FACTORS AFFECTING THERAPY DROPOUT

FOR MALTREATING FAMILIES WITH

INSTITUTION INVOLVEMENT

By

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Bachelor of Arts

University of Kansas

Lawrence, Kansas

2003

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
May, 2007

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ACKNOWLEDGEMENTS

First and foremost, I would like to give special appreciation to my family for their encouragement and support throughout my efforts to obtain a master's degree these last three years. My dad, mom, and brother have been such wonderful role models and have taught me the importance of working hard to achieve your dreams. They have continued to be a wonderful support system throughout all my endeavors, and I could not have achieved all that I have without their love and support. My parents' Sunday trips to Stillwater for lunch and late night phone calls with my brother have been motivators to get through even the most trying times. I am grateful to have them in my life, for they truly are the best people that I know.

Next, I would like to thank Andy for his words of encouragement, love, and understanding these last three years. I met him at the beginning of this amazing journey, and we have made so many wonderful memories along the way. He has been my rock, helping me to stay calm during the hard times, and celebrating with me during the good times. I can honestly say that this journey would not have been as great if he were not a part of it. I feel blessed to have had such an amazingly strong and caring man to share this journey with.

I would like to give many thanks to my major thesis advisor, Dr. Charles Hendrix, for believing in me as I learned to become a therapist and for his belief in my project. He has been instrumental in my growth as a therapist and has taught me what it means to stand up for what you believe in, whether it is for your clients, a cause, or for yourself.

His commitment to my thesis project and desire to help me learn the research process has helped to make my project one that I am very proud of. It has truly been a blessing to have learned from him these last three years, and I am proud to call him my mentor. His passion for therapy, teaching, and his students is inspiring, and I hope to one day continue his legacy as a mentor to beginning therapists. His passion and dedication have helped me to achieve my dream, and for that, I will always be grateful.

I would also like to express gratitude to my thesis committee members, Drs. Glade Topham and Brandt Gardner, who provided me with much assistance throughout my project. I would like to thank each for their suggestions, feedback, and expertise. In addition, I would like to thank Dr. Topham for aiding in my development as a therapist. I would also like to thank Dr. Gardner for providing me with so many wonderful opportunities in the research world.

Lastly, I would like to thank my cohort, Jennifer, Leigh Ann, Angie, and Marissa, for such wonderful memories and great friendships. We have shared joys, fears, past experiences, and future dreams. They have been a constant support to me, and I am honored to call these ladies my friends and colleagues. I never expected to make such great friends while in Oklahoma, and I am thankful to have had their friendship throughout this journey. We are all starting a new chapter in our lives, and I am excited to see what new memories we can share with each other next.

To all that have made this journey possible, thank you.

TABLE OF CONTENTS

Chapter Page

I. INTRODUCTION 1

Problem Statement 3
Theoretical Framework 6
General Systems Theory 6
Systems, subsystems, and hierarchy 7
Boundaries 8
Positive and negative feedback loops 10
Summary 12
Purpose 12

II. LITERATURE REVIEW 15

Client Factors 15
Client Resources 16
Client Beliefs 18
Family Characteristics 19
Family Influences 20
Summary 20
Therapist Factors 23
Therapist Characteristics 23
Therapist Competence 24
Therapeutic Alliance 24
Congruence of Therapist and Client Perspectives 25
Summary 27
Institutional Factors 28
Referral Source 28
Summary 28

III. METHODOLOGY 30

Sample 30
Data Collection Methods 31
Instrumentation 33
Telephone Intake 33
Background Form 34

Chapter Page

Diagnosis and Treatment Plan 34
Termination Report 35
Summary 35
Data Analysis Plan 36
Analysis of Hypotheses 36
Hypothesis 1 37
Hypothesis 2 39
Summary 40

IV. RESULTS 41

Sample Demographics 41
Primary Female Client Demographics 42
Primary Male Client Demographics 46
Hypothesis Testing 48
Hypothesis 1 48
Client Factors 48
Hypothesis 2 58

V. DISCUSSION 68

Hypothesis Testing Discussion 68
Hypothesis 1 68
Hypothesis 2 71
Limitations 76
Sample Size 76
Sample Generalizability 76
Therapist Experience 77
Missing Data 77
Implications 78
Implications for Researchers 78
Implications for Clinicians 78
Recommendations for Future Research 80
Conclusion 81

REFERENCES 83

APPENDICES 90

Appendix A 90
Appendix B 93
Appendix C 98
Appendix D 101
Appendix E 104

Chapter Page

Appendix F.....107
Appendix G.....110
Appendix H.....112

LIST OF TABLES

Table Page

1. Client Variables 38

2. Hope Variables....................39

3. Therapy Outcome Variables 40

4. Mean Ages for Females and Males....................43

5. Ethnic Differences between Females and Males in Frequencies....................43

6. Institution Involvement for Females and Males in Frequencies....................44

7. Marital Status Differences between Females and Males in Frequencies....................44

8. Frequency Differences in Highest Level of Education Completed for Females and Males....................45

9. Differences in Occupation for Females and Males in Frequencies 46

10. Analysis of Variance for Female Age....................48

11. Analysis of Variance for Male Age 49

12. Marital Status Differences between Females and Males in Percentages....................50

13. Analysis of Variance for Yearly Income and Fee Quoted....................51

14. Money Concerns among Target Groups in Percentages....................52

15. Analysis of Variance for Female Present State of Health....................52

16. Analysis of Variance for Male Present State of Health 53

17. Analysis of Variance for Female Highest Level of Education Completed....................53

18. Analysis of Variance for Male Highest Level of Education Completed 54

Table | Page

19. Ethnic Differences among Groups in Percentages 56

20. Analysis of Variance for Female Hope 56

21. Analysis of Variance for Male Hope 57
22. Analysis of Variance for Global Assessment of Functioning 57

23. Percentage Differences for Referral Source and Therapy Outcome 59

24. Analysis of Variance for Total Number of Sessions 60

25. Analysis of Covariance for Total Number of Sessions Attended 61

26. Analysis of Variance for Yearly Income (in thousands) for Total Sample 62

27. Analysis of Covariance for Mean Yearly Income (in thousands) for Total Sample 63

28. Analysis of Variance for Yearly Income (in thousands) for No Institution Involvement 63

29. Analysis of Variance for Yearly Income (in thousands) for Institution Involvement 65

30. Analysis of Covariance for Mean Yearly Income (in thousands) - Institution Involvement 66

LIST OF FIGURES

Figure Page

1. Mean Differences in Female Age 49

2. Mean Differences in Male Age...50

3. Mean Differences in Highest Level of Education Completed for Females 54

4. Mean Differences in Highest Level of Education Completed for Males.................55

5. Differences between Groups in Mean Total Number of Sessions...........................60

6. Differences in Mean Yearly Income for Total Sample...62

7. Mean Yearly Income for No Institution Involvement 64

8. Differences in Mean Yearly Income for Institution Involvement 65

CHAPTER I

INTRODUCTION

Child maltreatment remains a grave problem that plagues many families in our society. Indeed, in 2003, of the 3,353,000 children who were subjects of a child maltreatment investigation or assessment, 906,000 children were found to be victims of some form of child maltreatment. Specifically, 60.9% were victims of neglect, 18.9% were victims of physical abuse, 9.9% were victims of sexual abuse, 4.9% were victims of emotional or psychological abuse, and 2.3% were victims of medical neglect (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2005). Often the perpetrator is someone the child knows, usually an individual responsible for caring for and supervising the child. In 2003, more than 80% of maltreated children were abused by at least one parent, with mothers acting alone with 40.8% of the child victims, fathers acting alone with 18.8% of the child victims, and mothers and fathers acting together with 16.9% of the child victims. Only 13.4% of the total child victims were abused by a non-parental perpetrator (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2005). These statistics suggest that the majority of child maltreatment cases reside in the family system, a relationship in which the child should feel the safest.

In many child maltreatment cases, judges issue court orders based on Child Protective Services worker recommendations. Court orders may include substance abuse treatment, mental health counseling, parenting classes, or placement of children with

relatives (Rittner & Dozier, 2000). Most often, maltreated children are initially taken out of the abusive environment and placed into legal care by a child protection agency. Types of legal care that children may be placed into following an abuse or neglect report include kinship foster care, when the child is placed with relatives, non-relative foster care, when the child is placed with non-relative caretakers, or other group care (Hurlburt et al., 2004). In order to protect the child's best interests, the court often requires the parental perpetrators to seek therapeutic services as a requirement for reunification (Butler, Radia, & Magnatta, 1994). Furthermore, Hurlburt et al. (2004) suggested the importance of appropriate and timely mental health services for families in order to reduce long-term, negative consequences for children in the child welfare system and placement instability for those children removed from their homes after an allegation of abuse or neglect. Consequently, a court or social service agency frequently mandates maltreating families to attend family therapy sessions for the purposes of addressing and resolving the problem of child abuse or neglect within the home (Dinkmeyer, White, & Bosley, 1999).

Family therapy has led to successful outcomes for parent, child, and parent-child interactions in child abuse and neglect populations (Borrego, Urquiza, Rasmussen, & Zebell, 1999; Chaffin et al., 2004; Dombrowski, Timmer, Blacker, & Urquiza, 2005; Gershater-Molko, Lutzker, & Wesch, 2003; James & Mennen, 2001). For example, Parent-Child Interaction Therapy (PCIT) has been proposed as an effective family therapy intervention for the child physical abuse population (Herschell & McNeil, 2005), particularly in reducing the number of re-reports of physical abuse among abusive parents and their children (Chaffin et al., 2004). Borrego et al. (1999) found that PCIT succeeded

in reducing child behavior problems, parental stress, and increasing positive parent-child interactions. Other family therapy interventions employed with families who have experienced or are at-risk for abuse show improvement in parenting skills. Examples of effective family therapy interventions include the use of praise, behavioral descriptions, verbal reflections, parental knowledge of child health care, and increased home safety (Dombrowski et al., 2005; Gershater-Molko et al., 2003).

In summary, child abuse and neglect is a serious problem for many families as the majority of maltreatment cases occur among parents and their children. Children who are abused or neglected are frequently removed from the abusive environment to ensure their safety while their parents are mandated to receive mental health services. Hence, maltreating families are often referred to family therapy in order to improve the family relationship prior to reunification.

Problem Statement

Family treatment is shown to be an effective family therapy approach for both parents and children by reducing child behavior problems, increasing positive parent-child interactions, improving parenting skills, and reducing re-reports of physical abuse (Borrego et al., 1999; Chaffin et al., 2004; Dombrowski et al., 2005; Gershater-Molko et al., 2003). However, maltreating parents who wish to be reunited with their children frequently discontinue family therapy prematurely or fail to comply with mandated mental health counseling (Gershater-Molko et al., 2003; Rivara, 1985). Lau and Weisz (2003) found that children accompanied to family treatment by a maltreating parent were almost three times more likely to prematurely terminate than families who did not have a history of maltreatment. Furthermore, maltreated children accompanied to family

treatment by a non-perpetrating parent are also likely to end treatment early compared to non-maltreated children. Previous researchers propose that while maltreatment alone is associated with premature termination of family therapy, children who attend family therapy with their maltreating parent are significantly more at-risk for ending therapy early and without the support of the therapist. Consequently, those who drop out of therapy may not receive all the benefits that therapy has to offer (Ogrodniczuk, Joyce, & Piper, 2005). Thus, they decrease their chances of improving the parent-child relationship and terminating abusive behaviors.

Rittner and Dozier (2000) examined the outcome of 202 mothers under court order for substance abuse and mental health treatment whose children were placed into kinship foster care under supervision by Child Protective Services (CPS). Based on court reports made by CPS workers, an indication of "good," "fair," or "poor" showed level of compliance with "good" meaning attended at least 50% of scheduled meetings, "fair" meaning attended at least 50% of meanings but tested positive for substances, and "poor" was given to those mothers who made no effort to obtain treatment or refused treatment, tested positive for substances, or who had a drug-exposed newborn. At the end of the first six months of treatment, 48% were deemed noncompliant ("poor"), and 52% were making efforts to comply with the mandated treatment ("good"). Of the 48% of mothers who were deemed noncompliant, 11.9% showed partial compliance. At the end of the second six months of treatment, the number of compliant mothers decreased to 39.2%, and the number of noncompliant mothers increased to 49.2%. The level of compliance for fathers in this study was found to be comparable to that of mothers. As time passed, maltreating parents were more likely to not follow through with their treatment, which

often held consequences for them in terms of reunification with their children. Other researchers found that less compliant mothers are more likely to lose custody of their children (Atkinson & Butler, 1996). Therefore, if parents do not succeed in meeting the requirements of the court system or social service agency, then their children remain in another's custody.

Despite their desire for reunification, maltreating parents often discontinue family therapy before their treatment goals are met, which may suggest that there are factors that contribute to the difficulty of complying with mental health counseling. Factors that parents perceive as barriers to seeking help for their family and of which are still present throughout therapy may ultimately affect clients' ability to stay engaged in the therapy process. McCabe (2002) found that Mexican American parents of children receiving outpatient psychotherapy who reported more perceived barriers to treatment were more likely to terminate therapy prematurely. Moreover, clients who drop out of therapy show a significantly greater number of barriers than those who complete therapy, suggesting that certain factors are keeping them from being successful in treatment (Kazdin, Holland, & Crowley, 1997). Specifically in cases of child maltreatment, noncompliant mothers often change residences, lead transient lifestyles, abuse alcohol and drugs, experience episodes of spousal violence, engage in criminal behaviors, and are younger and more disadvantaged, which could be examples of factors that affect therapy outcome (Butler et al., 1994). While maltreating parents may perceive aspects of their own lives as factors that affect whether or not they complete therapy, Reis and Brown (1999) suggested that numerous client, therapist, and administrative factors may be related to psychotherapy dropouts.

Although a considerable amount of literature has documented the problem of premature termination in marriage and family therapy (Allgood & Crane, 1991; Bischoff & Sprenkle, 1993; Wang et al., 2006; Williams, Ketring, & Salts, 2005), there is a paucity of literature related to the child abuse population specifically that examines how client factors, often described in literature as barriers, may be associated with dropout in family therapy. By becoming aware of the factors that affect therapy dropout for maltreating families, clinicians may gain a better understanding of what influences their clients' choice to drop out of therapy before their goals are met. These answers may also aid clinicians in developing ways that they can help to reduce some of the constraints that families face when trying to stay engaged in therapy.

Theoretical Framework

Even though family therapy has been shown to be a successful treatment approach to maltreating families, these families tend to drop out of therapy before their goals are met, which suggests that something may be keeping them from completing therapy. Using general systems theory as a theoretical framework, this paper intends to examine the problem of premature termination in the child abuse and neglect population. Furthermore, this paper proposes general systems theory as a theoretical framework that will help to explain how client factors are related to dropout specific to these families.

General Systems Theory

General systems theory is used to explain the behavior of complex systems, like families, by looking at how components of the system are interrelated. The four major assumptions of general systems theory are (1) all parts of the system are interconnected, (2) systems must be understood as wholes, (3) all systems affect their environment, and

the environment affects all systems, and (4) systems are not reality, but a way of knowing (White & Klein, 2002). Key concepts of general systems theory include system, subsystem, hierarchy, boundaries, and feedback loops (Whitchurch & Constantine, 1993; White & Klein, 2002).

Systems, subsystems, and hierarchy. Systems are sets of interrelationships or sets of components that affect their environment. Systems can interact, grow, and change with their environment. For example, a family is a system composed of individual family members who "operate through transactional patterns" that "regulate family members' behavior" (Minuchin, 1974, p.51). Minuchin (1974) postulated that family systems contain subsystems that include individual members or dyads based upon generation, sex, interest, or function. Each member of the family system may participate in multiple subsystems. Examples of family subsystems are listed as follows: spouse subsystem, parental subsystem, and sibling subsystem. The spouse subsystem forms when two individuals, such as a husband and wife, unite with the purpose of developing a family. The parental subsystem contains the two members of the spouse subsystem, but they must now attend to the growth of their child without losing the mutual support gained from each other before the introduction of children into their family. Finally, the sibling subsystem contains the children in the family system. The siblings in the family first learn to socialize through their interactions with each other. Another example of a subsystem is the parent-child subsystem. The subsystems within the family are delegated into hierarchical layers such that some subsystems have more power than other subsystems (Minuchin, 1794; Whitchurch & Constantine, 1993; White & Klein, 2002).

For example, the sibling subsystem comes lower in the hierarchy than the parental subsystem, so the parents will have more authority over their children.

