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FACTORS RELATED TO DISCONTINUATION AT SEVERAL PHASES OF CLINIC CONTACT

by

Barry Richard Lindstrom

A Dissertation Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

August

1986

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ACKNOWLEDGEMENTS

I would like to express my appreciation for the time and effort of those who have contributed to the completion of this dissertation. I would like to thank Joseph A. Durlak, Ph.D., my director, for his guidance and encouragement, and especially for his help in editing the many drafts of this manuscript. I would like to thank Cliff Kaspar, Ph.D., for his cooperation as Director of the Doyle Center and for serving as a reader and Alan S. DeWolfe, Ph.D., and Thomas Pallmeyer, Ph.D., for their helpful comments as readers. I would like to thank the staff at the Doyle Center for their support and cooperation in this study and Ralph Levinson, Ph.D., in particular for his help in initiating this research at the clinic.

I would also like to thank my family for their encouragement and support of all my endeavors. Specifically, I would like to thank my wife, Bonnie, to whom this is dedicated, for her perspective and understanding.

VITA

The author, Barry Richard Lindstrom, is the son of Mr. and Mrs. Wallace H. Lindstrom. He was born June 2, 1959, in Denver, Colorado. His elementary education was obtained in the public schools of Denver, Colorado, and San Diego, California. His secondary education was completed in 1977 at John Marshall High School, Milwaukee, Wisconsin.

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CHAPTER I

INTRODUCTION

This study was conducted as an initial program evaluation at a Child Guidance Clinic affiliated with a large urban university in the midwest, with the author acting as consultant to the staff. Atkisson, Brown and Hargreaves (1978) describe four progressively evolving levels of evaluation activity: (a) Systems resource management, (b) client utilization, (c) outcome of intervention and (d) community impact. This study addresses the Clinic staff's questions regarding the second level of evaluation, client utilization of services.

Premature termination, or "dropout," from clinic contact is a concern in most, if not all, clinic settings. Several years ago, a program evaluation committee was formed at the Clinic to investigate premature termination at each phase of clinic contact. As a result, new forms were developed to record case disposition and related information at several phases of clinic contact. Until the time of this study, the data these forms contain had not been collated or analyzed and the consistency with which this information had been recorded was unknown. The present study was conducted in order to address this need.

Specifically, the questions addressed by this program evaluation were:

1. What are the characteristics of the clinic population with

which the Clinic has contact?

2. What proportion of clients continue at each phase of clinic contact? What are the specific dispositions of those clients that discontinue at each phase? In particular, what proportion of clients terminate unilaterally at each phase of clinic contact?

3. What factors, if any, predict premature (unilateral) termination at each phase of clinic contact?

4. How adequate are present record keeping procedures in addressing these questions?

Given the limited degree to which psychotherapy research is utilized in clinical practice (e.g., Morrow-Bradley & Elliot; Sargent & Cohen, 1983) and the need for the evaluation of the utility of program evaluation findings (Davis & Salasin, 1975), an additional question regarding the impact of the evaluation process was addressed by the author. That is, "What are the staff's expectations and opinions regarding the utility of the evaluation process for making decisions regarding the Clinic's service and training policies?" In other words, would the clinic staff act upon the recommendations based upon the findings of this study that pertained to clinic procedures or policies.

The general purpose, therefore, of the present study was to describe patterns of client utilization of service and to evaluate factors affecting these patterns. Specifically, the percentage of clients discontinuing at several phases of clinic contact and factors affecting discontinuation were investigated. Additionally, the utility of this

evaluation for the clinic staff and decision making processes was evaluated. The present study thus addresses the clinic staff's questions about client utilization and assesses the impact of so doing.

CHAPTER II

LITERATURE REVIEW

Premature termination from treatment has been investigated under the various labels of "attrition," "dropout," "defection," and its converse, "engagement in treatment," with a diversity of operational definitions. In order to avoid the pejorative and often erroneous connotations of terms such as "dropout," the present paper will use the terms _continuers_ and _discontinuers_ to refer to clients who continue in or terminate from clinic contact, respectively, unless discussing definitions used in specific studies. Similarly, because not all early terminations are indeed "premature," the term _discontinuation_ will be used to describe this clinic process and area of research. Discontinuation can occur at several phases in the clinic process (e.g., intake, diagnostic assessment, therapy). In order to avoid confusion, the present review will use "discontinuation from _clinic contact_" to discuss discontinuation in general and "discontinuation from _therapy_" only when referring to that specific phase of clinic contact.

The majority of research on discontinuation from clinic contact has focused on individual adult clients and has been reviewed elsewhere (Baekeland & Lundwall, 1975; Brandt, 1965). The present review of the literature will focus on studies evaluating discontinuation from child,

adolescent, or family treatment (the primary modalities used at the Clinic). Studies on discontinuation from "Parent Training" as an approach to child treatment have been reviewed elsewhere (Forehand, Middlebrook, Rogers & Steffe, 1983) and will not be considered here.

Overview of Prior Research

Most studies of discontinuation have sought to distinguish clients who discontinue clinic contact from those who continue based on retrospective investigation of variables related to the client (e.g., demographic, diagnostic or personality characteristics and expectations or motivation), the therapist (e,g, experience, orientation), and clinic and therapy processes (e.g., frequency of sessions, amount of time on waiting list). A few studies have measured client's expectations (e.g., Plunkett, 1984) or therapist's predictions (e.g., Gaines & Stedman, 1981) prospectively and some have conducted follow-up studies to determine clients' reasons for discontinuation (e.g., Farley, Peterson & Spanos, 1975; Lowman, Delange, Roberts & Brady, 1984; Richardson & Cohen, 1968).

Unfortunately, two major and related methodological problems have plagued the research on factors related to discontinuation from clinic contact. The first problem is the different operational definitions of discontinuers utilized by investigators. The second concerns the different phases of clinic contact at which discontinuation is investigated (e.g., initial inquiry, intake, diagnostic evaluation, therapy).

Two types of operational definitions for "dropouts" have been employed. Most commonly, researchers have defined discontinuers numerically, according to the number of sessions attended (e.g., Cole & Magnussen, 1967; Levitt, 1957, 1958; McAdoo & Roeske, 1973; Plunkett, 1984; Ross & Lacey, 1961). The cutoff points utilized have varied from study to study and appear, in many cases, to have been arbitrarily determined. Other studies have defined discontinuers clinically, on the basis of how they terminated from treatment (either *unilaterally*, against the advice of the therapist or clinic, or *mutually*, with the consent or recommendation of the therapist or clinic; e.g., Beitchman & Dielman, 1983; Gaines & Stedman, 1981; Novick, Benson, & Rembar, 1981; Singh, Janes, & Schechtman, 1982; Tuckman & Lavell, 1959). These definitions are not, however, equivalent or interchangeable. Morrow, Del Gaudio and Carpenter (1977) found a marked lack of agreement between numerical definitions (using mean and median number of sessions as cutoffs) and a clinical definition (unilateral vs. mutual termination) in the classification of clients as discontinuers. In general, then, clients who either fail to attend some minimal and often arbitrary number of sessions or terminate against the therapist's advice are labelled "dropouts."

A second methodological problem is the point of clinic contact at which continuers and discontinuers are compared. Studies have varied as to whether they have examined clients who failed to attend scheduled intake appointments (e.g., Gaines, 1978), dropped out during (e.g., Cohen & Richardson, 1970) or after (e.g., McAdoo & Roeske, 1973) the

diagnostic phase, "defected" from a treatment waiting list after an evaluation interview (e.g., Magder & Werry, 1966), or dropped out at some time during treatment (e.g., Gaines & Stedman, 1981). In general, the phase of clinic contact is arbitrarily determined in studies using numerical definitions of discontinuers. Some studies using clinical definitions have controlled for the phase of clinic contact (e.g., Gaines & Stedman, 1981; Tuckman & Lavell, 1959) but others have combined discontinuers across several phases of clinic contact (e.g., Novick et al., 1981; Singh et al., 1982). Combining discontinuers across phases creates heterogeneous groups and limits the likelihood and interpretability of significant findings. If the discontinuer group contains clients who discontinued after intake and after the diagnostic phase, for example, it is difficult to determine whether significant factors distinguish clients who discontinued after one or both of these phases. Also, the effects of factors strongly related to discontinuation at one phase may be masked when several phases are combined. Several investigators have suggested that different factors may affect discontinuation at different phases of clinic contact (Cohen & Richardson,1970; Tuckman & Lavell, 1959; Viale-Val, Rosenthal, Curtiss & Marohn, 1984). Few studies, however, have systematically and effectively controlled for the phase of clinic contact within an individual study. Thus, a systematic investigation of factors affecting discontinuation after each phase of clinic contact is needed.

The Present Review

The present review of the literature focuses on factors affecting discontinuation at four phases of clinic contact (initial inquiry, intake appointment, diagnostic evaluation, and therapy). It is difficult, however, to categorize all studies according to this schema because some studies do not differentiate between each phase of clinic contact and therefore compare groups across several phases. In order to be conservative, the review considers heterogenous groups of discontinuers at the lowest level of continuation. For example, if a group of discontinuers contains clients who either failed to attend the intake appointment or dropped out of the diagnostic phase it will be reviewed in the discussion of clients who failed to attend the intake appointment. It is felt that such an approach will be conservative because the client groups will become increasingly homogeneous as the comparisons move toward the therapy stage of clinic contact.

Studies included in the following review examined factors related to discontinuation from clinic contact in child, adolescent or family therapy. This review is extensive, if not exhaustive, and is considered to be representative of the research on discontinuation in these treatment populations. The phase of clinic contact investigated and the methodological problems of the studies reviewed are summarized in Table 1. The findings of several studies presented in Table 1 will not be considered in this review, however, due to methodological problems or the inability to classify them according to the present schema. The

TABLE 1

Summary of Studies Reviewed

Senior Author	Year	Phase of Clinic Contact[a]	Methodological Problems
Gaines	1978	I	
Lowman	1984	I	1: (0/2 or more)
Viale-Val	1984	I, II, III, IV	1: (0,1-3,4-16,17+), 2, 3, 4, 5
Cohen	1970	II, IV	5, 6
Lake	1960	II	5
Ewalt	1972	II	7, 8
Tuckman	1959	II, III, IV	3, 4, 5, 9, 10
Madger	1966	III	5, 11
Levitt	1957	III	1: (0/20)[b]
Levitt	1958	III	1: (0/5)[b]
Cole	1967	III	1: (4/12)[b], 5
McAdoo	1973	III	1: (0/5)[b]
Plunkett	1984	III	1: (8 weeks)[b], 8, 12
Ross	1961	III	1: (5/16)[b]
Hunt	1962	III	7
Blechman	1981	III	9, 12
Williams	1964	III, IV	5

Note. Table 1 continues on following page.

TABLE 1 (continued)

Summary of Studies Reviewed

Senior Author	Year	Phase of Clinic Contact[a]	Methodological Problems
Gaines	1981	IV	3, 5
Beitchman	1983	IV	13
Novick	1981	I-IV[c]	5, 7
Singh	1982	I-IV[c]	3, 5, 6, 7, 9, 10

[a] Phase at which discontinuation from clinic contact was investigated: I = Initial Inquiry (phone contact); II = Intake appointment; III = Diagnostic Evaluation; IV = Therapy.
[b] After completing diagnostic phase of clinic contact.
[c] No distinction made between phases of clinic contact: Mutual vs. Unilateral termination compared across all four phases combined.

Key to methodological problems:
1 = Definition of discontinuers based on arbitrary number of sessions (No. for discontinuers / No. for continuers).
2 = Clinical & numerical definition of discontinuers combined.
3 = Inclusion of subjects still in treatment as continuers.
4 = Polytomous criterion variable(s) without followup analysis.
5 = Polytomous predictor variable(s) without followup analysis.
6 = Control group of unknown composition.
7 = Discontinuers compared across phases.
8 = Inclusion of subjects who received therapy elsewhere.
9 = Inclusion of subjects who were referred out.
10 = Inclusion of subjects who moved, were institutionalized, etc.
11 = No follow-up on whether clients actually entered therapy.
12 = Inclusion of subjects who did not need further treatment.
13 = Questionable analysis.

study by Magder and Werry (1966) will be excluded from the review because the authors categorized clients' placed on a waiting list after an assessment interview according to their response to a telephone inquiry (whether or not they were still prepared to accept treatment for their child when it would be offered) rather than according to whether or not they actually came in for therapy. This method was not utilized by any other study and it cannot be assumed that clients' verbal response and later behavior would have been equivalent. The studies of Novick et al. (1981) and Singh et al. (1984) will be excluded from consideration because they did not control for phase of clinic contact and cannot be categorized according to the present schema.

The review of the specific findings will proceed according to the phase of clinic contact investigated. Methodological limitations of each study will also be discussed where appropriate. A summary of these methodological problems and related issues will be presented in the Summary and Conclusions section following this detailed review. The reader may wish to proceed directly to this section.

Discontinuation During the Initiation of Treatment

Studies investigating variables affecting discontinuation from treatment during the intial stages of treatment (e.g., initial inquiry, intake, diagnostic evaluation) will be considered in this section. That is, clients who discontinue after their Initial Inquiry (fail to attend the intake appointment) or discontinue after the intake or during the diagnostic phases of clinic contact. Table 2 shows the variables examined at these phases of clinic contact in the studies reviewed.

TABLE 2

Variables Affecting[a] Discontinuation During the

Initiation of Treatment

	Senior Author and Year of Study							
	Fail to Attend Intake			After Intake/ During Diagnostic				
Variable	Gaines '78	Lowman '84	Viale-Val '84	Cohen '70	Lake '60	Ewalt '72	Tuckman '59	Viale-Val '84
Child's:								
Age (child/adol)			0[b]	0	M	+	0	0
Sex		+	0	M			0	
Birth Order				0	0[c]			
School				+[d]				
Grade				0				
Diagnosis:							+[e]	
In-External			0[f]	+[g]				0
Specific Problems						+[h]		
Family:								
Race			+	0			0	+
SES	0		+	0[j]	+			+
No. Parents in home				+	0[k]	0[l]	+[m]	
No. Siblings				0	0[c]			
Parents:								
Age		+				0		
Religion				0	0[c]		0[n]	
Motivation					+	+		
Attitude twd. agency					+	+		
Attitude twd. child				+[p]				

Note. Table 2 continues on following page.

TABLE 2 (continued)
Variables Affecting[a] Discontinuation During the Initiation of Treatment

Variable	Fail to Attend Intake			After Intake/ During Diagnostic				
	Gaines '78	Lowman '84	Viale-Val '84	Cohen '70	Lake '60	Ewalt '72	Tuckman '59	Viale-Val '84
Distance to clinic	0			0			+[q]	
Referral source:	0[r]		0[r]	0[r]		0	+	0[r]
Parent attitude twd.		0			0	0		0
Child attitude twd.			+[b]					+[b]
Treatment:								
Waiting list	0			+	0			
No. parents involved	0				0			
Previous treatment			+	0		0		+
Frequency			+					+
No. staff involved[s]				0				

[a] + = significant, 0 = nonsignificant, M = matching variable.
[b] Adolescent population only.
[c] Test of similarity for matched groups, not significant.
[d] Public vs. private.
[e] Number of categories (more than 3).
[f] Also includes school problems vs. suicidal behavior, but is unclear.
[g] Affective syndromes.
[h] Is stubborn. (displays of anger, fights outside home not significant).
[j] Income.
[k] Marital Status.
[l] Adoptive or stepmother in home.
[m] Living arrangement (No. parents; relatives; institution; foster home).
[n] Whites only.
[p] Post-hoc ratings from case records.
[q] City resident/not.
[r] Coercive/non coercive.
[s] Staff turnover, and no. trainees on case.

Discontinuation After Initial Inquiry. Only three of the studies reviewed examined clients who failed to show up for the initial appointment (Gaines, 1978; Lowman et al., 1984; Viale-Val et al., 1984). None of the variables examined in the first two studies overlapped. Gaines (1978) reported that Socioeconomic status (SES), number of weeks on the waiting list, approximate distance from the clinic, and coercivness of the referral source were not significantly related to attendance at an initial family evaluation session. Lowman et al. (1984) reported that clients (families) who made an initial inquiry but did not attened any sessions had children who were female, in higher grades, exhibited more behavioral than personality problems and had older parents. The study by Viale-Val et al. (1984) included only adolescents, limiting comparison to the other two studies. Moreover, the Viale-Val et al. (1984) study has several important methodological limitations. Because disposition was used as one criterion variable with four levels (one for each point of discontinuation), it is difficult to determine which variables are significant at which point of clinic contact. Rather than comparing discontinuers and continuers at each phase of clinic contact, Viale-Val et al. (1984) made one overall comparison of four groups of clients. Given this analysis, a variable that is significantly related to overall disposition cannot be assumed to be significant at each phase of clinic contact. In spite of the limitations of their study, Viale-Val et al. (1984) concluded that adolescents who failed their initial appointments were more likely to be white, lower class (V), and had a history of pre-

vious outpatient treatment and a negative attitude toward the referral. Conclusions from this study regarding the relationship between discontinuation and SES are further limited by the fact that 95% of the sample was from levels IV and V.

In sum, it is difficult to draw any conclusions about clients who fail to show up for their initial appointment based on these the studies because of their limited number, the lack of overlap among the variables and treatments examined and methodological problems.

Discontinuation After Intake or During the Diagnostic. It was not possible, in the studies reviewed, to distinguish between clients who prematurely terminate after the intake interview and those who terminate at some point during the diagnostic evaluation. This was due, in part, to lack of information about or differences between clinic procedures.

