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When Youth Mental Health Care Stops: Therapeutic Relationship Problems and Other Reasons for Ending Youth Outpatient Treatment

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Child and adolescent treatment ends for a variety of reasons, but little is known about the underlying factors or about whether any such factors are linked to premature dropout. To address these gaps, the authors administered their Reasons for Ending Treatment Questionnaire (RETQ) to the parents of 344 referred youth (aged 7–18 years), from 10 clinics, who had ended outpatient treatment. A factor analysis identified six factors, all showing good test–retest reliability and internal consistency. One of these, Therapeutic Relationship Problems, accounted for the most variance (16%) and was the only factor, other than Money Issues, that distinguished therapy dropouts from completers. The findings highlight major themes underlying decisions to end child therapy, and they highlight the importance of the therapeutic relationship.

Children[1] who begin outpatient mental health care end it for a variety of reasons, with parents (or guardians) typically playing the most significant role in the decision (Cohen & Richardson, 1970; Weisz & Weiss, 1993; Weisz, Weiss, & Langmeyer, 1987, 1989). Previous research on treatment termination has focused primarily on demographic and clinical factors (e.g., ethnicity, family structure, child symptom severity—see, e.g., Kendall & Sugarman, 1997; Weisz et al., 1987) and referral and treatment characteristics (e.g., Farley, Peterson, & Spanos, 1975). This research, although very useful, neither illuminates the actual decision process that leads to ending treatment nor suggests remedies in cases of premature termination.

Understanding the decision process requires documenting specific reasons for ending treatment. A few investigative teams have done this by questioning parents: (a) Gould, Shaffer, and Kaplan (1985) focused on dropouts from a university-based research clinic; (b) Kazdin and colleagues (e.g., Kazdin, Holland, Crowley & Breton, 1997) focused on children in a university research clinic for conduct problems; and (c) Kendall and Sugarman (1997) focused on children in a university research clinic for anxiety disorders. Several reasons for termination noted in these studies fit some categories of the Kazdin et al. (1997) *barriers to treatment model*—especially (a) practical obstacles, (b) a perception that treatment is demanding or not relevant to the child's problems, and (c) a poor relationship with the therapist.

In the present study, we built on previous work by interviewing parents after their children had ended outpatient treatment. We too asked about reasons for ending treatment, but our approach differed from previous studies in that (a) unlike some previous research focused only on treatment dropouts, we sampled the full range of children who had applied and been accepted for treatment, regardless of when they had stopped; (b) unlike all previous parent questionnaire studies, which have focused on university-based research clinics, we studied community clinics, which are arguably more representative of most everyday child treatment, and we included 10 such clinics (vs. 1, in each previous study) in an effort to further increase representativeness; and (c) we used factor analysis to probe for dimensions underlying treatment termination decisions.[2]

Of the various dimensions that might emerge from our factor analysis, threats to the therapeutic relationship was the one that connected most clearly to a major theme in the treatment literature. The relationship, or alliance, has been depicted by various therapy researchers as either curative in its own right (e.g., Strupp, 1989), necessary for therapy to continue and be effective (Shirk & Saiz, 1992), or critical to client motivation and compliance (Stark, Rouse, & Livingston, 1991). Indeed, many child therapists rate the therapeutic relationship as more important than the techniques used in treatment (Kazdin, Siegel, & Bass, 1990). All this suggests that problems in the therapeutic relationship might account for substantial variance in decisions to end treatment.

As noted, we sought a representative picture of factors underlying termination across all stages of treatment, by sampling clinic

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[1] Throughout this article, we use the term *children* to refer to both children and adolescents, except where we need to distinguish between the two age groups.

[2] Kazdin et al. (1997) applied principal-components analysis (PCA) to their 44-item Barriers to Treatment Participation Scale but concluded that responses were best represented by the total score rather than by separate factor scores.

families who had been accepted for therapy, with no restrictions as to timing of or reasons for ending treatment. In addition, we sought specifically to shed light on *premature* termination, a very common problem in child therapy (estimated rates range from 28% to 85% of children who begin treatment; see, e.g., Armbruster & Kazdin, 1994; Weisz & Weiss, 1993). We agree with Armbruster and Kazdin (1994) that research needs to go beyond assessment of child and parent characteristics to identify processes underlying attrition. Toward this end, after we identified factors for the full sample, we assessed whether any of those factors might distinguish between those who ended treatment appropriately and those who terminated prematurely.