Boundaries. Systems also have boundaries that create a border between the system or subsystem and the environment that affect the flow of information between the system or the subsystem and the system's environment (White & Klein, 2002). Minuchin (1974) suggested that boundaries can be classified into three main types: rigid, clear, or diffuse. These boundaries are used to indicate who participates in the family system and how they participate.

A rigid boundary in a family system contains members that function separately but lack belonging or group cohesion. In families with rigid boundaries, communication between family members becomes difficult and may lead to the extreme of disengagement. In addition, a rigid boundary could separate the family system from the outside world. For instance, a rigid boundary surrounding the family system may make seeking therapy and even opening up to a therapist more difficult than family systems with clear or diffuse boundaries. Because a rigid boundary affects the ease of communication between other systems, such as a mental health or social service agency, families with rigid boundaries may perceive more barriers to staying engaged in therapy services than other families. Those barriers that are still present during the therapy process may ultimately affect the families' outcome in therapy. Specifically, families who have institution involvement by a social service agency for child abuse may become overwhelmed with input from the agency and develop a rigid boundary by shutting everyone out of their lives.

On the other hand, families that have diffuse boundaries tend towards decreased distancing and increased communication and concern among family members that may take away from each member's personal autonomy. Taken to the extreme, diffuse boundaries can be considered enmeshment in a family (Minuchin, 1974). Like rigid boundaries, diffuse boundaries can affect the flow of information from the family system to the outside world, as well. For example, families who have institution involvement for child abuse and who have diffuse boundaries may also become overwhelmed with input from the social service agency, but instead of shutting down like a family with rigid boundaries, they do not know what to do with the information and often seek help from anyone they can.

Clear boundaries are considered ideal for optimal family functioning. Clear boundaries allow for contact between members of the subsystem as well as outside of the family system such that there is cohesion in the family. Clear boundaries also allow for autonomy of family members without causing disruption to the family system (Minuchin, 1974). A family system with clear boundaries might deal with involvement from a social service agency by taking in the input from the agency, identifying their options for improving their situation, and seeking help from a therapist or even from the social service agency.

Lastly, the developmental life cycle of the family may affect boundaries. For instance, parents may employ a more rigid boundary when their children are young to ensure protection and control by means of family rules and limit-setting. In contrast, an adolescent may need a more diffuse boundary to account for the adolescent's growing independence and right to autonomy (Minuchin, 1974).

Positive and negative feedback loops. Feedback is defined as "information about a system's performance that comes to the system from outside" (Montgomery & Fewer, 1988, p. 183). This kind of information can often be found in the form of feedback loops. Positive and negative feedback loops occur in systems and are error-activated, meaning that they are activated by something different than what was expected by the system. These feedback loops always begin with a perturbation, which is some change in the system that is felt by the system's members and interpreted in some way. The system may respond to the interpretation of the change in two ways: a negative feedback loop or a positive feedback loop (Montgomery & Fewer, 1988). In simpler terms, the family system receives information called an input (perturbation), makes sense of the input in some way, and then acts upon the interpretation of the input by providing an output of behaviors that either restores the system to the original state (negative feedback loop) or allows for change and growth within the system (positive feedback loop).

A negative feedback loop works to restore equilibrium, or homeostasis, to the system, such that the perturbation in the system is minimized, and the system's organization is not affected. More specifically, Speer (1970) indicated that when the perturbation occurs, behaviors are elicited within the family system to aid in maintaining the system's original functioning, of which he refers to as morphostasis. Thus, a negative feedback loop is enacted when the input is not expected and not wanted by the members of the family system. Within the parent-child relationship, an example of a negative feedback loop may transpire if a child throws a temper tantrum in order to get a toy from the store. The parent, who is embarrassed about the tantrum, gives in to the misbehavior

by purchasing the toy, so the child will calm down. Therefore, the child learns that misbehavior will get him what he wants.

The positive feedback loop also begins with a perturbation, or deviation, that the family system interprets in some way. In contrast to a negative feedback loop, a positive feedback loop is deviation-amplifying and acts to produce more variation in the system behavior by tending towards organizational change (Montgomery & Fewer, 1988; Whitchurch & Constantine, 1993; White & Klein, 2002). Speer (1970) suggested that positive feedback loops increase the difference between the new information or behavior and the family system's original standards rather than decreasing the differences, which is the goal of negative feedback loops. Furthermore, positive feedback loops are considered to be system-enhancing as well as helping to increase the viability of the family system. Thus, positive feedback loops help to create growth within a system, also referred to as morphogenesis, that may involve changes in relationship interactions, values, rules, and structural changes (Speer, 1970). An example of a positive feedback loop often occurs among parents and their adolescent children. The adolescent's curfew is 11 p.m. on the weekends, but the senior in high school has recently been missing her curfew by 30 minutes. The parents consider the breach of curfew and decide to extend the adolescent's curfew to 11:30 to account for their child's growing independence and signs of responsibility. The parents' reaction to the perturbation (the adolescent missing her curfew) led to a structural change within their household.

Maltreating families who are involved with institutions, such as social service agencies, may also respond to input with a negative or positive feedback loop. If abuse has occurred, the maltreated child is taken from the home, and the system receives input

from the agency about the requirements for reunification. A negative feedback loop occurs when the family perceives the requirements as controlling or overwhelming and chooses not to complete the requirements for regaining custody of the child. Therefore, they do not regain custody of the child, and the parent-child relationship does not improve. On the other hand, the family may interpret the input they receive from the social service agency as a need for change and a better relationship with their children. Consequently, they choose to complete the necessary requirements for reunification with the intent of reunifying with their child, which is a positive feedback loop.

Summary. In summary, general systems theory is helpful in understanding the relational dynamics of a family system. This study will utilize key concepts, such as system, subsystem, hierarchy, boundaries, and positive and negative feedback loops, to better understand the systemic interactions of maltreating parents and their children who have institutions involved in their lives. General systems theory concepts will also be used to more fully understand factors that affect dropout for maltreating families in family therapy.

Purpose

Barriers to help-seeking can keep clients from attending therapy to achieve their goals. However, achieving therapy goals still remains a struggle for some clients whose barriers are still present in their lives, even after they have been attending therapy sessions. Many maltreating families are required by a court or social service agency to attend family therapy sessions in order to regain custody of their children following an allegation of child abuse or neglect (Butler et al., 1994; Dinkmeyer et al., 1999). Despite their desire for reunification, many families who have institutions involved in their lives

for abuse and neglect seem to drop out of therapy before their goals are met, which indicates that certain factors may influence their choice to end therapy prematurely.

The purpose of this study is to identify and describe factors associated with therapy dropout by families with institutions involved in their lives for child abuse and neglect. Therefore, the current study will address the following research questions: (1) What factors keep families with institution involvement for child abuse and neglect from completing therapy? and (2) Are families with institution involvement more likely to prematurely terminate therapy than families without institution involvement? This study will test the following hypotheses:

H1. Families with institution involvement for child abuse and neglect will display significantly more of the client factors identified in literature as barriers than families who do not have institution involvement.

H2. Families with institution involvement for child abuse and neglect are more likely to drop out of therapy than families without institution involvement.

Answering these questions will prove beneficial to clinicians who work with this vulnerable population as well as the social service agencies who refer them for services. An awareness of the specific client factors that affect therapy dropout for maltreating families may help clinicians and social service agencies to gain a better understanding of what keeps these clients from staying engaged in their treatment, improving the parent-child relationship, and ultimately regaining custody of their children. By being cognizant of these factors, clinicians and others who work with these families may develop ways to reduce some of the constraints that maltreating families face, so these families can stay engaged in therapy and are able to achieve their goals. Ultimately, the present study

seeks to expand the current knowledge base of dropout research for maltreating families by including a broad range of client variables.

CHAPTER II

LITERATURE REVIEW

Premature termination from family therapy has been shown to be a problem for many maltreating families (Gershater-Molko et al., 2003; Lau and Weisz, 2003; Rittner & Dozier, 2000; Rivara, 1985). Moreover, many of these families drop out before completing their goals for therapy, so they may not be acquiring the skills and resources they need to care for their children and of which are required for them to regain custody of their children (Ogrodniczuk et al., 2005). Research has shown that clients' perceptions of barriers to engagement in therapy may be affecting their ability to successfully complete therapy, so they can make the much needed changes in their lives (Kazdin et al., 1997; McCabe, 2002; Reis & Brown, 1999). Barriers to therapy that are still present in client's lives after beginning therapy services may eventually affect their chances of a successful outcome in therapy.

Client Factors

Previous research has identified a number of client, therapist, and institutional barriers to therapy and factors that affect therapy dropout (Cunningham & Henggeler, 1999; Dinkmeyer et al., 1999; Grevious, 1985; Johnson, Harrison, Burnett, & Emerson, 2003; Kazdin et al., 1997; Shor, 1998; Spoth, Redmond, Hockaday, & Shin, 1996). Using smaller sub-groupings of these factors may make more explicit the influences they have on client success in therapy. Client factors that may affect dropout include client resources, client beliefs, family characteristics, and family influences.

Client Resources

Socioeconomic status (SES), age, marital status, culture, level of education, and health status have been shown to be factors associated with therapy dropout (Bischoff & Sprenkle, 1993; Dinkmeyer et al., 1999; Kazdin et al., 1997). Clients who drop out of therapy are more likely to be of lower SES, lack financial resources in the nuclear or extended family, be from a minority group, be younger, report health problems, and be a single parent (Bischoff & Sprenkle, 1993; Dinkmeyer et al., 1999; Kazdin et al., 1997). Additionally, therapy dropouts tend to live further from the clinic and earn less than $10,000 a year (Frankel & Simmons, 1992; Williams et al., 2005). Consistent with research, the effects of poverty and low income have been endorsed by parents as barriers to seeking help. Not surprisingly, low SES families are more likely to report financial concerns related to treatment engagement than higher SES families (Bussing, Zima, Gary, & Garvan, 2003). Cost of services has been shown to affect engagement in therapy such that engagement may be affected if the client perceives the services as costing too much (Johnson et al., 2003; Kissane, 2003).

Physical and mental health problems have also been identified as factors that affect therapy dropout. A study investigating therapy outcome among chronically depressed patients found that clients with a comorbid anxiety disorder were more likely to drop out of therapy prematurely when compared to those clients that completed therapy (Arnow et al., 2007). Other researchers have documented the effects of physical health problems, including lack of exercise, smoking use, and psychiatric comorbidity, on treatment attrition (Clark, Niaura, King, & Pera, 1996).

When examining factors relating to children, younger, maltreated children are less likely to obtain mental health services than older children (Hurlburt et al., 2004) while parental recognition of child behavior problems increases as children age, which may increase the chances of seeking help (Bussing et al., 2003). Other research has not shown age to be a significant contributor to therapy dropout among families (Shapiro, 1974). In addition, children who are placed into care outside of the home, such as nonrelative foster care or group care, are also more likely to receive mental health services, which suggests that there may be barriers to service use when children remain in their homes (Hurlburt et al., 2004). Gender, however, has not been shown to be a factor contributing to therapy dropout (Shapiro, 1974).

Level of education has been shown to be a factor related to dropout in family therapy. In a study of Mexican-American children and their parents in outpatient therapy, parents with higher levels of education were less likely to terminate prematurely from therapy. Conversely, parents with lower levels of education were more likely to terminate prematurely (McCabe, 2002).

Lastly, research has shown ethnicity, particularly minority status, to predict early termination among families. In their research on treatment attrition among Caucasian and African American families attending outpatient treatment for externalizing problems, Kazdin, Stolar, and Marciano (1995) found a higher rate of dropout among African American families than White families. They found that the African American families in this study had a lower SES and family income than their Caucasian counterparts. Among the African American families, they also found a higher percentage of single parent families as well as children living with a non-biological caregiver.

Culture and religion play an important role in families. They can be involved directly or indirectly in many decisions made throughout a person's life, including the decision to seek and remain engaged in therapeutic services. How problems are described, whether they choose to seek help, and who they choose to seek help from is often determined by clients' cultural beliefs and values (Cauce et al., 2002). Religion and culture can be characterized as another factor that influences engagement in family therapy for many people if there is conflict between religious and/or cultural beliefs and treatment goals (Peterson, Gable, Doyle, & Ewigman, 1997). Culture and religion affect not only the way clients perceive situations of child maltreatment but also their willingness to involve others in situations of child abuse and neglect; some prefer to not involve anyone outside of the nuclear family, some prefer to involve their religious leader, and others prefer to involve people outside the religious community, such as social workers or policemen (Shor, 1998).

Client Beliefs

In order to stay engaged in therapy, clients must first believe that they need help. Researchers have found that one of the most common perceived parental barriers was no perceived need for help (Bussing et al., 2003). No perceived need for help for family problems can affect therapy dropout. Parents who believe that their children's emotional or behavioral problems should be dealt with at home using increased discipline methods, rather than family therapy, are more likely to terminate family therapy prematurely (McCabe, 2002). The need for help may change over time, as well. The client may perceive that the problem has improved and help is no longer needed, which greatly influences their future engagement in therapy (Wang et al., 2006).

In addition, having a positive attitude towards seeking help was found to be associated with seeking professional help and remaining engaged during the therapy process (Mojtabai, Olfson, & Mechanic, 2002). Client attitudes regarding therapy influence their decision to seek help not only for themselves but for their family, as well. The impact of stigma may greatly influence a client's choice to attend therapy. Stigma related to therapy has been shown to be a perceived barrier for parents, particularly for parents of girls (Kissane, 2003). Negative expectations of the therapy process have also been shown to be a common perceived barrier, particularly for African American parents (Bussing et al., 2003). These results suggest that perceived stigma or negative expectations of therapy may keep parents from seeking help for their children.

Other client beliefs have been shown to affect client success in therapy. A lack of confidence, low self- and academic-esteem, a need for encouragement, personal problems, low empowerment, poor self-efficacy expectations, and a history of interpersonal ineffectiveness often dishearten clients and affect their feelings of capability for change (Cunningham & Henggeler, 1999; Johnson et al., 2003). Parents who drop out of therapy also tend to display characteristics of helplessness and negativity (Frankel & Simmons, 1992).

Family Characteristics

Certain family characteristics often are seen as factors that affect successful completion of therapy. A change in the structure of the family through separation, divorce, remarriage, or death can hinder a family's ability to complete therapy successfully (Dinkmeyer et al., 1999). Client dropout was found to be associated with parent-child relationship factors like harsh child-rearing practices, low parental bonding

with the child, inaccurate developmental expectations of the child, few tender feelings for the child, and child behavior problems (Cunningham & Henggeler, 1999; Kazdin et al., 1997; Peterson et al., 1997; Timmer et al., 2005). The number of children in the family has been found to be a predictor of therapy dropout, even suggesting that the more children in a family, the more likely a family member is to report a lack of cooperation from family members as a reason to not attend therapy (Allgood and Crane, 1991; Wang et al., 2006).

Family Influences

Influences from family members, such as willingness to attend family therapy sessions, also affect successful therapy outcomes. Family concerns about confidentiality will hinder therapy if clients are unsure about what information will be available to those outside of the therapy session (Grevious, 1985). Lack of cooperation from family members to attend therapy has also been shown to influence engagement in therapy (Wang et al., 2006). Clients report that their partner's desire to participate in therapy affects the decision to complete therapy. Fathers' lack of involvement in treatment has been found to be a client variable associated with therapy dropout (Bischoff & Sprenkle, 1993). Fathers were important in the decision to attend therapy as they were more likely to decline treatment participation than mothers (Spoth et al., 1996).

Summary

A multitude of client-related factors have been shown to affect successful completion of therapy. These client-related factors include client resources, client beliefs, family characteristics, and family influences. Using general systems theory as a theoretical framework, client-related factors, often referred to in the literature as barriers

to therapy, may be better understood using the concepts of boundaries and negative feedback loops.

First, client-related factors may be understood when explained using the concept of boundaries. Characteristics specific to the client can contribute to the boundaries surrounding the system or subsystems such that some characteristics may contribute to a rigid boundary, some may contribute to a clear boundary, and some may contribute to a diffuse boundary. Rigid boundaries surrounding the family system and between family members may be particularly important in understanding therapy dropout. This type of boundary may affect the therapist's ability to provide effective family treatment. One factor that could particularly affect the development of rigid boundaries is influence from family members, such as family loyalty, willingness to participate in treatment, or cultural/religious beliefs about seeking treatment for family problems. Some families may choose to not seek help from a therapist because working on family problems outside the family system is prohibited or considered disloyal. Furthermore, some cultures and religions may not believe in seeking help from mental health professionals, particularly if there are family problems (Cauce et al., 2002; Peterson et al., 1997). In this case, there is a rigid boundary surrounding the family system that does not allow for much integration between dealing with problems within and outside of the family system. At the same time, a rigid boundary surrounding the family can allow for a more diffuse boundary between subsystems as they seek help from family members or from a religious leader.

