PARENT-REPORTED TREATMENT OUTCOMES VERSUS CLINICIAN JUDGMENT: CORRELATES OF PSYCHOTHERAPY IMPROVEMENT WITH CHILDREN

A Dissertation

by

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ABSTRACT

This retrospective exploratory study used archival data for 96 children who underwent psychotherapy at the university-based community mental health center. Information gathered from parents and clinicians-in-training served to explore patterns of client treatment outcomes at termination of psychotherapy and the application of clinical judgment by clinicians-in-training. The Youth Outcome Questionnaire 30.2 (YOQ 30.2) is a treatment outcome measure used to monitor the occurrence of observed behaviors or symptom change in children during the course of psychotherapy. The Behavior Assessment System for Children – Second Edition (BASC-2) is a comprehensive measure of the behavioral and emotional functioning in children used to identify mental health difficulties. This study expanded on the literature about the validity of the YOQ 30.2 as a measure of symptom intensity in children undergoing psychotherapy when compared with the BASC-2. The study identified characteristics in children that are conducive to successful termination of psychotherapy in training mental health centers. The distance from the client's home to the clinic was the only significant predictor for treatment improvement for clients who attended between 6 and 20 sessions. The number of attended sessions was confirmed as a predictor of treatment success at termination. Finally, the YOQ 30.2 treatment improvement rates served as confirmation of the clinical judgment novice clinicians-in-training apply at the time of termination.

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CHAPTER I

INTRODUCTION

Mental health disorders in children are deviations in their expected social, emotional and cognitive development (Centers for Disease Control and Prevention [CDC]; 2013). Such disorders are of severe concern because yearly between 13% and 20% children in the United States suffer from a mental illness (CDC, 2013; National Research Council and Institute of Medicine [NRCIM]; 2009). Other children, who may not have a diagnosable mental illness, also present with behavioral or emotional difficulties that are equally debilitating and stressful for their parents, siblings, peers, teachers and communities. While such difficulties vary individually in depth, breadth and scope, the extant literature indicates that mental health treatments in the form of psychotherapy significantly alleviate the symptoms of maladaptive emotional and behavioral functioning in children (Campbell, Norcross, Vasquez, & Kaslow, 2013).

According to the American Psychological Association psychotherapy comprises "any group of therapies, used to treat psychological disorders, that focus on changing faulty behaviors, thoughts, perceptions and emotions that may be associated with specific disorders" (APA, 2014, p. 16; Gerrig & Zimbardo, 2002). Other definitions of psychotherapy exist, with broader and narrower assumptions of what constitutes the facilitation of change in clients that lessens the maladaptive symptoms that they experience (Norcross, 1990). Regardless of how one defines psychotherapy, current best practices in mental health necessitate that the treatments that clinicians select to implement with clients be the result of sound psychological research.

During the past 50 years, researchers sought to accumulate evidence of what kinds of psychotherapies serve to improve the emotional and behavioral functioning of children. Randomized control trials established the efficacy of treatments in highly controlled, laboratory-like settings, while effectiveness research demonstrated the use of these treatments in natural, less controlled clinical settings (Seligman, 1995). These empirical endeavors culminated with several well-documented, effective child psychotherapy treatments. Together, these treatments comprise a set of interventions commonly called evidence-based treatments (EBTs; Kazdin, 2008a, 2008b; Weisz, Ugueto, Cheron, & Herren, 2013).

EBTs are specific interventions or techniques found to be effective with particular disorders (e.g., cognitive behavior therapy for depression). A broader but equally important concept related to EBTs is that of evidence-based practices in psychology (EBPs). While EBTs relate to the interventions implemented with clients and their respective evidence of success for the client's disorder, EBPs are concerned with the integration of these interventions into the clinical practice in relation to individual clients' characteristics, culture, and preferences. In EBPs, the client comes first, providing unique characteristics that set the tone for what types of EBTs the clinician will implement to treat the problem at hand (APA Presidential Task Force on Evidence-Based Practice, 2006).

A significant characteristic that EBTs and EBPs bring to clinical practice is the concern for data and accountability. Accountability is important because of health care system limitations on the cost of service and number of psychotherapy sessions available

to clients. With the enhanced standards of care and increased accountability imposed by the Patient Protection and Affordable Care Act (Public Law No: 111–148, March 23, 2010), there is pressing need to engage in constant monitoring of psychotherapy outcomes to facilitate accountability.

Accountability matters to both the client and the clinician. "How much therapy is enough?" and "Is therapy working?" are questions that directly relate to client and family expectations, clinician development of expertise, policymaking and treatment planning. In the era of EBTs and EBPs, the continued measurement of clients' response to psychotherapy allows clinicians to correct the course of treatment and adjust interventions to optimize progress (Burlingame, Lambert, Reisinger, Neff, & Mosier, 1995; Burlingame, Wells, Lambert, & Cox, 2004; McClendon et al., 2011).

In the case of children, families present as an added variable in the context of treatment duration and outcome measurement. With the use of instruments such as the Youth Outcome Questionnaire 30.2 (YOQ 30.2; Burlingame et al., 2004), parents of children undergoing psychotherapy become primary reporters of the symptom changes observed in clients. For children not yet equipped to use self-report measures, parent-reported data serve as the major source of information that clinicians utilize to adjust interventions during the course of treatment (Burlingame et al., 2001). Corrections to the interventions implemented and modifications to the client's treatment goals are inherent to EBPs. These corrections and modifications require the use of the clinician's clinical judgment, a concept integral to the acquisition of expertise among future psychologists (Shapiro, 2009).

The literature contains several definitions of what constitutes clinical judgment. One such definition suggests that clinical judgment is the integration of the clinicians' informal conceptualization and judgment with the accessible research-based information (Shapiro, Friedberg, & Bardenstein, 2006). In adjusting treatments to the client's needs, the clinician engages in a decision-making process guided by the combination of empirical evidence, interactions with and observations of the client, collaboration with peers, and use of previous professional expertise. The incorporation of this array of information is important when implementing treatments, but novice clinicians do not necessarily have the ability to engage in this process competently (Shapiro, 2009).

The use of treatment outcome data by clinicians applying clinical judgment to correct treatment for clients in training mental health centers is important because the quality of the standards that the clinicians learn and apply early on may remain stable overtime (Volker et al. 2010). The extant literature is rich on the effectiveness of psychotherapy with children, the use of EBTs and EBPs with children and the use of outcome data to guide clinical practice. A gap exists, however, in the area of empirical investigations that explore the role of parent-reported treatment outcome data and its role in the application of clinical judgment by clinicians-in-training at training mental health centers in the community.

The primary goal of this study is to address this gap. As the field of psychology strengthens its foundation with the implementation of empirically validated practices, the training standards of future health service providers require constant re-evaluation. The hope is that with evidence of the integration of the use of treatment outcome measures

and clinical judgment development processes in clinicians, this study may assist with the relevant integration of evidence-based practices early on in the preparation of the future clinical workforce.

CHAPTER II

LITERATURE REVIEW

The frequency of American youth who present with mental health difficulties is a pervasive and growing problem with detrimental consequences to the children, their families, and their communities. National data between 2005 and 2011 estimate that up to 20% of the U.S. children population have a diagnosable mental disorder (CDC, 2013; NRCIM, 2009). Poor behavioral and emotional functioning, even if not at clinical levels to warrant official diagnoses described in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM 5; American Psychiatric Association, 2013), strain health care, special education, and juvenile forensic programs. Mental health difficulties among individuals under 24 years of age can cost the country as much as $250 billion annually (Eisenberg & Neighbors, 2007) and rates of service claims to health insurers show a steep increase of 24% between 2007 and 2010 (Health Care Cost Institute, 2012).

Surveillance from governmental agencies including the CDC, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that some disorders have higher diagnosable rates than others do. Specifically, for children with ages between 3 and 17 years, Attention-Deficit/Hyperactivity Disorder (ADHD) ranked highest among all diagnoses reported by parents (6.8%), followed by Conduct Disorders (3.5%), Anxiety Disorders (3.0%), Mood Disorders (2.1%) and Autism Spectrum Disorders (1.1%; CDC, 2013).

Effectiveness of psychotherapy with children

The concern with how clinicians appropriately intervene to alleviate maladaptive behavioral symptoms in children is not a new trend. Initially, research in the field was not up to par with the modern empirical standards and investigations did not carefully examine the effectiveness of psychological treatments. The initiative to document the effectiveness of psychotherapy started with Eysenck (1952) with a review of more than 7,000 adult cases that he deemed ineffective. Following on these steps, Levitt conducted a review of child psychotherapy cases and concluded that children were also receiving treatments that did not help in their recovery from emotional difficulties (Levitt 1957, 1963).

Since that time, several works have documented psychotherapy as an evidence-based recourse to treat behavioral and emotional difficulties in children (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Shirk & Karver, 2003; Weisz, Jensen-Doss, & Hawley, 2006; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). Empirical investigations in controlled settings compiled evidence of the efficacy of several treatments for different disorders, followed by the effectiveness studies in more community-oriented clinical settings. Overall, mean effect sizes for these treatments vary from medium to large, ranging between .5 and .8 according to Cohen's categories (Cohen, 1988). General approaches such as Cognitive Behavioral Therapy to treat depressive disorders or specific manualized treatments such as *Coping Cat* (Kendall & Hedtke, 2006) for anxiety or *The Incredible Years* (Webster-

Stratton & Reid, 2010) for conduct disorders follow the current standards for evidence-based treatments (EBTs; Weisz et al., 2013).

The implementation of EBTs in clinical settings allows for research and practice to join forces for the application of evidence-based practices in psychology (EBPs; APA, 2006) and for the good of the client. Such integration however, does not come without controversy. Though EBTs are presently the gold standard for the provision of psychotherapy with children, not all of the components of the EBTs help all children all the time. One fundamental practice when implementing EBTs is to monitor carefully the client's feedback about symptom improvement to allow for adjustments in treatment (Campbell et al., 2013; Shimokawa, Lambert, & Smart, 2010).

Accountability and outcome measurement

The landscape for the provision of health care services in the United States has changed substantially in the recent years. Federal efforts to improve quality standards have called for "safe, effective, patient-centered, timely, efficient and equitable" care (Institute of Medicine, 2001, p. 7) and within behavioral health providers, similar expectations are in order (President's New Freedom Commission on Mental Health, 2003). EBTs within the scope of EBPs come as a direct response of these expectations and represent not only a suggestion, but also a precondition for the implementation of effective interventions (APA, 2006).

The current health care law of the land is the Patient Protection and Affordable Care Act (PPACA; Public Law No: 111-146, March 23, 2010). The PPACA stipulates that any services that individuals receive should be efficient and cost effective

(Rosenbaum, 2011); this requirement is endorsed in part by the focus on accountability with the implementation of EBTs and the measurement of outcomes in clients undergoing psychotherapy.

Different ways exist to conceptualize and measure psychotherapy outcomes in clients. One such way considers that psychotherapy outcomes influence not only the client, but also the clinician and the society at large (Strupp & Hadley, 1977). Using this approach, Lambert (1983) proposed that of utmost importance is the clients' subjective assessment of functioning, based on their symptoms of emotional distress, personal relationships and well-being in social environments such as work and family. More recently, evidence demonstrates that a best practice for monitoring psychotherapy outcomes involves having the clinician ask clients to provide regular feedback on their level of satisfaction with the treatment and overall services, level of distress and their perceptions of the levels of their quality of life (Maruish, 1999). In the case of young children undergoing treatment but not equipped to engage in deep subjective appraisals, parent reports are used to gauge the quality of response to treatments.

As described by Lambert (2013), the use of standardized measures to monitor client feedback is essential to reduce poor outcomes and enhance successful completion of services. As such, several of these measures are available in the United States with the primary purpose of informing clinicians about necessary corrections in the course of treatment to optimize psychotherapy effects (Lambert, Hansen, & Finch, 2001; Lueger et al., 2001; Miller, Duncan, Sorrell, & Brown, 2005). Among these standardized outcome measures are the Outcome Questionnaire (OQ) family of instruments (Lambert, Morton,

et al., 2004; Wells, Burlingame, Lambert, Hoag, & Hope, 1996) that measure treatment outcome by quantifying the level of emotional distress in clients. The most updated versions comprise the Outcome Questionnaire-45 (OQ-45; Lambert, Huefner, & Reisinger, 1996) for use with adults and the child and adolescent version, the Youth Outcome Questionnaire 30.2 (YOQ 30.2; Burlingame et al., 2001, 2004, 2005; Wells, Burlingame, & Lambert, 1999).

