MEASURING DROPOUT FROM THERAPY USING THE BARRIERS TO TREATMENT PARTICIPATION SCALE

by

REBECCA OAKES

A dissertation submitted to the Graduate Faculty in Educational Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy,

The City University of New York

2005

INFORMATION TO USERS

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

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

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

This manuscript has been read and accepted for the
Graduate Faculty in Educational Psychology in satisfaction of the
dissertation requirement for the degree of Doctor of Philosophy.

4/21/05
Date

Chair of Examining Committee

4/21/2005
Date

Executive Officer

Professor Helen Johnson

Professor Joseph LiPuma

Natosha Huggins-Cupid, M.A.

Supervision Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

MEASURING DROPOUT FROM THERAPY USING

THE BARRIERS TO TREATMENT PARTICIPATION SCALE

by

REBECCA OAKES

Advisor: Professor Georgiana Tryon

The purpose of this study was to investigate if the Barriers to Treatment Participation Scale (BTPS; Kazdin et al., 1991) can be used to predict differences between dropouts and continuers in therapy. This was the first study in which the BTPS was administered at the beginning of treatment rather than after dropout had occurred. Total barriers scores, obtained after the second session, on the Barriers to Treatment Participation Scale – Parent Version, modified for this population, significantly predicted dropout from therapy, $\chi^2(1) = 4.37, p = .037$, over and above seven traditional risk factors of dropout (SES, income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology) Therapist BTPS total barriers scores did not significantly predict dropout over and above what was predicted by the seven risk factors identified in the literature review, $\chi^2(1) = .176, p = .675$. Because the BTPS assesses practical obstacles to attending therapy sessions, perceptions regarding the relevance and demands of treatment, and the relationship or alliance with the therapist, this finding suggests that client dropout is a function of a complex process rather than simple demographic variables.

ACKNOWLEDGEMENTS

First, I would like to thank my advisor, Dr. Georgiana Tryon. She provided me with a wonderful opportunity to research a subject of personal importance to me. Working with her was a great experience and a excellent introduction to the field of academic research. I would also like to thank Dr. Gross, Dr. Johnson, and Dr. LiPuma for their involvement and thoughtful contributions to the study.

My deepest gratitude is extended to everyone at HeartShare Human Services, especially Ken Callahan and Irena Kirkyla, who first saw the value of this dissertation. Thanks also to all the staff at South Brooklyn Services and Bensonhurst Family Services. A special thanks to my friend and professional colleague Natosha Huggins-Cupid, whose energy and drive helped make the data-gathering portion of this dissertation happen.

I'd like to give a special thanks to my friend and classmate Pamela Mitchell for her kindness and guidance throughout the entire graduate program. Also, I would like to thank my parents and close family and friends for their continued encouragement as I completed the dissertation.

Finally, I am most grateful to my husband Sean for his unwavering love and support throughout my entire graduate studies. His pride in me is the greatest reward of this accomplishment.

Table of Contents

List of Tables

List of Figures

CHAPTER 1

Introduction

Client dropout represents a serious barrier to the delivery of effective psychotherapy. Baekeland and Lundwall (1975) report that 30% - 60% of the client population drops out of psychotherapy. Forty percent of clients attend only one to two sessions of psychotherapy (Fiester & Rudestam, 1975; Pekarik, 1983a). Dropout poses problems for therapists, clinic administrators, and researchers. High dropout rates raise concerns about the efficacy of psychotherapy. Dropouts have been shown to have poorer outcomes than therapy completers (Pekarik, 1983a, 1992) suggesting that members of the dropout population failed to benefit from their brief time in therapy. When therapists invest their time in seeing clients who eventually dropout, the cost-effectiveness of therapy is called into question. Dropout can cause fiscal and morale problems at mental health clinics. Most clients dropout of therapy by not showing up for appointments, which represents lost revenues and wasted time for clinicians. Therapists may also feel an emotional cost associated with attrition. When clients don't return for therapy, therapists may feel like they have failed or been rejected by clients. This stress could lead to job dissatisfaction on the part of therapists and/or high staff turnover.

Studies show that clients who dropout of therapy very early in the process have the poorest therapeutic outcomes (Pekarik, 1983a, 1992). Such studies suggest that psychotherapy is failing to reach a portion of the client population that is clearly in need of help and does not improve on its own. In hopes that clients at high-risk for dropout

could be identified earlier in the therapeutic process and helped before attrition occurs, researchers have searched for ways to identify dropouts. Despite the large body of studies on this topic, a clear profile of dropout has not emerged.

The definition of dropout varies across studies and contributes to mixed findings and different dropout rates. While most researchers would agree that client dropout is a problem, a lack of a uniform definition of dropout impedes research on this issue. Wierzbicki and Pekarik (1993) concluded that the therapist's judgment may be the best method for defining dropout, because it allows therapists the flexibility to assess each client termination individually. Using this method, dropouts are defined as clients who leave therapy at any point in the therapeutic process without approval from their therapist. Other methods of determining dropout, such as a duration-based method (i.e., number of sessions), carry assumptions about the length of the therapeutic process. In a meta-analysis of 125 studies, Wierzbicki and Pekarik (1993) showed that the dropout rate differs substantially as a function of the definition of dropout. Given the variety of definitions employed, the results of dropout studies are vastly disparate.

Early research focused on client variables such as demographic characteristics or the presence of psychological distress that could accurately lead to a profile of the client who is more likely to dropout of therapy. Despite the large number of studies on this topic, no such profile has been identified. The most consistent finding to emerge is that increased risk of dropping out has been linked to client lower socioeconomic status (Armbruster & Fallon, 1994; Baekeland & Lundwall, 1975; Garfield, 1978; Trepka, 1986; Wierzbicki & Pekarik, 1993).

The quest for client risk factors for dropout has lead to investigations of client psychopathology (Kendall & Sugarman, 1997; Richmond, 1992), expectations (Hardin, Subich, & Holvey, 1988), self-efficacy regarding treatment (Longo, Lent, & Brown, 1992), and readiness for change (Smith, Subich, & Kalodner, 1995) as well as parental psychopathology (Venable & Thompson, 1998). As was the case with studies of client demographic characteristics, these investigations frequently produced conflicting results. Other researchers turned their attention to the study of therapist characteristics that might predict client dropout. These researchers investigated therapist gender (Betz & Shullman, 1979; Epperson, 1981), experience level (Krauskopf, Baumgardner, & Mandracchia, 1981), and social influence characteristics (Martin, McNair, & Hight, 1988; Tryon, 1989) with equivocal results.

Studies investigating the client-therapist relationship have examined client-therapist problem definition (Epperson, Bushway, & Warman, 1983), locus of blame (Tracey, 1988), and working alliance (Mohl, Martinez, Ticknor, Huang, & Cordell, 1991). Among these investigations, the working alliance studies have generally shown that when clients and therapists have poorer working alliances (lower agreement on the tasks and goals of therapy and poorer therapeutic bond), clients tend to drop out of therapy (Tryon & Kane, 1995). Finally, investigations of administrative variables have shown that placing clients on a waiting list does not generally lead to client dropout (Pulakos & Morris, 1995), but client referral by others rather than self often leads to dropout, particularly when child clients have been referred by the schools (Gould, Shaffer, & Kaplan, 1985).

Thus far, the many studies seeking to determine factors associated with client therapy dropout have yielded equivocal results, and client dropout continues to be a problem. In their search for dropout risk factors, researchers seem to have studied almost every variable conveniently at hand. These studies have not been based on a theoretical formulation of client dropout. An exception to this is Kazdin, Holland, and Crowley's (1997) Barriers to Treatment model that proposes that families experience multiple barriers associated with participating in treatment and that these barriers increase the risk of dropping out. Barriers include practical obstacles, perceptions that treatment is demanding and of little relevance to the child's problems, and a poor relationship or alliance with the therapist.

The Barriers to Treatment Participation Scale (BTPS; Kazdin, Holland, & Bretton, 1991) groups several potential obstacles to treatment into one assessment instrument and provides for an understanding of the unique contribution of each obstacle to dropout. The BTPS assesses barriers in five domains: stressors and obstacles that compete with treatment, treatment demands and issues, perceived relevance of treatment, relationship with the therapist, and critical events. Parents and therapists are given separate versions of the scale. Elevated scores on the BTPS have been demonstrated to explain dropout behavior independent of other family, parent, and child risk factors (Kazdin et al., 1997). The findings of Kazdin et al. (1997) represent a shift away from individual client and therapist variables towards a more integrated approach to dropout.

Kazdin et al. (1997), however, studied families after they had already dropped out of treatment. Thus, their answers to the BTPS items could have been after-the-fact

justifications for dropping out. Also, once families have left treatment, little can be done to address potential obstacles to treatment attendance. For these reasons, this study examined families' perceptions of barriers to treatment before dropout occurred in order to predict dropout. The findings may help focus the attention of child and family therapists on indicators of dropout that may be addressed before clients leave treatment unilaterally.

CHAPTER 2

Literature Review

This literature review begins with an explanation of the negative effects of dropout and a discussion of the definition of the term. The findings of studies of client and therapist variables related to dropout are reviewed, as well as findings on how dropout relates to specific aspects of the therapeutic process. Finally, the Barriers to Treatment model of child and family therapy attrition is discussed.

Dropout poses problems for therapists, clinic administrators, and researchers. High dropout rates raise concerns about the efficacy of psychotherapy. Studies show that clients who dropout of therapy very early in the process have the poorest outcomes (Pekarik, 1983a, 1992). In a study at a community health clinic, Pekarik (1983a) found that 47.2% of a client population (n = 89) dropped out within the first two visits. At a three-month follow-up, clients who dropped out of therapy within the first two visits differed significantly on their responses to the Brief Symptom Inventory (BSI; Derogatis, 1975) from clients who terminated therapy with the mutual agreement of their therapists. Members of the dropout group endorsed significantly more problems than did clients who completed treatment. The groups had not differed significantly on BSI scores at the start of therapy. In a later study, Pekarik (1992) found similar results among adult and child psychotherapy dropouts. Early dropouts (clients who dropped out after one to two sessions) were less well adjusted than later dropouts (clients who dropped out after three or more visits) for both adults and children, as measured by scores on the BSI and the Child Behavior Checklist (CBCL; Achenbach & Edelbrock,

1983). These studies suggest that psychotherapy is failing to reach a portion of the client population that is clearly in need of help and does not improve on its own.

Before reviewing the dropout literature, it should be noted that this literature tends to use the terms "psychotherapy", "therapy", "counseling", and "treatment" interchangeably, often within the same article. The literature also uses the words "therapist" and "counselor" interchangeably. This dissertation uses the terms "therapist" and "therapy" because those are the terms by which the practitioners at the agency studied describe themselves and what they do. Unlike efficacy studies that provide precise treatment definitions, dropout studies generally examine client leave taking behavior from what Seligman (1995) has referred to as "psychotherapy as it is done in the field" (p. 966).

Researchers have searched for ways to identify dropouts in hopes that clients at high-risk for dropout could be identified early in the therapeutic process and helped to stay in treatment. The dropout literature is difficult to summarize, because studies vary according to a number of variables (i.e., the type of therapy employed, presenting client problems). The only consistent finding of dropout literature is the lack of consistent findings. Below is a review of the treatment dropout literature. Any review must begin with a discussion about the definition of dropout. The definition of dropout varies across studies and contributes to mixed findings and different dropout rates.

Definition of Dropout

While most researchers would agree that client dropout is a problem, the lack of a uniform definition of dropout impedes research. Dropout has been defined in four different ways: 1) client failure to schedule an appointment after intake, termed

"termination by failure" (Anderson, Hogg, & Magoon, 1987; Archer, 1984; Betz & Shullman, 1979; Epperson, 1981; Epperson et al., 1983; Folkins, Hersch, & Dahlen, 1980; Gould et al., 1985; Hardin et al., 1988; Krauskopf et al., 1981; Longo et al., 1992; May, 1990; Pulakos & Morris, 1995; Rodolfa, Rapaport, & Lee, 1983; Weisz, Weiss & Langmeyer, 1987); 2) failure to keep scheduled appointments (Armbruster & Fallon, 1994; Kendall & Sugarman, 1997; Kokotovic & Tracey, 1987; Lawe, Horne, & Taylor, 1983; Richmond, 1992; Smith et al., 1995; Trepka, 1986); 3) failure to attend a minimum number of sessions (Fiester, 1977; Gunzburger, Henggler, & Watson, 1985; Hoffman, 1985; Holmes & Urie, 1975; Kazdin & Mazurick, 1994; Kokotovic & Tracey, 1990; Martin et al., 1988; Mohl et al., 1991; Tracey, 1988; Venable & Thompson, 1998); or 4) leave taking without therapist approval (Kazdin et al., 1997).

Each of these definitions of dropout carries assumptions about the length of the therapeutic process. A duration-based definition of dropout (i.e., a failure to attend a minimum number of sessions) implies that a low number of sessions should be considered treatment failure. This definition of dropout is based on the assumption that therapeutic success can only be achieved with a certain number of visits (Pekarik, 1985b).

Pekarik (1983b) found that what researchers or therapists term dropping out might not represent a negative outcome from the client's perspective. In his study, 103 clients at a community mental health center were given the BSI before therapy began and at a three-month follow-up interview after termination of therapy. Clients were considered dropouts if therapists judged the clients as needing services beyond their last session. By this definition, 45% of the sample were dropouts. Dropouts gave reasons

for termination that fell into three categories: No Need for Services, Dislike of Services, and Environmental Constraints. The No Need for Services and Environmental Constraints groups had significant post-dropout decreases in BSI scores, while the Dislike of Services group did not have significant changes in BSI scores. Therefore, the majority of dropout clients did not express negative feelings about therapy, and they reported fewer symptoms after dropping out. Pekarik (1983b) concluded that dropout after a small number of therapy sessions is not necessarily a rejection of therapy or an indication of treatment failure.

Therapists and clients have been found to vary in their expectations for how long treatment should last. In a survey of 173 therapists at 43 mental health clinics, Pekarik and Finney-Owen (1987) found that, while the mean length of treatment at a community mental health center was 5 visits, the therapists preferred 11 or more sessions, and nearly one-third of therapists preferred 21 or more sessions. Therapists also tended to overestimate the length of time clients spend in treatment. Pekarik and Finney-Owen hypothesized that this may have been due to the fact that therapists spent most of their time working with clients who come for long-term therapy.

Results of the survey also indicated that therapists might overestimate the extent to which clients view therapy as a positive experience. Therapists and clients were asked to identify the reasons why clients dropped out of therapy. "Dislike of Therapy" was indicated as a dropout reason by 26% of clients and only 11% of therapists. Therapists (59%) were more likely to endorse "Problem Solved or Improved," than clients (39%). Because therapists tended to overestimate the length of time their clients spent in treatment and underestimate their clients' dissatisfaction, Pekarik and Finney-

Owen (1987) suggested that therapists might have an overly positive view of the therapeutic process.

Pekarik (1985b) found that the therapist judgment definition of dropout was better able to differentiate dropouts from completers than the duration-based definition. He studied 152 dropouts from a community mental health clinic. Dropout was defined using both a duration-based method (1-5 visits = early dropout, 6 or more visits = late dropout) and therapist judgment of successful therapy completion or dropout (dropouts = 76%, completers = 24% with this latter definition). Differences between clients divided on the basis of therapist judgment were far more distinctive than differences between clients divided on the basis of treatment duration. Using the duration-based definition of dropout, clients did not did not differ significantly on any variables. However, using the therapist judgment definition, dropouts and continuers differed on 11 of the 18 variables. Dropouts were more likely to be Title IX eligible, non-white, lower income, and have less education than continuers. Dropouts included higher percentages of children, clients referred by another person or agency, and clients without previous treatment experience. A higher proportion of clients dropped out of group than individual therapy. Three of four therapist variables distinguished between dropouts and completers. Dropping out was associated with therapists who had little experience, preferred longer treatments, and used treatments oriented toward personality change rather than problem-oriented approaches.

Wierzbicki and Pekarik (1993) concluded that the therapist's judgment may be the best method for defining dropout, because it allows the therapist the flexibility to assess each client termination individually. The termination-by-failure and the

duration-based methods both attempt to define dropout in a quantifiable and reliable manner. However, ultimately, the judgment of dropout must come from the therapist. The danger in using therapist judgment for a definition of dropout is lack of reliability because therapists vary in their assumptions about the appropriate length of therapeutic treatment (Wierzbicki & Pekarik, 1993).

Dropout rate. The dropout rate from therapy has been estimated to be between 30% to 60% (Baekeland and Lundwall, 1975). In a meta-analysis of 125 studies, Wierzbicki and Pekarik (1993) showed that the dropout rate differs substantially as a function of the definition of dropout. The dropout rate was highest when dropout was defined as leave taking without therapists' approval (48.43%). Dropout defined by failure to attend a scheduled session was 35.87%, and dropout defined by failure to attend a minimum number of sessions was 48.23%.

Given the wide variety of definitions employed, it is not surprising that the results of dropout studies are vastly disparate. The majority of research has focused on client variables. The results of these studies are presented below.

Client Variables

Demographic characteristics. Results of studies attempting to identify client demographic variables associated with dropping out from therapy have been equivocal. Increased risk of dropping out has been linked to client lower socioeconomic status (Armbruster & Fallon, 1994; Baekeland & Lundwall, 1975; Garfield, 1978; Trepka, 1986; Wierzbicki & Pekarik, 1993). However, other studies have failed to find a link between client socioeconomic status and dropping out behavior (Gould et al., 1985; Weisz, et al., 1987). Some studies have found that dropout is associated with client

minority status (Armbruster & Fallon, 1994; Kazdin & Mazurick, 1994; Kendall & Sugarman, 1997; Wierzbicki & Pekarik, 1993). Other researchers have found that minority status is not associated with dropout (Gould et al., 1985). Single parenthood has been found to relate to dropout from therapy (Armbruster & Fallon, 1994; Kazdin & Mazurick, 1994; Kendall & Sugarman, 1997), and single parenthood has been found to be unrelated to dropout (Gould et al., 1985). Parents with limited education have been found to be at increased risk of dropout (Wierzbicki & Pekarik, 1993); yet Kendall and Sugarman (1997) found no link between parent education and dropout. A mother's age has been found to relate dropout (Kazdin & Mazurick, 1994), and mother's age has been found to have no relationship to dropout (Kendall & Sugarman, 1997).