Rigid boundaries between family members may also affect therapy dropout. For instance, a rigid boundary between family members may exist if one person in the

parental subsystem does not agree to participate in therapy or if the client does not perceive a need for help. Therefore, if families believe that they are unable to remain engaged in therapy because of beliefs that seeking help is prohibited or disloyal to the family, a rigid boundary may lead to increased distancing from treatment and a lack of cohesion and communication between client and therapist.

In addition, client-related barriers to therapy may be further explained using the concept of feedback loops. A negative feedback loop may explain the process of child maltreatment and noncompliance in therapy. A report of child maltreatment within a family system may be followed by a court order for the family system to receive therapy and possible placement of the child into another's care, which is a perturbation in the system that is intended to achieve morphogenesis. The family system may perceive barriers, which include client resources, client beliefs, family characteristics, and family influences, that influence their engagement in therapy. The family system then reacts to the perceived client-related barriers in ways that seek to maintain morphostasis, such as choosing to drop out from therapy and not complying with the courts' requirements for reunification. Therefore, when the family system chooses to drop out from therapy, the chances of recidivism may be much greater compared to those families who gain more effective parenting skills via the therapy process.

In summary, the use of the general systems theory concepts of boundaries and negative feedback loops may better explain how client-related factors, such as client resources, client beliefs, family characteristics, family influences, may be perceived as barriers to receiving therapeutic services by clients and their families. The concepts also aid in the understanding of the relationship between client factors and therapy dropout.

Therapist Factors

A number of client-related factors have been noted to affect therapy dropout. However, research should not overlook the potential impact of the therapist on dropout. Dropout from family therapy can also be affected by factors associated with the therapist. These factors include therapist characteristics, therapist competence, the therapeutic alliance, and congruence between the therapist and the client.

Therapist Characteristics

Therapist characteristics, such as gender and race, have been shown to influence therapy retention (Bischoff & Sprenkle, 1993). Specifically in a study of marital therapy dropouts, having a male intake clinician was associated with dropout in marital therapy, particularly if the clinician was inexperienced in therapy. The authors suggest that inexperienced, male clinicians may take longer to develop therapy skills required to meet the needs of married couples seeking therapy (Allgood & Crane, 1991). Matching gender between therapist and client was also found to be associated with premature termination, particularly among African American females and Caucasian males (Williams et al., 2005).

Race of the therapist may affect therapy dropout. Researchers have suggested that mental health agencies "who represent the 'majority' may lack the cultural competence necessary for effective outreach and service provision," which may affect clients' decisions to stay engaged in treatment (Cauce et al., 2002, p. 50). Furthermore, a lack of understanding and appreciation for the client's cultural values has been found to be a common therapist barrier (Cunningham & Henggeler, 1999). McCabe (2002) found

that clients who were ethnically matched with the therapist were less likely to drop out of therapy.

Therapist Competence

The amount of clinical experience and clients' perceptions of therapist competence have been shown to influence retention in therapy (Bischoff & Sprenkle, 1993; Cunningham & Henggeler, 1999; Dyck, Joyce, & Azim, 1984). In one study, clients considered "continuers," having attended therapy for five or more sessions and who had a mutual agreement with the therapist regarding termination, rated their therapists as considerably more competent, knowledgeable, understanding, sensitive, accepting, and good listeners when compared with those who terminated therapy, early or late, and without mutual agreement of their therapist. When compared to early terminators, late terminators, those who terminated therapy after five or more sessions and without the mutual agreement of their therapist, echoed the continuers perceptions of their therapist as understanding and interested in helping them (Dyck et al., 1984).

Therapeutic Alliance

Since therapy is an interactive process, one could make the assumption that the interaction between the therapist and the client plays an important role in understanding why clients choose to continue or prematurely terminate therapy. The alliance between the therapist and his or her clients is particularly powerful in helping clients to stay engaged in their treatment. Bischoff and Sprenkle (1993) found that engaging in highly active behaviors, such as joining with clients, has been shown to greatly decrease client dropout. Other components that lead to a strong therapeutic alliance are strong emotional connections between the therapist and the family members, confidence in the therapist's

abilities, and agreement between the therapist and family members on therapy goals. Conversely, factors that lead to a weak therapy alliance include disagreement over therapy goals and the perception of therapists, in general, as mistrusting (Beck, Friedlander, & Escudero, 2006).

Furthermore, in a study of families dealing with child abuse and neglect, therapeutic alliance was found to be associated with therapy outcome in a number of ways. Agreement between clients and therapist on therapy goals was found to be an important aspect of the therapeutic alliance. In addition, feelings of trust, respect, and caring were found to be a moderator of posttreatment levels of violence. Specifically, family therapy with maltreating families who reported higher levels of violence pretreatment necessitated a trusting relationship with their therapist to begin making the changes toward a healthier family relationship (Johnson & Ketring, 2006). Thus, these research findings suggest that if clients, particularly maltreating families, do not feel an emotional connection with their therapist, the therapeutic alliance may be harmed, which could greatly increase the chances of premature termination from family therapy.

Congruence of Therapist and Client Perspectives

Agreement between therapist and client can influence the amount of engagement clients are willing to put into family therapy (Cunningham & Henggeler, 1999). Researchers have found that when therapists and clients have differing views about the problem, treatment goals, or strategies for overcoming the problem, therapist and client frustration and client dropout are more likely to occur (Cunningham & Henggeler, 1999). Reluctance to be videotaped, beliefs that the treatment is not very relevant, and a history of conflict with other mental health providers or social service agencies are common

barriers and factors related to therapy dropout (Cunningham & Henggeler, 1999; Johnson et al., 2003; Kazdin et al., 1997; Spoth et al., 1996).

Treatment acceptability, or “the extent to which consumers of treatment (e.g., children, adolescents, parents, and mental health professionals) view the treatment as reasonable, justified, fair, and palatable,” has been shown to be related to perceived barriers to treatment (Kazdin, 2000, p.158). Perceived barriers have been shown to predict parent and child evaluations of treatment acceptability. Specifically, clients who report more barriers view treatment as less acceptable than clients who report fewer barriers but receive the same treatment.

Therapist reactions to the types of problems that clients bring to therapy have been found to impede engagement. Blaming clients for their problems, having negative perceptions, and showing disgust for certain types of behavior, like sexual and physical abuse, have been shown to affect the therapist’s ability to maintain engagement in therapy among family members and the perpetrator (Cunningham & Henggeler, 1999; Grevious, 1985). In fact, clients whose therapists feel positive regard towards them are more likely to continue in treatment as opposed to clients whose therapists feel less positive regard towards them. Clients whose therapists feel less positive regard are more likely to terminate prematurely (Shapiro, 1974). Furthermore, even therapists’ perceptions of their clients’ prognosis influenced continuation or dropout of therapy. Predictions of discontinuation or a less hopeful prognosis were found to be associated with therapy dropout (Bischoff & Sprenkle, 1993; Shapiro, 1974) while clients whose therapists held a more hopeful prognosis for them were more likely to continue treatment (Shapiro, 1974).

Summary

In summary, factors associated with the therapist, such as therapist characteristics, therapist competence, the quality of the therapeutic alliance, and congruence between the perspectives of the client and therapist have been shown to affect therapy dropout. Gender and race (Bischoff & Sprenkle, 1993), the amount of clinical experience and degree of competence (Bischoff & Sprenkle, 1993; Cunningham & Henggeler, 1999; Dyck et al., 1984), the strength of the therapeutic alliance (Bischoff & Sprenkle, 1993; Johnson & Ketring, 2006), and incongruence between client and therapist perspectives on the problem and treatment (Cunningham & Henggeler, 1999) have been identified as factors that lead to therapy dropout. The general systems theory concept of boundaries may provide a better understanding of how these particular therapist factors contribute to therapy dropout for many families.

The strength of the therapeutic alliance is shown to be a significant factor in therapy dropout (Bischoff & Sprenkle, 1993; Johnson & Ketring, 2006). If the family system perceives seeking outside help for family problems as disloyal or prohibited, developing a strong relationship with the therapist may become more difficult. A weak therapeutic alliance may influence the development of a rigid boundary surrounding the family system. The family system may seek to develop a rigid boundary to protect their family from a perceived distrustful relationship. The clients may choose not to disclose personal information to their therapist, or they may choose to discontinue therapy sessions, all of which would greatly inhibit their chances of achieving their therapy goals.

Institutional Factors

In addition to client and therapist factors perceived by clients as barriers to completion of therapy, institutional factors may also affect dropout. Many types of social institutions, such as social service agencies, may affect therapy dropout. More specifically, who the clients are referred to therapy by may influence therapy dropout.

Referral Source

As discussed previously, many families are referred to family counseling by family or juvenile court through a court-order (Staudt, Scheuler-Whitaker, & Hinterlong, 2001) especially if there has been an allegation of child abuse or neglect. Clients who are referred by an institution are more likely to end therapy prematurely than clients who are self-referred or referred by an individual professional (Bischoff & Sprenkle, 1993). How much choice parents have about receiving services, how the treatment is presented to the family, and the expectations for the family's outcome created by these referral sources may affect the client's determination to complete treatment (Cunningham & Henggeler, 1999). Therefore, clients referred by an institution may feel that they do not have a voice in the therapeutic process thereby influencing their choice of whether to continue or discontinue treatment.

Summary

In summary, institutional factors have been shown to affect therapy outcome. In addition to client and therapist-related factors, the referral source may affect therapy dropout among families. Specifically, clients referred by an institution are more likely to drop out of therapy than clients who are self-referred or referred by an individual professional (Bischoff & Sprenkle, 1993). General systems theory may provide a clearer

picture of how referral source affects many families' decisions to end therapy prematurely.

Similar to the client and therapist factors, the concept of boundaries may help to explain the impact of referral source on therapy dropout. If clients feel that attending therapy with a specific outcome for their family is being imposed upon them by an institution, the family system may develop a rigid boundary in order to keep the institution from having power over their family. Similarly, clients may feel that they do not have a voice, rather they are being told what to do and how to live. Choosing to end therapy before therapy goals are met may be a way for clients to resist the requirements of the institution and regain some choice over their own lives.

CHAPTER III

METHODOLOGY

The purpose of this quantitative study was to identify and describe client factors associated with therapy dropout. Additionally, the study determined if families with institution involvement, such as court or Child Protective Services, for child abuse and neglect are more likely to drop out of therapy than families without such institution involvement. Therefore, in order to come to a better understanding of therapy dropout for families with institution involvement for child abuse and neglect, this quantitative research study utilized descriptive, inferential, and comparative research methods to test each hypothesis.

Sample

The target population was families who presented for therapy for child abuse and neglect at a marriage and family therapy training facility at a south-central state university between February 2000, and June 2005. During this five year period, the target groups were selected on the following variables: presenting problem, whether or not institutions were involved in the case, and type of case. These variables were found in clinic paperwork that was utilized in the study. Specifically, the research study included cases that received therapy for child abuse and neglect with institution involvement, such as Child Protective Services. The court system was also considered an institution in this study because the court system often works with Child Protective Services to mandate family counseling after an abuse or neglect allegation. The

subjects in the sample involved the perpetrator of the abused/neglected child, the child, and other relevant family members. The comparison group included families with children who received therapy for a presenting problem other than child abuse and neglect and who did not have institution involvement by Child Protective Services or the court system. The study included only cases which attended therapy at the same facility between the dates of February 2000, and June 2005. The study excluded cases who attended therapy before February 2000, and after June 2005. The sample drawn is a convenience/availability sample as the researcher is a marriage and family therapy intern and has easy access to confidential, client files.

Data Collection Methods

The study analyzed already-collected data from the marriage and family therapy training facility, which is in a Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) accredited master's degree program. The training facility is an on-campus clinic that specializes in relational therapy, such as individual counseling in relation to the client's family-of-origin, marriage or relationship counseling, and family counseling. The training facility is managed by marriage and family therapy interns who are working towards their master's degrees in Human Development and Family Science with a specialization in Marriage and Family Therapy. As marriage and family therapy interns, they are required to complete 500 client-contact hours, in which they have direct contact with the client, in order to be eligible to graduate with a master's degree in marriage and family therapy. Therapy sessions at the clinic are supervised by a clinical supervisor at all times from a room specifically designed for observation by the supervisor and other marriage and family therapy interns.

To make an appointment, clients phone the training facility to schedule a counseling session with a marriage and family therapy intern. During the initial phone call, clients complete a telephone intake (see Appendix A) with a marriage and family therapy intern. The telephone intake takes approximately five to ten minutes to complete and consists of questions inquiring about the client's family, contact information, presenting problem, financial status, session availability, and referral source. Then, the telephone intake is given to the director of the training facility or another clinical supervisor to assign a marriage and family therapy intern as the therapist or co-therapist for the clients requesting a therapy session. After being assigned the case, the therapist or co-therapist phones the client to schedule an appointment for a first session using the contact information provided on the telephone intake. The family schedules an initial appointment and is asked to arrive twenty to thirty minutes prior to that appointment to complete two pieces of clinic paperwork: the background form (see Appendix B) and a Family Adaptability and Cohesion Evaluation Scale (FACES III) (see Appendix C) (Olson, Portner, & Lavee, 1985).

During the initial appointment, the clients read and, if they choose, sign the Counseling Agreement form (see Appendix D), in which they consent to the observation, recording, and utilization of confidential data of their case. They also read and, if they choose, sign the Client's Rights form (see Appendix E), which informs clients of their rights, including confidentiality, limits to their confidentiality, and therapy services provided by the clinic. Depending on the length of treatment, additional paperwork is completed by the client that includes additional FACES III forms. Following each therapy session, the therapists complete a session summary that summarizes what the

client said during the session, homework, session and therapy goals, and whether progress was made toward these goals (see Appendix F). A diagnosis and treatment plan was completed by the therapist following the client's third therapy session that includes a summary of the presenting problem, a diagnosis of the client, and a summary of the proposed treatment (see Appendix G). At the conclusion of treatment, a termination report was completed by the therapist that includes the number and type of sessions attended (individual, couple, or family), a summary of the presenting problem at the beginning of therapy, and a summary of the problem at the end of therapy (see Appendix H). The session summaries, diagnosis and treatment plan, and termination report are reviewed and signed by the clinical supervisor.

Instrumentation

For analysis, this study utilized data selected from four clinic forms: the background form, telephone intake, diagnosis and treatment plan, and termination report. These instruments are based upon the client's self-reports and the therapist's perspectives throughout the duration of therapy. The researcher utilized these instruments to gain a better understanding of the variables that may contribute to therapy dropout for families with institution involvement for child abuse and neglect. These instruments were also used to describe therapeutic outcomes for families with institution involvement and families without institution involvement.

Telephone Intake

The researcher examined the telephone intake form (see Appendix A) for the client's perspectives regarding questions from the intake form using information regarding the presenting problem, referral source, and financial information. All reports

are based on client responses to the therapist's inquiries during the telephone interview in which the telephone intake was completed.

Background Form

The background form (see Appendix B), a self-administered questionnaire completed by the client, was reviewed by the researcher. This instrument provided the researcher with information regarding the client's personal information including demographic information, immediate family, extended family, deceased family members, medical history, reasons for seeking services, seriousness of the problem, how likely the problem is to change, what the client hopes to gain from services, and referral source. From this form, the researcher explored the client's responses to the following sections: age, ethnicity, highest level of education completed, marital status, health status, reason for seeking services, seriousness of problem, how likely the problem is to change, and referral source.

Diagnosis and Treatment Plan

The diagnosis and treatment plan (see Appendix G) is completed by the therapist after sessions three, twelve, and at termination. This instrument provides information on the family's definition of the problem, diagnosis, and proposed treatment. The fifth axis of the DSM-IV is listed on the diagnosis and treatment plan as global assessment of functioning (American Psychiatric Association, 2000). The global assessment of functioning score (GAF) evaluates individual psychological, social, and occupational level of functioning. Based on the therapist's evaluations of the individual client, the therapist assigns a GAF score between 0 and 100, with 0 indicating inadequate

information and 100 indicating superior functioning. For this study, the researcher focused on the GAF scores as a measure of client level of functioning.