Method

Families were recruited from 10 community clinics in California at the time of initial child intake assessment. Multiple measures were obtained at the time of intake and thereafter. Of special interest in this study were demographics and Child Behavior Checklist (CBCL; Achenbach, 1991) reports, obtained before treatment, and Reasons for Ending Treatment Questionnaire (RETQ) reports, obtained after treatment had ended. The CBCL is a widely used, well-validated problem-report measure that generates broadband *internalizing* (e.g., anxiety, depression) and *externalizing* (e.g., aggression, delinquency) scores. The 41-item RETQ (see Table 1) was adapted from an excellent longer questionnaire by Gould et al. (1985); we simplified the response scale and some item wording, added new items, and combined some original items to reduce redundancy and parent burden.

The sample included 344 client families who had contacted a clinic, completed intake, and been accepted for treatment and assigned a therapist. We included all participants regardless of the point at which their clinic contact ended. Client age range was 7–18 years ($M = 11.73$, $SD = 2.60$); 63% were boys; 51% were Caucasian, 16% African American, 14% Latino, and 19% mixed or other. The 9-point Hollingshead (1975) occupation mean was 3.47 ($SD = 3.12$, higher scores = higher socioeconomic status; SES), lower middle SES reflected such occupations as truck driver, police officer, and postal clerk. CBCL *T* scores (internalizing $M = 64.0$, externalizing $M = 65.5$) placed the average child above the 90th percentile on the basis of national norms.

To assess how well the sample represented clinic cases in general, we used *t* tests and chi-square tests to compare our sample of 344 with the 134 who did not complete the RETQ. The two groups did not differ on age, gender composition, ethnic proportions, SES, or CBCL internalizing or externalizing; but number of treatment sessions was lower for RETQ than for non-RETQ cases ($M = 13$ vs. 19, $p < .05$). Thus, the results reported below may be more representative of somewhat shorter term cases than a full sample of all clinic cases would have been.

We also compared cases for which we did ($n = 219$) and did not ($n = 125$) have therapist reports on therapy completion; those lacking therapist data had lower SES ($M = 2.56$ vs. 3.86, $p<.05$) and lower CBCL internalizing scores ($M = 62.27$ vs. 64.41, $p < .05$) but did not differ on gender, age, ethnicity, CBCL externalizing, or number of sessions. Thus, analyses comparing completers and dropouts (below) are somewhat less representative of very-low-SES families and internalizing youth than is the case with our full sample. Of course, our large sample generated substantial power to detect modest group differences; none of the differences in this or the previous paragraph survived a Bonferroni correction.

Results

Correlations were calculated among ratings for the 41 RETQ items. This formed a 41×41 product-moment correlation matrix, which we subjected to an unweighted least squares extraction. This yielded 12 factors with eigenvalues greater than 1; a scree plot showed a break in the slope at the 6th factor, and the residual correlation matrix showed very few residuals greater than .05 when 6 factors were extracted. Following Comrey and Lee (1992), we used loadings of .35 as a cutoff for inclusion of items within a factor. Orthogonal (varimax) rotations were performed, yielding the factors shown in Table 1. Factor 1, Therapeutic Relationship Problems, was prominent, accounting for about 16% of the variance.

To assess test–retest reliability of the factor scores, we obtained RETQs at two times ($M = 11.33$-day interval, $SD = 4.83$) for 10% of the sample ($n = 36$). We also computed Cronbach's alpha for each factor for the full sample. The test–retest correlation and alpha, respectively, were .91 and .91 for Therapeutic Relationship Problems, .84 and .79 for Family and Clinic Practical Problems, .88 and .75 for Staff and Appointment Problems, .93 and .71 for Time and Effort Concerns, .76 and .67 for Treatment Not Needed, and .93 and .72 for Money Issues.

Next we assessed whether any of the factor scores could be predicted from child and family characteristics. In each of six multiple regression analyses, one for each factor, we simultaneously entered child's age, gender, ethnicity (Caucasian vs. Other), SES, and CBCL internalizing and externalizing as independent variables and factor score as the dependent variable. Higher externalizing scores were associated with higher scores on Therapeutic Relationship Problems ($\beta = .25$, $p < .01$) and Staff and Appointment Problems ($\beta = .20$, $p < .05$). Scores on Time and Effort Concerns were related to SES; of interest, higher SES families were more likely to report stopping treatment because it required too much time and effort ($\beta = .16$, $p > .05$).[3]

Another wave of analysis assessed whether scores on any of the six factors might distinguish treatment dropouts from treatment completers. To classify cases into the two groups, we coded clinic record information entered by therapists. Following Huey (1998), we used one set of entries (e.g., statements that termination was "against therapist advice" or "premature") to indicate dropout status, and another set of entries (e.g., statements that termination was "appropriate" or "with therapist agreement") to indicate treatment completion. Inter-rater reliability was assessed by two raters, independently coding 30 cases. Cohen's kappa was .86 (κs $> .74$ are conventionally classified as "excellent"; Fleiss, 1981).

