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Examining therapists' perceptions of barriers to treatment with youth and their families : a mixed methods study

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Pepperdine University

Graduate School of Education and Psychology

EXAMINING THERAPISTS' PERCEPTIONS OF BARRIERS TO TREATMENT WITH YOUTH AND THEIR FAMILIES: A MIXED METHODS STUDY

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Gimel Rogers

December, 2015

Judy Ho Ph.D., ABPP – Dissertation Chairperson

This clinical dissertation, written by

Gimel Rogers

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirement of the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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UCLA Youth Stress and Mood Program
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06/14 – 06/15
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- Provide clinical evaluations and risk assessment on adolescents and their parents as part of a multisite study.
- Conduct phone screens, clinic intakes, and group therapy.
- Maintain accurate documentation on each client, service, and interaction.

Pepperdine Community Counseling Center
Clinical Psychology Extern
09/12 – 04/15
Supervisors: Michelle Margules, Psy.D. and Anat Cohen, Ph.D.

- Provide assessment, intake, individual and couples counseling services, and maintain accurate documentation on each client, service and interaction.

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Clinical Psychology Extern
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- Provided assessment, intake, group and individual counseling services to youth on the female unit, and assessment, intake, and group counseling to the male units.
- Co-facilitated adolescent DBT Skills group on Interpersonal Effectiveness and Distress Tolerance on the female unit with mental health and general population youth.
- Co-facilitated Life Skills and Anger Management groups on a high core male unit.
- Maintained accurate documentation on each client, service, and interaction.

- Followed all safety and SPAR guidelines when assessing for suicidal ideation or plans during treatment.

A Partnership of The Harrell Research Group at Pepperdine University and the youTHink Program of the Zimmer Children's Museum
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- Intense family intervention services by providing thorough home evaluations and parenting skills.
- Provided comprehensive adolescent assessment and intervention utilizing STEP and The Seven Challenges.
- Collaborated with caseworkers to give feedback to the families that resulted in impactful resolution.

ABSTRACT

The present study identified and quantified five main barriers to treatment categories, deducted first from the qualitative dataset, then consolidated with the results of the quantitative dataset. Clinicians (*N*=36) that worked with youth and their families participated. The main findings suggested five parent themes (*practical obstacles, poor alliance with the therapist, therapist's perceptions, socioemotional, and cultural*) and seven concept groups (*transportation, financial, logistical, attendance, therapeutic relationship, lack of communication, and lack of engagement*). Implications provide strategies to ratify some of these barriers, such as gathering data on youth clients and their families. For the purposes of this study, the terms *children*, *adolescents*, and *youth* will be used interchangeably and will be defined as any individual under the age of 18.

Keywords

children, adolescents, youth, treatment barriers, premature termination

Introduction

Decades of clinical research have generated a growing body of evidence-based treatments for child and adolescent behavioral and emotional difficulties (Kazdin & Weisz, 2003), suggesting that negative consequences of youth mental disorders, such as an increased risk for substance use, impairments in social functioning, and greater risk for adult mental disorders (Podell et al., 2013), could be significantly decreased with adequate and consistent mental health treatment (Lindsey et al., 2013). Unfortunately, it appears that many youth in the United States are not receiving mental health services or terminate treatment prematurely. Studies indicate between 13-20% of U.S. children meet criteria for a mental health disorder in a given year (Perou et al., 2013; U.S.Department of Health and Human Services, 1999), and 40% of children with one mental disorder have comorbid disorders (Perou et al., 2013). One study found the overall prevalence of disorders with severe impairment was 22.2% (Merikangas et al., 2010). The considerable rate of disorders with severe impairment, and the increasing rates of mental disorders in youth as evidenced in part by an 80% increase in youth hospitalizations due to mood disorders between 1997 and 2010 (Perou et al., 2013) indicate an urgency for effective treatment.

Current literature identifies factors contributing to the large number of youth in the U.S. unmet mental health needs, defined as having a need for mental health services, but not having access to, or utilizing, services, and lacking adequate mental health professionals in the face of increasing rates of mental disorders (Kataoka, Zhang, & Wells, 2002). Approximately half of children with mental disorders do not receive treatment within a given year (Center for Disease Control, 2009), and many youth who need treatment are never referred to mental health services. In addition, studies reveal that up to 79% of families with mental health needs did not use services in a given year (Kataoka et al., 2002), and out of the estimated 17% of youth diagnosed with a mental disorder, one in eight is receiving services, and only one in four has ever received care (Zerr & Pina, 2014). Populations that may be particularly vulnerable to lack of access to mental health services include ethnic minority youth and uninsured families (Kataoka et al., 2002). Studies indicate that out of all youth receiving treatment, minority children such as African Americans and Latinos, and their families have a higher unmet need than do Caucasian children (Gopalan et al., 2010; U.S. Department of Health and Human Services, 1999).