Termination Report

Lastly, the researcher used the termination report (see Appendix H) completed by the therapist upon closing the case to determine the reasons for termination. The therapist can choose one of four options for termination status: completion of therapy, client request, no shows/cancellations (letter sent by therapist), or other. *Completion of therapy* indicates that the client completed therapy goals and terminated with the consent of the therapist. *Client request* indicates that the client requests to end therapy. For example, clients may request to end therapy if they are unable to afford the therapy fee or if scheduling conflicts arise. *No shows/cancellations* signify that the clients did not show for their therapy appointment. In this case, the therapist sends a letter to the clients in order to persuade them to attend therapy sessions. Lastly, *Other* indicates any other reason than those listed above to describe the reason for termination. From this form, the researcher will investigate reasons for termination. These indications along with number of sessions attended were used to develop an outcome variable that included dropouts, continuers, and completers. Dropouts included those who attended one or two therapy sessions and did not complete goals. Continuers included those who attended three or more therapy sessions but did not complete goals, and completers included those who completed their therapy goals.

Summary

In summary, this study used already-collected data from a marriage and family therapy training clinic at a south-central state university. The clinic is a training facility

for master's students in marriage and family therapy, who are supervised by a clinic supervisor. At this training clinic, clients can be seen individually, as a couple, or as a family for relational problems. Specifically, the sample included therapy cases that have institution involvement for child abuse and neglect. The comparison group included family cases with children who sought treatment for problems other than child abuse and neglect and who did not have institution involvement. Clinic forms, including the telephone intake, background form, diagnosis and treatment plan, and termination report were examined to gain client as well as therapist perspectives on the family system, the presenting problem, factors that affect therapy dropout, referral status, and termination status.

Data Analysis Plan

This study employed a quantitative research design to test the hypotheses. A quantitative research method involves using strategies such as experiments or surveys to collect data from selected instruments that will produce statistical results (Creswell, 2003). The purpose of the current study is to identify and describe factors associated with dropout of family treatment for families with institution involvement for child abuse and neglect. This study incorporated quantitative methods by identifying group differences in therapy outcome and factors that affect therapy dropout for clients with institution involvement and clients without institution involvement.

Analysis of Hypotheses

In this quantitative study, the hypotheses were tested using a one-way analysis of variance (ANOVA), an analysis of covariance (ANCOVA), and a chi-square test for one-way designs. The one-way ANOVA is a method of statistics that is used to test for group

differences in two or more populations that differ on one independent variable. The ANCOVA is a method of statistics that uses a covariate, information from a continuous, independent variable, to remove systemic individual differences among subjects from the estimate of experimental error. The chi-square test for one-way designs, a type of nonparametric statistical test, is used to test categorical, frequency data that includes one independent variable with two or more levels. Often called a goodness-of-fit test, the chi-square test is used by researchers to ascertain whether the observed frequencies differ systematically from the theoretically expected frequencies or whether the differences are due to chance. If significant differences were found, post hoc comparisons were utilized to determine where the differences occurred (Shavelson, 1996).

Hypothesis 1. Hypothesis 1 states that families with institution involvement for child abuse and neglect will display significantly more of the client factors identified in literature as barriers than families without institution involvement. To test hypothesis 1, the researcher utilized a one-way ANOVA to explore group differences on client factors related to dropout of family therapy when comparing families with institution involvement and families without institution involvement. The client factors of family characteristics and family influences as well as all therapist factors identified in the literature review will not be analyzed due to limitations in the data. A chi-square test for one-way designs was also used to test differences on categorical variables. Specific client variables are shown in greater detail on Table 1.

Table 1

Client Variables

Variable	Source	Question(s)
Income	Telephone Intake	Yearly income before taxes.
		Any financial considerations?
Cost	Telephone Intake	Fee.
Age	Background Form	Age.
Marital Status	Background Form	Are you married?
		If yes, how long?
		Times married before.
Ethnicity	Background Form	Ethnicity.
Health Status	Background Form	Circle your current state of health:
		Excellent Good Fair Poor.
Level of Education	Background Form	Highest level of education completed.
Hope	Background Form	How serious would you say this problem is right now?
		How likely do you think the problem is to change?

Furthermore, the researcher combined two questions from the background form regarding client perspectives on seriousness of the problem and likelihood for change to measure the hope variable. The researcher identified the responses of “not at all serious” and “slightly serious” as a low degree of seriousness. A high degree of seriousness was

illustrated by the responses of “moderately serious” and “very serious.” To determine degree of likelihood for change, the researcher selected the responses of “not at all likely” and “slightly likely” as a low likelihood for change. Conversely, “moderately likely” and “very likely” were considered a high likelihood for change.

Low and high seriousness and likelihood for change were developed into a table in order to measure client hope in three levels (low, moderate, high). For example, a low degree of seriousness and a high likelihood of change would indicate a level of high hope. A high degree of seriousness and a high likelihood of change would indicate a moderate level of hope. A low degree of seriousness and low likelihood of change as well as a high degree of seriousness and a low likelihood of change would indicate a level of low hope. The hope variable is shown in greater detail in Table 2.

Table 2

Hope Variables

Likelihood For Change	Seriousness of Problem	
	Low	High
High	High Hope	Moderate Hope
Low	Low Hope	Low Hope

Hypothesis 2. Hypothesis 2 states that families with institution involvement for child abuse and neglect are more likely to drop out of therapy than families without institution involvement. To test this hypothesis, a one-way ANOVA was employed to determine group differences on therapy outcome among families with institution involvement and families without institution involvement. An ANOCVA test was also

used to control for problem severity using the GAF score found on the diagnosis and treatment plan. The variables of presenting problem and referral source were taken from the telephone intake and the background form. The variable of therapy outcome was taken from the termination report on the section stating reasons for termination. These variables and their sources are further described in Table 3.

Table 3

Therapy Outcome Variables

Variable	Source	Question(s)
Referral Source	Telephone Intake	How did you hear about us?
		Who referred you?
	Background Form	Who referred you to our services?
		If self-referred, how did you find out about our services?
Therapy Outcome	Termination Report	Reasons for Termination:

Summary

In summary, this study employed quantitative methods of measurement to test the hypotheses. A one-way ANOVA, ANCOVA, and chi-square test for one-way designs were used to determine group differences among families with institution involvement and families without institution involvement on therapy outcome and factors associated with therapy dropout for treatment for child abuse and neglect. These quantitative methods of analysis aided in a better understanding of the problem of therapy dropout among families with institution involvement and without institution involvement.

CHAPTER IV

RESULTS

The current study yielded a total sample of 71 cases in which all participants attended at least one therapy session and completed the initial clinic paperwork. The methods of analysis used to evaluate the results of the hypotheses were chi-square tests, one-way analysis of variance (ANOVA) tests, and analysis of covariance (ANCOVA) tests. The one-way ANOVA was used to test for group differences in two or more populations that differ on one independent variable. Post hoc comparisons were used to determine where the differences occurred. The ANCOVA used a covariate to remove systemic individual differences among subjects from the estimate of experimental error. The chi-square test was used to test categorical, frequency data that include one independent variable with two or more levels (Shavelson, 1996).

Sample Demographics

Of the 71 cases in the sample, the comparison group included 41 family cases with children that did not have institutional involvement by Child Protective Services or the court system for child abuse or neglect. The experimental group included thirty cases that did have institutional involvement with Child Protective Services or the court system for child abuse or neglect. Of the 30 with institutional involvement, 23 cases (32.4%) were referred by Child Protective Services, and 7 cases (9.9%) were referred by court. Of the 41 without institutional involvement, twenty five cases (35.2%) were self-referred, 8 cases (11.3%) were referred by an individual therapist, 6 cases (8.5%) were referred by

a school/teacher, and 2 cases (2.8%) were referred by a doctor. The total sample consisted of the following types of therapy received at the training facility: 6 individual (8.5%), 12 couple (16.9%), 50 family (70.4%), and 3 mixed (4.2%). A mixed therapy type indicates that the clients received an equal combination of more than one type of therapy. The total number of sessions attended ranged from 1 to 38 sessions (M = 5.68, Mdn = 4.00, mode = 1). Three cases (4.2%) did not report this identifying information. Of the 68 cases, 24 cases attended therapy sessions only once or twice and were classified as dropouts for this study. The number of family members ranged from two to seven with the majority of families having three to five people in the family (M = 4.28, Mdn = 4.00, mode = 4). Four cases (5.6%) did not report number of family members. Yearly income ranged from \$0 to over \$100,000 for 54 cases (in thousands, M = 15.11, Mdn = 11.00, mode = 0). Seventeen cases (23.9%) did not report yearly income.

Primary Female Client Demographics

The primary client data was separated into smaller sub-groupings of primary female and primary male. A status of primary female indicated the most significant adult female in the case. A status of primary male indicated the most significant adult male in the case. The total number of subjects was 110. The number of primary females who attended therapy was 70. For one case in the sample, the primary client was a single father. Of the 70 females, clients were classified into five groups: 34 mothers (47.9%), 17 wives (23.9%), 10 female individuals (14.1%), 7 female partners (9.9%), and 2 grandmothers (2.8%). Ages ranged from 20 to 88 years of age (M = 33.85, Mdn = 31.50, mode = 24) (see Table 4).

Table 4

Mean Ages for Females and Males

	Mean	
	Females	Males
Age	33.85	36.45

The sample included 31 Caucasian females (43.7%), 10 females (14.1%) identified themselves as American Indian/Alaska Native, and 1 female (1.4%) was of a mixed ethnic background (see Table 5). Data from 29 cases (40.8%) did not report ethnicity. Of the 70 primary female clients, 41 (58.6%) did not have institution involvement in their case, and 29 (41.4%) did have institution involvement in their case (see Table 6).

Table 5

Ethnic Differences between Females and Males in Frequencies

	Females	Males
Ethnicity		
African American/black		1
Amer. Indian/Alaska Ntv.	10	2
Hispanic/Latino		1
White/Caucasian/Euro.	31	22
Mixed Ethnic Bkgd.	1	1

Table 6

Institution Involvement for Females and Males in Frequencies

	Females	Males
	Institution Involvement	
No Institution	41	21
Institution	29	19

Thirty three females reported being married (46.5%) while 35 female clients (49.3%) were not married (see Table 7). Three cases (4.2%) did not report marital status. For the married female clients, number of years married ranged from less than one year to 50 years (M = 11.23, Mdn = 7.00, mode = 4). Thirty six cases (50.7%) did not report length of marriage. Thirty three females (46.5%) reported never having been married before, 19 females (26.8%) reported having been married once before, 12 females (16.9%) reported having been married twice before, and 1 female (1.4%) reported having been married three times before. Six cases (8.5%) did not report prior marriage information.

Table 7

Marital Status Differences between Females and Males in Frequencies

	Females	Males
	Marital Status	
Married	33	28
Not Married	35	12

Client education levels ranged from elementary to graduate school with the majority of female clients having attended some high school (19.7%), graduated from

high school (40.8%), and some college (22.5%) (see Table 8). Twelve females (16.9%) worked as other professionals, managers, teachers, and nurses; twelve females (16.9%) worked in sales, technicians, and clerical; ten females (14.1%) identified themselves as homemakers; nine females (12.7%) identified themselves as students; seven females (9.9%) were general service employees; four females (5.6%) worked as laborers, factory workers, or waitresses; three females (4.2%) worked in skilled and building trades, farmer; two females (2.8%) identified their occupation as other; and one female (1.4%) was unemployed (see Table 9). Eleven cases (15.5%) did not report occupation.

Table 8

Frequency Differences in Highest Level of Education Completed for Females and Males

	Females	Males
	Highest Level of Education Completed	
Graduate School	1	1
4 Year College	4	4
Some College	16	10
High School	29	13
Some High School	14	7
Elementary	1	

Table 9

Differences in Occupation for Females and Males in Frequencies

Occupation	Females	Males
Other	2	1
Prof., doctors, lawyers, executives		4
Other prof., managers, teachers, nurses	12	5
Skilled/building trades, farmers	3	11
Sales, techs., clerical	12	4
Laborer, factory worker, waitress	4	3
General Service	7	2
Homemaker	10	
Student	9	3
Unemployed	1	2

Primary Male Client Demographics

The number of primary male clients who attended therapy was 40. Of the 40 males, the clients were classified into five groups: 16 husbands (22.5%), 8 male partners (11.3%), 7 fathers (9.9%), 7 step fathers (9.9%), and two were mother's male friends (2.8%). Ages for males ranged from 19 to 59 years (*M* = 36.45, *Mdn* = 34.50, mode = 24) (see Table 4). Twenty two males (31.0%) identified themselves as Caucasian, two males (2.8%) were American Indian/Alaska Native, one male (1.4%) was African American/black, one male (1.4%) was Hispanic/Latino, and one male (1.4%) identified with a mixed ethnic background (see Table 5). Of the 40 primary male clients, 21

(52.5%) did not have institution involvement in their case, and 19 (47.5%) did have institution involvement in their case (see Table 6).

Twenty eight males (39.4%) were married, and twelve males (16.9%) were not married (see Table 7). Thirty one cases (43.7%) did not report marital status. The number of years married ranged from less than one year to 23 years (*M* = 9.04, *Mdn* = 7.00, mode = 5). Eighteen males (25.4%) report having never been married before, 13 males (18.3%) have been married once before, four males (5.6%) have been married twice before, two males (2.8%) have been married three times before, and one male (1.4%) has been married four times before. Thirty three cases (46.5%) did not report prior marriages.

Highest level of education completed for males ranged from some high school to graduate school with the majority of males attending some high school (9.9%), graduating from high school (18.3%), and attending some college (14.1%) (see Table 8). Eleven males (15.5%) worked in skilled and building trades, or farmer; five males (7.0%) worked as other professionals, managers, teachers, or nurses; four males (5.6%) worked as professionals, doctors, lawyers, or executives; four males (5.6%) worked in sales, technicians, or clerical; three males (4.2%) worked as laborers, factory workers, or waitresses; three males (4.2%) identified themselves as students; two males (2.8%) worked as general service employees; two males (2.8%) were unemployed; and one male (1.4%) identified his occupation as other (see Table 9). Thirty six cases (50.7%) did not report occupation.

Hypothesis Testing

The statistical analyses used to test hypotheses 1 and 2 were chi-square tests, one-way ANOVA statistics, with post hoc comparisons using least significant difference (LSD) t test, and the ANCOVA method of statistics.

Hypothesis 1

Hypothesis 1 states that families with institution involvement for child abuse or neglect will display significantly more of the client factors identified in literature as barriers than families without institution involvement. Differences between clients with institution involvement and without institution involvement were tested using one-way ANOVA tests and chi-square tests.

Client Factors. Differences between ages for clients who had institution involvement and who did not have institution involvement were tested using a one-way ANOVA. Results indicate that there was a significant difference in age between females without institution involvement (M = 36.70, SD = 12.56) compared to females with institution involvement (M = 29.79, SD = 7.88), F(1, 66) = 6.64, p = .01 (see Table 10).

Table 10

Analysis of Variance for Female Age

Source	*df*	*F*	*p*
	Between groups		
Age	1	6.64	.01
	Within groups		
Age	66		

While not significant for males in this study, there was a slight difference in age of men who did not have institution involvement (*M* = 37.10, *SD* = 10.19) and for men who did have institution involvement (*M* = 35.74, *SD* = 12.39), $F(1, 38) = .145$, *ns* (see Table 11). Figures 1 and 2 display in graphical form the differences in mean ages for females and males with and without institution involvement.

