone using all this psychological language for you which makes no sense. And if your not learned in that area, it's like you figuring out all your problems for yourself and solving them for yourself in the end, and just having her there to guide you in the right direction. And to support you if you fall off the edge. **(E)**

In a similar way, F. emphasized that while counseling provided her with the opportunity to make changes, it was through her own efforts that she did so. When asked what helped her, she said:

> The counseling. Being able to speak openly about how I feel . It was all me, I had to make all those big steps to change myself and I did by coming to counseling. **(F)**

In addition to the value she placed on her relationship with her therapist, C. explained what she learned from the experience of treatment:

> I felt comfortable, I bared my soul to her. I mean I know we weren't best friends or anything...but I learned more about myself from someone else other than family. And I learned to react to certain things differently, think about certain situations whenever they would arise differently. Like when I was younger, I was like a firecracker. I would get mad, and violent. I mean I would slam the doors, kick things, punch the walls, I would get very physical, emotional, and verbal. I would curse left and right. I was very extreme in all those ways. And now, I won't even snap. Get crazy, and just take a deep breath. **(C)**

Negative Aspects Of Treatment

The Routine of Treatment

Several adolescents with both types of terminations reported that they became tired of coming to treatment and disliked coming when they did not feel the need for treatment. Some indicated that, at times, they needed to break up the monotony and routine of coming to treatment every week. For example, D., who reported his treatment experience as positive, in retrospect, attributed ending treatment, in part, to the fact that he was tired of it:

> Probably I was getting tired of it, for all I know, yeah, I think I was getting tired of it. **(D)**

Similarly, E., who expressed much satisfaction with treatment, indicated that while in the early stages of treatment she found it necessary to see her clinician on a weekly basis, she later found weekly sessions tiresome and unnecessary. She described how she negotiated with her clinician to change the frequency of her sessions while still keeping the "door open" for help and support, as needed. Her comments speak to the need for clinicians to be both available and flexible in meeting adolescents' needs:

> For me the negative would be having to come every week, 'cause I would just get tired. I was glad to go to college, 'cause it was just a change. Every three months just to get to change to a new class, a different routine. I think it's necessary, just for me, after a while I'd just get tired of certain things...I mean after awhile I get tired of certain things, certain routines. I just can't handle it. And I'd explain to her, you know, I probably don't need to come often and she was like, OK. She was fine with that, she didn't pressure me into coming, she kept her door just open, and knowing that helped. I knew she was there if I needed her. **(E)**

Likewise, who was also satisfied with his experience in treatment, indicated that he disliked coming to sessions when his mother asked him to, although he felt no need:

> The worst thing I felt was coming when I didn't need to come or coming because my mother called me and said I had to come. **(A)**

K. explained what she disliked most:

> Worst thing I guess is the days when we didn't have anything to talk about because then it was just dead boring. **(K)**

Too Much Time and Effort

Two of the adolescents with addressed terminations reported that coming to treatment required too much time and effort. From the beginning, I. did not feel that he needed treatment. He emphasized how much time it took from his very busy schedule:

> The worst thing would definitely be that it took time out of my schedule. That I had to spend an extra whatever amount of time coming here. I was pretty busy, because I had to go to summer school, and then after that I think I went to work and then I had to go to prep school so counseling had to fit in there somewhere, so counseling took time out of my schedule. **(I)**

Similarly, M. focused on the difficulty he had getting to treatment as well as the time it took away from his schedule. He explained what he most disliked about treatment:

> I'd say the transportation myself. I had to take the bus and the train. It was just too far. It was just sometimes it would be hard for me to get down. I would get home late from school, it would be like, because after school, I would go out, go to the park or something. By coming here I would be like, I would have like missed the park or something. And then I would have baseball too. It took me away from that sometimes. **(M)**

Lack of Effective Parental Involvement and Family Therapy

Six of the fourteen adolescents with both unaddressed and addressed terminations expressed multiple concerns regarding parental involvement in treatment. These included, the lack of parental support for treatment, parents needed help more than they did, and family problems were not resolved. Two boys with unaddressed terminations clearly voiced concerns that their mothers needed help, as much, if not more, than they did. While they felt that they had benefitted from treatment, they also indicated that their treatment experiences had made them aware of the fact that their mothers needed help with their own difficulties. In contrast to the adolescents with unaddressed terminations who reported improvements in their relationships with parents, G. discontinued treatment because of his frustration about the lack of improvement in the problems he had with his mother. Although he was frustrated that his relationship with his mother did not improve, he reflected on what he learned through the course of treatment and described how he has come to understand the problem:

> I wanted to do something my way or whatever because I thought it was taking so long and I didn't want to be coming here for a whole long five years and nothing would be solved and stuff. I just felt that it took too long to solve the problem or whatever because my mother wasn't coming in much and then I was also feeling like I feel right now, that it's not me, the problem...Now I finally figured out what the problem is, because I know I do things wrong but I'm a good person. I don't do drugs or anything like that or have sex with girls and be making them pregnant...I be cooking and all those kind of things and my mother just doesn't respect that...I always thought it was little things like my brother disrespecting me or he was always getting favoritism and stuff like that. I don't even know cause those were problems, but they were not the problem ...I think it was because of the problem between she and my father in the past and stuff where she felt, because after someone tells you I'm going to marry you and then someone leaves you while you're pregnant and stuff and to raise two kids by yourself.....now I understand it was not my problem because I'm not the one

> who left her, whatever years ago, and stuff and I can't help that...I'm just saying in my case, I didn't think it was always my fault and no one was listening to me except for *(clinician)* so I wanted my mother to hear something about it too. So I wanted her to be there some days when I was speaking clearly and I had the right words in my mouth and I could express what I was saying. I wanted her to be there but she wasn't. **(G)**

In a similar way, as a result of his own counseling, A. was able to identify his mother's limitations. He explained his view that his mother's difficulties had nothing to do with him and felt that she needed help herself:

> I felt that she needed the counseling. She needed it herself because she had a lot of issues, especially with my father, and I don't think she's over him and I don't think she ever will be. I think she needed it more. **(A)**

As discussed, three of the adolescents with addressed terminations reported difficulties with their parents as their primary concern. These adolescents, however, disliked having their parents involved in treatment and ultimately terminated treatment because these difficulties were not resolved. Thus, parental involvement in treatment was a complicated and often unsuccessful endeavor. N., regarded the lack of parental support for her treatment as the worst part of the experience:

> The worst thing was the interference of my parents. I think my parents should be left alone. I don't think family counseling is good--that's's the way my family is, we don't really get along, I keep my distance, I can do everything except talk to her, I can do whatever I want as long as I take care of my responsibilities. I think it was beneficial but my parents were in the way. They wanted me to get help but they were interfering with me getting help. **(N)**

Similarly, K., who had both individual and family therapy, ultimately terminated because of unresolved problems with her mother. She expressed her frustration with the lack of success of family treatment:

> It was the same issues and I was like, I think I went for a year and a few months and it was like repeating the same thing over and over. It wasn't like, there was nothing new, and she kept telling me I have to try to work it out with my mother and I tried to talk to her and it doesn't work. **(K)**