Clients who discontinue after Intake or during the Diagnostic phase do not appear to differ systematically from those who continue on the variables examined. The child's age distinguished between discontinuers and continuers during the diagnostic phase in only one out of four studies examining this variable. Ewalt, Cohen and Harmatz (1972) reported that discontinuers were more likely to be 12-years-old or older. The child's sex was not a significant determinant of discontinuation in any study at this phase. One study used age and sex as a matching variable (Lake & Levenger, 1960). Race was a significant factor in only one of the four studies examining this variable at this phase of treatment (Viale-Val et al., 1984). Clients from lower SES groups were

more likely to discontinue in both of the studies assessing this variable at this phase (Lake & Levinger, 1960; Viale-Val et al, 1984). This should be interpreted with caution, however, because Lake & Levinger (1960) did not describe their sample and Viale-Val et al. (1984) reported that 95% of their sample was from the two lowest levels of SES (IV & V). Moreover, Cohen and Richardson (1970) reported that family income was not significant at this phase of clinic contact.

Family composition was investigated in several ways with different findings. Cohen and Richardson (1970) reported that the number of parents in the home, but not the number of siblings, was related to discontinuation at this phase. Interpretation of this finding is limited, however, because the control group was defined as cases that did not terminate unilaterally. It was unclear if this deinition included cases that were referred out or discontinued for reasons other than mutual termination. The presence of a step-parent in the home was significantly related to discontinuation in one study (Tuckman & Lavell, 1959) but not in another (step- or adoptive mother only; Ewalt et al., 1972). Tuckman and Lavell (1959) do not report what analysis they conducted, however, making it difficult to evaluate their conclusions. Moreover, the criterion variable was polytomous (more than two categories: continued, client terminated and clinic terminated) and it is unclear which categories were significantly different. Furthermore, the clinic terminated group was very heterogeneous, consisting of clients who were referred elsewhere or were no longer "eligible" for service. This group

was not equivalent to those in other studies and the exclusion of these clients from the analysis would have been more appropriate. Living arrangement (family composition) was also a polytomous variable making it difficult to determine which categories were significantly different. In the absence of any follow up analyses the only conclusion that can be drawn is that living arrangement and dispostion after intake are associated. Parents' religion was not significant in either study investigating this factor (Cohen & Richardson, 1970; Tuckman & Lavell, 1959).

Parents' attitudes toward the clinic (Ewalt et al., 1972; Lake & Levenger, 1960) and toward the child (Cohen & Richardson, 1970; Lake & Levenger, 1960) were significantly related to discontinuation. The studies of Lake and Levenger (1960) and Ewalt et al. (1972) both developed composite indices to predict continuation in treatment. Lake and Levenger (1960) reported that discontinuers were less likely to be cooperative during the interview or to agree with the interviewer regarding the nature of the child's disturbance. Lake and Levenger (1960) reported that discontinuers were less aware of their child's disturbance and of their contribution to its occurrence. They were also less likely to see the problem as something for which the family as a whole was responsible, and in which they had to participate to find a solution (Lake & Levenger, 1960). Similarly, Ewalt et al. (1972) reported that parents who reported that the desire only for a modification of the child or the environment and were worried more about pressure from community authorities than about the effect of the problem on the child were less likely

to continue. Although Ewalt et al.'s (1972) findings are intuitively appealing and bear consideration, there are several limitations to this study. Most importantly, the client groups are poorly defined. The discontinuer group contained clients who dropped out at multiple points of clinic contact and the continuer group included clients who received treatment at other clinics. Interpretation of these findings is greatly hampered by these limitations.

The type presenting problem was insufficiently investiagted to draw any firm conclusions. Cohen and Richardson (1970) reported that discontinuers were more likely to present complaints of the "affective type" (p. 80) and Tuckman and Lavell (1959) reported that discontinuers tended to have more than three categories of presenting problems. Unfortunately, these two studies appear to be addressing different dimensions of the presenting problem, type and severity. Moreover, no one has investigated the possible interactions between presenting problems or diagnosis, duration and discontinuation.

Distance from the clinic was not significant in one study (Cohen & Richardson, 1970) and was only significant for one of three measures in another study (city resident/non resident; Tuckman & Lavell, 1959). Findings related to the referral source were also contradictory. Discontinuers were reported to have been ill prepared or pressured by the referral in one study (Cohen & Richardson, 1970). Other studies found no differences in the source of referral (Tuckman & Lavell, 1959; Ewalt et al., 1972) or in the client's attitude toward the referral (Ewalt et

al., 1972; Lake & Levenger, 1960). Viale-Val et al. (1984) reported that adolescent clients' attitude toward the referral was a significant indicator of discontinuation during this phase.

Few variables related to the treatment process were examined at this phase in treatment. A history of previous treatment was significant for an adolescent population (discontinuers were less likely to have had previous therapy; Viale-Val et al., 1984) but not for a more general clinic populations (Cohen & Richardson, 1970; Ewalt et al., 1972). The amount of time on a waiting list was significant in one (Cohen & Richardson, 1970) study but not in another (Lake & Levenger, 1960). The number of parents involved in treatment was not significant in the one study that examined this variable (Lake & Levenger, 1960). The number of trainees involved in a case was not significant in the only study examining this variable (Cohen & Richardson, 1970).

In sum, the child's age, sex and race appear to be poor predictors of discontinuation at this phase of clinic contact; findings related to family composition are contradictory. SES was significant in two studies but these findings are questionable and need further cross validation. Parents' religion, the family's distance from the clinic, and the source of referral appear to have little relationship to discontinuation. Parents' attitudes toward their child and the clinic appear to be most likely to be related to discontinuation at this point. Parents who discontinued tended to be less cooperative, less internally motivated to seek help, and less aware of their child's problems. These variables

need further investigation, however, particularly in interaction with other variables before any firm conclusions can be drawn. Variables related to the clinic process were not sufficiently studied at this phase. Parental attitudes do appear to be important, however, and may interact with factors related to the clinic process.

Discontinuation After the Diagnostic

Studies comparing clients who complete the Intake and Diagnostic phases and subsequently do or do not continue into therapy will be discussed in this section. Studies examining discontinuation after the diagnostic phase have varied in their approach. Some studies have simply examined whether or not clients began therapy and others have examined whether clients have continued on for some minimum number of sessions. Table 3 shows the variables affecting discontinuation after the diagnostic phase investigated in the studies reviewed.

Findings related to discontinuation after the diagnostic phase are also contradictory. Interpretation of these findings is hindered by the range of sessions used to define this phase of clinic contact. For example, cases considered to have been "dropouts" could have had from four (e.g., Levit, 1957, 1958) to as many as 12 (e.g., McAdoo & Roeske, 1973) diagnostic sessions before being labelled discontinuers. Secondly, the fact that many of the clients in these studies attended a large number of diagnostic sessions (e.g., McAdoo and Roeske 1972) may limit the amount or generalizability of significant findings. There may be fewer differences between discontinuers and continuers after both groups have attended many diagnostic sessions.

TABLE 3

Variables Affecting[a] Discontinuation After the

Diagnostic Phase of Clinic Contact

	Senior Author and Year of Study								
Variable	Levitt '58	Cole '67	McAdoo '73	Ross '61	Hunt '62	Blechman '81	Viale-Val '84	Tuckman '59	Williams '64
Child's:									
Age (child/adol)		M	M	0	0		0[x]	0	+[b]
Sex		C	M	C	0			0	0
Birth Order									+[c]
School									0[d]
Grade									0
Diagnosis:		0[e]	M[f]					+[g]	
In-External							0		
Duration		+[h]	+[j]						
Severity	0[k]								
Specific Problems			0[l]	+[m]					
Family:									
Race				0			+	0	0[n]
SES		M[p]	M	0[p]	+	+[q]	+		0[n]
No. Parents in home			M[r]					0[s]	0[n]
No. Siblings			0[t]			+			0[n]
Parents:									
Age		M	0[t]						
Religion								+[u]	+[c]
Motivation	0[k]								
Distance to clinic			0[t]					+[v]	

Note. Table 3 continues on following page.

TABLE 3 (continued)
Variables Affecting[a] Discontinuation After the

Diagnostic Phase of Clinic Contact

Variable	Levitt '58	Cole '67	McAdoo '73	Ross '61	Hunt '62	Blechman '81	Viale-Val '84	Tuckman '59	Williams '64
Referral source:			0[t]	0			0[w]	+	0[c]
Parent attitude twd.							0		
Child attitude twd.							+[x]		
Treatment:									
Waiting list		+	0	+					
No. parents involved		+		+					
Previous treatment				0			+		
Frequency							+		

a + = significant, 0 = nonsignificant, M = matching variable, C = controlled for this variable by selection (e.g., boys only).
b Between clients who completed treatment and those who failed to begin.
c Between clients who lost contact before receiving recommendations or refused recommendations and those who entered therapy. Not clients who accepted recommendations but failed to begin therapy.
d Public vs. private.
e Nine categories, not given.
f On broad categories (psychotic, neurotic etc.)
g Number of categories (more than 3).
h 6 months. j 1 year.
k Post-hoc ratings from case records.
l Developmental difficulties, "unusual" behavior.
m Developmental difficulties, "unusual" behavior, somatic disorders, and truancy (runaway, antisocial behavior not significant).
n Distinguished clients who lost contact with agency before Dx feedback.
p Income. q "Occupational prestige."
r Marital Status.
s Living arrangement (No. parents; relatives, institution; foster home).
t Test of similarity for matched groups, not significant.
u Whites only.
v Near/far, same/other health district.
w Coercive/non coercive.
x Adolescents only.

The child's age does not appear to be related to discontinuation at this phase of treatment. Williams and Pollack (1964) were the only investigators to report significant findings for the child's age. Clients who failed to begin therapy were more likely to be in the over-14-year-old group than clients who entered and later completed therapy (Williams & Pollack, 1964). This study compared six disposition groups on multiple variables and the authors note that the few significant differences found may be attributable to chance (Williams & Pollack, 1964). Similarly, the child's sex was not significant for any of the three studies examining this variable at this stage. Several studies either matched subjects by age and sex or controlled for sex by using only males (see Table 3). The child's birth order distinguished clients who refused the offer of treatment or did not maintain contact after the diagnostic from those who entered treatment (Williams & Pollack, 1964). Race did not significantly distinguish between those who did and did not continue into treatment in any study. Williams and Pollack (1964) reported that race distinguished only those clients who lost contact with the agency before receiving the diagnostic feedback and did not, therefore, enter treatment.

Findings regarding SES are also contradictory. Based on a comparison of clients who did and did not enter enter treatment, Hunt (1962) concluded that "entrance into psychotherapeutic treatment is strongly related to occupational status and that specific disposition of cases is similarly related" (p. 209). Unfortunately, the relationship between

SES and specific disposition was not statistically tested. Hunt (1962) notes that the differences between the treatment and no treatment groups was greatest between middle (II) and lower (IV) SES clients; suggesting a non-linear relationship between SES and discontinuation or an interaction between SES and some other factor. Other studies have failed to obtain similar results (Viale-Val et al., 1984). Blechman et al. (1981) reported that "occupational prestige" (as a measure of SES) was significantly related to non-engagement in family therapy.

Viale-Val et al. (1984) reported that "for the intermediate phase of therapy (4-16) sessions few variables were related to termination" (p. 566). This lack of findings may be due to the composition of this group which is unclear and appears dissimilar to those considered at this phase by other studies (numerical and clinical definitions of discontinuers were used but it is unclear which definition was used for which analysis).

Family composition was investigated by two studies. Blechman et al. (1981) reported that families that discontinued tended to have more children. Tuckman and Lavell (1959) reported that living arrangements were not related to discontinuation. Parents' expectations regarding the duration of treatment were significant in the only study to investigate this variable. Clients whose expectations were met were more likely continue (Plunkett, 1984). In addition, parents' expectations regarding the form of treatment showed a similar trend toward significance (Plunkett, 1984). Further examination of the relationship between parents'

expectations and discontinuation in replication of these findings is needed.

The child's overall diagnosis was not significant in the only study addressing this variable (Cole & Magnussen, 1967). The presence or absence of specific presenting problems was significant in some studies although no consistent patterns emerged. For example, antisocial behavior was significant in one study (Blechman et al., 1981) but not another (Ross & Lacey, 1961). Similarly, Ross and Lacey (1961) reported that "developmental difficulties" and "unusual behaviors" were significant factors but McAdoo and Roeske (1973) failed to replicate these findings. Tuckman and Lavell (1959) reported that the number of categories of symptoms was a significant factor, but do not report on the specific categories. The duration of the presenting problem was significant in two studies using different cutoffs. Clients with problems of less than six months' (Cole & Magnussen, 1967) or one year's (McAdoo & Roeske, 1973) duration were more likely to terminate rather than continue past the diagnostic phase. The length of the diagnostic phase in these studies differed.

Findings related to referral source are inconclusive. Referral source was significant in the two studies investigating this factor (Tuckman & Lavell, 1959; Williams & Pollack, 1964). Williams and Pollack (1964) reported that referral source distinguished clients who entered treatment only from those who refused treatment recommendations, however, and not from those who accepted the recommendation and later

failed to continue. Tuckman and Lavell (1959) reported that clients who terminated at this phase were more likely to be referred by the courts. Ross and Lacey (1961) reported, however, that involvement with juvenile court was not a significant predictor of discontinuation at this phase.

Few variables related to the clinic and treatment processes were consistently investigated. The amount of time on a waiting list distinguished discontinuers from continuers in two studies (Cole & Magnussen, 1967; Ross & Lacey, 1961) but not in a third (McAdoo & Roeske, 1973). Cole and Magnussen (1967) reported that a shorter time on the waiting list was related to discontinuation and suggested that willingness to wait was a measure of parental motivation. Two studies reported that the number of parents involved was related to discontinuation, both suggesting that discontinuation was more likely if only one parent was involved (Cole & Magnussen, 1967; Ross & Lacey, 1961). It is unclear, however, if the number of parents living at home was controlled for.

In sum, the child's age, sex and race do not appear to be related to discontinuation at this phase of clinic contact. Findings related to SES, family composition, diagnosis and referral source are inconclusive. The duration of the presenting problem and coerciveness of the referral source were significant in some studies but findings were contradictory and require further cross validation. Interactions among these and other variables should also be investigated. Factors related to the treatment process have been insufficiently studied. It appears, however, that there may be some support for the hypothesis that having two

parents involved (at least at this phase of clinic contact) may mitigate against discontinuation.

Discontinuation From Therapy

Studies considered in this section compared the disposition (terminated unilaterally or completed therapy) of clients who completed any relevant intake and diagnostic procedures, and entered therapy. Table 4 shows the variables related to discontinuation from therapy examined in the studies reviewed.

The findings regarding the relationship between factors related to the child and his or her family and discontinuation during therapy are inconclusive. The child's age and sex were not significant predictors of discontinuation during therapy in any of the four studies assessing these variables. The type of school and the child's grade were not significant in either of the two studies analyzing this variable.

Race was significant in only one (Viale-Val et al., 1984) of the four studies examining this variable. This finding is questionable, however, for several reasons. Viale-Val et al. (1984) examined only adolescents in psychoanalytically oriented therapy using two different defintions of continuers (mutual termination and 17+ sessions). The authors report "contradictory results found when data is analyzed using the two different criteria of unilateral termination and length of treatment," (Viale-Val et al., 1984, p. 566) but do not provide separate results for each definition. It is unclear which definition their results are based on because the authors report their findings only in

TABLE 4

Variables Affecting[a] Discontinuation From Therapy

Variable	Senior Author and Year of Study					
	Gaines '81	Beitchman '83	Tuckman '59	Cohen '70	Viale-Val '84	Williams '64
Child's:						
Age (child/adol)	0		0	0	0[p]	0
Sex	0		0	0		0
Birth Order				0		
School				0[b]		0[b]
Grade						0
Diagnosis:		0[c]	+[d]			
In-External	0[e]			+[f]	0	
Duration	0	0				
Family:						
Race			0	0	+	0
SES	0	+[g]		0[h]	+	0
No. Parents in home	0		+[j]	0		0
No. Siblings				0		+
Parents:						
Religion			0	0		0[k]
Attitude twd. child				+[l]		
Distance to clinic	0		+[m]	0		

Note. Table 4 continues on following page.

TABLE 4 (continued)

Variables Affecting[a] Discontinuation From Therapy

Variable	Gaines '81	Beitchman '83	Tuckman '59	Cohen '70	Viale-Val '84	Williams '64
Referral Source:	+		0	0[n]	0[n]	0
Parent attitude twd.					0	
Child attitude twd.					+[p]	
Treatment:						
Waiting list				0		
Previous treatment				0	+	
Frequency		+[q]			+	
Hospitalization		+[r]				
Attendance at 1st sess.	+					
No. staff involved [s]				0		

[a] + = significant, 0 = nonsignificant.
[b] Public vs. private.
[c] Group for the Advancement of Psychiatry (GAP) schema.
[d] Number of categories (more than 3).
[e] Home vs. school problems
[f] Antisocial behavior.
[g] Significant interaction with hospitalization status and Rx frequency.
[h] Income.
[j] Living arrangement (No.parents; relatives; institution; foster home).
[k] Whites only.
[l] Post-hoc ratings from case records.
[m] City resident/not.
[n] Coercive/non coercive.
[p] Adolescents only.
[q] Significant interaction with hospitalization status.
[r] Significant interaction with diagnosis.
[s] Staff turnover, and no. trainees on case.

terms of "stayability" (Viale-Val et al., 1984, p. 565). Moreover, the validity of these findings is further limited by the authors' inclusion of clients still in therapy as continuers. SES was significant in two of the three studies including this variable (Beitchman & Dielman, 1983; Viale-Val et al., 1984) although the results are questionable in the latter because 95% of the sample was from levels IV and V.