Table 11

Analysis of Variance for Male Age

Source	*df*	*F*	*p*
	Between groups		
Age	1	.145	.706
	Within groups		
Age	38		

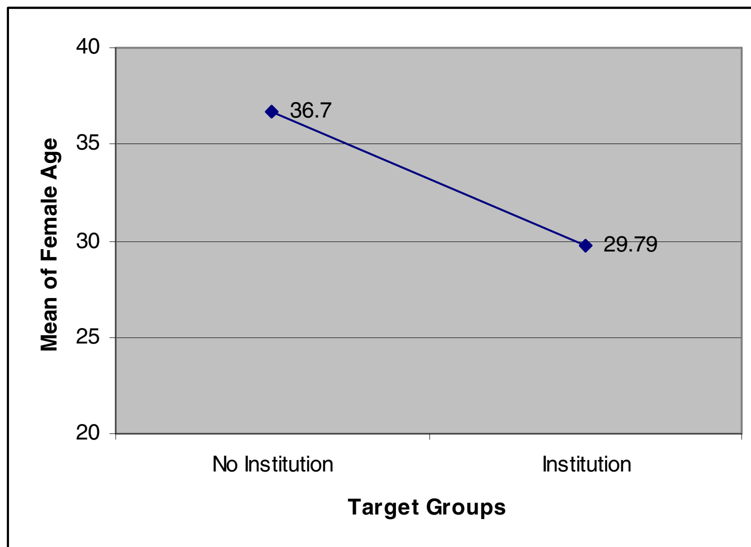

Figure 1. Mean Differences in Female Age

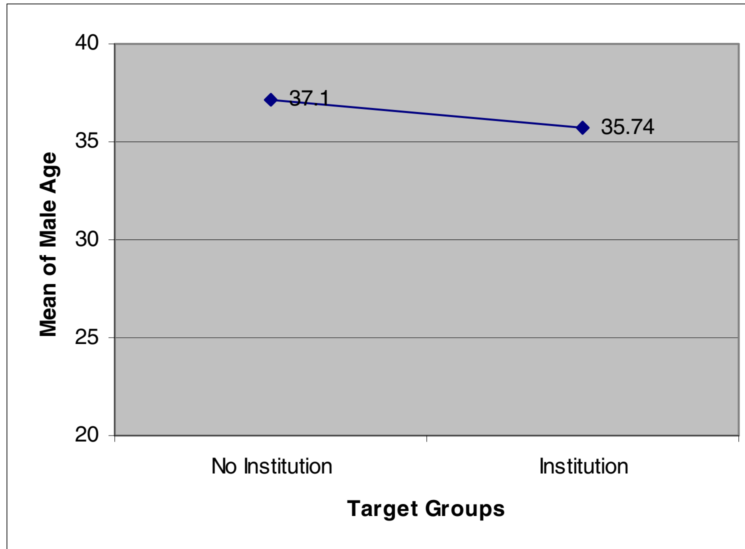

Figure 2. Mean Differences in Male Age

The researcher used a chi-square test to examine marital status among female and male clients without institution involvement and with institution involvement (see Table 12). However, significant differences were not found between the two groups on marital status for either females, $X^2(1, N = 68) = .207$, *ns,* or males $X^2(1, N = 40) = 2.53$, *ns*.

Table 12

Marital Status for Females and Males in Percentages

	Females		Males	
	Institution	No Institution	Institution	No Institution
Married	51.7%	46.2%	57.9%	81.0%
Not Married	48.3%	53.8%	42.1%	19.0%

An examination of the one-way ANOVA showed no significant difference in yearly income between clients with institution involvement and without institution involvement, $F(1, 52) = .451$, *ns*, or fee quoted, $F(1, 59) = .197$, *ns* (See Table 13). Means (with standard deviations in parentheses) for clients without institution

involvement on yearly income (in thousands dollars) and fee quoted (in dollars) were 16.57 (21.09) and 19.40 (17.18), respectively. Means (with standard deviations in parentheses) for clients with institution involvement on yearly income and fee quoted were 13.29 (12.52) and 17.58 (13.87), respectively.

Table 13

Analysis of Variance for Yearly Income and Fee Quoted

Source	*df*	*F*	*p*
	Between groups		
Yearly Income	1	.451	.505
Fee Quoted	1	.197	.659
	Within groups		
Yearly Income	52		
Fee Quoted	59		

Money concerns for clients without institution involvement and with institution involvement were analyzed using a chi-square test (see Table 14). While the majority of cases reported some form of money concern, results identified no significant differences between groups on types of money concerns, $X^2(5, N = 61) = 4.35$, *ns*.

Table 14

Money Concerns among Target Groups in Percentages

	Target Groups		
Money Concerns	No Institution	Institution	Total
No	18.4%	21.7%	19.7%
Yes, Student	15.8%	0%	9.8%
Yes, Low Income	26.3%	30.4%	27.9%
Yes, Fin. Problems	15.8%	21.7%	18%
Yes, Don't Know	18.4%	17.4%	18%
Debt	5.3%	8.7%	6.6%
Total	100.0%	100.0%	100.0%

Results from a one-way ANOVA test did not show significant differences in present state of health between clients without institution involvement and with institution involvement. For females, no significance was found for those without institution involvement (M = 2.17, SD = .811) and those with institution involvement (M = 2.11, SD = .577), $F(1, 61)$ = .092, *ns* (see Table 15).

Table 15

Analysis of Variance for Female Present State of Health

Source	*df*	*F*	*p*
	Between groups		
Health	1	.092	.763
	Within groups		
Health	61		

For males, no significance was found for those without institution involvement (*M* = 1.85, *SD* = .813) and those with institution involvement (*M* = 1.94, *SD* = .574), $F(1, 34) = .132$, *ns* (see Table 16).

Table 16

Analysis of Variance for Male Present State of Health

Source	*df*	*F*	*p*
	Between groups		
Health	1	.132	.718
	Within groups		
Health	34		

An analysis of a one-way ANOVA showed a significant difference on highest level of education completed among clients with institution involvement and without institution involvement for both females and males. For females, significance was found for those without institution involvement (*M* = 3.43, *SD* = .835) and those with institution involvement (*M* = 4.36, *SD* = .826), $F(1, 63) = 19.73$, $p = .00$ (see Table 17).

Table 17

Analysis of Variance for Female Highest Level of Education Completed

Source	*df*	*F*	*p*
	Between groups		
Education	1	19.73	.000
	Within groups		
Education	63		

For males, significance was found for those without institution involvement (*M* = 3.06, *SD* = .998) and those with institution involvement (*M* = 4.18, *SD* = .728), $F(1, 33) = 14.26$, $p = .00$ (see Table 18). Figures 3 and 4 display differences in highest level of education completed among females and males with institution involvement and without institution involvement.

Table 18

Analysis of Variance for Male Highest Level of Education Completed

Source	*df*	*F*	*p*
	Between groups		
Education	1	14.26	.001
	Within groups		
Education	33		

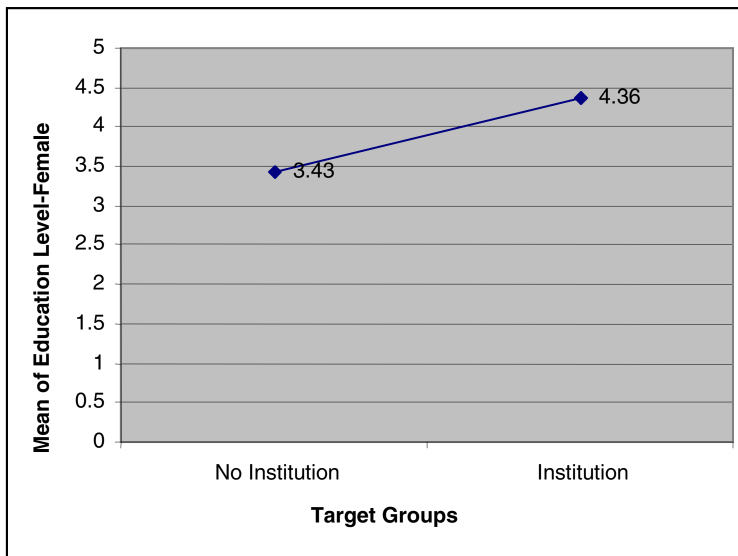

Figure 3. Mean Differences in Highest Level of Education Completed for Females

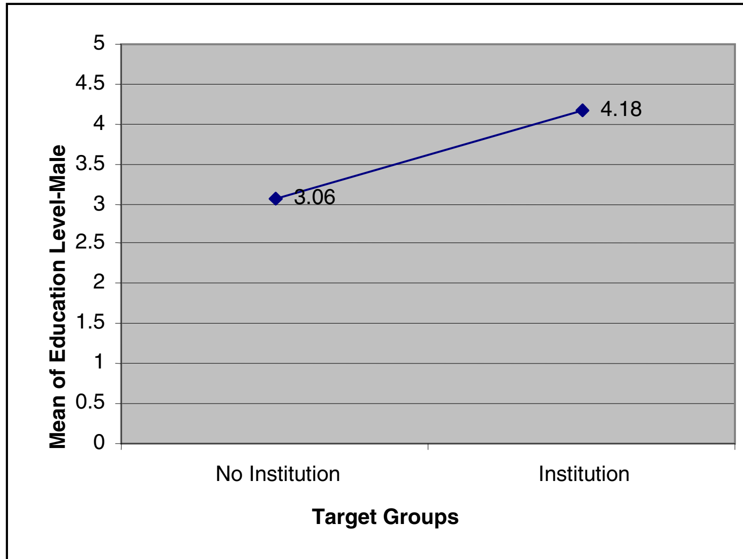

Figure 4. Mean Differences in Highest Level of Education Completed for Males

The researcher used a chi-square test to examine the difference in ethnicities among clients without institution involvement and clients with institution involvement. For females, no significant difference in ethnicity was found between females without institution involvement and with institution involvement, $X^2(2, N = 42) = .819$, *ns*. For males, no significant difference in ethnicity was found between males without institution involvement and males with institution involvement, $X^2(4, N = 27) = 5.46$, *ns* (see Table 19).

Table 19

Ethnic Differences among Groups in Percentages

	Females		Males	
Ethnicity	Institution	No Institution	Institution	No Institution
African American			8.3%	.0%
American Indian	20.0%	25.9%	.0%	13.3%
Hispanic			8.3%	.0%
Caucasian	80.0%	70.4%	75.0%	86.7%
Mixed	.0%	3.7%	8.3%	.0%

A one-way ANOVA analyzed client hope between clients with institutional involvement and clients without institutional involvement. For females, no significant difference in hope was found between those without institution involvement ($M = 2.06$, $SD = .69$) and those with institution involvement ($M = 2.00$, $SD = .69$), $F(1, 58) = .106$, *ns*, (See Table 20).

Table 20

Analysis of Variance for Female Hope

Source	*df*	*F*	*p*
	Between groups		
Hope	1	.106	.746
	Within groups		
Hope	58		

For males, no significant difference in hope was found for males without institution involvement ($M = 1.94$, $SD = .66$) and males with institution involvement ($M = 1.94$, $SD = .68$), $F(1, 31) = .000$, *ns*, (See Table 21).

Table 21

Analysis of Variance for Male Hope

Source	*df*	*F*	*p*
	Between groups		
Hope	1	.000	.988
	Within groups		
Hope	31		

Global assessment of functioning (GAF Score) was analyzed using a one-way ANOVA test. This analysis included both males and females because the therapist chose whether to diagnose either the primary female client or primary male client in each case. Results showed no significant differences on GAF scores between clients without institution involvement ($M = 64.40$, $SD = 14.19$) and with institution involvement ($M = 60.53$, $SD = 17.37$), $F(1, 68) = 1.05$, *ns*, (See Table 22).

Table 22

Analysis of Variance for Global Assessment of Functioning

Source	*df*	*F*	*p*
	Between groups		
GAF Score	1	1.05	.309
	Within groups		
GAF Score	68		

In summary, one-way ANOVA tests and chi-square tests were used to examine differences among clients with institution involvement and without institution involvement on client factors, including age, marital status, yearly income, fee quoted, money concerns, present state of health, highest level of education completed, ethnicity, hope, and GAF score. Significant differences were found for client age and highest level of education completed between clients with institution involvement and clients without institution involvement. Significant differences between clients with institution involvement and without institution involvement were not found for all other client factors.

Hypothesis 2

Hypothesis 2 states that families with institution involvement for child abuse or neglect are more likely to drop out of therapy than families without institution involvement. Three main categories were identified to describe therapy outcome: dropout, continuer, and completer. A therapy dropout was considered to have attended two or fewer sessions and not completed goals. A therapy continuer was deemed as having attended three or more sessions and not completed goals. A therapy completer was identified as having completed goals. The comparison group was identified as not having institution involvement in the case, and the experimental group was identified as having institution involvement in the case. A chi-square test revealed frequencies in therapy outcome for the target groups (see Table 23). However, results indicate that the relationship between institutional involvement and therapy outcome was not statistically significantly, $X^2(2, N = 71) = 3.54$, *ns*.

Table 23

Percentage Differences for Referral Source and Therapy Outcome

	Target Groups		
Outcome	No Institution	Institution	Total
Dropout	36.6%	26.7%	32.4%
Continuer	51.2%	43.3%	47.9%
Completer	12.2%	30.0%	19.7%
Total	100.0%	100.0%	100.0%

Results show that hypothesis 2 was not supported but rather shows a trend toward the opposite of the initially proposed hypothesis. Specifically, 15 cases (36.6%) that did not have institution involvement dropped out of therapy compared to the 8 cases (26.7%) that did have institution involvement and dropped out of therapy. In addition, 21 cases (51.2%) that did not have institution involvement continued in therapy without completing goals while only 13 cases (43.3%), of which did have institution involvement, continued in therapy without completing goals. Conversely, 9 cases (30.0%) that did have institution involvement completed therapy whereas only 5 cases (12.2%), of which did not have institution involvement, completed therapy.

The total number of sessions attended was analyzed using a one-way ANOVA test. Results showed significant differences in total number of sessions attended for clients without institution involvement (M = 4.23, SD = 3.72) and with institution involvement (M = 7.62, SD = 8.02), $F(1, 66) = 5.42$, $p = .02$, (See Table 24). See Figure 5 for differences in means for total number of sessions attended for clients without institution involvement and clients with institution involvement.

Table 24

Analysis of Variance for Total Number of Sessions

Source	*df*	*F*	*p*
	Between groups		
# of Sessions	1	5.42	.023
	Within groups		
# of Sessions	66		

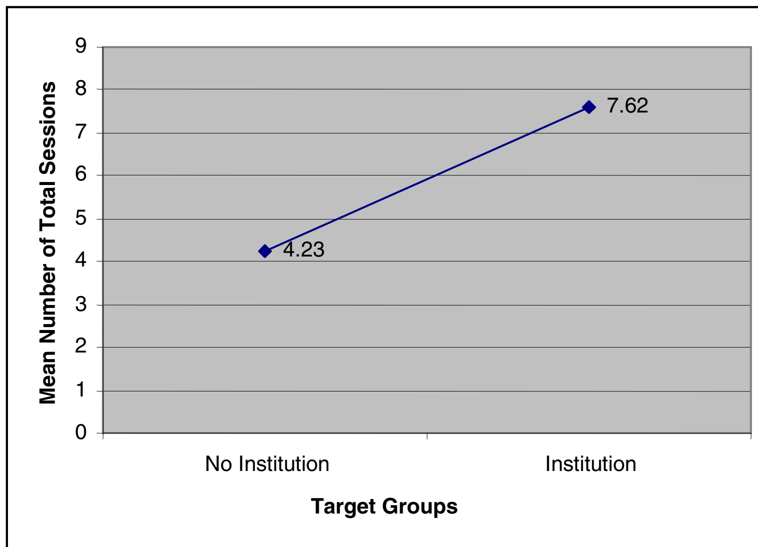

Figure 5: Differences between Groups in Mean Total Number of Sessions

An ANCOVA test was used to control for problem severity when examining the significant differences among clients with institution involvement and clients without institution involvement on total number of sessions attended. Problem severity was explained using the GAF score, identified as the covariate, which is assigned by therapists to a client in the case to describe current level of functioning. Even after controlling for problem severity using GAF scores, significant differences in total number

of sessions attended between clients with institution involvement and clients without institution involvement, $F(1, 64) = 5.43$, $p = .02$ (see Table 25).

Table 25

Analysis of Covariance for Total Number of Sessions Attended

Source	*SS*	*df*	*MS*	*F*	*p*
Group	193.86	1	193.86	5.43	.023
Covariate	33.30	1	33.30	.93	.338
Error	2283.74	64	35.68		
Total	4709.00	67			

One-way ANOVA tests were performed on all the client variables used in hypothesis 1 to determine group differences in therapy outcome. Three one-way ANOVA tests were used to test group differences in yearly income (in thousands) and therapy outcome for the total sample, for only clients without institution involvement, and for only clients with institution involvement. Results show significant differences in yearly income (in thousands) between therapy dropouts ($M = 8.17$, $SD = 6.96$), continuers ($M = 13.16$, $SD = 13.98$), and completers ($M = 30.91$, $SD = 27.24$) for the total sample, $F(2, 51) = 7.31$, $p = .00$ (see Table 26).

Table 26

Analysis of Variance for Yearly Income (in thousands) for Total Sample

Source	*df*	*F*	*p*
	Between groups		
Yearly Income	2	7.31	.002
	Within groups		
Yearly Income	51		

Post hoc testing using LSD revealed significant differences among dropouts and completers (p = .00) and continuers and completers (p = .00) for the total sample. No significant differences were found between dropouts and continuers (p = *ns*). Figure 6 shows mean yearly income differences of therapy dropouts, continuers, and completers for the total sample.

