CHILDREN'S MENTAL HEALTH TREATMENT
IN RURAL AND URBAN COMMUNITIES:
DO PARENTAL EXPECTATIONS
AFFECT TREATMENT INITIATION AND CONTINUANCE?

DISSERTATION

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By

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To Bill, Rachel and Mom
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CHAPTER I

Introduction

As the 20th century is nearing its end, children's mental health is receiving increasingly more attention (Johnson, 1993; Knitzer, 1982; Koyanagi & Gaines, 1993; Stroul & Friedman, 1986). In the final two decades, a number of federally-funded organizations have been created to address the mental health services needs of children and youth, including the Child and Adolescent Service System Program (CASSP, 1984), the National Alliance for the Mentally Ill, Children and Adolescents Network (NAMI CAN, 1988), and the Federation of Families for Children's Mental Health (FFCMH, 1989). The treatment needs of children with emotional and/or behavioral disorders are of growing concern to parents and professionals across a wide variety of disciplines. However, there appears to be a gap between the proportion of children who are in need of mental health treatment and those who receive such treatment (Knitzer, 1982; Tarico, Low, Trupin, & Forsyth-Stephens, 1989). In her review of the status of mental health services for children, Tuma (1989) reported that of the estimated 15% to 19% of children in the United States who are suffering from emotional and/or behavioral problems, 3% to 8% are identified as having a serious emotional disturbance. Furthermore, Tuma estimated that 70% to 80% of the children in need are not receiving mental health services. Child advocates in psychology, social work and related
disciplines must strive to bridge this gap between the children in need of help and the available mental health services.

The dual forces of prematurely dropping out of treatment and residing in a rural area may contribute to this gap. For a variety of reasons, parents may be unable or unwilling to keep a child in mental health services until treatment is completed (e.g., Pekarik, 1991; Wierzbicki & Pekarik, 1993), thereby reducing the potential benefit of such treatment. Families living in rural areas may be more highly influenced by the factors related to dropout because of the added burdens of greater distances to fewer services (e.g., Petti & Leviton, 1986; Wagenfeld, 1990) and higher rates of poverty (e.g., Cordes, 1989; Human & Wasem, 1991) common to rural populations. This study attempted to address these forces, focusing on unmet parental expectations as a potential factor in premature dropout from treatment for low income families living in urban to rural areas.

Premature Termination from Mental Health Services

Contributing to the problem of children not receiving sufficient mental health services is the proportion of parents (and their children) who drop out of treatment prematurely. The data on rates of dropping out of children's mental health services vary, including 93% (Hunt, 1961), 68% (Sirles, 1990), 27% (Dubey, O'Leary, & Kaufman, 1983), and 25% (Day & Reznikoff, 1980b). This wide variability is similar to that identified in adult mental health treatment (Chesney, Brown, Poe, & Gary, 1983; Goldin, 1990; Horenstein, 1975; Overall & Aronson, 1963). Studies have shown that people who drop out of treatment usually do so within the first six sessions, and often after only one or two sessions
(Backeland & Lundwall, 1975; Lorion, 1974; Overall & Aronson, 1963; Sue, 1977). In a study of the variables related to dropout for 321 children and families, Sirles (1990) revealed that 68.3% of the cases self-terminated from services, with approximately two-thirds of the cases closing during the early stages of contact (intake and diagnostics). Additionally, Larsen, Attkisson, Hargreaves, and Nguyen (1979) found that the clients who were less satisfied with services dropped out within the first month.

In a recent meta-analysis, Wierzbicki and Pekarik (1993) identified a mean dropout rate of 47% across 125 studies involving adult, child and mixed (adult and child) clients. An analysis of variance revealed no significant difference in dropout rate for the three client groups. These authors noted that the dropout rate differed significantly as a function of the definition of dropout. This problem with comparability of dropout definitions has been identified by other researchers (e.g., Backeland & Lundwall, 1975; Brandt, 1965; Morrow, DelGaudio, & Carpenter, 1977; Pekarik, 1985a). Defining dropouts as clients who fail to attend a scheduled session after attending one and continuers as clients who attend a minimum number of sessions, or as differentiating between dropouts and continuers on the basis of a predetermined number of treatment sessions, have been common in the literature (e.g., Beckham, 1992; Lowman, Delange, Roberts, & Brady, 1984; Fiester & Rudestam, 1975; Levitt, 1958; Weisz, Weiss, & Langemeyer, 1987). This is problematic because termination before treatment is complete, as well as appropriate termination, can occur after any number of sessions or any length of treatment duration (Pekarik, 1985a; Wierzbicki & Pekarik, 1993). An alternative
technique includes therapists' judgments of inappropriate termination (e.g., Farley, Peterson, & Spanos, 1975; Swett & Noones, 1989; Tutin, 1987). This may provide a more accurate definition because early completers and later dropouts will be included in the appropriate groups. However, there exists the potential for reduced reliability since therapists may use different criteria to judge appropriate termination (Wierzbicki & Pekarik, 1993). In the Wierzbicki & Pekarik meta-analysis cited above, the mean dropout rate across all client groups (adults, children, and mixed) was 36% for studies that employed the failure to attend method and 48% for studies using both the therapist's judgment and the number of sessions methods. In summary, the lack of a consistent definition is problematic and might account for the wide range of dropout rates in both the child and adult mental health services literature.

Even though the definitional inconsistencies exist, it is helpful to review the literature in which researchers have identified the variables potentially related to treatment dropout. For both adult and child studies, the demographic characteristic most frequently evaluated in relation to higher rates of treatment dropout is low socioeconomic status (SES) (Baekeland & Lundwall, 1975; Garfield, 1986; Wierzbicki & Pekarik, 1993). Some researchers have supported the association (McMahon, Forehand, Griest, & Wells, 1981; Pekarik, 1985) and other researchers have found no relationship between SES and treatment continuance (Beckham, 1992; Day & Reznikoff, 1980b; Poliacoff, 1983; Weisz et al., 1987).
The variable of age has also revealed conflicting results. Carpenter, Morrow, DelGaudio, & Ritzler (1981) found that younger adults were more likely to dropout of treatment, yet Pekarik (1991) found that the age of adult clients was positively correlated with treatment dropout. Studies of child treatment revealed both an association between increased age of parents and dropout (Lowman, et al., 1984) and no relationship between these variables (Orme & Boswell, 1991; Pekarik, 1991).

Other demographic characteristics related to dropout are being female for adult clients and children (Lowman et al., 1984), being of the opposite gender than the therapist for adult clients (Orme & Boswell, 1991; Tutin, 1987), and being nonwhite for adult clients (Pekarik, 1985). Results of other studies, however, have not supported these group differences on demographic variables (Sledge, Moras, Hartley, & Levine, 1990; Weisz et al., 1987). In a review of the literature on the relationship between the demographic variables and dropout from treatment, Garfield (1986) concluded that there is a "frequent relationship between social class and length of stay, some relationship between educational level, and no clear relationship between length of stay and such variables as age, sex, and psychiatric diagnosis" (p. 223).

Some researchers who have included both adult and child (and parent) clients in the same study have demonstrated that the adult dropouts differed in demographic characteristics from continuers, whereas the child samples do not reflect these differences, even on SES (Pekarik, 1991; Pekarik & Stephenson, 1988). Wierzbicki and Pekarik (1993) corroborated this finding in their 125 study
meta-analysis and concluded that adult and child samples should be studied separately. Taken together, these studies demonstrate that it is unclear which demographic variables are truly related to discontinuance of children's mental health services.

Looking beyond demographic characteristics, three other clusters of variables related to dropping out of treatment have been identified in the literature across both adult and child studies: (a) treatment variables such as severity of the presenting problem (Lochman & Brown, 1980; McAdoo & Roeske, 1973; Ross & Lacey, 1961; Sirles, 1990; Tutin, 1987), previous treatment experience (Fiester, Mahrer, Giambra, & Ormiston, 1974; Marsh, Zabarenko, Stoughton, & Miller, 1989; Pekarik, 1985), and referral source (Carpenter et al., 1981; Pekarik & Stephenson, 1988); (b) family/social barriers including affordability (Lorefice, Borus, & Keefe, 1982; Sharfstein & Taube, 1982; Takeuchi, Leaf, & Kuo, 1988), accessibility (Acosta, 1980; Cohen, 1972; Graziano & Fink, 1973; Stefl & Prosperi, 1985), and acceptability (Clausen & Huffine, 1975; Farley et al., 1975; Lee, Gianturco, & Eisdorfer, 1974); and (c) mental health system barriers such as availability (Leaf, Bruce, Tischler, & Holzer, 1987; Scott, Balch, & Flynn, 1984; Stefl & Prosperi, 1985), delays in scheduling appointments (Leigh, Ogborne, & Cleland, 1984; Sirles, 1990), and poorly coordinated specialized services (Knitzer, 1982; Tuma, 1989). These findings appear to be more consistently, albeit modestly, supported in the literature than do demographic variables. It is possible that these factors have a more direct influence on treatment dropout and the family/social and mental health system barriers may be more amenable to changes
that can potentially increase treatment continuance. In other words, it would be
difficult to alter a client's age, gender or SES; however, it seems possible to
impact, for example, the affordability, availability and coordination of mental
health services for children.

In summary, the research that addresses dropout from child therapy is
limited. There are too few studies to draw firm conclusions (Pekarik &
Stephenson, 1988). In Baekeland and Lundwall's (1975) review, only 5 of the 362
treatment continuance studies involved child clients, and Wierzbicki and Pekarik
(1993) reported on only nine more child studies that have been published since the
earlier review. Most of the researchers who have evaluated the impact of
demographic variables have not found them to be consistently related to
continuance for children's mental health services. Pekarik (1991) concluded that
the relationship between the wide array of client variables (both demographic and
otherwise) and dropout has been modest and unreliable (Pekarik, 1991). An even
greater problem is the definitional inconsistency that has plagued dropout research.
This inconsistency is, however, gaining more attention in the research and may be
reduced in future studies.

Client Expectations for Mental Health Services

An additional factor that has been considered as an influence on premature
termination from both adult and child treatment is client expectations for mental
health services (Farley et al., 1975; Murphy, 1976; Sledge et al., 1990; Wierzbicki
& Pekarik, 1993). After reviewing the adult dropout literature, Pekarik (1985)
concluded that "discrepant expectations of clients and therapists regarding the
duration and goals of treatment could account for much of the dropout rate and associated problems" (p. 114). Additionally, Wierzbicki and Pekarkin's (1993) meta-analysis findings led them to conclude that adult clients' and parents' expectations for treatment may be more important than demographic variables in predicting treatment continuance. This conclusion was also reached by Garfield (1986) in his review of the literature on dropout.

Researchers have presented consistent evidence that adult clients expect treatment to be fairly brief (e.g., Budman & Gurman, 1988; Garfield, 1986; Pekarkin, 1991). Garfield and Wolpin (1963) found that 70% of adult clients expected therapy to last 10 sessions or less, and of those nearly 75% expected treatment to require no more than five sessions. Similar findings were reported by Gelso and Johnson (1983), who revealed that 87% of adult clients expected 12 or less sessions of treatment, with three visits as the modal expectation. Pekarkin and Wierzbicki (1986) found adult clients' expectations for treatment duration to be significantly correlated with actual treatment duration (p<.01), with expected and attended number of sessions relatively low (73% expected and attended 10 or less appointments). A stepwise regression analysis revealed that expected number of visits was the only variable (others included gender, SES, referral source, previous therapy, treatment modality, therapist degree and experience) that significantly increased the predictability of adult client duration in treatment (Pekarkin & Wierzbicki, 1986).

The results are not as conclusive when looking specifically at the few studies that have assessed parental expectations for treatment duration. Day and
Reznikoff (1980b) reported that parents generally expected treatment to last for more than three or four sessions, but parents were not directly asked how many sessions they expected the treatment to involve. Summary data provided by Weiss and Dlugokinski (1974) revealed that the average parent expectation for treatment duration was 2.89 (2 = two to three sessions, 3 = four to six sessions). Pekarik (1991) provided the most detailed data, revealing that the majority of parents (74%) expected treatment for their child to last six to 10 sessions, with 76% of the sample of children actually receiving six to ten sessions of treatment. Pekarik (1991) was also the only researcher who analyzed the relationship between expected and actual treatment duration, revealing that expected number of visits was not a significant predictor of treatment sessions attended for child clients.

Looking beyond expected duration of treatment, the literature is unclear about the exact nature of the relationship between client expectations for treatment experiences and treatment dropout. Overall and Aronson (1963) found that adult clients of an outpatient psychiatric clinic whose expectations were most discrepant from their experiences were significantly less likely to return for treatment following an initial interview. Heine and Trosman (1960) found that adult terminators of psychotherapy tended to expect to be passively cooperative, given medicine, and provided with diagnostic information; expectations that were less congruent with those of the therapist than were the expectations of the continuers. Day and Reznikoff (1980b) demonstrated that inappropriateness of expectations for child therapy (e.g., anticipating that the therapist will tell a child "the answer" to her/his problem or will not have her/him play in therapy), on the parts of both
parents and children, was related to dropout before the sixth treatment session. When Farley et al. (1975) asked parents to provide reasons for prematurely ending treatment, they found that 46% had unfulfilled expectations. Conversely, Weiss and Dlugokinski (1974) revealed no significant correlations between the expectations of parents and the number of treatment sessions attended using the questionnaire developed by Overall and Aronson (1963). Leiman (1977) found that unmet expectations regarding the helpfulness of the initial phase of treatment were not a predictor of treatment dropout for parents.

Duckro, Beal and George (1979) reviewed the literature on the effects of disconfirmed client expectations on psychotherapy, without differentiating between adult and child treatment. Consistent support for the assumption that disconfirmed client expectations are highly correlated with dropout rates was found in the literature prior to 1962. However, after 1962, the findings regarding this assumption were mixed. Duckro et al. identified ambiguous definitions and global assessments of client expectations to be contributing factors to the mixed results from 1962 to 1979. They described two definitions of expectations used interchangeably throughout the literature without researchers dealing specifically with the distinction. Duckro et al. identified studies in which expectations have been defined as "the anticipation of some event", whereas other studies have defined expectations as having "a preference that some event should occur" (p. 270). Of the four studies published since 1979 that addressed expectations for treatment and provided enough measurement information to identify the definition used, all chose the anticipation type to measure parental expectations (Bonner &
Everett, 1982; Day & Reznikoff, 1980a, 1980b; Munger, 1988), the first three of which used the same measure.

The interpretation of the data based on the anticipation type of expectation definition is complicated. First, knowing whether or not some event is going to occur will be affected by one's previous experience. No study using the anticipation definition of expectation adequately addressed this issue in the analyses. Second, it is common for the data to be interpreted not in terms of whether expectations are satisfied in treatment, but rather in terms of accuracy of expectations relative to therapist knowledge of the generally occurring activities in treatment (e.g., Burck, 1978; Day & Reznikoff, 1980b). And third, considering the issue of anticipation from a consumer perspective, knowledge of activities that occur in therapy does not appear to be as influential on one's decision to prematurely terminate treatment as does desiring certain services to be provided. For example, if an individual anticipates being asked about her/his childhood but is not, this inaccurate knowledge may or may not influence her/his choice to end treatment. However, if that individual prefers being asked about her/his childhood but is not, this person may feel that services were not adequately rendered and choose to discontinue treatment. Also, if one believes a certain event is common in therapy and does not want to experience that event, it is more likely that this individual will never initiate services in order to avoid the unwanted event.

One further issue regarding expectation research involves the development of the expectation questionnaires. The majority of researchers developed measures based on clinician- or researcher-driven beliefs regarding the relevant
factors in therapy that should be measured. Day and Reznikoff (1980b) developed
the Therapy Survey which measures the appropriateness of the parent's
expectations for child therapy. Item content was determined by reviewing the
literature for conclusions made by previous investigators and by accumulating staff
members' experiences with clients. Specific items included in the questionnaire
tapped knowledge about confidentiality, the length and frequency of sessions, the
occurrence of play, and the effectiveness of therapy. Other researchers have used
the Therapy Survey to measure parental expectations for child therapy (Bonner &
Everett, 1982; Day & Reznikoff, 1980a).

Munger (1988) developed the Expectation Survey Questionnaire to measure
parental expectations (anticipation type) about child therapy. The questionnaire
was created by requesting a panel of mental health counselors to rate each item in
a question pool on a scale of "relevance to your understanding of clients at the
inauguration of therapy" (p. 729). The Expectation Survey Questionnaire includes
items about the type of professional the parent thought could help their family, the
family members who would be involved in treatment, the delay between the
service request and the first appointment, and the length of treatment.

Other researchers have focused on client expectations (both adults and
parents) of therapist behavior and theoretical orientation, such as being
active/directive, passive, supportive, medically-oriented, or psychologically-
oriented (Horenstein, 1975; Overall & Aronson, 1963; Weiss & Dlugokinski,
1974). In these studies, the anticipation type of expectation was usually measured.
Although expectations for therapist characteristics such as being directive, passive
or supportive are related to the current discussion (and addressed in the following section), it is likely that the clinician's orientation (e.g., medical or psychological) is more important to clinicians who have studied different theoretical perspectives on the etiology and treatment of psychopathology than to parents who are not commonly aware of different theoretical orientations of therapists.

In general, these studies on client expectations are limited by the utilization of different definitions for expectations with the more recent studies using only the anticipation type, by their use of different measures of expectations, and by their reliance on clinician- or researcher-driven item content. This does not suggest that these previous studies have not contributed to our knowledge of the influence of expectations (as defined and measured) on treatment continuance. Rather, the argument here is that when evaluating expectations for treatment, researchers should consider the factors which have been identified by clients as preferred by them and that these previously neglected client-generated factors are likely to have a greater impact on treatment continuance than those generated by researchers. A parallel of this argument of focusing on the information gathered from clients is found within the clinical literature. As an example, Moore-Kirkland (1981) presented her thesis that, in order to engage clients in the therapeutic process, the clinician must first adequately understand the nature of the client's motivation and spend the initial phase of treatment learning about the client's needs and desires for treatment. "In general, the importance of meeting clients where they are, understanding their motivations and perceptions, and working with them and with available support systems toward mutually determined goals cannot be emphasized
too strongly" (p. 51).

It is the contention of this author that information from clients regarding their perceptions of the factors that are important in the therapeutic process must be the basis of assessment. In the area of children's mental health, there is a growing body of literature which focuses on parent-generated data (e.g., Friesen, 1989; Friesen, Koren, & Koroloff, 1992; Tarico et al., 1989). Cournoyer and Johnson (1991) pointed out that "views of parents have important implications for work with children," especially when one considers that "parents regulate access of children to services" (p. 399).

Lishman (1978) interviewed selected parents with whom she had previously worked regarding their satisfaction with her services. She found that dissatisfied parents felt blamed and criticized by her at the contract setting stage of treatment. Most parents, regardless of satisfaction level, were confused about the assessment and/or treatment described by the clinician. Lishman also found that parents wanted to receive concrete information about strategies to deal with their children and acknowledgment that they have strengths. Lishman concluded that clinicians must be more aware of the impact of client experiences, particularly at the referral and initial contact phase of child therapy.

Sung (1989) assessed the mental health needs of American families overseas in relation to the family needs perceived by the providers of mental health services. When given 10 choices, the top three problems identified by parents were (1) language difficulties, (2) lack of transportation, and (3) juvenile behavior problems; whereas, the service providers believed the top three problems for
families were (1) marital and family conflicts, (2) raising children, (3) lack of educational opportunities. Similar discrepancies between parents and providers were revealed regarding the services which were most desired by parents. When presented with a list of 10 services, the top three listed by parents were (1) transportation, (2) emergency medical care, and (3) dental care for dependents; whereas, providers listed (1) marital and family counseling, (2) programs for cross-cultural understanding, and (3) guidance in parenting. This study revealed two important points: service providers did not have an accurate picture of the mental health needs of the families in their area, and parents perceived as important a number of concrete services not commonly related to mental health services.

In an effort to address the issue of unmet needs of families and children with emotional disorders, Tarico et al. (1989) assessed 31 parents regarding their perspectives on service needs and barriers. These researchers revealed that unmet needs included concrete services, such as treatment for other family members, special education options, referral services, and support groups. Being provided with treatment alternatives for their children was reported by parents as a service desired but only sometimes met by clinicians. The barriers to services listed by these parents included having their child's problems minimized, overlooked or denied by professionals; being met with skepticism regarding their presentation of their child's problems; being blamed for their child's problems; and not receiving validation for their perception of their child's problems. Overall, Tarico et al. found that parents desired more open communication with providers, especially
regarding available resources and being actively included in the treatment planning process.

In summarizing a national survey of parents with children suffering from emotional and/or behavioral disorders, Friesen (1989) found a discrepancy between the behaviors of professionals deemed as important (i.e., preferred) by parents and the frequency with which those behaviors occurred during interactions between parents and professionals. Based on the percentage of parents rating a behavior as "very important," the top five behaviors of professionals were honesty (87%), a respectful and non-blaming attitude (82%), supportiveness toward the child (79%), supportiveness toward the parent (75%), and including the parent in decisions (73%). Although rank order was the same, the percentages of parents reporting that each of those behaviors "often occurs" were 75%, 71%, 66%, 57%, and 57%, respectively. It is encouraging to see that large proportions of parents felt their needs were being met; however, the discrepancy between the proportion of parents deeming behaviors as important yet not perceiving those behaviors as occurring often is distressing.

In a later publication, Koroloff, Friesen and Koren (1992) factor analyzed the data from Friesen's (1989) national survey, resulting in two factors associated with professional behaviors. The first factor was defined primarily by relationship-oriented items (e.g., honest, respectful, supportive), whereas the second variable was defined primarily by concrete services items (e.g., providing information, providing an accurate evaluation, advocating for child). These results are in contrast to those reported by earlier studies which have shown that concrete
services are more important to parents than are relationship-based variables (e.g., Sung, 1989; Tarico et al., 1989).

As identified earlier, the experiences of clients during the initial stage of therapy appear to be significant regarding their decision to continue or discontinue treatment. The services and provider behaviors listed above which parents have identified as important or preferred are likely to have more of a contribution in the early portion of treatment than after the therapeutic relationship has been established (B.J. Friesen, personal communication, August 6, 1992). In other words, if certain experiences in treatment for their child are important to parents (e.g., support for the parent, information about treatment alternatives, help with securing concrete resources), and those do not occur within the first few meetings, the likelihood of continuance in treatment is hypothesized to be low. This does not suggest that the factors measured by other researchers (e.g., knowledge about treatment events or the therapist's theoretical orientation) are not important to parents, but rather that those factors may be more influential in the later stages of treatment, once the parent has had their more immediate needs met.