The OQ-45 is a measure designed to meet the demand for standardized psychotherapy outcome measurement in adults. Normed using samples of individuals in the community and clinical settings, this self-report questionnaire has 45 items that clients answer before each of the treatment sessions they attend to track their overall level of distress. The extant literature indicates that the OQ-45 is psychometrically sound and sensitive to treatment change, thus it is widely used in the United States and internationally (Lambert, 2013). The items on the OQ-45 yield a Total Score as well as scores for the Symptom Distress, Interpersonal Relations and Social Role subscales, respectively (Lambert, 2005).

Within the OQ family, the YOQ 30.2 (Burlingame et al., 2001, 2004, 2005) is the most current version of the child and adolescent form for the OQ measures. The YOQ 30.2 is 30-item improved version of the original 64-item YOQ 2.0 (Burlingame et al., 1996) and Youth Outcome Questionnaire Adolescent Self-Report (Wells, Burlingame & Rose, 2003). The YOQ 30.2 has two forms, the Parent Report that parents of clients complete and the Self-Report that older children and adolescents complete before each attended treatment session.

Key to the theoretical framework used with the YOQ30.2 is the widely used concept of Reliable Change Index (RCI; Haderlie, 2011). Among many of the proposed indexes of clinical change, the methodology offered by Jacobson and Truax (1991) is the most reliable assessment of changes in test scores (Temkin, 2004). The RCI uses pre- and post- comparisons of psychometrically derived scores to determine change patterns following interventions with clients (De Souza Costa & De Paula, 2015). For the scale for which it is being calculated, the RCI is derived from a formula that uses the scale's internal consistency and standard deviation for the sample in question (Busch et al., 2013). With the YOQ 30.2, the Total Score is used to measure the RCI to determine how much change is required to establish success in psychotherapy. According to the RCI framework, the sensitivity to change and treatment outcome are measured as recovered, reliably improved, no change, or deteriorated. The literature discusses the advantages and disadvantages of using the RCI as a measure of response to treatment in clients when compared to other comparison indices of clinical change in psychotherapy (i.e., difference scores, crossing clinical threshold, and added value scores; Wolpert, et al., 2015). Discussion of these methodologies is beyond the scope of this study. For a more in-depth discussion of this topic, readers may are refer the work by Wolpert and colleagues (Wolpert et al., 2014).

One advantage of utilizing the RCI to measure significant change following interventions with client is the psychometrically sound basis for its calculation. To that end, the RCI aims at identifying the reliable change in symptoms in the absence of measurement error. A disadvantage of the use of RCI is the low sensitivity that the RCI

possesses to measure small yet clinically relevant changes in clients. Similarly, while reliable change may be met via the RCI score, not necessarily is the change clinically significant (Wolpert et al. 2015). The Measures section of the Methods chapter contains a detailed discussion of the psychometric properties and the RCI of the YOQ30.2.

While the YOQ 30.2 is considered to have acceptable psychometric properties, the literature indicates that more validation studies of the YOQ were conducted using the 2.0 version rather than the 30.2 version (McClendon et al., 2011; Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010). More specifically, at this time no evidence exists of studies that explore the sensitivity to change of the YOQ 30.2 when evaluated against instruments that measure psychological dysfunction in children and adolescents such as the Child Behavior Checklist (Achenbach, 1991; Achenbach & Rescorla, 2004). Finally, the current literature is void of studies that evaluate the YOQ 30.2 when compared to the Behavior Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2004), a broad-band measure of behavioral and emotional functioning that has been used as an outcome measure, but not outcome that results from the implementation of EBTs for psychotherapy in children (McClendon et al., 2011). One of the goals of the proposed study is to address this gap in the literature.

Parental motivation for treatment with children

Despite the established effectiveness of child psychotherapy, the continued implementation of EBTs and increased accountability for outcomes, difficulties with treatment retention and engagement are still a matter of great concern for clinicians (Ingoldsby, 2010; Kazdin, 1996; Shuman & Shapiro, 2002; Thompson, Bender, Lantry,

& Flynn, 2007). Estimates of premature termination of treatment among children can range from 30% to 75% (Garfield, 1994; Gopalan et al. 2010; Kazdin, 1990, 1996; Warnick et al., 2012). In addition to the personal loss for the client for failure to achieve treatment goals, unsuccessful termination is costly for the clinicians and disrupts the implementation and assessment of the efficacy of the EBTs (Armbruster & Kazdin, 1994). The extant research has attempted to anticipate predictors for dropout in treatment, but challenges still exist to pinpoint how to optimize treatment completion (Warnick et al., 2012).

Several studies have investigated the individual trait-like characteristics in families that are predictors of poor retention and treatment completion (Wierzbicki & Pekarik, 1993), but there is mixed evidence about how well these predictors are confirmed during replication studies (Shuman & Shapiro, 2002). This holds truth for variables such as socioeconomic status, child psychopathology, parent psychiatric diagnoses, single-parent households, minority ethnicity status and neighborhood of residence (Ingoldsby, 2010). For other researchers, investigations that concentrate on understanding the processes of psychotherapy related to client and family engagement are crucial to improving rates of timely and successful completion (Baker-Ericzén, Jenkins, & Haine-Schlagel, 2013). Client attendance rates, client and family alliance with the clinician, motivation to change and the expectations about treatment are some of the variables that are associated with parental engagement to the psychotherapy with children (Thompson et al., 2007). One goal of this study is to augment this literature.

Clinical expertise in future clinicians

The need for high quality training of future professional clinicians is not a new debate among psychology trainers (Christensen & Jacobson, 1994; Callahan et al., 2014; Durlak, 1979; Health Service Psychology Education Collaborative, 2013; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). Efforts to enhance the standardization of the training in psychology aim at having graduates seek affiliation to specialty certification boards as minimum requirements for responsible practice (Belar, 2011, 2012).

Following the guidelines proposed by the APA Presidential Task Force on Evidence-Based Practice (2006) to the implementation of EBTs within EBPs, increased attention is being given to the basic competency that clinicians-in-training obtain during their graduate programs. Most importantly, there is concern about the degree to which trainees are prepared to incorporate clinical judgment to gauge accurately when to adjust EBTs to meet the needs of their clients when progress in treatment is not occurring at acceptable rates (Rozensky, 2013).

The extant literature shows evidence that improvement has occurred in the quality of the training offered to future clinicians about the theoretical foundations and rigorous implementation of EBTs (Collins, Leffingwell, & Belar, 2007). The same is not demonstrated for the training that is offered to acquire competence in clinical judgment during the implementation of such treatments (Kazdin, 2008b; Hershenberg, Drabick, & Vivian, 2012; Volker et al., 2010). Investigators interested in how clinicians apply judgment categorize this process as being not entirely reliable, but greatly

substantiated by face validity and flexibility (Wierzbicki & Pekarik 1993). Face-validity is singularly evident in cases when the clinician stipulates that a client's degree of symptom alleviation and attainment of treatment goals is not sufficient to constitute a significant change in their level of distress. Flexibility is most noticeable in cases when clinicians adjust interventions to correct the course of treatment to optimize outcomes (Reis & Brown, 1999). These corrections directly comply with the standards proposed by EBPs where the clinician and the client consult throughout the duration of treatment to identify, based on the client's unique characteristics and needs, what intervention is most indicated to facilitate the process of alleviating maladaptive symptoms and enhance successful treatment completion (Layne, Steinberg, & Steinberg, 2014; Wilton & Slim, 2012).

Some have argued that expertise in EBPs subsumes the clinical judgment required in the process of clinical decision-making, implementation of treatments and monitoring of client progress. To apply clinical judgment, clinicians must necessarily monitor their client's progress to allow for well-informed corrections in the course of treatment (DeLeon & Kazdin, 2010; Lambert, Bergin, & Garfield, 2004; Tracey et al., 2014). There is no evidence of any investigations about the application clinical judgment by clinician's in training in university-based mental health centers with the use of treatment outcome measures such as the YOQ 30.2.

Statement of the problem

The use by clinicians-in-training of parent-reported treatment outcome data to adjust treatments for clients in mental health centers is important because the quality of

the standards that the clinicians learn and apply early on may remain stable overtime. In order to improve the treatment outcomes of children undergoing psychotherapy provided by clinicians-in-training at mental health centers, methods need to be established to enhance the application of clinical judgment during the course of treatment to prevent client dropout and improve outcome.

The present study had several purposes. The first purpose was to expand on the validation of the YOQ 30.2 as a measure of symptom intensity in children undergoing psychotherapy by measuring the agreement in level of problem behaviors at intake reported on the YOQ 30.2 with the behavioral functioning that parents report on the BASC-2. The second purpose was to explore the characteristics in children undergoing psychotherapy at training mental health centers that are conducive to success at the time of termination of services. Third, this study was to examine the utility of the YOQ 30.2 as a measure of treatment outcome for psychotherapy in children when compared to the judgment of clinicians at the time of termination.

Research questions

Research question 1. At the time of intake for psychotherapy how do parent-reported scores on the YOQ 30.2 correlate with the parent-reported level of symptom severity on the BASC-2, a broad-band measure of behavioral functioning? It was hypothesized that the parent reports on the YOQ 30.2 PR at intake would have significant positive correlations with the composite scores of the parent report form BASC-2 PRS.

Research question 2. What are some characteristics in children and their parents seeking services at a community training mental health clinic that are conducive to a greater rate of improvement of symptoms at termination of psychotherapy as measured by the YOQ 30.2?

First, it was hypothesized that positive parental level of commitment to treatment as measured by the clients' attendance ratio (i.e., attended sessions within all scheduled sessions) would be significantly and positively correlated with the rate of improvement of symptoms in clients as measured by the YOQ 30.2.

Second, it was hypothesized that the distance between the client's residence and the CAC would significantly influence the attendance rate and treatment improvement in clients as it represented an obstacle for parents to bring clients for sessions. Specifically, residence distance from the CAC was expected to be significantly, negatively correlated with attendance rate. Analyses of the distance impact on attendance considered distance both as an interval variable (number of miles) and as a dichotomous variable (close residence versus far residence) to account for more precise identification of characteristics in clients.

Third, it was hypothesized that the parental motivation for treatment of clients that parents reported at the time of intake would be associated with the quality the treatment improvement at termination. Specifically, parental motivation to treatment was represented by the parents' endorsement of three questions in the Child History Form. These questions gather information on the parents' (a) perceived seriousness of their child's problem; (b) perceived importance of the child overcoming these problems;

and (c) perceived expectation that services at the mental health center will help the child. It was hypothesized that the importance of the help to be received at the mental health center would be significantly and positively correlated with the rate of improvement of symptoms in clients as measured by the YOQ 30.2.

Research question 3. For clients exposed to psychotherapy at a training mental health clinic in the community, does progress in therapy measured by parent-reported ratings on the YOQ 30.2 PR at the time of intake and termination correlate with the clinician's judgment of progress made at termination of services (sufficient progress [SP] made versus not sufficient progress [NSP] made)? As the treatment improvement (TI) was the difference between the YOQ 30.2 PR at termination (PRT) and the YOQ 30.2 PR at intake (PRI), the greater the difference between PRT and PRI, the higher was the clients' TI at termination. To demonstrate the development of clinical judgment in clinicians, it was hypothesized that, overall, terminations with SP would have higher TI than terminations with NSP.

CHAPTER III

METHODOLOGY

The proposed study was retrospective in nature. Following IRB approval, the study used an extant de-identified database of records from minor clients who had received psychotherapy services provided by clinicians-in-training at the Counseling and Assessment Clinic (CAC) at Texas A&M University in Bryan, Texas.

Setting

The CAC is a non-profit research and training clinic for students enrolled in the Counseling Psychology and School Psychology doctoral programs in the Educational Psychology Department at Texas A&M University. The CAC is located within HealthPoint, a federally qualified community health center managed by the Brazos Valley Community Action Agency. The CAC serves community members of the Bryan-College Station area and the surrounding communities within Brazos, Burleson, Grimes, Robertson, and Washington Counties with an estimated population of 298,000 (U.S. Census Bureau, 2014).

The CAC operates using a sliding fee schedule, which allows for the low income, uninsured, or indigent population to receive mental health services. The CAC sees children, adolescents, and adults with a range of psychological symptoms. For children and adolescents, presenting problems range from internalizing (e.g., depression, anxiety) to externalizing (e.g. hyperactivity, conduct problems). Biological parents, foster parents or legal guardians bring the minor clients to the CAC. For the purpose of this study, any

adult(s) bringing an underage individual to receive treatment was considered the parent, while the minor individual receiving services is considered the client.