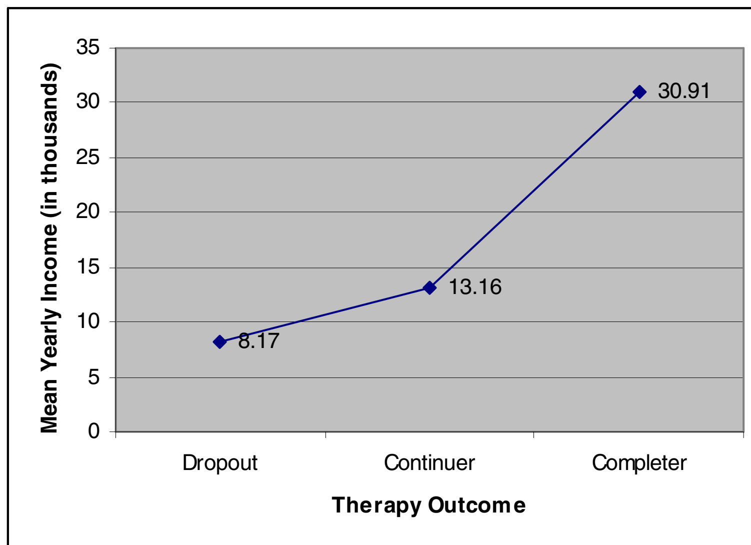

Figure 6: Differences in Mean Yearly Income for Total Sample

Yearly income and therapy outcome for the total sample were examined using an ANCOVA test controlling for problem severity. GAF scores were identified as the

covariate describing problem severity. Even after controlling for problem severity, significant differences in yearly income were found between dropouts, continuers, and completers, $F(2, 49) = 3.45$, $p = .04$ (see Table 27).

Table 27

Analysis of Covariance for Mean Yearly Income (in thousands) for Total Sample

Source	*SS*	*df*	*MS*	*F*	*p*
Group	1687.14	2	843.57	3.45	.040
Covariate	949.10	1	949.10	3.88	.055
Error	11987.65	49	244.65		
Total	28912.00	53			

Results of a one-way ANOVA for only clients without institution involvement found no significant differences in yearly income (in thousands) for therapy dropouts ($M = 8.64$, $SD = 8.15$), continuers ($M = 16.57$, $SD = 17.36$), and completers ($M = 34.00$, $SD = 39.06$), $F(2, 27) = 2.79$, *ns* (see Table 28). However, results show lower income for dropouts and continuers and higher income for completers.

Table 28

Analysis of Variance for Yearly Income (in thousands) for No Institution Involvement

Source	*df*	*F*	*p*
	Between groups		
Yearly Income	2	2.79	.079
	Within groups		
Yearly Income	27		

Because the analysis of the one-way ANOVA approached significance at the p = .07 level, post hoc testing was utilized to determine where possible differences may have occurred. Post hoc comparisons using LSD revealed a significant difference among dropouts and completers (p = .03) for clients without institution involvement. No significant differences were found between dropouts and continuers (p = *ns*) and continuers and completers (p = *ns*). Figure 7 shows means for yearly income among dropouts, continuers, and completers for clients without institution involvement.

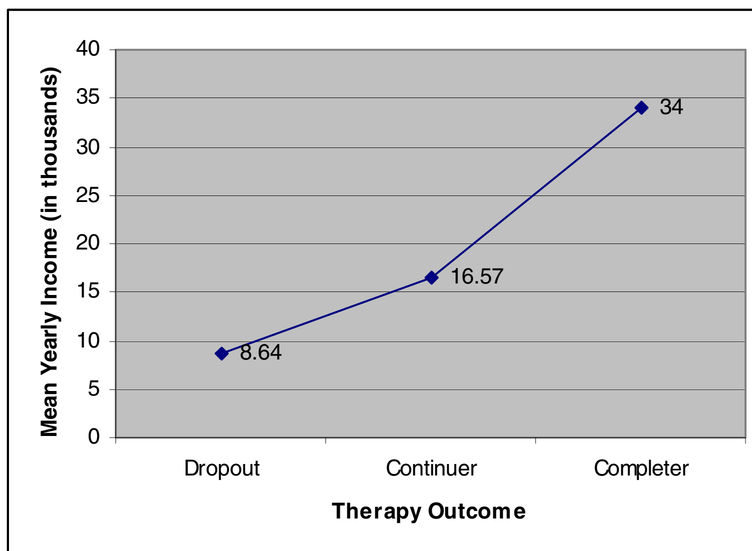

Figure 7: Mean Yearly Income for No Institution Involvement

For clients with institution involvement, results demonstrate significant differences among therapy dropouts (M = 7.43, SD = 5.03), continuers (M = 8.82, SD = 6.35), and completers (M = 28.33, SD = 15.68) when analyzing yearly income, $F(2, 21)$ = 10.70, p = .00 (see Table 29).

Table 29

Analysis of Variance for Yearly Income (in thousands) for Institution Involvement

Source	*df*	*F*	*p*
	Between groups		
Yearly Income	2	10.70	.001
	Within groups		
Yearly Income	21		

After having tested for differences in yearly income and therapy outcome for clients with institution involvement, post hoc testing using LSD revealed significant differences between completers and both dropouts (*p* = .00) and continuers (p = .00), and no significant difference between dropouts and continuers (*p* = *ns*). Figure 8 shows mean yearly income differences of therapy dropouts, continuers, and completers for clients with institution involvement only.

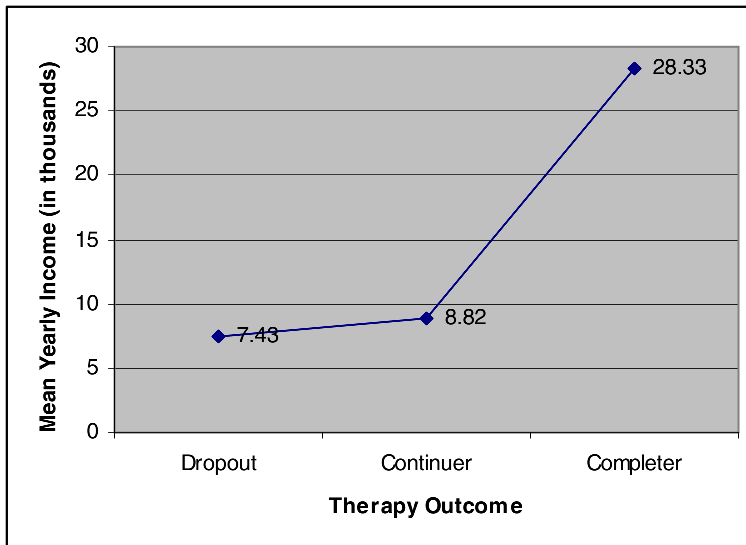

Figure 8: Differences in Mean Yearly Income for Institution Involvement

Mean yearly income and therapy outcome for clients with institution involvement were analyzed using an ANCOVA test. Problem severity was controlled for using GAF scores as the covariate. Even after controlling for problem severity, significant differences in mean yearly income were found between therapy dropouts, continuers, and completers, $F(2, 20) = 9.15$, $p = .00$ (see Table 30).

Table 30

Analysis of Covariance for Mean Yearly Income (in thousands) - Institution Involvement

Source	*SS*	*df*	*MS*	*F*	*p*
Group	1629.02	2	814.51	9.15	.002
Covariate	3.49	1	3.49	.04	.845
Error	1781.19	20	89.06		
Total	7843.00	24			

In summary, a combination of one-way ANOVA tests with post hoc comparisons using LSD, ANCOVA statistics, and chi-square tests were used to assess for significant differences in therapy outcome among clients without institution involvement and with institution involvement. No significant differences were found between therapy dropouts, continuers, and completers for those with and without institution involvement. However, significant differences were found in total number of sessions attended between clients with institution involvement and without institution involvement such that clients with institution involvement attended more sessions that those without institution involvement. Significance held even after controlling for problem severity. Significant differences were also found in yearly income (in thousands) between clients with and without institution involvement with clients who have institutions involved in

their cases indicating a higher yearly income than clients without institution involvement. Lastly, significant differences in yearly income were found between therapy dropouts, continuers, and completers for the total sample as well as for only those clients with institutional involvement, even after controlling for problem severity. Post hoc comparisons using LSD revealed significant differences between completers and both dropouts and continuers for the total sample and clients with institutional involvement. Post hoc comparisons also found significant differences among dropouts and completers for clients without institutional involvement.

CHAPTER V

DISCUSSION

Hypothesis Testing Discussion

This study assessed quantitative variables, such as demographics, treatment, and therapy outcome, in relation to families attending therapy who have institution involvement, such as court or Child Protective Services, for child abuse and neglect or who do not have institution involvement but attend therapy for any other family-related presenting problem.

Hypothesis 1

Hypothesis 1 stated that families with institution involvement for child abuse and neglect will display significantly more of the client factors identified in literature as barriers than families without institution involvement. Due to limitations in the data collection, the researcher was unable to analyze therapist factors for this study as well as the client factors of family characteristics and family influences. Results indicate that hypothesis 1 was partially supported. An analysis of client factors that included client resources and client beliefs yielded several significant results. However, the majority of results did not show significant differences between clients with institution involvement and clients without institution involvement.

Significant differences were found for age among female clients with institution involvement and without institution involvement such that females without institution involvement were older than females with institution involvement. While significance

was not found for male age, results showed that males without institution involvement were slightly older than males with institution involvement, similar to that of females. These findings were consistent with those found in the literature stating that in child maltreatment cases, mothers are often of a younger age (Butler et al., 1994). This significant difference in female age could be due to the fact that females with institutional involvement for child abuse and neglect may not have the parenting skills to deal with family conflict or other family issues that may simply come with maturity. Therefore, they are court-ordered to obtain counseling to gain these skills while older females may have enough parenting skills to deal with the problem before they decide on their own to seek therapy.

Significant differences were also found for both females and males with and without institution involvement on highest level of education completed. Specifically, males and females with institution involvement in their case had higher levels of education than males and females without institutions involved in their case. This is a surprising finding and may be explained in relation to the trend found in hypothesis 2 that clients with institution involvement were more likely to complete therapy than clients without institution involvement. In relation to hypothesis 2, the significant differences in highest level of education completed for clients with institution involvement and clients without institution involvement is consistent with those found in the literature stating that parents with higher levels of education are less likely to terminate from therapy, and parents with lower levels of education are more likely to terminate from therapy (McCabe, 2002). This surprising finding may also be due to the small size of the sample. Alternative results may have been found if the sample size was larger or if the targets

groups were closer in size. Because this was such a surprising finding, further investigation should be done in order to determine whether these findings would say the same or would change with a larger, more equally distributed sample.

No significant differences were found among males and females with and without institutional involvement on marital status, yearly income, fee quoted, money concerns, present state of health, ethnicity, client hope, global assessment of functioning (GAF score) and whether or not a client was referred to therapy. Nevertheless, a comparison of females and males indicated that the majority of clients reported a fairly equal breakdown of those married and not married, a fairly low income and fee quoted, some form of money concern, a fair state of health, Caucasian ethnic status, and moderate levels of hope concerning the problem. Clients with and without institutional involvement also showed GAF scores in the moderate range, indicating some mild symptoms or some difficulty in functioning but generally functioning pretty well and having some meaningful, interpersonal relationships.

These findings point to greater similarities than differences among males and females with institution involvement and without institution involvement on these client factors. Knowledge that clients with institution involvement are more similar than different than clients without institution involvement may be an important finding for clinicians to consider. Clinicians who have negative perceptions of their clients and poor prognoses for their future in therapy have been shown to affect therapy dropout while positive regard and more hopeful prognoses predicts continuation in therapy (Bischoff & Sprenkle, 1993; Cunningham & Henggeler, 1999; Grevious, 1985; Shapiro, 1974). For clinicians who have negative perceptions of clients with institutions involved in their

lives for child abuse or neglect, these findings may help to expand clinicians' perspectives such that therapy with clients with institution involvement is not much different than therapy with clients without institution involvement. These findings may also challenge clinicians to develop greater positive regard or more hopeful prognoses for families with institutional involvement.

Similarities may be explained by the composition of the sample. No significant differences were found in ethnicity most likely because the majority of the sample was Caucasian. Similarities in income, fee quoted, and money concerns may be explained in that the selected training clinic is affiliated with a medium-sized, south-central state university and often provides services to low-income families. In addition, significant differences in hope were not found between clients with institution involvement and clients without institution involvement perhaps because clients without institution involvement sought therapy for problems equally as serious as child maltreatment leading both groups to have similar levels of hope. More significant findings may have been found if the sample size was larger and the institutional and non-institutional groups were closer in size.

Hypothesis 2

Hypothesis 2, which states that families with institution involvement for child abuse and neglect are more likely to drop out of therapy than families without institution involvement, was not supported. However, while significance was not found, there did appear to be a trend to the opposite of the original hypothesis with a greater percentage of clients who did not have institution involvement identified as dropouts or continuers than clients who did have institution involvement. In addition, a greater percentage of clients

with institution involvement were identified as therapy completers when compared to clients without institution involvement. Within the no institutional involvement group, the majority of clients were identified as dropouts and continuers, which acknowledges that some factors are keeping these families from completing their goals, while within the institutional involvement group, the majority of clients were identified as continuers or completers. This is a surprising finding given that literature has found that maltreating families are more likely to drop out of therapy than non-maltreating families (Gershater-Molko et al., 2003; Lau & Weisz, 2003; Rivara, 1985). The size of the sample and inequality of the target groups could have contributed to this surprising finding and lack of statistical significance. Because the sample was small and the target groups were unequal in size, more significant results may have been found if the research was conducted with a larger sample or if target groups were closer in size.

While these findings are not consistent with those found in the literature stating that maltreating families are more likely to drop out of therapy before their goals are met (Gershater-Molko et al., 2003; Lau & Weisz, 2003; Rivara, 1985), they may be due to the nature of having an institution, such as Child Protective Services or the court system, in clients' lives. As was identified in the literature, social service agencies often develop requirements, such as attending therapy, in order for maltreating families to regain custody of their children (Butler et al., 1994; Dinkmeyer et al., 1999). Essentially, the social service agency is requiring maltreating parents to attend therapy sessions if they wish to reunify with their children. Thus, maltreating parents may have an external motivating factor that other families seeking therapy who do not have institutions involved in their lives for child abuse and neglect do not have. This may explain why

many families who seek therapy but do not have institution involvement terminate from therapy before completing their therapy goals.

Significant differences in total number of sessions attended were found between clients without institution involvement and clients with institution involvement. In particular, clients with institution involvement attended more sessions than clients without institution involvement. This is a surprising finding given the current research stating that maltreating parents are more likely to drop out of therapy without completing their therapy goals (Gershater-Molko et al., 2003; Lau & Weisz, 2003; Rivara, 1985), yet these findings actually show that clients with institution involvement attend more therapy sessions than clients without institution involvement. Perhaps this is due to the fact that in order to regain custody of their children, maltreating parents with institutional involvement must complete their therapy goals which may require more therapy sessions to complete than clients without institutional involvement. This finding could also be due to the fact that because child abuse and neglect is a serious problem, more sessions were required by maltreating families to treat the problem and improve the parent-child relationship so that they may regain custody of their children. However, even after controlling for problem severity, significant differences in total number of sessions attended emerged between clients with institution involvement and clients without institution involvement.

These findings may also be explained using the general systems theory of positive feedback loops. In this study, clients with institution involvement were more likely to complete therapy and attend a greater number of sessions than clients without institution involvement. Clients without institution involvement were more likely to drop out or

continue in therapy without completing their goals and attend a fewer number of sessions than clients with institution involvement. Clients with institutions involved in their lives for abuse and neglect may have interpreted the input they received from courts or social service agencies as a need for change and a better relationship with their children. Therefore, they chose to stay in therapy until they completed their goals with the hope of regaining custody of their children.

Additional statistical tests were performed to determine specific variables that contribute to therapy outcome for clients with and without institution involvement. The study yielded highly significant differences in yearly income among therapy dropouts, continuers, and completers for the total sample as well as for those clients with institutions involved in their cases, which still held even after controlling for severity of the problem. Results indicated that dropouts and continuers were more likely to have a lower yearly income, and completers were more likely to have a higher yearly income. Significant differences in yearly income were consistently shown among dropouts and completers and continuers and completers for the total sample and for clients with institution involvement. While yearly income did not yield significance for clients without institution involvement, a significant difference in yearly income was found between dropouts and completers.