In summary, client expectations have been shown to influence treatment continuance for both adults and parents (e.g., Day & Reznikoff, 1980b; Farley et al., 1975; Overall & Aronson, 1963). The specific expectation that treatment will last a short time is influential in the choice of adults to discontinue treatment early (Pekarik & Wierzbicki, 1986); however, it is not clear that this is also the case for parents with children in treatment (Pekarik, 1991). Duckro et al. (1979) pointed out a number of methodological problems with the expectation literature prior to
1979 and later studies have not addressed the preference type of expectation. The information gathered from the studies of treatment variables that are important to parents (Friesen, 1989; Lishman, 1978; Tarico et al., 1989) can guide research on the influence of treatment expectations of the preference type on treatment continuance, an issue in this area of study that has not been adequately addressed.

Client Expectations for Therapist Personality Characteristics

A client's expectations for and perceptions of the personality characteristics of the therapist are likely to be influential in the therapeutic process. A number of researchers have surveyed both the general public and mental health services consumers to identify a set of expected therapist personality characteristics (e.g., Nunnally & Kitross, 1958; McGuier & Borowy, 1979; Wood, Jones, & Benjamin, 1986). Nunnally and Kitross (1958) surveyed the general public and found that people generally anticipated mental health professionals to be sincere, strong and warm. Using the same survey method thirty-five years later, Wollersheim and Walsh (1993) revealed a similarly positive view by the public. This adult sample anticipated mental health professionals to be helpful, patient, understanding and dedicated. The limitation of these studies is that they do not address the potential impact of expectations on initiating treatment. It would be informative to know whether the people who expect therapists to be less sincere, warm, understanding, etc. are the people who are less likely to initiate treatment.

Other studies have gathered therapist characteristic information from individuals who have participated in treatment. Hartlage and Sperr (1980) asked adults to identify "ideal" therapist characteristics. They found that the majority of
people preferred therapists who are honest, friendly, understanding, unselfish, direct and warm. In a study of the impact of giving clients a choice of therapists, Hollander-Goldfein, Fosshage, and Bahr (1989) found that adult clients preferred therapists who were described as positive, likeable, competent, accepting, warm and empathic. Persons, Persons, and Newmark (1974) asked clients at an exit interview from a university student counseling center to list the therapist characteristics that were most helpful. Those characteristics endorsed most frequently included giving honest feedback, being interested and concerned, being perceptive and insightful, and being warm and friendly.

Researchers have demonstrated that personality characteristics of the therapist are positively correlated with treatment outcome and client satisfaction (e.g., Henry, Schacht, & Strupp, 1986; Lorr, 1965; Silove, Parker, & Manicavasagar, 1990). Lorr (1965) extracted five factors from responses of 523 adult psychotherapy patients on a therapist evaluation questionnaire. The five factors characterized therapists on dimensions of "understanding", "accepting", "authoritarianism", "independence-encouraging", and "criticism-hostility." All of the dimensions were positively and significantly correlated with patient satisfaction and treatment outcome. Henry et al. (1986) revealed that successful treatment outcomes were related to high levels of therapist behaviors labelled "helping and protecting" and "affirming and understanding", and to low levels of "blaming and belittling" comments. During the process of developing an extensive two-part therapist rating scale, Silove et al. (1990) revealed five dimensions of therapist characteristics. Analyses revealed significant positive correlations
between client satisfaction and the "care-concern", "communication", and "charisma" dimensions, and significant negative correlations between client satisfaction and the "directive-controlling" and "critical-confronting" dimensions. A multiple regression analysis revealed that the "care-concern" scale score accounted for 39% of the variance, with 50% of the variance being accounted for by the five scale scores combined. Williams and Chambless (1990) used a shorter scale, the Therapist Rating Scale (Williams, 1989), to reveal that positive treatment outcome for adults with agoraphobia was significantly correlated with caring and involved therapists.

When evaluating the expectation literature, Goldstein (1962) concluded that the characteristics a client anticipates the therapist to have could be dependent upon the type of clinician providing mental health services. Goldstein (1962) cited results from other studies (Chance, 1959; DeHaan, 1958) to support this claim. At a medical setting where medical students provided therapy, the clients anticipated therapists to be active, supportive and directive (DeHaan, 1958), whereas clients anticipated social workers to be advice-giving, supportive and relatively protective (Chance, 1959).

Other studies have evaluated the influence of therapist personality characteristics on treatment continuance (e.g., Apfelbaum, 1958; Farley et al., 1975; Overall & Aronson, 1963). Alexander, Barton, Schiavo and Parsons (1976) demonstrated that therapist characteristics were significantly related to treatment continuance. Although expectations were not measured, families who worked with therapists receiving lower scores on the relationship dimensions (affect-
behavior integration, warmth, and humor) of ratings made by their clinical supervisors were more likely to terminate from treatment early and unsuccessfully. Farely et al. (1975) reported that 75% of their parent sample identified their child therapists as friendly, interested in their child, and competent. Of the 25% of parents who rated their therapists negatively on these characteristics, one-third reported that this influenced their choice to prematurely terminate treatment.

In a landmark study of expectations and treatment continuance, Apfelbaum (1958) utilized a Q-sort to identify the therapist personality characteristics most associated with treatment dropout. University students who dropped out of outpatient therapy were significantly more likely to expect their therapist to have characteristics in the "model" cluster (well-adjusted, diplomatic, nonjudgmental, permissive), than in the "nurturant" (guiding, giving, protective) and "critic" (critical, analytical, unindulgent) clusters. The drawback to this study is that Apfelbaum did not report whether the expectations were met or not (i.e., the therapist characteristics experienced). This is the same limitation of Weiss and Dlugokinski's (1974) findings that parents' expectations (anticipation type) for certain therapist characteristics were unrelated to length of stay in treatment.

The only study that compared expectations (anticipation type) to actual experiences was performed by Overall and Aronson (1963). They found that low income adults anticipated therapists to be active but permissive, and to have a medical-psychiatric orientation to treatment. After calculating discrepancies between anticipated and experienced therapist characteristics, Overall and Aronson reported that clients who did not return for treatment had significantly
greater discrepancy scores than those clients who did return.

In summary, people generally expect mental health professionals to possess what can be labelled as positive personality characteristics (e.g., warm, supportive, friendly). The above studies indicate that therapist personality characteristics can be influential on a client's experience in treatment. There is some empirical support for therapist characteristics impacting client satisfaction and treatment outcome. The body of research on the influence of clients' expectations of therapist personality characteristics on treatment continuance is small, inconsistently involves anticipation or preference types of expectations, and infrequently relates expectations to actual experiences; therefore firm conclusions cannot be drawn. In addition, these limitations are even more marked in parental expectations for child treatment due to the reduced number of studies.

The Rural Community

Dropping out of children's mental health services has been the issue of interest thus far. The research on the impact of client expectations and therapist characteristics were reviewed with the goal of isolating findings related to children's mental health services. Research in the area of parental expectations as they relate to treatment continuance is lacking. There is virtually no research available that evaluates these expectancy variables while taking into account the impact of living in a rural area. This is important when one considers the possibility that people in rural areas are underserved by the mental health community (e.g., Kelleher, Taylor, & Rickert, 1992; Lee, Gianturco, & Eis dorfer, 1974). Before reviewing this literature, it is important to describe what is meant
by "rural" and what is known about mental health problems and services in rural versus urban areas.

There is consensus throughout the literature that no standard, adequate method for defining rurality exists (Clayton, 1977; Matthews, 1988; Miller & Luloff, 1981; Smith & Parvin, 1973). Wagenfeld (1990) pointed out that "rural" and "nonmetropolitan" definitions are interchangeably used to identify subjects as rural. Wagenfeld (1990) contended that "rural" refers to population density, whereas "nonmetropolitan" involves patterns of trade and association. Murray and Keller (1991) also make this distinction, providing the following definitional criteria:

As defined by the U.S. Bureau of the Census, rural populations consist of people who live in places or towns of less than 2,500 inhabitants and in open country outside the closely settled suburbs of metropolitan cities. By contrast, urban areas consist of cities with 50,000 or more inhabitants and the closely settled areas around them, as well as communities that have at least 2,500 persons but are outside those urbanized areas.

...MSA's [metropolitan statistical areas] have a total population of at least 100,000 (75,000 in New England), comprise one or more central cities with at least 50,000 inhabitants, and include adjoining areas that are socially and economically related to the central city. (p. 220)

A number of researchers have chosen to use the population density definition (e.g., Carscaddon, George, & Wells, 1990; Flaskrud & Kviz, 1984; Lee et al., 1974; Munger, 1988), others have used the MSA criteria (e.g., Blouch,
1982; Deavers, 1992; Sherman, 1992), and others have not clearly reported the criteria used to define rurality (Burns, Burke, & Ozarin, 1983; Cohen, 1972). Murray and Keller (1991) concluded that neither of the U.S. Bureau of Census definitions satisfactorily define rurality. Apparently, other researchers have reached the same conclusion and created their own criteria. Windley and Scheidt (1983) used population density (i.e., number of people per square mile of an area) and occupational criteria (not provided) to define the level of rurality in 39 eastern Kansas counties. To define rurality, Smith and Parvin (1973) used an index with nine factors: population density; percent of persons living in rural areas; total population; percent employment in agriculture, fisheries and mining; percent of persons living on farms; average annual percent of change in population, 1940-1970; percent employment in medical and dental professions; percent employment in entertainment and recreation services; and percent employment in service work. Using a multiple discriminant analysis, Miller and Luloff (1981) found that 90% of their subjects were correctly classified as rural based on five factors: occupation, family structure, personal characteristics, religion, and residence characteristics (including residence at age 16 years). The use of different definitions for rurality continue throughout the literature.

In order to learn from the researchers who focus on rural mental health issues and to hopefully identify any trends not apparent in the literature reviewed, the Research and Training Center on Rural Rehabilitation Services affiliated with the University of Montana was contacted. It was not surprising that their conclusion was similar: "each [publication] conceptualizes/categorizes rural in a
different manner" (N. Arnold, personal communication, September 1, 1992).

In spite of these definitional differences, researchers have generally proposed that people living in rural areas suffer from greater prevalence of psychological problems and inadequate mental health services (e.g., Keller & Murray, 1982; Murray & Keller, 1991; Wagenfeld, 1990). People who live in rural areas are disproportionally poor, elderly and chronically ill (Cordes, 1989; Norton & McManus, 1989; Rowland & Lyons, 1989). These characteristics have been associated with a greater risk for mental disorder (Human & Wasem, 1991; Wagenfeld, Goldsmith, Stiles, & Manderscheid, 1988). The National Mental Health Association (1988) reported that adults living in rural areas have experienced rapid increases in suicide attempts, family violence and depression. Looking at prevalence rates for rural adolescents, Garfinkel, Hoberman, Parsons, and Walker (1988) found increasingly higher rates of depression, suicide attempts, and suicidal ideation among rural youth. Higher rates of sexual abuse of children and adolescents have also been associated with rural areas (Finkellhor, 1979; Petti, Benswanger, & Fialkov, 1987). However, in a recent review, Wagenfeld (1991) reported that the rates of most psychiatric disorders are higher in urban settings. Again, methodological problems led Wagenfeld to conclude that "the jury is still out on this issue" (p. 511).

The evidence regarding the paucity of mental health services in rural areas is, however, more conclusive. Wagenfeld's (1991) review found that large sections of rural America are without mental health services. Human and Wasem (1991) identified economic issues as the primary factor in the limited mental
health services available in rural areas. Petti and Leviton (1986) stated that mental health services for children and adolescents are particularly lacking. One reason for this is the reduced number of psychologists providing services in rural areas (Blouch, 1982; Murray & Keller, 1991; National Commission on Children, 1990; Richards & Gottfredson, 1978). Examining the distribution of psychologists in the northeastern United States, Keller, Zimbelman, Murray, and Feil (1980) found a significant positive correlation between county population density and the number of psychologists per 100,000 people. Additionally, 77.5% of the counties with less than 100 people per square mile lacked a single registered psychologist.

Kelleher et al. (1992) reported that families may counteract this by seeking mental health services for children within the medical health care sector; however, census statistics indicated that only 9% of the pediatricians in this county practice in rural areas.

Adding another layer to this already problematic situation, many researchers have identified accessibility to mental health services as distinctively difficult for people living in rural communities (e.g., Human & Wasem, 1991; Murray & Keller, 1991). Long distances must be travelled to reach the limited services in rural areas (Burns et al., 1983; Gerber & Semmel, 1983; Keller & Murray, 1982). Flax, Wagenfeld, Ivens, and Weiss (1979) reported that a typical rural mental health service delivery area is 5,000 square miles and the largest of these areas is more than 60,000 square miles. In a study of the effects of distance on the use of outpatient services in a rural mental health center in Kansas, Cohen (1972) found that a distance of 30 or more miles to the center was related to a 50%
to 80% reduction in utilization of services.

Acceptability of mental health services has also been noted as a barrier related to rurality (Blouch, 1982; Burns et al., 1983; Flakerud & Kviz, 1983; Kelleher et al., 1992). Lee et al. (1974) performed a general survey of 223 homes in rural areas and found that although there was a high prevalence of mental health problems among the residents, the majority sought no help. The researchers identified factors contributing to the limited utilization of mental health services by the residents, including fear of being identified as mentally ill and not knowing the purpose of the mental health clinic. Summarizing a series of special hearings held by the National Institute on Mental Health, Kelleher et al. (1992) reported "the stigma surrounding mental disorders was seen as the greatest barrier to effective mental health care for rural people with mental illness" (p. 846). Human and Wasem (1991) identified factors contributing to this problem of acceptability, including a history of helping one's self, beliefs about the cause of emotional disorders and the appropriate healer, and lack of knowledge about mental disorders and services.

The evidence regarding knowledge of and attitudes about mental health treatment among rural populations is, however, not conclusive. Although Lee et al. (1974) found that lack of knowledge about the purpose of mental health treatment has been a barrier to treatment for rural populations, nine years later Flakerud and Kviz (1983) revealed a generally high level of knowledge of the services that were available and the symptoms associated with mental illness. Additionally, positive attitudes about mental health treatment appear to be
increasing among rural populations (Flaskerud & Kviz, 1983; Hargreaves & DeLay, 1979). In a discussion of rural community mental health, Gonzales, Hays, Bond and Kelly (1983) stated that rural populations will be more likely to utilize mental health treatment if the programs are more closely designed to match rural values, belief systems and resources. Gonzales et al. (1983) pointed out that higher levels of poverty and lower levels of education in rural populations may contribute to lower mental health treatment utilization rates.

The studies described in the previous sections that identified the point at which treatment dropout most likely occurs have not directly assessed rural populations. Only one study that addressed expectations for treatment did so with a sample of rural people (Munger, 1988). In their critique, Keller and Murray (1982) maintained that the norms, values and expectations of people in rural areas are of fundamental importance to the delivery of mental health services. The literature available, however, appears to focus on the identification of rural barriers to initiating treatment rather than the factors that affect continuance in treatment. Due to these apparent barriers to treatment utilization, it is imperative to better understand the variables associated with dropout from children's mental health services. Once those families who live in rural areas actually initiate the services, it is important to increase the likelihood that they participate in treatment until it is completed.

**Hypotheses and Significance of the Current Research**

The relative impact of unmet parental expectations for child therapy and therapist personality characteristics on treatment initiation and continuance for low
income families living in urban to rural areas was the focus of the current study. It was hypothesized that:

1. Unmet parental expectations for their child's therapy will affect treatment continuance. Specifically,
   a. parents who dropout of treatment will have significantly higher levels of unmet expectations for child therapy,
   b. parents who dropout of treatment will have significantly higher levels of unmet expectations of the preference type than of the anticipation type, and
   c. parents who dropout of treatment will have significantly higher levels of unmet parent support/involvement expectations than unmet consumer needs expectations.

2. Unmet parental expectations for and perceptions of therapist personality characteristics will affect treatment continuance. Specifically,
   a. parents who dropout of treatment will have significantly higher levels of unmet expectations for therapist personality characteristics, and
   b. parents who dropout of treatment will perceive the therapist as significantly less caring and involved.

3. Unmet parental expectations for child therapy will have a greater impact on treatment dropout than will unmet parental expectations for therapist characteristics.

4. Parental expectations for child therapy and therapist personality characteristics will be lower for parents who never initiate treatment than for those
who do initiate treatment.

5. The level of family rurality will have a significant impact on the above hypotheses. That is, the effects of unmet expectations and experiencing a less caring/involved therapist on treatment dropout will be significantly greater for rural than for urban populations. The differences are hypothesized to be due to variables found to be associated with rurality:

   a. greater perceived negative stigmatization associated with mental health services,

   b. greater distance from services,

   c. less parental education, and

   d. lower family income.

It is assumed that the overall goal of increasing the likelihood of children receiving mental health treatment after being deemed as in need of such services is important to the children's mental health community. This study could have an impact on that goal by:

1. increasing our understanding of parents' expectations for child therapy and the impact these have on initiation of and dropout from treatment when they are not met;

2. increasing our understanding of the impact of parents' expectations for and perceptions of therapist personality traits, especially as they affect treatment initiation and dropout when they are not met;

3. providing us with new information which can be disseminated to clinicians in order to guide their behavior and attention to parents' expectations
and perceptions; and

4. potentially having a positive effect on treatment continuance for children with emotional and/or behavioral disorders.
CHAPTER II

Method

Subjects

The sample of parents (see Footnote 1) included in this study was drawn from the group of 165 comparison families who participated in the Center for Mental Health Services research demonstration grant called the Family Connections Project (see Appendix A). The selection criteria for families included in the Family Connections Project were:

1. A child was referred for mental health services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medicehck process (a Medicaid program).

2. The referred child was not in an institutional placement.

3. A parent was involved in the management of the child's mental health services and was available for the assessments.

4. The referred child was 4 to 17 years old. For those who were 14 to 17 years old, the children were not seeking mental health services without parental knowledge.

5. The referred child had participated in no more than three mental health services appointments.
Of the 165 Family Connections Project families, 6 were excluded because they were put on a waiting list by the mental health agency and had not received services by the follow-up assessment, 2 because the mental health professional who performed the intake evaluation determined that the child did not need mental health treatment, 2 because the parent had not directly participated in the child's treatment, 19 because a follow-up assessment was not completed (e.g., parent unlocated or refused, before assessment due date), and 16 because incomplete data was collected. This resulted in a sample of 120 families.

The frequencies of selected demographic characteristics for the total sample are presented in Table 1. The respondents in this sample were primarily birth parents (85%), Caucasian (90%), between 21 and 39 years of age (81%), unmarried or separated (62%), unemployed (63%), and educated to the high school level or higher (80%). Approximately half of the children who were referred for mental health services were male (58%), with the majority being Caucasian (86%) and 4 to 12 years old (89%). Most of the families lived within 10 miles of the mental health center to which they were referred (81%). Although 44% of the families fell into the second lowest SES level (VI) based on the Hollingshead (1975) four factor index, 62% had an annual household income of less than $10,000 suggesting that the Hollingshead index did not completely capture the poverty level of these families.
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</table>

NOTE: n=120.
*a "Respondent" is used in place of "parent" for the purposes of this data presentation.*
The total sample of families was categorized into three groups based on their treatment status identified during the follow-up interview (described below): treatment continuers, treatment dropouts, and noninitiators of treatment. Treatment dropouts were the 16 families who prematurely ended child treatment without the agreement of the therapist by the four month follow-up assessment. Treatment continuers were the 82 families who either were still receiving treatment at the time of the follow-up assessment or who ended treatment with the agreement of the therapist. Noninitiators of treatment were the 22 families who never received any mental health services even though such services were recommended.

Procedures

The families were recruited for the Family Connections Project by trained research interviewers who received the referral information through a predetermined process arranged with each of the County Mental Health Program Directors and set of referral sources. The parents were contacted first by mail with a letter and flyer describing the project (see Appendix B). In some cases, the parents were requested to return a Reply Form (see Appendix B) if they were interested in receiving a telephone call about the project. The research interviewers then contacted parents by telephone (see Appendix B for the Initial Telephone Contact Script) to further describe the project and request permission to meet (usually in the parent's home for her/his convenience). Upon arrival at each parent's home, the interviewer first secured informed consent (see Appendix C).
Once consent was secured, each parent responded to a brief interview (see Appendix D) and completed a set of questionnaires (see Appendix E) which addressed child behavior problems, expectations for child treatment, and expectations for therapist personality characteristics. For doing this as part of the overall project, each parent received $25.

Approximately four months after the initial assessment, the research interviewers contacted each parent by telephone (see Appendix B for the Telephone Script for Follow-Up Interviews) to schedule the follow-up assessment. During this data collection point, the parents were interviewed again and completed a second set of questionnaires. These measures focused on mental health services received, continued expectations for and experiences in child therapy, and perceived therapist personality characteristics. Those parents who never initiated treatment for their child only reported their continued expectations for therapy events. For doing this follow-up assessment as part of the overall project, each parent received another $25.

Measures

The interviews and questionnaires that the parents completed satisfied the needs of both this study and the larger research project. The measures listed below and included in Appendices D and E are those relevant only to this study.

Initial Assessment. The items listed below represent the initial assessment which took approximately one-and-one-half hours for the parents to complete.
1. A parent interview (see Appendix D) gathered the following data for this study:

   a. Demographic information, including child's gender, age and race (items 1-3); and parent age, race, marital status, educational level, and relationship to the child (items 7-9, 13-14); and family distance from the mental health office (item 19).

   b. Family socioeconomic status (Hollingshead, 1975; items 12-15), as well as annual household income (item 16).

   c. Previous treatment experiences for the child currently referred for treatment, other children, and the parent her/himself, as well as the parent's satisfaction with those services (items 21-22, 25, 27). The satisfaction ratings were measured by a five-point Likert scale (1 = all bad to 5 = all good).

   d. Expected barriers to treatment, including accessibility (e.g., transportation problems, too far to travel), inconvenience, parental and family burden, negative stigma associated with treatment, parental attitudes and beliefs (item 39).

   e. Expected duration of treatment measured in number of months (item 40).

   f. Population type measured by (a) the city/town listed in their address and its associated population defined by the Oregon 1990 Census (item 17), (b) whether or not the family lived inside that city's/town's limits and the distance in miles from that city/town if they lived outside its limits (item 18), (c) distance in
miles to the mental health office to which their child was referred (item 19), (d) the parent's self rating of living in a rural or urban area (item 8 of the Follow-Up Interview), and (e) the US Census rating for the family's county (metro or nonmetro). Each of these factors were assigned a value from one to five, resulting in a total population type score that could range from 25 denoting very urban to 5 denoting very rural (see Appendix F for the scoring codes and method). For example, a family living within the city limits of Eugene, Oregon (population 112,669) received a "5" for city size, a "5" for living within the city limits, and a "5" for the metro Census rating for Lane County. The family also received a "4" for living within five miles of their mental health office and a "5" for rating their area as urban. This resulted in a total score of "24" denoting an urban population type. Alternatively, a family living 22 miles outside of Nyssa, Oregon (population 2,629) received a "2" for town size, a "1" for living more than 20 miles outside the town limits, and a "1" for the nonmetro Census rating for Malheur County. The family also received a "1" for living over 20 miles from their mental health office and a "1" for rating their area as rural. This family received a total score of "6" denoting a rural population type.