The child and adolescent clients at the CAC receive services from doctoral students in School Psychology completing practicum experiences that serve to establish basic competency in the provision of psychotherapy and implementation of evidence-based treatments. Though still in training, for the purposes of this study, these students are called clinicians. These clinicians were advanced students in their program and some of them already had a master's level degree in the field of mental health. Depending on the profile of the clinicians, bilingual services in Spanish can be provided to clients. For this study, services were provided only in English. Clinicians practiced under the supervision of licensed psychologists, called supervisors, who were faculty at Texas A&M University in the School Psychology Program. To ensure close monitoring of the services provided at the CAC, clinicians participated in weekly 2-hour group and 1-hour individual supervision meetings, respectively.

Participants

Participants for this study are the clients and parents with all information aligned with the client or child. No experimental design randomization for services occurred within the clients' files considered for this study; there were no events expected to affect the clients adversely. Age was the primary criterion considered for inclusion of the clients in the study. Clients came from a pool of terminated counseling files at the CAC for children aged between 6 and 11 years at the time of initiation of psychotherapy services between the years of 2010 and 2015. A second criterion was a minimum of four

treatment sessions attended at the CAC. The four sessions were the least number required to allow for the calculation of a treatment improvement rate after receiving psychotherapy. More information about this variable is described in the Procedures section below. Table 1 displays descriptive data of the sample.

Table 1 Demographic Characteristics of Participants (n = 96)

Demographic Characteristics	Mean	Min	Max	SD	n	%
Age	9.03	6.00	11.90	1.66	96	100
Distance to the CAC (miles)	11.22	1.50	45.57	11.37		
Close residence (< 20 miles)	5.98	1.50	18.94	3.67	76	79.20
Far residence (> 20 miles)	31.16	22.59	45.57	8.05	20	20.80
Attendance						
Sessions attended	13	4	38	7.38		
Total Sessions Scheduled	18	4	45	8.79		
Attendance Rate	.72	.33	1	.15		
Parent Motivation to Treatment	23.76	7	30	4.76	80	
L.A. - Seriousness	7.06	2	10	1.90	88	
L.B. - Importance	8.42	0	10	2.29	88	
L.C. - Help	8.8	1	10	2.14	80	
BASC-2 PRS:C Composites T-Scores						
Externalizing	65	33	100	15.25		
Internalizing	64	32	113	16.71		
Behavioral Symptoms Index	66	37	97	13.32		
Adaptive Skills	39	23	60	8.85		
YOQ 30.2 PR Raw Scores						
PRI	44	5	88	17.78		
PRT	34	1	85	18.91		
TI	-10	-47	35	14.62		

Demographic Characteristics	n	%
Gender		
Male	45	46.90
Female	51	53.10
Ethnicity		
Black	8	8.30
Hispanic	29	30.20
White	53	55.20
Other	6	6.30

Table 1 continued

Demographic Characteristics	n	%
Behavioral Data Rater		
Mother or Female Guardian	92	95.80
Father or Male Guardian	3	3.10
Other	1	1
City of Residence		
Bryan	43	44.80
College Station	27	28.10
Caldwell	5	5.20
Navasota	4	4.20
Other	17	17.70
Initial Diagnosis		
No diagnosis	8	8.30
Externalizing Disorder	53	55.20
Internalizing Disorder	19	19.80
Both Int. & Ext. Disorders	16	16.70
Termination Diagnosis		
No diagnosis	24	25
Externalizing Disorder	45	46.90
Internalizing Disorder	13	13.50
Both Int. & Ext. Disorders	14	14.60
Decision to Terminate Treatment		
Mutual Agreement	43	44.80
Clinician initiated	21	21.90
Client initiated	32	33.30
Progress at Termination		
Not Sufficient Progress Made	47	49
Sufficient Progress Made	49	51

Note. The BASC-2 PRS:C is the Behavior Assessment System for Children, Second Edition, Parent Rating Scale for Children (6-11), the YOQ 30.2 is the Youth Outcome Questionnaire 30.2 Parent Rating Form, PRI is the Parent Rating at Intake, PRT is the Parent Rating at Termination, and TI is the Treatment Improvement. For Parent Motivation, Likert-type (0-10) parent ratings items on the Child History Form are: L.A: "How serious are your child's problems?"; L.B- "How important is it for your child to get over his/her problems soon?"; and L.C "How much do you think it will help your child to get to the mental health center?"

Within the 96 clients, the average age was 9.03 years old (SD=1.66). Ages ranged from 6 years to 11.90 years. The majority of clients were male (n = 51, 53.1%) and White (n = 53, 55.2%). The remaining clients were Hispanic (n = 29; 30.2%), Black

(n = 8, 8.3%) and "Other" that included mixed races and ethnicities (n = 6, 6.3%). The behavior rating measured were predominantly obtained from the clients' mother or female legal guardian (n=92, 95.8%). Only four of them chose to complete the measures in Spanish (BASC-2 PRS:C and Child History Form); however, clients were served in English. Clients received services because parents sought treatment for behavioral difficulties or their school or primary care provider referred them for services. Initial diagnoses were predominantly related to externalizing disorders (n = 53; 55.2%) and 13 was the average number of sessions they attended (SD= 7.38). Termination diagnoses were primarily associated with externalizing disorders (n=45, 46.9%).

Distance as a factor

Given that the distance traveled for the client to receive services may represent a deterrent to the number of psychotherapy sessions attended, the distance from the clients' residence to the CAC was taken into account. The expectation was that the majority of these clients would be community members residing in Brazos County in Texas and residents of the Bryan-College Station metropolitan area and adjacent rural communities within the Brazos River Valley. Calculations for the distance between the CAC and the residence of the clients was found to be more reliable at the zip code level rather than the street address and number level. This was primarily due to inconsistent reporting and physical moves of the family. To ensure accuracy in the mileage distance between the clients' place of residence and place of treatment, distances were determined using a zip code calculation application called Zip Code API. The company RedLine 13 is responsible for managing this web-based application available at www.zipcodeapi.com.

Most of the clients were residents of the cities of Bryan (n = 43, 44.8%), College Station (n = 27, 28.1%), Caldwell (n = 5; 5.2%), and Navasota (n = 4; 4.2%). The remaining participants (n = 17; 17.7%) resided in various cities within the Brazos Valley region. Localities in this group included Bremond, Brenham, Hearne, Iola, Lexington, Madisonville, Normangee, Rockdale, and Washington-on-the-Brazos. Distances covered to reach the CAC located at 3370 South Texas Avenue in Bryan, TX ranged from 1.5 miles to 45.57 miles (M=11.23; SD=11.37).

Analyses with distance as a dichotomous variable categorized two groups of clients based on the distance to the CAC. The first group of clients, called *close residence*, resided within 20 miles from the CAC (min = 1.5; max = 18.9). This group included the majority of the clients (n = 76, 79.2%) who travelled on average close to 6 miles to reach the CAC (SD = 3.67). The second group, called *far residence*, resided more than 20 miles away from the CAC (min = 22.6; max = 45.6). This group included fewer clients (n = 20; 20.8%) who travelled on average 31.2 miles to reach the CAC (SD = 8.05).

Socioeconomic status

Gathering of information on the socioeconomic status (SES) for the clients seen at the CAC usually occurs when the clients' parents verbally reported the information to the Service Coordinators during the telephone intake. For the duration of treatment at the CAC, there is no official verification of the income reported. Historically, SES for the CAC clientele presents with minimal variance and skewness towards lower income levels. Income classification used the Federal Poverty Level published annually by the

U.S. Department of Health and Human Services. Specific data for the clients included in the study was not available; however, administrative data with income information for the years 2010-2015 was available for the population of 6-12 years age group of CAC clients. Records indicated that there were 202 clients aged 6-12 years served within those years. As with the subsample for this study, males represented most of the population (n = 112; 55.45%). Meeting the expectations of low variance levels of income, nearly half of the population for the study (n=105; 52.0%) fell within the <100% Poverty bracket of the Federal Poverty Level guidelines. The second highest income group reported was within the >185% Poverty (n = 57; 28.2%), followed by the 100-150% Poverty (n = 24; 11.9%) and 150-185% Poverty (n = 16; 7.9%) categories. Considering the SES guidelines for the year 2015, families with up to four members would present with a maximum annual income of US $24,250 (100% poverty line).

Procedures

Following approval by Texas A&M University's Institutional Review Board to use the dataset described above, selection of the terminated cases followed specific guidelines. The client's age served as the primary inclusionary criteria for this study. The sample was comprised of cases for clients aged 6 to 11 years at the time of intake for services at the CAC. Although administrative records estimated between 100 and 125 potential clients would meet the age criterion to be included in the study, only 106 cases were identified. Within these cases, other criteria narrowed the sample to 92 cases to be included in the study. A section below describes the inclusion criteria in detail. To augment the number of cases used in the study, an amendment to the IRB approved the

inclusion of the terminated files for the year 2015. With this inclusion, out of 121 possible terminated cases between 2010 and 2015, 96 met criteria to be included in the study.

The primary reason for excluding 25 files were age inconsistencies and missing data at the level of the measures considered in the study. First, within the initial pool of 109 clients, 11 were excluded for being above the age range for the administration of the BASC-2 PRS:C. Second, for 14 of the files excluded, there were missing scores for the BASC-2, the YOQ 30.2, or both the BASC-2 and the YOQ 30.2. While there was no viable way to ascertain the reason for the absence of these measures within the excluded files, speculations were that the oversight was primarily due to human error or clinical judgment decision by supervisors not to use either or both measures.

The included files met all inclusionary criteria for the study. First, as duration of psychotherapy services at CAC varies substantially, inclusion of cases was restricted to clients with a minimum number of four attended sessions. This requirement was imperative for calculation of the treatment improvement observed clients as measured by the YOQ 30.2 and is explained in the section below.

Second, a minimum of four administrations of the YOQ 30.2 PR during the attended sessions was a required condition for cases to remain in the study sample. Consideration of the YOQ 30.2 data was restricted to cases of YOQ parent scales responded in English. Though the YOQ 30.2 is available in Spanish, the CAC only administers the self-report Spanish form, not the parent report Spanish form. For the sample, cases without the YOQ 30.2 in English or with YOQ Self-report administrations

were excluded (n=5). To strengthen the validity of the parental endorsement of the clients' behavioral functioning at the beginning of treatment, the parent ratings on the YOQ 30.2 PR at the time of the intake considered the YOQ.30.2 Total Scores yielded for the first two sessions at the CAC. This variable was called the Parent Rating at Intake, or PRI. Likewise, the behavioral functioning of clients at termination considered the YOQ 30.2 PR Total Scores for the two last sessions attended at the CAC. This score was named Parent Rating at Termination, or PRT. The treatment improvement variable, or TI, resulted from the difference between PRT and PRI. Hence, clients with less than four treatment sessions were excluded from the sample because a treatment improvement score for them could not be calculated. The Measures section below describes in detail the process used to calculate the treatment improvement rate.

Third, inclusion of cases took into consideration the administration of the BASC-2 PRS:C. Cases where BASC-2 PRS:C, regardless of the language of completion, were not available were excluded (n=4). Consideration of the acceptable validity of the BASC-2 PRS:C ratings was not taken into account to exclude cases.

Fourth, criteria for inclusion considered the parental endorsement of the motivation items (items L.A through L.C) on the Intake Questionnaire – Child History Form. Absence of answers for one or more of these items affected the planned analyses used to answer research question 2 and were considered missing data (n=16). This did not necessarily mean these cases were excluded from consideration for the planned analyses to answer research questions 1 and 3.

CAC procedures

The procedures implemented at the CAC during the assignment of clients, supervision of clinicians, delivery and course of treatment, and gathering of information from parents are integral to the understanding of the design for this study. The following section describes these procedures.

Potential clients at the CAC needed to pass a telephone screening evaluation performed by one of two Service Coordinators on staff. The Service Coordinators were upper-level doctoral students in either School Psychology or Counseling Psychology who had mandatorily completed their practicum experience at the CAC with distinction. Screening evaluations occurred when the parent called the clinic to seek services for the client. For severe levels of psychopathology, Service Coordinators made referrals to other mental health sources in the community (e.g., local Mental Health and Mental Retardation authority). For the cases appropriate to receive services at the CAC, the Service Coordinators completed the Telephone Screening Evaluation (TSE; Appendix D) to record demographic information for the client and the presenting problems reported by the parent. The TSE was the document that the supervisors utilized to make determinations on selecting the clients to assign to the clinicians. After the client was assigned to the clinician in consultation with the clinician's supervisor and the parent was contacted via telephone, the parent and the client came to the CAC to attend the Intake Interview. During the Intake Interview, parents completed measures (BASC-2 PRS:C and YOQ.30.2 PR) and forms (e.g. Child History Form; Appendix A) that assisted clinicians in the process of formulating a diagnosis of a mental disorder,

conceptualizing a treatment plan, and monitoring treatment outcomes. The Measures section below provides information on this documentation.