Family composition was measured in several ways. The number of parents living at home was not significant in any of the three studies using this definition. Whether the child lived with parents, relatives or in a foster care or an institution was significant in the one study utilizing this dimension (Tuckman & Lavell, 1959). The number of siblings was significicant in one study (Williams & Pollack, 1964) but not in the other study using this measure (Cohen & Richardson, 1970). The sex of siblings was not significant in the only study to examine this variable (Williams & Pollack, 1964). The child's position in the birth order was not significant in either of the two studies addressing this variable (Cohen & Richardson, 1970; Williams & Pollack, 1964). Parent's religion was not significant in any of the three studies investigating this factor.

Findings regarding presenting problems and diagnosis were mixed. Diagnostic classification according to the Group for the Advancement of Psychiatry (GAP) schema was not significant in the one study using this system. The authors noted that the lack of significant findings may be due to the questionable reliability of this system (Beitchman & Dielman,

1983). No studies used DSM II or III classifications. Of the two studies that examined the internalizing/externalizing dimension one was significant (Viale-Val et al., 1984) and one was not (Gaines & Stedman, 1981). Viale-Val et al. (1984) reported that adolescents who remained in therapy were more likely to have internalizing symptoms. The duration of the presenting problem was not significant in either of the two studies addressing this dimension (Beitchman & Dielman, 1983; Gaines & Stedman, 1981). Two studies addressed the issue of diagnosis idiosyncratically. Cohen and Richardson (1970) reported that discontinuers reported a greater incidence of antisocial behavior as a presenting complaint than did continuers. Tuckman and Lavell (1959) reported that discontinuers tended to have presenting problems in more than three categories. Unfortunately, these categories were not delineated or analyzed individually.

The dimensions of referral source examined differed between studies (actual source, self vs. other, coercive vs. non coercive). Only one of five studies examining referral source reported significant findings. Clients who discontinued were more likely to be referred by "institutions" than be referred by "individuals" or be self-referred (Gaines & Stedman, 1981). Distance from the clinic was only significant in one study out of three and only when defined as whether the family lived within the city limits (Tuckman & Lavell, 1959).

Of the few variables related to the therapist and treatment process examined, none were included in more than one study at this stage.

Staff turnover, re-application for treatment, and the amount of time on a waiting list, were not significant in the one study that addressed these variables (Cohen & Richardson, 1970). The amount of time before the case file was closed and the presence of attempts at follow-up were significant (Cohen & Richardson, 1970). These findings seem trivial, however, because they indicate only that when therapists are uncertain about whether a case has terminated they wait a longer time before closing the file and and make attempts to contact the clients in order to determine the case status. Outpatient clients were less likely to terminate "against medical advice" than clients whose treatment included hospitalization in the one study comparing these treatments (Beitchman & Dielman, 1983). The analysis in this study is, however, questionable. Nonetheless, the authors report that the relationship between treatment type and discontinuation from therapy in this study is best explained by its significant interaction with diagnosis and SES rather than in a linear fashion (Beitchman & Dielman, 1983). Gaines and Stedman (1981) reported that therapist's ratings of the family after the diagnostic phase were related to discontinuation, although therapist's predictions of treatment outcome were not significant. The continued case involvement of the rater may have had a self fullfilling effect. Cases in which the whole family attended the first therapy session were more likely to continue (Gaines & Stedman, 1981).

In sum, it appears that demographic variables are poor predictors of discontinuation during therapy. Variables related to the child's pre-

senting problem and diagnosis, the therapist and the treatment process have been insufficiently studied to draw conclusions about their relationship to discontinuation at this point in clinic contact. Further investigation of the effects of treatment types and modalities, both as main effects and in interaction with other variables, is needed.

Summary and Conclusions

It is difficult to combine and compare the results of the studies reviewed for several reasons. For example, studies have differed on the phase of clinic contact investigated, the definitions of discontinuers and continuers utilized, and the variables investigated. Comparisons between studies are further hindered by the the lack of information provided by many studies. In general, descriptions of subjects, therapists, clinic procedures and type of treatment offered are inadequate. These variables may be significantly related to discontinuation. Treatment type, for example, may differentially affect discontinuation. Shapiro and Budman (1973) report different rates of discontinuation for individual and family therapy. More complete descriptions of the treatments involved in studies of discontinuation are as important in identifying differential effects of treatment type on discontinuation. The same can be said of therapist or treatment process variables. Additionally, many studies neglect to report nonsignificant findings which would aid in the generalization of findings across studies.

Methodological limitations of the research reviewed included confusing or confounded defintions of discontinuers, the combining of sev-

ral phases of clinic contact, and the inclusion of inappropriate subjects. For example, studies have included clients who were referred out or discontinued for reasons other than unilateral termination as discontinuers. Similarly, clients who have discontinued for reasons other than mutually agreed terminations have been included as controls. Also, some studies have included clients who are still in therapy as continuers. This is problematic because these clients may terminate unilaterally later. Thus, clients still in therapy should be excluded because their eventual reasons for discontinuing clinic contact are unknown. Thus, many studies have compared very heterogeneous groups of discontinuers or continuers and often across more than one phase of clinic contact.

Aside from the methodological difficulties summarized above, the lack of consistent findings between studies may reflect real differences between settings, or setting specificity. It is possible that there are few real trends across settings because discontinuation may be more influenced by clinic process factors or the interaction between clients and settings. Studies of discontinuation at multiple sites have, for example, consistently reported large amounts of variability between settings (e.g., Blechman et al., 1981; Tuckman & Lavell, 1959). More investigation of factors related to the clinic processes and the clients' reactions to them is needed, however, to support such a hypothesis.

In sum, it appears that few reliable conclusions can be drawn from the research on discontinuation from clinic contact at child and family clinics. The one consistent trend is that the child's age, sex and race have little association with discontinuation at all phases of clinic contact. There do not appear to be any trends in the types of variables (client variables or clinic variables) that predict discontinuation at different phases of clinic contact. The lack of findings may be due, however, to the lack of replication of variables and insufficent control of the phases of clinic contact across studies. Additionally, there has been insufficient investigation of the setting and type of treatment, and other variables related to clinic and treatment processes.

Before concluding this review, brief mention must be made of one additional issue: The question of whether clients who discontinue treatment "prematurely" should be considered "dropouts" or treatment failures (May, 1984; Papach-Goodsitt, 1985; Pekarik, 1983a; Silverman & Beech, 1979). Several factors would suggest not. Follow-up studies have consistently reported improvement in symptoms as a reason for discontinuation. These findings have held true for child (e.g., Farley, Peterson & Spanos, 1975; Lowman et al., 1984; Richardson & Cohen, 1968) and adult clinic populations (e.g., May, 1984; Papach-Goodsitt, 1985; Pekarik, 1983a, 1983b). It should be noted, however, that studies with child clients have relied solely on parental report of improvement. Because it is possible that the child's improvement was the most socially desir-

able reason for parents to provide for terminating from clinic contact. Future investigations should control for social desirability or rely on more objective measures of improvement. Studies that have assessed pre- and post-therapy adjustment of adult outpatients have found that follow-up adjustment was significantly related to the reasons given for discontinuation as well as the number of sessions attended (May, 1984; Papach-Goodsitt, 1985; Pekarik, 1983a, 1983b). In one study, clients who reported that they dropped out of treatment because they no longer needed service showed greater improvement on the Brief Symptom Inventory than those who dropped out because they disliked the services (Pekarik, 1983a). These findings suggest that not all clients who discontinue clinic contact are dropouts or treatment failures. Such conclusions would seem to be equally plausible for child and family clinic populations, but must await more rigorous replication.

The purpose of this study is twofold. The first is to address two of the methodological problems discussed above--namely, the use of heterogeneous comparison groups and the inadequate control of the phase of clinic contact investigated. This study is designed to investigate the effect of variables related to the child, his or her family and the clinic process on discontinuation (i.e., unilateral termination) from clinic contact. Specifically, several variables investigated by previous studies will be examined including the child's age, sex and presenting problems; his or her family's race, SES, income, composition and geographic location; and the referral source. Given the limited and

contradictory findings in the literature, it is hypothesized that none of these variables will be significantly related to discontinuation. In addition, several variables related to the clinic process will be examined. Specifically, the quarter of the year in which each phase of clinic contact was initiated and the amount of time between phases; whether there were co-therapists; the therapists' discipline, sex and year of training; the supervisor's discipline and whether it was the same as the trainee; the proportion of sessions attended; the diagnostic recommendations and the family's response to the diagnostic feedback; and the discipline of the consultant will be examined. It is hypothesized that these variables will be more predictive of discontinuation than demographic variables. Moreover, this study will look at selected variables at several phases of clinic contact in order to assess the possible interaction between phase of clinic contact and variables that are significantly related to discontinuation. It is hypothesized that the relationship between the variables and discontinuation will vary as a function of the phase of clinic contact investigated.

Secondly, the present study will examine the practical significance of the obtained research findings. That is, to what extent will the clinic staff act upon any recommendations based on the findings of this study that have implications for clinic procedures or policies. The literature suggests that the answer to this question will be negative.

CHAPTER III

METHOD

Setting

This study was conducted at an outpatient Child Guidance Clinic affiliated with a large urban university in the midwest. The clinic is a training site for graduate students in Clinical Psychology and Social Work. The clinic's supervisory staff consists of four male, Ph.D., Psychologists and four female, MSW, Social Workers. The same staff members were employed at the clinic during the two year period of this study. The clinic trains 12 psychology students and 14 social work students each year. Approximately half of the psychology students and about one fourth of the social work students train at the clinic for two years. A pool of approximately 50 different trainees was included in the present study. The sex of the psychology trainees is fairly evenly distributed between males and females, but the majority of social work trainees are female. Overall, approximately 70% of the trainees are female. In the present study 93% of the clients were seen by trainees.

It is the clinic's policy that families must be involved in order for children to receive treatment. Following their initial contact with the clinic (usually by telephone) all clients are referred to the intake worker. If appropriate, clients are scheduled for an intake appointment.

Most of the cases in this study (83%) were interviewed by the same intake worker. Other clinic staff members conducted 12% of the intake interviews and 4% were done by trainees. The intake interview includes taking a history of the presenting problem, a discussion of clinic policy and setting the fee on a sliding scale. After the intake interview a graduate trainee is assigned by the clinic staff as diagnostician for several assessment sessions with the family.

The diagnostic phase varies in length and generally includes obtaining a detailed history of the presenting problem and the child's development, and an assessment of family functioning and enviromental stressors. In most cases information about the parents' own families of origin is also gathered. The diagnostic phase may include psychological testing and/or consultation with outside agenices, most frequently the child's school. After the diagnostic phase is completed, the case is staffed with an outside consultant (either a Social Worker or a Psychiatrist) and treatment recommendations are formalized. Following this staffing, families are given written feedback and recommendations by the diagnostician. Families who agree with recommendations for treatment then begin therapy, either with the diagnostician or a new therapist. Treatment modalities utilized most often include family and marital therapy and individual therapy for the identified patient. Periodically, treatment review staffings are conducted with outside consultants following the process just described. On occasion, psychological testing is done during the therapy phase.

In the present sample, the average number of days between the client's initial telephone contact with the clinic and the scheduled intake appointment was 15 (SD = 22, median = 9, mode = 7). The average length of time between the intake appointment and the first diagnostic session was 24 days (SD = 17, median = 21, mode = 15). Clients who discontinued during the diagnostic phase attended an average of 2.3 diagnostic sessions (SD = 1.6). Clients who discontinued after the diagnostic attended an average of 6.2 diagnostic sessions (SD = 2.2), whereas clients who continued after the diagnostic attended an average of 7 diagnostic sessions (SD = 2.2).

Subjects

The sample for this study included clinic cases scheduled for intake appointments between September, 1983 and December 1985 (N = 240). This time period was chosen in order to provide a representative sample of cases and encompass two full academic years. The beginning date of this study corresponds to the end date of a previous study summarizing the population and case disposition at the clinic (Cliffer & Kaspar, 1984). The end date was was sufficiently removed from the time of data collection to insure that the maximum number of cases could be utilized with the inclusion of few cases that had just initiated clinic contact. Only a few cases were initially excluded from the study. These exclusions involved cases nonrepresentative of the clinic's usual outpatient services and included: cases that were only involved in STEP groups (parent education classes, n = 15), cases in which the child resided at

a residential facility (n = 8) and Day School cases (severely emotionally disturbed children excluded from the public school system who attend a Day School affiliated with the Child Guidance Clinic, n = 8). One additional case was excluded because of lack of intake information. All information was obtained and anonymously recorded from routinely kept clinic records.

Of the 171 cases that attended intake appointments, 62% involved preadolescent children (age 12 or under) and 38% involved adolescents. Thirty-two percent of the "identified patients" were females and 68% were males. Although the Clinic uses the DSM-III diagnostic classification system, formal diagnoses are not made until after the diagnostic phase. For those cases completing the diagnostic phase of clinic contact (n = 100), Axis I diagnoses were recorded in 89% of the cases. Of these; the primary diagnoses were: Parent-Child Problem (17%), Dysthymic Disorder (10%), Anxiety and Adjustment Disorders (18%), Conduct Disorders (21%), Oppositional Disorder (7%), Attention Deficit Disorders (8%), other diagnoses (10%) and "Diagnosis Deferred" (9%). These percentages for age, sex, and diagnosis are typical of Child Guidance Clinic populations.

Single parent families accounted for 46% of the sample, the majority of these families were headed by the mother. An additional 15% of the sample included single parent families that had other adults residing with the family (other relatives or parent's mates). Intact, multigenerational families accounted for 22% of the sample and 11% of the

cases were remarried families. In 6% of the cases the child was not living with either natural parent (this includes foster families and children living with relatives other than their parents). When scaled according to the parents' level of education and employment, the majority of the cases were from middle to lower SES families (Hollingshead scale: I-3%, II-6%, III-35%, IV-34%, V-22%). The majority of the cases were White (60%); 26% of the clients were black, 9% were Hispanic and the remaining 5% of the cases included American Indian, Asian and other racial backgrounds. The most common referral sources for clients were schools (42%) and other mental health facilities (22%). Court and lawyer referrals accounted for 13% of the referrals and Clinic clients referred 6% of the cases. The other referral sources included hospitals, family and friends, the state Department of Child and Family Services (DCFS) and self referred clients.

CHAPTER IV

RESULTS

Clinic Record Keeping

One of the main questions addressed by the present study pertains to the adequacy of the Clinic's current record keeping policies and procedures for addressing questions regarding case disposition and the outcome of clinic contact. Because of the impact of the quality of available data on the interpretation of subsequent analyses this question was addressed first. In particular, the level of utilization of the case disposition forms developed by the Clinic's program evaluation committee was investigated. These forms were implemented in March, 1984 and only those cases for which the use of these forms was possible were included in this analysis.

Record Keeping at Initial Inquiry

Only limited data, including general demographic information and a brief description of the presenting problem, are recorded at the time of the initial telephone contact. At the time of data collection this information had not always been recorded on standardized forms, however, limiting its accessibility. Data were accessible on these forms for only 52% (36/69) of the clients who failed to attend scheduled intake appointments. Furthermore, this sample of cases for whom data were

accessible did not appear to be entirely random. For a portion of the period covered, these data were summarized on telephone contact summary forms (n = 20). Information for other cases was obtained from the standard telephone contact forms used currently by the center (n = 16). Moreover, data were gathered and recorded differently for cases that did and did not attend intake. In the present study, data for clients who did not attend intake were obtained from telephone contact records and data for cases that did attend intake were obtained from intake records. In sum, the data obtained at the time of telephone contact were insufficient, limiting the interpretability of findings regarding clients who fail to attend the intake appointment.

Record Keeping After Intake

There is no clinic disposition form in use after the intake appointment because such information is included on other intake forms. The amount of data available on cases that discontinued after attending the intake appointment was generally limited, particularly for those cases where it was immediately apparent that the case would not be continuing (e.g., the narrative summary of the intake was missing for several of these cases.) The 28 cases that discontinued after the intake appointment were not officially opened as clinic cases and these records were kept separately in the clinic files.

Record Keeping After the Diagnostic

The program evaluation committee developed a disposition form to be completed after the diagnostic phase of clinic contact. Overall, the diagnostic disposition forms were completed in only 33% of the cases. They were completed in 19% of the cases that discontinued during the diagnostic phase, in 43% of the cases that discontinued after the diagnostic phase of clinic contact, and in 33% of the cases that continued after the diagnostic phase. These forms did not appear to be missing in a systematic manner. For cases without these forms, information regarding disposition was usually obtainable from other clinic records, particulary those that contained the standardized outline for diagnostic assessments.

Record Keeping During Therapy

Overall, the disposition forms to be completed at the time of transfer or at the conclusion of treatment were completed in only 48% of the cases. Of the cases that are currently in treatment and have been transferred, the transfer form was completed in 57% of the cases. These forms did not appear to be missing in a systematic manner. For cases without the disposition forms it was often difficult to determine the beginning and end of therapy, and the number of sessions attended. This was particulary difficult for cases that were transfered but did not engage with the new therapist. In most cases these files contained only copies of letters sent to clients inquiring about the desire for service and/or closing the case. The underutilization of the disposition forms

was more problematic at the therapy phase of clinic contact because other records reflecting therapy contact (e.g., monthly progress notes, transfer/closing summaries) are less standardized than at the diagnostic phase.