Others felt that their parents needed help more than they did. As J. explained:

> I think my mother and grandmother needed it more than me, I don't know if the counselor thought that. My grandmother used to always say that I need counseling. **(J)**

Similarly, M. explained that while the focus of treatment was on him, he realized that his entire family, particularly his parents, needed the help:

> I just feel like it's not me. I just feel like it's the whole household. I wanted the whole household to be changed or whatever. That would make me do better in school and stuff. Like, people say I want you to do better in school, and then on the other hand they are not doing their part like man and woman and stuff. I don't know like finding jobs and stuff. I guess you could say they are a little worse. I guess my mom is like tired of seeing him all day. You know, you do nothing around the house, like cleaning and everything. Your not having a job, helping and stuff. And she just had to get a second job for herself so she could make more money I guess. And then me, I have to work. I do my little jobs here and there. Um, I felt like they were always blaming me about things that I would do instead of looking at themselves, just things that I'm doing and stuff. **(M)**

SUMMARY OF THE QUALITATIVE DATA

Similarities and Differences Between Unaddressed and Addressed Terminations

Throughout this chapter, the similarities and differences between the unaddressed and addressed terminations have been discussed. A summary of these similarities and differences in the adolescents' experiences of the beginning, middle, and ending phases of treatment as well as their evaluation of treatment will be provided.

Beginnings

With the exception of one adolescent who was self-referred, all of the other adolescents in the qualitative sample were referred to treatment at the request of concerned adults. Consequently, for all the adolescents, the early engagement process played a critical role in the way in which they experienced treatment. Clear differences emerged, however, between the adolescents with unaddressed and addressed terminations in their initial responses to treatment. The majority of the adolescents with unaddressed terminations had a positive and receptive stance to the treatment process. Alternatively, those with addressed terminations were initially much less receptive.

While many of the adolescents with both unaddressed and addressed terminations demonstrated predictable reservations and doubt about engaging in treatment, their reasons were different. Many of the adolescents with unaddressed terminations had negative expectations because of prior negative mental health experiences. On the other hand, the adolescents with addressed terminations generally had reservations about

treatment because they did not identity a need for it. The adolescents with unaddressed terminations were clearly more receptive to the encouragement of the referral source, while many of those with addressed terminations focused less on the encouragement and support and more on the mandate of the referral source.

The Experience of Treatment

Overall, the adolescents with unaddressed terminations were more engaged in the treatment process as evidenced by: their growing trust in the relationship with the clinician: the identification of a problem(s) to work on; the presence of clear goals and a focus for treatment; and active efforts to solve problems. In contrast, adolescents with addressed terminations experienced treatment in more varied ways. Some were engaged and working on problems, while others were either indifferent or disengaged. Several of those who were initially engaged became frustrated when they were unable to solve problems they experienced with their parents. Others never engaged about their own concerns, nor did they identify treatment goals or even a focus for work in treatment.

Termination of Treatment

There were more differences than similarities among the adolescents with unaddressed and addressed terminations, in their reasons for terminating treatment and the ways that they did so. While the majority of the adolescents with unaddressed terminations terminated treatment because they felt that they had resolved their problems, only one of the adolescents with an addressed termination reported problem resolution. This finding

departs from both the existing research (Mallucio, 1979; Cochran & Stamler, 1989) and common "practice wisdom," as many clinicians associate completed termination with successful treatment, and dropout from treatment with failure.

While adolescents with unaddressed terminations expressed satisfaction with treatment because they had reached their goals and resolved problems, half of the six adolescents with addressed terminations expressed relief because the treatment experience was over. A striking finding in this study is that feelings of sadness and loss, traditionally associated with the termination process (Levinson, 1977), were reported only by those with unaddressed terminations who did not experience a clinical termination process.

Evaluation of Treatment

There were similarities as well as clear differences in the overall evaluation of treatment between the adolescents with unaddressed and addressed terminations. While the adolescents with unaddressed terminations evaluated their treatment experience considerably more positively than those with addressed terminations, there were similarities in what both groups found helpful and/or not helpful about treatment.

The striking differences in the evaluation of treatment between the two groups focused on goal attainment. Those with unaddressed terminations reported considerably more specific changes in managing their feelings, changing their behavior, and improving their relationships with their parents than those with addressed terminations. In addition, while

both groups reported that one of the best aspects of the treatment experience was having someone to talk to, the adolescents with unaddressed terminations placed much more emphasis on the quality of the relationship with the clinician, as a factor that contributed to their satisfaction with treatment. Several of the adolescents with both unaddressed and addressed terminations reported that they became tired of the routine of treatment as well as coming when they did not feel the need to. Finally, parental involvement was seen as both a strength and a limitation for both the adolescents with unaddressed and addressed terminations. While adolescents in both groups identified family involvement as a strength of the treatment experience, several from each group also identified it as a limitation.

In the final chapter, the quantitative and qualitative findings will be summarized and implications for practice, program development, and research will be provided.

CHAPTER VI

SUMMARY OF QUANTITATIVE AND QUALITATIVE DATA IMPLICATIONS FOR PRACTICE, PROGRAM DEVELOPMENT, AND RESEARCH

Introduction

The quantitative and qualitative findings from this study generate new practice-relevant knowledge about adolescent treatment termination patterns and their meaning. The implications of this knowledge can enhance clinical practice, program development, theory development, and future research with adolescents. This chapter reviews some of the salient quantitative and qualitative findings regarding how and why adolescents with both acknowledged and unacknowledged terminations discontinued treatment. While the generalizability of the findings must be weighed cautiously because of the small size of the sample and the single site from which they are drawn, several specific recommendations will be provided that can be utilized within the mental health program at the Adolescent Center for the enhancement of practice, program development, staff training, and the development of future research.

Overview of the Quantitative and Qualitative Findings

As discussed in Chapter II, previous quantitative studies (Baruch et al, 1998; Suzuki, 1989; Viale-Val et al., 1984) on adolescent termination from treatment have focused exclusively on unacknowledged "dropout" from treatment. While these studies have identified patterns of termination from treatment with adolescents and variables

associated with continuing and dropping out of treatment, no research has focused on how adolescents who dropout of treatment assess treatment and experience its termination (Ambruster & Kazdin, 1994; Laufer, 1992). The absence of the clients' perspective in the study of treatment termination has led to assumptions that clients who dropout of treatment necessarily assess services negatively and that dropout from treatment represents failure (Ambruster & Kazdin, 1994; Sweet & Noones, 1989).

With the exception of two studies (Cochran & Stamler, 1989; Marx & Gelso, 1987) that included older adolescents (college age students), existing studies of completed termination from treatment (Fortune, 1985; 1987; Fortune et al., 1991; 1992; Kramer, 1986; Mallucio, 1979; Quintana & Holahan, 1992) have focused exclusively on adults. Moreover, only three of these studies (Cochran & Stamler, 1989; Mallucio, 1979; Marx & Gelso, 1987) utilized client reports of the termination process, and only one (Mallucio, 1979) utilized both client and clinician reports of the termination process.