These contradictory results have failed to produce a demographic profile of the typical dropout. One of the most consistent finding in the literature, however, is that dropout is related to socioeconomic status (Armbruster & Fallon, 1994; Baekeland & Lundwall, 1975; Garfield, 1978; Wierzbicki & Pekarik, 1993). In a meta-analysis of 125 studies, increased risk of dropping out was found to relate to client minority status, lower level of education, and lower socioeconomic status (SES) (Wierzbicki & Pekarik, 1993).

Armbruster and Fallon (1994) found that families from upper SES classes were more likely to continue therapy than families from lower classes, regardless of minority or single parent status. This study examined factors that affected dropout in 304 families at a university child guidance clinic. Dropout was defined as a unilateral decision on the part of the client to end therapy at any phase of therapy. For this study, therapy was divided into four phases: preclinic contact, evaluation, completion of

evaluation, and treatment. In this study, 45 % of the 304 clients dropped out. Across all phases of therapy, families headed by a single parent were more likely to dropout than dual parent families, insured families were more likely to continue than uninsured families, and minorities were more likely to dropout than non-minorities. However, when SES was controlled for, minority and single-parent status no longer significantly predicted dropout. These researchers also found that SES was related to family cohesion. Higher SES status and a high family cohesion score on the Family Environment Scale (FES; Moos & Moos, 1986) were associated with continuation across all treatment phases. All other demographic variables failed to relate to dropout both across, as well as within, treatment phases. These demographic variables were gender of child, birth order, living with biological parent, previous psychiatric contact, emergency admission, medication, family size, special education status, treatment modality, reason for referral, and referral source (Armbruster & Fallon, 1994).

Other studies using different definitions of dropout, however, have failed to find a link between socioeconomic status and dropping out behavior (Gould et al., 1985; Weisz et al., 1987). Gould et al. (1985) found no differences in family demographic characteristics among dropouts or continuers. The sample was 345 children referred to a hospital clinic. Dropout was defined as failure to attend the next scheduled appointment after the initial screening visit. Using this definition, 38 children, or 11%, were defined as dropouts. No significant differences were found between groups of dropouts and continuers regarding SES of the family or marital status of the mother.

In summary, with the exception of SES, dropout studies have not found consistent associations with client demographic characteristics. Researchers further

attempted to identify the demographic characteristics of dropouts by studying the differences between clients who dropout early in therapy versus those who dropout later in therapy.

Demographic characteristics of early versus late dropouts. Clients who drop out early in the therapeutic process have been found to differ on various demographic characteristics from clients who dropout later (Armbruster & Fallon, 1994; Kazdin & Mazurick, 1994). Kazdin and Mazurick (1994) investigated family, parent, and child factors that could predict dropout among children referred for treatment for oppositional, aggressive, or antisocial behavior. The total sample size was 257 families. Families were classified as early dropouts, late dropouts, or completers. Early dropouts attended 6 or fewer therapy sessions. Late dropouts attended 7 to 14 therapy sessions. Completers attended seven to eight months of sessions, which was the full treatment regimen. Using these definitions, 52.5 % of the sample (n = 135) was identified as completers, 29.2 % as early dropouts (n = 75), and 18.3 % as late dropouts (n = 47).

Using a discriminant analysis, 18 variables differentiated completers versus early terminators; however only five variables differentiated completers versus late terminators. Variables were related to family, parent, and child characteristics. As compared to families from the completer group, families from the early dropout group had the following characteristics: single parent family, minority group, younger mother, living in a household headed by a non-biological parent, low income, poor living accommodations, and adverse child-rearing practices. Compared to parents from the completer group, parents from the early dropout group tended to have more perceived stress, a greater number of stressful life events, and a mother's history of antisocial

behavior. Compared to children from the completer group, children from the early dropout group tended to have more severe and chronic antisocial behavior, lower IQs, academic delays, and contact with antisocial peers (Kazdin & Mazurick, 1994).

Children from the late dropout group tended to have a history of antisocial behavior, low IQs, and poor adaptive functioning at school as compared to children from the completer group. Families from the late dropout group tended to have a younger mother and tended to be headed by a non-biological parent as compared to families in the completer group (Kazdin & Mazurick, 1994). Researchers concluded that subgroups of dropouts can be identified and that different factors related to their risk for dropping out. Also, variables used in this study were better at predicting early dropout from treatment compared to late dropout or completion (Kazdin & Mazurick, 1994).

Richmond (1992) also found that the demographic characteristics of dropouts differed according to the point at which adult clients dropped out of therapy. In this study, therapy was divided into three phases: intake, evaluation, and therapy. The sample was 624 clients who sought individual adult therapy at a mental health clinic. Clients who dropped out after the first session were classified as intake dropouts, clients who completed evaluation but did not begin therapy were classified as evaluation dropouts, clients who dropped out after therapy had begun were classified as therapy dropouts, and clients who completed the treatment were classified as completers. Clients who had a greater probability of being classified as intake dropouts were young, minority-group members who reported little stress. Clients who had a greater

probability of being classified as evaluation dropouts or therapy dropouts were male minority group members with little education.

Armbruster and Fallon (1994) studied family dropout at different stages of therapy. For this study, therapy was divided into four phases: preclinic contact, evaluation, completion of evaluation, and treatment. Specific predictors unique to each stage of therapy emerged. Having a child under the age of five was a significant predictor of dropout in the preclinic contact phase. A lack of insurance was a significant predictor for those who dropped out during the evaluation phase. Having school-age children was a significant predictor of dropout after completing the evaluation, but before beginning treatment. Therefore, preschool children were at risk for dropping out in the early phase, and older children were at risk of dropping out in later phases.

In summary, the demographic characteristics of dropouts have been found to differ according to the point at which dropouts terminate treatment (Armbruster & Fallon, 1994; Kazdin & Mazurick, 1994; Richmond, 1992). Kazdin and Mazurick (1994) found that demographic variables used in their study were better able to classify early dropouts rather than late dropouts. For example, a parent's perceived stress and number of stressful life events and a mother's history of antisocial behavior related to early dropout; yet no parental demographic variables were found to relate to later dropout from therapy. Seven demographic variables were found to relate to families who dropout early from treatment, but only two demographic variables were found to relate to families who dropout later from treatment.

Kazdin and Mazurick (1994) found that client minority group membership was only related to families who dropped out early from therapy; however, Richmond (1992) found that minority group membership related to adult client dropout from all phases of therapy. Kazdin and Mazurick found that a perceived high levels of parental stress was related to early dropout, while Richmond (1992) found that adults' reported low levels of stress was related to early dropout. Armbruster and Fallon (1994) found that children who dropout in the early stage of therapy tended to be of preschool age, while children who dropped out later in therapy tended to be of school age. Thus, findings about the demographics characteristics of dropouts according to the phases at which they terminate therapy are also inconclusive and possibly related to whether the clients are families or individual adults.

Caretakers' psychological characteristics. The dropout rate of children from therapy has been linked to the presence of psychological symptoms in their caretakers (Gould et al., 1985; Venable & Thompson, 1998). Venable and Thompson (1998) studied the parent characteristics that might influence withdrawing children prematurely from therapy. Results suggest that a caretaker's intrapunitive hostility is predictive of children's dropout. The study involved 85 caretakers of children referred for therapy at community mental health centers or private practice. In this study, dropout was defined as a unilateral decision on the part of the parents to end therapy in less than 10 sessions. Using this definition, 36% of the sample population qualified as dropouts. Researchers looked at the relationship of six predictor variables and membership in three groups using a predictive discriminate analysis. Hostility, anxiety, depression, and paranoia were measured using the Symptom Checklist 90-R (SCL-90-R; Derogatis, 1994).

Intrapunitive and extrapunitive hostility were measured with The Hostility and Direction of Hostility Questionnaire (HDHQ; Caine, Foulds, & Hope, 1967).

The three groups were: group (1) dropouts, defined as those who dropped out by unilateral decision before the completion of 10 sessions (n = 31, 36%); group (2), defined as those who reached therapeutic goals regardless of number of sessions (n = 18; 21%); and group (3), defined as those who attended 10 sessions although they had not completed goals yet (n = 36, 42%). The six predictor variables were able to correctly predict group membership best for the dropout group (77 %), followed by the compliance by attending group (61%), and the compliance by achieving goals group (11%). Intrapunitive hostility had the largest relationship to dropout when considered alone as a univariate predictor. Intrapunitive hostility was defined as self-criticism and delusional guilt. The mean intrapunitive hostility scores for caretakers in the dropout group (6.19) was almost a full standard deviation larger than the means of the caretakers in compliance by achieving goals group (3.78) and the compliance by attending sessions group (3.68).

Gould et al. (1985) found that parents of dropouts had higher scores on 8 of the 9 symptom factors of the BSI. Four of these factors (Obsessive-Compulsive, Hostility, Phobic Anxiety, and Psychoticism) yielded scores that were in a similar range to those of adult psychiatric outpatients.

Adult dropout psychological characteristics. Several psychological characteristics have been found to relate to adult clients who dropout of therapy. Poor interpersonal skills have been linked to dropout in adults (Hoffman, 1985). When studying 287 clients of a private non-profit community health center referred for

individual, marriage, and family therapy, Hoffman (1985) found that parents and individuals with interpersonal relationship problems were more likely to dropout of treatment. The study compared the relationship of several demographic characteristics to dropout. In this study, dropout was defined as unilateral client termination before completion of the third therapeutic session. Using this definition, the overall dropout rate was 32.4%. Clients with a presenting problem in the area of interpersonal relationships were more likely to dropout of therapy, while clients with more serious disorders such as psychotic diagnosis, thought disorders, or those with previous psychiatric treatment experiences were most likely to remain in therapy.

Trepka (1986) found that clients with higher levels of psychopathology tended to complete treatment. Trepka, a clinical psychologist, studied 118 adults seeking individual therapy from him over a two-year period. Clients were classified into four groups. The non-attenders group never attended any therapy sessions; the non-engagers group failed to attend after the initial session, the non-completers group dropped out after treatment had begun, and the completers group finished treatment. Total attrition for this study was 40.6%. Trepka (1986) found that non-attenders tended to have a history of past psychiatric referrals. Non-engagers tended to be of a lower SES, were unemployed, and were referred by agents that had a poorer quality relationship with the psychologist. Non-completers were found to be very similar to completers, except that completers had more severe psychological disorders than non-completers (Trepka, 1986).

Richmond (1992) studied the psychiatric and diagnostic characteristics of adult dropouts at three different phases of therapy. For this study, therapy was divided into

three phases: intake, evaluation, and therapy. Clients were classified into four groups: intake dropouts, evaluation dropouts, therapy dropouts, and completers. Intake dropouts were more likely to be hostile, tense, suspicious, and uncooperative. Intake dropouts had lower levels of guilt feelings. The intake dropouts also tended to be more prone to unusual mannerisms, thought content, and hallucinations. Intake dropouts differed from completers in that they were less likely to have a *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*; American Psychiatric Association; 1980) Axis II diagnosis, or a passive or avoidant personality style. Intake dropouts had external problems such as domestic violence or drug abuse as the primary complaint.

Evaluation dropouts were less functionally impaired, more tense, and had lower levels of guilt feelings. Evaluation dropouts differed most from completers in tending to present with a domestic violence problem rather than adjustment, grief, self-growth, or psychosexual problems.

Clients who had a greater probability of being classified as therapy dropouts were tense, grandiose, and uncooperative. Therapy dropouts reported more somatic concerns and low levels of guilt feelings. Therapy dropouts differed from completers in being more prone to *DSM-III-R* (revised *DSM-III*; American Psychiatric Association, 1987) Axis II personality disorders, and were more likely to present with domestic violence issues, while completers were more likely to present with adjustment, grief, self-growth, and psychosexual or family problems. Richmond (1992) hypothesized that these clients may have had trouble being introspective as a result of their problems. Richmond also hypothesized that the hostile and resistant clients may have resented having to give detailed personal information during the assessment phase of therapy.

Richmond suggested that dropouts may need to feel immediate positive benefits from therapy in order to continue with therapy.

Tryon (1984) found that the nature of a client's problem was related to the total number of sessions attended. Clients seeking help with personal problems attended the most sessions followed by those seeking vocational counseling, and finally those seeking freshmen test feedback. Also, a significantly greater number of clients receiving personal therapy terminated their therapy by failing to return for a scheduled session (40%) compared to vocational (15%) and test feedback clients (16%).

In conclusion, adult psychopathology has been associated with dropout from therapy. The results of these studies; however, have sometimes been conflicting (i.e., Trepka, 1986 vs. Richmond, 1992). As a result, there is no particular adult psychopathology that predicts dropout.

Child dropout psychological characteristics. Studies have consistently shown that the age and sex of a child is not associated with child dropout (Gould et al., 1985; Kazdin & Mazurick, 1994; Kendall & Sugarman, 1997; Weisz et al., 1987). However, the findings are conflicting as to whether a child's diagnosis is significantly related to dropout. Kazdin and Mazurick (1994) found that child dropout from therapy was significantly related to children having the diagnosis of conduct disorder, a history of academic dysfunction, poor social behavior, low IQ, low adaptive functioning, and a history of antisocial behavior.

Kendall and Sugarman (1997) found that children who dropped out of therapy for the treatment of anxiety were more likely to report less anxious symptomology than were children who continued in therapy. Participants were 190 children with anxiety

disorders. Dropout was defined as a unilateral decision to terminate before the end of time-limited (16 – 20 week) treatment. This definition produced a group of 23 children. Completers were compared with dropouts. Chi-square tests and analyses of variance failed to yield significant differences between groups based on child's age, gender, mother's age, mother's level of education, and family income. However, on diagnostic interviews, children who completed treatment reported more anxiety than those who dropped out. Dropout was significantly related to minority status, single parenthood, and placement on a waiting list.

Other researchers have found no significant relationship between child diagnoses and dropout. Armbruster and Fallon (1994) found that clinical measures such as the CBCL, the Vineland Adaptive Behavior Scale (VABS; Sparrow, Balla, & Cicchetti, 1985), the Children's Global Assessment Scale (C-GAS; Shaffer et al., 1983), and DSM-III-R (American Psychiatric Association, 1987) failed to predict dropout. However, Armbruster and Fallon (1994) found that children who had high CBCL externalizing scores and came from families with high scores on the conflict subscale of the FES were at greater risk for dropping out of therapy.

Weisz et al. (1987) found no differences between children who dropped out of therapy and those who remained. They studied 304 children referred to community mental health clinics. Dropout was defined as a failure to return after the intake session. Continuers were defined as those who attended five or more sessions. Dropouts numbered 166, while continuers numbered 138. When demographic variables such as child's age, SES, birth order, number of children living at home, the presence or absence of changes in family structure, number of miles from home to the clinic were

entered into a canonical discriminant analysis, the combination did not significantly distinguish dropouts from continuers.

Weisz et al. (1987) found dropouts and continuers had no significant differences on the Child Depression Inventory (CDI; Kovaks & Beck, 1977) or the number of previous outpatient sessions in another setting. A canonical discriminant analysis including the Activities, Social and School scale competence T scores, and the internalizing and externalizing T scores from the CBCL failed to show any significant group differences. Gould et al. (1985) found that ethnicity, age, or sex of the child client, and CBCL or the Teacher Report Form scores yielded no significant differences between dropouts and continuers on externalizing or internalizing symptoms.

In summary, findings regarding child psychological symptoms and dropout are conflicting. Child dropout from therapy has been found to be associated with both the presence of psychological symptoms (Kazdin & Mazurick, 1994) and a lack of psychological symptoms (Kendall & Sugarman, 1997). Dropout has also been found to have no relationship to psychological symptoms (Armbruster & Fallon, 1994; Gould et al., 1985; Weisz et al., 1987).

Client expectations. Researchers have looked at how adult clients' expectations about therapy relate to dropout (Gunzburger et al., 1985; Hardin et al., 1988; Pekarik, 1985a). Pekarik (1985a) reviewed the dropout literature and concluded that most clients expect to attend a few visits, want interventions to directly impact their problems, want treatment goals to focus on resolution of immediate emotional issues rather than sweeping personality or behavioral changes, and may be satisfied with a modest level of improvement. The majority of clients have fewer than 6 visits (Garfield, 1978).

Pekarik suggested that it would be unrealistic to expect clients to suddenly commit to 10 or more sessions. Pekarik advocated using a crisis intervention model in which actual treatment is delivered in the very first session, and the total number of session is minimal, 8 or less.

Gunzburger et al. (1985) found that dropouts were less likely than continuers to say that the first therapy session fulfilled their expectations. In this study, 45 students at a university counseling center were given self-report measures regarding their initial session of therapy, the therapists' characteristics, and their relationship with the therapists. The results of these measures were compared to the clients' dropout or continuer status. Clients were designated dropouts if they failed to attend more than four sessions. Dropouts were less likely than continuers to report that the initial session was helpful and less likely to have a positive attitude about returning for future sessions. Because dropouts reported dissatisfaction with therapy after the initial session, the researchers speculated that dropouts may have made their decision to leave therapy by the end of the first session. Dropouts did not differ from continuers in their perceptions of therapist empathy, warmth, or genuineness.

Hardin et al. (1988) found that pretherapy expectations did not differentiate dropouts from continuers. In this study, 80 clients at a university counseling center were given the Expectations About Counseling Questionnaire (EAC; Tinsley, Workman, & Kass, 1980). The EAC measures client attitudes, client perceptions of therapist characteristics, and client perceptions of the process of therapy. Dropout was defined as failure to return after the intake session. Clients who dropped out did not have different pretherapy expectations, as measured by the EAC, from clients who

continued therapy. Thus, these two studies of client expectations yielded conflicting results.

Therapy pretraining. Pretraining is designed to teach clients about the role they will play in the therapy process and about how to take responsibility for therapeutic change. At a university counseling center, Lawe et al. (1983) showed that clients who received no pretraining were more likely to dropout of therapy than those who received pretraining. In this study, dropout was defined as a failure to keep a scheduled appointment. Clients received either general training, specific training, or no pretraining. In general pretraining, clients discussed goals and procedures to familiarize them with the therapy experience. In specific pretraining, individual therapists explained their personal styles and expectations for therapy. Sixty percent of the dropout population came from the no pretraining group. Clients from the three groups showed no differences in their perception of the client-therapist relationship or their amount of self-exploration.

