

Giving Up On Child Psychotherapy: Who Drops Out?

John R. Weisz

University of North Carolina at Chapel Hill, and
Medical College of Virginia/Virginia Treatment Center for Children

Bahr Weiss

University of North Carolina at Chapel Hill

David B. Langmeyer

North Carolina Division of Mental Health, Mental
Retardation, and Substance Abuse Services

Do dropouts from child psychotherapy differ from those who stay for treatment? To find out, we studied 6-17-year-old outpatients, 166 who completed intake but did not appear for therapy and 138 who continued in therapy for an average of 13 sessions. The groups were compared on demographics, on Child Behavior Checklist broadband and narrow-band syndrome scores, on Children's Depression Inventory scores, on therapist age and sex, and on parent perceptions of clinic and child. No reliable group differences were found. The striking group similarity may have implications for clinic-based outcome research.

Which children drop out of psychotherapy before treatment has run its course? The question is important for both pragmatic and empirical reasons. Youngsters who begin therapy but then drop out may fail to receive needed intervention. Moreover, clinics invest considerable staff time in intake and therapist assignment; thus, premature termination is costly. If reliable correlates of premature termination can be identified, clinics might take remedial action to increase the extent to which services, once arranged for, are used.

If no reliable correlates of premature termination can be found, that information, too, might prove useful, particularly for clinic-based research on therapy outcomes. Such research has been difficult for clinics to mount because their policies usually prohibit random assignment of referred individuals to no-treatment groups; thus, rigorous treatment-control comparisons usually cannot be made (see Kazdin, 1986; O'Leary & Borkovec, 1978). However, clinics may not need to abandon the use of control groups altogether. It may be useful, at times, to compare treated groups with "control" groups who begin treatment but do not continue.

At first, this notion may seem naive. Clinic dropouts might be expected to differ from continuers on important, clinically relevant dimensions of personality and adjustment. In reality, though, a child's continuation in treatment may often depend

less on child characteristics than on such situational factors as the availability of transportation and the hectic schedule of a parent's day on the appointment date, factors that are rather diverse and seemingly unsystematic. Research thus far has actually revealed negligible differences between continuers and dropouts on child demographic, personality, and psychopathology measures (e.g., Gould, Shaffer, & Kaplan, 1985; Levitt, 1957). After similar null findings with parents' Minnesota Multiphasic Personality Inventory (MMPI) scores, McAdoo and Roeske (1973) concluded that "the defector group is similar to the continuer group and may be used as an appropriate control group for child psychotherapy" (1973, p. 328; see also Levitt, 1971).

This conclusion may be premature, though, until we have extensive evidence on whether child characteristics correlate with continuation in treatment. Most relevant evidence was gathered prior to the development of such standardized, well-validated measures as the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983). Such measures should reduce the likelihood that null findings are merely the result of measurement error. To our knowledge, only Gould et al. (1985) have used such standardized child measures in comparing dropouts and continuers, and they found no significant group differences on those measures. Our study compared dropouts and continuers on CBCL measures, on the Children's Depression Inventory (CDI; Kovacs & Beck, 1977), on potentially relevant demographic characteristics, and on parent perceptions. We also investigated adult findings indicating that therapist age and sex, and the interaction of therapist and client age and sex, may influence continuation in treatment (e.g., Karasu, Stein, & Charles, 1979; Lasky & Salmone, 1977).

Method

The initial pool of 469 children, aged 6-17 years, had been taken by their parents or guardians to one of nine public mental health clinics (four urban, five rural). Following McAdoo and Roeske (1973), (a) we defined *dropouts* as cases in which clinic treatment had been recommended and offered, but neither the child nor other family members

Funding was provided by North Carolina Department of Human Resources Contract 41626 and by National Institutes of Mental Health Grant 1 R03 MH38450. We thank the young clients, the parents, and the staff members of the following clinics for their participation: Dorothea Dix Hospital Outpatient Psychiatry Clinic, Durham Community Guidance Clinic, John Umstead Outpatient Clinic, and the area mental health, mental retardation, and substance abuse programs for the following North Carolina counties: Cumberland, Forsyth-Stokes, Gaston-Lincoln, Randolph, Surry-Yadkin, and Vance-Granville-Franklin-Warren.