In response to these gaps in existing research, this study generated data about both acknowledged and unacknowledged and clinically addressed and unaddressed terminations from treatment. This was achieved through the integration of quantitative and qualitative methods, utilizing both existing information from client records and original data from interviews with adolescents. The quantitative findings present data about the clinical and non-clinical (e.g., demographic, organizational) correlates of acknowledged and unacknowledged terminations. The qualitative findings present an

analysis of the adolescents' experience of treatment, how and why they terminate from treatment, and how they assess their treatment experience retrospectively.

Existing quantitative studies of "dropout" from treatment with adolescents (Baruch et al, 1998; Suzuki, 1989; Viale-Val et al., 1984) have established that adolescents "dropout" of treatment frequently and consequently, they often do not participate in a clinically orchestrated or recognized termination process. Consistent with findings from these studies, in this study, "unacknowledged" terminations occurred almost twice as frequently (66%) as "acknowledged" terminations (34%).

Acknowledged/Addressed Terminations

Traditionally, termination has been conceptualized in the social work literature (DeWald, 1964; Levinson, 1977; Ortmeyer, 1978; Shapiro, 1980; Ward, 1984) as a distinct phase in the treatment process in which a planned and conscious closure or ending of the therapeutic relationship occurs. In this study, the ways in which "acknowledged terminations" occurred departs considerably from this traditional conceptualization. Findings indicate that termination was acknowledged and/or discussed in only 34% of the one hundred cases in the sample. Moreover, termination included an "addressed" clinical process, defined as a face-to-face discussion between the adolescent and the clinician in one or more therapy sessions, in only 19% of the cases in the sample. In contrast, in the remaining 15% of the acknowledged cases in the sample, which represented almost one-half (44.1%) of the acknowledged cases, termination was acknowledged only through a

telephone conversation, without a face-to-face "clinical process". Finally, when termination was acknowledged and addressed, within the context of treatment, it was typically a brief process. Among the one hundred cases in the sample, a termination process that ranged from two to five sessions occurred in only 10% of the cases. In the remaining 9% of the cases, the termination process was accomplished in just one session.

While experts on treatment with adolescents (Ekstein, 1983; Miller, 1990; Mishne, 1986; Novick, 1976;1990), recommend that clinicians wait for adolescents to initiate termination, in this study, termination was initiated by adolescents in approximately one-half (52.9%) of the acknowledged cases. There were statistically significant relationships found between acknowledged terminations and both an expressed desire to discontinue treatment by adolescents and/or parents, and non-adolescent (clinician, parent, placement) initiated terminations. These findings were supported by the qualitative data. Specifically, in more than one-half (four of the six) cases of addressed terminations, termination was initiated by the clinician when adolescents expressed a desire to terminate primarily because they were disinterested in and disengaged from treatment, or when both the adolescents and clinicians believed that treatment was not progressing successfully. Moreover, by contrast to previous research (Fortune et al. 1991; Mallucio, 1979; Quintana & Holahan, 1992) in which adults described completed termination as a mutual process, adolescents and clinicians agreed about the decision to terminate in only about one-half (55.8%) of the acknowledged cases.

Also contrary to previous research in which acknowledged (completed) termination has been associated with successful treatment (Cochran & Stamler, 1989; Fortune, 1987; Fortune et al., 1991; 1992; Mallucio, 1979; Marx & Gelso, 1987; Quintana & Holahan, 1992), findings from this study suggest that termination was more likely to be acknowledged when adolescents expressed ambivalence, disinterest, and dissatisfaction with treatment and when they were disengaged from and/or dissatisfied with treatment. Specifically, quantitative findings indicated that adolescents who were not able to acknowledge having a problem and were not motivated for treatment were more likely to have acknowledged terminations. In addition, there was a statistically significant relationship between clinical disengagement at the time of termination and acknowledged terminations. These quantitative findings were confirmed with qualitative data. Thus, interviews with adolescents with "addressed" terminations more frequently revealed a lack of interest in and motivation for treatment in the beginning and throughout the treatment process. In other words, qualitative data indicated that "addressed" cases tended to be the less successful treatment cases.

Acknowledged terminations occurred more frequently among adolescents who were: Caucasian and Asian; self-referred or referred from schools; had school, particularly academic, problems, and were diagnosed as depressed and with conduct problems. In addition, acknowledged terminations occurred more frequently when adolescents received more therapy (7-138) sessions over a longer period of time (8-57 months) and multiple (three or four) types of treatment modalities/services (individual, family, group,

psychiatric). The relationships between participation in both group and psychiatric services and acknowledged terminations were statistically significant.

Unacknowledged/Unaddressed Terminations

Alternatively, quantitative findings provided the following profile of adolescents who had the highest percentages of unacknowledged terminations or the highest "dropout" rate. These adolescents were Hispanic, African-American, and Biracial, and referred by parents; had diagnoses of parent-child conflicts and other family problems; acknowledged a problem at intake; and were motivated for (or "willing to try") treatment

The qualitative findings revealed that the adolescents with unacknowledged terminations had characteristics that were similar to those who had terminations that were "acknowledged without a clinical process". While many of the adolescents with "unaddressed" (unacknowledged and acknowledged without a clinical process) terminations had predictable reservations about the treatment process, they generally described a process of engagement and involvement in the beginning of and throughout the treatment process. In fact, the majority of the adolescents who did not address termination within a "clinical process", were considerably more engaged in and satisfied with their treatment experience than those with whom termination was clinically addressed. In other words, qualitative data indicated that "unaddressed" cases tended to be the more successful treatment cases.

Overall, the adolescents with unaddressed terminations were engaged in the treatment process as evidenced by their growing trust in the relationship with the clinician; the identification of a problem(s) and/or focus for work; the presence of clear goals and a focus for treatment; and active efforts to solve problems. The most frequently reported factors that contributed to their decisions to terminate treatment included developmental thrusts toward separation, independence, and autonomy; improvement and/or resolution of their problems; and the interruption of treatment by situational factors. Moreover, some of the adolescents with unaddressed terminations did not discuss termination because they felt it would be difficult to say goodbye. In addition, they did not experience termination as an "ending" but instead wanted to keep the "door open" for future contact with the clinician.

Most surprisingly, adolescents with unaddressed terminations evaluated their treatment experience considerably more positively than those with clinically addressed terminations. Adolescents with unaddressed terminations reported specific changes in managing their feelings, changing their behavior, and improving relationships with their parents. In addition, the adolescents with unaddressed terminations emphasized the positive quality of the relationship with the clinician as a factor that contributed to their satisfaction with treatment. These findings depart dramatically from both existing research (Cochran & Stamler, 1989; Fortune, 1987; Fortune et al., 1991; 1992; Mallucio, 1979; Marx & Gelso, 1987; Quintana & Holahan, 1992) and common assumptions by

clinicians that completed termination is associated with successful treatment and dropout from treatment with failure.

Implications and Recommendations for: Clinical Practice, Program Development, and Research

If generalizable, the findings from this study have possible implications for clinical practice and program development with adolescents and may suggest future directions for the development of theory and research on termination with adolescents. Moreover, the findings may have relevance to administrators and clinicians who provide mental health services to adolescents. Clearly, they provide several specific recommendations intended to enhance practice, program development, and staff effectiveness, as well as provide directions for future research at the Adolescent Center.