Holmes and Urie (1975) found that prepared children, age 6 to 12, were less likely to dropout of therapy. In this study, 88 children at a community mental health center were assigned to a therapy prepared group or therapy nonprepared group. A significantly lower proportion of prepared than nonprepared clients dropped out of therapy, indicating that the preparation of clients for therapy reduced the dropout rate. In this study, dropout was defined as a failure to return after the third session. Prepared clients showed a greater understanding of the therapy process. Thus, these two studies show that preparing clients for therapy by pretraining can decrease dropout.

Self-efficacy. The social cognitive model of Bandura (1986) has been used to explain client commitment to attendance at therapy. According to this theory, self-efficacy, outcome expectations, and goals relate to people's decision to persist in therapy. In a study at a university counseling center, Longo et al. (1992) studied how self-efficacy and outcome expectations about therapy related to motivation to continue therapy. In this study, dropout was defined as a failure to return after the intake session.

Self-efficacy refers to people's beliefs about their ability to perform particular behaviors. Self-efficacy was assessed using a 20-item scale developed specifically for this study. The scale measured clients' self-efficacy about therapy in three general areas:1) their ability to engage in difficult in-session behaviors such as emotional expression, 2) their ability to manage barriers to coming to therapy, and 3) their ability to take personal initiative in solving problems. Clients' outcome expectations were measured using the Outcome scale from the EAC. Motivation was measured using the Motivation scale from the EAC. Self-efficacy, more than client outcome expectations, was able to predict clients' motivation to return to therapy after the initial session. Self-efficacy was the primary discriminating variable between continuers and dropouts. Low self-efficacy was significantly related to client dropout (Longo et al., 1992).

Readiness for change. Dropout has been studied from the perspective of a transtheoretical model of client change (DiClemente & Prochaska, 1982). According to this model, people go through five stages of readiness for change: precontemplation, contemplation, preparation, action, and maintenance. In the precontemplation stage, the client is either unaware of or has no desire to change behavior. In the contemplation stage, the client is aware of a problem but has not made a formal decision to change. In

the preparation stage, the individual has decided to take action shortly with regard to the problem or has unsuccessfully acted on it in the recent past. In the action stage, the individual has begun effectively to change behavior, but has not changed to the desired level. The final stage is maintenance in which clients attempt to stabilize their gains and prevent relapse.

Smith et al. (1995) studied early termination by assessing clients' readiness for change using the Stage of Change Scale (SCS), a 32-item instrument with four sub-scales (Precontemplation, Contemplation, Action, and Maintenance) designed to assess the five stages of change (DiClemente & Prochaska, 1982). The preparation stage is indicated if a client's Contemplation and Action subscale scores are tied as the highest scores. In a study of 74 students at a university counseling center, a client's change stage at the start of treatment was found to relate to prognosis in therapy. Clients who entered therapy at the precontemplation stage dropped out of therapy in greater numbers than would have been expected by chance. Those who entered therapy in the preparation and action stages completed therapy in greater numbers than would have been expected by chance. Thus, knowing a client's stage of change before the start of therapy may allow the therapist to know which clients are at risk for dropout.

Smith et al. (1995) measured how frequently clients who successfully completed therapy used twelve types of change processes outlined by Prochaska, DiClemente, and Norcross (1992). Some of the processes were cognitive in nature, such as re-evaluating alternatives and raising an awareness of a problem. Some processes were behavioral, such as changing an aspect of the environment and setting up contingency management plans. Others were social in nature, such as seeking out relationships with others and

developing a social support network. Clients who completed therapy used all these types of processes of change more often than premature terminators (Prochaska et al., 1992). In fact, clients in the later stages of change, such as action and maintenance, were found to use all types of process more frequently that those in the precontemplation stage. Behavioral processes of change were used most often (Prochaska et al., 1992).

Culture. Ethnic and racial minority groups in the United States have been reported to underutilize mental health services when compared to the majority group (Flaskerud, 1986). Dropout has also been conceptualized as an outcome due to service provider ignorance of cultural expectations and cultural rules for appropriate delivery of services (Dana, 1993). Culture is a complex variable because it contains aspects of acculturation, problem definition, locus of control, and demographic variables.

Studies that investigate the relationship of minority status to dropout show equivocal results. Some studies have found that dropout is associated with client minority status (Armbruster & Fallon, 1994; Kazdin & Mazurik, 1994; Kendall & Sugarman, 1997; Wierzbicki & Pekarik, 1983). Other researchers have found that minority status is not associated with dropout (Gould et al., 1985).

Sue (1977) analyzed demographic variables and utilization patterns from 17 community mental health centers and found a 50% dropout rate for Black, Asian, and Native American clients. The dropout rate for Hispanic clients was 42%. Both these dropout rates differed significantly from the 30% dropout rate of Caucasian clients. Dropout was defined as failure to return after one contact with the agency. Multiple step-wise correlations showed that Black, Asian, and Native American clients were still

more likely to dropout than Caucasian clients despite controlling for other demographic variables such as income, marital status, and education

In a meta-analysis of 125 studies, increased risk of dropping out was found to relate to client minority status, lower level of education, and lower socioeconomic status (Wierzbicki & Pekarik, 1993).

However, Flaskerud (1986) did not find a relationship between dropout and ethnicity. Flaskerud (1986) compared dropout rates among ethnic minorities at four community mental health agencies. Dropout was defined as the client having less than four visits or terminating therapy without the therapist's consent. No significant difference was found in dropout status based on ethnicity of clients. Each client was administered a culture-compatibility interview and given a score from one to nine, one point for each of nine components of cultural-compatibility. There were no significant correlations between total culture-compatibility score and dropout status or any of the culture compatibility components and dropout status.

Culture is a more complex variable than simple minority status. Culture is also influenced by acculturation, which refers to the extent to which the original culture has been retained, as well as the extent to which the dominant society and worldview has been accepted (Dana, 1993). Acculturation may affect the nature of symptoms, client understanding of symptoms origins, presenting complaints, and reaction to intervention by the family. Acculturation is hard to measure, because the degree of acculturation differs within generations as well as individual members of a family.

Several theories provide a comprehensive framework for describing the interaction between acculturation and the perception of mental health services. Reasons

for a poor fit between service providers and multicultural populations has been explained in terms of a differences in world-view (Kearney, 1975). The world-view of a culture functions to make sense of life experiences. Components of world-view include group identity, self-concept, values, beliefs, and language. Values, beliefs, and language provide a basis for perception of the need for particular services, relevant kinds of service, desired qualities in service providers, and a culturally acceptable style of service delivery. Beliefs influence the causes and nature of health and illness, the power of spirituality, and the extent of perceived control and responsibility over one's own life. Some cultures view illnesses as being caused by magic, dreams, spirit events, forces in nature, and malevolent others. As mentioned previously in this literature review, Tracey (1988) found that dropout was related to client-therapist agreement about clients' perceptions about their responsibility for the cause and solution for their problems. Also, Epperson et al. (1983) found that clients were more likely to dropout after one session when problem recognition by therapists was absent. Similarly, Gunzburger et al. (1985) found that dropouts were less likely than continuers to say that the first therapy session fulfilled their expectations.

According to alternative resource theory, many minority groups use alternative resources for help with emotional problems (Flaskerud, 1986; Padilla, Ruiz, & Alvarez, 1975). Hispanic-Americans with psychological problems first turn to family or culturally familiar organizations such as the church to solve mental health problems (Padilla et al., 1975). After exhausting these resources, they turn to the mental health system as a last resort. Alternative resources include family physicians, but also traditional healers such as herbalists, acupuncturists, root doctors, and spiritualists.

According to Hines and Boyd-Franklin (1996) African-American families may follow a similar pattern in that they tend to use churches as a primary source of support before seeking professional help. Many African-American churches provide a complete support system including marriage enrichment classes, health promotion classes, support groups for alcohol and drug abuse, as well as after-school programs for youth (Hines & Boyd-Franklin, 1996).

According to barrier theory, incongruities between the assumptions and characteristics of traditional Hispanic culture and those of the mental health system act as a barrier to seeking help (Rogler, 1983). For example, mental illnesses such as depression or schizophrenia tend to be described as "nerves." Hispanics tend to view prayer as a more effective treatment than therapy, and believe that other family members can best cure a person. Hispanic culture is also influenced by the ideas of spiritualism, in which problems are viewed as a result of an invisible world of good and bad spirits that intrude into human affairs. In some Hispanic communities, spiritualists, those trained in dealing with spirits, are reported to be more numerous that mental health professionals. According to the barrier theory, when differences decrease between Hispanic culture and the existing mental health system, utilization rates will increase among Hispanics (Rogler, 1983).

In conclusion, findings regarding culture and dropout are conflicting. Culture is a complex variable that is influenced by level of acculturation. World-view theory (Kearney, 1975), alternative resources theory (Flaskerud, 1986; Padilla et al., 1975), and barriers theory (Rogler, 1983) provide conceptual frameworks for studying the

influence of culture on dropout. Since this dissertation studied mostly minority clients, a three-item cultural scale was used to examine the effects of culture on dropout.

Summary. Studies of client characteristics related to therapy dropout have yielded few unequivocal results. Clients from lower SES groups appear more prone to dropout as do child clients whose caregivers have greater psychopathology. Training both child and adult clients about what to expect in therapy has been shown to reduce dropout.

Therapist Variables

This group of studies represents a shift in focus from client variables to therapist variables associated with dropout. Fiester (1977) stated that the influence of therapists should be studied in the dropout literature, because therapists are not uniform in their impact on the therapy process. Fiester (1977) found that therapists with higher dropout rates differ from therapists with lower dropout rates. Therapists were classified as having a high dropout rate if their clients dropped out at a rate higher than the clinic average. Dropout was defined as a client's failure to return for more than two sessions. Clients were given a measure of satisfaction with the therapeutic process, the Therapy Session Report (TSR; Orlinsky & Howard, 1966), immediately after the initial session. Higher and lower dropout rate therapists varied, not on demographic characteristics, but on the scores their clients gave them on process variables as measured by the TSR. Therapists with high client dropout rates had clients who more often endorsed items indicating that the therapist was anxious, ineffectual, and directed the interview. Fiester (1977) concluded that process dimensions have greater explanatory power than

demographic characteristics; however, many studies have included findings on how therapist demographic characteristics relate to dropout.

Gender. Several researchers have investigated whether the gender of the therapist is related to dropout (Betz & Shullman, 1979; Epperson, 1981; Krauskopf et al., 1981; Reiher, Romans, Anderson, & Culha, 1992; Rodolfa et al., 1983; Weisz et al., 1987). Weisz et al. (1987) found that client dropout was unrelated to therapist gender or age. Several researchers have examined if the gender of the client, therapist, or intake worker affects dropout. In a study of 300 students seeking services at a university counseling center, Betz and Shullman (1979) found that clients of both sexes tended to return for therapy after an intake interview with a female therapist rather than with a male therapist. Dropout was defined as any failure to return for a scheduled session after intake. Return rates after intake interviews with female therapists were 83% for male clients and 85% for female clients. Return rates after intake interviews with male therapists were 68% for male clients and 85% for female clients. Return rates did not differ as a result of therapist experience or type of referral. However, others have not easily replicated the effects for gender.

One attempt to replicate this study found the opposite results. Epperson (1981) found that male therapists had a higher client return rate than female therapists. Dropout was defined as any failure to return for a scheduled session after intake. In a study of 309 students seeking therapy at a university counseling center, he found a significant main effect for the gender of the therapist on the return rates of clients. Clients seeing male therapists returned at a rate of 79%, while 66% of clients seeing female therapists returned. This significant main effect for therapist gender held up on

return rate for the second and third therapy sessions. Therapist experience or client referral problem did not have an affect on return rate.

Krauskopf et al. (1981) did not find a significant difference in the percentages of clients returning after intake to male and female therapists. Dropout was defined as any failure to return for a scheduled session after intake. Of the 539 students seeking therapy services at a university counseling center, clients referred to female therapists returned 80.4% of the time and clients referred to male therapists returned 80.3 % of the time. Clients returned significantly more often when there was agreement with their therapists on the problem definition (83.6%) than when there was disagreement on problem definition (72.9%). Clients did not differ in their rate of return based on therapist experience or referring problem.

Thus, results are mixed regarding the influence of therapist gender on a client's likelihood to return after one therapy session. Tryon (2002) has questioned the utility of studying the affect of client and therapist gender on dropping out of therapy. Rodolfa et al. (1983) suggested that findings relating to dropout and gender of the therapist or client may actually represent broader phenomena such as clients' underlying attitudes towards males and females or different socialization processes of men and women.

Experience. Several researchers have found that a therapist's experience level is not related to dropout (Betz and Shullman, 1979; Epperson, 1981; Krauskopf, et al., 1981). However, Rodolfa et al. (1983) found a significant difference in return rate based on therapist experience level. They studied 692 students who sought therapy at a university counseling center. Dropout was defined as any failure to return for a scheduled session after intake. No significant differences in return rate were found in

regard to intake therapists' gender (male – 91.9%; female – 95.3%) or intake therapists' experience (intern – 90.5 %; senior staff – 93.4 %). Clients assigned to female therapists returned at a similar rate as did clients assigned to male therapists (female – 93.8%;

male – 92.3%). However a significant difference was found in regard to the assigned therapists' experience level. Practicum students had a significantly higher number of dropouts (14.6%) than did interns (1.9%) or senior staff (6.6%). Also, the number of days from intake to assignment was significantly longer for the dropout group (7.96 days) than for the returning client group (3.54 days). The length of the intake interview was also significantly shorter for the returning clients (69.73 minutes) as compared to those who dropped out of therapy (95.22 minutes). Results also showed that gender had little affect on return rates.

Therapist social influence characteristics. Researchers have examined whether dropping out of therapy can be explained using social influence theory (Strong, 1968). According to this theory, the therapy interview can be conceptualized as an interpersonal influence process. Clients must perceive therapists as possessing the resources to help, or influence, them. These resources have been operationalized as three therapist source characteristics: the client's perception of the therapist's expertness, trustworthiness, and attractiveness. Dropping out has been found to relate to overall client satisfaction (Kokotovic & Tracey, 1987), but not to the specific source characteristics.

Kokotovic and Tracey (1987) studied 144 students who came for therapy at a university counseling center. Dropout was defined as a failure to return for any

scheduled therapy session following intake. Ratings on the Client Satisfaction Questionnaire – Short form (CSQ-S; Larsen, Attkisson, Hargreaves, & Nguyen, 1979), which is a three-item questionnaire designed to measure the overall satisfaction with therapy, were the best predictors of returning for therapy after intake. Social influence variables (i.e., therapist source characteristics) were assessed using the Counselor Rating Form – Short version (CRF-S; Corrigan & Schmidt, 1983). The social influence variables of therapist expertness and trustworthiness were related to return after intake, but the significance of these variables was due to variance shared with client satisfaction and not due to a unique effect of these variables on dropout. The researchers noted that the three source characteristics as measured by the CRF-S, may actually comprise one unitary factor that is highly related to client satisfaction.

In a similar study, Tryon (1989) administered the CRF-S to 308 college students after their initial visit to a university counseling center. CRF-S scores did not differentiate between clients who dropped out after the initial session and clients who continued therapy. Clients who dropped out later in therapy, however, did differ from those who continued in their CRF-S ratings of therapists. These results suggest that therapist social influence characteristics may become more important as therapy progresses.

In contrast, Martin et al. (1988) found that scores on the CRF-S were unable to significantly discriminate dropouts from continuers. In this study of clients at a university counseling center, dropping out was defined as a unilateral decision on the part of clients to leave therapy before completing four sessions. Dropouts and continuers did not differ in the ratings of their therapists' expertise, attractiveness, or

trustworthiness (Martin et al., 1988). Thus, the results of studies of the effects of therapist social influence variables on client dropout are equivocal.

Summary. There have been fewer studies of therapist characteristics related to dropout than there are studies of client characteristics. Results of studies of therapist variables have yielded no consistent relationships between therapist gender, experience, or social influence characteristics and client dropout from therapy.

Client-Therapist Working Relationship

Problem definition. Rather than studying the relationship of client or therapist characteristics to dropout, other researchers have examined the relationship between dropout and client-therapist working process. These researchers believe that the characteristics of members of the therapeutic dyad are less important in determining dropout than how they work together. Specifically, these researchers have examined the relationship of dropout to client-therapist agreement on client problems and locus of blame as well as the client-therapist working alliance.

Epperson et al. (1983) found that clients were more likely to dropout after one session when problem recognition by therapists was absent. In this study of 758 clients at a university counseling center, dropout was defined as failure to return after an initial session. Prior to the initial session, clients wrote statements about their problems that a researcher matched to one of 21 problem definitions. Immediately following the initial interview, therapists were asked to identify their client's problem from the list of 21 problem definitions. Problem definition agreement was determined by the extent to which the therapist was able to accurately identify the client's problem from the list. Clients whose definition of the problem was recognized by their therapists were less

likely to dropout after one session than clients whose problem definitions were not recognized by therapists.

Martin et al. (1988) studied 148 students at a university counseling center. In this study, dropout was called Early Premature Termination (EPT). EPT referred to clients' failure to return within 25 days after their first or second session. Clients who attended more than three sessions or clients who terminated by mutual agreement with their therapists regardless of the number of sessions attended were not included in the EPT category. Results of a MANOVA showed that clients' ratings of whether their therapists understood their presenting problems did not differentiate groups of EPT's from non-EPT's.

Locus of blame. Tracey (1988) found that dropout was related to client-therapist agreement about clients' perceptions about their responsibility for the cause and solution for their problems. Locus of blame refers to whether clients blame themselves (internal locus of blame) or blame others (external locus of blame) for the cause of their problems. Locus of control refers to whether clients take responsibility for solving their problems (internal locus of control) or feel others are responsible for solving their problems (external locus of control). In a study of 33 clients at a university counseling center, Tracey (1988) found that clients who dropped out of therapy had a mismatch of client-therapist agreement on the locus of blame for the cause of the client's problem. Clients were classified as dropouts if they failed to attend more than four sessions, failed to attend the last scheduled session, and scored below the mean on the Counseling Outcome Measure (COM; Gelso & Johnson, 1983). Clients with therapists who agreed on the extent to which the client was responsible for their problem reported

higher satisfaction after the first session and did not dropout of therapy. The researcher concluded that a match between client and therapist locus of blame about the cause of the client's problem could be essential in the first few sessions to prevent dropout. The researcher suggested that therapists make sure their attributions about problem blame match those of their clients during the first few sessions in order to increase client satisfaction with the therapy process.