2. The Parent Survey-I (adapted from the "Characteristics of Professionals section of the Parent Survey developed by Friesen, 1989; see Appendix E) assessed parent expectations for child therapy. It is a 25-item set of questions regarding parent expectations for the events which will occur in their child's treatment. The parents were asked to rate each item in two ways: (a) "How
important is it to you that the therapist will do this?" (preference type of expectation), and (b) "Do you think the therapist will actually do this?" (anticipation type of expectation). The preference rating involved a 4-point Likert scale of responses (1 = not at all to 4 = very). The anticipation rating involved a choice of "Yes", "No", or "Don't Know." The Parent Survey-I included by giving an example to help respondents differentiate between these two types of ratings. The example was selected by the author from previous measures that were similar to the Parent Survey-I.

Four items were included in the Parent Survey-I to assess general beliefs/opinions about children's mental health services and therapists in order to determine whether more negative beliefs were held by parents who either did not initiate or prematurely discontinued treatment. Parents were asked to respond, on a 4-point Likert scale of choices (agree strongly, agree somewhat, disagree somewhat, disagree strongly), to four items regarding their opinions:


b. Mental health treatment for children helps children cope better emotionally.

c. Child therapists need to have children of their own before they can really know how to help parents manage child behavioral and/or emotional problems.

d. Having my child and/or family involved in mental health treatment
makes me feel uncomfortable.

The development of the Parent Survey-I followed general guidelines for scale construction (Carmines & Zeller, 1979; DeVellis, 1991) to ensure adequate content validity. An item pool was generated based on previously developed measures of and literature about parental expectations for therapy. The items used by Friesen (1989) for her national survey of parents were used as the base set of questions. Some items were added to include content from other surveys and to incorporate parental reports from other sources, and other items were omitted due to their being unrelated to this sample. Finally items were added due to the author of the national survey noting that their omission from the original survey resulted in the loss of information identified later in discussions with parents as important (B.J. Friesen, personal communication, August 31, 1992). The items generated were reviewed by the research team of the larger research demonstration project for relevance to issues important to parents participating in children's mental health services. Items were revised for clarity and the resulting pool of 25 items was established.

Factor analyses were performed to support the relationship-based and concrete services item groupings proposed when the Parent Survey-I was developed. These factors were not evidenced by the analyses, nor were factors that presented sensible clusters of items. However, the analyses did suggest an alternative way of grouping and interpreting the items that was similar to that originally proposed, but had greater face validity and reliability. These groupings
were labelled consumer needs (14 items) and parent support/involvement (11 items) and used as scores for the Parent Survey, along with a total score (see Table 2). The internal consistencies of these scores, measured by Cronbach's alpha (α), were .86 for consumer needs, .81 for parent support/involvement, and .88 for the total score. When included in any of the scores, item 24 reduced the internal consistency; therefore it was omitted from all of the scores and analyses.

3. The Therapist Rating Scale-I (Williams, 1989; see Appendix E) was administered to assess parental expectations of therapist personality traits. It is a 23-item questionnaire which instructed the parents to rate each item in the following way: "How important is it to you that the therapist will have this trait?" The rating was on a 4-point Likert scale (1 = not at all to 4 = very).

The Therapist Rating Scale-I was adapted from the Therapist Rating Scale developed by Williams (1989) in a study of 33 subjects receiving treatment for agoraphobia. The Therapist Rating Scale-I was developed by selecting a subset of items from the "caring/involved" factor of Williams' (1989) measure. This factor displayed a high degree of internal consistency (α = .94), had a significant test-retest reliability (p < .0001), and included eight dimensions with three to four items in each dimension: warmth, respectfulness, interest, empathy, encouraging approach, tolerance, congruence, and being liked by the client. Due to the high degree of internal consistency for the items in each of the dimensions in the "caring/involved" factor, only three items from each of the eight dimensions were included in the current scale. The three items from each dimension were chosen
Table 2

Items In Parent Survey Scores

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Is supportive to you</td>
</tr>
<tr>
<td>3</td>
<td>Is supportive to your child</td>
</tr>
<tr>
<td>4</td>
<td>Provides an accurate evaluation of your child's problems</td>
</tr>
<tr>
<td>5</td>
<td>Works with other organizations</td>
</tr>
<tr>
<td>7</td>
<td>Provides information about available treatment methods for your child</td>
</tr>
<tr>
<td>8</td>
<td>Provides information about practical child-raising techniques</td>
</tr>
<tr>
<td>10</td>
<td>Includes you in making decisions about the treatment for your child</td>
</tr>
<tr>
<td>11</td>
<td>Follows up with you to see how things worked out</td>
</tr>
<tr>
<td>12</td>
<td>Is honest with you</td>
</tr>
<tr>
<td>13</td>
<td>Provides useful information about available resources</td>
</tr>
<tr>
<td>14</td>
<td>Values your opinions and knowledge about your child</td>
</tr>
<tr>
<td>16</td>
<td>Gives you information and materials about problems your child has</td>
</tr>
<tr>
<td>18</td>
<td>Provides counseling for your child</td>
</tr>
<tr>
<td>22</td>
<td>Keeps you informed about your child's progress in treatment</td>
</tr>
</tbody>
</table>

Consumer Needs Score

Parent Support/Involvement Score

<table>
<thead>
<tr>
<th>Item #</th>
<th>Item Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Helps you cope with raising your child</td>
</tr>
<tr>
<td>2</td>
<td>Is supportive to you</td>
</tr>
<tr>
<td>6</td>
<td>Treats you with respect</td>
</tr>
<tr>
<td>9</td>
<td>Is available to you on a 24-hour basis</td>
</tr>
<tr>
<td>15</td>
<td>Helps you get some relief from your childcaring responsibilities for a short time</td>
</tr>
<tr>
<td>17</td>
<td>Cares about how you feel and what you need as a parent</td>
</tr>
<tr>
<td>19</td>
<td>Provides individual counseling for you</td>
</tr>
<tr>
<td>20</td>
<td>Provides counseling for your family</td>
</tr>
<tr>
<td>21</td>
<td>Has you attend treatment sessions with your child</td>
</tr>
<tr>
<td>23</td>
<td>Tells you the things your child says during treatment</td>
</tr>
<tr>
<td>25</td>
<td>Gets your permission before releasing your child's records to anyone</td>
</tr>
</tbody>
</table>
by identifying those that appeared to be the most related in content. This pool of 24 items was reduced by 1 because it was identical to item 12 of the Parent Survey-1. This final set of 23 Therapist Rating Scale items and the 1 Parent Survey item displayed high internal consistency (α = .89).

4. The Child Behavior Checklist/4-18 (CBCL; Achenbach, 1991; see Appendix E) was used to measure the level of each child's behavior problems. This renormed version of the Child Behavior Checklist (Achenbach & Edelbrock, 1983) is a 113-item three-point Likert-type rating scale of child behavior from the perspective of the child's parent. Each behavior problem is rated on a three-point Likert scale (1 = "not true", 2 = "somewhat or somewhat true", 3 = "very or often true"). It was developmentally normed for children aged 4-18 years, and factored into nine clinical scales (withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior, aggressive behavior, and sex problems). However, only the total behavior problems, and the two broad categories of internalizing and externalizing behavior problems were of interest for this study.

The CBCL/4-18 was standardized on a sample of 4,220 clinically referred and nonreferred boys and girls aged four to 18 years, divided into two gender groups and seven age groups (4-5, 6-7, 8-9, 10-11, 12-13, 14-15, 16-18). Analyses revealed significant differences (p < .01) between referred and nonreferred children on all items except five.
**Follow-up Assessment.** The items listed below were included in the four-month follow-up assessment, which ranged from 30 to 90 minutes, depending upon the level of the child's involvement in mental health services (i.e., the more involvement, the more questions to answer).

1. A parent interview (see Appendix D) gathered the following data for this study:
   a. Changes in the family's population type, if applicable (item 7).
   b. Mental health services received since the initial assessment and the parent's satisfaction with those services (items 9-11, 13-15, 18-22).
   c. Parent comments about whether or not, in general, their expectations for the services were met or unmet (item 17).
   d. Barriers to treatment which were experienced, resulting in either not initiating treatment and/or ending treatment prematurely (items 9 and 18).

2. The CBCL was readministered to assess the child's current level of behavior problems perceived by the parent.

3. The Parent Survey-II (see Appendix E) was administered to assess parents' actual experiences in mental health services and to assess the preference type of expectations a second time. Parents were asked to respond to the same 25-items as in the Parent Survey-I in two ways: (a) "How important was it to you that the therapist did this?" (1 = not at all, 4 = very), and (b) "How often did the therapist actually do this?" (1 = not at all, 4 = a lot). The second method of inquiry was considered a measure of frequency for each item. To identify whether
or not the parents' expectation were unmet, discrepancy scores were calculated between the parents' importance ratings at the initial assessment and frequency ratings at the follow-up assessment, and between anticipation ratings at the initial assessment and the frequency ratings at the follow-up assessment. The discrepancy scores were summed to form the consumer needs and parent support/involvement subscores, as well as a total score which included all of the items in the two subscores. Discrepancy scores were interpreted in three ways: (a) met equated with preferred/anticipated and performed or not preferred/anticipated and not performed; (b) unmet equated with preferred/anticipated but not performed; and (c) exceeded equated with not preferred/anticipated but performed. Because other researchers have evaluated discrepancies between expectations and experiences (Farley, 1975; Leiman, 1977; Overall & Aronson, 1963) without isolating only unmet expectations, exceeded expectations were evaluated separately. However, unmet expectations were the primary focus of this study. For the parents who did not initiate treatment for their child, discrepancy scores could not be calculated. However, an analysis of the change in their initial to follow-up importance ratings was made and was considered relative to the change evidenced by the ratings of the continuers and dropouts.

Parents were also asked to respond to the same four opinion items and analyses were performed to identify any changes in opinions from initial to follow-up assessments and to highlight any group differences.
4. The Therapist Rating Scale-II (see Appendix E) was administered to assess parental perceptions of therapist personality characteristics. Parents were asked to respond to the same 23 items as in the Therapist Rating Scale-I, rating them in the following way: "How much does this describe the personality of your child's therapist since treatment began?" (1 = not at all, 4 = very much). This method of inquiry provided a measure of the degree to which each item characterized the therapist's perceived personality. Discrepancy scores between the parents' importance ratings from the initial assessment and the degree ratings from the follow-up assessment were calculated and summed across all items to result in a total unmet expectation score (including item 12 from the Parent Survey). Again, discrepancy scores were interpreted in three ways: (a) met equated with preferred and perceived or not preferred and not perceived; (b) unmet equated with preferred but not perceived; and (c) exceeded equated with not preferred but perceived. As with the Parent Survey, the exceeded expectations were analyzed separately yet the emphasis of this research was on unmet expectations. For parents who did not initiate child treatment, the Therapist Rating Scale-II was not given, therefore no discrepancy nor unmet expectation scores could be calculated.
CHAPTER III

Results

Of the total sample of 120 families, 18% did not initiate services. A dropout rate of only 16% (n=16) was evidenced in the group of 98 families who initiated children's mental health services.

Subjects within the Continuer, Dropout and Noninitiator groups could not be matched on any variables; however, analyses of variance (ANOVAs) and chi-square tests ($\chi^2$) performed to compare the three groups on demographics (child's age, gender, and race; respondent's relationship to the child, age, race, marital status, employment status, educational level; socioeconomic status, annual household income; miles to the mental health office), on child CBCL T scores at initial and follow-up assessments, and on parental satisfaction with past mental health services for the referred child, other children, and self, revealed no significant differences. The frequencies of these variables for each group are presented in Table 3.

Unmet Parental Expectations for Child Therapy

Unmet parental expectations for child therapy for the Continuer and Dropout groups were derived from discrepancy scores between individual pairs of items on the Parent Survey-I and Parent Survey-II questionnaires. A discrepancy score was calculated by subtracting the frequency or degree rating of an event
Table 3  

Child and Family Characteristics By Group

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Continuers</th>
<th>Dropout</th>
<th>Noninitiators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
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<tr>
<td>Child's Gender</td>
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<tr>
<td>Female</td>
<td>36</td>
<td>43.9</td>
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</tr>
<tr>
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<td>Child's Age</td>
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<td>4-7 Years</td>
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<tr>
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<td>13-18 Years</td>
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<tr>
<td>African American</td>
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Table 3 (cont.)

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<thead>
<tr>
<th>Characteristic</th>
<th>Continuers</th>
<th></th>
<th>Dropout</th>
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<th>Noninitiators</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
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<td>&lt; 7th Grade</td>
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<td>31.3</td>
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<td>High School Diploma</td>
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</tr>
<tr>
<td>V</td>
<td>21</td>
<td>25.6</td>
<td>4</td>
<td>25.0</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>VI</td>
<td>37</td>
<td>45.1</td>
<td>5</td>
<td>31.3</td>
<td>11</td>
<td>50.0</td>
</tr>
<tr>
<td>III</td>
<td>18</td>
<td>22.0</td>
<td>7</td>
<td>43.7</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>II</td>
<td>4</td>
<td>4.9</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>I</td>
<td>2</td>
<td>2.4</td>
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<td>0.0</td>
<td>0</td>
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<td>Household Income</td>
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<td></td>
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</tr>
<tr>
<td>&lt; $10,000</td>
<td>45</td>
<td>54.9</td>
<td>12</td>
<td>75.0</td>
<td>18</td>
<td>81.8</td>
</tr>
<tr>
<td>$10,000-$14,999</td>
<td>20</td>
<td>24.4</td>
<td>2</td>
<td>12.5</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>$15,000-$19,999</td>
<td>7</td>
<td>8.5</td>
<td>1</td>
<td>6.3</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>5</td>
<td>6.1</td>
<td>1</td>
<td>6.3</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>$35,000-$44,999</td>
<td>2</td>
<td>2.4</td>
<td>0</td>
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<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>$45,000-$54,999</td>
<td>2</td>
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<td>0</td>
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<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>≥ $55,000</td>
<td>1</td>
<td>1.2</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Distance to Mental Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 1 mile</td>
<td>10</td>
<td>13.0</td>
<td>5</td>
<td>31.3</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>2 - 5 miles</td>
<td>34</td>
<td>44.2</td>
<td>7</td>
<td>43.8</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>6 - 10 miles</td>
<td>19</td>
<td>24.7</td>
<td>3</td>
<td>18.8</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>11 - 20 miles</td>
<td>9</td>
<td>11.7</td>
<td>0</td>
<td>0.0</td>
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<td>33.3</td>
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<tr>
<td>≥ 21 miles</td>
<td>5</td>
<td>6.5</td>
<td>1</td>
<td>6.3</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Initial CBCL&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total T: Clinical</td>
<td>54</td>
<td>65.9</td>
<td>11</td>
<td>68.8</td>
<td>16</td>
<td>72.7</td>
</tr>
<tr>
<td>Internalizing T: Clinical</td>
<td>42</td>
<td>51.2</td>
<td>8</td>
<td>50.0</td>
<td>13</td>
<td>59.1</td>
</tr>
<tr>
<td>Externalizing T: Clinical</td>
<td>49</td>
<td>59.8</td>
<td>8</td>
<td>50.0</td>
<td>15</td>
<td>68.2</td>
</tr>
<tr>
<td>Follow-Up CBCL&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total T: Clinical</td>
<td>36</td>
<td>47.4</td>
<td>8</td>
<td>50.0</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Internalizing T: Clinical</td>
<td>30</td>
<td>37.5</td>
<td>6</td>
<td>37.5</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>Externalizing T: Clinical</td>
<td>38</td>
<td>50.0</td>
<td>6</td>
<td>37.5</td>
<td>9</td>
<td>40.9</td>
</tr>
</tbody>
</table>
Table 3 (cont.)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Continuers</th>
<th></th>
<th>Dropouts</th>
<th></th>
<th>Noninitiators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Parental Satisfaction with Past MHS(^b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred Child(^c)</td>
<td>44</td>
<td>74.6</td>
<td>9</td>
<td>75.0</td>
<td>11</td>
<td>100.0</td>
</tr>
<tr>
<td>Other Child(ren)(^d)</td>
<td>19</td>
<td>65.5</td>
<td>8</td>
<td>88.9</td>
<td>6</td>
<td>85.7</td>
</tr>
<tr>
<td>Self(^e)</td>
<td>42</td>
<td>80.7</td>
<td>6</td>
<td>60.0</td>
<td>7</td>
<td>70.0</td>
</tr>
</tbody>
</table>

**Note**: MHS= Mental Health Services  
\(^a\)Frequencies listed include only those children for each group who fell in the clinical range (T \(\geq 64\)) for Total, Internalizing and Externalizing Behavior Problems.  
\(^b\)Frequencies listed include only those parents in each group who selected the two most favorable ratings of the 5-point Likert scale (1=all good; 2=mostly good, some bad).  
\(^c\)n=59 Continuers, n=12 Dropouts, n=11 Noninitiators.  
\(^d\)n=29 Continuers, n=9 Dropouts, n=7 Noninitiators.  
\(^e\)n=52 Continuers, n=10 Dropouts, n=10 Noninitiators.

from the expectation for that event.

When calculating unmet anticipation expectations, the Parent Survey-I scale format of Yes-No-Don't Know for expectations and the Parent Survey-II 4-point Likert scale (1=not at all, 4=very) for the frequencies were not comparable; therefore the data were converted before calculating discrepancy scores. The frequency item responses were converted into a Yes-No format by recoding scores of 1 (not at all) to No and scores of 2, 3 and 4 (varying degrees of frequency) to Yes, and were be interpreted as an event having occurred or not.

The possible discrepancy scores for unmet preference expectations are presented in Figure 1 and for unmet anticipation expectations in Figure 2.

Discrepancy scores reflect the unmet and exceeded expectations described in the previous chapter. Recoding of the discrepancy scores was required in order to analyze the two kinds separately. For the preference type, the unmet expectations were isolated by recoding all of the discrepancy scores reflecting
<table>
<thead>
<tr>
<th>Event Frequency</th>
<th>Not At All</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Very 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not At All</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Very 4</td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Discrepancy scores for the Parent Survey unmet preference expectations. (Interpretation of discrepancy scores: 0 = met expectation; 1, 2, 3 = unmet expectation, -1, -2, -3 = exceeded expectation.)

<table>
<thead>
<tr>
<th>Event Occurred</th>
<th>Don't Know</th>
<th>No 1</th>
<th>Yes 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No 1</td>
<td>-2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Yes 2</td>
<td>-3</td>
<td>-1</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 2. Discrepancy scores for the Parent Survey unmet anticipation expectations. (Interpretation of discrepancy scores: 0 = met expectation; 1 = unmet expectation; -1 = exceeded expectation; -2, -3 = no initial expectation.)
exceeded expectations (the negative values in Figure 1) to 0. For the anticipation type, the exceeded expectation discrepancy scores (-1 in Figure 2) were also recoded to 0, and the no expectation discrepancy scores resulting from a Don't Know response on the Parent Survey-I (-2 and -3 in Figure 2) were recoded to 0 as well. The remaining unmet expectation discrepancy scores were then summed across the items to provide the three unmet expectation scores for the Parent Survey (total, consumer needs, and parent support/involvement) with higher scores indicating a higher level of unmet expectations.

To isolate the exceeded expectations for the preference items, the unmet expectation discrepancy scores were recoded to 0 and the absolute value of the exceeded expectation discrepancy scores was taken. For the anticipation items, the unmet expectation discrepancy scores were also recoded to 0, as were the no expectation discrepancy scores, then the absolute value of the exceeded expectation discrepancy scores were taken. The remaining discrepancy scores were then summed to form the three scale scores, with higher scores denoting higher levels of exceeded expectations.

Individual t-tests were first performed on the unmet expectation total, consumer needs and parent support/involvement scores to identify any differences in the two group means. Due to disparate sample sizes (n=16 for Dropouts, n=82 for Continuers), Levene's test for equality of variances was used for all t-tests and the appropriate t-value and significance levels are reported. The results of these t-tests are presented in Table 4. The analyses revealed that the Continuer and Dropout groups differed significantly on unmet preference expectations for the
Table 4
Unmet Parental Expectations for Child Therapy Events

<table>
<thead>
<tr>
<th>Score</th>
<th>Continuers</th>
<th></th>
<th>Dropouts</th>
<th></th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferencea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19.59</td>
<td>15.17</td>
<td>31.56</td>
<td>17.32</td>
<td>2.82</td>
<td>.006**</td>
</tr>
<tr>
<td>Consumer Needs</td>
<td>11.07</td>
<td>9.94</td>
<td>18.63</td>
<td>10.03</td>
<td>2.78</td>
<td>.007**</td>
</tr>
<tr>
<td>Parent Support/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>9.09</td>
<td>6.88</td>
<td>13.94</td>
<td>8.99</td>
<td>2.05e</td>
<td>.055</td>
</tr>
<tr>
<td>Anticipationb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.18</td>
<td>3.16</td>
<td>5.31</td>
<td>5.58</td>
<td>2.18e</td>
<td>.044*</td>
</tr>
<tr>
<td>Consumer Needs</td>
<td>1.26</td>
<td>2.20</td>
<td>3.00</td>
<td>3.35</td>
<td>2.64</td>
<td>.010**</td>
</tr>
<tr>
<td>Parent Support/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>1.00</td>
<td>1.41</td>
<td>2.50</td>
<td>2.97</td>
<td>1.98e</td>
<td>.065</td>
</tr>
</tbody>
</table>

aPossible scores ranged from 0 to 72. bPossible scores ranged from 0 to 24.
Levene's test for equality of variances was significant at the p<.05 level; therefore the t and p values presented are for unequal variances.
*p<.05. **p<.01.
total ($p<.01$) and consumer needs ($p<.01$) scores, and on unmet anticipation expectations for the total ($p<.05$) and consumer needs ($p<.01$) scores. The parent support/involvement scores were not significant for either the preference or anticipation types of unmet expectations. These results indicate that parents in this sample who dropped out of child treatment had significantly higher levels of total unmet preference and anticipation expectations than parents who continued in child therapy beyond the follow-up assessment point, supporting the first hypothesis (1a). When considering the consumer needs and parent support/involvement unmet expectations, the consumer needs type was significantly higher for the Dropouts, but the parent support/involvement type was not.

Individual t-tests were also performed on the three Parent Survey summary scores to compare the groups on exceeded expectations (see Table 5). The Continuers reported significantly higher levels of exceeded preference expectations on the total score ($p<.05$) and of exceeded anticipation expectations on the consumer needs score ($p<.05$). These results suggest that parents who continue in child treatment are experiencing more than they expected of the preference type overall (total score) and more than they anticipated specifically regarding their consumer needs. [Unmet expectations will be the focus of the remaining presentation of results unless exceeded expectations are explicitly identified.]