Implications and Recommendations for Clinical Practice

Reconceptualization of Termination: Use of a Developmental Model

As discussed, both quantitative and qualitative findings from this study suggest several reasons that existing theoretical models of termination are not consistent with the way that termination occurs in clinical practice. Consequently, the patterns of termination identified in this study provide initial support for reconceptualization and revision of existing theory about termination with adolescents. As indicated by the findings from this study, termination was frequently brief or non-existent. In previous research conducted in this setting (Mirabito, 1993) clinicians also suggested the need to think about termination with adolescents differently:

> Is there such a thing as premature termination with adolescents or is it normal for them to leave treatment? It really depends on how clinicians conceptualize termination.
>
> The concept of termination with adolescents needs refocusing. I think that we can't even think about termination with adolescents. It's like an ebb and flow. Developmentally, they need to develop their own coping capacities on their own. Termination should be seen differently with adolescents--we shouldn't get shocked when they dropout of treatment--we're totally on a different track.
>
> We need to operationalize termination with adolescents. We have not defined it. My practice with adolescents is changing the way I think about termination. We should shape the termination phase by what we see in practice. We should take advantage of what we see to develop our own theory.

Adolescents with unaddressed terminations, who were engaged in treatment and found it useful, indicated that they did not have the same expectations for a termination process as clinicians. Those interviewed in this study associated the discontinuance of treatment to growth and development rather than ending or terminating. Since adolescents are in the process of continual development, cognitively and emotionally, and because they may not want to permanently terminate a good relationship they have had with a clinician, it may be more appropriate to structure treatment cessation with a process of "review, evaluation, and follow-up", rather than "termination". Thus, reframing the termination process in this way would emphasize and capitalize on adolescents' growth and development, rather than on terminating or ending, which more accurately captures and is consistent with their experience of development. Moreover, since adolescents in this study were concerned with the resolution of specific difficulties and utilized treatment toward this end, this conceptualization of the discontinuance of treatment would provide an opportunity to review progress made in specific areas of development.

Many adolescents in this study returned for future mental health services, suggesting a developmental model of service delivery to appropriately meet their developmental needs. This approach permits adolescents to keep the "door open" for future contact with the clinician and also provides an opportunity to track and monitor future growth and/or address new problems. In addition, an "open-door" approach to treatment capitalizes on the "maturational crises" that bring adolescents to treatment. However, it requires that clinicians and their practice settings be flexible and creative in their response to adolescents as well as diverse in their provision of treatment options.

As indicated by the findings in this study, since adolescents frequently do not directly express their desire and/or readiness to terminate from treatment, clinicians should explain, prepare, and educate adolescents in the beginning of treatment about the process for the conclusion and discontinuance of treatment. This should include an explanation of and education about how goals are reviewed throughout the treatment process as well as proactive exploration, throughout the treatment process, of adolescents' perceptions of goal attainment. Moreover, when adolescents do express a desire to terminate, a careful assessment of readiness to terminate should be made and alternative modalities (e.g. group or family therapy) should be considered.

Engagement in Treatment

The functional approach to social work (Shapiro, 1980) suggests that the beginning and ending phases of treatment are closely related. Although this study was concerned with

termination from treatment, both quantitative and qualitative findings suggest that the initial process of engagement in treatment is a critical factor that contributes to and is closely linked to the termination process. Specifically, quantitative findings indicate that adolescents who did not acknowledge having a problem or were not sufficiently motivated for treatment never became fully engaged in treatment and consequently were more likely to have acknowledged terminations. These findings were supported by qualitative findings that indicated that a lack of adequate engagement of adolescents and/or their parents in treatment resulted in termination. Thus, while adolescents who are engaged in and satisfied with treatment often want to keep the "door open", adolescents who are disengaged from and dissatisfied with treatment want to "keep the door shut", from the beginning of and throughout the treatment process.

Collaboration with Referral Sources

When adolescents are unmotivated for treatment because they do not recognize a problem or are unclear about the problem, initial intervention efforts may need to focus on helping them develop motivation or further clarify whether there is a need for treatment. Similarly, when there is a lack of agreement between the adolescent and the referral source regarding the problem, the focus of intervention may need to be with the referral source rather than, or in conjunction with, the adolescent. This is particularly important when the referral source is a parent or guardian as engagement of the family in the initial stage of treatment may be required if an adolescent does not identify a need for treatment. Interventions with referral sources should include strategies to help them work with

adolescents (and/or parents) to develop adequate motivation for treatment. In addition, further collaboration with the referral source, may establish that treatment may not be indicated, given the adolescent's or family's lack of interest in treatment. Instead of treatment, other interventions, such as the clinician's consultation with the referral source (school, agency, or medical professional) or a family member (parent or guardian) may be indicated. Moreover, these kinds of interventions may result in lowering the rate of dropout from treatment.

Implications and Recommendations for Program Development

Implementation of an "Exit Interview"

In order to ensure that treatment is concluded in an effective manner, a structured process of termination, similar to that which is utilized for the process of intake and evaluation, should be implemented within the mental health program at the Adolescent Center. The alternative model of termination that has been suggested, could be systematically implemented within the mental health program in the form of an "exit interview". Thus, the goal of outreach efforts would focus on holding an "exit interview" with the adolescent and/or parent with the purpose of reviewing and evaluating treatment goals and the experience of treatment. If implemented systematically within the mental health program, this process could have potential benefits for clients, clinicians, and the overall mental health program. While this process is typically attempted via outreach calls and letters, as indicated by the fact that the majority (66%) of cases in this study did not document closure of the treatment experience, it is often not achieved.

Implementation of this process would provide adolescents and/or parents with an opportunity to review progress made in treatment and to assess, with the clinician, whether continued treatment or termination of treatment is indicated. In addition to an interview, adolescents and/or parents could complete an evaluation form that would provide an assessment and evaluation of the treatment experience. In addition, if indicated, plans for future services and/or follow-up could be made. Since adolescents with unacknowledged terminations interviewed in this study evaluated their treatment experience positively yet there was no documentation of termination from treatment in their records, systematic documentation of treatment outcome and closure would potentially result in increased program effectiveness. In addition, this process would increase staffs' sense of efficacy, competence, and satisfaction with their work.

Collaborative Treatment Plans

The findings from this study suggest that adolescents are frequently focused on the resolution of specific problems and they may view problem resolution differently than clinicians. In order to involve clinicians and adolescents in an active and collaborative treatment process, it is recommended that they systematically and collaboratively develop initial treatment plans and review and revise these every three months (or sooner, if indicated), as mandated by the mental health program. In order to more fully utilize adolescents' perspectives of treatment and ensure that treatment planning is a collaborative process, it is recommended that both clinicians and adolescents sign initial treatment plans and treatment updates. This process will provide opportunities for

adolescents and clinicians to more fully assess the need for and, if indicated, utilize alternate treatment strategies, such as groupwork, family therapy, and/or parental involvement when treatment goals are not adequately achieved. It is possible that this systematic process of collaborative goal setting and review could reduce the rate of unacknowledged terminations by increasing options for more effective intervention strategies.