Reliability of Clinic Records

In order to estimate the consistentcy with which clinical information was recorded on different Clinic forms, 20 files were randomly selected and examined. Information from the case disposition forms (e.g., dates and numbers of sessions, reason for discontinuation) was compared to information recorded on other clinic forms (e.g., Diagnostic assessments, monthly progress notes, transfer/closing summaries.) Information from these different sources was in 90% agreement. Thus, other clinic records seemed to be a reliable source of information for case files that did not contain the case disposition forms. In sum, information obtained from all Clinic records seemed to be reliable indicators of clinical status.

Data Analysis

Criterion Variable

The criterion variable was case disposition, a dichotomous variable indicating whether or not clients continued to maintain involvement with the clinic at each phase of clinic contact. There were five points at which continuation/discontinuation could occurr:

1. Clients could fail to show up for the intial intake appointment.
2. Clients could discontinue after completing the intake

appointment.

3. Clients could discontinue during the diagnostic phase (before the case is staffed with the consultant).

4. Clients could discontinue after the diagnostic phase (after the case is staffed), but before formal treatment begins.

5. Clients could discontinue during therapy.

Overall, case disposition can be examined as a proportion of all cases attending intake appointments and as a proportion of the cases continuing at each phase of clinic contact. These data, and the percentage of cases still in each phase at the time of data collection are presented in Table 5.

An important aspect of case disposition is the specific manner in which clinic contact was discontinued. Clinic forms permit recording of six possible reasons for discontinuing clinic contact:

1. Mutual termination: further treatment not recommended.

2. Mutual termination: further treatment recommended but client cannot make use of treatment at this time.

3. Client withdrew against agency's advice with prior notification.

4. Client withdrew against agency's advice without prior notification.

5. Client referred elsewhere.

6. Other (e.g., client moved).

The disposition for each case and reasons for discontinuation (when appropriate) were determined from information recorded on the case

TABLE 5

Overall Case Disposition

N	Disposition	Percentage of Intakes (N = 171)	Percentage of Phase[a]
240	total cases scheduled for intake		
-69	cases failed to attend intake	---	29
171	cases attended intake		
-28	cases discontinued after intake	16.4	16 (13)[b]
143	cases began diagnostic		
-4	cases still in diagnostic	2.3	
-31	cases discontinued during diagnostic	18.1	22 (16)
108	cases completed diagnostic (staffed)		
-24	cases discontinued after diagnostic	14.0	22 (15)
84	cases entered therapy		
-38	cases still in therapy	22.2	
46	cases discontinued during therapy	27.0	(56)
		TOTAL 100.0	---

[a] Percentage of cases in each disposition as proportion of cases remaining at the beginning of each phase of clinic contact. These do not sum to 100%.

[b] Numbers in parentheses indicate percentage of unilateral terminations.

disposition forms in the clinic files. As discussed above, all case files did not contain disposition information on the forms developed by the Clinic's program evaluation committee. Determination of the case dispositions and the reasons for discontinuing clinic contact for cases without the appropriate forms was made from other written case materials and summaries contained in the clinic files. Moreover, cases for which the reason for discontinuation was not apparent from available case materials were categorized as "Clinic record incomplete." This method of data collection allowed for the reliable and conservative recording of the maximum amount of data available from the clinic files.

The number and percentage of reasons for discontinuation at each phase of clinic contact are presented in Table 6. It can be seen from Table 6 that the majority of terminations from each phase of clinic contact were unilateral.[1] Moreover, these percentages may be underestimated for cases that discontinued during the diagnostic or therapy phases of clinic contact because of the number of cases for which the clinical record was incomplete.

Factors Affecting Discontinuation

Another question addressed by this study was to examine factors affecting discontinuation at each phase of clinic contact. The analysis of these factors compared cases that did and did not continue at each

[1] The percentages recorded in Table 6 reflect the proportion of unilateral terminations out of the cases discontinuing at each phase. The percentages of unilateral terminations out of all cases continuing at each phase are recorded in parentheses in the second column of Table 5.

TABLE 6

Number and Percentage of Reasons for Discontinuation

at Each Phase of Clinic Contact

Reason for Discontinuation	Phase of Discontinuation from Clinic Contact							
	After Intake		During Diagnostic		After Diagnostic		During Therapy	
	N	%	N	%	N	%	N	%
Mutual termination:								
Rx completed	0	0	0	0	0	0	2	4.4
Rx incomplete	1	3.6	0	0	3	12.5	2	4.4
Unilateral termination:								
With notice	7	25.0	11	35.5	10	41.7	16	34.8
Without notice	15	53.6	12	38.7	6	25.0	10	21.7
Referral out	4	14.3	0	0	1	4.2	2	4.4
Other	1	3.6	2	6.2	3	12.5	8	17.1
Clinic record incomplete	0	0	6	19.4	1	4.2	6	13.1
TOTAL:	28	100.0	31	100.0	24	100.0	46	100.0

Note. The reasons for discontinuation correspond to those on the clinic forms for recording case disposition. "Clinic record incomplete" indicates that the disposition form was not completed and the reason for discontinuation was not clear from other materials in the clinic record.

phase of clinic contact--continuers and discontinuers, respectively. For the Initial Inquiry (telephone contact) phase, clients who did and did not attend scheduled intake interviews were compared (clients who were seeking information only or were referred elsewhere were excluded from this analysis).

For the Intake and Diagnostic phases of clinic contact, only those clients who terminated unilaterally (with or without prior notification of the clinic or therapist) were included as discontinuers. That is, cases that were terminated mutually and those that were referred out, discontinued for other reasons or for which the disposition was unclear, were excluded from these analyses. This was done for several reasons. First, there were too few cases in these other dispositions (mutual termination, referral out, other) to make a meaningful comparison of all reasons for discontinuation. Secondly, the inclusion of these cases would create a heterogenous group of discontinuers, limiting interpretation of the findings. Cases that discontinue because they are referred elsewhere, or because clients move should be differentiated from those that terminate unilaterally and these cases should be differentiated from those that terminate mutually. Cases that terminated unilaterally with and without giving prior notification to the clinic were combined because this distinction was not always clearly made and in order to provide sufficient numbers of discontinuers for the analyses.

Cases were only included in analyses of phases that they had completed. For example, clients who were still involved in the Diagnostic phase of clinic contact at the time of data collection were considered only in the analysis of the Initial Inquiry and Intake and phases because their disposition after the Diagnostic phase was unknown. Thus, cases that were still in a given phase at the time of data collection were excluded from the analysis for that phase. As can be seen from Table 5, 24.5% of the sample in the present study were still active cases; 2.3% were still in the diagnostic phase and 22.2% were still in therapy. These criteria for inclusion provided for the maximum number of subjects at each phase of clinic contact without including subjects of unknown or irrelevant disposition; creating homeogeneous groups of fewer clients at each phase of clinic contact.

The factors affecting discontinuation from clinic contact were examined by chi-square analyses. All analyses were done using the Statistical Package for the Social Sciences (SPSS-X R.2) and chi-square values are reported without Yates' correction. The number of subjects reported for each analysis does not equal the total number of subjects at each phase of clinic contact due to missing data on the given predictor variable.

Discontinuation After Initial Inquiry. The 36 cases that failed to attend their scheduled intake for which data were accessible were compared to the 171 cases that attended the intake appointment. As can be seen from Table 7, only one of the eight variables investigated dis-

criminated between continuers and discontinuers at this phase of clinic contact.

The reporting of several different PRESENTING PROBLEMS (drawn from the list of 27 problems on the clinic's most recent intake forms) was statistically significant. If "difficulties in peer relationships," $\underline{X}^2$ (1, $\underline{n}$ = 198) = 5.16, $\underline{p}$<.03, "fearfulness or apprehension," $\underline{X}^2$ (1, $\underline{n}$ = 198) = 5.04, $\underline{p}$<.03, or "discipline problems at home," $\underline{X}^2$ (1, $\underline{n}$ = 198) = 5.47, $\underline{p}$<.02, were reported, there was a greater likelihood that the case would attend the intake appointment. Unfortunately, three statistics significant at the .05 level from the 34 statistics calculated at this phase could easily be attributable to chance ($\underline{p}$<.20, Sakoda, Cohen, & Beall, 1954). Thus, the statistical significance of individual presenting problems at this phase of clinic contact does not appear to be a reliable finding and cannot be accepted with much confidence.

Discontinuation After Intake. The 22 cases that terminated unilaterally after the intake interview were compared to the 143 cases that continued and began the diagnostic phase of clinic contact. As can be seen from Table 7, the clients' RACE was the only significant predictor of discontinuation after intake. White and Black clients did not differ from the expected percentage of clients continuing, but all other races combined were three time more likely to discontinue than White and Black clients, $\underline{X}^2$ (2, $\underline{n}$ = 154) = 8.38, $\underline{p}$<.02. Only 14% of the clinic population falls, however, into this "other" category. Once again, however, the probability of at least one statistic significant at this level by

TABLE 7

Effects of Factors Related to Discontinuation

at Three Phases of Clinic Contact

Variable	Phase of Clinic Contact		
	Initial Inquiry	After Intake	During/After Diagnostic
Child's:			
Age (child/adol)	ns	ns	ns
Sex	ns	ns	ns
Birth Order	--	ns	ns
Presenting Problems:			
Specific problems (27)	*	ns	ns
Number of problems	--	ns	ns
Family:			
Race (W/B/Other)	--	*	**
SES	--	ns	ns
Income	--	ns	*
No. Parents in home	ns	ns	*
No. Children in home	ns	ns	ns
Catchment area	--	--	ns
Referral (school/other)	ns	ns	ns
Quarter clinic phase began	ns	ns	ns
Time to next clinic phase	ns	--	ns
Has child: (yes/no)			
repeated a grade	--	ns	ns
evalauted by board of Ed.	--	ns	ns
had police contact	--	ns	ns
been in Juvinile court	--	ns	ns
had DCFS contact	--	ns	ns
Did family: (yes/no)			
plan to appeal fee	--	ns	ns
have insurance	--	ns	ns
agree to continue	--	ns	ns

Note. ns = not significant, -- = variable not examined at this phase because of incomplete information. *$p<.05$. **$p<.01$.

chance alone from the 46 statistics calculated at this phase of clinic contact does not exceed chance expectations ($p < .50$, Sakoda et al., 1954).

Discontinuation During the Diagnostic. There were no significant differences between clients who terminated unilaterally during (before the staffing, $n = 23$) or after (case was staffed, $n = 16$) the diagnostic phase on the child's age and sex; and the race, SES and composition of the family. Therefore, the 39 cases that discontinued during or after the diagnostic phase were compared to the 84 cases that completed the diagnostic and began therapy at the clinic.

As can be seen from Table 7, the NUMBER OF PARENTS living with the child was significantly related to discontinuation. Cases with two natural and/or step parents living at home were more likely than expected to continue, X^2 (1, $n = 116$) = 4.42, $p < .04$. Standardized residual scores for each cell were not significant, however, suggesting that this effect, although statistically significant, was not strong enough to provide much predictive improvement over base rates of continuation at this phase of clinic contact.

The client's RACE was again significantly related to discontinuation, X^2 (2, $n = 119$) = 9.65, $p < .008$. White and Black clients did not differ significantly from the expected percentage of clients discontinuing after the diagnostic, but all other races combined were less likey to discontinue. This is the opposite of the effect of race on discontinuation after intake. These findings suggest that non-white/non-black

clients are less likely to continue after intake but that, if they do continue, they have a very high likelihood of continuing through the diagnostic phase and beginning therapy.

The client's INCOME and the FEE set at the intake interview were both significantly related to discontinuation at this phase. Because the fee is based on family income, only the effect of income will be discussed. Income was examined as a four level variable (Public aid, up to $10,000, $10-19,999, and over $20,000). Clients who received public assistance were more likely to discontinue, whereas clients with incomes above $20,000 were less likely to discontinue during or after the diagnostic phase, $\underline{X}^2$ (3, $\underline{n}$ = 117) = 8.72, $\underline{p}<.04$. Clients in the two middle categories did not differ from the expected rate of discontinuation.

Table 8 shows several additional variables related to the therapist and clinic process that were used to compare cases that discontinued during or after the diagnostic and those that continued into therapy. None of these variables were significant. Thus, only three variables were significant predictors of discontinuation at this phase of clinic contact. Unfortunately, three significant statistics obtained from the 53 calculated at this phase could easily be attributed to chance ($\underline{p}<.40$, Sakoda et al., 1954). Again, the reliability of these findings is questionable and they cannot be accepted with confidence.

A robust investigation of the effects of the child's presenting problems and diagnostic categorizations was hindered by several problems. During the period covered by this study the Clinic had imple-

TABLE 8

Effects of Factors Related to Discontinuation During or After the Diagnostic Phase

Variable	During/After Diagnostic Combined	After Diagnostic Only
	Phase of Clinic Contact	
Co-Diagnosticans (yes/no)	ns	
Diagnosticians':		
discipline (psyc./soc. wk.)	ns	
year at clinic (first/second)	ns	
sex	ns	
Supervisors' discipline (PhD/MSW)	ns	
same/different from trainee	ns	
Proportion of sessions attended (median)	--	**
Rx Recommendations (yes/no):		
Child/Adolescent	--	ns
Family	--	ns
Marital	--	ns
Couple	--	ns
Response to Feedback (agree/other)	--	**
Consultant (MD/MSW)	--	ns

Note. ns = not significant, -- = variable not examined at this phase because irrelevant or unavailable for this comparison (e.g., clients who discontinued during the diagnostic were not staffed and did not receive feedback.)
** $p < .01$.

mented a new intake form which included a list of 27 specific presenting problems. This list did not contain subscales or categorizations of presenting problems and was available for only 84 cases (49% of the cases attending intake.) Because this list contained a large number of problems, many of which had low rates of occurrence, a preliminary analysis was conducted using ad-hoc subscales considering broad dimensions of presenting problems. Four scores reflecting the presence or absence of: school problems, externalizing problems, internalizing problems, and developmental problems were calculated. None of these problem clusters were significantly related on the basis of chi-square analyses to discontinuation after Intake, or during or after the Diagnostic phase. Although the clinic uses DSM-III diagnostic classifications, formal diagnoses are not made until after the diagnostic phase. This limited the number of cases for which diagnoses were available. As a result there were too few cases in each diagnostic category to conduct meaningful, reliable analyses. The limitations of the above data are important. Larger samples given formal diagnoses and/or the use of psychometrically adequate behavior checklists would have been preferable in investigating the relation between presenting problems and discontinuation.

Discontinuation After the Diagnostic. Table 8 shows the variables that were used to compare only those clients who discontinued after the diagnostic phase (n = 16) and those who continued (n = 84) into therapy. Clients who discontinued during the diagnostic phase were not included

in these analyses because this information was either irrelevant or unavailable for these cases (e.g., cases that discontinued during the diagnostic phase were not staffed and therefore had no consultant or treatment recommendations.) As can be seen from Table 8, the PROPORTION of SESSIONS ATTENDED was significantly related to discontinuation. Clients who attended fewer than 80% (the median percentage of sessions attended) of the scheduled diagnostic sessions were nine times more likely to discontinue than those who attened better than 80% of the sessions, X^2 (1, n = 66) = 7.60, $p < .006$.

The clients' RESPONSE to the DIAGNOSTIC FEEDBACK was also significant. Clients who did not "agree" with the feedback from the diagnostic case staffing (i.e., "agreed in part" or "wished to review" the feedback) were six times more likely to discontinue after the diagnostic than those who agreed with the feedback, X^2 (1, n = 80) = 11.34, $p < .0008$. (Clients who "wished to review" the feedback, n = 6, were the least likely to continue after the diagnostic but there were too few cases to analyze the specific responses to the feedback.) Nevertheless, these findings suggest that the clients' response to the diagnostic feedback is an important predictor of continuation into therapy.

An examination of the standardized residuals for each cell (observed value minus expected value divided by the square root of the expected value) showed both of these variables to be strong predictors of continuation after the diagnostic phase of clinic contact. Moreover, the probability of obtaining two significant statistics at this level by

chance alone from the seven statistics calculated at this phase is small ($p<.001$, Sakoda et al., 1954). Thus, the proportion of sessions attended and clients' response to the diagnostic feedback appear to be strong, reliable findings.

Discontinuation From Therapy. Because there is no next phase into which clients can continue after the Therapy phase of clinic contact, the logical comparison groups at this phase would have been cases which terminated mutually and those that terminated unilaterally (rather than continuers vs. discontinuers). Because of the limited number of cases that were recorded as mutual terminations from therapy ($n = 4$), however, examination of factors affecting disposition from therapy was not possible. Moreover, there was no systematic measurement of outcome or improvement in presenting problems in the clinic records. Thus, without the client's reason for leaving (mutual vs. unilateral termination) as a criterion and in the absence of reliable measures of change or improvement, there was no meaningful way to examine the outcome of this phase of clinic contact.

Impact of evaluation

In addition to addressing the Clinic staff's questions regarding clients' discontinuation from clinic contact, the second goal of this study was to assess the expectations and opinions of the clinic staff regarding the utility of the evaluation findings for clinic decision making procesess. In order to accomplish this, the clinic staff was

given a pre questionnaire assessing their expectations and opinions about the current study. They were asked their opinions about the importance of the questions being addressed, whether they thought the process would be useful, and what findings they expected. After the data were analyzed, a written report of the findings and conclusions of the evaluation were presented to the clinic staff. Finally, after this presentation the staff were given a post questionnaire (which included a summary of the findings from the analyses) assessing their reponse to the study's specific findings their clinical utility. The pre- and post- questionnaires, and the report to the clinic staff are included as appendices A, B, and C, respectively.