In addition to unmet need, premature termination from mental health services is also a concern for youth and families struggling with emotional/behavioral concerns. In general, premature termination is defined as the parent, guardian or family, or youth terminating against the advice of the clinical team (Garcia & Weisz, 2002; Kazdin, Mazurick, & Siegel, 1994). As many as 40%-75% of children and adolescents who are referred to mental health services fail to initiate or complete an appropriate course of treatment as recommended by the clinical team (Robbins, Turner, Alexander, & Perez, 2003; Gonzales, Weersing, Warnick, Scahill, & Woolston, 2011). These are concerning numbers, given that children and adolescents who drop out of treatment prematurely are found to function more poorly in a variety of settings, than those who complete an adequate course of therapy, generally, eight or more sessions (Robbins, et al., 2003). Of the children and families who actually receive mental health treatment, it is estimated that between 30% and 80% terminate prematurely, with many completing less than half of the recommended course of therapy as determined by the clinical team (Ingoldsby, 2010; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012).

One important factor that may contribute to premature termination is the quality of the therapeutic relationship. Robbins et al. (2003) examined the relationship between therapeutic alliance and retention. They found that youth who prematurely terminated treatment had a stronger alliance rating with the parents than the adolescent participants, suggesting that therapists who inadvertently validate the parents' concerns more than those of the adolescent may increase the likelihood of dropout. These findings support the use of previously established knowledge about logistical barriers and therapeutic factors that contribute to treatment attrition.

With regard to unmet need and early termination, several studies reveal the consequences of untreated or under-treated youth. Researchers found that families who discontinue services prematurely may require more intensive and more costly services in the future due to continued and even worsening symptoms (O'Connell, Boat, & Warner, 2009; Warnick et al., 2012). Several studies found that untreated mental disorders in youth are associated with academic underachievement/school failure, conduct disorder, depression, increased risk-taking, and substance use as well as chronic physical health problems such as asthma, diabetes, epilepsy, and increased injuries (Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007; Gonzales et al., 2011; New Freedom Commission on Mental Health, 2003; O'Connell et al., 2009; Perou et al., 2013). There is also an increased risk of further mental health problems in adulthood such as criminal activity, substance use disorders, and depression (O'Connell et al., 2009; Perou et al., 2013; Zerr & Pina, 2013). Furthermore, the potential consequences of untreated or under-treated youth mental disorders include long-term societal costs, such as the high price of specialized care when untreated disorders become more severe, lost productivity for not only children, but their parents as well, social disruption in the schools, and community disruption (O'Connell et al., 2009). Literature underscores the importance of addressing factors that lead to unmet need and premature termination, as not obtaining needed treatment or not receiving an adequate course significantly contribute to many negative long-term consequences for families and their communities. Therefore, it is imperative to identify the most common barriers to treatment utilization for youth and families that need professional services.

Purpose

The aim of this study is to examine the types of specific barriers to treatment attendance and adherence that mental health providers encounter with their youth and family clients. The clinician perspective was chosen for this study as they represent an important stakeholder in the therapeutic process, and a focus on their unique perspective as treatment providers may help to inform other related studies that may advance the field, such as evaluating the types of strategies providers utilize to address the barriers they perceive to impede treatment. Further, it may be difficult to gain access to our other major population of interest, namely, youth and families who never engaged in treatment in the first place or prematurely terminated, for research purposes and to further understand their perspective. Therefore, this study seeks to understand the clinician perspective first and foremost, with the hope that the results will help inform other related questions for investigation.

The present study will utilize mixed methods analyses to identify the most common barriers experienced by the participants and to gain a deeper understanding of factors that may contribute to premature termination. In addition, the researchers will examine whether there are relationships between therapist ethnicity, gender, and professional status (licensed v. unlicensed) and the specific types of barriers with which they perceive their clients struggle. It is hoped that the results of this study will add to the body of literature addressing treatment barriers and adherence for youth, and inform a future study that will attempt to identify specific strategies used to address these barriers and prevent premature termination.