Client-therapist congruence on locus of blame was not, however, related to therapeutic outcome as measured by the COM. The COM measures the extent of client change in behavior, self-esteem, self-understanding, and overall change as a result of attending therapy. Clients and therapists did not often achieve congruence on the locus of control for the solution to the client's problem. Therapists usually assumed more responsibility for change than did clients. A mismatch on this dimension had no relation to either dropout or therapeutic outcome.

Therapeutic alliance. Mohl et al. (1991) found that the formation of a helping alliance between client and therapist during the initial interview significantly related to client continuation in therapy. In this study at a university counseling center, 81 clients rated their impression of therapy and their therapist using the Helping Alliance Inventory (HAI; Alexander & Luborsky, 1986). Clients filled out the scale immediately following the screening interview. Early dropouts were defined as clients who dropped out in five or fewer sessions. Early dropouts indicated a less positive helping alliance as measured by the HAI than did those who continued beyond five sessions. Early dropouts rated their screening interview as less helpful, providing less new understanding, and less satisfying than those who ultimately continued therapy. Early

dropouts also reported that they felt less well liked by their therapist, regarded the therapist as less respectful, and viewed the therapist as more passive than clients who continued after five sessions of therapy.

The working alliance (Gelso & Carter, 1985) refers to the belief that both parties of the therapeutic relationship have established a bond with each other and can work together towards a mutual goal. The establishment of a working alliance is assumed to be critical in the early stages of therapy, and researchers have looked at whether a poorer working alliance could explain dropout. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989) is a self-report instrument with three subscales that measure client and therapist perceptions of agreement on the goals of treatment and the tasks necessary to achieve these goals as well as the development of a personal bond between client and therapist.

Kokotovic and Tracey (1990) studied how the establishment of the working alliance related to the dropout rate of 144 clients at a university counseling center. Dropout was defined as attendance at four or fewer sessions. A set of nine client-related variables, among them scores of the three subscales of the client WAI, failed to discriminate continuers from dropouts following the first therapy session (Kokotovic and Tracey, 1990). Also eight therapist-related variables, among them the therapist WAI subscale scores, failed to differentiate between continuers and dropouts following the first therapy session. Client satisfaction, as measured by the Client Satisfaction Scale (CSS; Tracey, 1986), also failed to show discrimination between dropouts and continuers. These results are in contrast to Kokotovic and Tracey's earlier study (1987) in which client satisfaction, as measured by the CSQ-S, was able to discriminate

dropouts from continuers. Researchers noted that working alliance may not be established during the first session, and therefore it may not be a good predictor of client dropout after the first session.

In a series of articles, Tryon and Kane (1990, 1993, 1995) studied the affect of client-therapist working alliance, assessed later in therapy, on client premature termination. They administered the HAI to 102 clients and their therapists after an average of 8 therapy sessions at a university counseling center (Tryon & Kane, 1990). Clients who later terminated prematurely rated the working alliance with their therapists significantly lower than did clients who terminated with mutual agreement of their therapists. Therapists' ratings were unrelated to type of client termination. In a later study, Tryon and Kane (1993) administered the WAI to 91 clients and their therapists after the third therapy session. In this study, therapists' ratings of the working alliance significantly predicted premature termination, and clients' ratings were not related to termination type. Finally, Tryon and Kane (1995) administered the WAI to 109 college student clients and their therapists after the third session, and found that both clients and therapists gave lower working alliance ratings in dyads where clients would later terminate prematurely. Thus, it appears that weaker working alliances, assessed somewhat later in therapy, may be indicators of potential client dropout.

Administrative Variables

Researchers have also focused on variables outside of the therapy relationship in their search for clues to client dropout. Some have speculated that clients might be more likely to dropout if they were other than self-referred. Others believed that clients

who spend longer times on waiting lists might begin therapy in a dissatisfied state and, thus, be more likely to dropout.

Referral source. Trepka (1986) found that adult clients who dropped out were more likely to have been referred by physicians with whom the treating psychologist had little contact. Trepka (1986) hypothesized that these referring agents may have failed to properly prepare clients for a referral or may not have selected appropriate clients for referral. Adult clients who dropped out during the intake and evaluation phases of therapy tended to be referred by others rather than be self-referrals (Richmond, 1992). Armbruster and Fallon (1994), however, found that a referral for mandated therapy had no relation to adult client dropout behavior.

Families referred by schools are more likely to dropout (Gould et al. 1985). Gould et al. (1985) found that an interaction between referral source and caretaker characteristics related to child dropout from therapy. They found that 52% of caretakers who failed to return with their children for therapy after the intake session were referred by schools. The researchers also found that among school referrals, the dropouts' parents exhibited significantly more symptomology than the attenders' parents on the BSI. There were no significant differences, however, between the dropouts and attenders who had been referred by sources other than schools. Therefore, the effect of a school referral on dropping out was greater for disturbed parents than for non-disturbed parents.

Waiting lists. Several researchers have examined whether being placed on a waiting list significantly increases the risk of premature termination. College counseling centers frequently have waiting lists because the level of demand for therapy

services frequently outweighs the supply of therapists. Thus, most studies in this section were conducted with college student clients. Results may not generalize to the child clients.

Folkins et al. (1980) examined the effects of being wait listed on client dropout. Dropout was defined as a failure to return after the intake session. Differences were found in dropout according to wait list condition; however, these differences disappeared when clients were allowed to walk into the clinic and get an immediate session. In this study, 150 clients were placed in one of three different wait list conditions regarding the amount of time elapsed between calling the clinic for an appointment and the day of the scheduled appointment. Group one had to wait 3 days or less, group two waited 6 to 8 days, and group three waited 16 to 19 days before being called for an appointment. A chi-square analysis revealed a highly significant relationship between amount of wait time and appointment keeping behavior. No shows for group one were 24% (n = 12), no shows for group two were 38% (n = 20), and no shows for the longest wait time group were 54% (n = 27). However, when results were calculated to include those who walked into the clinic for an emergency session despite being placed on a wait-list differences between groups disappeared. Amount of wait time was not found to relate to eventual number of sessions.

Similarly, Anderson et al. (1987) found that the length of time spent on a waiting list had no impact on continuation in therapy, regardless of whether clients were seeking help for vocational or personal problems. In this study, 1,688 students seeking therapy at a university center were classified as having primarily vocational or primarily personal/social reasons for seeking therapy. Dropout was defined as a failure to return

after the intake session. No differences between groups were found in relation to dropout (13.4% for vocational and 13 % for personal/social). No differences were found for time on waiting lists relative to dropout status and presenting problem (vocational dropouts , M = 2.7 weeks, SD 2.1 and vocational continuers M = 2.6 weeks, SD 2.1; Personal/social dropouts M = 2, SD 1.7, Personal/social continuers M = 2.2 weeks, SD 1.9.)

Phone surveys of college-age clients who did not return for therapy services after initial sessions found that they did not return because they experienced a reduction in the initial stress that caused them to seek help (May, 1990; Pulakos & Morris, 1995). May (1990) conducted a telephone survey of 27 students who had been placed on a waiting list after an intake session at a university counseling center and failed to come in for services once they were offered. The wait list was from 2 to 10 weeks long. Results showed that only 7% of clients cited dissatisfaction with not receiving therapy earlier as a reason for not coming for services. The most common reason cited was that clients no longer felt the need for therapy because their problem had been resolved (33%). The remaining clients indicated that they were undecided about pursuing therapy (30%), did not receive a follow-up letter (15%), were no longer enrolled as students (7%), or had decided to seek therapy elsewhere (7%). Therefore, the majority of clients did not cite dissatisfaction with the being placed on a waiting list as the reason for dropping out. May (1990) points out, however, that this survey was not anonymous, and students may have concealed their negative reactions.

Pulakos and Morris (1995) used a written questionnaire to follow-up with students who failed to return to a university counseling center after being placed on a

post-intake waiting list. Students reported a significantly stronger need for therapy when they first contacted the center than when they completed the questionnaire, suggesting that the need for services was reduced without treatment. Students gave a variety of reasons for not returning for therapy, but did not indicate a lack of satisfaction with the clinic as one of the reasons. They rated their interactions with the clinic to be average and their likelihood of recontacting the clinic in the future to be average. Clients with presenting problems of anger and hostility were more likely to call to check on their waiting list status than clients with a presenting problem of vocational concerns. These researchers also point out that the lack of anonymity in their survey may have confounded the results.

Similarly, Archer (1984) gave a written questionnaire to 59 students at a large university counseling center who failed to come back to therapy after being placed on a wait list after attending an initial intake session. Clients who were initially rated by their therapists as having the most urgent problems reported the greatest amount of dissatisfaction with having to wait. Reaction to being placed on a waiting list varied according to the clients' reported reasons for seeking services. Those with vocational concerns were more likely to report feeling better after only an intake session (May 1990) and were less likely to follow up on services after being placed on a waiting list (Pulakos & Morris, 1995).

Summary. Overall results show that waiting lists do not necessarily have a negative impact on attrition after the initial session, especially when clients are allowed to walk-in for emergency sessions. Results relating referral source, self or others, to

adult dropout are mixed, but there is evidence that referrals by schools can lead to child treatment dropout especially when parents have considerable psychopathology.

Barriers to Treatment Model

Most of the studies examining dropout have not been theory driven and have looked primarily at client and therapist descriptive characteristics or other variables of convenience to researchers (i.e., time on waiting list). This rather piece-meal approach to client attrition has yielded equivocal results. Variables such as working alliance, therapist social influence, and client readiness for change have theoretical bases, but they were developed to explain therapy outcome, not client unilateral termination. What is needed is a theoretical model to explain dropout that integrates client and therapist characteristics with various therapy processes.

The Barriers to Treatment Model was developed specifically to explain dropout of children and families (Kazdin et al., 1997). The Barriers to Treatment Model proposes that families experience multiple barriers associated with participating in treatment and that these barriers increase the risk of dropping out. These barriers include practical obstacles, perceptions that treatment is demanding and of little relevance to the client's problems, and a poor relationship or alliance with the therapist. To measure these barriers Kazdin and colleagues developed the Barriers to Treatment Participation Scale (BTPS). The BTPS assesses barriers in five domains: relevance of treatment, treatment demands and issues, relationship with the therapist, life stressors, and critical events. Parents and therapists are given separate, parallel versions of the scale.

Elevated scores on the BTPS have been demonstrated to explain dropout behavior independent of many of the family, parent, and child risk factors covered in previous sections of this literature review (Kazdin et al., 1997). In this study, 242 families sought treatment at a community mental health clinic. The children of these families were referred for oppositional, aggressive, and antisocial behavior. Parents were administered the BTPS scale after they dropped out or after therapy was completed. Researchers also assessed 12 other characteristics of the parents, children, and families referred for treatment that had been associated in other studies with dropout risk for children displaying oppositional and antisocial behavior: Hollingshead-Redlich socioeconomic class, income level, being on public assistance, minority group, mother's age, single-parent family, adverse child rearing, parent stress total, life events, parent's antisocial history, children's conduct disorder symptoms, and children's history of antisocial behavior. Kazdin et al. (1997) conducted a hierarchical regression analysis where they predicted dropout from the 12 risk factors and the 12 risk factors plus the parents' total barriers scores. They found that total barriers scores significantly increased the ability to predict dropout. The analysis was repeated with the therapists' total barriers scores. They also added significantly to dropout prediction when other risk factors were controlled. These results showed that barriers experienced over the course of treatment added in an incremental way that which was not explained by other family, parent, and child factors to predicting who drops out of treatment.

BTPS scores were compared among families with high or low risk factors for dropping out. Families were placed in a high-risk group if they had the presence of more than 6 of the 12 risk factors. Families were placed in the low-risk group if they

had 6 or fewer risk factors. High-risk families that did not perceive therapy participation as difficult were much less likely to dropout early from therapy. In the high-risk group, a lower proportion of cases dropped out of treatment if parent and therapist total BTPS scores were below the median for the total sample population. Therefore, the perception of few barriers to treatment may serve as a protective factor against dropping out of treatment among high-risk families (Kazdin et al., 1997).

Effect sizes for the BTPS subscales distinguishing dropouts from completers were examined. The BTPS subscale of Relevance of Treatment had the largest effect size in distinguishing dropouts from completers. The BTPS subscale Treatment Demands and Issues, which measures the extent to which clients viewed treatment as demanding, failed to differentiate completers from dropouts.

This study provided preliminary support for the validity of the BTPS scale and the Barriers to Treatment Model of client dropout. This study also used the therapist judgment of dropout definition. This definition has been found to be the best definition of dropout because it allows for flexibility on the part of the therapist in determining dropout (Wierzbicki & Pekarik, 1993).

The Kazdin et al. (1997) study was conducted after dropout occurred. When families have dropped out, they can no longer receive the help they once sought. Rather than knowing what factors are associated with dropout after the fact, it would be beneficial to be able to identify families at risk for dropout before it occurs. Such identification might lead to interventions to prevent client unilateral termination. To date, a study has not been conducted to investigate the ability of scores on the BTPS to predict dropout.

Problem Statement

Dropout is viewed as a negative event because it is assumed that the clients are still in need of help when they terminate services prematurely. Therapists are familiar with the idea that some clients will dropout of therapy prematurely; however, therapists are not certain how to predict who among their client population will fall into this category. Should therapists be able to quickly identify those clients at high risk of dropping out, presumably therapists could take steps to prevent dropout before it occurs. Despite numerous studies on the subject of dropout, a clear profile of the high-risk dropout client has never been developed. Demographic variables, therapist variables, aspects of the referral process, and the formation of the therapeutic alliance have been studied, yet few consistent findings have emerged.

This lack of findings may point to the idea that dropout is the function of a more complex process. The problem of dropout needs to be studied from a conceptual model in order to address all the facets of the dropout process. Barriers to Treatment is a conceptual model that proposes that families experience multiple barriers associated with participating in treatment and that these experiences increase the risk of dropping out (Kazdin et al., 1997). Thus far, the BTPS, which assesses Barriers to Treatment, has been used to explain dropout only after it has occurred.

Purpose of the Study

The purpose of this study was to investigate if the BTPS can be used to predict differences between dropouts and continuers in therapy. Specifically, this study predicted family dropout from psychotherapy using a set of seven predictors that are considered dropout risk factors in the literature just reviewed (SES, income level,

receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology) and mothers' and therapists' scores on the Barriers to Treatment Participation Scale (BTPS; Kazdin et al., 1991). This was the first study in which the BTPS was administered at the beginning of treatment rather than after dropout had occurred.

Hypotheses

The Barriers to Treatment conceptual model posits that families experience multiple barriers associated with participating in treatment and that these experiences increase the risk of dropping out. Kazdin et al. (1997) conducted a hierarchical regression analysis where they predicted dropout from risk factors they identified in the literature and from the risk factors plus the total barriers scores on the BTPS. They found that total barriers scores for parents and therapists significantly increased the ability to predict dropout. In view of this, the following hypotheses were advanced:

H01: Parent BTPS total barriers score will significantly predict dropout over and above what is predicted by risk factors identified in the literature review.

If Hypothesis 1 is confirmed, each barrier subscale score will be tested to see how well it alone predicts dropout over and above the other risk factors.

Also, because the majority of clients in this study were from minority groups, a newly added three-item Culture subscale, derived from the cultural studies literature, was added to the Parent BTPS total barriers score to test if the Parent BTPS total barriers score including this new subscale would significantly predict dropout over and above what was predicted by risk factors identified from the literature review (SES,

income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology).

H02: Therapist BTPS total barriers score will significantly predict dropout over and above what is predicted by risk factors identified in the literature review.

If Hypothesis 2 is confirmed, each barrier subscale score will be tested to see how well it alone predicts dropout over and above the other risk factors.

Also, because the majority of clients in this study were from minority groups, a newly added three-item Culture subscale, derived from the cultural studies literature, was added to the Therapist BTPS total barriers score to test if the Therapist BTPS total barriers score including this new subscale would significantly predict dropout over and above what was predicted by risk factors identified from the literature review (SES, income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology).

CHAPTER 3

Method

Participants

Client participants were 33 mothers at two sites of a community-based counseling agency located in Brooklyn, New York. All services were free of charge at this agency. In order for clients to be eligible to receive services at the agency, families needed only to have at least one child under the age of 18 living in the home and live within a specific distance of the agency. For the purposes of this study, the term client referred to the mother of a family who signed up for services. Participant selection was equitable. All clients who signed up for services were solicited to participate. Data were gathered between August 2003 and May 2004. During that time, site #1 opened 49 cases. Nine clients were not given surveys due to concerns about literacy/language comprehension, and 5 clients dropped out before the survey could be administered; of the remaining 35 clients, 1 client chose not to participate in the study, and therapists forgot to give the survey to an additional 9 clients. Thus, 25 of the 35 eligible mothers (71%) participated in the study.

At site #2, 42 cases were opened between November 2003 and May 2004. Seven clients were not given surveys due to concerns about literacy/language comprehension and eight clients dropped out before the survey could be administered. This left a total of 27 clients who were eligible for the study. Of these 27, 1 client chose not to participate in the study, and therapists forgot to give the survey to 18 clients. Thus, at

this site only 8 of the 27 eligible mothers (30%) participated in the study. Overall, of the 62 clients at both sites who were eligible to participate, 53% (33) participated.

Table 1 presents client participants' descriptive statistics. All 33 participants were women who mostly sought help for family-related issues. The majority (70%) were single parents from ethnic minorities (73%) with an average age of 39 years. Most of the mothers (64%) had a high school education or less, and 64% earned $1,500 a month or less, with 21% receiving public assistance. Over half (55%) were in the two lowest socioeconomic status levels representing machine operators, semiskilled workers, unskilled laborers, and menial service workers. The agency does not gather data on the presence of clinical diagnoses in children, so the exact nature or severity of psychological symptoms in the child population of this study is unknown.