Correspondence concerning this article should be addressed to John R. Weisz, Department of Psychology, Davie Hall 013A, University of North Carolina, Chapel Hill, North Carolina 27514.

had appeared for any sessions after intake, and (b) we defined *continuers* as cases in which the child, with or without other family members, continued for at least 5 therapy sessions and did not terminate against the recommendation of the therapist. Continuers averaged 13.27 sessions ($SD = 6.55$).

We identified 166 dropouts and 138 continuers. The dropouts included 91 boys and 75 girls; 125 were White, 40 were Black, and 1 was Native American. Mean age was 11.59 years ($SD = 3.25$); socioeconomic status (SES) ratings, based on parent occupations, spanned the nine levels of Hollingshead's (1975) scale, with a mean of 4.29 ($SD = 1.89$). Continuers included 86 boys and 52 girls; 109 were White, 28 were Black, and 1 was Native American. Mean age was 11.17 years ($SD = 3.02$); SES ratings spanned all nine levels, with a mean of 4.47 ($SD = 1.91$).

Across the two groups, children were assigned to a total of 61 different therapists in the nine clinics. This diversity helped insure that our findings would not reflect idiosyncratic characteristics of any single therapist, clinic, or location. For the dropout group, 61% of the therapists were women, 95% were White, and average age was 38.7 years ($SD = 10.3$). For the continuer group, 52% of the therapists were women, 100% were White, and average age was 37.9 years ($SD = 8.7$). At intake, the parent filled in the CBCL. Child competence and adaptation are reflected in CBCL *T* scores for Activities (e.g., hobbies), Social (e.g., friendships), and School (e.g., grades) scales. Child problem behavior is reflected in separate broadband factor scores for internalizing (e.g., sadness, worrying) and externalizing (e.g., fighting, arguing). In addition, narrow-band *T* scores (e.g., for depression, delinquency) are generated separately for boys and for girls aged 6–11 years and 12–16 years. (In the present study, we scored 17-year-old subjects as 16-year-old subjects).

At intake, children filled in the CDI (we deleted a suicide item because of concerns about suggesting suicide to children). Six months later, and again at 12 months, parents were asked to complete a questionnaire. At 6 months, 111 of the parents responded; at 12 months, 116 responded. Also at 6 and 12 months, we searched clinic records to identify present and previous services received, in part to classify youngsters as dropouts or continuers. We also wrote to therapists to request their age and ethnic group. Although several therapists had relocated with no forwarding address, we did receive responses from 38 therapists for 79 dropouts and 91 continuers.

Results

Child Demographic Variables

The dropout and continuer groups were first compared on demographic characteristics: age, SES, birth order, number of children living at home, the presence or absence of changes in family structure (e.g., separation or divorce) during the 6 months following intake, and the number of miles from home to the clinic. When all these demographic variables were entered into a canonical discriminant analysis, the combination did not significantly distinguish the dropout and continuer groups ($p = .23$). Group means for these and other variables are shown in Table 1.