Our first aim is to examine the clinicians' perceptions of types of barriers to treatment with youth and their families utilizing quantitative and qualitative data. Based upon previous research (Gopalan et al., 2010; Kazdin, Holland, & Crowley, 1997; McKay & Bannon, 2004; Murdock, Edwards, & Murdock, 2010) which found that therapists are more likely to identify client and situational factors as reasons for premature termination than to identify therapist and therapeutic relationship factors, we hypothesize that all clinician participants will endorse the following categories of barriers most often: (a) Practical Obstacles (e.g., financial burden, transportation problems, and time constraints), (b) Poor Alliance with the Therapist (e.g., therapeutic relationship), and (c) Socioemotional (e.g., negative beliefs about therapy). Our second aim explores possible associations between specific clinician characteristics (ethnicity, gender, and license status) with the categories of barriers to treatment clinicians experience in their practice. This aim is exploratory and no specific hypothesis is stated.

Methods

Research Design

The current study utilized the mixed methods research design. Mixed methods research involves the collection, analysis, and interpretation of related quantitative and qualitative data components exploring the same underlying phenomenon, and addresses research questions from both a logical and intuitive perspective (Onwuegbuzie & Leech, 2006; Tashakkori & Creswell, 2007) in a more varied and comprehensive manner than either quantitative or qualitative approaches alone (Creswell, 2013a; Small, 2011). Mixed methods was utilized throughout the study, including study design, data collection, analysis, and interpretation phases. In the study design phase, the two primary aims of the study were developed and the type of data that would inform each aim was proposed, which involved both quantitative and qualitative components. In the data collection phase, our study collected quantitative (i.e., self-report questionnaire) and qualitative (i.e., individual interviews or focus group interviews) data concurrently (i.e., during the same stage and at the same time point for all participants) to examine the types of barriers clinicians experience in their practice. In the analyses stage, both quantitative and qualitative analyses using SPSS and Dedoose, respectively, were conducted concurrently (at one stage without a recursive or sequential process). However, qualitative data analysis was slightly dominant, as it was undertaken first during the analytic stage to help uncover common barrier themes, which then informed the development of overarching barrier categories that subsumed the original 31 specific barriers from the self-report questionnaire. Therefore, the present study is a fully mixed concurrent dominant status design, defined as a study that mixes qualitative and quantitative research concurrently at one or more stages or across stages, and either the qualitative or quantitative phase is given more weight (Leech & Onwuegbuzie, 2009).

Recruitment

After receiving full IRB approval, clinician participants were recruited for the study. The first step in the recruitment process included contacting 21 clinics within Los Angeles county, asking to speak to the clinic director or a licensed staff clinician, and requesting permission to visit the clinic in order to post the recruitment letter and flyer. Once permission was granted by a staff member of the agency, a research associate visited in person to post the flyer. If permission was not granted, no further action was taken. Following distribution of recruitment letters and flyers, interested participants contacted the project as directed by the letter and flyer, either through phone or email. The contact information for the project was a centralized confidential voicemail system and email address accessible by research associates only. Following contact by interested potential participants, research associates returned contact by phone to schedule an in-person individual or small group meeting with individuals to overview the project, complete consent forms, and administer the questionnaire and interview. In this initial phone contact prior to the in-person meeting, research associates overviewed the project, emphasized the voluntary nature of participating in the study, and ensured that potential participants understood they could withdraw participation at any time. In the in-person meeting, research associates once again overviewed the project, emphasized the voluntary nature of participating in the study and reminded participants that they could withdraw participation at any time. Furthermore, a script was utilized to review the consent form, which once again emphasized the voluntary nature of participating in this study and the option to withdraw participation at any time.

Compensation and Funding

As an incentive to participate in the study, every individual who attended one of the interview sessions was offered a $35 Target gift card. Participants were offered the gift card whether or not they chose to complete the survey (e.g., withdrawing participation during a data collection session). Thus, the receipt of the gift card was not contingent on completing the data collection interview. We were able to offer this form of compensation at the current time because we were fortunate to receive an award from the Pepperdine COASTAL run/walk fund for children's outreach in the amount of $1,200. In addition, we were able to receive funding from private donors through fundraising efforts, and raised an additional $1,600 for the project.

Data Collection

All data collection occurred through either individual interviews conducted by one research interviewer, or small focus group interviews (3-8 participants) conducted by one or two research interviewers. During the interview, each participant was invited to complete a self-report questionnaire and also to provide narrative answers to verbal questions.