We were able to classify 135 cases as dropouts, and 84 cases as completers (for the other cases, clinic records were unavailable or

[3] The fact that higher SES families were more likely than low-SES families to end treatment because they perceived it as requiring too much time or effort may seem counterintuitive at first blush. Finding time and energy to go to the clinic would seem to be objectively *more* difficult for lower SES families than for higher SES families. However, *subjective* judgments about time and effort may be more harsh among families who are more privileged economically and thus perhaps more inclined to expect arrangements to be made that are convenient for them. Lower SES families, by contrast, may have more experience dealing with service agencies in which obtaining help is both time-consuming and physically draining. It may also be the case that higher SES families have alternative services available because of their income levels, so that time and effort issues might prompt an exit from the clinic; lower SES families, lacking alternatives, might be more likely to tolerate the inconvenience and remain in treatment.

Table 1
Factor Loadings for Varimax Six-Factor Solution

Factor and item	Factor, loading	Eigenvalue	% Variance	Mean factor score
Factor 1: Therapeutic Relationship Problems		6.46	15.72	.27
33. The therapist didn't seem to be doing the right things.	.90			
31. The therapist didn't seem to understand.	.83			
30. The therapist didn't talk about the right problems.	.77			
35. My child's treatment was not clearly explained to me.	.73			
32. My child or I didn't like the therapist.	.70			
34. The therapist didn't seem to be helping.	.69			
36. One or more of the staff members did not seem competent.	.65			
28. There was something we did not like about one or more of the staff members.	.55			
40. I felt that the therapist or staff did not spend enough time with my child alone.	.55			
41. I felt that the therapist or staff did not spend enough time with my child and other family members together.	.54			
39. I felt that the therapist or staff did not spend enough time with me alone.	.54			
16. I decided that going to the clinic would not help my child.	.51			
29. There was something about the clinic that my child or I did not like.	.45			
37. We waited too long at appointments.	.45			
38. No one would see us at our appointments.	.42			
Factor 2: Family and Clinic Practical Problems		2.96	7.22	.13
26. We had family problems that prevented us from going.	.59			
2. Someone in the family got sick.	.47			
38. No one would see us at our appointments.	.46			
21. We moved away from the area.	.42			
41. Therapist didn't spend enough time with the family.	.41			
37. We waited too long at appointments.	.41			
39. The therapist didn't spend enough time with us alone.	.37			
4. We didn't know how to get to the clinic.	.37			
18. We had transportation problems.	.35			
22. It was too hard to make babysitting arrangements for my other children.	.35			
Factor 3: Staff and Appointment Problems		2.44	5.96	.26
14. The staff member I talked to on the phone did not seem very nice, or did not seem interested in helping.	.80			
15. The staff member I talked to on the phone did not seem very competent.	.72			
28. There was something we did not like about one or more of the staff members.	.43			
5. The appointment they gave us was too far in the future.	.42			
13. I found another counselor or clinic to help my child.	.39			
7. The appointment they gave us interfered with my work schedule.	.36			
6. The appointment they gave us interfered with my child's school.	.36			
Factor 4: Time and Effort Concerns		1.94	4.74	.19
24. We didn't have enough time.	.79			
3. I felt that too much travel time was involved.	.66			
23. It took too much effort to go.	.57			
7. The appointment interfered with my work schedule.	.35			
Factor 5: Treatment Not Needed		1.79	4.38	.30
25. We decided that things were ok after all—that my child didn't really need to change.	.74			
10. I felt that help was no longer necessary because my child got better.	.63			
12. I didn't really feel that my child had a problem.	.58			
Factor 6: Money Issues		1.38	3.38	.17
27. I had a misunderstanding with the clinic over the payment of fees.	.75			
17. The services cost too much.	.49			

lacked the therapist entries needed for classification). We compared dropouts with completers on factor scores for the six factors and on child gender, age, ethnicity, CBCL internalizing, CBCL externalizing, and family SES. The tests were nonsignificant for each of the child and family factors and for four of the six RETQ factors. However, the Therapeutic Relationship Problems factor showed higher mean scores for dropouts than for completers, $t(217) = -2.23$, $p < .05$ ($M = 0.33$ and 0.21, respectively). The two groups also differed on the Money Issues factor, with mean ratings higher for dropouts than for continuers, $t(217) = -2.56$, $p < .05$ ($M = 0.23$ and 0.10, respectively).