To directly analyze the difference between unmet expectations of the preference and anticipation types for the Dropout group, scores were first
Table 5

Exceeded Parental Expectations for Child Therapy Events

<table>
<thead>
<tr>
<th>Score</th>
<th>Continuers</th>
<th></th>
<th></th>
<th>Dropouts</th>
<th></th>
<th></th>
<th></th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preference</strong>^a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.70</td>
<td>3.83</td>
<td>1.38</td>
<td>1.63</td>
<td>2.25^c</td>
<td>.029*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Needs</td>
<td>1.12</td>
<td>2.31</td>
<td>.38</td>
<td>.72</td>
<td>1.28</td>
<td>.204</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Support/</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>1.72</td>
<td>2.24</td>
<td>2.24</td>
<td>1.41</td>
<td>1.02</td>
<td>.581</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anticipation</strong>^b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>.99</td>
<td>1.94</td>
<td>.38</td>
<td>.62</td>
<td>1.25</td>
<td>.216</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumer Needs</td>
<td>.38</td>
<td>1.07</td>
<td>.06</td>
<td>.25</td>
<td>2.36^c</td>
<td>.021*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Support/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>.63</td>
<td>1.14</td>
<td>.31</td>
<td>.48</td>
<td>1.11</td>
<td>.271</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

^aPossible scores ranged from 0 to 72. ^bPossible scores ranged from 0 to 24.
^cLevene's test for equality of variances was significant at the p<.05 level; therefore the t and p values presented are for unequal variances.
*p<.05.
standardized to make the two different measurement scales comparable. (The different scales for the two types of unmet expectation scores are presented in Figures 1 and 2, p. 53). Paired t-tests revealed no significant differences between the preference and anticipation types of unmet expectations across all three scores (total, consumer needs, parent support/involvement). The hypothesis (1b) that parents who dropped out of child treatment would have significantly higher levels of unmet preference expectations relative to unmet anticipation expectations was not supported.

The results of paired t-tests comparing the parent support/involvement and consumer needs types of unmet expectations for Dropouts are presented in Table 6. A significant difference was revealed for unmet preference expectations ($p<.05$), but not for unmet anticipation expectations, with parents who dropped out of child treatment experiencing higher levels of unmet consumer needs expectations. The hypothesis (1c) that the unmet parent support/involvement expectations would be significantly higher for parents who dropped out of treatment was not supported. The opposite finding, a significantly higher level of unmet consumer needs expectations was revealed, yet for only the preference type of unmet expectations.

**Unmet Parental Expectations for Therapist Characteristics**

The total score for unmet and exceeded expectations for therapist characteristics were derived from the discrepancy scores based on the paired responses to the Therapist Rating Scale-I and Therapist Rating Scale-II in the same manner as the total score for unmet preference expectations for the Parent Survey
Table 6

Unmet Consumer Needs versus Parent Support/Involvement Expectations for Dropouts

<table>
<thead>
<tr>
<th>Score</th>
<th>Consumer Needs</th>
<th>Parent Support/ Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Preference</td>
<td>18.63</td>
<td>10.03</td>
</tr>
<tr>
<td>Anticipation</td>
<td>3.00</td>
<td>3.35</td>
</tr>
</tbody>
</table>

**p<.01.

described above and depicted in Figure 1. No subscale scores were computed for the Therapist Rating Scale. The results of the t-tests comparing the unmet and exceeded expectations for therapist characteristics of the Continuers and Dropouts are presented in Table 7. This analysis revealed support for the hypothesis that parents who dropped out of child treatment would experience significantly higher levels of unmet expectations for therapist characteristics ($p<.05$). However, the Continuers did not experience a significantly higher level of exceeded expectations for therapist characteristics as they did for therapy events.

All of the items of the Therapist Rating Scale were derived from the "caring and involved" cluster of the questionnaire developed by Williams (1989).
Table 7

Unmet and Exceeded Parental Expectations for Therapist Characteristics

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Continuers</th>
<th></th>
<th>Dropouts</th>
<th></th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmet</td>
<td>8.44</td>
<td>12.46</td>
<td>17.44</td>
<td>15.78</td>
<td>2.53</td>
<td>.013*</td>
</tr>
<tr>
<td>Exceeded</td>
<td>6.57</td>
<td>5.95</td>
<td>5.44</td>
<td>6.00</td>
<td>.70</td>
<td>.487</td>
</tr>
</tbody>
</table>

*Note. Possible scores ranged from 0 to 72.

A t-test revealed that the parents who dropped out of child therapy perceived the therapist as significantly less caring and involved (M = 68.8, SD = 19.53) than the parents who continued in treatment beyond the follow-up assessment (M = 82.5, SD = 15.34), t(96) = 3.12, p < .01, supporting the hypothesized effect.

Comparison of Unmet Parental Expectations for Therapy Events and Therapist Characteristics

In order to compare the relative impact of unmet parental expectations for therapy events and therapist characteristics on dropout, a logistic regression was performed. The goal of this analysis is to find the best fitting model to describe
the relationship between a set of independent variables (unmet expectations) and
an outcome or event (a parent will drop out of treatment) represented by a
dichotomous dependent variable (Hosmer & Lemeshow, 1989). Additionally, the
functional relationship between the dependent variable and each independent
variable can be interpreted (Hosmer & Lemeshow, 1989). The independent
variables included in this logistic regression were the total unmet preference,
anticipation and therapist characteristic expectation scores. It is important to note
that these three scores were all highly and significantly correlated ($p<.001$);
therefore, the interpretation of the importance of each of the independent variables
was more complicated (Tabachnick & Fidell, 1989).

Using variable selection which forces all of the independent variables into
the model at once, the resulting model chi square was significant, $\chi^2(3,98) = 9.48,$
$p<.05$. This indicated that the logistic coefficients for the unmet expectation
variables (the independent variables) included in the model were significantly
different from zero (Norusis, 1992). Therefore, knowing the level of the unmet
expectation scores significantly increased the likelihood of correctly predicting
that a parent will drop out of child treatment. However, the analysis also revealed
that the individual independent variables were not significant, indicating that they
did not add any unique contribution to the prediction, beyond their shared
contribution. This did not provide support for the hypothesis (3) that unmet
expectations for treatment have a greater impact on a parent's tendency to dropout
than unmet expectations for therapist characteristics.
Expectations of Parents Who Never Initiate Treatment

The initial expectations for both therapy events and therapist characteristics for parents who never initiated child treatment were compared to those for all parents who did initiate treatment, regardless of their status at the follow-up assessment. T-tests revealed no significant differences between Noninitiators and Continuers/Dropouts for any of the expectation scores. T-tests were also performed comparing the Continuers and Dropouts, as well as the Continuers and Dropouts/Noninitiators on initial expectations. All were nonsignificant.

Paired t-tests between the initial and follow-up importance ratings were also performed. There were no significant differences for the total, consumer needs or parent support/involvement scores for any of the groups. This suggests that the Noninitiators did not differ from the parents who initiated treatment (Continuers/Dropouts) regarding the consistency of their expectations for therapy events.

The Impact of Rurality

To evaluate whether the level of family rurality had a significant impact on the effects of unmet parental expectations, another logistic regression analysis was performed adding the population type variable (see Appendix F for the calculation of population type scores). Since some of the population type data was collected at the follow-up assessment, five cases from the Continuer group were omitted from this analysis because the families moved to a qualitatively different area (i.e., not within the same town or city) before the follow-up assessment. The variable selection method forcing all independent variables in at once resulted in a
nonsignificant model chi-square, \( \chi^2(4,93) = 9.11, p=0.058 \), indicating that adding the population type variable reduced the likelihood of predicting group membership. Therefore the hypothesis that the impact of unmet parental expectations on treatment dropout would be greater for rural than for urban families was not supported.

Although the data did not support the impact of rurality, the variables hypothesized to be associated with rurality were examined. These variables were (a) greater perceived negative stigmatization being associated with mental health services measured at both assessment points, (b) greater distance from services, (c) lower level of parent education, and (d) lower family income. First, correlations between the population type score and the four rurality variables were computed (see Table 8). Only two of the correlations were significant: between miles to the mental health office and the population type score \( (r=0.55, p<0.001) \) and between initial and follow-up negative stigmatization \( (r=0.32, p<0.001) \). The former significant correlation is understandable because miles to the mental health office is one of the variables used to calculate the population type score. The latter significant correlation was used to support the inclusion of only one of the stigmatization ratings (the data from the initial assessment was included) in the following analyses.

To evaluate the proportion of the variance in population type accounted for by these four variables (negative stigmatization, distance from services, parental education, and family income), a multiple regression analysis was performed. The resulting model accounted for 32% of the variance in population type \( (R^2=0.32, \)
Table 8

Correlations Among Population Type Score and Other Rurality Variables

<table>
<thead>
<tr>
<th></th>
<th>Initial Stigma</th>
<th>Follow-Up Stigma</th>
<th>Parent's Education</th>
<th>Family Income</th>
<th>Miles to MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potype</td>
<td>-.09</td>
<td>.08</td>
<td>.08</td>
<td>-.13</td>
<td>.55***</td>
</tr>
<tr>
<td>Initial Stigma</td>
<td></td>
<td>.32***</td>
<td>.02</td>
<td>.14</td>
<td>.01</td>
</tr>
<tr>
<td>Follow-Up Stigma</td>
<td></td>
<td>.04</td>
<td>.09</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td>Parent's Education</td>
<td></td>
<td></td>
<td>.01</td>
<td></td>
<td>.11</td>
</tr>
<tr>
<td>Family Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.07</td>
</tr>
</tbody>
</table>

Note: *N = 115. MH = Mental Health. Potype = Population Type.

*Item on Parent Survey-I and -II: Having my child and/or family involved with mental health services makes me feel uncomfortable.

***p<.001

*p<.0001). However, because the miles to the mental health was the only variable highly correlated with population type, the partial regression coefficients were examined. The t-tests for the coefficients were nonsignificant for all variables except miles to the mental health office (t=6.81, p<.0001). A further test of this was made by performing another multiple regression analysis including only the three variables other than miles to the mental health office. The model resulting from this latter analysis, which excluded distance to services, accounted for only 3% of the variance (R²=.03, p=.35). These results contradict the hypothesis that
negative stigmatization, lower parental education level and lower family income are associated with rurality for this sample of families and using this method of defining population type.

Additional Variables Related to Treatment Dropout

The four opinion questions included in the Parent Survey (initial and follow-up) were analyzed for differences among the three groups. The item statistics for each group are presented in Table 9. ANOVAs revealed no significant differences among the groups for the initial assessment responses to these items, although the follow-up ratings did reveal some significant group differences. The ANOVA for the opinion that treatment helps children cope better emotionally was significant ($F=3.29$, $p<.05$); however, post hoc analyses did not reveal any significant differences between group pairs. The only other significant difference found was for the negative stigmatization item ($F=4.02$, $p<.05$). The post hoc analyses revealed a significant difference between the Continuers and Noninitiators ($p<.05$), with the Noninitiators reporting greater feelings of discomfort being associated with mental health services than the Continuers.

The parents who either continued in or dropped out of treatment were asked in the follow-up interview whether they received the services they expected. A chi square test for the two groups was not significant, with 78% of the Continuers and 69% of the Dropouts reporting that they received the services expected.

During the initial interview, parents reported the expected duration of treatment for the referred children. An ANOVA comparing the three treatment status groups (Continuers, Dropouts, and Noninitiators) was not significant,
Table 9

Parent Survey Opinion Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Continuers</th>
<th></th>
<th>Dropouts</th>
<th></th>
<th>Noninitiators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Parent Survey - I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Reduces Child Behavior Problems</td>
<td>1.70</td>
<td>.77</td>
<td>1.50</td>
<td>.52</td>
<td>1.68</td>
<td>.57</td>
</tr>
<tr>
<td>Treatment Helps Children Cope Emotionally</td>
<td>1.35</td>
<td>.64</td>
<td>1.38</td>
<td>.50</td>
<td>1.59</td>
<td>.50</td>
</tr>
<tr>
<td>Child Therapists Need Their Own Children to Help Other Parents</td>
<td>2.50</td>
<td>1.07</td>
<td>2.25</td>
<td>.86</td>
<td>2.50</td>
<td>1.14</td>
</tr>
<tr>
<td>Uncomfortable Having Child In Mental Health Services</td>
<td>3.48</td>
<td>.80</td>
<td>3.31</td>
<td>1.01</td>
<td>3.18</td>
<td>1.01</td>
</tr>
<tr>
<td>Parent Survey - II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Reduces Child Behavior Problems</td>
<td>1.67</td>
<td>.79</td>
<td>1.56</td>
<td>.81</td>
<td>1.81</td>
<td>.66</td>
</tr>
<tr>
<td>Treatment Helps Children Cope Emotionally</td>
<td>1.35</td>
<td>.62</td>
<td>1.75</td>
<td>.93</td>
<td>1.64</td>
<td>.78*</td>
</tr>
<tr>
<td>Child Therapists Need Their Own Children to Help Other Parents</td>
<td>2.27</td>
<td>1.05</td>
<td>2.00</td>
<td>.97</td>
<td>2.59</td>
<td>1.05</td>
</tr>
<tr>
<td>Uncomfortable Having Child In Mental Health Services</td>
<td>3.49</td>
<td>.76</td>
<td>3.63</td>
<td>.62</td>
<td>3.00</td>
<td>.98*</td>
</tr>
</tbody>
</table>

Note: Likert scale for all items: 1 = Agree Strongly, 2 = Agree Somewhat, 3 = Disagree Somewhat, 4 = Disagree Strongly.
* p < .05
indicating that the expected duration of treatment was similar for the parents in the three treatment status groups. A t-test was performed to compare the Noninitiators to those parents who initiated treatment (Continuers and Dropouts). This analysis was also nonsignificant. Of descriptive interest, however, is the range of expected duration for child treatment reported by the parents in the entire sample (see Table 10). Only one-third of this sample expected treatment to be brief, using the criterion of 12 sessions or less (3 months for weekly appointments, 6 months for bimonthly appointments) cited in previous studies (e.g., Budman & Gurman, 1988; Gelso & Johnson, 1983; Pekarik, 1991). To the contrary, 36% of this parent sample expected the child to be in treatment for 7 to 12 months and 32% expected treatment to take 1½ years or more. Of those latter parents, 6% expected the referred child to be in treatment for the rest of his/her life.

Table 10

Frequencies for Expected Duration of Treatment

<table>
<thead>
<tr>
<th>Expected Duration</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months or less</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>7 to 12 months</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>1½ to 2 years</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Forever</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

NOTE: n = 110 (10 parents responded "Don't Know").
Also during the initial interview, the parents were asked to identify which of a set of barriers they expected to potentially interfere with their ability to initiate and/or continue child treatment. The frequencies for these barriers are presented in Table 11. Chi square analyses were not significant when comparing Continuers and Dropouts. However, chi-square analyses were significant for the Noninitiators and the Continuers/Dropouts for the barriers of too far to travel, \( \chi^2(1,120)=5.85, p<.05 \), and uncomfortable being associated with mental health services, \( \chi^2(1,120)=4.53, p<.05 \). The latter barrier is associated with the acceptability barrier identified by other researchers. The significant finding supports the dependent relationship between this barrier and the parent's treatment status, with a greater proportion of Noninitiators reporting that they expected feeling uncomfortable to be a barrier. The former barrier (too far to travel), along with transportation problems and confused about the next step in the process, are related to the accessibility barrier identified earlier. The analyses revealed that a dependent relationship exists only between treatment status and the barrier too far to travel, with a larger proportion of Noninitiators expecting travel distance to interfere with child treatment initiation.

Actual barriers experienced by those parents who never initiated treatment are presented in Table 12 and for those who dropped out of treatment in Table 13. [Barriers not endorsed by the parents in a group were not listed in that group's Table.] Although no tests of significance could be applied to these data, the frequencies can be reviewed. The most frequently reported barriers for the Noninitiators were time conflict and being confused about the next step in the
Table 11

Percentage of Respondents in Each Group Endorsing Expected Barriers to Mental Health Services

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Continuers</th>
<th></th>
<th>Dropout</th>
<th></th>
<th>Noninitiators</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Transportation Problems</td>
<td>25</td>
<td>30.5</td>
<td>3</td>
<td>18.8</td>
<td>9</td>
<td>40.9</td>
</tr>
<tr>
<td>Child Care Problems</td>
<td>24</td>
<td>29.3</td>
<td>5</td>
<td>31.3</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>Too Far to Travel</td>
<td>14</td>
<td>17.1</td>
<td>0</td>
<td>0.0</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Time Conflict</td>
<td>49</td>
<td>59.8</td>
<td>8</td>
<td>50.0</td>
<td>10</td>
<td>45.5</td>
</tr>
<tr>
<td>Child Refuse Treatment</td>
<td>17</td>
<td>20.7</td>
<td>4</td>
<td>25.0</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Confused About Next Step</td>
<td>24</td>
<td>29.3</td>
<td>3</td>
<td>18.8</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Disruptive to Family Routine</td>
<td>15</td>
<td>18.3</td>
<td>4</td>
<td>25.0</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Decide Child Doesn't Need Mental Health Services</td>
<td>15</td>
<td>18.3</td>
<td>1</td>
<td>6.3</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Believe MHS Not Helping</td>
<td>30</td>
<td>36.6</td>
<td>3</td>
<td>18.8</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Uncomfortable Being Associated with MHS</td>
<td>9</td>
<td>11.0</td>
<td>1</td>
<td>6.3</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>Disagree with Diagnosis or Treatment Approach</td>
<td>25</td>
<td>30.5</td>
<td>3</td>
<td>18.8</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Not Liking Therapist or Program</td>
<td>28</td>
<td>34.1</td>
<td>4</td>
<td>25.0</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>15.9</td>
<td>2</td>
<td>12.5</td>
<td>5</td>
<td>22.7</td>
</tr>
</tbody>
</table>

Note: Multiple barriers could be endorsed by each parent. MHS = Mental Health Services.
children's mental health services process. Time conflict and not believing the mental health services were helping were the most frequently reported barriers for the Dropouts. Although being confused about the next step in the process, an accessibility barrier, supports previous research, the other accessibility-related barriers (e.g., travel distance, transportation problems) were only partially influential for the Noninitiators. Few Dropout parents reported that the accessibility barriers interfered with their ability to participate in treatment. Time conflict was the most influential family barrier relative to child care problems and mental health services being disruptive to the regular family routine for both groups; however, these latter two barriers were instrumental for approximately one-third of the Noninitiators. Acceptability (i.e., discomfort being associated with mental health services) measured by this interview question did not appear to be influential for a large proportion of the Noninitiators (18%) nor for any of the Dropout families.
Table 12

Barriers Experienced by Noninitiators

<table>
<thead>
<tr>
<th>Barrier</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Conflict</td>
<td>11</td>
<td>50.0</td>
</tr>
<tr>
<td>Confused About Next Step</td>
<td>11</td>
<td>50.0</td>
</tr>
<tr>
<td>Disruptive to Family Routine</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Child Care Problems</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>Child Didn't Need MHS</td>
<td>6</td>
<td>27.3</td>
</tr>
<tr>
<td>Didn't Think MHS Would Help</td>
<td>5</td>
<td>22.7</td>
</tr>
<tr>
<td>Too Far To Travel</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Discomfort Being Associated with MHS</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Problems Connecting with MHS Agency</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Transportation Problems</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Child Refused Treatment</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Didn't Think MHS Would Meet Cultural Needs</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>Thought MHS Would Conflict with Religious Beliefs</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Didn't Think MHS Provider Would Speak Language</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Family Member Illness</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>Could Not Afforda</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Parent Forgot Appointment</td>
<td>1</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Note: Multiple barriers could be endorsed by each parent. MHS = Mental Health Services.

aThis family lost their eligibility for the child's medical card.
Table 13

Barriers Experienced by Dropouts

<table>
<thead>
<tr>
<th>Barrier</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Conflict</td>
<td>6</td>
<td>37.5</td>
</tr>
<tr>
<td>Didn't Think MHS Were Helping</td>
<td>4</td>
<td>25.0</td>
</tr>
<tr>
<td>Child Refused Treatment</td>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>Problems Connecting with MHS Agency</td>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>Child Doing Better</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Disliked Therapist or Program</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Uncomfortable with Therapist’s Gender</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Moved without Re-initiating MHS</td>
<td>2</td>
<td>12.5</td>
</tr>
<tr>
<td>Confused About Next Step</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Transportation Problems</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>MHS Were Not Meeting Cultural Needs</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Too Far To Travel</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Disruptive to Family Routine</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Family Member Illness</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>Could Not Afford*</td>
<td>1</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Note: Multiple barriers could be endorsed by each parent. MHS = Mental Health Services.

*This family lost their eligibility for the child’s medical card.
CHAPTER IV

Discussion

The primary goal of this study was to evaluate the effects of unmet parental expectations for child therapy and therapist characteristics on treatment continuance for low income families living in urban to rural areas. The results generally support the negative influence of unmet parental expectations on continuance in child therapy. Specifically, unmet preference and anticipation expectations for therapy events were significantly greater for the parents who dropped out of treatment when such unmet expectations concerned consumer needs but not when they concerned parent support/involvement. When directly compared with each other, the impact of unmet expectations for consumer needs was significantly greater than unmet expectations for parent support/involvement using the preference type of definition. Specifically, the findings suggest that once a parent initiates treatment for a child, it would be helpful for the therapist to discuss a parent's consumer-oriented expectations with her/him in order to identify potential shortcomings of the services available relative to the parent's expectations. This reminds us that therapy is a service, and like other services, consumers can be dissatisfied and seek out alternative approaches to a problem. Therapists must re-evaluate interpretations of treatment discontinuance as a problem in the client/parent (e.g., resistance, cognitive dissonance) and consider
that unmet consumer expectations may also be at work when a parent decides to end treatment prematurely.

At the outset of treatment, time taken to evaluate a parent's expectations could prove to be valuable by (a) increasing the therapist's understanding of the parent's consumer needs, (b) better preparing the parent for what to expect if she/he has unrealistic or inaccurate expectations about mental health services, (c) providing the parent with an opportunity to feel empowered by the therapist's interest in their needs, and (d) creating a collaborative relationship between the parent and therapist on behalf of the child. The additional finding that parents whose experiences exceeded their expectations (total score for preference expectations, consumer needs score for anticipation expectations) were significantly more likely to continue in child treatment further emphasizes the impact of attending to the parent's expectations.

Unmet expectations for therapist characteristics also negatively impacted treatment continuance for parents, with those who dropped out perceiving the therapist as significantly less caring and involved. Unfortunately, this factor may be more difficult to address for a therapist because it requires the therapist to inquire about her/his personality traits and may raise self-esteem issues. However, the results of this study also suggest that keeping a parent in child therapy until it is complete may be more likely if the parent's perception of the therapist's characteristics is discussed. This discussion could lead to clarification of misunderstandings, an adjustment in the therapist's style to better match the needs of the parent, education of the parent regarding realistic expectations, or a mutual
decision that personality differences cannot be reconciled.

The finding that unmet parental expectations for child therapy do not have a greater impact on treatment dropout than do unmet expectations for therapist characteristics indicates that they work together to influence a parent's decision to end treatment. This is not surprising because of the interaction between the mental health services provided and the provider of those services. These two variables are potentially impossible to separate because the therapist's personality and style will influence the recipient of the services as they are being provided. Therefore, these variables (services and therapist) should be addressed together by the therapist.