Quantitative self-report data. The first part of the data collection strategy involved the distribution of a brief written quantitative questionnaire, which was completed individually by each participant on his or her own. The Clinician Questionnaire was developed by adapting the list of barriers to treatment from The Child and Adolescent Services Assessment (CASA)

(Ascher, Farmer, & Angold, 1996) and the Barrier to Treatment Participation Scale (PTPS) (Kazdin et al., 1997). The Clinician Questionnaire asks participants to identify barriers to treatment that they most commonly witnessed clients experience in the duration of their clinical practice. The first portion of the questionnaire required participants to endorse all barriers that apply to the question from a list of 31 choices. Additionally, they were given the option of filling in barriers that are not provided in the list. Please see Appendix B for the Clinician Questionnaire. In addition, Clinician Participants were asked to complete a brief demographic questionnaire which asked them to report their age, gender, race/ethnicity, marital status, relationship of adults in household, household income, primary language, years residing in the U.S., education attainment (i.e., Less than High School, High School/GED, Some College, 2-Year College Degree (Associates Degree), 4-Year College Degree (BA,BS), Master's Degree, Doctoral Degree, and Professional Degree, as it is not number of years of education but categories), professional status (i.e., Practicum Student, Intern, LCSW, MFT, MSW, MD, Psy.D., Ph.D., or Other), years of practice as a clinician, and current type of practice setting (i.e., Private Practice, Medical Group, Community Mental Health Clinic, School of University Based Counseling Center, Social Services Agency, Outpatient Hospital, Residential Treatment Center, Inpatient Hospital, and Other). Please see Appendix C for the Demographic Questionnaire.

Individual and group interviews. The second part of data collection for this study involved conducting individual and group interviews with counselors, where the trained interviewers followed a standard format of reading aloud open-ended questions from the interview script and participant responses were recorded using a confidential audiotape. Eight interviewers were trained in the interview protocol by the auditor of this study to conduct interviews with clinician participants. The interview protocol consisted of a semi-structured interview script which posed 10 open-ended questions regarding clinician perceptions of barriers to treatment for patients, and strategies they utilize to encourage patient participation and retain patients in services. Specific questions included asking participants how they discuss barriers to treatment with their clients, and how their clients communicate with them about barriers they are experiencing. They were also asked to discuss what strategies seem to be effective in maintaining client attendance, as well as methods they utilize to overcome logistical barriers with clients, such as transportation or financial barriers. In addition, the participants were asked about ways in which they overcome therapeutic barriers with their clients, such as lack of motivation or unrealistic expectations. The participants were also asked to discuss their perceptions of the importance of rapport and methods they use to establish strong therapeutic relationships.

Our data was gathered from four individual interviews and six group interviews between February and August of 2012. The group interviews involved approximately 3-8 clinician participants and 1-2 researchers/interviewers. The individual interviews were completed in an average of 30 minutes, and the small group format sessions were completed in an average of 45 minutes. All interviews were audio recorded for accurate transcription for data analyses.

Participants

Sample characteristics.

Clinician participants. Clinician participants included 36 counselors from two local mental health clinics including Open Paths Counseling Center and South Bay Center for Counseling. The participants included 10 practicum students (30.3%) working under licensed clinicians, nine interns (26.5%), two licensed clinical social workers (5.9%), seven marriage and family therapists (20.6%), one social worker (2.9%), and four psychologists (11.7%). Sociodemographic variables gathered from the clinicians included age, gender, race/ethnicity, marital status, relationship of adults in household, household income, primary language, number of years in the U.S., and education. Participants were asked to indicate their highest level of education from a list ranging from grade school to doctoral level training. They were also asked to state their years of clinical experience and current practice setting. Household income was assessed by asking participants to select a specific level of income ranging from <$10,000 to < $80,000+. The participants included 17 White participants (50%), two African American participants (5.9%), 10 Latino participants (29.4%), and five participants from other ethnic backgrounds (14.7%), ranging in age from 25 to 62 years of age (*M*=41.09, *SD*=10.33). The participants' educational backgrounds were composed of 67.6% masters degrees, 14.7% 4-year college degrees, 14.7% doctoral degrees, and 2.9% professional degrees, with years in the profession ranging from one to 39 (*M*=8.62, *SD*=9.840). Primary practice settings included community mental health clinic (61.8%), private practice (20.6%), other (5.9%), school or community based counseling center (2.9%), social services agency (2.9%), and 5.9% did not indicate. Ninety-four percent endorsed English as their primary language, although only 79.4% indicated English as the language spoken in the home.

Research participants. The research team was composed of three graduate students, who acted as coders, and one auditor. The background of each researcher was considered in order to address potential biases and desired outcomes of the study.