Moving forward, the clinician met with the client and parent for weekly 50-minute sessions. These meetings include mandatory monitoring of treatment outcomes via the parent completion of YOQ 30.2 PR, a symptom-level treatment outcome measure prior to the start of the session. After the first three sessions at the CAC, the clinician generated the Intake Report (Appendix B) with a specified diagnosis, treatment plan, and individualized goals. The duration of treatment at the CAC varied according to the specific needs of the client and the judgment of the clinician-supervisor dyad of the clients' attained progress. Termination of psychotherapy occurred following sufficient progress made by the client or not. At the time of a transfer or termination of the case, the clinician generated a Termination Summary (Appendix C) with a summary of the services provided, specific level of progress made (sufficient or not sufficient), and indications of possible need for continued treatment.

Measures

The data from the clients' files included measures completed by the parent and the clinician, or generated by administrative personnel and software at the CAC. The parent-completed measures included (a) an Intake Questionnaire – Child History (see Appendix A), (b) the Youth Outcome Questionnaire 30.2 – Parent Report (YOQ 30.2 PR; Burlingame et al., 2001, 2004, 2005), and (c) the Behavior Assessment System for Children, Second Edition – Parent Rating Scales, Child (BASC-2 PRS:C; Reynolds & Kamphaus, 2004). The clinician-generated documents are (a) the CAC Intake Evaluation

Report (see Appendix B) and (b) the CAC Termination Summary (see Appendix C). Client attendance records generated by Titanium, a record management software and client/parent demographic information available on the Telephone Screening Evaluation (Appendix D) complete the information used for data analysis.

Intake Questionnaire - Child History Form

The Intake Questionnaire – Child History Form (CHF; Appendix A) was a demographic and history questionnaire developed by the CAC with the goal of accurately and comprehensively collecting information on the client as reported by the parent. The parent completed the CHF during the first visit to the CAC before the Intake interview began. Completion of the form likely ranged from 20-30 minutes depending on the level of detail about the child history that the parent shared. The CHF requires a fifth grade reading level and is available in English and Spanish. When a parent completed the CHF, they needed to provide demographic information about the client and the family including the client's educational, psychological and medical history. On the CHF, the parent also reported the current concerns that brought the client to the CAC and the parent's perceptions of the need for treatment of the client, the importance of the improvement of symptoms in the client, and the expected help to available to the client at the mental health center. Variables of interest in the CHF include demographic information on the client and parent (e.g., age, gender, ethnicity, linguistic background) and the Likert-type scale questions that parents endorse about their motivation towards the treatment offered to their child at the CAC. Specifically, the parent's rating on the item L.A "How serious are your child's problems?" (0 = not serious to 10 = extremely

serious) served as an indication of the parent's perceived seriousness of the problem with the client. The item L.B "How important is it for your child to get over his/her problems soon?" (0 = not important to 10 = extremely important) indicated the parent's perceived importance to change. Finally, the item L.C "How much do you think it will help your child to get to the mental health center?" (0 = will not help at all to 10= will really help a lot) conveyed the parents' perceived expectation of treatment outcome. For this study, there was consideration of the scores on the three questions separately and combined. For the latter, the addition of the three scores formed a variable called Parent Motivation for Treatment, or PMT.

Youth Outcome Questionnaire 30.2 - Parent Rating Form

The Youth Outcome Questionnaire 30.2 (YOQ 30.2; Burlingame et al., 2001, 2004, 2005) is a newer, shorter version of the Youth Outcome Questionnaire Version 2.01 (Burlingame et al., 1996) and the Youth Outcome Questionnaire Adolescent Self-Report (Wells, Burlingame & Rose, 2003). The YOQ 30.2 is a 30-item 5-point Likert-type questionnaire (never or almost never = 0 to always or almost always = 4) used to measure the treatment progress of children and adolescents receiving mental health treatment. Parents complete the Parent Report (PR) form for clients between ages 4 to 17 years and the clients themselves complete the Self-Report form if they are between ages 12 to 17 years. The current study considered data obtained via the YOQ 30.2 PR in English for children aged 6 to 11 years at the time of intake for treatment. Unlike other measures devised to identify psychopathology in children and adolescents such as the Child Behavior Checklist (CBCL; Achenbach, 1991) and the Conners 3 (Conners,

2008), the YOQ 30.2 PR is intended to assess the occurrence of observed behaviors or symptom change over time. Parents completed the YOQ 30.2 PR every time they checked their child in to attend a session. Historically, the completion time for the YOQ 30.2 PR lasts between 4 to 10 minutes depending on how careful raters endorse their responses.

The OQ Analyst® was the software used to administer, score, and generate the reports that clinicians utilize to monitor the progress of their clients. The OQ Analyst® also serves as a database to manage the successive administrations of the YOQ 30.2 PR for clients over time. The OQ Analyst® is a well-established tool to effectively track treatment change and inform clinicians about the client's outcome and the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) (OQ Analyst, 2016) lists it as an adequate evidence-based tool to monitor client treatment outcome of psychotherapy. At the CAC, following the completion by the parent of the YOQ 30.2 PR, front desk personnel generated printouts that were included in the client paper file and served as the source of data for this study.

The YOQ 30.2 manual provides comprehensive information on its psychometric properties (Burlingame et al., 2004). The standardization norms for the YOQ 30.2 used community, inpatient and outpatient samples of the population. The internal consistency reliability was high at .96 for the YOQ 30.2 PR. Reliability resulted from using Cronbach's alpha with normative samples of 1091 individuals for the community and 2732 individuals for the patient subgroups. Specifically, for the Total Score of the YOQ

30.2 PR for the community and patient samples, reliability levels were at .92 and .94, respectively.

Data on the concurrent and discriminant validity of the YOQ 30.2 PR indicates that it is a valid measure of treatment outcome in children and adolescents. For the convergent validity, specifically, comparisons of the Total Score for the YOQ 30.2 with the Total Score of the Child Behavior Checklist (Achenbach, 1991) for 423 children in the community ages 6 to 12 a correlation of .76, a moderately high score. As for the discriminant validity, construct validity results from comparing the means of the YOQ 30.2 PR scores for the community, inpatient and outpatient samples are indicative that there was significant difference between the levels of symptoms reported by parents in the clinical and non-clinical children. One-way ANOVA analyses of the Total Score means at the .001 level of significance demonstrated that, on average, the community samples presented as the healthiest, while the inpatient sample exhibited with the highest level of pathological symptoms (Community, M = 17.3; Outpatient, M = 43.3; Inpatient, M = 68.1; Burlingame et al., 2004).

The YOQ 30.2 yields a Total Score and six experimental scale scores that cover a wide array of psychological symptoms. These scales are: somatic, social isolation conduct problems, aggression, hyperactivity/distractibility and depression/anxiety. During this investigation, statistical analyses only included the YOQ 30.2 PR Total Score. The Total Score is the main score within the YOQ 30.2 and serves as a global index of the level of functioning of the client. The Total Score is a raw score and ranges from 0 to 120; itis the most appropriate score to track change in clients overtime because

of its stronger psychometric properties amongst all of the YOQ 30.2 scores. Specifically, the Total Score has the highest reliability and validity when compared to the six experimental scales (Burlingame et al., 2004). By using this score, the clinician has access to information regarding the current level of functioning of the client in relation to previous scores and the normative populations. The higher the score on the YOQ 30.2 PR total, the more significant is the level of symptoms, distress, or problems that the parent observes in the client. It is based on the Total Score that the YOQ 30.2 stipulates a reliable change index (RCI) to measure reliable improvement in symptoms in clients.

To understand the RCI for the YOQ 30.2, information about cutoff scores for clinical levels of symptomatology is required. To measure the severity of symptoms in children using the parent rating form of the YOQ 30.2 the cutoff score is 29. Total Scores between 30 and 55 are classified as mild to moderate severity of symptomatology. The scores that fall below and above this range represent normal and severe levels of symptoms, respectively.

The clinical and normative samples used in the standardization procedures of the YOQ 30.2 derive an RCI with a value of 10. That is, for the YOQ 30.2 Total Score, clients must have a change of at least 10 raw score points to be categorized as having demonstrated clinically significant change in their level of emotional distress (Burlingame et al., 2004). Therefore, during the course of treatment clients whose Total Score decreases by 10 or more raw score points are considered reliably improved, whereas clients demonstrating an increase of 10 raw score points or more are classified as reliably worsened or deteriorated. Clients who begin therapy in the dysfunctional

range (30 or above), demonstrate reliable improvement, and terminate therapy in the functional range (29 or below) are classified as recovered. Finally, clients whose Total Scores do not change in any direction by at least 10 points are classified as having made no change (Haderlie, 2011).

For this study, treatment improvement as measured by the YOQ 30.2 PR considered the Total Scores at intake and termination. For the Total Scores on the YOQ 30.2 PR, the two first sessions attended by the client represented the intake. This was done to strengthen the reliability of the reports by parents of their child's functioning. The average of these scores represented the Parent Rating at Intake, or PRI. Likewise, the last two sessions attended by the client were the termination. The average of these scores represented the Parent Rating at Termination, or PRT. Treatment improvement after psychotherapy, or TI was the interval variable obtained by difference between PRT and PRI.

Behavior Assessment System for Children – Second Edition

The Behavior Assessment System for Children – Second Edition (BASC-2; Reynolds & Kamphaus, 2004) is a broadband comprehensive assessment tool of the behaviors and emotions in children, adolescents and young adults in different environment and circumstances. The BASC-2 was developed to assist clinicians in the identification of the level of symptoms, differential diagnosis and treatment planning of the psychiatric disorders described in the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000; Volker et al., 2010). The BASC-2 is comprised of measures used with individuals ages 2 to 25. These measures may be

completed by parents/caregivers, teachers, and clients, but for the purpose of this study, only one of three forms of the Parent Rating Scales forms was considered, the Parent Rating Scales - Child (PRS:C). The PRS:C is used with the parents and caregivers of children ages 6 to 11. The PRS:C has 160 items and completion usually lasts 20 minutes. The measure requires that raters have at minimum a fourth grade reading level and is available in English and Spanish.

The PRS:C contains nine clinical and five adaptive scales that generate four composites scales: Externalizing Problems, Internalizing Problems, Behavioral Symptoms Index, and Adaptive Skills. The nine clinical scales are Aggression, Anxiety, Attention Problems, Atypicality, Conduct Problems, Depression, Hyperactivity, Somatization, and Withdrawal. The five adaptive scales are Activities of Daily Living, Adaptability, Functional Communication, Leadership, and Social Skills). The scores for the clinical and adaptive scales were used in the study within the level of the composite scales.

The BASC-2 parent scales utilize four-point frequency scale response options (i.e., 0 = Never, 1 = Sometimes, 2 = Often, and 3 = Almost Always). Scoring and reporting uses the BASC-2 Assist software that generates the calculation of the scale and composite scores, validity indexes and identified strengths and weaknesses for the client's profile. For the BASC-2, standardized *T*-scores have a mean of 50 and a standard deviation of 10. For the Clinical scales, where high scores represent problems, scores between 60 and 69 (i.e., between one and two standard deviations) suggest the child is within the "At-Risk" range for problems, while scores above 70 (above two

standard deviations) fall in the "Clinically Significant" range. For the Adaptive scales, where low scores represent problems, scores between 31 and 40 suggest "At-Risk" level of concern, with scores lower than 30 indicating "Clinically significant" level of concern. The BASC-2 also provides validity scales that indicate when interpreters should exercise caution with interpretation of invalidate *T*-scores altogether. The BASC-2 Assist can also provide information pertaining to the diagnostic criteria specified on the DSM-IV-TR. As of May 2013, a newer version of the DSM is available, the DSM-5, but the majority of the participants in the study received services at the CAC under the DM-IV-TR diagnostic criteria rules. The clients in this study were all administered the BASC-2 as the BASC-3 (Reynolds & Kamphaus, 2015) was not available until 2015.

The BASC-2 manual provides comprehensive information on its psychometric properties (Reynolds & Kamphaus, 2004). For the purposes of this study, the primary variables of interest from the BASC-2 PRS:C were the four composite scales (Externalizing Problems, Internalizing Problems, Behavioral Symptoms Index, and Adaptive Skills). Normative samples included general and clinical populations. Internal consistency was high across scales and forms for both the general and clinical samples (from .89-.95). Test-retest reliabilities ranging from one to eight weeks since the first administration yielded acceptable correlations (from .76 to .92). Overall, inter-rater reliability ranged from .89 to .95, while for the PRS scales specifically median inter-rater reliability was in the .70s for both composite and individual scales.