The fruitfulness of differentially defining expectations as preference and anticipation types described by Duckro et al. (1979) was not supported by this study. In most cases, the unmet parental expectations for therapy did not differ when comparing those measured using the preference versus the anticipation definitions. Additionally, both resulted in significant differences between the groups for the consumer needs cluster of items. This suggests that the sample of parents in this study either did not differentiate between the two interpretations of expectations or they did differentiate between them but it did not alter their pattern of response.

This study, unlike the majority of previous studies (e.g., Balch, 1973; Bonner & Everett, 1982; Munger, 1988; Sung, 1989), sought to identify the impact of unmet expectations rather than merely comparing initial expectations of parents. To do this, actual experiences in treatment had to be measured, thereby omitting
parents who never initiated treatment from the analyses. Dividing parents/clients into Continuer, Dropout and Noninitiator groups has not been included in previous studies. The analyses comparing the parents in the Noninitiator group to the Continuers and Dropouts (i.e., initiators) did not reveal differences in expectations for therapy events or therapist characteristics.

These results suggest that researchers who analyzed only initial expectations (Apfelbaum, 1958; Burck, 1978; Day & Reznikoff, 1980b; Heine & Trosman, 1960; Horenstein, 1975; Weiss & Dlugokinski, 1974) may have insufficiently answered the question of the impact of expectations on treatment dropout by ignoring whether or not the expectations were met. Notably, this study did not support previous findings that initial expectations alone differentiate between those parents who continue in child treatment from those who dropout (Day & Reznikoff, 1980b; Heine & Trosman, 1960). The different finding could be due to the groups in this study being similar on a number of characteristics and being composed of primarily welfare families. These families are likely to share common experiences within service systems, thereby creating generally similar expectations. Once services were initiated, the difference between those who remained and those who dropped out was more affected by the discrepancy between the expectations and the experiences with services and therapists.

The level of family rurality did not significantly influence the effects of unmet parental expectations concerning either treatment services provided or therapist characteristics. The evidence suggests that families who live in rural areas are not more likely to be influenced by unmet expectations than those who
live in urban areas. Rather, unmet expectations influence a parent's decision to prematurely end child treatment regardless of the degree of family rurality, and dropping out of treatment appears to be more influenced by the quality of services than a characteristic of the population.

For the most part, results of the Parent Survey opinion items analyses did not reveal significant differences between the three treatment status groups. During the initial assessment, parents generally reported believing that mental health treatment reduces behavior problems and helps children cope emotionally, child therapists may not need children of their own in order to help parents, and being associated with mental health services did not make them feel uncomfortable. However, results from the follow-up data revealed that the groups differed in their opinion about treatment helping children cope, with Dropouts in least agreement with this issue of helping. Additionally, the Noninitiators reported feeling significantly more uncomfortable being associated with mental health services than the Continuers. These findings suggest that (a) the parents who dropped out of treatment may have been influenced by their opinions about the effectiveness of treatment, and (b) the parents who did not initiate treatment may have been influenced by their feelings of discomfort being associated with mental health services. These conclusions should be considered in light of the finding that none of the groups reported significantly different opinions from the initial to follow-up assessments.

Interestingly, when asked the general question of whether their expectations were met by the mental health services they received, the majority of both the
Continuer and Dropout group parents reported having their expectations met, with a nonsignificant difference between the two groups. This question was most likely too general to address this issue, suggesting that, although tempting, one question may insufficiently capture the detail of the questionnaires employed to measure unmet parental expectations for child therapy.

Going beyond unmet parental expectations to further understand the reasons for a parent to end treatment prematurely, the barriers to treatment described by previous researchers were evaluated. It was revealed that Dropouts and Continuers did not differ on the barriers that they expected to interfere with treatment continuance; however, Noninitiators did report slightly different expectations than those parents who initiated treatment. A greater proportion of Noninitiators expected long travel distance and discomfort being associated with mental health services to interfere with their ability to initiate or continue in treatment. The travel distance barrier has been supported in previous research, but the other barriers in the list presented to these parents addressing accessibility, availability and compatibility were not more frequently endorsed by Noninitiators. The finding that expected barriers to services did not differentiate between the Dropouts and Continuers, and for the most part, the Noninitiators, is further support for researchers in this area to go beyond initial expectations to understand treatment initiation and continuance.

The findings regarding the barriers actually experienced by the Noninitiators and Dropouts only partially corroborated previous research addressing accessibility and family barriers as they relate to treatment initiation
and continuance. The accessibility barriers experienced by both groups in this study included being confused about the next step in the children's mental health services process, experiencing difficulty connecting with the mental health agency, and being too far to travel. The family barriers included time conflict, child care problems, and being disruptive to the regular family routine. Although simply descriptive, these findings suggest that many factors may be influencing a parent's decision to never initiate or to discontinue child treatment before it is completed.

The results of this study must be considered in light of some limitations. First, the sample sizes for the Dropout and Noninitiator groups were low and may have reduced the power of the statistical analyses. Although this was problematic for this study, it meant that many children received the mental health services for which they were referred.

Second, the questionnaires used to measure expectations for child therapy and therapist characteristics were newly developed. Feedback from this sample of parents and further review by experts in this field can be used to improve the questionnaires. Additional research to increase their reliability and validity is required.

And third, the method used to measure rurality was untested. Nonsignificant correlations between three of the variables previously associated with rurality (negative stigmatization, low parent education, and low family income) and the population type score used here suggest that the criteria chosen may not have accurately captured the rurality construct. However, an alternative interpretation is possible. The nonsignificant relationships between the previously
identified rurality variables and the population type score could be due to those variables being truly unrelated to rurality for this sample of families. This is likely for the variable of low income because the majority of families in this sample had to be low income for the child to be referred for services through the targeted medicaid program (EPSDT). Resultingly, low income families spanned the continuum from rural to urban, rather than being concentrated at the rural end as the hypothesized relationship suggested. Further study is necessary to adequately define rurality and identify the variables, if any, that are associated with it.

Although the primary goal of this study was to evaluate the impact of unmet parental expectations on treatment continuance, a noteworthy finding was also revealed. The 16% dropout rate for the families in this study who initiated treatment is much lower than the majority of dropout rates previously reported in the literature (e.g., Dubey et al., 1983; Hunt, 1961; Sirles, 1990). This dropout rate is even more impressive when considering the generally low SES level of these families -- a characteristic frequently associated with higher rates of dropping out of treatment (Backeland & Lundwall, 1975; Garfield, 1986; Wierzbicki & Pekarik, 1993). A number of explanations for this low dropout rate can be considered. First, all of the families were referred for children's mental health services through EPSDT. This process involves having a medical professional make a referral either based on their own observations or at the request of a concerned person (e.g., the parent, a teacher, a child protective services worker). Nearly half of the parents this sample requested the referral from their doctor or public health nurse. It is also possible that the other parents,
although not directly responsible for initiating the referral process, were supportive of the referral being made. Therefore, the EPSDT process may have selected highly motivated parents who desired mental health services for their children.

Second, the services provided to these families were possibly perceived as good and beneficial to the child. The significant finding that the parents who experienced unmet expectations were more likely to drop out also indicates that the parents whose expectations were met were more likely to stay in treatment. This suggests that the service providers were providing at least adequate, if not exceptional, services to the majority of families in this sample. It is also important to note that the services provided through the EPSDT program are free, thereby reducing the financial burden on families.

And third, the families in the Continuer group could become Dropouts at a later time. However, previous researchers have identified that dropout usually occurs in the early stages of treatment, commonly within the first 6 to 12 sessions (Backeland & Lundwall, 1975; Pekarik, 1991). This suggests that the three to four month time span used in this study allowed plenty of time for dropout to occur. Additionally, many of the previously published studies citing dropout rates used a similar method of identifying dropouts as was used in this study. Therefore, comparing the 16% dropout rate identified here to those reported in the literature is appropriate and may reflect an actual difference for this sample of parents.

Taken together, the findings from this study emphasize the need for parents who bring a child to a therapist for mental health services to be considered consumers of a service. They bring with them their own expectations for the
service, as well as other beliefs and life circumstances that may act as barriers to initiating or continuing mental health services for a child. As therapists, it is important to empower parents to identify their expectations for treatment so that they can be discussed and addressed throughout treatment in order to avoid having expectations unmet without the opportunity to intervene. Unmet parental expectations were found to be significantly different for parents who drop out of child treatment, therefore it is now the responsibility of those professionals who provide that treatment to take parental expectations into account in order to reduce the likelihood of a parent prematurely ending treatment for her/his child.
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Footnote

'The term parent was used in most cases throughout the text to designate the person in the role of the parent for the referred child and who provided the data, regardless of the actual biological relationship to the referred child. However, when this general term did not fit the data presented, the term respondent was used.
APPENDIX A

Description of the Family Connections Project:
An EPSDT Implementation and Access Study
FAMILY CONNECTIONS PROJECT:
EPSDT IMPLEMENTATION AND ACCESS STUDY

The two specific aims of the Family Connections Project are:

1. to study the effectiveness of an intervention designed to address the major problems related to service continuance within the children's mental health system in urban and rural areas, including:
   a. a complex service system,
   b. barriers such as lack of transportation or child care and long distance to services, and
   c. possible low motivation to follow through on the part of families whose children's mental health problems are not severe or long-standing;

2. to assess the implementation of a model of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) process in Oregon.

The overall goal of the intervention is to increase the number of Medicaid-eligible children who receive mental health evaluation and treatment services once they have been identified in the EPSDT screening process as needing them. This is being accomplished by increasing the responsiveness of the system to children and families through the introduction of a Family Associate who assists families in negotiating the service delivery system and overcome barriers to seeking and obtaining evaluation and treatment services. The paraprofessional Family Associate is a parent who has experience negotiating within the service delivery system for their child. The services of the Family Associate are intended to:

1. emphasize peer assistance rather than professional service,
2. focus on capacity-building, empowerment and competence enhancement,
3. be flexible and responsive to the needs of each individual family, and
4. provide information, social and emotional support, and access to concrete resources.

The Family Associates have a small flexible cash fund to purchase goods and/or services that help the family to initiate and continue mental health services. This fund is utilized when the free services available in the community do not adequately meet the specific needs of the families.

The research design includes data collection within a set of seven counties in Oregon, which range in population density from urban to rural. Of the families who will participate in this study, approximately one-half will be in the counties which receive the Family Associate intervention and one-half of the families will
be in the counties selected to serve as non-intervention comparison counties. In
the largest intervention county, an additional sample of families will be selected
for a within county comparison group. Parents of children who are referred for
mental health evaluations through EPSDT will be interviewed shortly after the
referral and at a point four months later, regarding their experiences and
satisfaction with the services they received. These parents will also be asked to
complete a set of standard child and family functioning scales at both data
collection points.

The second aim of this project is to address the need for more information about
how changes in the service system occur in response to the introduction of a new
way of organizing mental health services for low income children and families,
with specific emphasis on the issues of system change in rural areas. The overall
goal of this portion of the project is to examine the implementation of the Oregon
EPSDT plan for providing mental health services, which will result in the
dissemination of much-needed information to administrators and planners of
children's mental health in many states.

Data collection for this second component of the project will involve periodic
interviews of County Mental Health Directors, Treatment Planning Coordinators,
staff, and service providers, as well as reviews of written material about the county
mental health programs. Implementation information gathered will include, but
not be limited to, the impact of economic, political and social conditions; the
approach chosen by the county mental health authority for the delivery of EPSDT
services; the extent of interagency collaboration in the delivery of services; the
choice of staff and staffing patterns; and the barriers and solutions. An evaluation
of the effect of ruralness and increased distance from services will be an additional
focus of the analyses.
APPENDIX B

Parent Contact Materials
Dear Parent:

I would like to invite you to be in a research project called the Family Connections Project. It is studying the needs of families who are just getting started with mental health services for their child. The Lane County Mental Health Program is working with the Regional Research Institute at Portland State University on the project.

I understand that your child has been referred for mental health services. You can provide us with important information about what a family may need to make this experience easier. I have attached a description of our project (the purple sheet). Please note that we are paying $25 for each interview. I will be calling you in the next couple of days to describe the project in more detail and to see if you want to be in the project.

We would like to interview you if your child, who was referred for mental health services, is 4- to 17-years-old and has not had more than 3 mental health appointments.

You may choose whether or not to take part in the project. If you choose not to be in the project, your child’s mental health services will not be affected in any way.

I look forward to talking with you.

Best wishes,

Priscilla Warren
Research Interviewer
725-5198 or 1-800-547-8887 Extension 5198

Attachments

The Regional Research Institute for Human Services is affiliated with the Graduate School of Social Work
WHAT IS THE FAMILY CONNECTIONS PROJECT?

The Family Connections Project is a research project which is studying the needs of families just getting started with mental health services.

WHAT WOULD I BE ASKED TO DO IF I CHOOSE TO BE IN THE PROJECT?

We would like to interview you if your child, who was referred for mental health services, is 4 to 17-years-old. If you decide that you want to be in the project, an interviewer will ask you some questions about your child and any experiences you have had with the mental health service system. The interviewer will also ask you to fill-out some checklists about your child’s behavior and how your family copes. For doing this, you will receive $25. About 2-4 months later, the same person will interview you about the mental health services you have received and what you thought about them. Also, you will be asked to fill-out some checklists. For doing this, you will receive another $25.

WHAT IF I DO NOT WANT TO BE IN THE PROJECT?

Choosing not to be in the project means you will not do the two interviews nor fill-out any of the checklists. Your family’s mental health services will not be changed in any way.

WHO CAN I CALL IF I HAVE QUESTIONS?

If you have any questions or concerns about the research project, contact either Debi Elliott or Nancy Koroloff at the Regional Research Institute for Human Services at Portland State University, 725-4040 or 1-800-547-8887 (extension 4040).
Dear Parent:

I would like to invite you to be in a research project called the Family Connections Project. It is studying the needs of families who are just getting started with mental health services for their child. The Lane County Mental Health Program is working with the Regional Research Institute at Portland State University on the project.

I understand that your child has been referred for mental health services. You can provide us with important information about what a family may need to make this experience easier and what your experience was like. I have attached a description of our project (the purple sheet). Please note that we are paying $25 for each interview.

We would like to interview you if your child, who was referred for mental health services, is 4- to 17-years-old and has not had more than 3 mental health appointments.

You may choose whether or not to take part in the project. If you choose not to be in the project, your child's mental health services will not be affected in any way.

You do not have to make a decision right now. All I am asking you to do is to let us call you to give you more information and answer any questions you might have. If you are willing to get a phone call, please fill-out the Reply Form (yellow half-sheet) and send it to me in the attached postage-paid envelope. Once I receive that from you, I will call you.

Thank you for your time and willingness to consider being in the Family Connections Project.

Best wishes,

Priscilla Warren
Research Interviewer
725-5198 or 1-800-547-8887 Extension 5198

Attachments
FAMILY CONNECTIONS PROJECT: REPLY FORM

YES, I AM WILLING TO GET A PHONE CALL TO HEAR MORE ABOUT THE FAMILY CONNECTIONS PROJECT.

My name is: __________________________________________________________

My telephone number is: ______________________________________________

A good time to call me is: _____________________________________________

I do not have a phone, but I can be visited at my home on this day:

MONDAY  TUESDAY  WEDNESDAY  THURSDAY  FRIDAY  SATURDAY (circle the best day)

____ Morning  ____ Afternoon (check the best time of the day)

My address is: ________________________________________________________

FORMA DE RESPUESTA: PROYECTO "CONEXIONES FAMILIARES"

SÍ, LES PERMITO QUE SE COMUNICEN CONMIGO PARA INFORMARME MÁS SOBRE EL PROYECTO "CONEXIONES FAMILIARES."

Mi nombre es: ________________________________________________________

Mi teléfono es: ________________________________________________________

Una buena hora para llamarme es: _______________________________________

No tengo teléfono, pero me pueden visitar en mi casa el día:

LUNES  MARTES  MIERCOLES  JUEVES  VIERNES  SÁBADO (Encerrar el mejor día con círculo)

Mañanas____  Tardes____ (Señale la mejor hora del día)

Mi dirección es: ________________________________________________________
FAMILY CONNECTIONS PROJECT
SCRIPT FOR INITIAL TELEPHONE CONTACT
(INITIAL INTERVIEW -- COMPARISON)

Hello. My name is _________. I am with Portland State University. I'm working in a special research project called the Family Connections Project, which the _________ County Mental Health program is helping us with. (Use whatever is appropriate to your county.)

I sent you a letter introducing this Project a few days ago. Do you remember seeing that?

-OR-

You returned our reply form, and I am following up on that.

-OR-

The ________ County Mental Health program received a referral for (child's name) and I am following up on that.

I would like to tell you about the project and then, if you are interested, we can see if your family fits the criteria to be in the project. [NOTE: If person is Spanish-speaking, see last page.]

The Family Connections Project is a project which is studying the needs of families who are just getting started with mental health services. We know that sometimes it is hard for families who have just been referred to understand what is going to happen. We would like you to tell us what it's like for you and your family to get started in mental health services.

If you decide to be a part of the Family Connections Project, you will be asked to take part in two research interviews. I would do the first one with you in the next few days. I will call you in three to four months to schedule the second interview. Each interview would take between an hour to an hour and 1/2, and you will be paid $25 for each interview. If you choose to withdraw from the project before the second interview, you will be paid for the first interview only. Your choice about whether or not to be in, or continue in, this project will not affect your child's mental health services in any way.

WOULD YOU LIKE TO BE A PART OF THE FAMILY CONNECTIONS PROJECT?

A. (IF NO:) Accept a "no" response, thank them for their time, hang up.

(If respondent seems willing to talk, you might ask:) Do you have any concerns that we should know about as we talk with other families?
B. (IF PARENT HESITATES OR SEEMS UNSURE:)
   Let me give you some more information about the project or the interviews.
   - OR -
     Do you have any questions that I could answer?
   - OR -
     Could I mail some information to you and then give you a call when you have had time to go over it?

C. (IF YES:) Let me check a few things with you to make sure your family is eligible.

   I understand that (child's name) is the child being referred for mental health services. Is that correct?

1. Does (child's name) have a medical card? ____ Yes ____ No
   (IF NO, probe to see if they are clear about what a medical card is.
   Description: 1/2 sheet, computer printed, mailed each month, must show at the doctor's office.)
   (IF NO MEDICAL CARD → NOT ELIGIBLE.*)

2. Is (child's name) 4 to 18 years old? ____ Yes ____ No
   (IF CHILD IS YOUNGER OR OLDER → NOT ELIGIBLE.*)

3. Is (child's name) currently receiving any mental health services?
   ____ Yes ____ No
   (Verify that they are clear about what mental health services are.)
   (IF YES, ask how long. IF CHILD HAS BEEN EVALUATED AND IS PAST THE THIRD REGULARLY SCHEDULED TREATMENT SESSION → NOT ELIGIBLE.*)

4. Is (child's name) currently living with you? ____ Yes ____ No
   (IF NO: Where is s/he living?)
   (IF CHILD IS CURRENTLY LIVING IN A RESIDENTIAL TREATMENT CENTER OR AN INSTITUTION → NOT ELIGIBLE.*)

   (If child is living with another family:) Will you be the person responsible for getting (child's name) to mental health services? ____ Yes ____ No
   (IF NO → NOT ELIGIBLE.*)

   OK. Your family fits the criteria to be in this project. Let's go ahead and schedule a time I can see you. Would you like me to come to your home to do the interview?
*(WHEN A CHILD IS NOT ELIGIBLE:*)
I am sorry, but we are including only children who ____ (criteria not met) ____. Thank you for your time.

(If the person is upset about not being eligible, explain that the research project is limited to children who have certain characteristics. Remind the person that the child's/family's mental health services will be unaffected. If they continue to be upset, let them know you will give their name and phone number to the Project Manager, who will call them to discuss the situation. Remember to call Debi with this information.)

*[If you contact a Spanish-speaking person, read him/her the following: Yo no hablo español. Una persona que habla español le volverá a llamar.]*
FAMILY CONNECTIONS PROJECT
SCRIPT FOR INITIAL TELEPHONE CONTACT
(FOLLOW-UP INTERVIEW -- COMPARISON)

Hello. My name is ______. I am with Portland State University and am working on the research project called the Family Connections Project. I interviewed you 3 to 4 months ago for this research project about children's mental health services. Do you remember this project? (If the respondent does not know what you are talking about, provide information as necessary to help her/him recall the project.)

I am calling because it's time to schedule the second interview for the project. You may remember that the first interview involved me asking you a number of questions and you filling-out some forms. This second interview is very similar, except that I will be asking you questions about the mental health services (child's name) received, how satisfied you were with those services and any problems you may have experienced. I will also ask you about any changes in your family circumstances that have occurred since the first interview. Like before, we will be paying you $25 for doing this interview.

Before we schedule a time to meet, do you have any questions about doing this interview? (Respond to any questions the respondent may have. If the respondent says s/he does not want to do the interview, discuss her/his concerns, remind her/him of confidentiality, and reduce any fears. Bottom Line: Encourage, But Do Not Force The Respondent To Do The Interview.)

Let's go ahead and schedule a time I can see you. Would you like me to come to your home to do the interview? (Verify the information you have on the Notification of Follow-Up Interview form, especially their home address.)

* * * * * * *

Following the telephone call, prepare the assessment materials for the interview.
APPENDIX C
Informed Consent Form
INFORMED CONSENT

I, __________________________________________, agree to take part in the Family Connections Project, a research project run by the Regional Research Institute for Human Services at Portland State University. I understand that the project is studying better ways of making mental health services available to children and families. My part in the study involves an interview now and another interview in three or four months. I will let the research staff know if I move so they can find me for the second interview. I understand that a different person may call me for the second interview. I will receive $25 for each interview. I do not expect any other direct benefit from participation in the study.

________________________________________ has offered to answer any questions about the study. I understand that the research staff will have access to my file at the County and State Mental Health Departments. I understand that all information about me and my family will be confidential, except the following information which by law must be reported to the proper authorities:

(1) Information subpoenaed by a court of law (that is, demanded by a court of law).

(2) Suspected cases of abuse or neglect under Oregon state law. In other words, recent harm to a child will be reported.

(3) Information that individuals intend to harm themselves or others.

My name or identity will not be used in reports or for public discussion purposes. I may withdraw at any time from participation in this study without affecting the mental health services I or my family will receive.

I have read and understand this information and agree to participate in the Family Connections Project.

DATE ___________________ SIGNATURE _____________________

For questions or concerns about the research, please contact Nancy Koroloff or Debi Elliott at the Regional Research Institute for Human Services at Portland State University, 725-4040 or 1-800-547-8887, Ext. 4040.

For concerns about your treatment as a research participant, you may phone the Chairperson of the Human Subjects Research Review Committee, Portland State University, 725-3417.
APPENDIX D
Initial and Follow-Up Interviews
FAMILY CONNECTIONS PROJECT
INITIAL INTERVIEW

INTRODUCTION

When we first talked over the phone, I explained a little bit about the research project. Before we begin the interview, I would like to give you more information about the project and have you read a Consent form. This form briefly describes the Family Connections Project and your role in that project. I will then ask you to sign the Consent form which means you agree to be a part of the Family Connections Project. We have three options for you. You can read the Consent form in English, or we have it in Spanish, or I could read it to you. Which would you prefer? I will answer any questions you have about the project.