Pre Questionnaire

All eight staff members responded to the pre questionnaire (see appendix A). In general the staff reported that issues related to overall case disposition and discontinuation from clinic contact in particular were important and useful areas of research for the clinic to pursue. Half of the staff rated the issue of premature termination from therapy as "very important" and 37% rated it as "somewhat important." All of the staff felt that it would be "very" (63%) or "somewhat" (37%) useful to have research information on this subject. Moreover, all staff members felt that it would be "very" (87%) or "somewhat" (13%) useful to have information on how many clients discontinue at each phase of clinic contact, and 75% thought it would be "very useful" to know what factors effect termination at each phase of therapy (1 response was

missing). In addition, all believed it would be worth the time and effort to do research routinely at the Clinic. Most of the staff reported a willingness to spend time contributing to research efforts. Three staff members (37%) reported being "very willing," and two (25%) were "somewhat" willing to spend time doing research. Of the three remaining staff members, one was "minimally willing," one reported that s/he did not have time and one did not respond.

The staff was somewhat divided on what effects the information on client termination would have on their future decisions about clinic and training policies and procedures. Several people reported that the degree of impact would depend on how different or new the information was, and/or whether needed changes could be made. Several people were uncertain about the effects. Several others felt strongly that such information would have an impact and suggested that it might prompt changes in the types and modes of therapy provided by and taught at the clinic.

The staff was also asked to suggest factors that they thought would be related to discontinuation at each phase of clinic contact. In general, most of the variables suggested related to the clients' motivations for and expectations about therapy, contextual factors related to the family situation and reasons for seeking help, and the amount of change in the presenting problems. Unfortunately, most the variables suggested by the clinic staff could not be examined by the present study because such information was not available from the clinic records. A

complete listing of these variables at each phase of clinic contact is included in the Report to the Clinic Staff in Appendix C.

Post Questionnaire

All seven staff members returned the post questionnaire (see Appendix B). One staff member had left the agency during the time this study was conducted. Trends on the post questionnaire were similar to those on the pre questionnaire. In general, the staff appears interested in and positive about the present study and the possibility of conducting additional research on this subject. Three staff members (43%) reported that they thought it was equally important to investigate all phases of clinic contact. The remainder of the staff was equally distributed among emphasizing the importance of one or more individual phases of clinic contact. Of the four staff members who emphasized individual phases, only one person stressed the importance of addressing client who fail to attend scheduled intake interviews.

All of the staff felt that it was "very important" (72%) or "somewhat important" (28%) to continuing using the case disposition forms developed by the clinic's program evaluation committee. All seven respondents felt that it was "very important" to gather new types of information about the factors affecting discontinuation at each phase of clinic contact. In general the staff emphasized the need for information regarding the client's perception regarding the clinic process and the improvement or lack thereof in the presenting problems. Additional sources of information regarding the outcome of therapy were also sug-

gested including, the therapist, his or her supervisor and outside agencies involved with the case (e.g., Probation, DCFS).

In response to the question about possible explanations for the low proportion of mutually agreed upon terminations at the clinic, most respondents discussed the discrepancy between client's and therapists perceptions and expectations of change. Several staff members also mentioned possible conflicts between clients' needs and desires and the needs of the clinic as a training agency. When asked about potential changes in clinic policy as a result of research findings, five staff members suggested a shortened diagnostic process or more brief, problem focused approaches to therapy. Several staff members stressed the need for more review of the clinic process and follow up of the significant findings of the present study. One staff member suggested a pilot program implementing and evaluating the changes that were suggested by the staff.

Overall, the staff's perceptions about the utility of conducting research at the clinic were very positive. All respondents indicated that they thought it was "very worthwhile" to do research routinely at the clinic and that it was "very important" to do research on the outcome or effectiveness of therapy at the clinic. Three (43%) of the staff members were "very willing" to spend time doing research at the clinic; three (43%) were "somewhat willing" and one (14%) was "minimally willing."

Recommendations

The report to the clinic staff was presented during a regular staff meeting (see appendix C). Staff response at this presentation was positive and a second meeting was held in order to continue the discussion after the staff members had an opportunity to review all of the findings and recommendations. The discussion at both of these meetings focused on the limitations of current clinic record keeping practices, the need for information on client's reactions to their clinic contact and the measurement of therapy outcome. Several recommendations were made to the Clinic staff.

Record Keeping. Although the disposition forms developed by the program evaluation committee provide an excellent means of tracking each client through the phases of clinic contact in a format that is easily accessible for research purposes, these forms are not being used consistently. Specifically, it was recommended that: (a) The case disposition forms be utilized on a more systematic basis at each phase of clinic contact, (b) the clinic staff consider possible reasons for the current underutilization of these forms (e.g., redundancy of information with other clinic records), (c) a means of monitoring the level of future utilization should be implemented, and (d) the current form for recording the disposition of telephone contacts be revised.

It was also recommended that the clinic employ some type of behavior or symptom checklist as a regular part of clinic record keeping. The use of a standardized measure with subscales (e.g., for internaliz-

ing and externalizing symptoms) would be most beneficial. Such measures might be filled out by therapists and clients and could be useful in the measurement of the outcome of therapy (discussed below).

Client Information. Most of the predictor variables suggested by the clinic staff on the pre questionnaire would appear to be more potent predictors of discontinuation than those investigated by the present study. For example, clients' expectations of and feelings about the clinic process, especially concerning changes in the presenting complaints, would appear to be potentially predictive of discontinuation. Unfortunately, the information needed to address these questions is not a regular part of current record keeping. Therefore, it was recommended that the clinic staff include information from the clients' perspective as a regular part of the clinic records. For example, clients' could be asked to rate how well they feel their therapist understands them, how satisfied they are with their clinic contact at that time or how hopeful they are that coming to the clinic will be helpful. Optimally, such information would be obtained at each phase of clinic contact. Followup data should also be obtained from discontinuers concerning their reactions to the clinic process and reasons for termination.

Therapy Outcome. Due to the lack of valid comparison groups at the therapy phase of clinic contact, it was recommended that the clinic staff implement a systematic measure of the amount of change or improvement during therapy as a regular part of clinic record keeping. If the

proportion of unilateral terminations from the therapy phase of clinic contact were used as an indicator of outcome, the effects of therapy at the Clinic would be greatly underestimated. Even if the proportion of mutual terminations from the therapy phase of clinic contact is underestimated because of under reporting or clinical bias, the question of the outcome or effectiveness of therapy remains. The inclusion of some additional criterion measure(s) for the outcome of therapy would greatly increase the validity and utility of future research efforts at the clinic. At the least such a criterion measure could include therapist's ratings of the degree of improvement or reduction in the presenting problems at each phase of clinic contact. In addition, information obtained directly from client's themselves (as discussed above) using checklists, rating scales or goal attainment scales would be important measures of outcome. Again, follow-up data on client's perceptions of the amount of change would be useful.

In summary, it was recommended that the clinic staff take action to address the limitations in the amount and type of data available for research on discontinuation from clinic contact. It was recommended that: (a) The case disposition forms be utilized regularly at each phase of clinic contact and that this use be monitored more closely, (b) the staff consider examining the relationship between termination from clinic contact and the variables suggested by the Clinic staff (e.g., clients' reactions to their clinic contact), and (c) the staff implement a more systematic measure of the outcome of therapy from both the therapist's and client's perspective.

Staff Response

In general, the clinic staff responded positively to the findings and recommendations of the present study. At the two staff meetings held to discuss this study, several methods of meeting these recommedations were discussed. In particular, the staff is investigating a method of putting all clinic record forms for each phase of clinic contact into packets and revising the clinic handbook to reflect these changes. These packets would include the case disposition forms and all other forms for each phase of clinic contact. It is hoped that this method will increase the consistency with which all clinic forms are used by making them more convenient. The staff also discussed developing a system for monitoring the utilization of all clinic forms and identifying cases that do not have all forms completed. Such a system could possibly be integrated with the packeting of all clinic forms, making it easier for supervisors to monitor all paperwork for each case.

Methods for gathering information from the clients' perspective regarding their reactions to the clinic process and improvement in symptoms were also discussed. Issues related to integrating pencil-and-paper measures for the clients with other record keeping practices at each phase of clinic contact were discussed (e.g., how, when and by whom these measures would be collected). The staff expressed a willingness to pursue these changes in clinic recording keeping with the hope that graduate students would also be interested in working on such projects.

CHAPTER V

DISCUSSION

The present study had two major goals. First, this study addressed two major methodological problems in the research on factors affecting premature termination from clinic contact in Child and Family clinics--namely, the use of heterogeneous groups of discontinuers as comparison groups and inadequate control of the phase of clinic contact investigated. Secondly, the present study sought to ascertain the practical significance of the obtained research findings. That is, whether the clinic staff would act upon the recommendations based on the findings of this study that had implications for clinic procedures or policies. The findings of this study will be discussed according to these two goals; first in relation to the literature on discontinuation in general and secondly, in relation to the impact of this evaluation.

Research on Discontinuation

Case Disposition

In the present study, 71% of the clients attended their scheduled intake appointments. Of these, 84% continued into the diagnostic phase and 64% completed the diagnostic phase of clinic contact. Half, (49%) of the clients who attended intake eventually entered therapy. It is difficult, however, to make comparion of these percentages with those

reported in other studies because of the different methods for calculating these numbers, differing criteria for inclusion of cases as discontinuers and differing definitions and lengths of each phase of clinic contact in the literature.

Given the length of the diagnostic phase at this clinic it is likely that the demarcation between the end of the diagnostic phase and the beginning of the therapy phase (the diagnostic staffing) is somewhat arbitrary and ambiguous. At least part of what occurs in "diagnostic" sessions is probably very similar to what occurs in "therapy" sessions. Thus, clients who complete the diagnostic phase but do not officially enter the therapy phase of clinic contact have nevertheless received some therapeutic services. In the absence of any outcome measures this hypothesis remains untestable, but it appears that almost two thirds of the clients who attend intake maintain clinic contact at least through some brief therapeutic contact (64% of the clients who attend intake remained at least through the completion of the diagnostic phase). Whether or not this contact results in the desired outcome (one possible reason for discontinuing clinic contact) needs to be evaluated.

Perhaps the most striking finding related to disposition in this study was the low proportion of mutually agreed upon terminations. This may be due, in part, to underreporting and the underutilization of the clinic's disposition forms. The rating of the reasons for discontinuation for cases without these forms was, however, conservative. The low proportion of mutual terminations was evident at all phases but is more

distressing during therapy. Although few cases would be expected to be mutually terminated during the intake and diagnostic phases of clinic contact when assessment is not yet completed, mutual termination from therapy is a hoped for and expectable outcome.

Several hypotheses regarding the low proportion of mutual terminations are possible. Most importantly, there may be discrepancies between clinicians' and clients' expectations and definitions of improvement in therapy. Thus, the low proportion of mutual terminations may be due to a general clinical bias that clients have not completed or benefitted sufficiently from therapy. This may be particulary true in training settings when the number of available clients is of concern. Supervisors may recommend that clients be retained longer in order to insure the availabilty of cases. In particular, cases may be transferred to new therapists or put on waiting lists for new therapists more often than need be. Thus, trainees have little experience in determining the appropriate end of therapy and mutually terminating with clients. Moreover, the outcome of therapy is obscured. Clients who are transfered and later terminate _unilaterally_ after attending a only a few or no sessions at all with their new therapist may have benefitted greatly from their work with their first therapist. Many of these clients might have terminated more _mutually_ before the transfer. An examination of clients' reasons for discontinuation at the time of transfer was not, however, possible in this study. Several staff members suggested this as an important area for investigation.

Factors Affecting Discontinuation

As predicted, demographic and related variables did not significantly predict discontinuation at any phase of clinic contact. Even when the phase of clinic contact was systematically investigated and homogeneous groups of discontinuers were utilized (unilateral terminations only) few of the factors investigated were significantly related to unilateral termination from clinic contact. Moreover, the the few significant findings obtained after Initial inquiry, after Intake and during or after the Diagnostic could be due to chance because of the large number of statistical tests calculated at these phases of clinic contact. Contrary to expectations, variables related to the clinic process were also poor predictors of discontinuation (e.g., the amount of time between phases and therapist variables were not significant.) The two variables that were reliably significant, the proportion of diagnostic sessions attended and clients' response to the diagnostic feedback, are generally related to the clients experience of their clinic contact. Finally, there was no support for the third hypothesis that factors would be differentially related to discontinuation as a function of the phase of clinic contact investigated. The only factors significantly related to discontinuation and not likely due to chance were relevant for only the diagnostic phase of clinic contact. Thus, firm conclusions regarding whether different factors affect discontinuation at different phases cannot be made at this time. Nevertheless, future studies should continue to control for phase of clinic contact to better address this question.

Overall, these results are discouraging from an experimental standpoint. The failure to find significant predictors of discontinuation from clinic contact could be due to limitations in: (a) the amount, and (b) the type of data available at this clinic. First, some of the analyses were hindered by missing data, particularly data related to the clinic process (e.g., dates, number of sessions etc.). In particular, the underutilization of the disposition forms hindered the determination of the reasons for discontinuation for some cases thus limiting the amount of reliable data. In general, less data were available for clients who discontinued contact with the clinic, especially for clients who failed to attend the intake interview. In addition, some of the analyses were hindered by the small number of subjects in a given category. This was due in part to considering only clients who terminated unilaterally as discontinuers. This problem might be ameliorated by continued collection of this information, providing a larger data base for future analyses. Most importantly, analyses of the interactions between possible predictors of discontinuation were not possible. Given the lack of main effects for the variables investigated in the present study and in the literature, an investigation of possible interactions between these types of predictor variables is needed.

Second, and more important, were the limitations on the type of data currently available. In general, demographic variables appear, both in the present study and in the literature, to be poor predictors of discontinuation from clinic contact. Variables related to the clinic

process also appear to have little predictive significance when considered alone. Although some demographic or clinic process variables may be predictive in some settings, it would appear to be more beneficial to examine the relationship between these variables and the clients' experience of the clinic process at each setting rather than looking for consistent findings across settings. For example, when asked what they thought would be most predictive of discontinuation, most of the clinic staff suggested variables related to the clients' expectations and experience of the clinic process. The fit between the clinic and the clients and the degree of cooperation between clients and therapists may be more predictive than demographic variables or clinic process variables alone. Unfortunately these types of variables have not been systematically investigated in the literature and are currently unavailable at the clinic at which this study was conducted.

Suggestions for Future Research

Given the lack of main effects of demographic, therapist and clinic process variables on discontinuation from clinic contact, two areas of future research need to be considered. First is the investigation of possible interactions between the types of variables that have been investigated. The second is the examination of factors related to the clients' reactions to their clinic contact. It is this latter area that is the most potentially fruitful.

Although the investigation of the interaction between client demographics and other variables may provide additional information, the

lack of significant main effects makes it difficult to focus such efforts. A multivariate examination of possible interactions among many variables requires large numbers of subjects, limiting the feasibility of such research efforts. In addition, the clinical utility of this type of information is limited. Although an understanding of factors that predict discontinuation might allow for changes in the clinic process (e.g., different treatment approaches for different types of clients) the fit between individual clients and the clinic process might not be improved. The use of demographic or other variables to identify cases at risk for discontinuation might result in large numbers of false positives and this method does not provide for immediate feedback between clients and clinic staff.

The second area that needs to be examined, is the clients' expectations and experience of the clinic process. It seems likely that it is the client's experience of the clinic process and the expectation that continued contact will result in a desirable outcome that is most predictive of continuation. Information from the clients' perspective is needed regarding both their satsisfaction with clinic contact (e.g., Lebow, 1982a, 1982b) and their perception of the outcome of therapy (e.g., Strupp & Hadley, 1977). Rather than looking for different demographic or descriptive factors that predict premature termination at different phases of clinic contact, the client's experience of and feelings about the clinic process needs to be directly measured at each phase of clinic contact. An ongoing assessment of the client's expecta-

tions and feelings about the clinic process would provide for more immediate feedback between the clinic staff and clients and the opportunity to address the concerns raised by the client. Although it can be assumed that this feedback is a natural part of any therapeutic relationship, systematic tracking and analysis of this process would be beneficial both to individual clients and the clinic. This may be particulary important in a training agency.

Perhaps the most important aspect of the clients' experience of the clinic process are their perceptions regarding the degree of improvement or change in the presenting problems. Follow up studies studies with adult (e.g., May, 1984; Papach-Goodsitt, 1985; Pekarik, 1983a, 1983b). and child (e.g., Farley, Peterson & Spanos, 1975; Lowman et al., 1984; Magder & Werry, 1966; Richardson & Cohen, 1968) populations have consistently reported improvement in symptoms as a reason for discontinuation of treatment among clients who were previously considerd "drop-outs." It should be noted, however, that studies with child clients have relied soley on parental report of improvement. It is possible that the child's improvement was the most socially desirable reason for parents to provide for terminating from clinic contact. Future investigations should control for social desirability or rely on more objective measures of improvement. Studies that have assessed pre- and post-therapy adjustment of adult outpatients have found that follow-up adjustment was significantly related to the reasons given for termination as well as the number of sessions attended (May, 1984; Papach-Good-

sitt, 1985; Pekarik 1983a, 1983b). These findings contradict the idea that clients who discontinue clinic contact are necessarily treatment failures. Such conclusions would seem to be equally plausible for child and family clinic populations, but must await more rigorous replication. Thus, a greater reliance on the prospective examination of information from the clients perspective at each phase of clinic contact, a systematic evaluation of outcome, and the continuation of follow up research will enhance our understanding of the reasons that clients discontinue their contact with the clinic.