Mothers' levels of psychological stress, as measured by the Global Severity Index (GSI) of the Brief Symptom Inventory-18 (BSI 18; Derogatis, 2000), averaged in the non-clinical range (54.74). GSI T-scores higher than 63 indicate clinical levels of symptomology. Twenty-four percent (n = 8) of participants scored in the clinical range.

Dropouts comprised 42% of the sample (14 dropouts, 19 continuers). Dropout was defined as discontinuing therapy against the therapist's judgment. Dropouts averaged 4 total therapy sessions and continuers averaged 20 sessions total. Continuers averaged 3.2 therapy sessions a month and dropouts averaged 1.3 sessions a month. Because this agency is funded in part by New York City's Administration for Children's Services, therapists are mandated to make contact with clients at least once a month while a case is open. Because this contact can be an unannounced home visit, the total number of visits in dropout cases could reflect therapists' attempts to reach out

to the family. Therefore the more informative statistic concerning session attendance for clients at this agency is the total number of times the client was seen each month while the case was open.

Table 1

Client Sample Descriptive Statistics

Descriptor	*N*	*Descriptor*	*N*	*Descriptor*	*N*
Gender		**Ethnicity**		**Marital Status**	
Female	33	Hispanic	13	Married	6
Male	0	Caucasian	9	Divorced	5
		African-American	8	Single, Never Married	12
Clinic Site		West Indian	1	Separated	7
Site I	25	Asian	0	Living With Partner	2
Site II	8	Other	2	Widow	1
Living With Partner		**Income Level**		**SES**	
Yes	10	≤ 500 month	9	Level I	3
No	23	≤ 1000 month	7	Level II	5
		≤ 1500 month	5	Level III	7
Single Parent		≤ 2000 month	4	Level IV	8
Yes	23	≤ 2500 month	6	Level V	10
No	10	> 2500 month	2		

Table 1 continued

Client Sample Descriptive Statistics

Descriptor	*N*	*Descriptor*	*N*	*Descriptor*	*N*
Problem		**Public Assistance**		**Level of Education**	
Child Behavior	25	Yes	7	Less than 7th Grade	1
Divorce	2	No	26	Junior High	0
Grief	1			Some High School	8
Marital Difficulty	0	**Dropout Status**		High School Graduate	12
Depression	3	Dropout	14	Some College/Training	5
Other	2	Continuer	19	College Graduate	4
				Graduate Degree	3

Descriptor	*M*	*SD*	*Range*	*N*
BSI 18 – Global Score	54.76	11.09	33-81	33
Age	39	10	18-62	33
SES	30.06	14.04	8-64	33

Note. BTPS = Barriers to Treatment Participation Scale, BSI = Brief Symptom Inventory, SES = Hollingshead Four Factor Index of Social Status

Each site employed 6 therapists, and all 12 chose to participate in the study. Therapists differed in the amount of cases they opened and the number of times they remembered to administer the survey, therefore the number of surveys linked to each therapist varied. A total of 10 therapists contributed surveys to the study, 6 from site #1 and 4 from site #2. Table 2 presents descriptive statistics for therapists. Seven therapists

were trained social workers who had a Masters of Social Work degree or a Masters degree in a related field, while three therapists had a Bachelor of Social Work or an undergraduate degree in a related field. Therapists also rated their theoretical orientation using three, five-point Likert scales (5 = high, 1 = low). Humanistic orientation was rated highest (4.0) followed by Psychodynamic (3.5) and Cognitive/Behavioral (2.4). Therapists had been with the agency from 6 months to 3 years. All therapists were female and ranged in age from 23 to 45 years old with an average age of 29 years.

Table 2

Therapist Sample Descriptive Statistics

Descriptor	*N*	*Descriptor*	*N*	*Descriptor*	*N*
Gender		**Years of Experience**		**Ethnicity**	
Female	10	Less Than One Year	2	Hispanic	1
Male	0	One Year	2	Caucasian	7
		Two Years	3	African-American	0
Site		Three Years	3	West Indian	1
Site 1	6			Asian	1
Site 2	4	**Years at the Agency**		Other	0
		Less than One Year	4		
Degree Level		One Year	3		
Bachelor's Degree	3	Two Years	1		
Master's Degree	7	Three Years	2		

Descriptor	*M*	*SD*	*Range*	*N*
Age	29	7	23-45	10
Years of Experience	1 yr. 10 mo.	1 yr.	6 mo. –3 yrs.	10
Years at the Agency	1 yr. 4 mo.	1 yr.	6 mo.-3 yrs.	10
Humanistic Orientation	4.0	.67	3-5	10
Psychodynamic Orientation	3.5	.71	3-5	10
Cognitive Behavioral Orientation	2.4	.52	2-3	10

Instruments

Therapist Questionnaire. Each therapist was given a questionnaire (see Appendix B) that asked for her specialty area of training, degree, years at the agency, and years of practice experience. Therapists also rated their theoretical orientation using three, five-point Likert items (5 = high, 1 = low). One item assessed the extent of therapist humanistic orientation, the second item assessed the extent of therapist psychodynamic orientation, and the third item assessed the extent of therapist cognitive-behavioral orientation. These items have been used in the therapy literature to rate theoretical orientation (Hill et al., 1988; Kirschner, Hoffman, & Hill, 1994).

Participant Questionnaire. This questionnaire (see Appendix C) was completed by clients (mothers of the families seeking treatment). Data regarding six risk factors for client dropout were taken from this form. It asked for marital status, highest level of school completed by the mother and father, and mother's and father's occupations. These questions formed the Hollingshead Four Factor Index of Social Status (Hollingshead, 1975) that was used to measure client SES. SES has been shown to be a client dropout risk factor in several studies (Armbruster & Fallon, 1994; Baekeland & Lundwall, 1975; Garfield, 1978; Trepka, 1986; Wierzbicki & Pekarik, 1993). The questionnaire also assessed the dropout risk factors of income level (Kazdin et al., 1991), receiving public assistance (Kazdin et al., 1991), minority group status (Armbruster & Fallon, 1994; Gould et al., 1985; Kazdin & Mazurick, 1994; Kendall & Sugarman, 1997; Wierzbicki & Pekarik, 1993), mother's age (Kazdin et al., 1991; Kazdin & Mazurick, 1994; Kendall & Sugarman, 1997), and single parent family status

(Armbruster & Fallon, 1994; Kazdin et al., 1991; Kazdin & Mazurick, 1994; Kendall & Sugarman, 1997). Clients also indicated their reason for seeking help.

The Brief Symptom Inventory 18. The Brief Symptom Inventory 18 (BSI 18; Derogatis, 2000) is a self-report symptom inventory designed to screen for psychological distress. The BSI 18 consists of 18 statements of problems that may have disturbed the client during the previous 7 days (i.e., "Faintness or dizziness" and "Feeling lonely"). Each statement is rated on a five-point scale from not at all (0) to extremely (4).

The BSI 18 yields a total of four scores; one global score (Global Severity Index [GSI]) and index scores for three psychological dimensions (Somatization [SOM] i.e., "Trouble getting your breath"; Depression [DEP] i.e., "Feeling no interest in things"; Anxiety [ANX] i.e., "Feeling fearful"). Internal consistency data were obtained using a non-clinical population of 1,134 adults. Internal consistency alphas averaged .82 and ranged from a low of .74 for SOM to a high of .89 for GSI (Derogatis, 2000). One-week test-retest reliability studies were not conducted on the BSI 18; however, test-retest reliabilities of the corresponding larger BSI scales averaged .80 with a low of .68 for SOM and a high of .90 for GSI (Derogatis, 2000). The BSI 18 was derived from the Brief Symptom Inventory (BSI; Derogatis, 1993) and its parent instrument the Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1994). The BSI and SCL-90-R were primarily designed as treatment outcome measures and monitoring measures, while the BSI 18 was developed as a screening instrument for psychiatric disorders and psychological disintegration. Correlations between the four scores on the BSI 18 and

the corresponding scores on the SCL-90-R were GSI .93, SOM .91, DEP .93 and ANX .96 (Derogatis, 2000).

The study used the Global Severity Index score to assess psychological symptoms in mothers. Psychological symptoms in children's caregivers have been shown to be a risk factor for therapy dropout (Gould et al., 1985; Venable & Thompson, 1998); therefore, mothers' psychological symptoms were assessed in this study. Scores on the Global Severity Index are computed by summing the scores on the three symptom dimensions. Raw scores may range from 0 to 72 with higher scores indicating a higher level of symptomology.

Barriers to Treatment Participation Scale (BTPS). The Barriers to Treatment Participation Scale (BTPS; Kazdin et al., 1991) was designed to evaluate barriers that families experience during the course of treatment. The underlying model for the scale is that, for many families, participation in treatment is a burden associated with multiple barriers. These barriers include practical obstacles, perceptions that treatment is demanding and of little relevance to the child's problems, and a poor relationship or alliance with the therapist.

The BTPS includes two sections. The first section consists of 44 items rated on a five-point scale ranging from 1(never a problem) to 5 (very often a problem). This section of the BTPS measures barriers in four domains; Relevance of Treatment (8 items), Treatment Demands and Issues (10 items), Relationship with the Therapist (6 items), and Life Stressors (20 items). The second section of the BTPS is the Critical Events scale that lists 14 items that describe discrete events that could lead to treatment termination (e.g., moving to another city, death of a family member). These items are

answered either yes or no. The total of 58 items and questions are given in an interview format that can be administered in person or by telephone after clients have left treatment. The items refer to events that have transpired during the course of treatment (e.g., obstacles in coming to treatment, child care difficulties), as well as current perceptions (e.g., alliance with the therapist, perceived relevance of treatment). The measure is phrased so that both dropouts and completers can answer the questions.

The Kazdin et al. (1997) study provided validity and reliability evidence for the BTPS scale. The overall correlation of the parent and therapist total barriers scores was significant, $r(239) = .45, p<.001$. Internal consistency for the total barriers scale of the parent version was .86 and the alpha for the total therapist version was .90. The subscales (Relevance of Treatment, Treatment Demands and Issues, Relationship with the Therapist, and Life Stressors) had coefficient alphas ranging from .61 to .80 (parent version) and .69 to .85 (therapist version). Intercorrelations among the subscales were all positive and in the low-to-moderate range. For the parent-completed measure, the subscale intercorrelations ranged from .21 to .41; for the therapist-completed measure, the intercorrelations ranged from .35 to .51.

The BTPS was developed in the context of an outpatient clinic that serviced children and families. The children (ages 2-13) were referred for oppositional, aggressive, and antisocial behavior (Kazdin et al., 1997). Data obtained regarding the scales were preliminary, because the sample was restricted and multiple tests of validity have not been completed.

For the purpose of this study, the BTPS was modified so that it could more accurately pertain to the sample population. Two items were dropped from the

Treatment Demands and Issues subscale because they were inapplicable. These items addressed the cost of therapeutic services, however services are free at this community mental health clinic. An additional 8 items were dropped from both versions of the BTPS because they pertained specifically to child clients (i.e., "My child refuses to come to sessions," or "My child has trouble understanding treatment"). Because this agency is funded in part by New York City's Administration for Children's Services, therapists are mandated to see any children in the client's household under the age of 18 at least once every three months, regardless of the child's participation in therapeutic treatment. Therefore, while therapists periodically saw all children, therapeutic goals did not necessarily involve children.

Three items pertaining to cultural factors were added to the BTPS. These three questions comprised a new subscale, called Culture. Previous versions of the BTPS did not address cultural influences on dropout behavior. In this study, the sample population was 73% ethnic minority – predominately Hispanic (39%). The contribution of culture as a variable is more complex than simple minority status. Question 35 ("I/The parent may feel the therapist does not understand my/his or her cultural background or values.") was added to assess the influence of culture on the working alliance. Dropout has also been conceptualized as an outcome due to service provider ignorance of cultural expectations and cultural rules for appropriate delivery of services (Dana, 1993). Culture is often intertwined with acculturation levels. Questions 36 ("I/The parent also seek help for personal problems from spiritual leaders and/or religious institutions.") and 37 ("Growing up, my family's/the parents family's personal problems were handled within the family rather than by outside professional.") were

added to address level of acculturation. According to alternative resource theory, many minority groups use alternative resources for help with emotional problems (Flaskerud, 1986; Padilla et al., 1975). Hispanic Americans with psychological problems first turn to family or culturally familiar organizations such as the church to solve mental health problems (Padilla et al., 1975).

The BTPS was also modified so that it could be given after the second session of treatment. The verb tenses of questions were changed from past tense to present and future tense. For the purpose of this study, the critical events section of the BTPS was not administered, because presumably, very few critical events would occur within the first two sessions of therapy. Other minor changes in wording were made to tailor the questions more specifically to the agency in which the study was conducted. Also, it was not administered using an interview format. Participants filled out the BTPS independently as a self-report measure. Parents and therapists were given separate, but parallel, versions of the scale.

The final modified version of the BTPS used in this study consisted of 37 items rated on the 5-point scale ranging from 1 (never a problem) to 5 (very often a problem). This BTPS measured barriers in five domains: Stressors and Obstacles that Compete with Treatment (17 items), Treatment Demands and Issues (6 items), Perceived Relevance of Treatment (6 items) Relationship with the Therapist (5 items), and Culture (3 items). The Total Barriers to Treatment score was calculated by adding the total sum of scores on the first 34 items, which comprise the four domains found in the BTPS (Kazdin et al., 1991). A secondary Total Barriers score was calculated by adding the

total sum of scores on all 37 items, including the three items of the Culture domain. See Appendix A for parent and therapist versions of the BTPS.

Procedure

When clients visit the agency for the first time, they are given the option of signing up for services that day or returning the following week. The sign up process involves filling out a form that is used to enter a family into the computer system that monitors social services for the City of New York. For the purpose of this study, the session in which the client signed this form was considered the first therapy session. At the end of the second session or before the beginning of the third session, clients were given a packet by their therapist regarding this study. The packet contained a letter of introduction and study description, two informed consent forms (one to be kept by the participant; see Appendix D), and the survey materials (BTPS-Parent Version, BSI-18, and the Participant Questionnaire). The clients completed the materials at the end of the second session of therapy or before the beginning of the third session so that they could give adequately informed answers about their perceptions of their therapists and their experience of therapy. Phillips (1985) presented nationwide attrition data on over 1,000,000 clients at outpatient clinics showing that the number of clients staying in treatment drops off sharply after the first few sessions. Thus, the BTPS was administered at this early time to insure assessment before clients were likely to drop out.

Clients were not allowed to take the packet home, but completed it in a private place at the agency and then returned it in a sealed envelope to their therapists. The clinical supervisor collected the packets, and once a week, the investigator went to the sites to collect packets and discuss projected client sign-up activity. The therapists wrote the client case initiation date (CID) number, agency site number, and therapist agency identification number on the BTPS-Parent Version before handing it to the parents and on the envelope clients used to return their surveys.

At an introductory meeting with the agency staffs at the beginning of the study, therapists were given a letter of introduction and study description, two informed consent forms (one to be kept by the therapist; see Appendix D), the Therapist Questionnaire, and several copies of the BTPS-Therapist Version. All therapists at both sites decided to participate in the study and filled out their consent forms at the meeting. Some therapists met individually with the investigator due to scheduling issues.

Therapists varied in the number of cases they contributed to the study. This variation was due to differences in the number of cases signed up by therapists and each therapist's ability to remember to administer the survey during the very specific time frame of after the second session or before the third session. Some therapists with full caseloads did not have occasion to sign up new cases, while new workers had to open an entire caseload of 15 cases. Table 3 gives the number of cases contributed by each therapist.

Table 3

Therapist Contribution of Cases

Site	*Therapist*	*Degree*	*Contributed Cases*	*Dropouts*
1	1	MSW	4	1
1	2	MPS	4	1
1	3	MSW	1	0
1	4	BA	3	1
1	5	MPS	6	0
1	6	BA	7	5
2	7	MSW	1	1
2	8	MSW	2	2
2	9	BSW	4	3
2	10	MSW	1	0

Note. MSW = Master of Social Work, MPS = Master of Professional Services, BA= Bachelor of Arts, BSW = Bachelor of Social Work

Therapists completed the BTPS-Therapist Version within the week of their clients returning the sealed packets to them. Therapists also coded the BTPS-Therapist Version with the therapist's agency identification number, the agency site number, and the CID and paper-clipped it to the respective sealed envelope in order to link each BTPS-Therapist Version with the proper client.

Clients were assigned to the dropout group or the continuer group based on their termination status. For the purpose of this study, dropout was defined by the therapist's

judgment. Therapist judgment of each case's dropout status was assessed by periodically calling case planners, reading off the CID dates, and asking therapists if this case had closed, and if so, if they judged this case to be a dropout.

To facilitate the overall data collection process, the investigator conducted a meeting with the clinical supervisors and agency administration before the data gathering began. At this meeting the investigator provided them with a brief summary of the study and their part in it. This was done to aid in compliance on the part of the therapists and clinical supervisors. All data were kept in a locked cabinet by the investigator. Consent forms were removed from packets, coded, and placed in a separate folder in the same locked storage cabinet.

Research Design

This was a correlational study that used two sets of variables (dropout risk factors identified from the literature and BTPS scores) to predict client dropout status.

Data Analysis

Data were analyzed using binary logistic regressions to predict dropout status. First, dropout risk factors identified from the literature (SES, income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology) were used to predict dropout. Next, BTPS scores were added to the regression equation to evaluate their ability to explain dropout over and above the conventional risk factors. This analysis was done twice – once with parent BTPS scores and once with therapist BTPS scores. When the logistic regression analysis revealed that the BTPS-Parent Version explained dropout over and above conventional risk factors, each BTPS – Parent Version subscale score was entered into

stepwise multiple logistic regression analyses to see how well each subscale predicted dropout over and above other risk factors.

Chi-square analyses and point bi-serial correlations were used to relate other data collected (i.e., therapists' specialty area, therapists' years of experience) to dropout status. A Pearson Product Moment correlation was done using therapist and parent BTPS scores. Coefficient alphas were calculated for therapist and parent BTPS total and subscale scores.

A supplementary analysis was done using the three-item culture subscale. BTPS scores, including the three culture questions, were added to a regression equation to evaluate their ability to explain dropout over and above the conventional risk factors. This analysis was done twice – once with parent BTPS scores and once with therapist BTPS scores. Coefficient alphas were calculated for therapist and parent BTPS total and subscale scores with the three culture questions included as a fifth subscale.