The BASC-2 manual describes several validation methods that delineate its similarity to other behavioral measures (Volker et al., 2010). When compared to the

ASEBA Child Behavior Checklist, the Conners Parent Rating Scale – Revised, the Behavior Rating Inventory of Executive Functioning, and its own predecessor, the BASC, the BASC-2 correlated in the .70s and .80s with the first three measures and in the .90s with the latter (Reynolds & Kamphaus, 2004). The BASC-2 also presents with acceptable multicultural sensitivity as evidenced by the Spanish versions the scales and inclusion of diverse groups within the standardization samples (Kohn, Scorcia, & Esquivel, 2007).

CAC Intake Evaluation Report

The CAC Intake Evaluation Report (IER; Appendix B) is a clinician-generated form. The primary goal of the IER is to document a clinician's initial assessment of a client's profile of strengths and weaknesses, designate the formulation and diagnosis case, and describe the appropriate treatment plan, specific goals and the broad descriptions of the techniques or evidence-based treatments chosen to reach such goals. Clinicians usually complete the IER after the client's third visit to the CAC. The IER includes the following sections: client's name, date of birth and age; dates of the evaluation, date of the report, presenting problems, procedures used to gather data, relevant client history, behavioral observations, results of assessment measures, case formulation, diagnostic impressions, and recommendations for treatment. For the purposes of this study, the principal variable of interest from the IER was the initial diagnosis specified by the clinician that was the basis for the treatment plan selected for the client. Given the possible DSM-IV-TR and DSM-5 diagnostic criteria warranted for each of the clients by the clinician on record, cases were grouped by the research team

into based on the symptoms categories. Specifically, three groups were devised: (a) externalizing disorder diagnosis; (b) internalizing disorder diagnosis; (c) dual diagnosis (both externalizing and internalizing); and no diagnosis for subclinical cases. For example, a client with a diagnosis of Oppositional Defiant Disorder was placed in the externalizing disorder category, a client with a diagnosis of Generalized Anxiety Disorder was grouped within the internalizing disorder category, and a client with a diagnosis of Autism Spectrum Disorder was considered in the dual diagnosis category. The same procedure was applied with the diagnoses warranted to clients at termination.

CAC Termination Summary

The CAC Termination Summary is a clinician-generated form used at the CAC with the primary goal of documenting a clinician's final summary of the services the client received at the CAC. Clinicians may generate this report when a client is terminating services at the CAC or when the clinician transfers a client to another clinician at the CAC for continuation of services. For the purposes of this study, this form will be called Termination Summary (TS, Appendix C).

The TS includes the following sections: client's name, designation as termination of services or transfer to another clinician, nature of the decision to terminate services (i.e.: mutual agreement to terminate, clinician-initiated termination, or client-initiated termination) and level of the progress of the client at termination (whether or not sufficient progress in psychotherapy was made). The TS also includes the summary of the services provided, the initial reason for referral, the reason for termination or transfer, whether follow-up or additional treatment needed, and the diagnostic consideration at the

initiation and termination of treatment. The TS was a major source of information for the present study. The TS contained information on who (mutual agreement, clinician, or client) initiated termination and the judgment applied by the clinician as having the client terminate services with sufficient progress made or not sufficient progress made. Given the novice status of the clinicians, such a judgment was the result of consultation with the supervisor for the case.

The application of clinical judgment by the clinician was restricted to the cases when the clinician terminated services with clients that were ending their treatment at the CAC. At times when clinicians transferred cases to another clinician and the clients did not return to services, this process was interrupted as the new clinician did not have the opportunity to work with the client. For those cases when the clients did not continue with treatment following a transfer and they dropped out of treatment, clients were considered as having initiated the termination and having completed treatment with not sufficient progress made.

The process of determining on the Termination Summary whether the client ended services with sufficient progress made or not sufficient progress made was not made independently by the clinician. This determination was made when, under the oversight of the clinical supervisor on the case, the clinician reviewed the current level of functioning of the client in treatment and the progress reported by the parent on the YOQ 30.2.

Telephone Screening Evaluation

The Telephone Screening Evaluation (TSE) (Appendix D) is the form that parents completed via telephone with the Service Coordinators when they called requesting services at the CAC. This form contains demographic information for the client and the parent (e.g., age, gender, ethnicity, income, education, residence, etc.) and brief details about the presenting problem and mental health history of the client. This form is the primary source of information that supervisors use to gather information about the client to determine who will be the clinician being assigned to the case. For the purposes of this study, descriptive statistical analyses used selective demographic variables on the TSE such as the place of residence, client age, and ethnicity.

Attendance records

At the CAC, Titanium Schedule (Titanium) is the tool used to manage clients' attendance records. Titanium is software used to manage client's records in university counseling clinics, disability centers, and training clinics. Titanium is used to schedule appointments and track the attended, cancelled, rescheduled or missed appointments of a client based on a unique client identifying number. For the purpose of this study, a ratio of the total number of sessions scheduled for the client and the total number of sessions attended by the client was used in the statistical analyses. While Titanium documents the appointment history for the client with the total number of sessions scheduled, missed, cancelled, rescheduled or attended by the clients, it has limitations in generating reports that break down these categories. Likewise, categories related to sessions rescheduled or cancelled by the clinicians are listed on the appointment history for the client, but are not

listed separately within the total statistic for the clients' attendance history. Furthermore, information on the rescheduling and cancellation initiated by the clinician was only available in the most recent clients files used in the sample. Cancellations or rescheduling of sessions due to weather conditions or other factors not related to the client were also not documented on Titanium. This issue is further discussed in the Limitations section in Chapter V.

Similarly, within the files used in the study there were cases of clients that had been seen at the CAC before the implementation of Titanium had been finalized. For these clients, the attendance records displayed on the Termination Summary generated by the clinician on record was used in to calculate the attendance ratio.

Regardless of the limitations described above, the total number of sessions scheduled for the client and the number of sessions attended by the client on Titanium were deemed the most reliable source of attendance. These were the numbers used in the attendance ratio calculated for the client. As such, the attendance ratio was the result of the number of sessions attended by the client divided by the total number of sessions scheduled for the client.

CHAPTER IV

RESULTS

The focus of this exploratory study was three-fold. First, comparisons of the parent-reported behavioral ratings of clients on the BASC-2 and the YOQ 30.2 sought to strengthen the validity of the latter instrument as a measure of treatment outcomes for children undergoing psychotherapy. Second, the study attempted to identify characteristics in children that are conducive to successful termination of psychotherapy in training mental health centers. Third, the study investigated the ability of clinician in training to assess clients' progress at the time of termination of psychotherapy when compared to the treatment outcome measure YOQ 30.2. Following the completion of the selection of the cases to be included in the data set, descriptive statistics tests with the variables used in the study measured the normality for the sample. Given the evidence in the literature of the high probability of attrition for psychotherapy treatment with children, it was of utmost importance to assess normality of attendance and number of sessions completed by termination. Analyses of skewness and kurtosis of the sample determined the shape and dispersion of the variables. The expectation was that the number of participants within the data set would directly affect the expectation of normality and power. Specifically, skewness and kurtosis for the two standardized measures used in the study (i.e., BASC-2 PRS:C and YOQ 30.2 PR) were of main interest. Subsequent to the identification of the data set used in the analyses for the study, there were considerations of possible outliers, or apparent non-normality by data points. Specifically, there was the anticipation that attendance for clients receiving

psychotherapy treatment for extended periods of time (i.e., number of sessions below 6 or above 20) would represent outliers. As such, analyses considered sessions attended within the total range of sessions of the sample and a subset of clients who attended a minimum of 6 sessions and a maximum of 20 sessions. To account for the concern with Type I and Type II errors, for all analyses reported the level of significance of $p = .05$ was set.

Description and normality of the sample

Within the study sample, the age of the clients ranged from 6 to 11.90 years (M = 9.03, SD = 1.65). Distance was non-normally distributed, with skewness of 1.57 (SE = .25) and kurtosis of 1.61 (SE = .49). Clients were categorized into two dichotomous groups according to the distance between their residence and the CAC. The *close residence* group comprised clients who resided within 20 miles of the CAC (n = 76, 79.2%). Distance from the CAC within this group ranged from 1.5 miles to 18.9 miles (M = 6.00, SD = 3.67). The *close residence* group was normally distributed for distance, with skewness of .73 (SE = .27) and kurtosis of .57 (SE = .54). The *far residence* group included clients who resided farther than 20 miles from the CAC (n = 20, 20.8%). Residences within this group ranged from 22.6 and 45.6 miles away (M = 31.16, SD = 8.05). The *far residence* group was normally distributed for distance, with skewness of .75 (SE = .51) and kurtosis of .62 (SE = .99).

Non-normality was observed with the attended sessions, which was expected as high attrition is observed in the psychotherapy treatments of children. The sessions attended ranged from four to 38 sessions (M = 13.40, SD = 7.39) with skewness of 1.20

(SE = .25) and kurtosis of 1.60 (SE = .49). Normality was observed for the total number of sessions scheduled for the clients, ranging from four to 45 (M = 18.30, SD = 8.79) with skewness of 0.97 (SE = .25) and kurtosis of 0.77 (SE = .49). Consideration was given to the attendance rate of clients. Attendance rate was calculated as a ratio of the sessions attended over the total number of sessions scheduled. Attendance rate ranged from to 0.33 to 1 (M = .72, SD = .15). The skewness value of 0.81 (SE = .25) and kurtosis of -0.62 (SE = .49) indicate a normal distribution for attendance rate.

For the YOQ 30.2, skewness and kurtosis were examined for the PRI, PRT, and TI. For the YOQ 30.2 PRI (M = 44.40, SD = 17.79), skewness of 0.05 (SE = .25) and kurtosis of -0.20 (SE = .49) indicated a normal distribution. For the YOQ 30.2 PRT (M = 34.20, SD = 18.91), skewness of 0.50 (SE = .25) and kurtosis of -0.04 (SE = .49) indicate a normal distribution. For the YOQ 30.2 TI (M = -10.20, SD = 14.63), skewness of 0.12 (SE = .25) and kurtosis of 0.47 (SE = .49) indicate a normal distribution for treatment improvement.

To test whether the distribution of the BASC-2 within the sample deviated from normal, skewness and kurtosis values were examined. Normality for the sample was observed for all four of the composite scores of the BASC-2. Among all composites, the skewness values ranged from 0.09 to 0.77 (SE = .25) while the kurtosis values ranged from -0.90 to -.01 (SE = .49). Means for the BASC 2 composite scores ranged from 39 to 65 with standard deviations that ranged from 8.85 to 16.71. As such, on average, clients presented with behavioral difficulties at most on the At-Risk level of concern within the BASC-2 (see Table 1).

For parent motivation, the three questions endorsed by parents were considered separately and combined as a Total Score, PMT. To test whether the distribution of endorsements for these questions deviated from normal, skewness and kurtosis values were examined. For question A (seriousness), endorsements were normally distributed with skewness of -.41 (SE = .26) and kurtosis of -.01 (SE = .51). Question B (importance), values for skewness and kurtosis were -1.66 (SE = .26) and 2.26 (SE = .51) and indicated non-normality. For question C (level of help), non-normality was also present as skewness was -1.26 (SE = .27) and kurtosis was 1.28 (SE = .53). For PMT, values for skewness and kurtosis were -1.09 (SE = .27) and 1.15 (SE = .53) and indicated non-normality.

Missing data occurred within the endorsement of these questions by the parents. For questions A (seriousness) and B (importance), only 88 out of the 96 or 91.66 percent of parents endorsed the items. For question C (level of help), only 80 or 83.33 percent of parents responded. For question A, measuring the parental perceived seriousness of the clients' problems, ratings ranged from 2 to 10 (n = 88; M = 7.1, SD = 1.89). Question B, concerned with the parental perceived importance of the client overcoming problems, had endorsement that ranged from 1 to 10 (n = 88, M = 8.40, SD = 2.30). Question C, referred to the parental perceived expectation of help to be received at the CAC and resulted in ratings ranging from 1 to 10 (n = 80, M = 8.20, SD = 2.15). When all three endorsements were combined, they yielded the PMT rating for 80 parents (M = 23.80, SD = 4.76).