Impact of Evaluation

The clinic staff's positive response to the research process in the present study is very encouraging and somewhat surprising. In general, clinicians do not utilize psychotherapy research (Morrow-Bradley & Elliot, 1986) or program evaluation (Davis & Salasin, 1975) findings in their clinical work. Contrary to what was expected, an overwhelming majority of the clinic staff were interested in pursuing the changes recommended in this study. This positive response may be due to several factors. Primarily, the program evaluation process and the questions addressed were initiated by the clinic staff. Thus, the author was a consultant to the staff, assisting them in answering their own questions. Davis and Salasin (1975) suggest that the combined role of evaluator and change consultant increases the utility of evaluation findings. Moreover, as shown on the pre questionnaire, the staff was very interested in this area of research initially, and had many ideas about why

clients discontinue clinic contact. The likelihood of the staff acting on this study's findings is further increased by the fact that most of the recommendations pertained to changes enabling them to pursue more systematically their initial ideas (most of which could not be examined in this study) regarding factors affecting discontinuation.

Furthermore, many of the findings and recommendations appeared to confirm the staff's preconceptions regarding discontinuation. In fact, some of the staff response appears to be stronger than that warranted by the findings alone. For example, most of the staff concluded that the findings suggested the need for a shortened diagnostic phase and more brief, problem oriented approaches to therapy. Such conclusions were based primarily on the percentages of clients discontinuing and the small proportion of mutual terminations at each phase of clinic contact. The clients' reactions to, and the therapeutic outcome of clinic contact were not, however, examined in this study. Given the absence of such information, and the paucity of significant predictors of discontinuation, many hypotheses might be generated and should be examined before concluding that the length or type of therapy are significantly related to discontinuation. For example, the clinic could change the length of the diagnostic phase for randomly assigned cases and examine the effects of this change on continuation into therapy. The staff's conclusions appear to be based more upon their clinical experience and original hypotheses than on the findings of this study. Thus, the findings and recommendations of this evaluation appear to fit with the staff's expectations, confirming their clinical intuition.

Finally, the timing of this study may have contibuted to the high degree of acceptance by the clinic staff. This study was conducted at a time when other changes related to training and research were going on both in the clinic itself and in the larger academic department with which it is affiliated. Thus, a climate suitable for the implementation of these recommendations and the continuation of similar research in this setting may be evolving. Although the staff's initial response to this study is strongly positive, the real test lies in the future and their ability to follow through on implementing the recommended changes. Due to current time constraints on the clinic staff (lack of time allotted for research in current job descriptions) and the Clinic's primary commitments to clinical service and training, the successful implementaion of these changes may depend, in part, on the continued collaboration of the Clinic staff and graduate students and faculty outside of the Clinic.

Summary and Conclusions

In conclusion, the present study has provided information about the percentage of, and factors affecting discontinuation at each phase of clinic contact. The general lack of significant predictors of discontinuation related to client demographics, therapist and clinic process variables suggests the need for a closer examination of other variables that might be predictive of discontinuation. An examination of clients' reactions to their clinic contact, for example, would provide a more accurate description of clients who have previously been considered

dropouts or treatment failures and a better understanding of their reasons for discontinuation. The findings of previous studies (e.g., Farley, Peterson & Spanos, 1975; Lowman et al., 1984; May, 1984; Papach-Goodsitt, 1985; Pekarik, 1983a, 1983b; Richardson & Cohen, 1968) suggest that this is an important line of investigation to pursue.

Although the results of this study were discouraging from an experimental standpoint they were encouraging from a clinical standpoint. That is, statistical analyses revealed few variables that significantly and reliably predicted discontinuation from clinic contact. Clinically, however, the staff's response to the research process and consideration of the recommendations for changes in record keeping procedures and areas of future research are very encouraging. Contrary to what is generally reported in the literature on clinicians' use of research findings, the clinic staff in the present study has taken this study's findings and recommendations into consideration and is taking steps to begin their implementation.

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APPENDIX A

PRE STAFF QUESTIONNAIRE

Dear Staff:

I am currently working on my dissertation examining the clinic population and patterns of service utilization at the Clinic. Specifically, I am addressing the questions raised several years ago when a committee was formed to begin examining client dropout or premature termination. This committee developed a series of forms to be filled out the end of each stage of treatment (i.e., after the Intake, Diagnostic, and Therapy phases of treatment were completed or when there was a change in therapists) to record the disposition of the case and related information at each point in treatment. The primary purpose of my dissertation is to gather and analyze the data from these forms and client's charts in order to provide you, the clinic staff, with information regarding the frequency and timing of premature client termination at the Clinic. Specifically, I will report on the numbers of clients who terminate at each phase in the treatment process and the factors that are related to the type of termination (unilateral vs. mutual). I will analyze "predictors" of premature termination related to the identifed patient (e.g., age, sex, presenting problem etc.) his or her family (e.g., family composition, SES etc.) and the treatment process at the Clinic (e.g., amount of time during and between each treatment phase, the number of therapists involved, treatment modality, etc.).

The second purpose of my research is to assess your expectations and opinions regarding the utility of gathering and analyzing such data for decision making and other clinic processes. In order to do this I need your cooperation. I am asking you to fill out this brief questionnaire regarding your expectations and opinions about the utility of such research at the Clinic. This is a "Pre" questionnaire. After the data analysis is complete I will provide you with a written report of the results at a staff meeting. At that time I will ask that you fill out a short "Post" questionnaire assessing your response to and opinions about the research process and findings. The information from these staff questionnaires will be used as a broad measure of the utility of conducting clinical research at the Clinic. It is hoped that this information, along with the specific findings, will assist you in the administration and provision of clinical services at the Clinic.

Thank you, in advance, for your cooperation in this project. I know how busy you are, but the time required of you is minimal and the benefits will hopefully outweigh this small investment. I will provide only group data regarding these questionnaires and your responses will remain anonymous. I would be happy, however, to provide you with feedback on your individual responses. If you would like to receive individual feedback please put your name on the questionnaire so that I can match your pre and post responses. If you would like to receive this feedback anonymously use a code number or pseudonym that you can easily remember. Please complete the attached questionnaire as soon as possible and place it in the folder by the mailboxes.

Thank you,

Barry R. Lindstrom, M.A.

Staff Questionnaire

Please write your answers in the space provided or circle your response on the scales provided to each of the following questions. Feel free to include additional comments.

1. What committees are you on at the Clinic (e.g., case assignment, program evaluation etc.)

2. How important is the issue of clients' premature termination from clinic contact?

+2	+1	0	-1	-2
Very Important	Somewhat Important	Neutral	Minimally Important	Not at All Important

3. How useful do you think it is to rely on clinical experience regarding premature termination from clinic contact?

+2	+1	0	-1	-2
Very Useful	Somewhat Useful	Neutral	Minimally Useful	Not at All Useful

4. How useful do you think it will be to have research information regarding premature termination from clinic contact?

+2	+1	0	-1	-2
Very Useful	Somewhat Useful	Neutral	Minimally Useful	Not at All Useful

5. I am going to examine how many clients terminate during each phase of clinic contact (i.e., Intake, Diagnostic, Therapy). How useful do you think it will be to have information about how many clients drop out at each *phase of clinic contact*?

+2	+1	0	-1	-2
Very Useful	Somewhat Useful	Neutral	Minimally Useful	Not at All Useful

6. What percentage of clients who call the center and are scheduled for an intake appointment do you think never make it in for *scheduled intake appointments*?
   -------%

7. What percentage of clients who attend the initial intake interview do you think terminate unilaterally *after* the *intake interview*?
   -------%

8. What percentage of clients who continue after the intake appointment do you think terminate unilaterally *during* the *diagnostic* phase of clinic contact?
   -------%

9. What percentage of clients who continue after the intake appointment do you think terminate unilaterally _after receiving the diagnostic feedback_?
_______%

10. What percentage of clients who complete the diagnostic assessment do you think terminate unilaterally during the _therapy_ phase of clinic contact?
_______%

I am going to analyze how well different factors "predict" unilateral termination. That is, termination against the advice of the therapist or clinic.

11. How useful do you think it will be to know which factors are related to unilateral termination at each phase of clinic contact?

+2	+1	0	-1	-2
Very Useful	Somewhat Useful	Neutral	Minimally Useful	Not at All Useful

12. What factors do you think are most related to clients' failure to show up for a _scheduled intake interview_?

13. What factors do you think are most related to unilateral termination _after the intake interview_?

14. What factors do you think are most related to premature termination _during_ the _diagnostic_ phase of clinic contact?

15. What factors do you think are most related to premature termination _after receiving the the diagnostic feedback_?

16. What factors do you think are most related to premature termination _during_ the _therapy_ phase of clinic contact?

17. How much do you think the answers to the questions about which types of clients terminate when and for what reasons will affect your thinking and decisions about <u>clinic</u> policies and procedures at the Clinic?

Why or why not?

18. How much do you think the answers to the questions about which types of clients terminate when and for what reasons will affect your thinking and decisions about <u>training</u> policies and procedures at the Clinic?

Why or why not?

19. Do you think it would be worth the time and effort to do research routinely at the Clinic?

Why or why not?

20. How willing would you be to spend time doing research at the Clinic?

+2	+1	0	-1	-2
Very Willing	Somewhat Willing	Neutral	Minimally Willing	Not at All Willing

21. What questions regarding premature termination would <u>you</u> like to have answered?

Name (or code number or pseudonym): Only if you desire individual feedback.______________________________

APPENDIX B

POST STAFF QUESTIONNAIRE

Dear Staff:

Attached is the "Post" questionnaire regarding your response to and opinions about the process and results of the study on case disposition at the Clinic. As before, your responses will remain anonymous. For your convenience, the major results and recommendations of the study are summarized on the questionnaire.

Thank you, again, for your cooperation in this project. It is hoped that the information from this questionnaire, as well as the specific findings of the study, will help you in the administration and provision of clinical services and training at the Clinic. Feel free to contact me if you have any additional questions or concerns.

Please complete the questionnaire as soon as possible and place it in the envelope by the mailboxes.

Thank you,

Barry R. Lindstrom, M.A.

Staff Questionnaire

Please write your answers in the space provided or circle your response on the scales provided to each of the following questions. Feel free to include additional comments.

The present study investigated the percentage of clients that discontinued at each phase of clinic contact. In particular, the percentage of clients that terminated unilaterally, or against the advice of the therapist or clinic was addressed. It was found that:

29% of the clients who call the center and are scheduled for an intake appointment do not make it in for this intake appointment.

13% of the clients who attended the initial intake interview terminated _unilaterally after_ the _intake_ interview.

16% of the clients who continued after the intake appointment terminated _unilaterally during_ the _diagnostic_ phase of clinic contact.

12% of the clients who continued after the intake appointment terminated _unilaterally after_ the _diagnostic_ phase of clinic contact.

56% of the clients who completed the diagnostic assessment terminated _unilaterally from_ the _therapy_ phase of clinic contact (this includes only closed cases because disposition for cases still in therapy is not yet known).

The factors related to unilateral termination at each phase of clinic contact were also addressed. The present study found that:

Clients who _failed to attend_ the _intake_ interview were less likely than those who attended to report "difficulties in peer relationships," "fearfulness or apprehension," or "discipline problems at home" as presenting problems.

Clients who terminated _unilaterally after_ the _intake_ interview were more likely to be from racial backgrounds other than black or white.

Clients who terminated _unilaterally during_ or _after_ the _diagnostic_ phase of clinic contact were: more likely to be from households with only one parent; more likely to be black and least likely likely to be from "other" racial backgrounds; and more likely to be on public aid and least likely to have a reported income of more than $20,000.

Clients who terminated unilaterally _after_ completing the _diagnostic_ phase of clinic contact were more likely to have attended fewer than 80% of the scheduled diagnostic sessions and were less likely to "agree" with the diagnostic feedback and recommendations.

An analysis of the factors related to termination _during_ the _therapy_ phase of clinic contact was not possible because of the lack of terminations classifed as "mutual" (only 9% of the terminations at this phase of clinic contact).

You may keep this page as a summary of the findings if you wish

1. For which of the following phases of clinic contact do you think it is most important to know the percentage of clients that terminate unilaterally?

    ____ Failure to attend intake interview.
    ____ Termination after intake.
    ____ Termination during the diagnostic (before staffing.)
    ____ Termination after the diagnostic phase (staffing held).
    ____ Termination during therapy.
    ____ This is equally important for all phases of clinic contact.
    ____ I do not consider this to be important information.

2. For which of the following phases of clinic contact do you think it is most important to know the factors affecting unilateral termination?

    ____ Failure to attend intake interview.
    ____ Termination after intake.
    ____ Termination during the diagnostic (before staffing.)
    ____ Termination after the diagnostic phase (staffing held).
    ____ Termination during therapy.
    ____ This is equally important for all phases of clinic contact.
    ____ I do not consider this to be important information.

In general, the analysis of factors affecting unilateral termination was limited by three factors. 1.) Missing data. In some cases this was by definition (i.e., less data are available on clients who terminate) and in some cases this was simply due to inadequate record keeping (i.e., lack of documentation for client contacts, especially for those who terminate), 2.) The underutilization of the disposition forms developed by the program evaluation committee, which made it difficult to determine the specific disposition and dates of clinic contact for some cases, and 3.) The lack of available data for most of the variables suggested by the clinic staff (especially those pertaining to clients' perceptions and expectations of the clinic process and changes in the presenting problems.)

3. How important do you think it is to continue to utilize the case disposition forms developed by the program evaluation committee.?

+2	+1	0	-1	-2
Very Important	Somewhat Important	Neutral	Minimally Important	Not at All Important

4. How important do you think it is to gather new information about the factors affecting unilateral termination at each phase of clinic contact (e.g., clients' expectations, symptom relief, etc.)?

+2	+1	0	-1	-2
Very Important	Somewhat Important	Neutral	Minimally Important	Not at All Important

What kinds of new information do you think it would be most important to collect?

5. In particular, an analysis of the factors related to termination *during* the *therapy* phase of clinic contact was not possible because of the lack of terminations classifed as "mutual" (only 9% of the terminations at this phase of clinic contact). What do you think is the best explanation for this small amount of mutually agreed upon terminations?

Several staff members suggested on the pre-questionnaire that the results from this type of research might indicate the need for different, more short term modes of therapy of therapy. The small proportion of mutual terminations from therapy *might*, for example, be interpreted as an indication that clients are not satsified with or benefitting fully from the modes of therapy currently offered at the Clinic. On the other hand, the relatively high percentage of clients entering the therapy phase of clinic contact and the average number of sessions attended might suggest otherwise.

6. Do you think the available information about which types of clients terminate when and for what reasons suggests the need for any changes in clinic policy? If yes, what changes do you think would be useful?

   If no, what information do you think would be important to have before making decisions about changes in clinic policy?

7. How worthuhile do you think it would be to do research routinely at the Clinic?

+2	+1	0	-1	-2
Very Worthwhile	Somewhat Worthwhile	Neutral	Minimally Worthwhile	Not at All Worthwhile

8. How important do you think it is for the Clinic to do research on the outcome or effectiveness of the different modes of therapy offered at the Clinic?

+2	+1	0	-1	-2
Very Important	Somewhat Important	Neutral	Minimally Important	Not at All Important

9. How willing would you be to spend time doing research at the Clinic?

+2	+1	0	-1	-2
Very Willing	Somewhat Willing	Neutral	Minimally Willing	Not at All Willing

OPTIONAL:
Name (or code number or pseudonym): ____________________________

APPENDIX C

REPORT TO THE CLINIC STAFF

Report to the Clinic Staff:

Case Disposition at the Clinic From

September, 1983 to December, 1985

Submitted by: Barry R. Lindstrom, M.A.

June 25, 1986

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Introduction

The purpose of this report is to provide an overview of the available information and findings regarding the disposition of clinic cases at each phase of clinic contact. This report addresses three general questions: 1.) What data are currently available regarding case disposition? In particular, the use of the disposition forms designed by the program evaluation will be addressed. 2.) How many clients discontinue at each phase of clinic contact and, of these, how many terminate unilaterally (against, the advice of the therapist or clinic)? and 3.) What factors are related to unilateral termination at each phase?

Overview of Cases Examined

The sample for this study included all clinic cases that attended intake appointments between September, 1983 and December 1985 (N = 171) with the exception of cases that were only involved in STEP groups (n = 15), cases from Boy's Hope (n = 7) and Day School cases. Two additional cases were excluded, one for lack of intake information and another because the child resided at a residential facility. In addition, 69 cases that failed to attend scheduled intake appointments were examined.

Of the 171 cases that attended intake, 62% involved children (age 12 or under) and 38% involved adolescents. Thirty two percent of the "identified patients" were females and 68% were males. Single parent families accounted for 46% of the sample, the majority of these families were headed by the mother. An additional 15% of the sample included single parent families that had other adults residing with the family

(other relatives or parent's mate). Intact, multigenerational families accounted for 22% of the sample and 11% of the cases were remarried families. In 6% of the cases the child was not living with either natural parent (this includes foster families and children living with relatives other than their parents). When scaled according to the parents' level of education and employment, the majority of the cases appear to be from middle to lower class families (Hollingshead scale: I-3%, II-6%, III-35%, IV-34%, V-22%). The majority of the cases were white (60%) and black (26%) clients. Hispanic clients accounted for 9% of the cases. The remaining 5% of the cases included American Indian, Asian and other racial backgrounds. The most common referral sources for clients were schools (42%) and other mental health facilities (22%). Court and lawyer referrals accounted for 13% of the referrals and clinic clients referred 6% of the cases. The other referral sources included hospitals, family and friends, DCFS and self referred clients.