CHAPTER 4

Results

Parent BTPS total scores averaged 46.85 out of a total possible score of 170 (34 questions). Higher scores indicate more barriers to participation in treatment. Relevance of Treatment averaged 9.03 out of a total possible score of 30 (6 questions). Treatment Demands and Issues averaged 7.31 out of a total possible score of 30 (6 questions). Relationship with Therapist averaged 6.70 out of a total possible score of 25 (5 questions). Life Stressors averaged 23.81 out of a total possible score of 85 (17 questions). Because there are no norms for the BTPS, it is not possible to interpret these scores. Table 4 gives descriptive statistics for the BTPS-Parent Version.

Table 4

BTPS Scores – Parent Version

Descriptor	*M*	*SD*	*Range*	*N*
Parent BTPS – Total Score	46.85	8.50	34-68	33
Relevance of Treatment	9.03	2.60	6-15	33
Treatment Demands and Issues	7.31	1.77	6-12	33
Relationship with Therapist	6.70	1.83	5-11	33
Life Stressors	23.81	5.01	17-40	33

Note. BTPS = Barriers to Treatment Participation Scale

Therapist BTPS total scores averaged 53.61 out of a total possible score of 170 (34 questions). Relevance of Treatment averaged 10.21 out of a total possible score of 30 (6 questions). Treatment Demands and Issues averaged 8.21 out of a total possible

score of 30 (6 questions). Relationship with Therapist averaged 7.88 out of a total possible score of 25 (5 questions). Life Stressors averaged 27.30 out of a total possible score of 85 (17 questions). Because there are no norms for the BTPS, it is not possible to interpret these scores. Table 5 gives descriptive statistics for the BTPS-Therapist Version. Client and therapist total BTPS scores were positively correlated, $r = .440$, $p = .011$, indicating similar assessments of client treatment barriers by both members of the therapeutic dyad.

Table 5

BTPS Scores – Therapist Version

Descriptor	*M*	*SD*	*Range*	*N*
Therapist BTPS – Total Score	53.61	8.59	37-76	33
Relevance of Treatment	10.21	2.89	6-19	33
Treatment Demands and Issues	8.21	2.10	6-14	33
Relationship with Therapist	7.88	2.19	5-14	33
Life Stressors	27.30	5.16	19-37	33

Note. BTPS = Barriers to Treatment Participation Scale

The BTPS was modified for this study in that certain questions were removed because they did not pertain to the sample population. Coefficient alphas indicated that internal consistency of the 34 remaining items that were part of the original BTPS were .81 for the parent version and .79 for the therapist version. Coefficient alphas for the subscales on the BTPS-Parent Version were: Relevance of Treatment, .51; Treatment Demands and Issues, .50; Relationship with Therapist, .56; and Life Stressors, .72. Coefficient alphas for the subscales of the BTPS-Therapist Version were: Relevance of

Treatment, .70; Treatment Demands and Issues, .64; Relationship with Therapist, .57; and Life Stressors, .61. Kazdin et al. (1997) reported BTPS coefficient alphas of .86 for the parent version and .90 for the therapist version. Coefficient alphas for the subscales were reported to range from .61 to .80 for the parent version and .69 to .85 for the therapist version. Thus, coefficient alphas for this study were lower than those found by Kazdin et al. (1997).

Hypothesis One

The first hypothesis predicted that the parent BTPS total barriers score would significantly predict dropout over and above what is predicted by risk factors identified from the literature (SES, income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology). A binary logistic regression was completed in which the seven dropout risk factors identified from the literature were entered as a first block to predict dropout or continuer status. The seven variables entered together did not significantly predict dropout status, $\chi^2(7) = 1.211, p = .991$. This finding supports the findings in the literature review that suggest that traditionally studied variables do not predictably relate to dropout. After controlling for these seven traditional variables, the parent BTPS total barriers scores were added to the regression equation. The parent BTPS total barriers score was found to significantly predict dropout when the other seven variables were controlled, $\chi^2(1) = 4.37, p = .037$. These results support the hypothesis that parent BTPS total barriers scores significantly predict dropout over and above what was predicted by the seven variables traditionally studied in the literature. Table 6 presents the results of this analysis.

Table 6

Variables in the BTPS – Parent Version Regression Equation

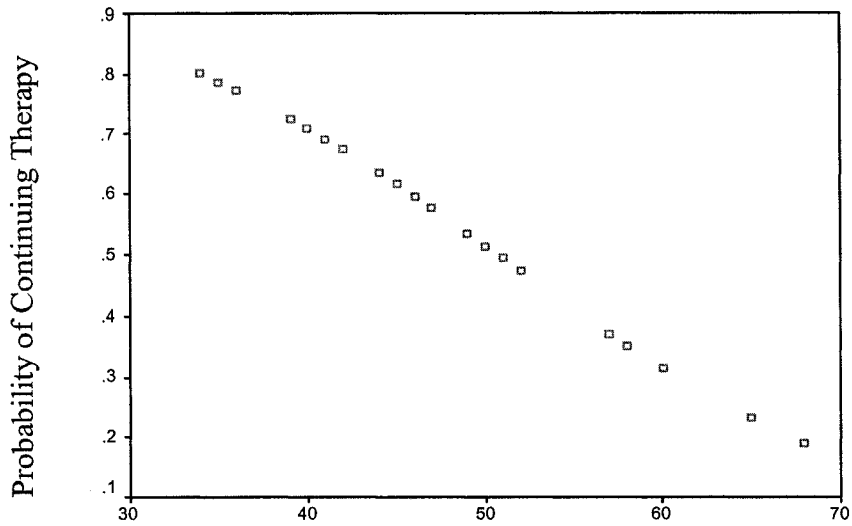
Variable	*B*	*S.E.*
SES	.004	.047
Minority status	.276	1.05
Public Assistance	-1.18	1.28
Income	.051	.340
Single Parent	-.640	.977
Age	.002	.004
BSI	.003	.041
Parent BTPS	-.106	.056

Note. BTPS = Barriers to Treatment Participation Scale, BSI = Brief Symptom Inventory, SES = Hollingshead Four Factor Index of Social Status

To further understand the usefulness of parent BTPS total barriers scores, a logistic regression was run predicting the probability of staying in therapy from the parent BTPS total scores. The equation showed a negative relationship. As a client's endorsement of barriers to treatment increase, her probability of staying in therapy decreased, $\chi^2(1) = 3.534$, $p = .060$. The results are displayed in Figure 1. This analysis excluded the seven traditional variables, as those were found to not be significant predictors of dropout.

Figure 1

Relationship of BTPS to Probability of Continuing Therapy



Because the first hypothesis was confirmed, each barrier subscale score was tested to see how well it alone predicted dropout over and above the other risk factors. Three of the four subscales were not found to significantly predict dropout over and above the other risk factors: Relevance of Treatment, $\chi^2(1) = 3.784, p = .052$, Life Stressors, $\chi^2(1) = 1.984, p = .159$, and Relationship with Therapist , $\chi^2(1) = .138, p = .710$. Treatment Demands, however, significantly predicted dropout over the other risk factors, $\chi^2(1) = 4.087, p = .043$. Thus, as perceived treatment demands increased, the likelihood of dropout increased.

In order to determine if individual questions could significantly predict dropout, regardless of the subscale to which they were assigned, each question in the BTPS-P was tested to see how much it alone predicted dropout. Question 19 from the Relevance of Treatment subscale ("I feel counseling does not focus on my life and problems.")

was found to significantly predict dropout, $\chi^2(1) = 12.172, p = .003$. This was the only BTPS-P item to predict dropout by itself.

Hypothesis Two

The second hypothesis stated that therapist BTPS total barriers score would significantly predict dropout over and above what is predicted by risk factors identified in the literature review (SES, income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology). Therapist BTPS total barriers scores did not significantly predict dropout over and above what was predicted by the risk factors identified in the literature review, $\chi^2(1) = .176, p = .675$. Table 7 presents the results of this analysis.

Table 7

Variables in the BTPS – Therapist Version Regression Equation

Variable	*B*	*S.E.*
SES	-.003	.044
Minority status	.019	.964
Public Assistance	-.951	1.241
Income	.051	.319
Single Parent	-.588	.929
Age	.000	.003
BSI	-.015	.038
Therapist BTPS	-.020	.047

Note. BTPS = Barriers to Treatment Participation Scale, BSI = Brief Symptom Inventory, SES = Hollingshead Four Factor Index of Social Status

Supplemental Analysis with Cultural Subscale Added to the BTPS

In the section above, the hypotheses were tested using the BTPS scales that were similar to those used by Kazdin et al. (1997). Hypotheses 1 and 2 were also tested using parent and therapist versions of the BTPS with a three-item Culture subscale added to the total score. Table 8 presents Parent and Therapist BTPS total score means and standard deviations when the Culture subscale was added. The Parent BTPS total barriers scores with the Culture subscale included averaged 52.30 with a total possible score of 185. Therapist BTPS total scores with the Culture subscale averaged 60.15 out of a total possible score of 185.

Table 8

BTPS Total Scores Including Culture Subscale

Descriptor	*M*	*SD*	*Range*	*N*
Parent BPTS – Total Score w/ Culture Subscale	52.30	9.26	38-73	33
Therapist BPTS - Total Score w/ Culture Subscale	60.15	9.64	43-88	33

Note. BTPS = Barriers to Treatment Participation Scale

The parent BTPS total barriers score with the Culture subscale included in the total score was found to be significant when the other seven variables were controlled, $\chi^2 = 4.91, p = .027$. These results also support the hypothesis that parent BTPS total barriers scores would significantly predict dropout over and above what is predicted by the seven variables traditionally studied in the literature. The Culture subscale, however, did not significantly predict dropout over and above the other risk factors, $\chi^2 = 2.113$, $p = .147$.

The therapist BTPS total barriers score with the Culture subscale included in the total score did not add significant variance when the other seven variables were controlled, χ^2 (1) = .018, $p = .892$. Thus, the adding the Cultural subscale to the client and therapist versions of the BTPS did not add to its predictability of dropout in this study.

The addition of the Cultural subscale to the BTPS slightly lowered the internal consistency of the BTPS-Parent Version from .81 to .80, but the internal consistency of the BTPS-Therapist Version stayed the same, .79. Coefficient alphas for the Culture

subscale were .14 for the parent version and .31 for the therapist version. Question 37 ("Growing up, my family's/the parents family's personal problems were handled within the family rather than by outside professional.") yielded the lowest item-total correlations on both versions of the scale (parent version = .09, therapist version = -.06). Question 35 ("I/The parent may feel the therapist does not understand my/their cultural background or values.") yielded an item-total correlation of .30 for the parent version, and .67 for the therapist version. Question 36 ("I/The parent also seek help for personal problems from spiritual leaders and/or religious institutions.") yielded item-total correlations of .44 for the parent version and .40 for the therapist version. These reliability coefficients for the Culture subscale are quite low suggesting that this subscale should not be used in future research.

Therapist and Agency Variables Relative to Dropout

Clients seen by therapists with Bachelor's degrees were more likely to dropout than those seen by therapists with Master's degrees, $\chi^2(1) = 4.758, p = .030$. A point bi-serial correlation indicated that therapists' endorsement of humanistic psychology was positively correlated with dropout, $r(31) = .514, p = .003$. The correlation of years of experience as a therapist and dropout approached significance, $r(31) = .338, p = .054$. As therapists' years of experience increased, the likelihood of clients continuing therapy tended to increase. Therapists' ages, $r(31) = -.219, p = .222$, and years of experience at the agency, $r(31) = .013, p = .943$, did not relate to dropout status.

Therapists' rating of their use of humanistic therapy did not correlate with years of experience, $r(8) = .171, p = .636$, or years at the agency, $r(8) = -.250, p = .487$. However, therapists' psychodynamic ratings were related to years at the agency,

$r(8) = .745, p = .013$, and years of experience, $r(8) = .686, p = .028$. Therapists' cognitive behavioral ratings were also related to years at the agency, $r(8) = .666, p = .035$, but not years of experience, $r(8) = .354, p = .316$. Therefore therapists with more years of experience at the agency were more likely to indicate the use of cognitive behavioral and psychodynamic therapies.

Chi square analyses indicated that individual therapist was not related to dropout status, $\chi^2(9) = 15.211, p = .085$; however clients at agency site number # 2 were more likely to dropout than clients at agency site #1, $\chi^2(1) = 4.588, p = .033$). A *t*-test revealed that therapists from site #1 had worked at the agency a significantly longer time, $M = 21$ months, $SD = 13$ months, than therapists at site #2, M = 9 months, $SD = 6$ months; $t(8) = 1.702, p = .047$. *T*-tests revealed no other significant differences between the sites on other therapist variables. Therapists from site #1 were on average older (32 years) as compared to therapists at site #2 (25 years); $t(8) = 1.535, p = .163$. Therapists from site #1 had an average of 27 months therapy experience, while therapists from site #2 averaged 15 months total therapy experience; $t(8) = 1.771, p = .115$. Chi-square analyses revealed no other significant differences between therapists at the two sites on the variables of ethnicity, $\chi^2(3) = 2.857, p = .414$, or degree, $\chi^2(1) = .079, p = .778$. Therefore, site #2, which had more dropouts, also had younger therapists with less therapy experience, as well as significantly less experience at the agency.

Supplemental Analysis of Dropouts and Continuers

An analysis of variance was conducted to determine significant differences between dropouts and continuers on the mean scores of the parent version of the BTPS. Mean total barriers scores did not differ significantly between dropouts and continuers,

$F(1,31) = 3.612, p = .067$. Mean scores on the subscales of the BTPS did not vary significantly between dropouts and continuers, although Treatment Demands approached significance, $F(1, 31) = 4.107, p = .051$. Analysis of variance of means of dropouts and continuers on the remaining subscales of the BTPS parent version were as follows: Relevance of Treatment, $F(1, 31) = 3.690, p = .064$, Relationship with Therapist, $F(1, 31) = .056, p = .815$, and Life Stressors, $F(1, 31) = 1.945, p = 173$. Table 9 presents the means and standard deviations associated with these analyses.

Table 9

Dropout and Continuer BTPS Scores – Parent Version

Descriptor	*Dropout*		*Continuer*	
	M	*SD*	*M*	*SD*
Parent BTPS – Total Score	50.00	9.01	44.53	7.51
Relevance of Treatment	10.00	3.35	8.31	1.60
Treatment Demands and Issues	8.00	2.25	6.78	1.13
Relationship with Therapist	6.79	1.63	6.63	2.01
Life Stressors	25.21	4.25	22.79	5.38

Note. BTPS = Barriers to Treatment Participation Scale

CHAPTER 5

Discussion

This chapter reviews study findings and discusses their implications for psychologists. The chapter also discusses the study's limitations and provides suggestions for further study. Results are best generalized to populations similar to the one studied.

Findings and Implications for Psychologists

Total barriers scores, obtained after the second session, on the Barriers to Treatment Participation Scale – Parent Version, modified for this population, significantly predicted dropout from therapy. The traditional variables of SES, income level, receiving public assistance, minority group membership, mother's age, single-parent family, and maternal psychopathology that had been found by some in the literature to predict dropout were not significant predictors of dropout behavior in this study. Because the BTPS assesses practical obstacles to attending therapy sessions, perceptions regarding the relevance and demands of treatment, and the relationship or alliance with the therapist, this finding suggests that client dropout is a function of a complex process rather than simple demographic variables.

This result also supports the finding of Kazdin et al. (1997) that families who dropout of therapy have experienced greater barriers to participation in treatment than clients who stay in treatment. Kazdin et al.'s (1997) study, however, administered the BTPS to clients after they had dropped out of therapy, and provided an "after the fact" explanation of dropout. It is more important for therapists to know *before* clients dropout of therapy what factors might be associated with premature termination. If

these factors are known, therapists can work with clients to clear the barriers and, hopefully, allow clients to continue treatment. Thus, clients in the present study completed the BTPS after the second session and their answers predicted dropout. The results further indicate that treatment demands in particular were predictive of later dropout. The Treatment Demands subscale consists of six questions that address clients' impressions of the difficulty level of treatment. Clients use this scale to comment on the length of treatment, the amount and difficulty of the work expected from them, and their perceived amount of control over how treatment proceeds. This scale, also addresses the quality of information and handouts, as well as the atmosphere at the agency. Clients also tended to drop out when they believed that treatment was less relevant to their problems (Relevance of Treatment subscale) than did clients who stayed in treatment. This subscale taps into clients' assumptions about the existence of a problem or their readiness for change. DiClemente and Prochaska (1982) found that clients who come into therapy with a greater degree of acceptance of their problem completed therapy more often than those who are not convinced they have a problem. Clients are sometimes referred for services before they are convinced they need help. If their therapists had known how clients felt about these issues, they could have adjusted the demands they made on the clients and discussed with clients the relevance of counseling to their particular problems, and perhaps the clients would have stayed in treatment.

Therapists' BTPS scores did not predict dropout. This suggests that the therapists did not see dropouts' barriers as being any different from those of continuing

clients. Since the client is the individual who drops out, not the therapist, it makes sense that the client's score on the BTPS would be more likely to predict dropout.

The results indicate that the BTPS may be a useful tool to determine client barriers that might lead to dropout. The BTPS could aid in more effective delivery of therapeutic services by allowing clients to identify, and therapists to recognize, indicators of dropout that may be addressed before clients leave treatment unilaterally and prematurely.

This measure could also help therapists understand their clients' concerns. Therapists typically use the first few sessions of therapy to assess the nature and scope of the client's problem and inform clients of the logistics of seeking services. Clients reciprocate by providing a brief history of the issues that lead to their seeking help. However, more than a simple exchange of information is taking place during these first few sessions. A therapeutic relationship is forming between client and therapist. This has been termed the working alliance (Gelso & Carter, 1985) or helping alliance (Alexander & Luborsky, 1986). Unsatisfactory alliances between client and therapist have been linked to dropout (Kokotovic & Tracey, 1987; Mohl et al., 1991; Tryon & Kane, 1990, 1993, 1995). Tryon and Kane (1990) found that only the client's rating of satisfaction with the working alliance, not the therapists rating, was related to dropout. Similarly, this study found that only parents' total barriers scores predicted dropout.