Therapist Variables

Next we focused on therapist demographics. We knew the gender of 58 therapists representing 244 of the children and the age and race of 38 therapists representing 170 children. (Only two therapists were non-White, so therapist race effects could not be studied.) Dropouts and continuers did not differ significantly in the age (*t* test) or sex (chi square) of their therapists

Table 1
Means for Dropouts and Continuers on Demographic, Therapist, Child Psychological, and Parent Perception Variables

Variable	Dropouts		Continuers	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Child demographic				
Sex (% boys)	55	0.50	62	0.49
Age	11.59	3.25	11.17	3.02
SES	4.29	1.89	4.47	1.91
Birth order	1.93	1.32	1.88	1.23
No. children at home	2.10	1.58	2.18	1.14
Changes in family	1.92	0.28	1.88	0.32
Miles to clinic	3.02	5.78	3.98	6.71
Therapist				
Age	38.70	10.28	37.93	8.70
Sex (% men)	39	0.49	44	0.50
Child psychological problem				
CBCL Activities	40.85	10.31	43.43	10.37
CBCL Social	37.19	9.23	37.07	9.90
CBCL School	36.00	11.19	36.84	9.88
CBCL Internalizing	66.55	10.18	66.75	9.09
CBCL Externalizing	68.16	10.24	68.68	9.05
CDI	13.73	8.74	11.63	7.57
No. previous sessions	0.43	2.12	0.43	1.56
Parent perception				
Six month				
Perceived change	3.98	0.91	3.94	1.01
Change due to family	2.57	1.19	2.64	0.92
Change due to clinic	3.88	0.85	4.29	0.77
Optimism about child	3.83	1.01	4.01	1.00
Go to clinic again	3.92	1.16	4.22	0.97
Twelve month				
Perceived change	4.02	1.06	4.13	0.82
Change due to family	2.77	1.27	2.88	1.13
Change due to clinic	3.74	0.78	4.10	0.85
Optimism about child	3.72	1.11	4.03	0.93
Go to clinic again	3.64	1.13	3.89	1.14

Note. CBCL = Child Behavior Checklist; CDI = Children's Depression Inventory; SES = socioeconomic status. CBCL scores are *T* scores on broadband dimensions; CDI means reflect raw scores.

(both $ps > .15$). We carried out two logistic regression analyses (Grizzle, Starmer, & Koch, 1969) of relations between child and therapist age (construed as continuous variables) and between child and therapist sex. Neither analysis was significant (both $ps > .25$). Note that the assumption of independent observations was violated here: Most of our therapists treated more than 1 child in the sample. However, such a violation increases the probability of finding significant results by chance. Because all our results were nonsignificant, none could be an artifact of the nonindependence.

Child Psychological Problems

Next, we tested relations between children's problems and their status as dropouts versus continuers. Two *t* tests revealed

no significant differences on CDI scores or on number of previous outpatient treatment sessions in other settings (a rough index of problem duration). Next, a canonical discriminant analysis including the Activities, Social, and School scale competence *T* scores and the internalizing and externalizing problem *T* scores from the CBCL showed no significant group differences ($p = .53$).

Additional analyses focused on *T* scores for narrow-band syndromes that have been identified in separate principal components analyses of the four Age \times Sex groups previously discussed. There are nine such factors for boys aged 6–11 years (e.g., schizoid-anxious, obsessive-compulsive), eight for girls aged 6–11 years, nine for boys aged 12–16 years, and eight for girls aged 12–16 years. Our 6–11-year-old boys included 52 dropouts and 51 continuers; our 6–11-year-old girls included 25 dropouts and 22 continuers; our 12–16-year-old boys included 43 dropouts and 36 continuers; and our 12–16-year-old girls included 46 dropouts and 29 continuers. Thus, we had reasonably powerful statistical tests. We grouped the narrow-band *T* scores within each Age \times Sex group to form four separate canonical discriminant analyses. In none of the four analyses did the combined narrow-band scores discriminate significantly between dropouts and continuers (all *F* values < 1.5 , all *p* values $> .18$).

Parent-Perception Variables

Finally, we examined parents' perceptions of the clinic and their child's experience there, as expressed in responses to the follow-up questions 6-months and 12-months after clinic intake. Parents were asked (a) How is your child now compared with his or her condition at the time of intake?; (b) How much of the change in the child (if change had occurred) was "caused by you or other family members?"; (c) How much of the change was due to "the services your child received" at the clinic?; (d) How optimistic or pessimistic "do you now feel about the concerns that brought your child to the clinic?"; and (e) "If you were to seek help again for your child, would you go back to the same clinic?" One canonical discriminant analysis included all questions at 6 months; a second included all questions at 12 months. The 6- and 12-month analyses were nonsignificant ($ps = .30$ and $.18$, respectively).