Overall Case Disposition

The overall disposition of the cases examined in this study was as follows:

N	Disposition by Phase	Percent of Intakes (N = 171)	Percent by Phase[a]
240	cases total		
-69	cases failed to attend intake	---	29
171	cases attended intake		
-28	cases discontinued after intake	16.4	16 (13)[b]
143	cases began diagnostic		
-4	cases still in diagnostic	2.3	
-31	cases discontinued during diagnostic	18.1	22 (16)
108	cases completed diagnostic (staffed)		
-24	cases discontinued after diagnostic	14.0	22 (15)
84	cases entered treatment		
-38	cases still in treatment	22.2	
46	cases discontinued during/after treatment	27.0	(56)
	TOTAL	100.0	---

a Percentage of cases remaining at the beginning of each phase of clinic contact. These do not sum to 100%.
b Numbers in parentheses indicate percentage of unilateral terminations.

Results By Phase of Clinic Contact

Clients Who Fail to Attend Intake Appointments

Data Considerations. By the fact of their limited contact with the center, limited data are available for clients who fail to attend intake appointments. Basic demographic information and a brief description of the presenting problem are obtained during the initial phone contact. This information is not always recorded on standardized forms, however, making its accessibility for research purposes somewhat limited. For a portion of the period covered, this data was summarized on phone contact summary forms (n = 20). Information for other cases was obtained from the individual phone contact forms, when available, used currently by the center (n = 16). Thus, data was accessible for 52% (36/69) of the clients who failed to attend scheduled intake appointments. This sample of cases for whom data was accessible was not, however, entirely random. Moreover, data is gathered and recorded differently for cases that do and do not attend intake. For the present study information about clients who did not attend intake was obtained at the time of their initial phone contact and data for those that did attend intake was obtained from case files. These factors limit the interpretability of findings regarding clients who fail to attend the intake appointment.

Disposition. A total of 69 cases failed to attend their scheduled intake appointments. This reflects only those cases for which intake

appointments were scheduled. People who called the center and were referred out or were not interested in services were not included in this study. This number is probably a slight underestimate due to the number of cases for which the disposition for this phase of clinic contact was categorized as "pending." The percentage of no-shows, 29% (69/240), appears, however, to be an accurate estimate. Thus, slightly under one third of the cases scheduled for intake fail to attend this appointment, discontinuing clinic contact after the initial phone contact. In general, staff predictions on the questionnaire were reasonably accurate. Although there was a wide range of responses (10-70% for "no-shows"), the average (mean) prediction was 34%.

Factors Affecting "No-Show." The 36 "no-show" cases for which data were accessible were compared to the 171 cases that attended the intake appointment. Few of the variables investigated discriminated between the client groups (no-show vs. attended intake).

The reporting of several different PRESENTING PROBLEMS (drawn from the list of problems used on the most recent intake forms) was statistically significant. If "difficulties in peer relationships" "fearfulness or apprehension" or "discipline problems at home" were reported, there was a greater likelihood that the case would attend the intake appointment ($p<.03$; $p<.03$; $p<.02$, respectively). Conversely, if these problems were not reported there was a greater likelihood that the case would fail to attend the intake appointment. There are several limitations, however, on these results. Presenting problems are recorded dif-

ferently during the phone contact and the intake interview (the checklist is not used for the phone contact) limiting the reliablity of these reports and the interpretation of these findings. Moreover, the utility of individual presenting problems as discriminating factors is questionable.

One additional finding that is somewhat contrary to what might be expected was the trend for cases with a greater NUMBER OF DAYS between the initial phone contact and the intake appointment to be more likely to attend the intake interview ($p<.08$). The median number of days between the client's initial phone contact with the intake worker and intake appointment was 9 ($M = 15$, mode = 7). Cases that were above this median number of days were more likely to attend the intake appointment than those that were scheduled for an intake within 9 days after their initial phone contact. Whether or not the intake appointments were cancelled and rescheduled was not controlled for. This trend suggests several hypotheses that might warrant further, more controlled investigation. It may be that clients who were more likely to come in were more likely to reschedule missed or inconvenient appointments. Conversely, cases that appeared more urgent and may have been at higher risk to fail intake appointments may have been scheduled for intake sooner. Interpretation of this trend is further hindered by the fact that for cases that failed to attend intake this variable was the number of days until the scheduled intake; but for cases that attended it was the number of days until the appointment was actually kept. Cases that attended

intake thus have a higher chance of a greater number of days between the call and the appointment due to the possibility of having rescheduled the appointment.

Most of the variables investigated were not significant. These included demographic variables (the child's sex and age-child/adolescent; the number of parents and the number of children in the family) and the referral source (school vs. other). The quarter of the year in which the intake was to occur was not significant, but there was a high degree of missing data for the clients that failed to attend intake which limits the validity of this analysis. Information about the family's race, SES, income and catchment area were not recorded for cases that failed to show for the intake appointment.

<u>Staff Suggestions</u>. The staff suggested many interesting variables on the questionnaire that might be related to failure to attend intake appointments. Unfortunately, these variables were not addressed by the present study because such information was not available. The suggested factors were: 1.) Clients' ambivalence; lack of internal motivation, 2.) Symptom relief from making the intial phone contact; easing of situational crisis, 3.) Disorganization of client family, 4.) Lack of external motivation, 5.) Logistics of making it in , 6.) Lack of capacity to enagage/level of pathology, 7.) Lack of family agreement about attending intake, 8.) Stigma of receiving mental health services, 9.) Negative reaction to initial phone contact, and 10.) Agency policy of full family involvement.

Clients Who Discontinue After the Intake Appointment

Data Considerations. The amount of data available on cases that discontinued after attending the intake appointment was somewhat limited, particularly for those cases where it was immediately apparent that the case would not be continuing. The 28 cases that discontinued after the intake appointment were not officially opened and these records are kept separately in the clinic files. Several cases that were referred by other agencies for "linkage" in which the client did not directly request services were not included in the sample.

Disposition. Of the 171 cases that attended intake, 28 (16%) discontinued after this appointment. Of the 28 cases that discontinued, 22 (78%) terminated unilaterally. Overall, 13% of all cases attending the intake appointment terminated unilaterally after intake. Staff predictions for the percentage of unilateral terminations at this phase of clinic contact ranged from 5 to 20% (M = 11%, mode = 10).

The specific dispositions of the 28 cases that discontinued after the intake appointment were as follows:

Disposition	N	%
Mutual termination- Rx completed	0	0
Mutual termination- Rx incomplete	1	3.6
Unilateral termination with notice	7	25.0
Unilateral termination without notice	15	53.6
Referral out	4	14.3
Other	1	3.6
Don't know, record incomplete	0	0
TOTAL:	28	100.0

Factors Affecting Termination. For the examination of factors discriminating continuers from discontinuers at this and each of the following phases of clinic contact, only those clients who terminated unilaterally were included as discontinuers. That is, cases that were terminated mutually and those that were referred out, discontinued for other reasons or for which the disposition was unclear, were excluded from this analysis. This was done for several reasons. First, there were too few cases in these other dispositions (mutual termination, referral out, other) to make a meaningful comparison of all dispositions. Secondly, the inclusion of these dispositions would create a very heterogenous group of discontinuers, limiting interpretation of the findings. Cases that discontinue because they are referred elsewhere, or because clients move should be differentiated from those that termi-

nate unilaterally and these cases should be differentiated from those that terminate mutually.

The clients' RACE was a significant predictor of unilateral termination after intake. White and Black clients did not differ from the expected percentage of clients continuing, but all others races combined were three time more likely to discontinue than White and Black clients ($p<.006$).

There were trends towards significance for three of the PRESENTING PROBLEMS on the intake checklist. Based on only those cases for which this data were directly available (those with the newest intake form), cases in which "suicidal or homicidal thoughts/actions," "runaway," or "withdrawn behavior" were indicated as a presenting problem were three times more likely to discontinue than cases in which these problems were not indicated ($p<.06$ for each problem).

None of the other variables investigated were significant predictors of unilateral termination after intake. These variables included: the child's age, sex and birth order; all other presenting problems, individually and by category (as described above), and the number of presenting problems listed; axis IV and V ratings at intake; the race, SES, income, and composition of the child's family; the referral source (school vs. other other); the clinic fee, and the quarter in which the intake occurred. Additional information available on the intake forms was also examined but was not significant. These variables included whether or not the child had repeated a grade, been evaluated

by the board of education, been in contact with the police or juvenile court, or had been involved with DCFS. Whether or not the family planned to appeal the fee, had insurance, or agreed to continue after intake were also not significant. The number of days between the phone contact and intake interview and the client's catchment area were not examined because they were not available for the clients who discontinued.

Staff Suggestions. The staff suggested the following factors that might be related to termination from clinic contact after the intake interview. Again, these factors were not investigated because this information is not systematically gathered or recorded in clinic records. The suggested factors were: 1.) Inappropriate candidates for treatment, 2.) Anxiety about beginning therapy, especially for parents, 3.) Disorganization of client family, 4.) Lack of motivation or external motivation, 5). Lack of expected symptom relief; unmet expectations; lack of help received, 6.) Center doesn't provide the right service, 7.) Lack of capacity to engage with the agency; inability to cope wih treatment psychologically, 8.) Unwillingness or inability to involve the entire family as is policy, 9.) Occurrence of crises which lead to involvement of other agencies, 10.) Anxiety or anger at the interview; negative reaction to the interviewer, 11.) Family disagreement about coming to the clinic 12.) Clarification of how agency works, 13.) Fear of commitment to treatment process, 14.) Disappointment with the center's physical plant.

Clients Who Discontinue During the Diagnostic

Data Considerations. One of the main questions addressed by the present study pertains to the utilization of the case disposition forms for each phase of clinic contact that were developed by the program evaluation committee. The reported percentages of these forms utilized relects the number of forms present in case files only for those phases of clinic contact that have taken place since the implementation of these forms. Because cases that were begun prior to September, 1983 were not included in the present study, any of these cases that were still involved with the clinic after the implementation of these forms were not included in this evaluation. Although the number of forms involved may thus be underestimated, the percentages reported here and in subsequent sections can be assumed to be an accurate reflection of the proportion of cases in which these forms were utilized.

The case disposition forms for completion after the diagnostic phase were completed in 19% of the cases that discontinued during the diagnostic phase.

Disposition. Of the 143 cases that began the diagnostic phase of clinic contact, 4 were still in this phase at the time of the data collection. Of the remaining 139 cases, 31 (22%) cases discontinued during the diagnostic phase (before the case had been staffed). Of these 31 discontinuers, 23 (75%) terminated unilaterally. Overall, 16.5% of those beginning the diagnostic phase terminated unilaterally during the

diagnostic phase. This may be an understimate because the specific disposition was unknown for 6 (19%) of the cases that discontinued at this point. Clients who discontinued during the diagnostic phase attended an average of 2 sessions.

The specific disposition of the 31 cases that discontinued during the diagnostic process were as follows:

Disposition	N	%
Mutual termination- Rx completed	0	0
Mutual termination- Rx incomplete	0	0
Unilateral termination with notice	11	35.5
Unilateral termination without notice	12	38.7
Referral out	0	0
Other	2	6.2
Don't know, record incomplete	6	19.4
TOTAL:	31	100.0

Factors Affecting Termination. There were no significant differences between clients who terminated unilaterally during (before the staffing) or after (case was staffed) the diagnostic phase on the child's age and sex; and the race, SES and composition of the family. Therefore, the following variables were used to compare all clients who terminated unilaterally (during and after combined) with those who continued after the diagnostic phase.

The NUMBER OF PARENTS living with the child was significantly related to unilateral termination at this phase of clinic contact.

Cases with two parents in the home were more likely than expected to continue (p<.04). The client's RACE was again a significant predictor (P<.008). White clients did not differ from the expected percentage of clients continuing after the diagnostic. Black clients were more likely than expected terminate and all other races combined were less likey to terminate. This is the opposite of the effect of race on unilateral termination after intake. This suggests that non-white and non-black clients are less likely to continue after intake but that, if they do continue they have a very high likelihood of continuing through the diagnostic phase and into the therapy phase of clinic contact. Investigation of the interaction between race and other variables was prohibited, however, by the small number of clients in this "Other" category.

The client's INCOME and the FEE set at the intake interview were both significantly related to unilateral termination at this phase (p<.04). Because the fee is based on income and is subject to changes, only the effect of income will be discussed here. Clients who were on public aid were twice as likely to unilaterally terminate during or after the diagnostic phase as were clients whose income was below $20,000 (and not on public aid) and three times as likely as clients whose incomes exceeded $20,000 (p<.04). In addition, clients whose income exceeded $20,000 were less likely to terminate than clients with reported incomes under $20,000. Clients whose income was less than $20,000 did not differ from the expected rate of termination.

None of the other variables investigated were significant. These included: the child's age, sex and birth order; the presenting problems recorded at intake (individually and by category), axis IV and V ratings at intake; the race, SES, income, catchment area and composition of the child's family; the referral source (school vs. other other); the number of weeks between intake and the beginning of the diagnostic phase, the quarter in which the intake occurred, whether or not testing was conducted during the diagnostic phase and whether or not there were codiagnosticians. Moreover, the discipline, sex and year of training of the diagnostician; the discipline of the supervisor and whether it was the same as or different from that of the trainee were not significant. None of the additional variables recorded on the intake forms (see "Factors affecting termination after intake, " above) were significant.

Staff Suggestions. The staff suggested the following factors as predictive of unilateral termination at this phase of clinic contact. Unless it is specifically noted, these variables were not examined because the appropriate information was not available. 1.) Problematic relationship with therapist; inadequate "fit" with therapist or agency, inexperience of the diagnostician (the trainee's year at the Doyle was not significant), 2.) Fear of change, 3.) Chaotic, disorganized families, 4.) Lack of expected symptom relief, 5.) Lengthy diagnostic (this was not significant, but was examined only for for those clients who terminated after the diagnostic phase and is discussed below), 6.) Failure to keep scheduled appointments, (this was significant, but was exam-

ined only for for those clients who terminated after the diagnostic phase and is discussed below), 7.) Lack of capacity to enagage in process, 8.) Anger/anxiety generated during the diagnostic process, 9.) Exacerbation of family conflict which makes attending painful.

Clients Who Discontinue After the Diagnostic Phase

Data Considerations. Overall, the diagnostic disposition forms were completed in 33% of the cases. They were completed in 43% of the cases that discontinued and 33% of the cases that continued after the diagnostic phase of clinic contact. (They were completed in only 19% of the cases that discontinued during the diagnostic phase.)

Disposition. Of the 108 cases that completed the diagnostic phase (cases that were staffed) 24 (22%) discontinued. Of these 24 discontinuers, 16 (67%) discontinued unilaterally. Thus, 15% of those completing the diagnostic terminated unilaterally. Of those cases discontinuing after the diagnostic phase, 19 (83%) attended a staffing feedback. Staff predictions for unilateral termination after the diagnostic phase ranged from 7 to 25% (M = 18%, mode = 25%). Clients who discontinued after the diagnostic attended an average of 6 sessions. Clients who continued after the diagnostic attended an average of 7 sessions.

The specific disposition of the 24 cases that discontinued after the diagnostic phase (after the case was staffed) were as follows:

Disposition	N	%
Mutual termination- Rx completed	0	0
Mutual termination- Rx incomplete	3	12.5
Unilateral termination with notice	10	41.7
Unilateral termination without notice	6	25.0
Referral out	1	4.2
Other	3	12.5
Don't know, record incomplete	1	4.2
TOTAL:	24	100.0

Factors Affecting Termination. The following factors discriminated between clients who unilaterally terminated after completing the diagnostic phase and those who continued. Clients who terminated during the diagnostic phase were not included here because this information was either inappropriate or unavailable for these cases. The PROPORTION of SESSION ATTENDED was a significant predictor of unilateral termination. Clients who attended fewer than 80% (the median percentage of sessions attended) of the scheduled diagnostic sessions were nine times more likely to discontinue than those who attened better than 80% of the sessions.

The clients' RESPONSE to the DIAGNOSTIC FEEDBACK was also significant. Clients who did not "agree" (either "agreed in part" or "wished

to review" the feedback) with the diagnostic feedback were six times more likely to terminate after the diagnostic than those who did agree ($p<.01$). (Clients who "wished to review" the feedback were the least likely to continue after the diagnostic but the limited amount of data on the cases that terminated, limited the analysis of specific responses to the feedback.) Nevertheless, these findings suggest that the clients' response to the diagnostic feedback is an important indicator of continuing into therapy. Examination of interactions between these variables was prohibited by the small number of cases that terminated unilaterally.

Many variables did not discriminate between clients who did and did not continue after the diagnostic. These variables included the modalities of treatment recommended (yes/no for child, adult or family therapy); whether or not testing was recommended; the discipline of the consultant (MSW/MD); and the number of diagnostic sessions scheduled and the number attended. Whether or not the diagnostician was to have continued as therapist was not examined because this information was lacking for many of the cases that terminated.

Staff Suggestions. The staff suggested the following factors as predictive of unilateral termination at this phase of clinic contact. Unless noted these an analysis of these variables was not possible due to lack of information. 1.) Lack of help, 2.) Resistance/ fear of change, 3.) Disagreement with feedback or unwillingness to comply; anxiety generated by feedback (client's response to the feedback was signif-

icant), 4.) Change of therapist (whether or not the diagnostician was to continue as therapist was not analyzed because this data was missing for most of the cases that terminated), 5.) Poor "fit" with therapist/agency process, 6.) Satisfaction with changes accomplished during diagnostic, 7.) Inability to engage in long term treatment process, 8.) Increase in family conflict, 9.) Inexperience of diagnostician (year of training at the clinic was not significant).