Consistent with the current literature describing the impact of low income on therapy dropout (Bischoff & Sprenkle, 1993; Bussing, et al., 2003; Williams et al., 2005), these results point to the impact of yearly income on clients' ability to stay engaged in treatment, especially if they have institutions involved in their lives for child abuse and neglect. Having a higher yearly income may reduce some of the barriers to treatment

engagement that seem to plague families with lower yearly incomes. For families with institutions involved in their lives, having a higher yearly income may contribute to completion of goals and, ultimately, regaining custody of their children whereas having a lower yearly income may make staying engaged in treatment more difficult. Lever, Piñol, and Uralde (2005) studied the impact of poverty on strategies for coping with stress and found that the more impoverished a person is, the less likely that they will have the resources to make decisions on how best to deal with stressful situations, especially if they do not have the personal support system available to back up their decisions. The lack of resources to deal with stressful situations then makes brainstorming strategies, choosing the best strategy, and acting out the strategy very difficult. This finding may help to explain the impact of poverty on clients' ability to deal with stress related to family conflict, losing child custody, and staying engaged in treatment. To explain the current study's findings, a possibility is that the economically poor in this study were also poorer on other resources, such as social support systems or the ability to make decisions to deal with stress, which may have become overwhelming enough to lead to the choice to drop out of therapy before meeting their goals.

In summary, the findings of this study added to the current knowledge base of dropout research with maltreating families. Clinicians now know that maltreating families with institutions involved in their lives are not much different on many client variables than other families who seek therapy but do not have institutions involved in their lives. This finding may help to challenge current therapist perspectives on working with maltreating families who are being mandated by Child Protective Services or the court system to attend therapy. In addition, this study has also provided researchers with

information about the therapy offered in university training clinics and the types of clients that university training clinics serve.

Limitations

There are limitations to the current study that researchers need to consider if this study is to be replicated as a whole or in portions. Study limitations include sample size, sample generalizability, therapist experience, and missing data.

Sample Size

One limitation of the current study involves the sample size. This could be one of the reasons that the data yielded trends among clients with institution involvement and without institution involvement and among therapy dropouts, continuers, and completers without producing significant results. The data set is a relatively small data set as only 71 families were included in the sample. In addition, the experimental groups used in the study, clients with institution involvement and without institution involvement, differed in size such that the group of clients with institution involvement was smaller than the group of clients without institution involvement. Results may have been different or additional significant differences may have been found if there had been a larger sample with which to compare results.

Sample Generalizability

Another limitation involves the generalizability of the sample. The participants in the data set are taken from only one setting: a marriage and family therapy training facility at a south-central state university that often serves low-income families. Due to these limitations, the client data in this study may not be representative of all families seeking therapy. In addition to increasing the sample size, researchers may want to

include client data from a variety of other mental health agencies, such as domestic violence shelters, youth shelters, or child and family services to provide a more solid basis for generalization.

Therapist Experience

Another potential limitation includes the experience of the therapist treating the families in the study. Much of the data was collected and recorded by marriage and family therapy interns. Although they were supervised by faculty clinical supervisors, the less experienced therapists may have had an impact on the quality of therapy received by families and may have affected those clients who eventually dropped out, continued, or completed therapy. Thus, the therapist's level of clinical experience may prove a limitation of the study when assessing therapy outcome.

Missing Data

Lastly, data was missing from the research instruments reporting on client data, the telephone intake and the background form. Data that was missing included many client demographic variables, such as number of family members, yearly income, ethnicity, marital information, and occupation. This may be that the client either did not know the answer to the question, such as yearly income, or they simply chose not to answer the question. The lack of client data in this study points to the need for therapists to make sure that clients are completing the information requested on the clinic paperwork in addition to making sure that the therapist is also completing all questions asked of the client during the telephone intake. This is an important factor for future research on this topic as well as for therapists to know complete information on their clients.

Implications

The results of this study provided potentially beneficial implications for future researchers who would like to replicate parts or the whole of this study. Implications for clinicians and other agencies who work with maltreating families, such as Child Protective Services, the court system, or Court Appointed Special Advocates (CASA) workers, will be reviewed.

Implications for Researchers

This study provided implications for future research in the areas of maltreating families, therapy outcome, and factors that affect therapy outcome. Future researchers may want to consider increasing the sample size and gaining more equal institution-involved and non-institution-involved groups in order to remove sample size and sample generalizability from the study's limitations. By removing these limitations, the analyses may reveal more significant findings, and the sample may be more representative of the population as a whole.

Implications for Clinicians

Results of this study may provide beneficial implications to clinicians and other professionals, such as Child Protective Services or the court system, who work with maltreating families who have institutions involved in their lives. Analyses of clients with institutional involvement and without institutional involvement demonstrated significant differences in client age and highest level of education completed. Knowing the differences between the two groups on these specific client factors may prove beneficial for clinicians working with this vulnerable population. If clinicians anticipate that maltreating parents will be younger and may not have developed the parenting skills

required to deal with family conflict but also have an adequate amount of education, then clinicians may be able to develop parenting programs aimed at teaching parenting skills in a more educational format. While significant differences were found for age and highest level of education completed, recognizing that these groups are similar in many ways may prove beneficial to clinicians, as well. This may be helpful for clinicians if they dislike working with vulnerable populations and have the belief that they are more difficult to work with. Because the two groups were so similar in characteristics, the belief that clients with institution involvement are different than other types of clients does not hold true. Therefore, therapy with clients who have institution involvement should not differ much from therapy with clients without institution involvement. Therapists should approach these cases much like they approach other types of cases.

This study found that yearly income played an important role in whether clients with institution involvement stayed engaged in their treatment such that therapy dropouts and continuers reported lower yearly income than therapy completers, who reported a higher yearly income. These results suggest that a lower yearly income could be perceived by clients as a financial barrier to staying engaged in treatment and finishing their goals. Clinicians who work with maltreating families may want to consider how they can help to reduce these financial barriers, such as reducing clinic fees for therapy sessions, incorporating payment plans, providing a certain number of free therapy sessions before charging clients, or including a sliding fee scale based on number of family members and total yearly income without taxes, to reduce the stress that comes with poverty. Clients who have a lower yearly income may feel a significant amount of stress associated with paying their bills and providing for their family. Therapists may

want to take an advocacy role for their clients by locating outside resources, such as Women, Infant, and Children (WIC) programs, to help decrease client stress.

Lastly, this study found that, while not significant, clients with institution involvement were more likely to complete therapy than clients without institution involvement, who were more likely to dropout and continue without completing goals. Thus, institution involvement may provide maltreating families with an extrinsic motivator that clients without institution involvement lack. While attending therapy because of an institution's requirement for regaining child custody may not be an intrinsic motivation, clinicians may want to take advantage of the extrinsic motivation that clients with institution involvement are bringing with them. Clinicians may want to consider how they can use that kind of motivation to help maltreating families with institutions involved in their lives successfully complete their goals, improve the relationships with their children, and regain child custody. For example, clinicians may want to play an advocacy role and let the clients know that they are on their side and want to help them regain custody of their children in addition to getting the court and Child Protective Services "off their back."

Recommendations for Future Research

Due to limitations in the data collection, the researcher was unable to test the client factors of family characteristics and family influences as well as the therapist factors of therapist characteristics, therapist competence, therapeutic alliance, and congruence between client and therapist perspectives. To gain a more complete picture of how client factors affect therapy outcome for maltreating families, future researchers

may want to examine more systemic client factors, such as family characteristics and family influences.

As indicated in the literature, therapist competence and level of experience have been shown to be related to therapy dropout (Bischoff & Sprenkle, 1993; Cunningham & Henggeler, 1999; Dyck, et al., 1984). Future research may want to look at how therapist level of clinical experience affects therapy outcome for families with institution involvement and without institutional involvement. Though the quality of the therapeutic alliance has been shown to contribute to client outcome in therapy for clients receiving family therapy for child abuse and neglect (Johnson & Ketring, 2006), the researcher was unable to evaluate the potential impact of the therapeutic alliance on therapy dropout for maltreating families in this study. Further research is warranted in this area to better understand how different qualities of the therapeutic alliance may affect maltreating families' choices to stay engaged in family treatment. Lastly, congruence between client and therapist perspectives on the problem and treatment of the problem has been shown to influence client dropout (Cunningham & Henggeler, 1999). Future researchers may want to compare client perspectives on seriousness of the problem and goals for therapy with therapist perspectives on seriousness of the problem and goals for the family.

Conclusion

In conclusion, child abuse and neglect is a serious problem for many families. Institutions, such as a social service agency or the court system, are often involved in these families' lives in order to look out for the well-being of the children who are being maltreated or are at risk for being maltreated. While this study found that similarities existed between clients with institution involvement and without institution involvement

on the majority of client factors, significant differences were found in age and highest level of education completed. In addition, significant differences were found between therapy dropouts, continuers, and completers, particularly if there was institution involvement in the clients' lives, such that completers indicated a higher yearly income than dropouts and continuers. Delivery of services to low-income populations, especially strategies for reducing financial constraints, remains extremely important for clinicians to consider, so low-income, maltreating families with institutions involved in their lives can stay engaged in the therapy services intended to improve their family relationships and end child abuse and neglect.

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APPENDIX A

Telephone Intake

CFS TELEPHONE INTAKE

Intake Person: ______________ Date: ______________

Time: ______________

Name ______________ Telephone Number(s) ______________

Street City, State Zip ______________ Best time to be contacted within 24 hrs ______________

Who made the call? ______________ Can leave a message (Y for yes, N for no):

Presenting Problem?

Who is in the family? (2-3 generation genogram)

Who else is involved in the problem?

How long has it been a problem? ______________

Is there any alcohol or drug use? ________ If yes, who and how much?

Who will be attending session?

Center for Family Services, 101 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058

CFS TELEPHONE INTAKE

Days available for sessions: ___Mon. ___Tues. ___Wed. ___Thurs. ___Fri. ___Any

Times available for sessions: __5p.m. __6p.m. __7p.m. __8p.m. ___Any ___Other, [ ]

Is anyone in the family on any kind of medication? If yes, who and what?

[ ]

Is anyone in the family receiving mental health services anywhere else? If yes, who, where, and for what?

[ ]

How did you hear about us? Who referred you?

____ Telephone Book

____ Referred by ________________________

____ Received services before

____ Other (explain below)

[ ]

Any financial considerations?

____ NO
____ YES (If yes, explain below)

[ ]

Yearly Income before taxes: ________________________

Fee: __________________

Therapist assigned ______________________________

Case # __________________

Additional Information

[ ]

Center for Family Services, 101 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058

APPENDIX B

Background Form

For Office Use Only
ID # ________
Family Member ________
Today's Date ________

Center for Family Services – Background Form
101 Human Environmental Sciences West
Stillwater, Oklahoma 74078

This information is part of your **confidential** file and will be available to CFS staff for reference / research purposes.

NAME ______________________ AGE ______ GENDER ________

ADDRESS ____
Street City, State Zip Code

HOME TELEPHONE ________________ WORK TELEPHONE ________________

RELIGIOUS PREFERENCE ______________ ETHNICITY ________________

PRIMARY OCCUPATION __________ HIGHEST LEVEL OF EDUCATION COMPLETED ___

ARE YOU MARRIED? _____ IF YES, HOW LONG _______ TIMES MARRIED BEFORE _____

ARE YOU A MILITARY VETERAN? _____ IF YES, YEARS OF SERVICE ______ TO ________

IMMEDIATE FAMILY
(SPOUSE, CHILDREN, AND STEP-CHILDREN) PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP TO YOU, AND CURRENT RESIDENCE (SAME AS YOU OR DIFFERENT).

NAME	GENDER	AGE	RELATIONSHIP TO YOU	RESIDENCE (CITY, STATE IF DIFFERENT)
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________
________	M F	____	________	SAME DIFFERENT ________

EXTENDED FAMILY
(PARENTS, BROTHERS, SISTERS, STEP-BROTHERS, AND STEP-SISTERS) PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP TO YOU, CURRENT RESIDENCE, AND MARITAL STATUS.

NAME	GENDER	AGE	RELATIONSHIP TO YOU	RESIDENCE (CITY, STATE)	MARITAL STATUS
________	M F	____	________	________	________

NAME	GENDER	AGE	RELATIONSHIP TO YOU	RESIDENCE (CITY, STATE)	MARITAL STATUS
________	M F	____	________	________	________
________	M F	____	________	________	________
________	M F	____	________	________	________
________	M F	____	________	________	________
________	M F	____	________	________	________
________	M F	____	________	________	________
________	M F	____	________	________	________

DECEASED FAMILY MEMBERS

(SPOUSE, CHILDREN, STEP-CHILDREN, PARENTS, BROTHERS, SISTERS, STEP-BROTHERS, AND STEP-SISTERS)
PLEASE LIST NAME, RELATIONSHIP TO YOU, AGE AT DEATH, DATE OF DEATH, AND CAUSE OF DEATH.

NAME	RELATIONSHIP TO YOU	AGE AT DEATH	DATE OF DEATH	CAUSE OF DEATH
________	________	____	________	________
________	________	____	________	________
________	________	____	________	________

MEDICAL HISTORY

FAMILY PHYSICIAN: NAME ________________________________

ADDRESS ________________________________

CIRCLE YOUR CURRENT STATE OF HEALTH: **EXCELLENT** **GOOD** **FAIR** **POOR**

PLEASE CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING DURING THE PAST 6 MONTHS:

___SEVERE HEADACHES
___SEVERE BACKACHES
___STOMACH PROBLEMS
___EATING PROBLEMS
___SEIZURES
___ UNEXPLAINED WORRY OR FEARFULLNESS
___FREQUENT TIREDNESS
___FREQUENT TROUBLE SLEEPING
___DIZZINESS OR FAINTING
___LARGE WEIGHT LOSS OR GAIN
___ASTHMA OR OTHER RESPIRATORY PROBLEMS
___OTHER PROBLEMS (PLEASE SPECIFY)

____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EXPERIENCED ANY OF THE BEFORE MENTIONED SYMPTOMS IN THE LAST SIX MONTHS? _________ IF YES, PLEASE EXPLAIN.

HAVE YOU EVER HAD A SERIOUS MEDICAL ILLNESS? ______ IF YES, PLEASE EXPLAIN.

HAVE ANY OF YOUR CHILDREN OR SPOUSE EVER HAD A SERIOUS MEDICAL ILLNESS? _____ IF YES, PLEASE EXPLAIN.

LIST ALL MEDICATIONS AND/OR DRUGS TAKEN WITHIN THE LAST 6 MONTHS, BOTH PRESCRIPTION AND NON PRESCRIPTION.

NAME OF MEDICATION/DRUG	REASON TAKEN	CHECK IF TAKING NOW
______________________________	__________________________	_________
______________________________	__________________________	_________
______________________________	__________________________	_________
______________________________	__________________________	_________

DO YOU SMOKE? _____ IF YES, HOW MUCH?

DO YOU THINK YOU SMOKE TOO MUCH?

DO YOU DRINK? _____ IF YES, HOW MUCH?

DO YOU THINK YOU DRINK TOO MUCH?

DO YOU THINK ANOTHER FAMILY MEMBER SMOKES OR DRINKS TOO MUCH? ______ IF YES, PLEASE EXPLAIN.

HAVE YOU EVER ATTEMPTED SUICIDE? _____ IF YES, GIVE DATE(S) AND DETAILS.

HAS ANYONE IN YOUR FAMILY EVER ATTEMPTED SUICIDE? _____ IF YES, GIVE NAME(S), RELATIONSHIP TO YOU, AND DETAILS.

ARE YOU CURRENTLY RECEIVING SERVICES FROM ANOTHER THERAPIST/COUNSELOR? _____ IF YES, WHO AND FOR WHAT?

HAVE YOU EVER BEEN TREATED BY ANOTHER THERAPIST/COUNSELOR? _____ IF YES, WHEN, WHERE, AND FOR WHAT?

FROM THE FOLLOWING LIST, PLEASE CHECK THE REASONS THAT YOU ARE SEEKING SERVICES AT THIS TIME:

__PERSONAL ENRICHMENT	__SINGLE PARENTING
__RELATIONSHIP ENRICHMENT	__PARENTING-TWO PARENT FAMILY
__MARITAL ENRICHMENT	__STEP-PARENTING
__FAMILY ENRICHMENT	__CHILD BEHAVIOR PROBLEMS
__MARITAL CONFLICT	__ADOLESCENT BEHAVIOR PROBLEM
__FAMILY CONFLICT	__ALCOHOL ABUSE-CHILD/ADOLESCENT
__SEXUAL PROBLEMS	__DRUG ABUSE-CHILD/ADOLESCENT
__PHYSICAL ABUSE	__ALCOHOL ABUSE-ADULT
__SEXUAL ABUSE	__DRUG ABUSE-ADULT
__DIVORCE ADJUSTMENT	__FAMILY STRESS
__ADJUSTMENT TO LOSS	OTHER (Specify) ______________________________

PLEASE DESCRIBE IN YOUR OWN WORDS THE MAJOR REASON FOR SEEKING OUR SERVICES AT THIS TIME.