Results indicated that clients seen by therapists with Bachelor's degrees were significantly more likely to dropout than clients seen by therapists with Master's degrees. Also, clients seen at site #1, the site that had employed therapists for a significantly longer period of time, were less likely to dropout out than clients seen at

site #2, which had therapists with significantly less experience at the agency. Pekarik (1985b) found that dropping out was associated with therapists who had little experience. Rodolfa et al. (1983) found a significant difference in return rate based on therapist experience level. Also, Tryon (1989) found that professional therapists (those with a Ph.D.) were significantly better able to engage clients to return after an intake session than practicum students. Similarly, this study found that education and years of experience at the agency predicted dropout.

Results showed that the Treatment Demands and Issues subscale was able to predict dropout over and above the other risk factors. This subscale addresses issues such as whether or not the client finds therapy more work than the client expected, or whether the assigned work was too difficult for the client. At this agency, parents who report problems with their child's behavior are typically trained in techniques such as behavior charts and the administration of reinforcements and consequences. The amount of effort demanded of parents may have come as a surprise to some parents, particularly those with the expectation that their children alone would be the focus of therapy.

Results showed that dropout was related to therapists' humanistic therapy orientation. However, therapists with more years total experience and more years at the agency were more likely to have cognitive behavioral or psychodynamic therapy orientations. Perhaps more experienced therapists were more comfortable using these more complex approaches to therapy that often involve challenging clients, interpreting issues, and sometimes assigning homework. Most beginning therapists are first trained in the humanistic technique, which involves client validation and reflective listening.

Perhaps dropouts were not satisfied with this passive approach to therapy and sought more challenge and direction in their sessions. Future research could examine the utility of the humanistic therapeutic approach with this client population.

Limitations of the Study

Results of this study should be interpreted cautiously because of limitations of the samples and the instrument used. The sample size was small and highly specific. Client participants came from a very small geographic area of Brooklyn. The majority of clients were single parents from ethnic minorities. Most of the mothers had a high school education or less, and 64% earned $1,500 a month or less. Over half were in the two lowest socioeconomic status levels representing machine operators, semiskilled workers, unskilled laborers, and menial service workers. Furthermore, the exact nature or severity of psychological symptoms in the child population of this study is unknown because the agency does not gather data on the presence of clinical diagnoses in children. Also, therapists forgot to administer the survey to almost half of the clients who were eligible for participation in the study. Perhaps incentives for therapists to help them remember to give the survey may have increased the response rate.

Also, a small portion of the client population at this agency is referred for family services by the Administration for Children's Services. Clients from this population tend to remain in therapy for a long period of time due to pressure from the referral source. Potentially, the dropout rate for this segment of the sample population could have been depressed due to this pressure.

Despite the fact that most of the clients were Latina and most of the therapists were Caucasian, this study did not find any association between cultural barriers and

dropout. It is important to note that 16 clients could not be given the BTPS because they could not read English well enough to complete it. This portion of the population that was excluded from the sample may have been less acculturated due to an inability to speak or read English. If these women could have participated in the study, the cultural barriers results might have been different.

The therapists in this study had little therapy experience. None of them had doctoral training, and about one-third had only a Bachelor's degree. The presence of therapists without graduate training is typical for this agency. The Administration for Children's Services, which is the primary funding source for the agency, mandates a policy of hiring at least one staff member at each site with a Bachelor's degree. The intention of this policy is that a student currently enrolled in the Master of Social Work program fills the position, thus allowing the agency to provide training opportunities. The inexperience of these Bachelor's level therapists may have contributed to the inability of the BTPS-Therapist Version to predict client dropout in this study. A sample of therapists with a wider range of experience and doctoral training may have produced different results.

The BTPS was modified for the purpose of this study so that it could more be more pertinent to the sample population. A total of ten items were dropped from both versions of the BTPS and the entire Critical Events section of the BTPS was not administered, because presumably, very few critical events would occur in clients' lives within the first two sessions of counseling. Modifications of the BTPS call into question the reliability and validity previously established for the instrument in the Kazdin et al. (1997) study.

Implications for Research

Future studies should continue to test the predictive power of the BTPS, while addressing the limitations of this study. Studies using the BTPS to predict dropout should be done with larger, more diverse samples of both clients and therapists. Future studies could examine the effectiveness of using BTPS information to deter clients from dropout. Interventions could be planned to address barriers-to-treatment. Therapists could use these interventions to address specific barriers identified by the BTPS client scores. The dropout rate of these clients could be compared to the rate of dropout of clients who had not had barriers interventions. The BTPS – Therapist Version should also be included in prediction studies with larger sample sizes. Perhaps in a future study, the BTPS could be translated so that reliability and validity could be established for a Spanish version. Also, should this instrument be translated into any language, a more fully developed cultural scale should be added to continue to assess for the influence of acculturation on barriers to treatment and the influence of cultural beliefs on the perception of therapy.

Appendix A

The Barriers to Treatment Participation Scale

Parent Version

Therapist Version

BTPS - Parent

[redacted]

Please rate from your perspective, the degree to which various problems apply to your family and are related to you coming to counseling. For each question, please CHECK ONE BOX ONLY.

1. Transportation (getting a ride, driving, taking a bus) to the agency for a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

2. Scheduling of appointment times for counseling.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

3. Counseling may last too long (too many weeks).

☐ Not too long ☐ May last a little too long ☐ May last too long ☐ May last much too long ☐ May last very much too long

4. Counseling is in conflict with another of my activities (classes, job, friends).

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

5. Counseling does not seem necessary.

☐ Counseling is very much needed ☐ Counseling is needed quite a bit ☐ Needed ☐ Needed a little bit ☐ Counseling is not needed

6. I do not like the therapist.

☐ I like the therapist a lot ☐ I like the therapist ☐ I like the therapist a little ☐ I do not like the therapist very much ☐ I do not like the therapist at all

7. Counseling is not what I expected.

☐ Just like I expected ☐ Mostly what I expected ☐ Sort of what I expected ☐ A little of what I expected ☐ Not at all what I expected

8. Information in the session and handouts seems confusing.

☐ Not confusing at all ☐ A little confusing ☐ Somewhat confusing ☐ Often confusing ☐ Very often confusing

continued on back

9. During the course of counseling I'm experiencing a lot of stress in my life.

☐ No stress during counseling ☐ A little bit of stress ☐ Some stress ☐ Moderate stress ☐ A lot of stress

10. I'm losing interest in coming to sessions.

☐ No, not losing interest at all ☐ Yes, a little ☐ Yes, I've lost a moderate amount ☐ Lost most of my interest ☐ I've lost all of my interest in coming

11. I've been sick on the day when counseling was scheduled.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

12. Crises at home make it hard for me to get to sessions.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

13. I feel I have to give too much personal information.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

14. Counseling adds another stress to my life.

☐ No added stress from counseling ☐ A little bit of added stress ☐ A moderate amount of added stress ☐ A good deal of added stress ☐ Adds a great deal of stress

15. I feel counseling does not seem as important as the sessions continue.

☐ As important ☐ A little less important ☐ Less important ☐ No longer as important ☐ Sessions not important at all

16. I feel counseling is more work than I expected.

☐ Not more work than expected ☐ A little more work than expected ☐ More work than expected ☐ Quite a bit more work than expected ☐ Very much more work than expected

17. The atmosphere at the agency makes it uncomfortable for appointments.

☐ Not a problem ☐ A slight problem ☐ A problem ☐ A big problem ☐ A very big problem

18. I do not feel that I have enough to say about what goes on in counseling sessions.

☐ Not a problem ☐ A slight problem ☐ A problem ☐ A big problem ☐ A very big problem

continued on next page

19. The parent feels that counseling does not focus in her/his life and problems.

☐ Counseling related to problems ☐ A little related ☐ Not really related ☐ Unrelated ☐ Counseling was very unrelated to problem

20. The parent seems to believe that the therapist does not seem confident in her/his ability to carry out programs.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

21. The parent believes that counseling does not seem to be working.

☐ Therapy helps a lot ☐ Therapy helps most of the time ☐ Helps a little ☐ Hardly ever helps ☐ Therapy has not helped at all

22. There was bad weather and this made coming to counseling a problem for the parent.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

23. The parent may feel that the therapist does not support her/his efforts.

☐ Therapist was very supportive ☐ Supportive most of the time ☐ Supportive ☐ Sometimes supportive ☐ Therapist never supportive

24. The assigned work for the parent to do as part of this counseling is much too difficult.

☐ Never too difficult ☐ Sometimes too difficult ☐ Too difficult on average ☐ Often too difficult ☐ Very often too difficult

25. The parent does not seem to have time for the assigned work.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

26. There is always someone sick in the home.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

27. The parent may believe that the therapist does not call often enough.

☐ Right amount of calling ☐ Calls once in a while ☐ Calls sometimes ☐ Calls only a few times ☐ Therapist never calls

28. Getting a baby-sitter so the parent can come to the sessions.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

continued on back

29. Finding a place to park at the agency.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

30. I am in disagreement with my husband, boyfriend, or partner about whether we should come to counseling at all.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

31. I am too tired after work to come to a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

32. My job gets in the way of coming to a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

33. Counseling takes time away from spending time with my children.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

34. I have trouble with other children at home, which makes it hard to come to sessions.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

35. My therapist does not understand my cultural background or values.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

36. I also seek help for my personal problems from spiritual leaders and/or religious institutions.

☐ Never ☐ Once in a while ☐ Sometimes ☐ Often ☐ Very often

37. Growing up, our family's personal problems were handled within my family rather than by outside professionals.

☐ Never ☐ Once in a while ☐ Sometimes ☐ Often ☐ Very often

Comments about coming to the agency:

_____

_____

_____

Thank you for completing this form!

BTPS Therapist

Site _____ **Heartshare CID**_____ **Client Initials**_____ **Case Planner ID #** _____

Please rate from your perception of the situation, the extent to which various problems apply to the family and are related to their coming to counseling. For each question, please CHECK ONE BOX ONLY.

1. Transportation (getting a ride, driving, taking a bus) to the agency for a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

2. Scheduling of appointment times for counseling seems to be an issue.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

3. The parent seems to believe that counseling may last too long (too many weeks).

☐ Not too long ☐ May last a little too long ☐ May last too long ☐ May last much too long ☐ May last very much too long

4. Counseling is in conflict with another of the parent's activities (classes, job, friends).

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

5. Counseling does not seem necessary to the parent.

☐ Counseling is very much needed ☐ Counseling is needed quite a bit ☐ Needed ☐ Needed a little bit ☐ Counseling is not needed

6. I do not believe that the parent likes the therapist.

☐ Likes the therapist a lot ☐ Likes the therapist ☐ Likes the therapist a little ☐ Does not like the therapist very much ☐ Does not like the therapist at all

7. Counseling is not what the parent expected.

☐ Just like expected ☐ Mostly what expected ☐ Sort of what expected ☐ A little of what expected ☐ Not at all what expected

8. Information in the session and handouts seems confusing to the parent.

☐ Not confusing at all ☐ A little confusing ☐ Somewhat confusing ☐ Often confusing ☐ Very often confusing

continued on back

9. During the course of counseling the parent is experiencing a lot of stress in her/his life.

☐ No stress during counseling ☐ A little bit of stress ☐ Some stress ☐ Moderate stress ☐ A lot of stress

10. The parent seems to have lost interest in coming to sessions.

☐ No, hasn't lost any interest at all ☐ Yes, a little ☐ Yes, a moderate amount ☐ Yes, most ☐ Lost all interest in coming

11. The parent was sick on the day when counseling was scheduled.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

12. Crises at home make it hard for the family to get to a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

13. The parent feels that she/he has to give too much personal information.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

14. The parent may feel that counseling adds another stressor to her/his life.

☐ No added stress from counseling ☐ A little bit of added stress ☐ A moderate amount of added stress ☐ A good deal of added stress ☐ Adds a great deal of stress

15. Counseling does not seem as important to the parent as the sessions continue.

☐ As important ☐ A little less important ☐ Less important ☐ No longer as important ☐ Sessions not important at all

16. The parent seems to feel that counseling is more work than expected.

☐ Not more work than expected ☐ A little more work than expected ☐ More work than expected ☐ Quite a bit more work than expected ☐ Very much more work than expected

17. The parent may feel that the atmosphere at the agency makes it uncomfortable for appointments.

☐ Not a problem ☐ A slight problem ☐ A problem ☐ A big problem ☐ A very big problem

18. It seems that the parent does not feel that she/he had enough to say about what goes on in counseling.

☐ Not a problem ☐ A slight problem ☐ A problem ☐ A big problem ☐ A very big problem

continued on next page

19. I feel counseling does not focus on my life and problems.

☐ Counseling related to problems ☐ A little related ☐ Not really related ☐ Unrelated ☐ Counseling very unrelated to problems

20. The therapist does not seem confident in my ability to carry out programs.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

21. Therapy does not seem to be working.

☐ Therapy helps a lot ☐ Therapy helps most of the time ☐ Helps a little ☐ Hardly ever helps ☐ Therapy has not helped at all

22. There is bad weather that is making coming to counseling a problem.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

23. I feel the therapist supports me in my efforts.

☐ Therapist is very supportive ☐ Supportive most of the time ☐ Supportive ☐ Sometimes supportive ☐ Therapist never supportive

24. The assigned work for me to do as part of counseling is much too difficult.

☐ Never too difficult ☐ Sometimes too difficult ☐ Too difficult on average ☐ Often too difficult ☐ Very often too difficult

25. I do not seem to have time for the assigned work.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

26. There is always someone sick in my home.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

27. The therapist does not call often enough.

☐ Right amount of calling ☐ Calls once in a while ☐ Calls sometimes ☐ Calls only a few times ☐ Therapist never calls

28. Getting a baby-sitter so I can come to the sessions.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

continued on back

29. Finding a place to park at the agency.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

30. The parent is in disagreement with her husband, boyfriend, or partner about whether they should come to counseling at all.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

31. The parent is too tired after work to come to a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

32. The parent's job gets in the way of coming to a session.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

33. It seems that counseling takes the parent away from spending time with her/his children.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

34. The parent has trouble with other children at home, which makes it hard to come to counseling.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

35. The parent may feel the therapist does not understand their cultural background or values.

☐ Never a problem ☐ Once in a while ☐ Sometimes a problem ☐ Often a problem ☐ Very often a problem

36. The parent also seeks help for personal problems from spiritual leaders and/or religious institutions.

☐ Never ☐ Once in a while ☐ Sometimes ☐ Often ☐ Very often

37. Growing up, the parent's family's personal problems were handled within the family rather than by outside professionals.

☐ Never ☐ Once in a while ☐ Sometimes ☐ Often ☐ Very often

Comments about the participation of the family in counseling (attention, commitment, involvement):

_____

_____

Thank you for completing this form!

SCORING KEY

BARRIERS TO TREATENT PARTICIPATION SCALE

REVISED

Competing Activities/Life Stressors (n=17)	Relationship with Therapist (n=5)
1	6
2	13
4	20
9	23
11	27
12	
14	
22	Treatment Issues/Logistics (n=6)
25	3
26	8
28	16
29	17
30	18
31	24
32	
33	Culture (n = 3)
34	35
	36
Relevance of Treatment (n=6)	37
5	
7	
10	
15	
19	
21	

Appendix B

Therapist Questionnaire

Therapist Questionnaire **Agency ID#** _____ **Site** _____

1. Please indicate the extent to which you feel each of these theoretical orientations reflects your personal therapeutic style.

Humanistic orientation				
Low				*High*
1	2	3	4	5

Psychodynamic orientation				
Low				*High*
1	2	3	4	5

Cognitive-Behavioral orientation				
Low				*High*
1	2	3	4	5

2. Highest educational degree received _____

3. Number of years experience as a therapist _____

4. Number of years at this agency _____

5. Check the ethnicity that best describes you:

☐ Hispanic ☐ Caribbean-American

☐ Caucasian ☐ Asian

☐ African-American ☐ other _____

6. Your age: _____ 7. Your gender: ☐ Male ☐ Female

Appendix C

Participant Questionnaire

Participant Questionnaire

Head of Household Status:
Living with spouse or partner Yes ☐ No ☐

Would you consider yourself a single parent? Yes ☐ No ☐

Please Check One: ☐ Married ☐ Divorced ☐ Single, Never Married
☐ Separated ☐ Living with Partner ☐ Widowed

Your Occupation: _____

Partner's Occupation: _____

Highest level of school you have completed:

☐ less that 7th grade
☐ junior high school (9th grade)
☐ some high school (10th or 11th grade)
☐ high school graduate
☐ some college or specialized training
☐ college or university graduate
☐ graduate degree

Highest level of school your partner has completed:

☐ less that 7th grade
☐ junior high school (9th grade)
☐ some high school (10th or 11th grade)
☐ high school graduate
☐ some college or specialized training
☐ college or university graduate
☐ graduate degree

Income level

Please Check One: ☐ $0 - $500/month ☐ $501 - $1000/month ☐ $1001 - $1500/month
☐ $1501 - $2000/month ☐ $2001 - $2500/month ☐ more than $2500/month

Are you currently receiving public assistance money? Yes ☐ No ☐

continued on back

Participant Questionnaire *Continued*

Check the ethnicity that best describes your family:

- ☐ Hispanic
- ☐ Caucasian
- ☐ African-American
- ☐ Caribbean-American
- ☐ Asian
- ☐ other_____

Indicate *one* category that best describes why you are seeking help

- ☐ child behavior problems
- ☐ divorce
- ☐ grief issues
- ☐ marital difficulty
- ☐ depression
- ☐ other (please specify)_____

Appendix D

Participant Letter, Informed Consent

Ph.D. Program in Educational Psychology

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
tel 212 817 8285 fax 212 817 1516

Dear HeartShare Case Planners,

My name is Rebecca Oakes and I am a former case planner at HeartShare Human Services (1996 – 2001), and I am currently a full-time graduate student at the Graduate School and University Center of the City University of New York earning my Ph.D. in Educational Psychology with a specialization in School Psychology. I am conducting my research for my dissertation under the auspices of the Graduate Center and in cooperation with HeartShare Human Services. I would greatly appreciate help from the HeartShare community in this endeavor.

The purpose of my dissertation is to research the potential problems that could interfere with receiving therapeutic services. The study is expected to investigate if the Barriers to Treatment Participation Scale can accurately identify potential problems that could lead to early dropout from therapy.