Staff Development and Training

While adolescents in this study presented most frequently for treatment because of family problems, quantitative findings indicate that adolescents who were referred by parents and those who had diagnoses of family difficulties had the lowest rates of acknowledged terminations. Parental and/or family involvement in treatment was viewed by the adolescents as both a strength and limitation of their treatment experience. Some adolescents with both addressed and unaddressed terminations found parental/family involvement helpful, while others identified a clear need for further help for their parents and more effective resolution of family problems. The findings also demonstrated the difficulties and complexities of effectively engaging parents and adolescents in treatment. These findings suggest both the value of and the critical need for further training and staff development to assist clinicians in the development of strategies for effective engagement of parents and adolescents within a family context.

Interviews with adolescents suggested that, at times, staffs' tendencies to either "get rid of" or "hold on to" (Ekstein, 1983) adolescents contributed to both acknowledged and unacknowledged terminations. As noted by Ekstein (1983), these countertransferential reactions that are common in the treatment of adolescents, indicate the need for staff to thoroughly and appropriately assess readiness for termination. Specifically, staff can continue to benefit from further efforts to both permit adolescents to "move on" as they make relative progress in their development, and further engage adolescents and their families when problems remain unresolved.

Development of a Clinical Information System

This study has demonstrated the benefits of utilizing the rich database of available information that can be obtained from the mental health records at the Adolescent Center. Future research efforts, however, can be enhanced by the development of a clinical information system. The development of this kind of database could include information that is routinely and easily obtained by clinicians pertaining to client characteristics, workers' interventions, and utilization of and termination from services. Information from "exit interviews" and client evaluation questionnaires obtained when services are discontinued can be part of this clinical information system. The development of this system will make it possible to more easily assess, monitor, and analyze patterns of service utilization and termination for the purposes of ongoing program evaluation and improvement.

Implementation of Follow-Up Interviews

Qualitative findings from the interviews with adolescents in this study provided a rich understanding, from the adolescents' perspective, of their experience of treatment and their evaluation of mental health services. Moreover, the positive response to this process by adolescents in this study suggests the value of continued utilization of client feedback to further develop and improve the mental health program. This method of evaluation would ensure that mental health services are consistent with adolescents' perceptions of their service needs. The fact that almost half of the adolescents interviewed indicated an intention to contact their clinician either to "reconnect" with them or to obtain services, attests to their satisfaction with services as well as their desire for an "open-door" approach to treatment.

In addition, follow-up interviews can provide an opportunity for adolescents to retrospectively reflect upon and process their experience of treatment. This was illustrated by the following comments about the follow-up interview made by adolescents who were either satisfied or dissatisfied with the services they received:

> It was a good process because now this is my little closure with how I felt about it so at least someone knows that I really, really, disliked it. It was good to have someone to talk to at the end that was not your counselor.

> It definitely made me think about things and clarify them for myself. Things I hadn't really thought about. I was glad for the opportunity to talk about it. Thank you.

These comments indicate the value of utilizing follow-up interviews conducted by an interviewer who did not provide services, in conjunction with other client feedback that is obtained at the time of termination.

Implications and Recommendations for Future Research

Findings from this study suggest new variables that could be measured in future research efforts. Specifically, a measurement of motivation for treatment, as rated by the adolescent, clinician, and referral source could be obtained in the first session. Other variables that can be further utilized include ethnicity of the adolescent and clinician, the presence of a contract and goals for treatment, and more specific measurement of goal attainment. The measurement of these variables would provide more specific information about factors that contribute to acknowledged and unacknowledged terminations.

Given the dearth of existing research on both completed (acknowledged) and uncompleted (unacknowledged) termination with adolescents, there is a critical need for further empirical studies of both types of termination. As demonstrated by this study, the utilization of both quantitative and qualitative methods and multiple data sources has resulted in a more complete picture of the termination process with adolescents than has been available in earlier studies. Future research can build on the clinical knowledge derived from this study in order to enhance both clinical practice and program development with adolescents.

APPENDIX A

Pilot Study: Clinicians' Views of the Termination Process

Interview Guide: Interview with Clinicians

This interview guide will be administered to social workers/ clinicians who provide individual, family, and group treatment to adolescents at the Adolescent Center.

Core Question:
What are the experiences of clinicians with unplanned and planned terminations in the mental health treatment of adolescents?

Preliminary Demographic Data:
How long have you worked at the Adolescent Center?
Did you work with adolescents prior to coming to the Adolescent Center? For how long?
Do you have an MSW?
When did you get your MSW?

Interview Questions

1. Can you describe your current practice with adolescents?
Probes:
Demographics of caseload; description of modality (individual, family, group); length of treatment (short, long term).

2. In your practice experience, what are your observations about how the adolescents you work with terminate treatment?
Probes:
Unilateral vs. mutual termination; planned vs. unplanned termination; how is it initiated?

3. How do you decide when to terminate treatment?
Probes:
At clinicians request; when progress made or goals reached; when agreed upon time limit is reached.

4. When you plan a termination, how do adolescents respond to the termination process?
Probes:
Ignore or minimize it; drop out of treatment; view it as rejection; request further treatment; utilize to consolidate treatment gains.

5. In a planned termination, how do you feel about the process of termination?
Probes:
Difficulty letting go of valued patients; relief; ambivalence/reluctance re: going through the termination process.

6. What are your experiences with adolescents who leave treatment without going through a termination process?
Probes:
How often does this happen? Do you attempt to get the termination process to happen by outreaching to them?

7. In your experience, what factors contribute to unplanned terminations (adolescents leaving treatment without terminating)?
Probes:
Lack of clarity re: treatment contract; lack of mutuality of adolescent and therapist re: goals of treatment; unresolved issues in treatment; adolescent's difficulties expressing emotions regarding termination.

8. Compared to other phases of treatment, there is a lack of attention to termination in the social work literature. How do you view the attention paid to termination in your own and your colleagues' practices?
Probes:
Is there deliberate attention in each case to the termination process? Importance of termination in daily work with clients?

9. What is your experience with adolescents who return to treatment after a planned or unplanned termination?
Probes:
How is this seen in relation to the developmental needs of adolescents?
Is this seen as the result of a treatment failure or a request for service with a different problem? Are they coming back to treatment to terminate or for help with another problem?