Discussion

Who drops out of outpatient child psychotherapy? Evidently, youngsters very similar to those who remain for a full course of therapy. In our sample, the dropouts and continuers were virtually indistinguishable on the basis of the child and family characteristics we assessed. Moreover, in contrast to the adult literature (e.g., Karasu et al., 1979; Lasky & Salmone, 1977), we failed to find significant interactions between therapist and client age or between therapist and client sex. Like McAdoo and Roeske (1973), we are unable to offer much help to those trying to predict and prevent premature child termination.

Our null results are based on substantial samples and cannot be attributed to low statistical power. Moreover, given our sam-

pling procedures, the findings are not likely to reflect the idiosyncratic characteristics of a single clinic or a small group of clinicians. Our findings might be viewed as supporting the position taken by Levitt (1971) and McAdoo and Roeske (1973): In outpatient child therapy, they argued, clients who drop out are so similar to clients who continue that dropouts may constitute an acceptable naturally occurring control group for outcome research.

However, much more evidence will be needed before this conclusion can be accepted with any confidence. And it will be important to follow-up on recent findings by Gould et al. (1985), which indicated that referral source and caretakers' symptomatology may relate to whether children drop out of therapy. Even if the present findings were replicated in numerous studies, it would still be advisable to use such naturally occurring control groups only when the alternative is no control group at all.

References

- Achenbach, T. M., & Edelbrock, C. S. (1983). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington: University of Vermont Department of Psychiatry.
- Gould, M. S., Shaffer, D., & Kaplan, D. (1985). The characteristics of dropouts from a child psychiatry clinic. *Journal of the American Academy of Child Psychiatry*, 24, 316–328.
- Grizzle, J. E., Starmer, C. F., & Koch, G. G. (1969). Analysis of categorical data by linear models. *Biometrics*, 25, 499–504.
- Hollingshead, A. B. (1975). *Four-factor index of social status*. Unpublished manuscript, New Haven, CT.
- Karasu, B., Stein, S. P., & Charles, E. S. (1979). Age factors in the patient-therapist relationship. *Journal of Nervous and Mental Disease*, 167, 100–104.
- Kazdin, A. E. (1986). Comparative outcome studies of psychotherapy: Methodological issues and strategies. *Journal of Consulting and Clinical Psychology*, 54, 95–105.
- Kovaks, M., & Beck, A. T. (1977). An empirical-clinical approach toward a definition of childhood depression. In J. G. Schulterbrandt & A. Raskin (Eds.), *Depression in childhood: Diagnosis, treatment, and conceptual models* (pp. 1–25). New York: Raven Press.
- Lasky, R. G., & Salmone, P. R. (1977). Attraction to psychotherapy: Influences of therapist status and therapist-patient age similarity. *Journal of Clinical Psychology*, 33, 511–516.
- Levitt, E. E. (1957). A comparison of "remainders" and "defectors" among child clinic patients. *Journal of Consulting Psychology*, 21, 316.
- Levitt, E. E. (1971). Research on psychotherapy with children. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 474–494). New York: Wiley.
- McAdoo, W. G., & Roeske, N. A. (1973). A comparison of defectors and continuers in a child guidance clinic. *Journal of Consulting and Clinical Psychology*, 40, 328–334.
- O'Leary, K. D., & Borkovec, T. D. (1978). Conceptual, methodological, and ethical problems of placebo groups in psychotherapy research. *American Psychologist*, 33, 821–830.

Received December 11, 1986

Revision received March 16, 1987

Accepted March 23, 1987 ■