The first researcher is a 27-year-old, African American female clinical psychology doctoral student. She emerged from a diverse socioeconomic background. She was raised in an upper-middle class environment, and lived equally in a north eastern state and a south eastern state. Although her parents are divorced, she and her sibling always had active parents who instilled Christian values, which translated into her active participation in the African Methodist Episcopal church. Based upon her background that encapsulates a wide variety of experiences, she understands the stigma behind mental health services that leads to treatment barriers, but believes that everyone could benefit from psychotherapy.

The second researcher is a 28-year-old, Caucasian female clinical psychology doctoral student. She was raised in Texas in an upper-middle-class family with one sibling and parents who are still married. Her background includes being raised in a Christian family and being taught that therapy is effective and worthwhile. She does not currently practice any specific religion, but maintains spiritual beliefs in a higher power. Based upon her background, previous experiences, and psychology training, she believes that everyone could benefit from psychotherapy and that everyone deserves to have adequate treatment for their mental health needs.

The third researcher is a 48-year-old, Arab-American Caucasian female clinical psychology doctoral student. She was born in Beirut, Lebanon and lived in Greece, Dubai and Cypress. She was raised in an upper-middle class family with two siblings and parents who remained married until 2010 when her father became a widow. Her background includes being raised in a Christian family even though her mother was a Druze. She is active in her Catholic faith community. Based upon her background that includes exposure to many cultures and religions, she believes that everyone deserves access to mental health services.

The auditor is a 35-year-old, Chinese-American female assistant professor of psychology and licensed psychologist who is the dissertation chair for this project. She is board certified in Clinical Child and Adolescent Psychology by the American Board of Professional Psychology. She was born in Taipei, Taiwan and immigrated to the U. S. at the age of 8, and has lived in various cities in New York and California. As a child she was raised in a working, lower class family until her adolescent years when her parents hard work resulted in a financially stable environment and they became part of the upper income class. Her parents have been married for 36 years. She was raised with spiritual beliefs and has pursued Catholicism actively since she was 18-years-old and currently actively participates in her faith community in Los Angeles, CA. She understands the stigma and various barriers in the mental health help seeking pathway and believes that everyone should have access to effective evidence-based care regardless of their socioeconomic status or severity of mental illness.

Transcription

Transcription of the sessions was completed by seven masters-level psychology graduate students who were recruited on a volunteer basis. Two of the transcribers were also the researcher participants in this study (Gimel, the 27-year-old African American female and Lyndsay, the 28-year-old Caucasian female). Prior to working with the data for the study, the transcribers were personally trained by the auditor of this study to transcribe sessions verbatim using a system adapted from University of Washington’s Thesis Manual. Each transcriber was instructed to utilize a standardized template that listed the time stamp in the first column and the questions posed by interviews and answers provided by clinician participants in the second column. Each audiotape was first transcribed by the first transcriber, then reviewed and edited by a second transcriber. The Lab Manager then reviewed the transcript against the audiotape to ensure accuracy and provided her sign-off to finalize the transcript (see Appendices D and E for transcription template and training protocol, respectively).

Coding

The coders for this study consisted of three doctoral level psychology graduate students (two of which were the primary researchers for the study). Their research supervisor served as the auditor. Prior to coding the transcripts, the 3 coders and auditor practiced coding until they achieved kappas of .75 and above on inter-rater reliability tests. The coders were trained to understand the essential concepts, terms, and issues that were relevant to the study. The coders were also each trained on the techniques of the coding method to be used in this study.

Human Subjects/Ethical Considerations

Confidentiality and maintenance of ethical standards for the treatment of research participants was maintained in several ways. First, limits of confidentiality for interviews and for research database inclusion were reviewed with clinician participants. All participants provided informed written consent to participate in the interview (please see Appendix F). All identifying information was redacted interview documents in order to preserve confidentiality upon transfer to the research database. Client participant demographic questionnaires and associated interview responses were assigned a research number to de-identify them for research purposes (Mertens, 2009). All individuals who handled the transfer of clinical data to the research database completed an Institution Review Board (IRB) certification course (see Appendix G).

In addition to the research data preparation, provisions were made so that those handling the de-identified data did so in a confidential and ethical manner. Prior to accessing research database content, researchers/coders, and transcribers completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to ensure adherence to ethical standards of participant research and handling confidential health information. Further, steps were taken to maintain confidentiality by making sure that research coders did not personally know the clinician participants prior to the study.