DATE: _____

INVENTORY OF VARIABLES

I. DEMOGRAPHIC INFORMATION

1. CASE # [ ]

2. CYP # [ ]

3. Mo. Admitted 1 2 3 4 5 6 7 8 9 10 11 12
4. Mo. Terminated 1 2 3 4 5 6 7 8 9 10 11 12

5. SEX 1) Male 2) Female

6. AGE (A) 12 13 14 15 16 17 18 19 20 21 22
7. AGE (T) 12 13 14 15 16 17 18 19 20 21 22

8. SCHOOL 1) YES 2) NO 3) N/A

9. GRADE 6 7 8 9 10 11 12 GED Coll-1 Coll-2 Coll-3
(Current or Last)

10. ETHNICITY
1) White
2) Afro-Amer.
3) Carib-Amer.
4) Hispanic
5) Asian
6) Other _____

11. BOROUGH
1) Manhattan
2) Bronx
3) Brooklyn
4) Queens
5) S.I.

12. ZIP [ ]

13. PUBLIC ASSISTANCE 1) YES 2) NO 3) NA
14. EMPLOYMENT 1) YES 2) NO 3) NA

II. MODALITY/LENGTH OF TREATMENT

15. TYPE 1) Assessment Only 2) Ongoing Treatment (Sessions beyond eval.)

16. INDIVID. _____

17. FAMILY _____

18. PSYCH. _____

19. GROUP _____

20. TOTAL # [ ]

21. ADMIT STATUS

1) Admitted once
2) Readmit--same clinician
3) Readmit--different clinician

LENGTH OF TREATMENT

22. 0 1 2 3 4 5 6 7 8 9 10 11 Months

23. 0 1 2 3 4 5 6 Years

III. REFERRAL INFORMATION

24. REFERRAL SOURCE
1) Parent/Family 4) Agency 7) Court/Probation
2) School 5) MSH 8) Self
3) AHC 6) Hosp. (Other) 9) Other_____

REASON for ADMISSION

25. Substance Use/Abuse	1) Yes	2) No	
26. Truancy/Attendance Problems	1) Yes	2) No	
27. Maladaptive Behavior--School	1) Yes	2) No	
28. Maladaptive Behavior--Home	1) Yes	2) No	
29. Maladaptive Behavior--Other	1) _____		2) No
30. Academic Problems	1) Yes	2) No	
31. Family Problems	1) Yes	2) No	
32. Personal Problems--Depression	1) Yes	2) No	
33. Personal Problems--Anxiety	1) Yes	2) No	
34. Personal Problems--Other	1)_____		2) No
35. Other	1)_____		2) No

36. REACTION to REFERRAL
1) No Knowledge of Referral
2) Uncertain/Unclear re: Problems
3) Acknowledges Problems
4) Denies Problems
5) Not Available
6) Other _____

37. MOTIVATION
1) Unmotivated 5) Not Available
2) Ambivalent 6) Other _____
3) Motivated

IV. ASSESSMENT INFORMATION

38. FAMILY
1) Single Mother 5) Two Parents 9) Group Home
2) Single Father 6) Grandparent(s) 10) Foster Home
3) Mo. & CL/Step Fa. 7) Other Family 11) Other
4) Fa. & CL/Step Mo. 8) Parent & Ext. Family _____

39. SERVICES CONFIDENTIAL 1) Yes 2) No 3) NA

40. PARENT (GUAR.) INVOLVED IN ASSESSMENT 1) Yes 2) No 3) NA

41. PAST MH/COUNSELING -- SCHOOL 1) Yes 2) No 3) NA
42. PAST MH/COUNSELING -- OUTPT. 1) Yes 2) No 3) NA
43. PAST MH/COUNSELING -- INPT. 1) Yes 2) No 3) NA

44. ABSENCE OF PARENT 1) Yes 2) No 3) NA

45. ABSENCE BY:
1. Death
2. Div./Separ.
3. Both Death and Div./Separ.
4. NA
5. Other _____
6. DNA

46. Other significant Losses 1) Yes 2) No 3) NA

47. # Losses 1) 1 4) 4 7) Other _____
2) 2 5) 5
3) 3 6) 0 8) NA

DIAGNOSIS

48. Adjustment Disorder 1) R/O 2) Yes 3) No
49. Dysthymia 1) R/O 2) Yes 3) No
50. O.D.D. 1) R/O 2) Yes 3) No
51. Conduct Disorder 1) R/O 2) Yes 3) No
52. Major Depression 1) R/O 2) Yes 3) No
53. PTSD 1) R/O 2) Yes 3) No
54. Parent/Child 1) R/O 2) Yes 3) No
55. Other 1) R/O)_____ 2) Yes-_____ 3) No
56. Axis II 1) Yes 2) Deferred 3) No
57. Axis II 1) R/O_____ 2) Yes-_____ 3) No

V. RISK FACTORS

58. SEXUALLY ACTIVE 1) Yes 2) No 3) NA
59. ALCOHOL 1) Yes 2) No 3) NA
60. DRUGS 1) Yes 2) No 3) NA
61. SCHOOL PROBLEMS 1) Yes 2) No 3) NA
62. TRUANT 1) Yes 2) No 3) NA
63. DROPOUT 1) Yes 2) No 3) NA
64. ABUSE/NEGLECT 1) Yes 2) No 3) NA
65. SEXUAL ABUSE 1) Yes 2) No 3) NA
66. COA 1) Yes 2) No 3) NA
67. COSA 1) Yes 2) No 3) NA

VI. TERMINATION OF TREATMENT (Last Termination)

68. Termination Initiated by:
1) Adolescent 4) Adol. & Parent
2) Parent/Family 5) Not available
3) Clinician 6) Other _____

69. Termination Discussed 1) Yes 2) No 3) NA
Termination Discussed.

70. In Session 1) Yes 2) No 3) NA

71. # of Sessions
1) 1 4) 4 7) 7 10) Other
2) 2 5) 5 8) 8 _____
3) 3 6) 6 9) 0 11) NA

72. Term. 1st Discussed
1) Last 5) 4 before last 9) NA
2) 1 before last 6) 5 before last 10) DNA
3) 2 Before last 7) 6 before last 11) Other
4) 3 before last 8) 7 before last _____

73. Term. Addressed By Telephone 1) Yes 2) No 3) NA
74. Term. Addressed by Letter 1) Yes 2) No 3) NA
75. Term. Adressed by Other 1) _____ 2) No 3) NA

76. Type of Termination
1) Completed Term.--client & clinician agree
2) Completed Term.--client wants to term./clin. disagrees
3) Completed Term.--clinic. wants to term./client disagre.
4) Uncompleted Term.--Not discussed
5) Information Not Available
6) Other _____

77. Outreach 1) Yes 2) No 3) NA
Outreach via:
78. Telephone 1) Yes 2) No 3) NA
79. Letter 1) Yes 2) No 3) NA
80. Other 1) _____ 2) No 3) NA

81. Contact made with adol. via Outreach 1) Yes 2) No 3) NA
82. Contact made with family via Outreach 1) Yes 2) No 3) NA

83. Result/Outreach
1) Termination occured over telephone
2) Client returned to terminate in session (in person)
3) Client returned to continue treatment sessions
4) Client agreed to return & did not follow through
5) No Contact made with client
6) Outcome not available from chart
7) Other _____

REASON(S) FOR TERMINATION

84. Clinician leaving agency	1) Yes	2) No	3) NA
85. Social Work Intern completed training	1) Yes	2) No	3) NA
86. Client expressed desire to end services	1) Yes	2) No	3) NA
87. Family expressed desire to end services	1) Yes	2) No	3) NA
88. Client stopped attending sessions	1) Yes	2) No	3) NA
89. Referred Out	1) Yes	2) No	3) NA
90. Client moving	1) Yes	2) No	3) NA
91. Client going to College	1) Yes	2) No	3) NA
92. Client schedule problem	1) Yes	2) No	3) NA
93. Client "Aging Out" of Program	1) Yes	2) No	3) NA
94. Clinician Assessed Ready b/cTher. Wk done	1) Yes	2) No	3) NA
95. Other 1) _____			2) No