Research question 1

The first research question investigated the correlations between the parents' report on the BASC-2 and the YOQ 30.2 at the time of the intake. It was hypothesized that the parent report form YOQ 30.2 PR at intake would have significant, positive correlations with the composite scores and selective subscale scores of the parent report form BASC-2 PRS:C. With the goal of enhancing the scope of the reports by parents of the level of functioning of the client, the YOQ 30.2 PR Total Scores for Session 1 and Session 2 were averaged and named the Parent Rating at Intake, or PRI. For the BASC-2 PRS:C, the four composite scores, Externalizing Problems, Internalizing Problems, Behavioral Symptoms Index, and Adaptive Skills were used in the correlation analyses. Two-tailed Pearson product-moment correlation coefficients were computed to assess the relationship between the level of symptoms reported on the BASC-2 and the symptoms reported on the YOQ 30.2 PRI.

Using Cohen's (1988) taxonomy for effect size, significant, strong correlations were found between the YOQ 30.2 PRI and all composite scores on the BASC-2. These correlations were as follows: Externalizing Problems, $r = .71$, $p = 0.01$; Internalizing Problems, $r = .59$, $p = 0.01$; Behavior Symptoms Index, $r = .80$, $p = 0.01$; and Adaptive Skills, $r = -.65$, $p = 0.01$. There were negative correlations with the Adaptive Skills Composite as the higher scores indicate better functioning on that composite. The highest of the correlations was found between the Behavioral Symptoms Index and the PRI. Table 2 provides the findings for the correlation coefficients between the BASC-2 PRS:C Composite Scores and the YOQ 30.2 PRI.

Table 2 Correlation coefficients (Pearson r) between the BASC-2 PRS:C composite scores and the YOQ 30.2 PR intake Scores (n = 96)

		r
1	YOQ 30.2 Parent Rating at Intake (PRI)	-
2	Externalizing Problems Composite	.71**
3	Internalizing Problems Composite	.59**
4	Behavioral Symptoms Index	.80**
5	Adaptive Skills Composite	-.65**

Note: $^{**}p < .01$. $^{***}p < .001$, YOQ.30.2 PRI is the Youth Outcome Questionnaire 30.2 Parent Rating at Intake, BASC-2 PRS:C is the Behavior Assessment System for Children-Second Edition,
Parent Rating Scales, Children Form (6-11).

Research question 2

The second research question investigated characteristics in clients and their parents that were conducive to a greater rate of improvement in symptoms at the time of termination of psychotherapy. These characteristics were commitment to treatment as measured by clients' attendance, distance covered to receive services at the CAC, and parental motivation to the treatment for clients.

Commitment to treatment

It was hypothesized that a high parental level of commitment to treatment as measured by the attendance rate of clients would be significantly and positively correlated with the rate of improvement of symptoms at termination as measured by the YOQ 30.2 TI. For the purposes of this study, commitment to treatment was the client's attendance rate as specified primarily by the Titanium records. Attendance rate was the

ratio of number of sessions attended by the client divided by the total number of sessions scheduled for the client. The averaged Total Score for the YOQ 30.2 PRT minus the averaged Total Score for the YOQ 30.2 PRI yielded the interval variable Treatment Improvement (TI). Given the non-normality of the sample for attendance and the wide range of attended sessions within the sample (4-38 sessions), the decision was made to consider the research question and hypothesis for a subsample not including the outliers for sessions attended. It was determined that treatment length between 6 and 20 sessions was to be considered for this subsample. As such, statistical analyses were conducted for the sample clients of who attended between 4 and 38 sessions and a subsample within this client who attended between 6 and 20 sessions. Table 3 provides descriptive data of this subsample.

Table 3 Demographic characteristics of subsample of participants (n = 72)

Demographic Characteristics	Mean	Min	Max	Standard Deviation
Age	8.99	6.00	11.90	1.59
Distance to the CAC (miles)	12.54	1.50	45.57	12.04
Attendance				
Sessions attended	11.93	6	19	4.04
Total Sessions Scheduled	16.94	8	35	5.76
Attendance Rate	.71	.44	1.00	.14
Parent Motivation to Treatment				
L.A. - Seriousness	7.00	2	10	1.94
L.B. - Importance	8.60	2	10	2.17
L.C. – Help	8.18	1	10	2.21
BASC-2 PRS:C Composites T-Scores				
Externalizing	64.70	33	100	15.53
Internalizing	63.63	32	108	16.43
Behavioral Symptoms Index	66.04	37	97	13.89
Adaptive Skills	39.61	23	60	8.96
YOQ 30.2 PR Raw Scores				
PRI	44.15	5	88	18.23
PRT	35.02	1	84	19.61
TI	-9.06	-47	20	12.80
		n	%	
Gender				
Male		33	45.84	
Female		39	54.16	
Ethnicity				
Black		6	8.33	
Hispanic		23	31.95	
White		40	55.55	
Other		3	4.17	

Note. The BASC-2 PRS:C is the Behavior Assessment System for Children, Second Edition, Parent Rating Scale for Children (6-11), the YOQ 30.2 is the Youth Outcome Questionnaire 30.2 Parent Rating Form, PRI is the Parent Rating at Intake, PRT is the Parent Rating at Termination, and TI is the Treatment Improvement. For Parent Motivation, Likert-type (0-10) parent ratings items on the Child History Form are: L.A: "How serious are your child's problems?"; L.B- "How important is it for your child to get over his/her problems soon?"; and L.C "How much do you think it will help your child to get to the mental health center?"

A simple linear regression was calculated to predict treatment improvement at termination based on attendance rate for the entire sample (n = 96). A statistically non-significant regression equation was found $F(1,94) = 3.32$, $p = .07$ with R^2 of .03. A second linear regression was calculated to predict treatment improvement at termination based on attendance rate for the subsample for number of sessions between 6 to 20 (n = 72). A statistically non-significant regression equation was found $F(1,70) = 1.37$, $p = .25$ with R^2 of .02.

Distance to the CAC

It was hypothesized that the distance between the clients' residence and the CAC would significantly influence attendance rate and treatment improvement. Distance was considered as an interval variable and as dichotomous variable. For this variable, residence for the clients were considered below and above 20 miles away from the CAC (*close residence* versus *far residence*). Taking into consideration the effect of distance on attendance rate, as with commitment to treatment, analyses were conducted for the entire sample (n = 96) and the subsample (n = 72). Linear regressions were calculated to predict outcomes based on distance.

Two-tailed Pearson product-moment correlations explored the relationship between the clients' residence distance from the CAC and treatment improvement at termination. For the entire sample (n = 96), this analysis was found to be statistically non-significant ($r = -.08$; $p = .21$). Within the subsample with between 6 and 20 sessions (n = 72), this analysis was found to be statistically non-significant ($r = .13$; $p = .14$).

Using the dichotomous variable for distance with clients separated into groups with *close residence* or *far residence* from the CAC, correlations were also statistically non-significant for the complete sample (n = 96), $r = .09$; $p = .17$. When the subsample (n = 72) within the distance groups was considered, a small, positive statistically significant correlation was found between distance and treatment improvement ($r = .20$; $p < .05$). Table 4 provides the correlations between distance and treatment improvement.

Table 4 Correlation coefficients between the distance from the CAC and YOQ 30.2 treatment improvement.

	YOQ 30.2 TI		
	N	*r*	*p*
Distance (sessions 4-38)	96	.08	.21
Distance (sessions 6-20)	72	.13	.14
Distance groups (sessions 4-38)	96	.09	.17
Distance groups (sessions 6-20)	72	.20	.04*

Note: $*p < .05$. YOQ.30.2 is the Youth Outcome Questionnaire 30.2. Distance was measured in miles without distinction from the CAC. The distance groups took into account close residence (< 20 miles) and far residence (> 20 miles) from the CAC.

Given the significant correlations between distance groups and treatment improvement for clients who attended between 6 and 20 sessions, a simple linear regression was calculated to predict treatment improvement at termination based on distance. A statistically non-significant regression equation was found $F(1,70) = 2.95$, $p = .09$ with R^2 of .04.

Using the dichotomous variable for distance with clients separated into groups with *close residence* or *far residence* from the CAC, an independent-samples t-test was conducted to compare treatment improvement for the close and far conditions within the clients who attended 6-20 sessions. A statistically non-significant difference was found in scores for close residence (M = -10.49; SD = 13.38) and far residence (M = -4.47; SD = 9.67) conditions [t (70) = -1.71, p = .90].

Parental motivation

Parent motivation to treatment was measured by the endorsement of three Likert-type questions on the Child History Form that measured the parents' perception about the clients difficulties and the treatment they were about to receive. It was hypothesized that higher scores for the parental endorsements on these questions would be significantly and positively correlated with the rate of improvement of symptoms. Similarly, when these scores were combined forming the PMT, it was hypothesized that PMT would be significantly and positively correlated with TI.

Two-tailed Pearson product-moment correlations explored the relationship between the parental motivation questions, PMT, and TI for both attended sessions groups (4-38 and 6-20). No significant correlations were found between treatment improvement and parental motivation questions. Specifically, these questions asked parents about (a) the seriousness of the client's presenting problem, (b) the importance of the client overcoming these problems, and (c) the expectation of help to be received at the mental health center. Table 5 lists these correlations.

Table 5 Correlation coefficients between treatment improvement and parent motivation questions by attended session groups.

Attendance Group		YOQ 30.2 TI		
		n	*r*	*P*
Sessions 4-38	Seriousness of client's problem	88	-.07	.51
	Importance of overcoming problem	88	-.16	.13
	Expectation of help at the CAC	80	-.05	.65
	PMT	80	-.12	.28
Sessions 6-20	Seriousness of client's problem	65	.00	.98
	Importance of overcoming problem	65	-.04	.71
	Expectation of help at the CAC	60	.04	.73
	PMT	60	-.02	.85

Note: YOQ.30.2 is the Youth Outcome Questionnaire 30.2. Sessions attended refers to the entire sample of the study with n = 96 that has attended sessions range between 4 and 38 and the subsample with n = 72 with a range of attended sessions between 6 and 20.

A multiple regression was conducted to predict treatment improvement in clients based on age, distance from the CAC, parent motivation for treatment, attendance rate, sessions attended, and level of symptoms at intake as measured by the BASC-2 PRS:C Behavioral Symptoms Index (BSI). The BASC-2 PRS:C BSI was chosen because it was found to have the highest correlation with the PRI. Table 6 provides information on the multiple regression analysis.

For model 1, with age as a predictor, a statistically non-significant regression was found [$F(1, 78) = .02$, $p = .89$], with an R^2 of 0.00 and $R^2_{Adjusted}$ of -0.01. For model 2, the BASC-2 PRS:C BSI was included and a statistically non-significant regression equation was found [$F(2, 76) = 1.15$, $p = .32$], with an R^2 of 0.03 and $R^2_{Adjusted}$ of -0.01.

Table 6 Summary of multiple regression analysis for variables predicting treatment outcome at termination (n = 80)

	Model 1					Model 2					Model 3				
Source	B	*SE* B	β	t	*p*	B	*SE* B	β	t	*p*	B	*SE* B	β	t	*p*
Age	-.13	.95	-.02	-.14	.89	.17	.98	.02	.17	.86	.30	.90	.04	.33	.74
BASC PRS:C BSI						-.13	.12	-.12	-1.07	.29	-.11	.19	-.10	-.93	.36
PMT						-.33	.34	-.11	-.96	.34	-.06	.33	-.02	-.19	.85
Attendance Rate											-16.17	11.42	-.18	-1.42	.16
Distance to CAC											.13	.14	.11	.98	.33
Sessions Attended											-.52	.23	-.29	-2.25	.02*
R^2			<.01					.03					.21		
$R^2_{Adjusted}$			-.01					-.01					.15		
F			.02					1.15					5.71***		

Note: ****p* < .001. BASC-2 PRS:C BSI is the Behavior Assessment System for Children-Second Edition, Parent Rating Scales, Children Form
(6-11) – Behavioral Symptoms Index Composite Score.

For model 3, distance from the CAC, attendance rate, and sessions attended were included. Using the enter method, it was found that distance from the CAC, sessions attended, and attendance rate explain a significant amount of variance in the treatment improvement of clients at termination of psychotherapy [$F(6, 73) = 5.71$, $p = .01$, with an $R^2 = .21$, $R^2_{Adjusted} = .15$]. The analysis shows that distance from the CAC [$\beta = .11$, $t(79) = .98$, $p = .33$] and attendance rate [$\beta = -.18$, $t(79) = -1.42$, $p = .16$] did not significantly predict treatment improvement, however sessions attended did significantly predict treatment improvement at termination of psychotherapy ($\beta = -.29$, $t(79) = -2.25$, $p = .02$).