Researcher Bias and Quality of Study

To ensure the quality of the study, each interviewer was personally trained by the auditor of the study utilizing standardized instructions for conducting the interviews. In order to consider potential biases that may have impacted coding procedures, the researchers and the auditor first explored their own expectations and biases by discussing the answers they anticipated the participants to provide and factors from their own personal and clinical experiences that led to specific expectations. This process allowed the coders to develop awareness regarding their own biases, and to consciously set aside their biases and code the data as objectively as possibly (Knox, Hess, Petersen, & Hill, 1997). In order to further address potential researcher biases and expectancies, the researchers engaged in self-reflection throughout the coding and analysis phases of the study. This process, known as reflexivity, further ensured the quality of the study. Reflexivity occurs when the researcher engages in critical self-reflection (Miller & Brewer, 2003). This practice requires the researchers to ask themselves a series of questions and reflect on the impact these answers may have had on the data and the analysis of the data (Miller & Brewer, 2003). Continuing the reflexive process at all stages of the study helped the researchers maintain awareness of ethical issues to consider, as well as broader social constructs that may have had an impact on the findings.

Reliability

Coding was conducted on all 10 transcripts, however one transcript did not contain any barriers, which resulted in nine coded transcripts. Transcripts were coded by three doctoral-level raters and by the auditor of this study using the Dedoose software application. Dedoose is a user-friendly “full featured web-based service for the input, management, analysis, interpretation, and presentation of qualitative and mixed method research data” (Dedoose, 2014, p.4). Each transcript was coded by all three coders who received extensive training in the coding system and referred to a detailed 72 page user guide. Coding and data integrity procedures were implemented and reflected similar studies. Inter-rater reliability among coders and the auditor was calculated for five parent themes and seven concept groups providing a total of 12 barrier codes (see Figure 1). Kappas for the codes ranged .78 to 1.0. Following this coding procedure, the auditor inspected the data for accuracy and obtained a Kappa of .95. Miles and Huberman (1994) suggest that inter-rater reliability should approach .90, it should be noted that .65-.80 = good agreement and >.80 = excellent agreement; therefore, the Kappas suggest overall excellent agreement for the barriers codes.

Study Variables

Sociodemographic variables. The ethnicity, gender, and professional status of clinician participants were provided by self-report. For ethnicity, clinician participants were asked to check the category they identified most with (White, African American, Latino, Asian, and Other). There were five individuals who identified as other but chose not to write in the optional blank space to provide more details. For clinician gender, they were asked to check the category they identified most with (male, female, or other). There was one individual who identified as other but chose not to write in the optional blank space to provide more details. Finally, for professional status, clinician participants were asked to check the category they identified most with (Practicum Student [Practicing Under Licensed Clinician], Intern [Practicing Under Licensed Clinician], LCSW, MFT, MSW, MD, Psy.D., Ph.D., or Other). This variable was then recoded into a binary variable (1 = unlicensed professional [e.g., a trainee or intern], 2 = licensed professional) for analyses.

Barriers encountered in treatment. Clinicians were presented with a list of 31 specific barriers and asked "in your experience as a clinician with youth clients and/or family therapy clients, which of the following barriers have affected client attendance and adherence? Check all that apply and rank them from most to least common (1 = most common, 2 = 2nd most common, etc.). You only need to rank the barriers that you have checked." These specific barriers were chosen for inclusion based on the Child and Adolescent Services Assessment (CASA; Ascher et al., 1996) and the Barrier to Treatment Participation Scale (PTPS; Kazdin et al., 1997). A space for participants to write in a barrier not listed was also provided. A graphic of the specific barriers presented on the questionnaire can be viewed in Appendix B. The top 5 ranked barriers from each participant's completed questionnaire was then entered into the study database. These specific barriers were then recoded into five overarching barrier categories for quantitative analyses, derived from the results from the qualitative strand of this study (1 = Practical Obstacles Barriers, 2 = Poor Alliance with the Therapist Barriers, 3 = Therapist's Perception Barriers, 4 = Socioemotional Barriers, and 5 = Cultural Barriers).

Method for Imputing Missing Data

Multiple Imputation (MI) was utilized to impute missing data values. MI is an iterative process that alternates between estimating the parameters for this distribution and using these values to predict the missing values. Once the process stabilizes, imputed values for the missing data are randomly obtained from its predictive distribution. Auto correlation function plots, where the iteration number, *k*, is plotted against the lag-k Pearson's correlation coefficient between the simulated parameter value at any cycle and its value *k* cycles later, can be used to assess the convergence of this process (Schafer, 1997). The MIs were performed for the incomplete variables at the clinician participant level using the MI procedure in SPSS statistical software version 22. In this study, five imputations were obtained as this should give an efficiency of 99% compared to using an infinite number of imputations (Rubin, 1987). The fully conditional specifications (MCMC) imputation method was used as the data has an arbitrary pattern of missing values, and we designated the maximum iterations at 10.