CIRCUMSTANCES WHEN TERMINATING

96. Failed/Cancelled Sessions	1) Yes	2) No	3) NA
97. Therapist Vacation/Absence	1) Yes	2) No	3) NA
98. End of school year	1) Yes	2) No	3) NA
99. Summer Vacation	1) Yes	2) No	3) NA
100. Client reschedules appt. & no compliance	1) Yes	2) No	3) NA
101. Clinician assessed further services needed	1) Yes	2) No	3) NA
102. Client Attending sessions regularly	1) Yes	2) No	3) NA
103. Other _____			
_____			
_____			
_____		2) DNA	3) NA

104. Status at Last Session
1) Situation/behavior improving
2) Situation/behavior worsening
3) Situation/behavior stable
4) Not available from chart
5) Other _____

STATUS OF PROBLEM AT TERMINATION (Clinician Report, per term. form)

105. Substance Use/Abuse	1) Improved	2) Unimproved	3) DNA
106. Truancy/Attendance	1) Improved	2) Unimproved	3) DNA
107. Maladaptive Behavior-Sch.	1) Improved	2) Unimproved	3) DNA
108. Maladaptive Behavior-Hm.	1) Improved	2) Unimproved	3) DNA
109. Maladaptive Behavior-Oth.	1) Improved	2) Unimproved	3) DNA
110. Academic Problems	1) Improved	2) Unimproved	3) DNA
111. Family Problems	1) Improved	2) Unimproved	3) DNA
112. Personal Problems-Depress.	1) Improved	2) Unimproved	3) DNA
113. Personal Problems-Anxiety	1) Improved	2) Unimproved	3) DNA
114. Personal Problems-Other	1) Improved	2) Unimproved	3) DNA
115. Other_____	1) Improved	2) Unimproved	3) DNA

STATUS OF PROBLEM AT TERMINATION
(Per Researcher's Report)

116. Substance Use/Abuse	1) Improved	2) Unimproved	3) DNA
117. Truancy/Attendance	1) Improved	2) Unimproved	3) DNA
118. Maladaptive Behavior-Sch.	1) Improved	2) Unimproved	3) DNA
119. Maladaptive Behavior-Hm.	1) Improved	2) Unimproved	3) DNA
120. Maladaptive Behavior-Oth.	1) Improved	2) Unimproved	3) DNA
121. Academic Problems	1) Improved	2) Unimproved	3) DNA
122. Family Problems	1) Improved	2) Unimproved	3) DNA
123. Personal Problems-Depress.	1) Improved	2) Unimproved	3) DNA
124. Personal Problems-Anxiety	1) Improved	2) Unimproved	3) DNA
125 Personal Problems-Other	1) Improved	2) Unimproved	3) DNA
126. Other_____	1) Improved	2) Unimproved	3) DNA

QUALITATIVE DATA/NOTES

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

If Termination Discussed,

127. Feelings Expressed Re: end by Client	1) Pos	2) Neg	3) NA
128. Feelings Expressed Re: end by Clinician	1) Pos	2) Neg	3) NA
129. Client Expressed desire for future services	1) Yes	2) No	3) NA
130. Clinician Invited for future services	1) Yes	2) No	3) NA

If READMIT:

131. # Readmits 1 2 3 4 5 6 7 8
132. # Workers 1 2 3 4

133. Status Last Session
1) Engaged
2) Disengaged
3) Not Available

APPENDIX C

ADOLESCENTS' VIEWS OF THE TERMINATION PROCESS

INTERVIEW GUIDE: INTERVIEW WITH THE ADOLESCENT

I'd like to talk with you about what it was like for you to receive and stop receiving counseling services at the Adolescent Center (AC). I am particularly interested in understanding your point of view about what your counseling experience was like while you were coming to see a social worker and also about how and why your counseling services stopped.

Appendix F, introducing the interview, will be read and reviewed at this point.

1. **Referral Information:**
   Probes:

- First, I'd like to talk with you about how your counseling services began. Can you remember:
- Whose idea was it for you to come to the AC for counseling (mental health) services?
- Who suggested you come here for counseling?
- how do you feel about the plan to see a social worker for counseling?
- To what extent was coming for counseling voluntary? Did you feel you had a choice about coming for counseling or did someone (parent, referral source, etc.) strongly encourage you or advise you to come?

2. **Expectations of Counseling:**
   Probes:

- What did you think counseling would be like?
- How did you and your social worker come to a decision on the goals of your counseling?
- Do you think you and your social worker had the same or different ideas about why you were coming to counseling and the goals or your counseling?
- Did you have any idea how long you would be coming for counseling?
- Did you and you counselor discuss how long you would be coming? If not, would this have been helpful/useful?
- In the beginning, did you and your counselor talk about what would happen if you wanted to stop coming to counseling? What was discussed?

3. **What was it like going to counseling sessions with a social worker?**
Probes:
- What were the sessions like?
- What did you do?
- What did the social worker do?
- How did you experience the counseling, e.g. helpful; boring; a waste of time; difficult; fun; unnecessary, etc?

4. **Can you tell me how your counseling sessions with the social worker stopped?**
Probes:
- When and why did you stop seeing the social worker?
- Whose idea was it to stop?
- Who did you know that you were ready to finish, or that you didn't need to come anymore?
- Did you expect to stop or did you stop without planing?
- Did you discuss together the idea of stopping with your social worker or did you stop coming when you felt you had enough?
- Did you discuss stopping with anyone else, parent/family member, referral source, friend?

5. **Do you remember what was happening in your meetings/sessions with your social worker when you stopped coming?**
Probes:
- Were there: vacations (client or worker's); absences (canceled/failed sessions); school year ending; difficult material; reluctance/disinterest in coming to sessions; satisfaction that problems were solved; dissatisfaction that problems were not solved?

6. **How did you feel about the way counseling services stopped?**
Probes:
- How satisfied were you with the way the services ended?
- How important was it to you to discuss ending with your social worker?

- **What do you think your social worker thought about your stopping/leaving?**
Probes:
- Did you feel that your social worker agreed with your decision or did your social worker want you to continue coming to counseling?
- Did you social worker contact you by phone or letter to discuss the ending of counseling with you?
- How did you react to this (outreach efforts)?

8. **If the client left without discussion of leaving: Can you tell me why you didn't mention to your social worker that you were ready to stop coming for counseling?**
Probes:
- Was embarrassed to do so; didn't want to hurt sw's feelings; didn't occur to them; didn't think it was necessary; discomfort related to authority position of social worker; difficulties expressing emotions or saying goodbye.

9. **When you stopped coming for services, did you think about coming back sometime in the future for more counseling?**
Probes:
- With the same social worker or a different one?
- Did your ideas about coming back influence the way you ended? (e.g. Did you think abut ending in the "terminal" or "final" sense or did you expect or think that you might return again some other time and therefore found no need/reason to say "goodbye")

10. **In looking back, how did you feel about the experience of coming to counseling?**
Probes:
- Were you satisfied, dissatisfied, neutral?
- Did you feel the counseling experience helped you in some way? In what way?
- What was the best thing about counseling?
- What was the worst thing about counseling?