To understand these effects more fully, we used *t* tests to compare dropouts and completers on each item of the Therapeutic Relationship Problems and Money Issues factors; we found significant differences on seven items of the first factor and one item of the second. Dropouts had higher ratings on (a) "The therapist didn't seem to be doing the right things" ($p < .05$), (b) "The therapist did not spend enough time with my child alone" ($p = .05$), (c) "The therapist didn't seem to be helping" ($p < .05$), (d) "My child's treatment was not clearly explained to me" ($p = .01$), (e) "One or more of the staff members did not seem competent" ($p = .05$), (f) "There was something about the clinic that my child or I did not like" ($p = .01$), (g) "I decided that going to the clinic would not help my child" ($p < .05$), and (h) "Services cost too much" ($p < .01$). Evidently, dropping out was related to a perceived lack of therapist involvement and investment in the child and parent, a belief that the therapist was not competent or effective, and a perception that going to the clinic was not going to help the child and was too costly anyway.

Notably, scores on Treatment Not Needed did not differentiate the dropout and completer groups. Neither did the single item "I felt that help was no longer necessary because my child got better" (both *p*s $> .30$). Dropping out apparently had more to do with concerns about the therapeutic relationship and about money than with the question of whether the child needed treatment.

Because some attrition literature suggests differences between early and late dropouts, we used a median split to divide our dropouts into two subsamples: 61 "early" dropouts (5 treatment sessions or less) and 60 "late" dropouts (6 sessions or more; 14 cases not classified because of missing data on the number of sessions completed). We compared the groups on all six factors and all demographic and clinical variables noted earlier. No differences were significant.[4,5]

Discussion

The findings highlight primary themes underlying the decision to end child treatment, and they highlight the significance of the therapeutic relationship. Six primary themes in the decision process, embodied in the six factors identified here, span a range of issues involving therapy process and therapist behavior, staff and appointment issues, and practical problems faced by the families. By far the largest percentage of variance was accounted for by Therapeutic Relationship Problems. The largest item loadings on this factor reflected concerns that the therapist did not seem to be doing the right things, talking about the right problems, talking enough with family members, or helping the child; that the therapist did not seem to understand or failed to explain the child's treatment clearly to the parents; and that the child or parent simply did not like the therapist.

Other factors pointed to the role of Family and Clinic Practical Problems (e.g., sick family member, transportation problems), Staff and Appointment Problems (e.g., clinic staff appearing to be uninterested or incompetent, appointments scheduled at inconvenient times), Time and Effort Concerns (e.g., too much travel time involved), a perception that Treatment (was) Not Needed (e.g., child got better), and Money Issues (e.g., misunderstanding over fees).

In addition to the general issue of ending treatment (at any time), we focused on *premature* ending. Dropping out was predicted only by Therapeutic Relationship Problems and Money Issues. These two themes were partially consistent with Kazdin et al.'s (1997) barriers to treatment model, which identifies five clusters of potential barriers that may predict dropping out; one of the five is "relationship with the therapist" (p. 455), and another is "treatment demands and issues" (one of which may involve money). Although the factors we identified for the full sample show considerable overlap with the barriers model, only two of the six factors predicted dropping out; this suggests a somewhat more focused account of attrition than the barriers model proposes.

Put simply, our findings indicate that dropping out had more to do with concerns about the therapeutic relationship and about money than even with the question of whether the child *needed* treatment (Factor 5) or had improved (Item 10). Analyses of specific items showed that parents of dropouts, compared with parents of completers, were more likely to perceive that the therapist was not invested in the child and parent, that the therapist was not competent or effective and not doing the right things, and that treatment was not only unlikely to help the child but that it "cost too much," as well.

Unlike previous studies examining parents' reasons for ending treatment in single university-based research clinics, the present study focused on multiple community mental health clinics. This approach entails strengths and limitations. One useful strength is fair representation of the settings, children, parents, therapists, and procedures of real-world youth clinical care. But a limitation is that the lack of structure and manualization in usual care makes some measurement less precise than what can be accomplished in a research clinic.

For example, in research clinic treatment protocols, it is clear when treatment is complete, so "dropouts" can be readily identified. In our sample, coders distinguished dropouts from completers

[4] There were two marginal effects. Early dropouts showed a trend toward higher CBCL internalizing scores ($p < .10$, *M*s = 65.95 and 63.10) and higher SES ($p < .10$, *M*s = 4.84 and 3.47) than did later dropouts.