Clients Who Discontinue During Therapy

Data Considerations. Overall, the disposition forms to be completed at the time of transfer or at the conclusion of treatment were completed in 48% of the cases. This is possibly a slight underestimate, but the overall utilization does not appear to exceed 55%. Of the cases that are currently in treatment and have been transferred, the transfer form was completed in 57% of the cases. For cases without the disposition forms it was often difficult to determine the beginning and end of therapy, and the number of sessions attended. This was particulary difficult for cases that were transfered but did not engage with the new therapist. In most cases these files contained only copies of letters sent to clients inquiring about the desire for service and/or closing the case. The underutilization of disposition forms appears to be the most problematic at the therapy phase of clinic contact because other forms of record keeping in the files (e.g., monthly progress notes etc.) are less standardized than at other phases (e.g., diagnostic assessments).

Disposition. Of the 84 cases that continued after the diagnostic phase, 38 were still in therapy at the time of data collection. Of the 46 cases that discontinued during the therapy phase of clinic contact, 26 (56%) terminated unilaterally. This may be a slight underestimate, however, because the specific disposition was unknown for 6 (13%) of the cases discontinuing during this phase. Staff predictions for unilateral termination from therapy ranged from 20 to 50% (M = 30%, mode = 20%). Thus, the staff tended to underestimate the amount of unilateral terminations at this phase of clinic contact.

The specific disposition of the 46 cases that discontinued during the therapy phase of clinic contact were as follows:

Disposition	N	%
Mutual termination- Rx completed	2	4.4
Mutual termination- Rx incomplete	2	4.4
Unilateral termination with notice	16	34.8
Unilateral termination without notice	10	21.7
Referral out	2	4.4
Other	8	17.1
Don't know, record incomplete	6	13.1
TOTAL:	46	100.0

Cases that terminated from the therapy phase of clinic contact for which disposition forms were included in the file attended an average of 19 therapy sessions (range 1 to 97). This number should be interpreted with caution, however, because it does not reflect all sessions attended

by all members or subsystems seen in therapy for a given case or control for the modality of therapy attended. Moreover, this average includes all cases closed during the therapy phase of clinic contact regardless of their specfic disposition (i.e., mutual termination, unilateral termination, referral out etc.). Further analysis of the number of sessions attended in all modalities is recommended. An increase in the utilization of case disposition forms at this phase of clinic contact would greatly facilitate such investigation.

Factors Affecting Termination. Because of the limited number of cases that were recorded as mutual terminations from therapy, examination of factors affecting disposition from this phase of clinic contact was not possible. Without type of termination (mutual vs. unilateral) as a criterion there was no meaningful way to examine the outcome of this phase of clinic contact. Moreover, there is no systematic measurment of outcome or improvement of presenting problems currently recorded in the clinic records. In the absence of an adequate criterion variable for this phase, possible trends regarding general termination from therapy were examined. Most specifically (as suggested by several staff members), the relationship between transfer/departure of the therapist due to the end of the training year and the termination of clients was addressed. Given the small number of cases involved and a high proportion of missing data, this question was not addressed statistically. Rather, an overview of the available data was made in order to suggest possible areas for future investigation.

Two different sets of data were examined. The first included all cases that were currently in or had terminated from the therapy phase of clinic contact in which a transfer of therapists had taken place. Of these 25 cases, 6 (24%) did not attend any sessions with the new therapist. Thus, about 75% of the cases transfered attended at least one session with the new therapist. This may be an overestimate, however, because cases which did not engage tended to have more missing data and these percentages only reflect a change in the primary case therapist. Information about changes in therapists for multiple members or subsystems of a family was not addressed. Morover, given the small number of cases involved, it was not possible to control for whether the transfer involved a family, couple or individual (child or adult) therapist.

The second set of data included only those cases that had terminated from the therapy phase of clinic contact. The month of termination was recorded in 33 of the 46 cases. The month and disposition of these cases are presented below:

Type of	Month											
Termination	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Mutual					1		1	1			1	
Unilateral	2	1			4	3	1	2	2	1		2
Referral Out										2		
Other	2				2	1						1
Don't Know					1				1			1
TOTAL	4	1	0	0	8	4	2	3	3	3	1	4

In general there were more terminations in May than any other month. By quarter, there were more terminations in the second (April, May, June) and third (July, August, September) quarters than at other times of the year. These are expectable trends, following the end of the training year. It is unfortunate that, given the amount and type of data available for disposition at this phase of clinic contact, analysis of the relationship between type of disposition, time of year and other factors cannot be addressed at this time.

Staff Suggestions. The staff suggested the following factors as predictive of unilateral termination from the therapy phase of clinic contact. No analysis of the factors affecting termination at this phase of clinic contact was possible. 1.) Symptom relief/change, 2.) Resistance/ fear of further change, 3.) Lack of expected symptom relief/ progress, 4.) Change in goals/needs, 5.) Change/termination of therapist, 6.) Poor "fit" with therapist/agency process; negative reaction to therapist, 7.) Inability to engage in long term treatment process, 8.) Increase in family conflict; getting in touch with angry hurtful feelings, 9.) Inexperience of therapist, 10.) Length of treatment.

Other Research Questions

Change in Functioning

Several staff members suggested that the degree of change in the clients functioning or a reduction in the presenting complaint (or lack thereof) were related to unilateral termination at several phases of

clinic contact. Unfortunately, no systematic assessment of these variables is included in the case files. The new intake forms provide for ratings of the client's level of stressors and degree of functioning (Axis IV and V of the DSM III). These axes are also rated on the disposition forms at each phase of clinic contact. The number of cases for which these ratings were available at each phase were minimal, however, due to the inconsistent use of the disposition forms. In addition, these axes were often omitted on other clinic forms (e.g., diagnostic or treatment staffing summaries). Moreover, the validity and reliability of these measures, even if used consistently, are probably inadequate for use as a measure of change. Thus, in order to effectively address the impact of improvement or lack of change on unilateral termination, some additional measures should be implemented.

"At Risk" Cases

There were too few cases identified as "At risk" to do a statistical analysis of its effect on case disposition. Only the number of cases so identified and their dispostion are provided here. Nineteen cases were identifiable as "At Risk" cases in the present study. Of these, 15 were so identified at the time of intake. Of these 15 cases 3 failed to attend the intake interview; 1 was referred out; 2 discontinued after the intake interview; 1 is still in the diagnostic phase, 2 are still in therapy; and 5 discontinued during the therapy phase of clinic contact. In one case the disposition was incertain. Of the 5 cases that discontinued during therapy, 3 terminated unilaterally and 2 had "other" dis-

positions. Two cases were identified as "At Risk" during the diagnostic phase (one is still in therapy and unilaterally terminated from therapy) and 2 during the therapy phase of clinic contact (one case is still in therapy and one case was referred out).

Staff Perceptions About Research

All eight staff members responded to the initial research questionnaire for a response rate of 100% (Thank you). In general the staff reported that unilateral termination from clinic contact is an important and useful area of research for the clinic to pursue. On the questionnaire, 50% of the staff rated the issue of premature termination from therapy as "very important" and 37% as "somewhat important." All of the staff felt that it would be "very" (63%) or "somewhat" (37%) useful to have research information on this subject. Moreover, all of the staff felt that it would be "very" (87%) or "somewhat" (13%) useful to have information on how many clients discontinue at each phase of clinic contact, and 75% thought it would be "very useful" to know what factors effect termination at each phase of therapy (1 response was missing). All of the staff reported that they thought it would be worth the time and effort to do research routinely at the Clinic and generally appear willing to spend time doing research. Three staff members (37%) reported being "very willing," and two (25%) were "somewhat" willing to spend time doing research. Of the three remaining staff members, one was "minimally willing," one reported that s/he did not have time and one did not respond.

The staff was somewhat divided on what effects the information about which clients terminate when and for what reasons would have on their thinking and decisions about Clinic and training policies and procedures. Several people reported that the degree of impact would depend on how different or new the information was, and/or whether needed changes could be made. Several people were uncertain about the effects. Several others felt strongly that such information would have an impact and suggested that it might prompt changes in the types and modes of therapy provided by and taught at the Clinic.

Summary and Recommendations

Case Disposition

In the present study, 71% of the clients who were scheduled for intake interviews attended intake. Of the clients who attended this initial intake interview, 84% continued into the diagnostic phase and 64% completed the diagnostic. Almost half (49%) of the clients who attended intake completed the diagnostic phase and entered the therapy phase of clinic contact. These percentages, along with those reported in an earlier study by Cliffer and Kaspar (1984) for the period from September, 1982 to September, 1983, are summarized below.

Length of Contact	1986 Study	1984 Study
Intake only	16%	20%
Intake and Partial Diagnostic	18%	5%
Intake and Full Diagnostic	14%	35%
(Still in Diagnostic)	(3%)	---
Intake, Diagnostic and Therapy	49%	40%

These percentages differ somewhat in the two studies. The largest difference between these two clinic samples is for clients who discontined during or after the diagnostic phase. These differences may reflect, in part, the way in which these clients were categorized in the two studies. When clients who discontinue during or after the diagnostic phase are considered together, 32% of the sample in the present study, and 40% of the sample in the earlier study continued after the intake interview but did not enter the therapy phase of clinic contact. These combined percentages are less discrepant.

Factors Affecting Unilateral Termination

Few of the factors investigated were significantly related to unilateral termination from clinic contact. Several specific presenting problems (from the new intake forms) were significantly related to failure to attend the intake interview. The clients' racial background was a significant predictor of unilateral termination after the intake interview and during and after the diagnostic phase but in different directions. Family income and the number of parents in the household were also predictive of unilateral termination during or after the diagnostic phase. The precentage of diagnostic sessions attended and the family's response to the diagnostic feedback were related to unilateral termination after the diagnostic phase of clinic contact. An analysis of the factors related to unilateral termination from the therapy phase of contact was not possible due to the lack of a meaningful comparison group.

The small number of significant predictors of unilateral termination identified by the present study appears to be due to three factors. First, some of the analyses were hindered by missing data, particularly data related to the clinic process (e.g., dates, number of sessions etc.). In addition, some of the analyses were hindered by the small number of subjects in a given category. In particular, analyses of the interactions between possible predictors of unilateral termination were not possible. This problem might be ameliorated by continued collection of this information, providing a larger data base for future analyses. Secondly, the underutilization of the disposition forms hindered the determination of specific dispositions and limited the amount of reliable data available. Finally, and probably most importantly, it appears that demographic variables and other data that are currently available in clinic records are poor predictors of unilateral termination (both in the present study and in the literature). Most of the variables suggested by the staff would appear to be more potent predictors of unilateral termination than those investigated by the present study. Unfortunately, the information needed to address these questions is not a regular part of current record keeping.

Given the general lack of significance for the variables investigated in the present study and the type of variables suggested by the clinic staff, it is recommended that the Clinic staff consider including some additional types of information in the clinic records. For example, clients' expectations of and feelings about the clinic process,

especially concerning changes in the presenting complaints, would appear to be potentially predictive of unilateral termination from clinic contact. Such information might be useful in helping to "fit" the clinic process to individual clients and is also an important dimension of measuring the outcome, or effectiveness of therapy.

Clinic Record Keeping

The disposition forms developed by the program evaluation committee appear to be an efficient and reliable source of information about the length, type, and consistency of clinic contact at each phase of the process. These forms provide an excellent means of tracking each client through the phases of clinic contact in a format that is easily accessible for research purposes. Unfortunately, these forms are currently underutilized. Because of the low percentage of disposition forms, the specific disposition was unknown for some cases in the present study. One of the reasons for the current underutilization of these forms may be the redundancy of some of the information these and other clinic forms (e.g., staffing summaries) contain. The program evaluation committee may wish to address this redundancy in order to provide for the most efficient means of record keeping for both clinical and research purposes. If the staff feels it is important to continue doing research at the Clinic, it is recommended that the disposition forms become a more regular part of clinic record keeping. Even if case disposition is not the primary research question, these forms can provide important summary information about each case at each phase of treat-

ment. For example, the month in which each phase begins and ends and the number of sessions attended are useful pieces of information in examining general trends in clinic processes.

The utility of current clinic records for research purposes appears to be most problematic during the therapy phase of clinic contact. The underutilization of the disposition forms was especially problematic when there were several therapists working with different members or subsystems of a family. Aside from the underutilization of the disposition forms, two additional concerns warrant consideration. The first is the low proportion of mutually agreed upon terminations. This may be due, in part, to under reporting and underutilization of the disposition forms. Cases for which the disposition could not be determined from other information in the clinical file (e.g., staffing and transfer summaries, letters to the client) were recorded as "Don't know, record incomplete." This rating of the therapy disposition for cases without disposition forms was conservative, but possibly less reliable than for cases which contained disposition forms.

More importantly, however, the staff may wish to address the high proportion of unilateral terminations in relation to the provision of services and training at the Doyle Center. The high proportion of unilateral terminations may be due to a general clinical bias that clients have not completed or benefitted sufficiently from therapy. Trainees thus have little experience in determining the appropriate end of therapy and mutually terminating with clients. Clients who are transfered

and later terminate unilaterally after attending only a few sessions or none at all with their new therapist may have benefitted greatly from their work with their first therapist and possibly could have terminated more mutually at the time of transfer. It is not clear at this time, however, whether clients who terminate after a change in therapists do so because they feel finished with therapy or because of concerns related to the transfer of the therapist.

Even if the proportion of mutual terminations from the therapy phase of clinic contact is underestimated because of under reporting or clinical bias, a second concern, the question of the outcome, or effectiveness of therapy remains. If the proportion of unilateral terminations from the therapy phase of clinic contact were used as an indicator of outcome, the effects of therapy at the clinic would be greatly underestimated. The relationship between therapy outcome and the type of termination from therapy and other relevant variables warrants further research efforts. The inclusion of some additional criterion measure(s) for the outcome of therapy would greatly increase the validity and utility of such future research efforts. At the least this criterion measure could include therapist's ratings of the degree of improvement or reduction in the presenting problems at each phase of clinic contact. In addition, information obtained directly from client's themselves such as checklists, or rating or goal attainment scales would be important measures of outcome. Most of the variables suggested as relevant by the Clinic staff pertained to the clients' experience and perception of the

clinic process and information about the context of their seeking help at the clinic. Such information would be best obtained directly from the clients. The development of a format for gathering such information in a manner that is helpful for research and clinical purposes should be considered. Follow-up data concerning client's reactions to the clinic process and reasons for termination would also be useful.

There are two final recommendations related to clinic records and future research efforts. First, if the staff decides that more information about the specific disposition of all intake calls is important, it is suggested that the current disposition form for phone contacts be revised somewhat to make it easier to record such information in a systematic manner. Given the large number of calls and the other responsibilities of the intake worker this form should contain the most important information in the most efficient manner possible. The duplication of effort involved in having phone contact disposition forms and separate phone contact summary forms decreases the efficiency and reliabilty of the recording of this information for both research and clinical purposes. Currently, these summary forms are not used on a regular basis. At the least, a more efficient form and recording process would allow for easier tracking of the number of calls and their disposition. In addition, the inclusion on the phone contact form of the format for recording family composition and presenting problems currently used on the intake forms might be helpful and would make comparisons between clients who do and do not attend intake more meaningful. The specific

disposition of the contact (e.g., information only, referral out, intake scheduled etc.) should continue to be be included. Inclusion of the dates of all scheduled appointments and their outcome (e.g., attended, failed, rescheduled etc.) would allow for more controlled investigation of factors related to failure to attend intake or other outcomes of the initial phone contact. Provision for the rating of other factors suggested by the staff as predictive of failure to attend (See "Factors affecting No Show," above) would also be useful for future research. For example, the intake worker could rate the clients' level of internal motivation for seeking help versus the amount of external pressure prompting the call for services.

Secondly, if the staff decides that is important to do future research involving presenting problems or diagnoses as variables it is recommended that the Clinic employ some type of standardized behavior/ symptom checkist. The use of a standardized measure with subscales (e.g., for internalizing and externalizing symptoms) would be beneficial for research and, most likely, clinical purposes. It is difficult to do research on a large number of individual presenting problems or diagnoses. Another possibility would be for the Clinic to develop its own measure, based on an analysis of the presenting problems on the intake forms or from other clinic records. Such a measure might also be incorporated as a measure of change or improvement over time.

In conclusion, the present study has provided information about the percentage of clients continuing at each phase and factors affecting

unilateral termination at each phase of clinic contact. Limitations on available data and current record keeping for research purposes have been discussed. Several areas for future research at the Clinic were discussed and suggestions made for possible changes in record keeping to facilitate the research process. Most generally, it is recommended that:

1. The case disposition forms be utilized on a more regular basis at each phase of clinic contact.

2. The staff consider examining the relationship between termination from clinic contact and the variables suggested by the Clinic staff. In particular, clients' perceptions and expectations of the clinic process, and changes in the presenting complaints was suggested by many staff members. Such information is not currently available.

3. The staff consider the implementation of a more systematic measure of the amount of change or improvement during therapy as a regular part of clinic record keeping. Optimally, this would include ratings from both the therapist and the client.

In general the Clinic staff appears interested in the possibility of future research at the Clinic. It is hoped that this report provides sufficient information for the Clinic staff to determine the priorites for and the feasibility of such research.

APPROVAL SHEET

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