(Hand the informed Consent form to the respondent. Give a brief overview of the project as you hand them the form. To provide this brief overview, you may want to review the Parent Flyer with them. Do you have any questions? (Make sure you review the exceptions to confidentiality with the respondent.) Please sign and date the form at the bottom to show that you agree to be a part of the project. (Give the respondent the pink copy.) This copy is for you to keep.

During this interview, I will be asking you questions about the child who has been referred for mental health services, your household and family, and any mental health service experiences you and your family have had. I will also be asking you about what it was like to have a child referred for mental health services. This information will help us learn more about how to help children and families get started in mental health services. Since your time is valuable, the Regional Research Institute will pay you $25 for each interview you complete. This first interview will last 1 to 1-1/2 hours. The interview in 3-4 months will last a little longer.

I will be writing down your answers during the interview. At times it may seem strange that I am writing and not looking at you when you talk. This is not because I am not interested in what you have to say. I want to be sure I write exactly what you say. When I am done asking you some questions, I will give you some forms to fill-out. We can stop the interview at any time to take a break if you wish. You have the right to skip any of the questions I ask you. Please take your time answering the questions. We want you to give your most honest opinions. Do you have any questions about the research or the interview before we begin?

I WOULD LIKE TO BEGIN BY ASKING YOU QUESTIONS ABOUT (child's name), YOU, AND YOUR HOUSEHOLD. THIS INFORMATION WILL HELP US UNDERSTAND HOW (child's name) CURRENT SITUATION AND FAMILY CIRCUMSTANCES MAY INFLUENCE HER/HIS MENTAL HEALTH SERVICES. THIS INFORMATION WILL BE USED FOR RESEARCH PURPOSES ONLY AND WILL NOT BE SHARED WITH ANY OTHER PERSON OR AGENCY.
Respondent’s FIRST name: ____________________ Child’s FIRST name: ____________________

1. What is [child’s name] sex? _____ Female, _____ Male.  

2. What is her/his date of birth? ___ / ___ / ___ (mo, day, yr)  

3. What is her/his race? (List term used by respondent following general category)  
   _____ African-American;  
   _____ American Indian or Alaskan Native;  
   _____ Asian or Pacific Islander;  
   _____ Hispanic;  
   _____ White;  
   _____ Other;  
   (If more than one race given, use "2" for second race)  

4. Is [child’s name] currently enrolled in school, including home school?  
   _____ YES,  
   _____ NO.  

   4a. (If YES, ask): What is her/his current grade in school? ______  

   4b. (If YES, ask): Does [child’s name] have an IEP (Individualized Education Plan)? An IEP looks like this (show example).  
   _____ YES, _____ DON’T KNOW, (after adequate probing; Go to #5)  
   _____ NO (Go to #5)  
   → (If has IEP, ask): What is the disabling condition s/he has an IEP for?  
   → (If has IEP, ask): What services is s/he receiving because of the IEP?  

   4c. (If NO, ask): Why is s/he not enrolled in school? (primary reason)  
   _____ too young, _____ between schools,  
   _____ dropped out, _____ summer vacation (ask #4d and #4e)  
   _____ expelled, _____ other.  

   4d. (If NO, ask): What was the last grade s/he completed? ______  
   (If on SUMMER VACATION, Go to #4e; otherwise Go to #5)  

   4e. (If on SUM. VAC, ask): Did [child’s name] have an IEP (Individualized Education Plan) at the end of the last school year? An IEP looks like this (show example).  
   _____ YES, _____ NO (Go to #5) _____ DON’T KNOW, (after adequate probing; Go to #5)  
   → (If had IEP, ask): What is the disabling condition s/he had an IEP for?  
   → (If had IEP, ask): What services was s/he receiving because of the IEP?  

5. Who currently has legal custody of [child's name]?
   ___ I do, ___ The state (CSD), ___ Other:

6. I am aware that [child's name] has a medical card. How does s/he qualify for a medical card?
   (primary reason)
   ___ Foster care, ___ Child's disability, ___ Low income, ___ Other:

7. How are you related to [child's name]?
   ___ Birth Mother, ___ Stepfather, ___ Adoptive Mother, ___ Grandfather,
   ___ Birth Father, ___ Foster Mother, ___ Adoptive Father, ___ Other,
   ___ Stepmother, ___ Foster Father, ___ Grandmother,

7a. (If respondent is anything other than a birth parent ask): How long has s/he lived with you?
   ___ Years, ___ Months, ___ Since Birth

8. What is your age? _______________ years

9. What is your race? (List term used by respondent following general category)
   ___ African-American, ___ American Indian or Alaskan Native, ___ Asian or Pacific Islander,
   ___ Hispanic, ___ White, ___ Other:

   (If more than one race given use "2" for second race)

10. To get a sense for the caregiving responsibility you have, we would like to know the number of people
    living in your home and how many of those people you have to spend time taking care of. We do not
    need to know who lives with you. Please tell me just the AGES of all the people in your home other
    than you and [child's name].

    | Person | Age  | Care | Person | Age  | Care |
    |--------|------|------|--------|------|------|
    | #1     | [53-54] | [06] | #4     | [50-59] | [10] |
    | #2     | [55-56] | [06] | #5     | [61-62] | [06] |
    | #3     | [57-58] | [07] | #6     | [63-64] | [07] |

10a. (If any teens [13 years & up] or adults are listed above, ask):
    Do any of the older children/adults who are living with you require extra care from you
    because they have a disability, for example, a physical handicap, a chronic illness, a
    developmental handicap, or a serious emotional handicap?
    (Put a V in the "Care" column by the people identified as dependent.)
11. Do you have someone who shares daily parenting/caregiving responsibilities with you, such as a family member, partner, spouse or ex-spouse, friend, etc.? ___ Yes, ___ No.

11a. [If YES, ask:] What is their relationship to you? [Primary person]

___ Spouse/Partner, ___ Multiple Relatives, ___ Friend(s),
___ Parent, ___ Sibling, ___ Babysitter,
___ Other Relative, ___ Boy/Girlfriend, ___ Other:

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR FINANCIAL RESOURCES. THIS INFORMATION IS CONFIDENTIAL AND WILL HELP US UNDERSTAND HOW A FAMILY'S RESOURCES MAY INFLUENCE MENTAL HEALTH SERVICES. THIS INFORMATION WILL BE USED FOR RESEARCH PURPOSES ONLY AND WILL NOT BE GIVEN TO ANY OTHER PERSON OR AGENCY.

12. Are you employed?

___ YES, → What is your job?

___ NO. (Go to #13) (Go to #13)

___ RETIRED, → What was your job?

13. What is your highest level of education?

___ Less than 7th grade, ___ Partial college (at least 1 year)
___ 7th, 8th, or 9th grade, ___ or specialized training,
___ 10th or 11th grade, ___ Standard college or university degree,
___ High school diploma, ___ Graduate school or graduate degree,
14. What is your current marital status or living arrangement?

<table>
<thead>
<tr>
<th>Status</th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>RETIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SINGLE</td>
<td>Have you ever been married?</td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>MARRIED or</td>
<td>Is your spouse/partner employed?</td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>LIVING AS</td>
<td></td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>MARRIED</td>
<td></td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>DIVORCED</td>
<td></td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>SEPARATED</td>
<td></td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
<tr>
<td>WIDOWED</td>
<td></td>
<td>-----</td>
<td>----</td>
<td>--------</td>
</tr>
</tbody>
</table>

- If Single: Have you ever been married? Yes or No (Go to #15)
  - If Yes, determine whether Divorced or Widowed, ask appropriate questions below.

- If MARRIED: Is your spouse/partner employed? Yes, No (Go to #15) Retired
  - If spouse/partner employed or Retired, ask:
    - What is/was your spouse/partner's job?
    - What is your spouse/partner's highest level of education?
      - Less than 7th grade
      - Partial college (at least 1 year)
      - 7th, 8th, or 9th grade
      - or specialized training/trade school
      - 10th or 11th grade
      - Standard college or university degree
      - High school diploma
      - Graduate school or graduate degree

- If Divorced or Separated: Is your (ex-) spouse employed? Yes, No (Go to #15) Retired
  - If (ex-) spouse employed or Retired, ask:
    - What is/was your (ex-)spouse's job?
    - What is your (ex-)spouse's highest level of education?
      - Less than 7th grade
      - Partial college (at least 1 year)
      - 7th, 8th, or 9th grade
      - or specialized training/trade school
      - 10th or 11th grade
      - Standard college or university degree
      - High school diploma
      - Graduate school or graduate degree

- If Widowed: Was your spouse employed? Yes, No (Go to #15) Retired
  - If late spouse employed or Retired, ask:
    - What was your spouse's job?
    - What was your spouse's highest level of education?
      - Less than 7th grade
      - Partial college (at least 1 year)
      - 7th, 8th, or 9th grade
      - or specialized training/trade school
      - 10th or 11th grade
      - Standard college or university degree
      - High school diploma
      - Graduate school or graduate degree
15. What are the sources of income in your household? (Check all that apply.)

___ Employment
___ Welfare/AFS
___ Social Security
___ AFDC (Aid to Families with Dependent Children)
___ Foster Care Support
___ Child Support
___ Supplemental Security Income (SSI)
___ Pension/retirement funds
___ Alimony
___ Deceased spouse’s estate
___ Other

15a. (If more than one source is given, ask)
Which is the primary source of income? (Circle one above.)

16. (Hand the ANNUAL INCOME card.) Listed on this card are some income levels. Please read the letter next to the annual income before taxes for your household. (Check one)

a. ___ Under $10,000,  e. ___ $25,000 to $34,999
b. ___ $10,000 to $14,999,  f. ___ $35,000 to $44,999
c. ___ $15,000 to $19,999,  g. ___ $45,000 to $54,999
d. ___ $20,000 to $24,999,  h. ___ $55,000 and up

NOW I WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT WHERE YOU LIVE AND HOW FAR YOU LIVE FROM SOME MAJOR LANDMARKS.

17. What city/town do you list as your address?

18. Do you live within this city/town’s limits?

___ YES, (Go to #19)
___ NO, ___ DON’T KNOW

(If NO or DON’T KNOW, ask): How many miles from this city/town do you live?

Miles.

19. How many miles do you live from:

_____ (miles) the nearest Post Office
_____ (miles) the nearest Public Library
_____ (miles) the nearest hospital
_____ (miles) your child’s school
_____ (miles) the mental health office that you will be going to

(If office not chosen yet, complete later)

20. Are there any times of the year when you cannot travel? ___ Yes, ___ No (Go to #21)

20a. (If yes, ask): When, for how long, and why can’t you travel?:

_____________________________
I WOULD LIKE TO ASK YOU QUESTIONS ABOUT (child's name) MENTAL HEALTH HISTORY.

21. FIRST, I WOULD LIKE TO KNOW WHAT TYPES OF MENTAL HEALTH SERVICES, IF ANY, (child's name) HAS RECEIVED. I WILL GO THROUGH A LIST OF SERVICE TYPES AND ASK YOU SOME QUESTIONS ABOUT EACH ONE.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Is s/he currently receiving?</th>
<th>(If yes for current services, ask):</th>
<th>In the PAST, has s/he ever received?</th>
<th>(If yes for past services, ask): [most recent service only]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient therapy or counseling?</td>
<td>_Yes_1, _No_2 [111]</td>
<td>How long has it been going on?</td>
<td>_Yes_1, _No_2 [123]</td>
<td>How long ago did it end? <em>124-126</em> How long did it last? <em>127-128</em></td>
</tr>
<tr>
<td>Counseling or group therapy at school?</td>
<td>_Yes_1, _No_2 [113]</td>
<td>How long has it been going on?</td>
<td>_Yes_1, _No_2 [129]</td>
<td>How long ago did it end? <em>130-132</em> How long did it last? <em>133-134</em></td>
</tr>
<tr>
<td>Day treatment?</td>
<td>_Yes_1, _No_2 [115]</td>
<td>How long has it been going on?</td>
<td>_Yes_1, _No_2 [135]</td>
<td>How long ago did it end? <em>136-138</em> How long did it last? <em>139-140</em></td>
</tr>
<tr>
<td>Residential treatment?</td>
<td>_Yes_1, _No_2 [117]</td>
<td>How long has it been going on?</td>
<td>_Yes_1, _No_2 [141]</td>
<td>How long ago did it end? <em>142-144</em> How long did it last? <em>145-146</em></td>
</tr>
<tr>
<td>Therapeutic foster care?</td>
<td>_Yes_1, _No_2 [119]</td>
<td>How long has it been going on?</td>
<td>_Yes_1, _No_2 [147]</td>
<td>How long ago did it end? <em>148-150</em> How long did it last? <em>151-152</em></td>
</tr>
<tr>
<td>Psychiatric hospitalization?</td>
<td>_Yes_1, _No_2 [121]</td>
<td>How long has it been going on?</td>
<td>_Yes_1, _No_2 [153]</td>
<td>How long ago did it end? <em>154-156</em> How long did it last? <em>157-158</em></td>
</tr>
</tbody>
</table>

*** (If all the answers are "No", then Go to #25.) ***
22. (If YES for any item in #21, hand the CHOICES card, ask:) Looking at List A on this Choices card, generally, how have you felt about the mental health services (child's name) received?
(Circle their choice.)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Mostly Good,</td>
<td>Mostly Good,</td>
<td>Mostly Bad,</td>
<td>All</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>Some Bad</td>
<td>Half Bad</td>
<td>Some Good</td>
<td>Bad</td>
<td></td>
</tr>
</tbody>
</table>

23. (If YES for any item in #21, ask:) While (child's name) was receiving those mental health services, were you ever given a name or diagnosis for (her/his) condition?

___ YES,  ___ NO (Go to #24)

(If yes, ask): What is the most current name or diagnosis for your child's condition?
(Check all that apply.)

___ Don't know/Can't recall
___ Adjustment Disorder
___ Anxiety Disorder
___ Attachment Disorder
___ Attention Deficit Hyperactivity Disorder
___ Autistic Disorder
___ Avoidant Disorder
___ Bipolar Disorder (Manic-Depression)
___ Childhood Depression
___ Conduct Disorder
___ Developmental Disorder (Mental Retardation)
___ Eating Disorder (Anorexia, Bulimia, Obesity)
___ Enuresis/Encopresis
___ Learning Disability
___ Obsessive Compulsive Disorder
___ Oppositional Disorder
___ Phobia
___ Post Traumatic Stress Disorder (PTSD)
___ Schizophrenia
___ Substance Abuse/Dependence
___ Tourette's Syndrome
___ Other: ____________________________
(If YES for any item in #21): NOW, I AM GOING TO READ A LIST OF THINGS THAT CAN GET IN A PARENT'S WAY OF GETTING THEIR CHILD TO TREATMENT, RESULTING IN MISSED APPOINTMENTS, NOT STARTING TREATMENT, OR ENDING TREATMENT BEFORE IT'S DONE.

24. Have any of these things ever gotten in the way of you being able to get your child to mental health services?

(Read each item; check all that apply)

- Transportation problems [163]
- Child care problems [164]
- Too far to travel [185]
- Could not afford [186]
- Time conflict [187]
- Process was too confusing [188]
- Disruptive to regular family routine [189]
- Did not think child needed mental health services [190]

Did not think the mental health services were helping [101]
Disagreed with diagnosis or treatment approach [102]
Child refused to be in treatment [103]
Did not feel comfortable being associated with mental health services [104]
Did not like therapist/counselor/social worker/program [105]
Other: ____________________________ [106]
NONE APPLY

25. Have you ever participated in mental health services with any other child(ren)?

Yes, ___ No, ___ (Go to #26) [107]

25a. (If yes, hand CHOICES card, ask): Looking at List A on the CHOICES card, generally, how have you felt about the mental health services she/he/they received? (Circle their choice.)

1 2 3 4 5
All Mostly Good, Half Good, Mostly Bad, All
Good Some Bad Half Bad Some Good Bad [108]

26. (If any child has received mental health services, ask): Were you ever involved with a parent support group when any of your children were receiving mental health services?

Yes, ___ No, ___ (Go to #28) [109]

27. Have you ever received any mental health services?

Yes, ___ No, ___ (Go to #28) [200]

27a. (If yes, hand CHOICES card, ask): Looking at List A on the CHOICES card, generally, how have you felt about the mental health services you received? (Circle their choice.)

1 2 3 4 5
All Mostly Good, Half Good, Mostly Bad, All
Good Some Bad Half Bad Some Good Bad [201]
(CHILD’S NAME) HAS BEEN REFERRED FOR MENTAL HEALTH SERVICES. SOMETIMES A PARENT HAS TO GO THROUGH MANY DIFFERENT STEPS TO GET FROM WANTING SERVICES TO ACTUALLY GETTING SERVICES. IN YOUR SITUATION, WE WOULD LIKE TO KNOW HOW THIS PROCESS HAPPENED.

ONE OF THE STEPS WE KNOW MAY OCCUR IS FOR A CHILD TO HAVE A MEDICHECK. THAT IS A VISIT WITH A MEDICAL PROFESSIONAL WHO RECOMMENDS THAT A CHILD RECEIVE MENTAL HEALTH SERVICES.

28. Who did the Medcheck for (child’s name)?
   (If the respondent says “The clinic”, “The doctor”, “The nurse”, or gives you a doctor’s/nurse’s name, ask if the clinic or the doctor/nurse is part of Public Health/Health Dept.)
   __ Private physician
   __ Public Health/Health Dept.
   __ School Nurse
   __ Other: ____________________________  [pee]
   __ No Medcheck done (explain below)

29. Who suggested that you get the Medcheck for (child’s name)?

__________________________________________

(Ask as many questions as necessary to trace back to the beginning of this process of wanting/needling mental health services. Describe any additional "system-related" steps below.)

__________________________________________

__________________________________________
30. When (child's name) had his/her Medicheck, were you given a form by the doctor/nurse recommending that (child's name) receive mental health services? It should look like this (show example).

| YES | NO   |

(If YES, ask): What were you told to do with it?

(If NO, ask): Were you given anything else in writing?

Yes, No (Go to #31)

(If given something else in writing, ask): What was it?

(If given something else in writing, ask): What were you told to do with it?

31. Have you received something in the mail from the mental health office?

| YES | NO   |

COMMENTS:

32. Did you receive a phone call from the mental health office?

| YES | NO   |

COMMENTS:

33. Did you call the mental health office?

| YES | NO   |

COMMENTS:
34. Has an appointment been made with the mental health office for (child’s name)?
   ____ YES, (If YES, ask:) When is your appointment? ____________ [200]
   (If YES, ask:) Was it difficult to get? ____ Yes, ____ No, (Go to #35) [210]
   __ NO

NOW THAT YOU HAVE DESCRIBED THE PROCESS YOU WENT THROUGH TO GET (child’s name)
INTO MENTAL HEALTH SERVICES, I WOULD LIKE TO ASK YOU WHAT YOU THOUGHT ABOUT
THAT EXPERIENCE:

35. (Hand CHOICES card:) Looking at LIST B on the CHOICES card, how easy or difficult do you
think the process was for you? (Circle their choice.)

   1  2  3  4  5
   Very Easy Somewhat Just Fine Somewhat Very
   Easy Somewhat Difficult Difficult

COMMENTS: ____________________________________________ [211]

36. Looking at LIST C on the CHOICES card, how do you feel about how long that process lasted?
   (Circle their choice.)

   1  2  3  4
   Way too Slow Kinda Slow, Just About Faster Than
   Kinda Slow, But OK Just About Right
   Slow Right

COMMENTS: ____________________________________________ [215]

37. About how long did the whole process take, from the point when you first started trying to get
Mental Health services for (child’s name) to the point when you got an appointment (OR now if no
appointment has been made)?
   _____ Weeks _____ Months [213-214]
38. Looking at LIST D on the CHOICES card, how satisfied are you with how you were treated throughout the process when **child’s name** was being referred for mental health services?  
(Circle their choice.)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Satisfied</td>
<td>Mixed Feelings</td>
<td>Dissatisfied</td>
<td>Very Dissatisfied</td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

---

I AM GOING TO READ YOU A LIST OF THINGS THAT SOMETIMES GET IN THE WAY OF TAKING A CHILD TO TREATMENT, RESULTING IN MISSED APPOINTMENTS, NOT STARTING TREATMENT, OR ENDING TREATMENT BEFORE IT IS DONE.

39. I would like you to tell me if it is possible that any of the following things may get in your way.
(Read each item; check all that apply.)

- Transportation problems [216]
- Child care problems [217]
- Being too far to travel [218]
- Time conflict [219]
- Child refusing to be in treatment [220]
- Being confused about next step [221]
- Being disruptive to regular family routine [222]
- Deciding child does not need mental health services [223]
- Not feeling the mental health services are helping [224]
- Not feeling comfortable being associated with mental health services [225]
- Disagreeing with diagnosis or treatment approach [226]
- Not liking therapist/counselor/social worker/program [227]
- Other: ____________________________________________ [228]

---

40. About how long do you think **child’s name** will be involved with mental health services?  
(If the respondent hesitates, encourage her/him to guess.)

______ Months _______ Years [229-230]

41. In closing, I would like to ask if there is anything you would like to add or comment on, or if you have any additional reactions to having **child’s name** referred for mental health services.

---

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(CONTINUE ON BACK IF NECESSARY)
(COMPARISON)

INTRODUCING THE QUESTIONNAIRES

We have finished the first part of this interview. Now I would like to ask you to fill out a few questionnaires. It should take about 20 to 40 minutes. Again, we have three options for you. You can read the questionnaires in English, or we have them in Spanish, or I could read them to you. Which would you prefer?

(Give a brief overview for each of the questionnaires. Point out the parts of the CBCL that are not completed. Emphasize that the questionnaires are double-sided. When s/he is done filling them out, say): Did you have any questions about any of the items?

(Respond to any questions s/he may have. If help is needed to understand an item, do your best to rephrase the item without changing the meaning of the item or providing the respondent with any additional information. Review each questionnaire to make sure all of the items were answered and say): I just need to quickly glance through these to make sure we filled everything out.

CLOSING SUMMARY FOR INITIAL INTERVIEW

(If the respondent is unable to complete the questionnaires, give her/him the option of keeping them to finish. Schedule a time to pick them up within the next couple of days. Explain that s/he will receive the $25 when the forms are completed and picked-up. Thank the respondent for her/his time and help thus far.)

(For those who complete all of the questionnaires, say): Thank you very much for participating in this interview. You have helped us a lot and we appreciate your time. Here is your $25 check. Please sign this receipt to show that you have received the $25 for this initial interview.

I will be contacting you in about three to four months to schedule a follow-up interview. We will need to know if there are any changes in your name, address or telephone number. You can call Debi Elliott, the Project Manager, at the phone number listed on your copy of the consent form to tell her about any changes (or on the Parent Flyer). She can also answer any questions you may have about the interviews or the research project. In case we have any trouble getting in touch with you, is there someone we could call who would always know where you are living?