[5] We checked for whether the factor structure found in the full sample might be at all evident in the early- and late-dropout samples. Low subject-to-item ratios (61/41, 60/41) made the two small-sample factor patterns highly unreliable and ruled out formal statistical comparison. However, most of the factors in the full sample—including Therapeutic Relationship Problems—appeared recognizable in the early- and late-dropout samples. Two full-sample factors appeared merged into one in the early-dropout sample, and three appeared merged into one in the late dropouts. Counting the merged-factor items as matches, 71% of the items loading on factors in the full sample loaded on comparable factors in the early-dropout group and 69% matched in the late-dropout group.

very reliably, but they did so by coding (from clinic records) clinician judgments as to whether therapy had been completed. In the nonmanualized care that prevails in most practice settings, the therapists may well be the only individuals who know what contents and duration they had planned for the treatment; thus, the therapists alone may be qualified to judge whether treatment was completed or ended prematurely. Such therapist judgments, however, show a level of subjectivity well beyond assessment of whether a child completed a structured treatment manual.

This highlights a tradeoff: studying treatment attrition in representative clinical practice contexts may lack some of the methodological precision that is possible in research clinics, but it offers superior external validity. Just as real-world clinical care differs in many ways from treatment done as a part of a research protocol (Weisz, Donenberg, Han, & Weiss, 1995; Weisz, Weiss, & Donenberg, 1992), it is possible that even the decision process and other determinants of ending treatment may differ across the two contexts. Thus, it is important to continue the study of reasons for ending treatment in clinical practice settings. It will also be important to strengthen the rigor of such research wherever possible.

Another useful goal is to complement questionnaire studies of parent-reported reasons for ending treatment with true experiments. Our understanding of the causal processes involved in termination may be enriched by an experimental approach in which key variables, such as those identified in this study, are manipulated and the effects on attrition and on reasons for ending treatment are examined. Whatever the approach investigators may take in the future, the present findings suggest that there is a good deal yet to be learned about child and parent experiences in clinical care and how these relate to decisions to stop the process.

References

Achenbach, T. M. (1991). *Manual for the Child Behavior Checklist/4–18 and 1991 Profile.* Burlington: University of Vermont, Department of Psychiatry.

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

Cohen, R. L., & Richardson, C. H. (1970). A retrospective study of case attrition in a child psychiatric clinic. *Social Psychiatry, 5,* 77–83.

Comrey, A. L., & Lee, H. B. (1992). *A first course in factor analysis.* (2nd ed.). Hillsdale, NJ: Erlbaum.

Farley, O. W., Peterson, K. D., & Spanos, G. (1975). Self-termination from a child guidance center. *Community Mental Health Journal, 11,* 325–334.

Fleiss, J. R. (1981). *Statistical methods for rates and proportions* (2nd ed.). New York: Wiley.

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.

Hollingshead, A. B. (1975). *Four-factor index of social status.* New Haven, CT: Yale University.

Huey, S. J. (1998) *Therapy termination among Black, Caucasian, and Latino children referred to community mental health clinics.* Unpublished doctoral dissertation, University of California, Los Angeles.

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to Treatment Participation Scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry, 38,* 1051–1062.

Kazdin, A. E., Siegel, T. C., & Bass, D. (1990). Drawing on clinical practice to inform research on child and adolescent psychotherapy: Survey of practitioners. *Professional Psychology: Research and Practice, 21,* 189–198.

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

Shirk, S. R., & Saiz, C. C. (1992). Clinical, empirical, and developmental perspectives on the therapeutic relationship in child psychotherapy. *Development and Psychopathology, 4,* 713–728.

Stark, K. D., Rouse, L. W., & Livingston, R. (1991). Treatment of depression in childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (pp. 165–206). New York: Guilford Press.

Strupp, H. H. (1989). Psychotherapy: Can the practitioner learn from the researcher? *American Psychologist, 44,* 717–724.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 688–701.

Weisz, J. R., & Weiss, B. (1993). *Effects of psychotherapy with children and adolescents.* Newbury Park, CA: Sage.

Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist, 47,* 1578–1585.

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

Weisz, J. R., Weiss, B., & Langmeyer, D. B. (1989). On dropouts and refusers in child psychotherapy: Reply to Garfield. *Journal of Consulting and Clinical Psychology, 57,* 170–171.

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