If you choose to participate, you will be asked to fill out an initial Case Planner Questionnaire form at the beginning of the study. You will also be asked to fill out a Barriers to Treatment Participation Scale before the third session, for every client of yours who chooses to participate in the study. Each month you will be asked to fill out a one question form regarding the termination status of each case that closes that was a part of the study. Your responses will be kept confidential and your participation will in no way affect your employment at HeartShare Human Services.

Included are two identical informed consent forms. If you chose to participate, return one with your completed Case Planner Questionnaire to the office manager or myself and keep the other for your records. If there are any questions regarding your participation, please call me at (718) 885-7788 or my supervisor Professor Georgiana Tryon at (212) 817-8293. If you have any questions regarding your rights as a human subjects research participant, you may call Hilry Fisher at (212) 817-7523, hfisher@gc.cuny.edu.

Thank you for your time and consideration.

Sincerely,

Rebecca Oakes

Rebecca Oakes, M.A.

Ph.D. Program in Educational Psychology

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
ph 212 817 8295 fax

Consent Form

My name is Rebecca Oakes and I am a student in the Educational Psychology Ph.D. Program at the Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project entitled "Measuring Dropout from Therapy Using the Barriers to Treatment Participation Scale." This is a research study of the potential problems that could interfere with receiving therapeutic services. The study is expected to investigate if the Barriers to Treatment Participation Scale can accurately identify potential problems that could lead to early dropout from therapy.

Participation in the study requires filling out three questionnaires. The first questionnaire will be filled out at the beginning of the study and should take approximately 5 minutes. Another questionnaire will be filled out for any client that chooses to participate in the study. This questionnaire will be filled out after the second session and should take approximately 15 minutes to complete. Finally, a form is to be filled out each month should a case close that chose to be part of this study. It should take only a few minutes to circle your choice on this form.

Your identity will remain confidential, because all questionnaires will be coded with your agency identification number only. The questionnaires will only be scored by myself and the information will not be made available to HeartShare Human Services. All information gathered will be kept strictly confidential, and will be stored in a locked file cabinet in my office, to which only I will have access. At any time you can refuse to answer any questions or decline to be a part of the study.

There is no known risk involved in the study. There will be approximately 52 client participants taking part in this study. The data gathering portion if the study is expected to take 4 to 6 months. I may publish results of this study, but the names of people, or any identifying characteristics, will not be used in any of the publications, unless I have your permission to do so. If you would like a copy of the study, please provide me with your address and I will send you a copy in the future.

If you have any questions about this research, you can call me at (718) 797-3554 or rloakes@earthlink.net, or my advisor Dr. Georgiana Tryon at 212-817-8293 or gtryon@gc.cuny.edu. If you have any questions about your rights as a participant in this study, you can contact Hilry Fisher, Sponsored Research, The Graduate Center/City University of New York, (212) 817-7523, hfisher@gc.cuny.edu.

Thank you for your participation in this study. I will give you a copy of this form to take with you. If you agree to fill out the questionnaires please sign below.

Rebecca Oakes

Participant's signature _____ Date _____ Investigator's signature _____ Date _____

Ph.D. Program in Educational Psychology

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
Tel 212 817 8205 Fax 212 817 1515

Dear HeartShare Clients,

My name is Rebecca Oakes and I am a former therapist at HeartShare Human Services (1996 – 2001), and I am currently a full-time graduate student at the Graduate School and University Center of the City University of New York earning my Ph.D. in Educational Psychology with a specialization in School Psychology. I am conducting my research for my dissertation under the auspices of the Graduate Center and in cooperation with HeartShare Human Services. I would greatly appreciate help from the HeartShare community in this endeavor.

The purpose of my dissertation is to research the potential problems that could interfere with receiving therapeutic services. The study is expected to investigate if the Barriers to Treatment Participation Scale can accurately identify potential problems that could lead to early dropout from therapy.

If you choose to participate, please complete the three self-report questionnaires that are enclosed, at the beginning of the third session. Please complete the questionnaires in their entirety. Your responses will be kept confidential and your participation will in no way affect your status as a client at HeartShare Human Services.

Included are two identical informed consent forms. If you chose to participate, return one with your completed questionnaires to the office manager or your case planner and keep the other for your records. If there are any questions regarding your participation, please call me at (718) 885-7788 or my supervisor Professor Georgiana Tryon at (212) 817-8293. If you have any questions regarding your rights as a human subjects research participant, you may call Hilry Fisher at (212) 817-7523, hfisher@gc.cuny.edu.

Thank you for your time and consideration.

Sincerely,

Rebecca Oakes

Rebecca Oakes, M.A.

Ph.D. Program in Educational Psychology

The Graduate School and University Center
The City University of New York
365 Fifth Avenue
New York, NY 10016-4309
tel 212 817 8285 fax 212 817 1536

Consent Form

My name is Rebecca Oakes and I am a student in the Educational Psychology Ph.D. Program at the Graduate Center of the City University of New York (CUNY), and Principal Investigator of this project entitled "Measuring Dropout from Therapy Using the Barriers to Treatment Participation Scale." This is a research study of the potential problems that could interfere with receiving therapeutic services. The study is expected to investigate if the Barriers to Treatment Participation Scale can accurately identify potential problems that could lead to early dropout from therapy.

Participation in the study requires filling out three questionnaires. It should take approximately 30 minutes to fill out these forms. Your therapist will also complete a questionnaire should you decide to participate in the study. Your confidentiality will be maintained. The only exception to this confidentiality would be if you indicate on the questionnaires that you may be of harm to yourself. In this instance the researcher would be obligated to inform your therapist. All answers to the questionnaires will be recorded only by myself, and will not be shared with HeartShare Human Services.

All information gathered will be kept strictly confidential, and will be stored in a locked file cabinet in my office, to which only I will have access. At any time you can refuse is answer any questions or decline to be a part of the study. You do not have to participate in this study in order to receive services. There is no risk involved in the study. There will be approximately 52 participants taking part in this study. The data gathering portion of this study will take approximately 4 to 6 months. I may publish results of this study, but the names of people, or any identifying characteristics, will not be used in any of the publications, unless I have your permission to do so. If you would like a copy of the study, please provide me with your address and I will send you a copy in the future.

If you have any questions about this research, you can call me at (718) 797-3554 or rloakes@earthlink.net, or my advisor Dr. Georgiana Tryon at 212-817-8293 or gtryon@gc.cuny.edu. If you have any questions about your rights as a participant in this study, you can contact Hilry Fisher, Sponsored Research, The Graduate Center/City University of New York, (212) 817-7523, hfisher@gc.cuny.edu. Thank you for your participation in this study. I will give you a copy of this form to take with you.

If you agree to fill out the questionnaires please sign below.

Participant's signature	Date	Investigator's signature	Date

References

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

Alexander, L.B., & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L. Greenberg & W. Pinsof (eds.), *The psychotherapeutic process: A resource handbook* (pp. 325-366). New York: Guilford Press.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington DC: Author.

Anderson, T.R., Hogg, J.A., & Magoon, T.M. (1987). Length of time on a waiting list and attrition after intake. *Journal of Counseling Psychology, 34*, 93-95.

Archer, J., Jr. (1984). Waiting list dropouts in a university counseling center. *Professional Psychology: Research and Practice, 15*, 388-395.

Armbruster, P., & Fallon, T. (1994). Attrition in child psychotherapy. In T.H. Ollendick & R.J. Prinz (Eds.), *Advances in clinical and child psychology* (Vol. 16, pp. 81-108). New York: Plenum.

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

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.

Betz, N.E., & Shullman, S.L. (1979). Factors related to client return following intake. *Journal of Counseling Psychology, 26*, 542-545.

Caine, G.M., Foulds, G.A., & Hope, K. (1967). *Manual of the Hostility and Direction of Hostility Questionnaire (HDHQ)*. London: University of London Press.

Corrigan, J.D., & Schmidt, L.A. (1983). Development and validation of revisions on the Counseling Rating Form. *Journal of Counseling Psychology, 30*, 64-74.

Dana, R.H. (1993). Multicultural assessment perspectives for professional psychology. Needham Heights, MA: Allyn and Bacon.

Derogatis, L.R. (1975). *Brief Symptom Inventory*. Baltimore: Clinical Psychometric Research, Johns Hopkins University.

Derogatis, L.R. (1993). *Brief Symptom Inventory (BSI) administration, scoring, and procedures manual* (3rd ed.). Minneapolis: NCS Pearson, Inc.

Derogatis, L.R. (1994). *Symptom Checklist-90-R (SCL-90-R) administration, scoring, and procedures manual* (3rd ed.). Minneapolis: NCS Pearson, Inc.

Derogatis, L.R. (2000). *Brief Symptom Inventory 18 (BSI 18) administration, scoring, and procedures manual.* Minneapolis: NCS Pearson, Inc.

DiClemente, C., & Prochaska, J.O. (1982). Self-change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance. *Addictive Behavior, 7*, 133-142.

Epperson, D.L. (1981). Counselor gender and early premature terminations from counseling: A replication and extension. *Journal of Counseling Psychology, 28,* 349-356.

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

Flaskerud, J.H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal, 22*, 127-141.

Fiester, A.R. (1977). Clients' perceptions of the therapists with high attrition rates. *Journal of Consulting and Clinical Psychology, 45*, 954-955.

Fiester, A.R., & Rudestam, K.E. (1975). A multivariate analysis of the early dropout process. *Journal of Consulting and Clinical Psychology, 43*, 528-535.

Folkins, C., Hersch, P., & Dahlen, D. (1980). Waiting time and no-show rate in a community mental health center. *American Journal of Community Psychology, 8*, 121-123.

Garfield, S.L. (1978). Research on client variables in psychotherapy. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of Psychotherapy and Behavior Change* (2nd ed., pp. 213-256). New York: Wiley.

Gelso, C.J., & Carter, J.A. (1985). The relationship in counseling and psychotherapy. *The Counseling Psychologist, 13*, 155-244.

Gelso, C.J., & Johnson, D.H. (Eds.). (1983). *Explorations in time-limited counseling and psychotherapy.* New York: Teacher's College.

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

Gunzburger, D.W., Henggler, S.W., & Watson, S.M., (1985). Factors related to premature termination of counseling relationships. *Journal of College Student Personnel*, 26, 456-460.

Hardin, S.I., Subich, L.M., & Holvey, J.M. (1988). Expectancies for counseling in relation to premature termination. *Journal of Counseling Psychology, 35*, 37-40.

Hill, C.E., Helms, J.E., Tichenor, V., Spiegel, S.B., O'Grady, K.E., & Perry, E.S. (1988). Effect of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35*, 222-233.

Hines, P.M. & Boyd-Franklin, N. (1996). African american families. In McGoldrick, M., Giordano, J. & Pearce, J.K. (Eds.), *Ethnicity and family therapy* (2nd. ed., pp. 66-84). New York: Guilford Press.

Hoffman, J.J. (1985). Client factors related to premature termination of psychotherapy. *Psychotherapy, 22*, 83-85.

Hollingshead, A.B. (1975). *Four Factor Index of Social Adjustment*. Unpublished manuscript. New Haven, CT: Yale University.

Holmes, D.S., & Urie, R.G. (1975). Effects of preparing children for psychotherapy. *Journal of Consulting and Clinical Psychology, 43*, 311-318.

Horvath, A.O., & Greenberg, L. (1986). The development of the Working Alliance Inventory. In L. Greenberg & W. Pinsoff (Eds.), *The psychotherapeutic process: A resource handbook* (pp. 529-556). New York: Guilford.

Horvath, A.O., & Greenberg, L. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-232.

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

Kazdin, A.E., Holland, L., & Bretton, S. (1991). *Barriers to Participation in Treatment Scale – Parent and Therapist Versions*. New Haven, CT: Yale University.

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

Kearney, M. (1975). World view theory and study. In B.J. Siegel (Ed.), *Annual Review of Anthropology* (Vol. 4, pp. 247-270). Palo Alto, CA: Annual Reviews.

Kendall, P.C., & Sugarman, A. (1997). Attrition in the treatment of childhood anxiety disorders. *Journal of Consulting and Clinical Psychology, 65*, 883-888.

Kirschner, T., Hoffman, M.A., & Hill, C.E. (1994). Case study of the process and outcome of career counseling. *Journal of Counseling Psychology, 41*, 216-226.

Kokotovic, A.M., & Tracey, T.J. (1987). Premature termination at a university counseling center. *Journal of Counseling Psychology, 34*, 80-82.

Kokotovic, A.M., & Tracey, T.J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology, 37*, 16-21.

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

Krauskopf, C.J., Baumgardner, A., & Mandracchia, S. (1981). Return rate following intake revisited. *Journal of Counseling Psychology, 28*, 519-521.

Larsen, D.L., Attkisson, C.C., Hargreaves, W.A., & Nguyen, T.D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning*, 2, 197-207.

Lawe, C., Horne, A., & Taylor, S. (1983). Effects of pretraining procedures for clients in counseling. *Psychological Reports, 53*, 327-334.

Longo, D.A., Lent, R.W., & Brown, S.D. (1992). Social cognitive variables in the prediction of client motivation and attrition. *Journal of Counseling Psychology, 39*, 447-452.

Martin, G.A., McNair, D., & Hight, W. (1988). Contributing factors to early premature termination at a college counseling center. *Journal of Counseling and Development, 66*, 233-236.

May, R.J. (1990). Are waiting lists really a problem? A follow-up survey of waitlist dropouts. *Journal of College Student Development, 31*, 564-566.

Mohl, P.C., Martinez, D., Ticknor, C., Huang, M., & Cordell, L. (1991). Early dropouts from psychotherapy. *The Journal of Nervous and Mental Disease, 179*, 478-481.

Moos, R.H., & Moos, B.S. (1986). *Family Environment Scale manual, 2nd edition*. Palo Alto, CA: Consulting Psychologist Press.

Orlinsky, D.E., & Howard, K.I. *The experience of psychotherapy: A prospectus on the psychotherapy session project* (Research Report 3(8)). Chicago: Institute for Juvenile Research, 1966.

Padilla, A.M., Ruiz, R.A., & Alvarez, R. Community mental health services for the Spanish-speaking surnamed population. *American Psychologist, 30*, 892-905.

Pekarik, G. (1983a). Follow-up adjustment of outpatient dropouts. *American Journal of Orthopsychiatry, 53*, 501-511.

Pekarik, G. (1983b). Improvement in clients who have given different reasons for dropping out of treatment. *Journal of Clinical Psychology, 39*, 909-913.

Pekarik, G. (1985a). Coping with dropouts. *Professional Psychology: Research and Practice, 16*, 114-123.

Pekarik, G. (1985b). The effects of employing different termination classification criteria in dropout research. *Psychotherapy, 22*, 86-91.

Pekarik, G. (1992). Posttreatment adjustment of clients who drop out early vs. late in treatment. *Journal of Clinical Psychology, 48*, 379-387.

Pekarik, G., & Finney-Owen, K. (1987). Outpatient clinic therapist attitudes and beliefs relevant to client dropout. *Community Mental Health Journal, 22*, 120-130.

Phillips, E. L. (1985). *Psychotherapy revised: New frontiers in research and practice.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.

Pulakos, J., & Morris, J.D. (1995). Waiting list dropouts: An evaluation. *Journal of College Student Development, 36*, 603-604.

Reiher, T.C., Romans, J.S.C., Anderson, P., & Culha, M. (1992). Clients who don't return following intake: A replication and extension. *Journal of College Student Development, 33*, 473-474.

Richmond, R. (1992). Discriminating variables among psychotherapy dropouts from a psychological training clinic. *Professional Psychology: Research and Practice, 23*, 123-130.

Rodolfa, E.R., Rapaport, R., & Lee, V.E. (1983). Variables related to premature terminations in a university counseling service. *Journal of Counseling Psychology, 30*, 87-90.

Rogler, L.H. (1983). *A conceptual framework for mental health research on hispanic populations* (National Institute of Mental Health Center for Minority Group Mental Health Program Monograph No. 10). Bronx, NY: Fordham University, Hispanic Research Center.

Seligman, M.E.P. (1995). The effectiveness of psychotherapy: The consumer Reports study. *American Psychologist, 50*, 965-974.

Shaffer, D., Gould, M.S., Brasio, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (C-GAS). *Archives of General Psychiatry, 40*, 1228-1231.

Smith, K.J., Subich, L.M., & Kalodner, C. (1995). The transtheoretical model's stages and processes of change and their relation to premature termination. *Journal of Counseling Psychology, 42*, 34-39.

Sparrow, S., Balla, D., & Cicchetti, D. (1985). *Vineland Adaptive Behavior Scales survey form manual.* Circle Pines, MN: American Guidance Service.

Strong, S.R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*, 215-224.

Sue, D.W. (1977). Community mental health services to minority groups – some optimism, some pessimism. *American Psychologist, 32*, 616-624.

Tinsley, H.E.A., Workman, K.R., & Kass, R.A. (1980). Factor analysis of the domain of client expectancies about counseling. *Journal of Counseling Psychology, 27*, 561-570.

Tracey, T.J. (1986). Interactional correlates of premature termination. *Journal of Consulting and Clinical Psychology, 54*, 45-51.

Tracey, T.J. (1988). Relationship of responsibility attribution congruence to psychotherapy outcome. *Journal of Social and Clinical Psychology, 7*, 131-146.

Trepka, C. (1986). Attrition from an out-patient psychology clinic. *British Journal of Medical Psychology, 59*, 181-186.

Tryon, G. S. (1984). Effects of client and counselor sex on client attendance at counseling. *Sex Roles, 10*, 387-393.

Tryon, G.S. (1989). A study of engagement and premature termination in a university counseling center. *Counseling Psychology Quarterly, 2*, 419-429.

Tryon, G.S. (2002). Engagement in counseling. In G.S. Tryon (Ed.), *Counseling based on process research: Applying What We Know* (pp. 1-26). Boston: Allyn & Bacon.

Tryon, G.S. & Kane, A.S. (1990). The helping alliance and premature termination. *Counseling Psychology Quarterly, 3*, 233-238.

Tryon, G.S., & Kane, A.S. (1993). Relationship of working alliance to mutual and unilateral termination. *Journal of Counseling Psychology, 40*, 33-36.

Tryon, G.S., & Kane, A.S. (1995). Client involvement, working alliance, and type of termination. *Psychotherapy Research, 5*, 189-198.

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

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

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*, 190-195.