NAME: _________________________________ RELATIONSHIP: ____________________________

TELEPHONE NUMBERS: ____________________ (Home) ____________________ (Work)

Again, thank you for your time. I have enjoyed talking with you.
FAMILY CONNECTIONS PROJECT
FOLLOW-UP INTERVIEW -- COMPARISON

Family ID#: 
Today's Date: 
First Interview Date: 
Interviewer: 

INTRODUCTION

As I mentioned on the phone, this is a follow-up interview to the interview you did about 3-4 months ago for the Family Connections Project. Before we begin, I would like to review the Consent form you signed before. As you recall, this form was the way for you to agree to be a part of this project and describes the confidential nature of the information you give us. I would like you to review it. You can review it in English or in Spanish, or I can read it to you. Which would you prefer? When you are finished, I will answer any questions you have. (Hand the Informed Consent form to the respondent.) Do you have any questions? (Make sure you remind the respondent about the exceptions to confidentiality.)

During this interview, I will be asking you questions about [child's name], the mental health services s/he received, how satisfied you were with those services and any problems you may have experienced. I will also ask you about any changes in your family circumstances that have occurred since the first interview. This interview will last about 1 to 1-1/2 hours. Because your time is valuable, the Regional Research Institute will pay you $25 for this interview.

As in the first interview, I will be writing down your answers as you give them to me. At times it may seem strange that I am writing and not looking at you when you talk. This is not because I am not interested in what you have to say. I want to be sure I write exactly what you say. When I have finished asking you questions, I will give you some forms to fill-out. We can stop the interview at any time to take a break if you wish. You have the right to skip any of the questions I ask you. Please take your time answering the questions. We want you to give your most honest opinions.

Do you have any questions about the research or the interview before we begin?

I WOULD LIKE TO BEGIN BY ASKING YOU QUESTIONS ABOUT [child's name], YOU, AND YOUR HOUSEHOLD. THIS INFORMATION WILL HELP US UNDERSTAND HOW [child's name] CURRENT SITUATION AND FAMILY CIRCUMSTANCES MAY INFLUENCE HER/ HIS MENTAL HEALTH SERVICES. THIS INFORMATION WILL BE USED FOR RESEARCH PURPOSES ONLY AND WILL NOT BE SHARED WITH ANY OTHER PERSON OR AGENCY.
### Respondent's FIRST name:  Child's FIRST name:

1. Is [child's name] currently living with you?  **YES**, [Go to #2]  **NO**
   
   **[13]**
   
   *(If NO, ask): Where is she/he living now?______________________________ [14]*

2. Did [child's name] consistently live with you since the first interview?
   **YES**, [Go to #3]  **NO**
   
   **[15]**
   
   *(If NO, ask): Where else has she/he lived?______________________________*
   
   *(If NO, ask): For how long?______________________________*

### 3. Is (child's name) currently enrolled in school, including home school?

**YES**

3a. *(If YES, ask): What is her/his current grade in school? ______
   
   **[16]**
   
   *(If YES, ask): Does [child's name] have an IEP (Individualized Education Plan)?  
   
   An IEP looks like this *(show example)*.
   
   **YES**,  **DON'T KNOW** *(after adequate probing; Go to #4)*
   
   **NO** *(Go to #4)*
   
   → *(If has IEP, ask): What is the disabling condition s/he has an IEP for?__________ [20-25]*
   
   → *(If has IEP, ask): What services is s/he receiving because of the IEP?__________ [26-31]*

**NO**

3c. *(If NO, ask): Why is s/he not enrolled in school? *(primary reason)*
   
   **[32]**
   
   *(too young, between schools, dropped out, summer vacation, other)*

3d. *(If NO, ask): What was the last grade s/he completed?__________ [33-34]
   
   *(If on SUMMER VACATION, Go to #3e; otherwise Go to #4)*

3e. *(If on SUMMER VACATION, ask): Did [child's name] have an IEP (Individualized Education Plan) at the end of the last school year?  
   
   An IEP looks like this *(show example)*.
   
   **YES**,  **NO** *(Go to #4)*
   
   → *(If had IEP, ask): What is the disabling condition s/he had an IEP for?__________ [36-41]*
   
   → *(If had IEP, ask): What services was s/he receiving because of the IEP?__________ [42-47]*
4. When the first interview was done, (child's name) had a medical card. Does she/he still have a medical card?
   __ YES, [Go to #5]    __ NO  
   [43]

4a. [If NO, ask:] Why doesn't she/he have a medical card anymore?

5. As you may recall from the first interview, we wanted to get a sense for the caregiving responsibility you have. To do that, we asked you to tell us the number of people living in your home and how many of those people you had to spend time taking care of. Since the first interview, have there been any changes in the number of people who are living in your home?
   __ YES, [Ask #5a and #5b]    __ NO, [Go to #6]  
   [If the respondent is not sure what s/he said the first time, ask #5a and #5b]  
   [50]

5a. [If YES, ask:] Please tell me just the AGES of all the people in your home other than you and (child's name).

<table>
<thead>
<tr>
<th>Person</th>
<th>Age</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>[51-52]</td>
<td></td>
</tr>
<tr>
<td>#2</td>
<td>[54-55]</td>
<td>[56]</td>
</tr>
<tr>
<td>#3</td>
<td>[57-54]</td>
<td>[59]</td>
</tr>
</tbody>
</table>

   __ N/A: Respondent and Child are the ONLY people in the home. [Go To #5]  

5b. [If any teens [13 years & up] or adults are listed, ask]: Do any of the teenagers/adults who are living with you require extra care from you because they have a disability, for example, a physical handicap, a chronic illness, a developmental handicap, or a serious emotional handicap? [Put a ✓ in the "Care" column by the people identified as dependent.]

6. Do you have someone who shares daily parenting/caregiving responsibilities with you?
   __ YES,    __ NO  [Go to #7]  
   [60]

6a. [If YES, ask:] What is their relationship to you? (primary person)
   __ Spouse/Partner,  __ Multiple Relatives,  __ Friend(s),
   __ Parent,  __ Sibling,  __ Babysitter,
   __ Other Relative,  __ Boy/Girlfriend,  __ Other,  
   [70]
7. Have you moved since the first interview?  ____ Yes,  ____ No (Go To #8) [71]

7a. (If MOVED, ask): What city/town do you list as your address? ________________ [72]

7b. (If MOVED, ask): Do you live within this city/town’s limits?

  ____ YES, (Go to #7c)  ____ NO  ____ DON’T KNOW, [73]
  → (If NO or DON’T KNOW, ask):
    How many miles from this city/town do you live?
    ____________________ Miles. [74-75]

7c. (If MOVED, ask): How many miles do you live from:

  ____ (miles) the nearest Post Office [76-77]
  ____ (miles) the nearest Public Library [78-79]
  ____ (miles) the nearest hospital [80-81]
  ____ (miles) your child’s school [82-83]
  ____ (miles) the mental health office [84-85]

  (child’s name) is/was going to ____________ [86-87]

7d. (If MOVED, ask): Are there any times of the year when you cannot travel?

  ____ YES,  ____ NO (Go to #8) [88]
  → (If YES, ask): When, for how long, and why can’t you travel?: ____________________

8. Do you consider your family as living in an area that is RURAL or URBAN (circle one)? [87]

COMMENTS: __________________________________________________________
NOW I WOULD LIKE TO ASK YOU ABOUT THE MENTAL HEALTH SERVICES (CHILD’S NAME) HAS RECEIVED SINCE THE FIRST INTERVIEW.

<table>
<thead>
<tr>
<th>9. Has (child’s name) received any mental health services since the first interview for this project?</th>
</tr>
</thead>
<tbody>
<tr>
<td>____ YES, [Go to #10]</td>
</tr>
</tbody>
</table>
| ____ NO  [If NO, ask: I am going to read you a list of things that can get in a parent’s way of getting their child to mental health services. Please tell me if any of these kept you from getting (child’s name) started in mental health services.  
  (Read each item; check all that apply; record anecdotal information.)] |
| ______ Transportation problems                   |
| ______ Child care problems                       |
| ______ Was too far to travel                     |
| ______ Time conflict                             |
| ______ Child refused to be in treatment          |
| ______ Confused about next step                  |
| ______ Would have been disruptive to regular family routine |
| ______ Decided child did not need mental health services |
| ______ Didn’t think mental health services would help |
| ______ Didn’t feel comfortable being associated with mental health services |
| ______ Didn’t think mental health services would meet child’s and/or your ethnic/cultural needs |
| ______ Thought it would conflict with child’s and/or your religious beliefs or spirituality |
| ______ Didn’t think anyone would speak child’s and/or your language (includes sign language) |
| ______ Other:                                   |
| ______ NONE APPLY                                |
| [Go to #23]                                     |
10. A child will usually receive a mental health evaluation before treatment/counseling begins. The evaluation is done to identify the child’s difficulties and decide what services are needed. Did (child’s name) receive a mental health evaluation?

<table>
<thead>
<tr>
<th><em>YES</em></th>
<th>[103]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(If YES, ask): Were you given the results of that evaluation?</strong></td>
<td><em>YES</em>, <em>NO</em></td>
</tr>
<tr>
<td><strong>(If results were given, ask):</strong></td>
<td>[104]</td>
</tr>
<tr>
<td>Were you shown a copy of the written report?</td>
<td><em>YES</em>, <em>NO</em></td>
</tr>
<tr>
<td>Did the therapist verbally review the results with you?</td>
<td><em>YES</em>, <em>NO</em></td>
</tr>
<tr>
<td><em>NO</em>, (Go to #12)</td>
<td>[105]</td>
</tr>
<tr>
<td><em>DON’ T KNOW</em>, (Go to #12)</td>
<td></td>
</tr>
</tbody>
</table>

11. (Hand the CHOICES card): Looking at LIST A on the CHOICES card, generally how satisfied were you with the mental health evaluation for (child’s name)? (Circle their choice.)

| 1 | 2 | 3 | 4 | 5 |
| Very Satisfied | Mixed | Dissatisfied | Very Dissatisfied | [107] |

**COMMENTS:**

12. Were you given a name or diagnosis for (child’s name) condition or disorder?

<table>
<thead>
<tr>
<th><em>YES</em>,</th>
<th>[108]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(If YES, ask): What is the name or diagnosis you were given? (Check all that apply.)</strong></td>
<td>[109]</td>
</tr>
<tr>
<td><em>Don’t know/Can’t recall</em></td>
<td>Eating Disorder (Anorexia, Bulimia, or Obesity)</td>
</tr>
<tr>
<td>Adjustment Disorder</td>
<td>Enuresis/Encopresis</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>Attachment Disorder</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>Oppositional Disorder</td>
</tr>
<tr>
<td>Autistic Disorder</td>
<td>Phobia</td>
</tr>
<tr>
<td>Avoidant Disorder</td>
<td>Post Traumatic Stress Disorder (PTSD)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>(Manic-Depression)</td>
<td>Substance Abuse/Dependence</td>
</tr>
<tr>
<td>Childhood Depression</td>
<td>Tourette’s Syndrome</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>Other: ___________________________</td>
</tr>
<tr>
<td>Developmental Disorder</td>
<td>[110]</td>
</tr>
<tr>
<td>(Mental Retardation)</td>
<td>[111]</td>
</tr>
</tbody>
</table>
13. Other than a mental health evaluation, what type(s) of mental health services has [child's name] received? (check all that apply)

___ Individual therapy [131] ___ Family therapy [133]
___ Group therapy [132] ___ Day treatment [134]
___ Other: _____________________________________________ [135]

14. How often do the scheduled appointments occur?

___ 1/week; ___ 1/two weeks; ___ 1/month;
___ Other: _____________________________________________ [136]

14a. Looking at List B on the CHOICES card, generally how do you feel about how often the appointments occur? (circle their choice)

1 Not Often 2 Just 3 Too

Enough Right Often [137]

COMMENTS: _____________________________________________
_________________________________________________________

15. How many mental health appointments has [child's name] attended?

(Encourage respondent to make her/his best guess. When necessary, show calendar to help respondent recall first appointment and count forward.)

___ Appointments Attended
___ N/A; Child in Day Treatment (i.e., not attending isolated appointments) [138-139]
16. Were there any scheduled appointments that (child's name) and/or you had to miss?

--- YES ---

(If YES, ask): How many appointments were missed? ________

(Use the calendar, if helpful)

(If YES, ask): I am going to read you a list of things that can get in a parent's way of getting their child to mental health appointments. Please tell me if any of these were reasons why (child's name) was unable to attend some of her/his mental health appointments. (Read each item; check all that apply; record anecdotal information.)

- Transportation problems
- Child care problems
- Was too far to travel
- Time conflict
- Child refused to attend treatment sessions
- Was disruptive to regular family routine
- Decided child did not need mental health services
- Didn’t feel the mental health services were helping
- Didn’t feel comfortable being associated with mental health services
- Didn’t think mental health services were meeting child’s and/or your ethnic/cultural needs
- Mental health services conflicted with child’s and/or your religious beliefs or spirituality
- Mental health worker didn’t speak child’s and/or your language (includes sign language)
- Disagreed with diagnosis or treatment approach
- Didn’t like therapist/counselor/social worker/program
- Other: ________________________________

--- NO ---

NONE APPLY (Go to #17)

17. Were the services (child's name) received the type you expected she/he would get?

--- YES ---

(Go To #18)  --- NO ---

17a. (If NO, ask): How have they been different?

__________________________________________________________

__________________________________________________________

__________________________________________________________
18. Is (child’s name) still receiving mental health services?

___ YES, [155]

[If YES, ask:] What type of services is she/he receiving now? (check all that apply)

___ Individual therapy [159] ___ Family therapy [161] ___ Other: [163]

___ Group therapy [160] ___ Day treatment [162] (Go To #19)

___ NO, [16] (If NO, ask): I am going to read you a list of things that can get in the way of getting a child to mental health services. Please tell me if any of these were reasons for (child’s name) ENDING mental health services.

(Read each item; check all that apply; record anecdotal information.)

___ Therapist said treatment was completed [164]

___ Child doing better, we chose to end treatment [165]

___ Transportation problems [166]

___ Child care problems [167]

___ Was too far to travel [168]

___ Time conflict [169]

___ Child refused to be in treatment [170]

___ Was disruptive to regular family routine [171]

___ Didn’t feel the mental health services were helping [172]

___ Didn’t feel comfortable being associated with mental health services [173]

___ Didn’t think mental health services were meeting child’s and/or your ethnic/cultural needs [174]

___ Mental health services conflicted with child’s and/or your religious beliefs or spirituality [175]

___ Mental health worker didn’t speak child’s and/or your language (includes sign language) [176]

___ Didn’t like therapist/counselor/social worker/program [177]

___ Disagreed with diagnosis or treatment approach [178]

___ Other: [179]

___ NONE APPLY

19. (Hand the CHOICES card): Looking at List A on this CHOICES card, generally, how satisfied have you been with the mental health services (child’s name) received? (Circle their choice.)

1 Very Satisfied

2 Mixed

3 Dissatisfied

4 Very Satisfied

5 Dissatisfied

COMMENTS: ____________________________
20. Looking at LIST A, generally how satisfied are you with how you have been treated as a parent/caregiver during [child's name] mental health services? (Circle their choice.)

1 2 3 4 5
Very Satisfied Mixed Dissatisfied Very Satisfied
Satisfied Feelings Dissatisfied

COMMENTS: __________________________________________________________

21. Looking at LIST A, generally how satisfied are you with the therapist(s) or counselor(s) who provided the mental health services for [child's name]? (Circle their choice.)

1 2 3 4 5
Very Satisfied Mixed Dissatisfied Very Satisfied
Satisfied Feelings Dissatisfied

COMMENTS: __________________________________________________________

22. Looking at LIST A, generally how satisfied are you with the level of involvement you had in [child's name] mental health services? (Circle their choice.)

1 2 3 4 5
Very Satisfied Mixed Dissatisfied Very Satisfied
Satisfied Feelings Dissatisfied

COMMENTS: __________________________________________________________

23. Since the first interview for this project, have you participated in a parent support group?
___ YES, ___ NO, (Go to #24)

23a. (If YES, ask): Looking at LIST C on the CHOICES card, generally how do you feel about having participated in the parent support group?

1 2 3 4 5
All Mostly Good, Half Good, Mostly Bad, All
Good Some Bad Half Bad Some Good Bad

COMMENTS: __________________________________________________________
COMPARISON FAMILIES

THE GOAL OF THIS RESEARCH PROJECT IS TO LEARN WHAT PARENTS NEED TO MAKE IT EASIER WHEN THEY ARE JUST GETTING STARTED IN THE CHILDREN'S MENTAL HEALTH SYSTEM. I WILL ASK YOU SOME QUESTIONS ABOUT THINGS THAT WOULD HAVE BEEN HELPFUL FOR YOU. I'D LIKE YOU TO THINK BACK OVER THE PAST FEW MONTHS, SINCE [CHILD'S NAME] WAS REFERRED FOR MENTAL HEALTH SERVICES, AND USE YOUR IMAGINATION TO COME UP WITH ANYTHING THAT WOULD HAVE MADE THE PROCESS EASIER FOR YOU. THE ANSWERS YOU GIVE ME WILL BE COMBINED WITH THOSE OF OTHER PARENTS AND WILL BE PRESENTED TO THE PEOPLE WHO MANAGE CHILDREN'S MENTAL HEALTH. THE GOAL IS TO IMPROVE THE SYSTEM.

23. Thinking back to when [child's name] was referred for mental health services, in general, what things could have made the process easier for you? [Encourage the respondent to be as creative as possible, no matter how unrealistic their ideas may be.]

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
24. I WOULD LIKE TO ASK YOU ONE LAST QUESTION. THIS IS ABOUT HOW YOUR FAMILY IS DOING NOW COMPARED TO OVER THE LAST FEW MONTHS.

[Show respondent graph]: This is a graph that will show how well your family was doing at two times in the past and right now. By "how well your family was doing" I mean, in general, how well your family was communicating, dealing with disagreements, and solving problems. Looking at the graph, this line ranges from "Really Great" to "Not Great, But OK" to "Really Badly". We will be using that range to describe your family.

Let's start when you were first interviewed for this project on [See first page for date]. Thinking back to that time, put an X on this line to show how well your family was doing.

[If necessary, help the respondent decide where to put the X. Make sure you do NOT decide for them, but rather just help them understand and manage the task.]

Now, thinking back to two months ago, which would be about ________, please put an X on this line to show how well your family was doing at that time.

Now, on this line, put an X to show how well your family is doing right now.

Before moving on to the questionnaires, is there anything you would like to add or comment on, or are there any additional reactions to getting [child's name] started in mental health services you would like to give us? ____________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
HOW WELL MY FAMILY WAS AND IS DOING

REALLY GREAT
10 10 10

NOT GREAT BUT OK
5 5 5

REALLY BADLY
1 1 1

FIRST INTERVIEW 2 MONTHS AGO RIGHT NOW
INTRODUCING THE QUESTIONNAIRES

We have finished the first part of this interview. Now I would like to ask you to fill out a few questionnaires. It should take about 25 to 30 minutes. Again, we have three options for you. You can read the questionnaires in English, or we have them in Spanish, or I could read them to you. Which would you prefer? (Give a brief overview for each of the questionnaires. Point out the parts of the CBCL that are not completed. Emphasize that the questionnaires are double-sided. When s/he is done filling them out, say): Did you have any questions about any of the items?

(Respond to any questions s/he may have. If help is needed to understand an item, do your best to rephrase the item without changing the meaning of the item or providing the respondent with any additional information. Review each questionnaire to make sure all of the items were answered and say): I just need to quickly glance through these to make sure everything is filled out.

CLOSING SUMMARY FOR FOLLOW-UP INTERVIEW

(If the respondent cannot complete the questionnaires, give her/him the option of keeping them to finish and schedule a time to pick them up within 2-4 days. Explain that s/he will receive the $25 when the forms are completed and picked-up. Thank the respondent for her/his time and help.)

(For those who complete all of the questionnaires, say): Thank you very much for participating in this interview. You have helped us a lot and we appreciate your time. Here is your $25 check. Please sign this receipt to show that you have received the $25 for this follow-up interview.

We hope to conduct another interview with you and other families in the future. It would probably happen sometime within a year. As we have done for the first two interviews, we would pay families for doing that interview. If it occurs, would you be willing to let us contact you again?

If [NO]: Again, thank you for your time. I have enjoyed talking with you.

If [YES, read]: Let's read over this form, which allows us to contact you for another interview, and to answer any questions you may have. Again, thank you for your time. I have enjoyed talking with you.
APPENDIX E
Questionnaires
# Child Behavior Checklist for Ages 4-18

**Child's Name:**

**Sex:**
- [ ] Boy
- [ ] Girl

**Age:**

**Ethnic Group or Race:**

**Today's Date:**

**Child's Birthday:**

**Father's Type of Work:**

**Mother's Type of Work:**

**Grade in School:**

- [ ] Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to write additional comments beside each item and in the spaces provided on page 2.

**Not Attending School:**

---

## I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skateboarding, bike riding, fishing, etc.

- [ ] None
  - a. __________________________
  - b. __________________________
  - c. __________________________

## II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do not include listening to radio or TV.)

- [ ] None
  - a. __________________________
  - b. __________________________
  - c. __________________________

## III. Please list any organizations, clubs, teams, or groups your child belongs to.

- [ ] None
  - a. __________________________
  - b. __________________________
  - c. __________________________

## IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

- [ ] None
  - a. __________________________
  - b. __________________________
  - c. __________________________

---

**Compared to others of the same age, about how much time does he/she spend in each?**

<table>
<thead>
<tr>
<th>Don't Know</th>
<th>Less Than Average</th>
<th>Average</th>
<th>More Than Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Compared to others of the same age, how well does he/she do each one?**

<table>
<thead>
<tr>
<th>Don't Know</th>
<th>Below Average</th>
<th>Average</th>
<th>Above Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**This form filled out by:**

- [ ] Mother (name):
- [ ] Father (name):
- [ ] Other - name & relationship to child:

---

For office use only ID #
V. 1. About how many close friends does your child have? □ None □ 1 □ 2 or 3 □ 4 or more
(Do not include brothers & sisters)
2. About how many times a week does your child do things with any friends outside of regular school hours?
(Do not include brothers & sisters) □ Less than 1 □ 1 or 2 □ 3 or more

VI. Compared to others of his/her age, how well does your child:

<table>
<thead>
<tr>
<th></th>
<th>Worse</th>
<th>About Average</th>
<th>Better</th>
<th>□ Has no brothers or sisters</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Get along with his/her brothers &amp; sisters?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Get along with other kids?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Behave with his/her parents?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Play and work by himself/herself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VII. 1. For ages 6 and older—performance in academic subjects. If child is not being taught, please give reason

<table>
<thead>
<tr>
<th></th>
<th>Falling</th>
<th>Below average</th>
<th>Average</th>
<th>Above average</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reading, English, or Language Arts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. History or Social Studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Arithmetic or Math</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Science</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. _____</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>f. _____</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. _____</td>
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<td></td>
</tr>
</tbody>
</table>

Other academic subjects—for example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., etc.