Research question 3

For children exposed to psychotherapy at a training mental health clinic in the community, does the treatment improvement measured by the parent reported ratings on the YOQ 30.2 PR at the time of intake and termination correlate with the clinician's judgment of progress made at termination of services (sufficient progress [SP] made versus not sufficient progress [NSP] made)? It was hypothesized that, overall, terminations with SP would have higher TI levels than terminations with NSP.

For the YOQ 30.2 treatment improvement, identified by subtracting PRI from the PRT, negative values represented the reduction in symptoms and gains in functioning in clients. On average clients presented with treatment improvement of -10 points (SD = 14.63). This mean treatment improvement for clients met the RCI level of 10 points described on the YOQ 30.2 manual (RCI = 10; Burlingame et al., 2004). Treatment improvement scores ranged from deterioration in symptoms of 35 points to improvement in symptoms of 47 points. At termination, diagnoses continued to be primarily

associated with externalizing disorders; still, frequency lowered to 45 cases or 46.9 percent of the clients. Most of the clients ended services at the CAC with the mutual agreement between the clinician and the client/parent (n = 43, 44.8%), and after sufficient progress made (n = 49, 51%).

The categories of judgment applied by the clinician (sufficient progress made [SP] versus not sufficient progress made [NSP]) were the criteria used to form two groups. For age, an independent-samples t-test was conducted to compare age for the SP and NSP conditions. A statistically non-significant difference was found in scores for SP (M = 9.05, SD = 1.62) and NSP (M = 9.00, SD = 1.70) conditions [t (94) = -.12, p = .90].

Chi-squared calculations were conducted for gender and ethnicity. For gender, chi-square results found a statistically non- significant difference among progress at termination groupings SP and NSP (χ^2 = .16, and p = .69). For ethnicity, chi-square results found a statistically non- significant difference among progress at termination groupings SP and NSP (χ^2 = 1.18, and p = .76).

To address the research question, the treatment improvement for SP (n = 49) and NSP (n = 47) groups was an independent-samples t-test was conducted to compare treatment improvement for the SP and NSP groups. A statistically non-significant difference was found in scores for SP (M = -13.91, SD = 12.03) and NSP (M = -6.31, SD = 16.14) conditions [t (94) = 2.62, p = .01].

CHAPTER V

CONCLUSIONS

The primary purpose of this exploratory study was to inform practitioners about the effects of the use of treatment outcome measures with young clients in a community-based mental health-training center. The study also aimed to inform supervisors and clinicians-in-training of some of the ramifications of their clinical practices with child clients.

The practice of measuring baseline data at intake is informative for clinicians and the YOQ 3.2 is a commonly used measure of symptom intensity in children undergoing psychotherapy. Using as a comparison measure the parent reports on the BASC-2, a well-established measure of broad-brand behavioral symptoms, significant correlations with BASC-2 composites confirmed that the YOQ 30.2 Total Score is an acceptable measure of behavior symptoms in children presenting to psychotherapy at the time of intake. The results from this study suggest that the YOQ 30.2 may be more sensitive to externalizing symptoms than internalizing symptoms.

Previous research does not support this finding. Prior evidence indicates that most of the variance on the YOQ forms is accounted for by the emotional distress dimension (Mueller, Lambert, & Burlingame, 1998). These inconsistent findings are not surprising given the limited psychometric evidence of the experimental scales when compared to the Total Score (Hill, 2004). It is possible that within the 30 items of the YOQ 30.2 more of them load on externalizing behavioral concerns. Moreover, it is evident that more clients presented with externalizing disorders diagnoses than

internalizing disorders diagnoses. This is suggestive that parents sought services for clients with overtly observable behavioral disruptions. This idea is supported by the parents' reports of referrals for services made by the clients' schools or pediatricians. It is possible that parents felt inclined to pursue mental health help for their children after receiving the suggestion to do so from professionals they trust or respect.

An added feature to the YOQ 30.2 is the ability to calculate RCI. Although the sample for the study presented with high homogeneity, it was sufficiently dispersed that, on average, clients demonstrated improvement in treatment that reached the levels of reliable change for the YOQ 30.2 of 10 points. This finding is particularly encouraging because it suggests that novice clinicians are complying with basic levels of delivery of psychotherapy to clients to account for gains in their functioning.

Client related factors

It is important to identify characteristics of children undergoing psychotherapy at training mental health centers that are conducive to success at the time of termination of services. The characteristics investigated were parent commitment as measured by the attendance rate of clients, distance from the clients' residence to the mental health center, and parent motivation. Age of the client, level of behavioral symptoms at the time of intake for psychotherapy and number of sessions were also considered.

It was hypothesized that the parental motivation for treatment of clients that parents reported at the time of intake would be associated with the level of treatment improvement at termination. Previous research suggested mixed evidence of predictors for successful termination of treatment. Although there is evidence that parental

commitment was one of the variables associated with improvement rates and attendance (Baker-Ericzén et al., 2013), for this study parent motivation did not hold as a predictor of treatment improvement. One possible reason for this finding is that there was little variance in on the ratings for the endorsements made by parent son the parent motivation to treatment questions. Average ratings on these items were high (7-8) indicating a possible threshold effect. That is, if ratings by parents had been more equally distributed, with score dispersion between 1-10, it is possible that endorsements on perceived appraisals could have predicted treatment outcome significantly.

It is also possible that parents' expectations of treatment are more complex than the questions they endorsed can describe. It is also possible that additional parent information would be necessary to effectively ascertain predictors of treatment success. To that end, previous research has found that characteristics specific to parents such as their response to the nature of symptoms in clients (internalizing versus externalizing), level of stress, and depression were predictive of level of parent appraisals and commitment to treatment with children (Godoy, Mian, Eisenhower, & Carter, 2014). Specific concerns exist regarding the identification of parental motivation at the beginning of treatment as it appears to be independent of demographic characteristics. Some measures already have been developed with the goal of identifying levels of parent motivation for treatment in children. One of these measures is the Parent Motivation Inventory (for details refer to Nock & Photos, 2006). This is an example of a tool that clinicians-in-training can utilize to more effectively have a deeper understanding of the motivators to treatment in parents.

Within this study, differences exist between attendance rate and attended sessions. Specifically, attended sessions take into account clients' completion of treatment session, while attendance rate considers missed appointments that could have been associated with the clinician on the case, not the client. While attendance rate was not predictive of treatment improvement, the number of sessions attended emerged as the only predictor of treatment progress at the termination of treatment. This is congruent with the research that suggests dropout is the primary obstacle to the provision of services to young clients. The lack of significant relationships between attendance rates and treatment improvement appeared counter-intuitive given that attendance is necessary for treatment delivery and treatment outcomes. Previous studies demonstrated that attendance is not the most effective descriptor of parental treatment engagement for children (Lindsey et al., 2014 Staudt, 2007) when it is considered as a behavioral component of treatment engagement. Evidence purports that parent engagement to the treatment of children has a behavioral component and an attitudinal component (Gopalan et al., 2010). It is possible that attitudinal influences affected the parent motivation in parents bringing their children to treatment. On that end, psychoeducation deficits might have played a role in determining parental compliance with bringing clients to session without necessarily engaging in attitudes that supported treatment. This attitudinal component was not directly measured in the present study. It is possible that treatment improvement, regardless of attendance rate, was accounted for by parental attitudinal engagement (e.g., emotional investment in treatment and engagement during sessions).

Analyses of the distance impact on attendance considered distance both as an interval variable (number of miles) and as a dichotomous variable (close residence versus far residence) resulted in non-significant results for attendance rate and treatment improvement. These findings were unexpected as previous studies demonstrated that distance from treatment centers was significantly and inversely associated with treatment attendance (Klitzman, Armstrong, & Janicke, 2015). Though unexpected, these findings were supported by the scant previous research available on parent motivation and related attendance to treatment sessions and client improvement over time (Nock & Photos, 2006). When attendance of clients was restricted to a minimum number of 6 sessions and a maximum number of 20 sessions, distance became a predictor of treatment outcomes. Indications are that when outliers are disregarded, distance, as expected, predicted treatment outcomes.

Clinician determination

From a training perspective, the extent to which clinicians-in-training determination of sufficient progress or not was in agreement with the YOQ 30.2 RCI was of interest. It was hypothesized that, at the time of termination, the clinical judgment clinicians exercised to categorize clients as ending treatment with sufficient progress made would be supported by higher treatment improvement rates on the YOQ 30.2 than the clients categorized as ending services with not sufficient progress made. The hypothesis was confirmed and provides information about the training being provided to the novice clinicians. The use of a treatment outcome measure appears to effectively inform supervisors about the congruent between the clinical judgment being

development by the novice clinician and the reliable change in clients. The research suggests that this is an important requirement for the continued refinement of the psychology training programs (APA, 2006; Vollmer, Spada, Caspar, & Burri, 2013).

Clinical implications

One of the goals of this exploratory study was to inform trainers and clinicians-in-training of the development of clinical judgment. Even though the study did not consider demographic and academic information about the clinicians-in-training, the findings offer evidence to support the continued use of standardized data to support clinical though subjective decision making by future psychologists. This is beneficial to the training of future child clinicians as that little research has evaluated systematic efforts to increase the accuracy the development of clinical judgment (Haderlie, 2011).

A related goal was to provide information about clients to predict dropout and enhance success at termination of psychotherapy. While distance for a constrained number of sessions attended predicted client outcomes at termination, all other predictors of client success were not confirmed. Still, the use of a treatment measure assisted in informing the application of the clinical judgment by clinicians. Though it is not clear at this time how robustly the treatment outcome data informs clinicians of any adjustments in practice to ensure positive outcomes for clients, continued use of a treatment outcome measure is clearly warranted.

A major implication of this study is to provide added research on the YOQ 30.2 as a comparison to a widely used broad-band measure of behavior and emotional functioning in clients at a community training mental health center. The use of the

BASC-2 at the time of intake appears to frame accurately the initial diagnosis and treatment planning for clients with clinicians-in-training. It is suggested that practices such as these continue to be applied in mental health training centers. Unfortunately, the findings in this study yielded little knowledge on the predictive variables in clients that are conducive to successful outcomes in psychotherapy.

Limitations

Several limitations were identified during the completion of this project. First, the sample, while not small, was significantly more homogeneous than is ideal. As the mental health center is a training clinic in a major university, the uninsured and underserved were the primary individuals who received psychotherapy services. This retrospective study also encountered limitations in the collection of the data available in the clients' files. This limited efficiency in data collection restricted the breadth of demographic data gathered from those files. Information regarding socioeconomic status was absent and limited the investigation of the predictors of treatment outcomes. In addition, while qualitative data were not collected for this study, it is possible that a mixed methods research design could have more comprehensively expanded the findings about characteristics in clients and parents that influence psychotherapy outcomes.

One important limitation observed was the determination made by the clinician of the sufficient progress made by the client or not sufficient progress made at the end of treatment. Specifically, the clinical judgment exercised by the clinician was, at least in part, informed not only by the YOQ 30.2 parent report scores and the clinical input of the

supervising psychologist on the case. Given the nature of the data and the procedures applied at the CAC, it was not possible to investigate the application of clinical judgment by the clinician without the use of the YOQ 30.2 sores as a source of information.

Another limitation was identified in the calculation of the attendance rate for clients. With attendance rate being the ratio between the sessions attended over the total number of sessions scheduled, no consideration was given to the number of sessions that did not occur due to cancellations on the part of the clinician, weather conditions, or other factors not related to the client. The level of commitment of the clinician is not accounted for on this study. Similarly, clinician characteristics were not considered, especially with regard to previous experience, number of active cases carried, and commitment to therapy as measured by punctuality and frequency of sessions completed. Historically, as the CAC is a training clinic associated with a university, while some clinicians elected to interrupt treatment sessions with clients during the academic holidays when classes are not in session, others preferred to offer sessions to their clients to ensure optimal continuation of care. More detailed information on the clinicians, their previous training, and their previous clinical experience were not accessible to the project. In the same way, attendance rate only considered the sessions attended by the clients in relation to all of the sessions scheduled. No consideration was given to detailed analyses of the nature of the difference between the sessions attended and scheduled. Analyses did not consider the number of no-shows or cancellations by the client. It is possible that detailed analyses of the attendance rates for the clients could

have identified patterns of attendance predictive of successful outcomes of psychotherapy in children.

In line with the data collection limitations mentioned above, the precision about the administration of the YOQ 30.2 is another area of concern. The parent ratings for clients during intake and termination considered the two first and last YOQ 30.2 PR administrations, respectively. Ideally, the sessions 1 and 2 would have been considered the intake to yield the PRI. Likewise, the next to last and last administrations would be the optimal use of YOQ scores to be considered in the calculation of the PRT.