11. **Were your goals for counseling reached?**
Probes:
- If so, why?
- If not, why not?

12. **In looking back, how did you feel about the way the counseling ended?**

13. **Did anything else come out of the counseling that you didn't expect?**
Probes:
- Anything positive or negative?

APPENDIX D

July 10, 1998

Adolescent Center

Dear .

I am a social worker at the Adolescent Center and a doctoral student at the Hunter College School of Social Work. I am writing to you to invite you to participate in a study that is part of a research project known as a dissertation. The purpose of the study is to learn about how young people, like yourself, who have used counseling services at the Adolescent Center, feel about the counseling services they received and also how they felt about stopping counseling services. By getting ideas and input from young people about how they felt about their counseling experience and also about how and why they stopped coming to counseling, we hope to improve, and possibly change, our counseling services.

I am contacting young people who stopped coming for counseling services in 1996. This is how I got your name and why I would be interested in speaking with you, if possible. It is important for you to know that the decision to participate in this study is completely voluntary, that is, the decision is completely up to you. It is important for you to know that whether or not you decide to participate in this study, any services that you receive at the Adolescent Center now or in the future will not be affected in any way.

If you decide that you want to participate in the study, you will be asked to come to an interview with me that will take approximately one and one half hours. During the interview you will be asked a series of questions about your experiences coming for and stopping counseling services at the Adolescent Center. There are no right or wrong answers in this study. You will be asked to describe as honestly as you can, your true feelings about receiving and stopping counseling services.

It is also very important for you to know that f you decide to participate in the study, the information that you discuss will be confidential. No one at the Adolescent Center will know about your participation in the study and none of the information that you discuss in the interview will be shared with anyone, either at the Adolescent Center, your home, or your school. In order to make the interview both private and convenient for you, we will meet at the Adolescent Center, or at a place near you that is most convenient. If you decide not to participate in the study, your services at the Adolescent Center now or in the future will not be affected in any way.

If you decide to participate in this study, you will have the opportunity to give your own opinions and ideas about the counseling services you received at the Adolescent Center. We believe that it is extremely important to know what young people think about counseling services so that we can do whatever we can to improve and change them. Participating in this study will give you a chance to let us know what you thought about your overall counseling experience. In addition, you will be given $15.00 and transportation expenses to and from the Adolescent Center, as reimbursement and appreciation for your time and participation in the study.

I hope that you will consider participating in this study. I am interested in answering any questions you may have about the study. I will by contacting you by phone in the next few weeks to talk with you more about the study, to answer any of your questions, and to see if you may be interested in participating. You can also feel free to call me at ____, if you'd like to find out more about the study. If you reach my phonemail, please leave me a message so I will be able to get back to you.

Thank you for your time and interest and I will be speaking with you soon.

Sincerely,

Diane Mirabito, A.C.S.W.
Social Worker
Adolescent Center

APPENDIX E

To: **Mental Health Staff**

From: **Diane Mirabito**

Re: **Update on Research Study on Termination**

Date: **July 15, 1998**

As most of you know, I am studying patterns of termination from mental health services with adolescents for my doctoral dissertation. A chart review of 100 charts, closed during 1996, has been completed. Data regarding termination patterns and a variety of psychosocial variables was obtained. At this point I am planing to conduct interviews with 10-15 adolescents who terminated their mental health services during 1996. I am selecting patients from the sample of 100 charts who illustrate several different patterns of termination, such as, completed and uncompleted terminations. Letters will be sent to those patients selected for the study, followed by telephone calls, to invite them to participate. The purpose of the interviews is to obtain the adolescents' perspectives on the counseling experience and the process of termination from counseling.

The interviews will take place at the Adolescent Center. The understanding made with the adolescents is that the content of the interviews will be confidential. Aggregate data obtained form the interviews regarding the adolescents' reactions, perspectives, and viewpoints of mental health services and the termination process will be provided to administrative and social work/mental health staff at the conclusion of the study. Names (of patients and staff) will not be used in the study and there will be no way to identify the contributions of specific participants.

If any of the selected patients display significant difficulties during the interview, an assessment will be made regarding the need for mental health services and services will be offered. Likewise, if adolescents request to contact their social worker for continued services or for any other reason, this process will be facilitated.

Thank you all for you contributions to this study, i.e., the work you have done with the adolescents who will be interviewed. Please feel free to discuss with me any questions about the study. I look forward to providing you with feedback (aggregate data) in the future.

APPENDIX F

My name is Diane Mirabito, I am a social worker here at the Adolescent Center and a doctoral student at the Hunter College School of Social Work. I would like to invite you to participate in a study that is being conducted as part of a research project known as a dissertation. Thank you for taking the time to see me. Before we begin the interview, I would like to explain to you its purpose and answer any of your questions.

I am interested in learning as much as I can from the young people who use the counseling services at the Adolescent Center. There are two purposes to this study. It is about how you felt about the counseling services you received here at the Adolescent Center and how you felt about stopping and leaving counseling. There are no right or wrong answers. What is most important is that you tell me as honestly as you can your true feelings.

Your participation in this interview is completely voluntary. If at any time you want to stop the interview or just take a break, please let me know. If you do not want to talk about a particular subject, you don't have to. Participation in the interview will in no way interfere with any services that you are now receiving or may receive in the future at the Adolescent Center. If you decide to stop the interview at any time, or if you do not want to discuss a particular topic, your services at the Adolescent Center now or in the future will not be effected.

I would like your permission to tape-record the interview and take notes in order to record as accurately as possible your ideas and viewpoints. If you do not want the interview to be tape-recorded, it will not be, and notes will be taken instead. Your name will not be used at all in the tape or in my notes of the interview. Instead, I will be giving your interview a code number and all the information that we discuss will be kept under your code number. All tapes and written notes will be kept in a locked file cabinet and destroyed when this project is completed.

What we talk about in this interview will be confidential. As you probably already know from your experience here with a social worker, the only information that would not be kept confidential would be information about any possible danger you may be in, such as, hurting yourself or hurting someone else. If, in the course of our discussion, you

tell me about any dangerous situation (i.e. hurting yourself or hurting someone else) that you are in right now, I will discuss with you a plan in order to make sure that you are safe, that is, that you are not in danger of hurting yourself or anyone else. In addition, I will talk with you about how you can get the help and assistance that you need, here at the Adolescent Center, or somewhere else.

Except for any information about hurting yourself or anyone else, I will not discuss the information we discuss in our interview with anyone. Specifically, I will not speak with anyone from home or school, or with your social worker or any other staff member here at the Adolescent Center. Also, the information from our interview will not become part of your record or file at the Adolescent Center. A report will be written about this study, however no names or identifying information will be used in the report. The general results of the study will be used to help improve, and possibly change, the way we provide counseling services at the Adolescent Center.

Do you have any questions about what I have said or are there any other questions that you would like to ask me about this study before we begin?

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