2. Is your child in a special class or special school? □ No □ Yes—what kind of class or school?

3. Has your child repeated a grade? □ No □ Yes—grade and reason

4. Has your child had any academic or other problems in school? □ No □ Yes—please describe

When did these problems start?
Have these problems ended? □ No □ Yes—when?

Does your child have any illness, physical disability, or mental handicap? □ No □ Yes—please describe

What concerns you most about your child?

Please describe the best things about your child:
Below is a list of items that describe children and youth. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child; circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

<table>
<thead>
<tr>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 1. Acts too young for his/her age</td>
<td>0 1 2 31. Feels he/she might think or do something bad</td>
<td></td>
</tr>
<tr>
<td>0 1 2 2. Allergy (describe):</td>
<td>0 1 2 32. Feels he/she has to be perfect</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3. Argues a lot</td>
<td>0 1 2 33. Feels or complains that no one loves him/her</td>
<td></td>
</tr>
<tr>
<td>0 1 2 4. Asthma</td>
<td>0 1 2 34. Feels others are out to get him/her</td>
<td></td>
</tr>
<tr>
<td>0 1 2 5. Behaves like opposite sex</td>
<td>0 1 2 35. Feels worthless or inferior</td>
<td></td>
</tr>
<tr>
<td>0 1 2 6. Bowel movements outside toilet</td>
<td>0 1 2 36. Gets hurt a lot, accident-prone</td>
<td></td>
</tr>
<tr>
<td>0 1 2 7. Bragging, boasting</td>
<td>0 1 2 37. Gets in many fights</td>
<td></td>
</tr>
<tr>
<td>0 1 2 8. Can't concentrate, can't pay attention for long</td>
<td>0 1 2 38. Gets teased a lot</td>
<td></td>
</tr>
<tr>
<td>0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe):</td>
<td>0 1 2 39. Hangs around with others who get in trouble</td>
<td></td>
</tr>
<tr>
<td>0 1 2 10. Can't sit still, restless, or hyperactive</td>
<td>0 1 2 40. Hears sounds or voices that aren't there</td>
<td></td>
</tr>
<tr>
<td>0 1 2 11. Clings to adults or too dependent</td>
<td>0 1 2 41. Impulsive or acts without thinking</td>
<td></td>
</tr>
<tr>
<td>0 1 2 12. Complains of loneliness</td>
<td>0 1 2 42. Would rather be alone than with others</td>
<td></td>
</tr>
<tr>
<td>0 1 2 13. Confused or seems to be in a fog</td>
<td>0 1 2 43. Lying or cheating</td>
<td></td>
</tr>
<tr>
<td>0 1 2 14. Cries a lot</td>
<td>0 1 2 44. Bites fingernails</td>
<td></td>
</tr>
<tr>
<td>0 1 2 15. Cruel to animals</td>
<td>0 1 2 45. Nervous, highstrung, or tense</td>
<td></td>
</tr>
<tr>
<td>0 1 2 16. Cruelty, bullying, or meanness to others</td>
<td>0 1 2 46. Nervous movements or twitching (describe):</td>
<td></td>
</tr>
<tr>
<td>0 1 2 17. Daydreams or gets lost in his/her thoughts</td>
<td>0 1 2 47. Nightmares</td>
<td></td>
</tr>
<tr>
<td>0 1 2 18. Deliberately harms self or attempts suicide</td>
<td>0 1 2 48. Not liked by other kids</td>
<td></td>
</tr>
<tr>
<td>0 1 2 19. Demands a lot of attention</td>
<td>0 1 2 49. Constipated, doesn't move bowels</td>
<td></td>
</tr>
<tr>
<td>0 1 2 20. Destroys his/her own things</td>
<td>0 1 2 50. Too fearful or anxious</td>
<td></td>
</tr>
<tr>
<td>0 1 2 21. Destroys things belonging to his/her family or others</td>
<td>0 1 2 51. Feels dizzy</td>
<td></td>
</tr>
<tr>
<td>0 1 2 22. Disobedient at home</td>
<td>0 1 2 52. Feels too guilty</td>
<td></td>
</tr>
<tr>
<td>0 1 2 23. Disobedient at school</td>
<td>0 1 2 53. Overeating</td>
<td></td>
</tr>
<tr>
<td>0 1 2 24. Doesn't eat well</td>
<td>0 1 2 54. Overtired</td>
<td></td>
</tr>
<tr>
<td>0 1 2 25. Doesn't get along with other kids</td>
<td>0 1 2 55. Overweight</td>
<td></td>
</tr>
<tr>
<td>0 1 2 26. Doesn't seem to feel guilty after misbehaving</td>
<td>56. Physical problems without known medical cause.</td>
<td></td>
</tr>
<tr>
<td>0 1 2 27. Easily jealous</td>
<td>0 1 2 56a. Acnes or pains (not headaches)</td>
<td></td>
</tr>
<tr>
<td>0 1 2 28. Eats or drinks things that are not food – don't include sweets (describe):</td>
<td>0 1 2 56b. Headaches</td>
<td></td>
</tr>
<tr>
<td>0 1 2 29. Fears certain animals, situations, or places, other than school (describe):</td>
<td>0 1 2 56c. Nausea, feels sick</td>
<td></td>
</tr>
<tr>
<td>0 1 2 30. Fears going to school</td>
<td>0 1 2 56d. Problems with eyes (describe):</td>
<td></td>
</tr>
</tbody>
</table>

*Please see other side*
<table>
<thead>
<tr>
<th>0 = Not True (as far as you know)</th>
<th>1 = Somewhat or Sometimes True</th>
<th>2 = Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 57. Physically attacks people</td>
<td>0 1 2 64. Strange behavior (describe):</td>
<td>0 1 2 65. Strange ideas (describe):</td>
</tr>
<tr>
<td>0 1 2 58. Picks nose, skin, or other parts of body (describe):</td>
<td>0 1 2 66. Plays with own sex parts in public</td>
<td>0 1 2 67. Stubborn, sulen, or irritable</td>
</tr>
<tr>
<td>0 1 2 60. Plays with own sex parts too much</td>
<td>0 1 2 61. Poor school work</td>
<td>0 1 2 62. Sudden changes in mood or feelings</td>
</tr>
<tr>
<td>0 1 2 62. Poorly coordinated or clumsy</td>
<td>0 1 2 63. Prefers being with older kids</td>
<td>0 1 2 64. Prefers being with younger kids</td>
</tr>
<tr>
<td>0 1 2 65. Prefers being with younger kids</td>
<td>0 1 2 66. Refuses to talk</td>
<td>0 1 2 67. Talks about killing self</td>
</tr>
<tr>
<td>0 1 2 68. Repeats certain acts over and over; compulsions (describe):</td>
<td>0 1 2 69. Talks or walks in sleep (describe):</td>
<td>0 1 2 91. Talks too much</td>
</tr>
<tr>
<td>0 1 2 70. Sees things that aren’t there (describe):</td>
<td>0 1 2 92. Screams a lot</td>
<td>0 1 2 93. Screams a lot</td>
</tr>
<tr>
<td>0 1 2 71. Self-conscious or easily embarrassed</td>
<td>0 1 2 74. Secretive, keeps things to self</td>
<td>0 1 2 95. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 72. Sets fires</td>
<td>0 1 2 75. Secretive, keeps things to self</td>
<td>0 1 2 96. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 73. Sexual problems (describe):</td>
<td>0 1 2 76. Secretive, keeps things to self</td>
<td>0 1 2 97. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 77. Secretive, keeps things to self</td>
<td>0 1 2 78. Secretive, keeps things to self</td>
<td>0 1 2 98. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 78. Self-concious or easily embarrassed</td>
<td>0 1 2 79. Secretive, keeps things to self</td>
<td>0 1 2 99. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 72. Sets fires</td>
<td>0 1 2 80. Secretive, keeps things to self</td>
<td>0 1 2 100. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 74. Secretive, keeps things to self</td>
<td>0 1 2 81. Secretive, keeps things to self</td>
<td>0 1 2 101. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 75. Shy or timid</td>
<td>0 1 2 82. Secretive, keeps things to self</td>
<td>0 1 2 102. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 76. Sleeps less than most kids</td>
<td>0 1 2 83. Secretive, keeps things to self</td>
<td>0 1 2 103. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 77. Sleeps more than most kids during day and/or night (describe):</td>
<td>0 1 2 84. Secretive, keeps things to self</td>
<td>0 1 2 104. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 78. Secretive, keeps things to self</td>
<td>0 1 2 85. Secretive, keeps things to self</td>
<td>0 1 2 105. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 79. Secretive, keeps things to self</td>
<td>0 1 2 86. Secretive, keeps things to self</td>
<td>0 1 2 106. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 80. Secretive, keeps things to self</td>
<td>0 1 2 87. Secretive, keeps things to self</td>
<td>0 1 2 107. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 81. Secretive, keeps things to self</td>
<td>0 1 2 88. Secretive, keeps things to self</td>
<td>0 1 2 108. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 82. Secretive, keeps things to self</td>
<td>0 1 2 89. Secretive, keeps things to self</td>
<td>0 1 2 109. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 83. Secretive, keeps things to self</td>
<td>0 1 2 90. Secretive, keeps things to self</td>
<td>0 1 2 110. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 84. Secretive, keeps things to self</td>
<td>0 1 2 91. Secretive, keeps things to self</td>
<td>0 1 2 111. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 85. Secretive, keeps things to self</td>
<td>0 1 2 92. Secretive, keeps things to self</td>
<td>0 1 2 112. Secretive, keeps things to self</td>
</tr>
<tr>
<td>0 1 2 86. Secretive, keeps things to self</td>
<td>0 1 2 93. Secretive, keeps things to self</td>
<td>0 1 2 113. Secretive, keeps things to self</td>
</tr>
</tbody>
</table>
# Parent Survey - I

Information about what you expect from mental health treatment for your child will help us understand how therapists can be most helpful to parents. Below is a list of things a therapist may do. We would like you to tell us the things you expect from the therapist who will be working with your child. Please rate each of the items in two ways:

1. How important is it to you that the therapist does this?
2. Do you think the therapist will actually do this?

**NOTE:** In this survey, the terms "treatment", "therapy", and "counseling" are all used to mean the mental health services children receive. The term "therapist" is used to mean the person who provides those mental health services (also called a "counselor", "social worker", or "psychologist").

**AN EXAMPLE:** It may be "very" important to you that the therapist makes home visits, but you do not think the therapist will actually do this. Your answer would look like this:

<table>
<thead>
<tr>
<th>How important is it to you she/he does this?</th>
<th>Do you think she/he will do this?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Yes</td>
</tr>
<tr>
<td>Very</td>
<td>No</td>
</tr>
<tr>
<td>Don't Know</td>
<td>Don't know</td>
</tr>
</tbody>
</table>

EX: Makes home visits

Please circle the best choice for each item on each rating.

<table>
<thead>
<tr>
<th><strong>How important is it to you she/he does this?</strong></th>
<th><strong>Do you think she/he will do this?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Yes</td>
</tr>
<tr>
<td>Very</td>
<td>No</td>
</tr>
<tr>
<td>Don't Know</td>
<td>Don't know</td>
</tr>
</tbody>
</table>

1. Helps you cope with raising your child
2. Is supportive to you
3. Is supportive to your child
4. Provides an accurate evaluation of your child’s problems
5. Works with other organizations (for example, school, children’s services, court) to make sure your child’s needs are met
6. Treats you with respect (that is, non-blaming)
7. Provides information about available treatment methods for your child
8. Provides information about practical child-raising techniques
9. Is available to you on a 24-hour basis (for example, in times of crisis)
10. Includes you in making decisions about the treatment for your child
11. Follows up with you to see how things worked out
12. Is honest with you
13. Provides useful information about available resources
14. Values your opinions and knowledge about your child
15. Helps you get some relief from your childcare responsibilities for a short time (for example, finding respite care)
16. Gives you information and materials about problems your child has
17. Cares about how you feel and what you need as a parent
18. Provides counseling for your child
19. Provides individual counseling for you
20. Provides counseling for your family
21. Has you attend treatment sessions with your child
22. Keeps you informed about your child’s progress in treatment
23. Tells you the things your child says during treatment
24. Tells you how long treatment will last
25. Gets your permission before releasing your child’s records to anyone

Please continue
We would like to know what your opinions are about mental health treatment for children. This will help us better understand how parents feel about child therapy. Please give us your most honest opinions. Please circle the best choice for each item in order to tell us how strongly you AGREE or DISAGREE with each of the following items:

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental health treatment for children reduces child behavior problems (for example, reduce fighting, wetting the bed, running away, etc.).</td>
<td>Strongly,</td>
<td>Somewhat,</td>
<td>Somewhat,</td>
<td>Strongly,</td>
</tr>
<tr>
<td>2. Mental health treatment for children helps children cope better emotionally (for example, feeling less sad, angry, worried, etc.).</td>
<td>Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>3. Child therapists need to have children of their own before they can really know how to help parents manage child behavioral and/or emotional problems.</td>
<td>Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>4. Having my child and/or my family involved in mental health services makes me feel uncomfortable.</td>
<td>Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
</tbody>
</table>

If you have any other opinions or comments about child treatment or therapists, please write them below:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
# PARENT SURVEY - II

Information about what you expect from mental health treatment for your child and what you actually receive will help us understand how therapists can be most helpful to parents. Below is a list of things a therapist may do. Thinking about the therapist who has been working with your child, please rate each of the items in two ways:

1. How important is it to you that the therapist did this?
2. How often did the therapist actually do this?

**NOTE:** In this survey, the terms "treatment", "therapy", and "counseling" are all used to mean the mental health services children receive. The term "therapist" is used to mean the person who provides those mental health services (also called a "counselor", "social worker", or "psychologist").

**AN EXAMPLE:** It may have been "very" important to you that the therapist made home visits, but the therapist "never" did it. Your answer would look like this:

<table>
<thead>
<tr>
<th>Not At All</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important is it to you she/he did this?</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>How often did she/he do this?</td>
<td></td>
<td></td>
<td></td>
<td>(1)</td>
</tr>
</tbody>
</table>

---

EX: Made home visits .................................................. 1 2 3 4 ... (1) 2 3 4

---

Please circle the best choice for each item on each rating.

<table>
<thead>
<tr>
<th>Not At All</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Very</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important is it to you she/he did this?</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>How often did she/he do this?</td>
<td></td>
<td></td>
<td></td>
<td>(1)</td>
</tr>
</tbody>
</table>

1. Helped you cope with raising your child ........................................ 1 2 3 4 ... 1 2 3 4
2. Was supportive to you .................................................. 1 2 3 4 ... 1 2 3 4
3. Was supportive to your child ........................................ 1 2 3 4 ... 1 2 3 4
4. Provided an accurate evaluation of your child's problems .... 1 2 3 4 ... 1 2 3 4
5. Worked with other organizations (for example, school, children's services, court) to make sure your child's needs were met ... 1 2 3 4 ... 1 2 3 4
6. Treated you with respect (that is, non-blaming) ......................... 1 2 3 4 ... 1 2 3 4
7. Provided information about available treatment methods for your child .... 1 2 3 4 ... 1 2 3 4
8. Provided information about practical child-raising techniques .... 1 2 3 4 ... 1 2 3 4
9. Was available to you on a 24-hour basis (for example, times of crisis) ... 1 2 3 4 ... 1 2 3 4
10. Included you in making decisions about the treatment for your child ... 1 2 3 4 ... 1 2 3 4
11. Followed up with you to see how things worked out ... 1 2 3 4 ... 1 2 3 4
12. Was honest with you .................................................. 1 2 3 4 ... 1 2 3 4
13. Provided useful information about available resources ... 1 2 3 4 ... 1 2 3 4
14. Valued your opinions and knowledge about your child ... 1 2 3 4 ... 1 2 3 4
15. Helped you get some relief from your child-care responsibilities for a short time (for example, finding respite care) ... 1 2 3 4 ... 1 2 3 4
16. Gave you information and materials about problems your child has ... 1 2 3 4 ... 1 2 3 4
17. Cared about how you felt and what you needed as a parent ... 1 2 3 4 ... 1 2 3 4
18. Provided counseling for your child ... 1 2 3 4 ... 1 2 3 4
19. Provided individual counseling for you ... 1 2 3 4 ... 1 2 3 4
20. Provided counseling for your family ... 1 2 3 4 ... 1 2 3 4
21. Had you attend treatment sessions with your child ... 1 2 3 4 ... 1 2 3 4
22. Kept you informed about your child's progress in treatment ... 1 2 3 4 ... 1 2 3 4
23. Told you about the things your child said during treatment ... 1 2 3 4 ... 1 2 3 4
24. Told you how long treatment would last ... 1 2 3 4 ... 1 2 3 4
25. Got your permission before releasing your child's records to anyone ... 1 2 3 4 ... 1 2 3 4

**Please Continue—**
We would like to know what your opinions are about mental health treatment for children. This will help us better understand how parents feel about child therapy. Please give us your most honest opinions. Please circle the best choice for each item in order to tell us how strongly you AGREE or DISAGREE with each of the following items:

<table>
<thead>
<tr>
<th>1. Mental health treatment for children reduces child behavior problems (for example, reduce fighting, wetting the bed, running away, etc.).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Strongly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Mental health treatment for children helps children cope better emotionally (for example, feeling less sad, angry, worried, etc.).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Strongly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Child therapists need to have children of their own before they can really know how to help parents manage child behavioral and/or emotional problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Strongly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Having my child and/or my family involved in mental health services makes me feel uncomfortable.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Strongly</td>
</tr>
</tbody>
</table>

If you have any other opinions or comments about child treatment or therapists, please write them below:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**THERAPIST RATING SCALE - I**

Information about what personality traits or characteristics you expect your child's therapist to have will help us understand how therapists can be most helpful to parents. Below is a list of statements describing personality traits. We would like you to tell us what you EXPECT the therapist who will be working with your child to be like. Please rate each of the items in terms of: How important is it to you that the therapist will have this trait?

Note: In this survey, the term "therapist" is used to mean the person who provides mental health services (also called a "counselor", "social worker", or "psychologist").

<table>
<thead>
<tr>
<th>Please circle the number of the best choice for each item:</th>
<th>How important is it to you she/he have this trait?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is enthusiastic about working with you</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>2. Says things that always agree with what he/she seems to think or feel</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>3. Tolerates your fears</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>4. Is a likeable person</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>5. Encourages you to keep trying</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>6. Respects your viewpoint</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>7. Has a personality and behaviors such that you would select him/her as your child's therapist if you had a choice</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>8. Respects you as an individual</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>9. Really likes you and shows it</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>10. Understands your words and the way you feel</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>11. Helps you feel happier</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>12. Is interested in you</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>13. You like your child's therapist</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>14. Is a warm person</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>15. Tries to see things through your eyes</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>16. Tolerates your wishes and needs</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>17. Gives you encouragement</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>18. Seems interested in your child's case</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>19. Is honest about how she/he feels about you</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>20. Seems interested in what you have to say</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>21. Is patient with you</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>22. Avoids being critical of you</td>
<td>1    2    3    4</td>
</tr>
<tr>
<td>23. Avoids making assumptions about how you feel</td>
<td>1    2    3    4</td>
</tr>
</tbody>
</table>
## THERAPIST RATING SCALE - II

Below is a list of statements describing personality traits or characteristics. We would like you to rate how much each statement describes the personality of your child's therapist since treatment began.

**NOTE:** In this survey, the term "therapist" is used to mean the person who provides mental health services (also called a "counselor", "social worker", or "psychologist").

<table>
<thead>
<tr>
<th>Please circle the number of the best choice for each item:</th>
<th>How much does this describe her/his personality?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not At All</td>
</tr>
<tr>
<td>1. Has been enthusiastic about working with you</td>
<td>1</td>
</tr>
<tr>
<td>2. Has said things that always agreed with what he/she seemed to think or feel</td>
<td>1</td>
</tr>
<tr>
<td>3. Has tolerated your fears</td>
<td>1</td>
</tr>
<tr>
<td>4. Has been a likeable person</td>
<td>1</td>
</tr>
<tr>
<td>5. Has encouraged you to keep trying</td>
<td>1</td>
</tr>
<tr>
<td>6. Has respected your viewpoint</td>
<td>1</td>
</tr>
<tr>
<td>7. Has had a personality and behaviors such that you would have selected this person as your child's therapist if you had been given a choice</td>
<td>1</td>
</tr>
<tr>
<td>8. Has respected you as an individual</td>
<td>1</td>
</tr>
<tr>
<td>9. Has really liked you and has shown it</td>
<td>1</td>
</tr>
<tr>
<td>10. Has understood what you have said and the way you have felt</td>
<td>1</td>
</tr>
<tr>
<td>11. Has helped you feel happier</td>
<td>1</td>
</tr>
<tr>
<td>12. Has been interested in you</td>
<td>1</td>
</tr>
<tr>
<td>13. You have liked your child's therapist</td>
<td>1</td>
</tr>
<tr>
<td>14. Has been a warm person</td>
<td>1</td>
</tr>
<tr>
<td>15. Has tried to see things through your eyes</td>
<td>1</td>
</tr>
<tr>
<td>16. Has tolerated your wishes and needs</td>
<td>1</td>
</tr>
<tr>
<td>17. Has given you encouragement</td>
<td>1</td>
</tr>
<tr>
<td>18. Has seemed interested in your child's case</td>
<td>1</td>
</tr>
<tr>
<td>19. Has been honest about how she/he has felt about you</td>
<td>1</td>
</tr>
<tr>
<td>20. Has seemed interested in what you have had to say</td>
<td>1</td>
</tr>
<tr>
<td>21. Has been patient with you</td>
<td>1</td>
</tr>
<tr>
<td>22. Has avoided being critical of you</td>
<td>1</td>
</tr>
<tr>
<td>23. Has avoided making assumptions about how you have felt</td>
<td>1</td>
</tr>
</tbody>
</table>
APPENDIX F
Population Type Scoring Method
Population Type Scoring Method

The data provided by each parent for items 17, 18, and 19 ("distance to the mental health office" only) of the Initial Interview, and item 8 of the Follow-Up Interview, as well as the US 1990 Census rating for each county, will be coded according to the following scheme:

City Size*
5 = ≥ 50,000
4 = 20,000 - 49,999
3 = 10,000 - 19,999
2 = 2,500 - 9,999
1 = < 2,500

Distance from City
5 = within city limits
4 = ≤ 5 miles
3 = 6 - 10 miles
2 = 11 - 19 miles
1 = > 20 miles

Distance to the Mental Health Office
5 = ≤ 1 mile
4 = 2 - 5 miles
3 = 6 - 10 miles
2 = 11 - 20 miles
1 = ≥ 21 miles

County Census Rating
1 = Rural (Polk, Malheur)
5 = Urban (Lane, Washington, Marion)

Self-Rating
1 = Rural
5 = Urban

Once coded, the three values will be summed to result in a "total population type score." The higher the score, the more urban the family's living circumstances are.

* Determined by the 1990 Oregon Census.