Even though validation of the YOQ 30.2 as a measure of behavior symptoms in children was achieved, when comparisons with BASC- 2 were conducted, some limitations are of concern. First, only the YOQ 30.2 Total Scores were compared with the BASC-2 Composite Scores. Ideally, this validation would also have occurred at the level of the experimental scales within the YOQ 30.2. Comparisons between the scales on the YOQ 30.2 and the clinical and adaptive scales of the BASC-2 rather than the Composite Score would offer more precise information about the profiles of clients presenting to treatment. Presently questions still exist about how well the YOQ 30.2 measures treatment outcomes for clients presenting with externalizing diagnoses versus internalizing ones.

Directions for future research

Given the above limitations, future research would benefit from investigating the YOQ 30.2 at the level of the six experimental subscales that comprise its Total Score. These investigations would better inform clinicians about what specific symptomatology

measured by the YOQ 30.2 during the course of treatment is more reliably informing client progress overtime. In addition, it is possible that increased precision about the treatment of session Total Scores on the YOQ 30. 2 may better inform trends in treatment in clients. Specifically, future studies should ascertain that the first two and last two scores considered for intake and termination precisely represent the first two and last two times the client received treatment.

It is possible that expansion to collecting more detailed information regarding parental motivation to treatment that may enhance the process of correcting the course of treatment during psychotherapy to prevent dropout and improve treatment outcomes at the time of termination. Parental motivation is an important variable in the provision of mental health services to children; still, investigation of parental motivation appears to be elusive. For future research aimed at identifying characteristics in parents and children that are predictive of psychotherapy outcomes, it would be beneficial to have a formal parent motivation to treatment measure included in the study. In addition, when motivation to treatment is considered, parental motivation is considered when clients are young children. Future research could consider including a client motivation to treatment measure as a way to identify more comprehensively predictive characteristics of successful outcomes for psychotherapy with children. In that sense, qualitative data on the motivations for treatment at both the parent and client level could also be considered. Specifically, information regarding parental need for services being provided at the mental health center might better inform clinicians about the particular needs of the families to ensure compliance with treatment. Finally, in the process of

developing enhanced methodology to train psychology students to become child clinicians, it is imperative that future research obtain information about the clinicians-in-training to ascertain more precisely, what variables are involved in their professional development.

Conclusions

Other mental health training centers may use the findings in this study to inform their practices and enhance the outcomes for their clinicians-in-training and clients. The clinical judgment applied by clinicians on the quality of progress achieved by clients at termination appears to be sound as compared with the YOQ 30.2 ratings. While the YOQ 30.2 was confirmed as a strong measure of treatment outcomes for clients, limited knowledge was obtained regarding the client and parent characteristics that predict treatment dropout or success. It is possible that qualitative data in a mixed method design may provide clarification on predictors of treatment success in children based on parent motivation.

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APPENDIX A: INTAKE QUESTIONNAIRE – CHILD HISTORY (CHF)

Intake Questionnaire – Child History
Counseling & Assessment Clinic (CAC)
Texas A&M University, MS 4225
College Station, TX 77843-4225

A. Identification

Today's Date: _____/ _____/ _____

Your child's name: _____ Date of Birth: ____/ _____/ _____

Age: _____ Ethnicity_____

Home street address: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____

Person completing this form: _____ Relation to child: _____

B. Referral: By whom were you referred to us? _____
Why have you come to the Counseling & Assessment Clinic today?

_____

_____

_____

_____

_____

_____

_____

C. Parents (Number of adults in the home? _____)

Mother:_____ Age: _____ Occupation: _____

Father:_____ Age: _____ Occupation: _____

Other parent figure: _____ Age: _____ Occupation: _____

How does the child get along with his/her mother?

_____

How does the child get along with his/her father?

_____

Child's School History

Dates From	To	School	Special Classes	Adjustment to school
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has child ever been retained or skipped a grade? Yes / No If yes, explain:

_____

D. Siblings (Number of siblings in the home? _____)

Name	Age	Sex (circle)	Highest grade completed	Occupation	Present health
_____	____	M or F	_____	_____	_____
_____	____	M or F	_____	_____	_____
_____	____	M or F	_____	_____	_____
_____	____	M or F	_____	_____	_____

E. Relatives

Have any relatives of this child experienced learning difficulties in school? (Circle) Yes

No

Explain:

_____

_____

_____

_____

Have any relatives of this child been seen by a mental health professional?

(Circle) Yes No

Explain:_____

H. Medical History:

1. Pregnancy:

What illness or difficulties did the mother have during pregnancy?

_____

Length of pregnancy: _____ months

Did the mother have any previous miscarriages? (Circle) Yes No

2. Birth:

Length of labor: _____ hours

Delivery was:__ normal __ easy __ difficult

Was the child healthy at birth?

_____

Weight at birth _____ pounds _____ ounces

Have the child ever had a serious head injury? (Circle) Yes No Please explain, giving approximate age:

_____

_____

Has the child been hospitalized? (Circle) Yes No

Explain:

_____

_____

_____

Does the child take any medications? (Circle) Yes No

Explain:

_____

_____

_____

I. Developmental Information

Please note the approximate ages that the following occurred:

_____ Sat alone _____ Talked in single words

_____ Crawled _____ Talked in sentences

_____ Toilet Trained _____ Walked

Has child had any development problems such as speech difficulties, communicating with others, carrying out instructions? (Circle) Yes No

Explain:_____

_____

_____

_____

_____

J. **Behavior**

Would you consider your child to be: __Overactive __ Fidgety__Average __ Underactive

Length of attention span: __ Long __ Average __ Short

Check anything that the child has had any trouble with:

_____ running _____ skipping _____ eating _____ writing _____crying

_____ tiredness _____ riding a bike _____ vision _____ speaking _____ sleeping

_____ aggression _____ playing alone _____ bedwetting _____ temper tantrums

_____ irritability_____ nightmares _____ sleepwalking _____ soiling _____ playing with others

Does your child get along well with other children? (Circle) Yes No

Explain:

_____

_____

_____

Does your child require much discipline? (Circle) Yes No

Explain:

_____

_____

_____

What types of discipline are used most regularly?

_____

_____

_____

K. School Adjustment

Does your child like school? __ Yes __ No

What subject does he/she like best?_____

Least? _____

Name some activities your child enjoys:

_____

Have you or your child's teacher noticed any letter, number, or word reversals?

(Circle) Yes No

Explain:_____

_____

Has your child's teacher observed any learning problems? (Circle) Yes No

Explain:

_____

_____

_____

Has your child ever been placed in any special classes? (Circle) Yes No

Explain:

_____

_____

_____

What, if any, behavior problems have you or the child's teacher observed with this child?

_____

_____

Has your child ever been evaluated or had any previous psychological or educational evaluations? If so, give name, date and place of evaluation:

_____

_____

_____

Has your child has any special interventions in school? (Circle) Yes No

Explain:

_____

_____

Please add any other additional information which you feel would be beneficial to us including any family problems which may have affected your child's school performance:

_____

_____

L. Additional Information about your Appointment

Please answer the following three questions. Just circle the number that shows how you feel.

a. How serious are your child's problems? (circle one number)

Not serious Extremely serious

0 1 2 3 4 5 6 7 8 9 10

b. How important is it for your child to get over his/her problems soon?

Not Important Extremely Important

0 1 2 3 4 5 6 7 8 9 10

c. How much do you think it will help your child to get to the mental health center?

Will not help at all Will help a lot

0 1 2 3 4 5 6 7 8 9 10

This is a strictly confidential patient record. Redisclosure or transfer is expressly prohibited by law.

APPENDIX B: CAC INTAKE EVALUATION REPORT

CAC Intake Evaluation Report

Name:

Date of Birth: Age:

Dates of Evaluation:

Date of Report:

Presenting Problems:

Procedures:

Relevant History:

Behavioral Observations:

Results:

Formulation:

Diagnostic Impressions:

Recommendations:

Clinician's signature Clinical Supervisor's signature

APPENDIX C: CAC TERMINATION SUMMARY (TS)

Texas A&M Counseling and Assessment Clinic
Note

Name: Oliver Twist **ID:** 00000
Type: Termination/Transfer Summary
Counselor: Carly McCord **Date and time:** 08/19/2013

Narrative:

Is this a Transfer? ____

Is this a Termination? ____

If Terminating, please mark the appropriate selection with an 'X'
__Mutual Agreement to terminate __Sufficient progress made OR __Not sufficient progress made
__Therapist-initiated termination __Sufficient progress made OR __Not sufficient progress made
__Client-initiated termination __Sufficient progress made OR __ Not sufficient progress made in treatment

SUMMARY OF SERVICES

1. Most Recent Counseling Service Provided (Adult Individual, Child/Adolescent Individual, Couples):
Most Recent Counselor:
Begin Date:
End Date:
# of Sessions:
# of No-Shows:
Total # of Sessions to date:
Total # of No-Shows to date:

2. Previous Counseling Service Provided (Adult Individual, Child/Adolescent Individual, Couples):
Previous Counselor:
Begin Date:
End Date:
# of Sessions:
# of No-Shows:

INITIAL REASON FOR REFERRAL:

SUMMARY OF COUNSELING PROGRESS (For clients seen <4 sessions with no intake report, provide a summary of contacts and history):

REASON FOR TERMINATION OR TRANSFER:

FOLLOW-UP, REFERRALS, OR NEED FOR FURTHER TREATMENT:

INITIAL DIAGNOSTIC CONSIDERATIONS:

TERMINATION/TRANSFER DIAGNOSTIC CONSIDERATIONS:

Signatures:

William A. Rae, PhD, Supervisor 08/25/2013

APPENDIX D: TELEPHONE SCREENING EVALUATION (TSE)

Texas A&M Counseling and Assessment Clinic
TELEPHONE SCREENING EVALUATION

Date:	8/25/13 8:15 PM	**Referred by:**	School counselor	**Billing Code:**	11A2A
Previous Client:	☐ Yes ☑ No	**Spanish-speaker:**	☐ Yes ☑ No	**Client #:**	
Client Name:	Child Client				
Client DOB:	02/02/02	**Age:**	11.6	**Gender:**	☑ Male ☐ Female ☐ Other
Self-reported Ethnicity:	2 White Hispanic	**Marital Status** (parent for a child):		Married	
# Family Members:	3	**Annual Family Income:**		$18,000.00	
Parent/Guardian:	Parent Client				
School:	XYZ Elementary	**Grade level:**	6th	☐ A&M ☐ Blinn	
Address:	2222 Paradise Lane, Our Town, TX 77777			**Major:**	
Check preferred number:		**OK to leave msg?**	☑ Yes ☐ No		
☐ **Home #:**	☐ **Work #:**		☑ **Cell #:**	(999) 999-9999	
Intake explained?	☑ Yes ☐ No	**Client informed of video/supervision?**		☑ Yes ☐ No	

Service requested:	**Fee:**
☑ **Counseling** ☑ **Individual** ☐ **Couples** ☐ **Group** ☐ **Assessment*** 7 **hours at** **per hr** **Psychoed=7hrs; Personality=5hrs; Career=3hrs*	**$5.00 per hr for self** **$0.00 total**

Client Availability: evenings are best

Presenting problem:

Acting out in school. Grades dropping from As to Ds in the last year.

Brief relevant history:

Parent reports that child has duisplayed innatetion and hyperactivity since the age of 3. Since age 7 child has been displaying aggressive behaviors. Parents discipline using verbal reprimands. And feel unable to control the child. For the past academic year child has been suspended multiple times from school and has also struck parents and school administrators on several occasions.

Duration of the problem:

Dx of ADHD by pediatrician 3 years ago; parents not open to medication.

Pre-existing DSM diagnosis (if applicable):

N/A

Assessment of risk (Ideations/Plans/Attempts/Feelings of hopelessness/Self-Injury/ homicidal risk): DENIED ☐

Child has punched fist into wall on multiple occasions. SI and HI denied.

Previous mental healthcare/Family hx:

Both parents have Dx of ADHD but are not medicated.

Current health and medications and provider (if applicable):

Good health though the client has difficulty going to sleep.

Phone intake by:	☑ **Catharina**	☐ **Marianela**	**Counselor Gender preference?**	☐ **Male**	☐ **Female**	☑ **None**
Type of case:	☑ **Routine**	☐ **Emergent**	☐ **Advanced**			
Assigned by:	☐ **Catharina**	☐ **Marianela**	☑ **Supervisor**			
Assigned counselor:	Daisy Duck	**Date assigned:**	**9/2/2013**			

DO NOT REMOVE THIS SHEET FROM THE CLINIC!
If not seen for intake session, please indicate phone contact attempts and disposition on Titanium.