Clinician participants had three different patterns of missing data. Two participants omitted ethnicity and gender responses, one participant omitted professional status response, and four participants omitted circling categories of barriers experienced in practice but responded to the narrative components of the questionnaire addressing the same question. Complete data was achieved for 29 of the 36 clinician participants (81%). The remaining 7 (19%) participants had at least one study variable with missing data. The completed case analysis using the pooled data obtained from MI resulted in a comparable distribution of participant ethnicity, gender, and professional status. The demographic characteristics of the clinician participants who had complete data were comparable to those with incomplete data. The missing data points occurred as a result of participants accidentally omitting an answer on a questionnaire, and the data appeared to be missing at random (MAR). Please see Figure 2 for a side by side comparison of original versus pooled demographic variable distributions.

Qualitative Data Analysis Approach

Qualitative data analysis procedures were utilized in order to code and draw conclusions from the collected data using the Dedoose software application. Data analysis was approached by utilizing grounded theory concepts which “aims to produce innovative theory that is ‘grounded’ in data collected from participants on the basis of the complexities and of their lived experiences in a social context” (Fassinger, 2005, p. 157). First, the data was prepared for an inductive content analysis. Data was approached to find theory and allows the move towards a hypothesis rather than starting with one. The interviews were transcribed verbatim by seven graduate student research assistants. Identifying information was not included in the transcripts, and participants were assigned random codes in order to maintain confidentiality. Each transcript was created by one graduate assistant and then reviewed by another research assistant to check for errors and consistency, then reviewed one more time by the Lab Manager who provided final sign off after reconciling any errors and ensuring accuracy.

After data preparation, the coders examined the data for specific themes that emerged from the clinician-participants, in accordance with recommendations for inductive content analysis (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). In accordance with guidelines for qualitative data analysis, the researchers coded the raw interview data by first coming to a consensus about the units to be coded, then coding all of the text and developing categories, and finally drawing conclusions about the coded data by consolidating the categories into overall themes. This three-part process involved open coding, creating categories, and abstraction (Elo & Kyngäs, 2007).

First, open coding began with the three researchers reading through each transcription as many times as necessary, making notes, and writing down thoughts and ideas until each felt she captured the essential headings to describe aspects that answered the research question (Elo & Kyngäs, 2007). Next, the two primary researchers independently grouped similar codes, generating category/concept labels for each grouping. Using the research question as a guide, the researchers agreed to code the data by searching for references to treatment barriers and strategies for addressing barriers to treatment, as well as any other relevant data. The researchers then submitted the concept groups to the other researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hsieh & Shannon, 2005). To hep ensure reliability of the researchers' process and findings, the auditor reviewed the categories and codes and examined notes that researchers took during the coding process.

The researchers then submitted the concept groups to the third researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hseih & Shannon, 2005). To help ensure reliability of the researchers' process and findings, the auditor reviewed the concept groups and abstracted codes as well as examined the steps and notes that the researchers took during the coding process. The purpose of this step was to make certain that the findings of the researchers have dependability and confirmability (Zhang & Wildemuth, 2009). This process involved reviewing data and notes of each researcher. The auditor then separately coded the transcribed data and noted her own thought processes. The auditor then reviewed the data and noted areas of agreement with the researchers' codes as well as areas for further thought. After a consensus was established among all three researchers and the auditor for organizing and coding the data into concept groups, the researchers and auditor each independently coded all transcripts and identified concepts that occurred throughout the data, and assigned sections of text, such as words or phrases, that represented a concept.

Following coding, the two primary researchers organized these groups hierarchically and identified Parent Themes, or theme titles that described one or several concept groupings (Elo & Kyngäs, 2007). The two primary researchers compared the themes they identified and reached an agreement on ways to collapse the categories into larger themes. More specifically, the researchers explored the categories that were initially identified, conducted cross-analysis procedures by organizing similar themes into categories, and looked for patterns and relationships between the themes and categories (Zhang & Wildemuth, 2009).

In this process, known as abstraction, the researcher moved back and forth between hierarchical concept levels (codes, concept categories/child codes, and parent themes), making sure all were tied back to the research question (Elo & Kyngäs, 2007). The researchers then submitted the theme hierarchy to the third researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hseih & Shannon, 2005). The auditor reviewed the abstracted codes, concept sub-categories, and Parent Themes. She offered feedback based on her own experience of coding transcripts, reviewing codes, and thinking about the data hierarchically. Following this review, the primary researcher adjusted codes and themes within the hierarchy to incorporate feedback. Final codes were determined after a second review of the hierarchy by the auditor. The coding was rechecked by each coder for consistency and was also reviewed by the auditor to ensure accuracy. Basic frequencies of coded responses were determined for each theme using the Dedoose software program.