HOW SERIOUS WOULD YOU SAY THIS PROBLEM IS RIGHT NOW? (CIRCLE ONE)

NOT AT ALL SERIOUS	SLIGHTLY SERIOUS	MODERATELY SERIOUS	VERY SERIOUS

HOW LIKELY DO YOU THINK THE PROBLEM IS TO CHANGE? (CIRCLE ONE)

NOT AT ALL LIKELY	SLIGHTLY LIKELY	MODERATELY LIKELY	VERY LIKELY

WHAT DO YOU HOPE TO GAIN FROM OUR SERVICES?

WHO REFERRED YOU TO OUR SERVICES? IF SELF-REFERRED, HOW DID YOU FIND OUT ABOUT OUR SERVICES?

APPENDIX C

Family Adaptation and Cohesion Evaluation Scale (FACES III)

FAMILY COMMUNICATION & SATISFACTION

ID# _____ FM# ____
Times Taken _____
Family Form = 2

Center For Family Services - Oklahoma State University

INSTRUCTIONS:

Communication and satisfaction are important aspects of family relationships. Please review the statements below and respond according to how you see **YOUR COMMUNICATION AND SATISFACTION** as it is **NOW.**

Put an X in one box

1 Almost Never	2 Occasionally	3 Sometimes	4 Often	5 Very Often	
☐	☐	☐	☐	☐	1. We are satisfied with how family members communicate with each other.
☐	☐	☐	☐	☐	2. Family members are good listeners.
☐	☐	☐	☐	☐	3. Family members express affection to each other.
☐	☐	☐	☐	☐	4. Family members avoid talking about important issues.
☐	☐	☐	☐	☐	5. When angry, family members say things that would be better left unsaid.
☐	☐	☐	☐	☐	6. Family members discuss their beliefs and ideas with each other.
☐	☐	☐	☐	☐	7. When we ask questions of each other, we get honest answers.
☐	☐	☐	☐	☐	8. Family members try to understand each other's feelings.
☐	☐	☐	☐	☐	9. We can calmly discuss problems with each other.
☐	☐	☐	☐	☐	10. We express our true feelings to each other.
☐	☐	☐	☐	☐	11. How often are you satisfied with the degree of closeness between members of your family.
☐	☐	☐	☐	☐	12. How often are you satisfied with your family's ability to cope with stress.
☐	☐	☐	☐	☐	13. How often are you satisfied with your family's ability to be flexible.
☐	☐	☐	☐	☐	14. How often are you satisfied with your family's ability to share positive experiences.
☐	☐	☐	☐	☐	15. How often are you satisfied with the amount of arguing that occurs between family members.
☐	☐	☐	☐	☐	16. How often are you satisfied with your family's ability to resolve conflicts.
☐	☐	☐	☐	☐	17. How often are you satisfied with the amount of time you spend together as a family.
☐	☐	☐	☐	☐	18. How often are you satisfied with the way problems are discussed in your family.
☐	☐	☐	☐	☐	19. How often are you satisfied with the fairness of criticism in your family.
☐	☐	☐	☐	☐	20. How often are you satisfied with your family's concern for each other.

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Date: _________ mm-dd-yy

Session # ___

FAMILY RELATIONSHIPS

ID# ____ FM# ___
Times Taken ____
Family Form = 2

Center For Family Services - Oklahoma State University

INSTRUCTIONS:
Family relationships are varied and differ greatly from family to family. Please review the statements below and respond according to **HOW YOU WOULD DESCRIBE YOUR FAMILY AS IT IS NOW.**

Put an X in one box

1 Almost Never	2 Once In A While	3 Sometimes	4 Frequently	5 Almost Always	
☐	☐	☐	☐	☐	1. Family members ask each other for help.
☐	☐	☐	☐	☐	2. In solving problems, the children's suggestions are followed.
☐	☐	☐	☐	☐	3. We approve of each other's friends.
☐	☐	☐	☐	☐	4. Children have a say in their discipline.
☐	☐	☐	☐	☐	5. We like to do things with just our immediate family.
☐	☐	☐	☐	☐	6. Different persons act as leaders in our family.
☐	☐	☐	☐	☐	7. Family members feel closer to other family members than to people outside the family.
☐	☐	☐	☐	☐	8. Our family changes its way of handling tasks.
☐	☐	☐	☐	☐	9. Family members like to spend free time with each other.
☐	☐	☐	☐	☐	10. Parent(s) and children discuss punishment together.
☐	☐	☐	☐	☐	11. Family members feel very close to each other.
☐	☐	☐	☐	☐	12. The children make the decisions in our family.
☐	☐	☐	☐	☐	13. When our family gets together for activities, everybody is present.
☐	☐	☐	☐	☐	14. Rules change in our family.
☐	☐	☐	☐	☐	15. We can easily think of things to do as a family.
☐	☐	☐	☐	☐	16. We shift household responsibilities from person to person.
☐	☐	☐	☐	☐	17. Family members consult other family members on their decisions.
☐	☐	☐	☐	☐	18. It is hard to identify the leader(s) in our family.
☐	☐	☐	☐	☐	19. Family togetherness is very important.
☐	☐	☐	☐	☐	20. It is hard to tell who does which household chores.

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Date: ________ mm-dd-yy Session # ___

APPENDIX D

Counseling Agreement

CENTER FOR FAMILY SERVICES
101 Human Environmental Sciences West
Stillwater, OK 74078
(405) 744-5058

Counseling Agreement

The Oklahoma State University Center for Family Services is dedicated to the treatment of families and the training of skilled family therapists. In an effort to offer clients the best therapy possible, the Center's family-oriented approach includes observation by fellow therapists-in-training, video-taping and diagnostic evaluation, if deemed appropriate.

I, the undersigned, do consent to the observation and video-taping of my therapy sessions. I understand that I may request the tape be turned off or erased at any time either during my session(s) or any time thereafter. I understand that any video-tapes will be used to assist the therapist(s) in working with me to improve the quality of therapy that I receive. I understand that I will not be video-taped without my verbal consent, at the time of taping, and that all video-tapes of sessions are erased immediately following viewing by my therapist(s). I acknowledge the importance of research in increasing the effectiveness of therapy and in training high quality therapists. I do consent to any research that may be completed through the clinic on my case. I understand that names are never used in research and that the Center for Family Services guarantees the confidentiality of my records.

Since OSU is an educational institution, I recognize that any counseling, testing, taping, or diagnostic work may be seen by other therapist interns, the clinical supervisor, and may be used for training purposes. No information about me may be given to any person outside the Center without my written consent unless mandated by law; including, but not limited to a court order and child abuse or neglect. However, if I am dangerous to myself or others, I am aware that mental health professionals have the responsibility to report information to appropriate persons with or without my permission.

I agree to notify the Center for Family Services at least 24 hour in advance should I need to cancel an appointment. If not, a fee for services will still be charged. Payment for services is due when services are rendered. I understand this fee to be $______per session. When I decide to discontinue therapy, I agree to discuss this with the therapist(s) at a regular therapy session, not by phone.

I understand that should I attend a therapy session impaired by alcohol or drug use that the session will be terminated and another session scheduled for a future time. This event will be treated as a missed session and charged at full fee.

I am aware that Oklahoma State University Center for Family Services is not an emergency service, and, that in an emergency situation if I cannot reach my therapist, I have been advised to contact local community mental health center or another crisis counseling center.

My rights and responsibilities as a client for the Center for Family Services, the procedures, and treatment modalities used have been explained to me and I understand and agree to them.

______________________________ ______________________________
(Name) (Name)

(Name)
(Name)

(Witness) (Date)

APPENDIX E

Client's Rights

CENTER FOR FAMILY SERVICES

101 Human Environmental Sciences West
Stillwater, OK 74078
(405) 744-5058

YOUR RIGHTS AS A CLIENT OF THE
OSU CENTER FOR F AMILY SERVICES

TO LEAVE the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others.

TO BE ADVISED in writing of all the services offered by CFS.

TO REFUSE any service which you do not want and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notation to that effect will be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.

TO CONFIDENTIALITY of records. Information in your records may not be given to any other person without your written consent or if mandated by law, including but not limited to a court order. However, if you are dangerous to yourself or others, mental health professionals have the responsibility to report information to appropriate persons with or without your permission. Another exception to confidentiality is in the case of child abuse, where Oklahoma law requires professionals to report such instances to the Oklahoma Department of Human Services.

Under no other circumstances may the therapist communicate information about you outside the CFS.

However, mental health professionals do have the right, when they deem necessary, to consult with other members of the supervisory and clinical team regarding treatment.

If you request that your records be sent to another professional or agency, your wishes will be fulfilled with promptness upon receipt of your written request for information and provided there is no outstanding balance on your CFS account.

The scope of the clinical services offered by the Center for Family Services is limited to:

- Premarital counseling
- Martial therapy, including problems of communication, marital discord, domestic violence and sexual adjustment.
- Family therapy, including discipline problems with children, school adjustment problems, adolescent rebellion, problems precipitated by loss of family members through death, desertion, occupational service, imprisonment, problems precipitated by the addition of family members through birth, adoption, foster care, or new living arrangements.
- Divorce counseling, including mourning the loss of the former marriage, acceptance of a new lifestyle and identity.
- Single parent counseling including any of the issues listed above plus the stresses of parenting as a single person.
- Remarriage counseling, including any of the issues listed above plus the complexities of combining two family groups.
- Counseling with single adults around issues related to the family in which they grew up as a child.

- CFS offers marriage and family therapy from a systems perspective of the family that integrates research based models of therapy including emotionally focused, strategic, solution-focused, and structural therapy into a brief therapeutic approach.

Services of the Center for Family Services *do not* include:

- Personality, ability, or vocational interest testing or evaluations.
- Custody evaluations
- Prescription of medications or treatment of problems for which medication or hospitalization may be the treatment of choice, such as major depression, suicidal intention, hallucinations, delusions, etc.

At least one parent must consent to the therapy of any minor children.

I have read, understand and accept the above statements concerning my rights as a clients of CFS and the scope of clinical services available.

____
(Client) (Client)

____
(Client) (Client)

____
(Date) (Therapist)

APPENDIX F

Session Summary

Case # | **Session Summary** | Date:

Therapist(s): | | **Session#** __

Pre-Session:

Therapy Goals:

TG1.

Session Goals:

SG1.

INSIGHT Model

Context:	Perspective	Process

Hypotheses:

H1.

Interactional Cycle:

Issues of Concern:	Minimal			Significant	
C1.	1	2	3	4	5

Homework from Prior Session:

Post-session: LvOb ___ RECORDED ___ TEAM ___

Clients Present:

Homework: Completed Not Completed

Break Question/Activity:

Summary of Session Content:

Supervisor Messages: Initials

Break	Phone

Interventions Used:

Progress Toward Session Goals	Minimal			Significant		Met(Y/N)
SG1.	1	2	3	4	5	N

Homework Given:

Progress Toward Therapy Goals:	Minimal			Significant		Met(Y/N)
TG1.	1	2	3	4	5	N

New Information from Session:

Context	Perspective	Process

Changes to Hypotheses:

None

Next Appointment: *Date:* *Time:*
Therapist:

Signature: ____________________________ Supervisor/Date: ______________________

Printed Name:

APPENDIX G

Diagnosis and Treatment Plan

Case #_

DIAGNOSIS AND TREATMENT PLAN

Date of First Session: Diagnosis for Session:

Family's Definition of the Problem

Diagnosis: Family Member Diagnosed:

Axis I: Clinical Disorders or Other Conditions That May Be a Focus of Clinical Attention

Axis II: Personality Disorders or Mental Retardation

Axis III: General Medical Conditions
None reported

Axis IV: Psychosocial and Environmental Problems
[ ] Problems with primary support group: ______________________________________
[ ] Problems related to the social environment: __________________________
[ ] Educational problems: ____
[ ] Occupational problems: ____
[ ] Economic problems: _______________________________
[ ] Housing problems: ____
[ ] Problems with access to health care services: ____
[ ] Problems related to interaction with the legal system/crime: ________________________________
[ ] Other psychosocial and environmental problems: ____
Axis V: Global Assessment of Functioning GAF = GARF =

Proposed Treatment

_____________________________ _____________________________ ____________
Therapist Supervisor Date

Center for Family Services, 101 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058.

APPENDIX H

Termination Report

Family ID#:________

CENTER FOR FAMILY SERVICES
101 Human Environmental Sciences West
Stillwater, Oklahoma 74078
(405)744-5058

Termination Report

Date of Intake:________

Date of First Session:________
Date of Last Session:________

Number of Sessions:_______
Official Termination Date:____

Therapist(s):____________________________

Type(s) of Therapy and Number of Sessions:

_____ Individual Therapy

_____ Couple/Marital Therapy

_____ Family Therapy

_____ Group Therapy

Reasons for Termination:

_____ Completion of Therapy

_____ Client Request

_____ No Shows/Cancellations (letter sent by therapist)

_____ Other, Please explain:

Were the clients referred to another agency/professional?

_____Yes - Where? ______________

_____ No

____
Therapist

_____________________ _______________________ ___________
Therapist Supervisor Date

Give a brief description of the presenting problem at the beginning of therapy and a description of the problem upon closure of therapy on the back of this report.

VITA

Sarah Elizabeth Wiedower

Candidate for the Degree of

Master of Science

Thesis: CLIENT, THERAPIST, AND INSTITUTIONAL BARRIERS TO FAMILY TREATMENT FOR CHILD ABUSE OR NEGLECT

Major Field: Human Development and Family Science with a specialization in Marriage and Family Therapy

Biographical:

Personal Data: Born in Wellington, Kansas on September 21, 1980, the daughter of Fred L. and Rose A. Wiedower.

Education: Graduated from Wellington High School, Wellington, Kansas in May of 1999; received Bachelor of Arts degree in Psychology from the University of Kansas, Lawrence, Kansas in December of 2003. Completed the requirements for the Masters of Science degree in Human Development and Family Science with a specialization in Marriage and Family Therapy at Oklahoma State University, Stillwater, Oklahoma in May of 2007.

Experience: Oklahoma State University Center for Family Services marriage and family therapy intern, Stillwater, Oklahoma, 2005-2007; Tulsa Women and Children's Center therapy intern, Tulsa, Oklahoma, 2006-2007; employed by Oklahoma State University, Department of Human Development and Family Science graduate research assistant, Stillwater, Oklahoma, 2004-2007; employed by Oklahoma State University, Department of Human Development and Family Science graduate teaching assistant, Stillwater, Oklahoma, 2006.

Professional Memberships: American Association for Marriage and Family Therapy, Oklahoma Association for Marriage and Family Therapy

Name: Sarah Elizabeth Wiedower Date of Degree: May, 2007

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: FACTORS AFFECTING THERAPY DROPOUT FOR MALTREATING FAMILIES WITH INSTITUTION INVOLVEMENT

Pages in Study: 113 Candidate for the Degree of Master of Science

Major Field: Human Development and Family Science with a Specialization in Marriage and Family Therapy

Scope and Method of Study: The purpose of this study was to identify and describe factors associated with therapy dropout by families with institutions involved in their lives for child abuse and neglect. Seventy one cases were included in the total sample. Thirty cases that had institution involvement, such as Child Protective Services or the court system, for child abuse or neglect were the experimental group, and forty one family cases with no institution involvement comprised the comparison group. One-way analysis of variance tests, post hoc comparisons, analysis of covariance statistics, and chi-square tests were used to test the hypotheses.

Findings and Conclusions: Significant differences between clients with and without institution involvement were found for female age and highest level of education completed. Clients with institution involvement were found to be younger and completed more education than clients without institution involvement. No significant differences were found between the target groups for male age, marital status, yearly income, fee quoted, money concerns, present state of health, ethnicity, hope, and GAF score. Significant differences were found in total number of sessions attended between clients with institution involvement and without institution involvement even after controlling for problem severity. Clients with institution involvement attended more sessions than clients without institution involvement. Significant differences were also found in yearly income between clients with and without institution involvement with clients who have institutions involved in their cases indicating a higher yearly income than clients without institution involvement. Lastly, significant differences in yearly income were found between therapy dropouts, continuers, and completers for the total sample as well as for only those clients with institutional involvement, even after controlling for problem severity. Dropouts and continuers were found to have a significantly lesser income than completers who had a much greater yearly income.

Advisor's Approval: _Charles C. Hendrix____