Researchers could not assume that an agreed upon coding system would definitely ensure that the entire body of data was coded consistently. Therefore the checking process during open coding and abstraction was important for a number of reasons, which included minimizing the impact of coder fatigue on coding, accounting for how pre-existing biases of each of the researchers can influence how they chose coding themes, and establishing inter-coder verification (Zhang & Wildemuth, 2009).

Results

To investigate the first aim, which examines the clinicians' perceptions of types of barriers to treatment with youth and their families, both qualitative and quantitative analyses were conducted using SPSS and Dedoose software, respectively. We analyzed the qualitative data to explore commonly defined barrier themes. These identified themes were then utilized to develop the variable labels of five overarching barrier categories. The 31 specific barriers endorsement collected from the written questionnaire was then recoded into these five overarching barrier categories for analyses.

The Meaning of Practical Obstacles Barriers

Previous studies have concluded that experience of stressors, logistical barriers, contextual, and obstacles are barriers to treatment (Gopalan et al., 2010; Kazdin et al., 1997; McKay & Bannon, 2004). This study defined those preceding barriers as Practical Obstacles which included transportation, financial, logistical, and attendance. McKay and Bannon (2004) categorized a specific logistical barrier as "lack of transportation," (p.909) and transportation was defined in this study as any hinderance that involved a vehicle in which the client was unable to attend treatment. Financial barriers in previous research was defined as "limited resources" (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008, p. 220); however, in this study Financial included all barriers related to funding difficulties (e.g., insurance, gas, bus tokens, etc.). Logistical captured all barriers that were related to scheduling or coordinating resources by modifying the definition of specific logistical barriers and agency obstacles as described in McKay and Bannon (2004). Attendance was operationalized by the study researchers as showing up late or not attending the session. Figure 3 and Figure 4 represents the percentage of practical obstacles reported by the participants and excerpts that reflects those barriers, respectively.

The Meaning of Poor Alliance with the Therapist Barriers

Perceptual and therapeutic barriers have been identified in the literature, including poor therapeutic alliance, level of perceived need for treatment, and expectations for therapy and treatment demands (Garcia & Weisz, 2002; Gopalan et al., 2010). The findings in this study support previous identified barriers, and defined the overarching theme as Poor Alliance with the Therapist. Poor Alliance with the Therapist encompassed concept groups of lack of engagement —client is not fully vested to treatment, therapeutic relationship —therapist and client (researchers operationalized client as parent or child) relationship is not concrete, and lack of communication —client does not express concerns and therapist does not address potential or existing roadblocks (see Figure 5 and Figure 6). Of particulate note, the study researchers operationalized these concept groups, as previous literature did not define. The overall analysis of the meaning Poor Alliance with the Therapist in this study was interpreted within the context of the therapist and client's proactive engagement in therapy.

The Meaning of Therapist's Perception Barriers

From the qualitative findings, the researchers coined a new barrier category, Therapist's Perception. Therapist Perception was operationalized by the study researchers as "attitudes of clinicians towards therapy clients and their families." As noted in Figure 7, excerpts reflect that the therapist may have assumed that the clients made excuses rather than actual life problems, which hindered them from attending therapy.

The Meaning of Socioemotional Barriers

From the transcripts, it was evident that all clients bring emotional experiences with them to therapy, and therapist may conceptually understand these emotions but do not recognize them as barriers to treatment. Therefore, the study researchers developed and operationalized a new barrier category, Socioemotional — “any feeling or emotion the client has about therapy that hinders the progress of treatment.” Of note as reflected in Figure 7, these emotions are sometimes derived from past therapeutic experiences.

The Meaning of Cultural Barriers

Similar to the barrier Socioemotional, many clinicians have some awareness that culture impacts the dynamics of treatment, but previous research did not distinguish culture as its own barrier. However, the data suggests the significance of cultural treatment barriers. Therefore, Cultural barrier is denoted as operationalized by the study researchers “behaviors, beliefs, values, and symbols that are transmitted and recreated in therapy that interferes with the progress of treatment.” (please see Figure 7).

Quantitative Findings

Quantitative data was conducted using SPSS software. The five barrier themes uncovered in the qualitative data analysis was utilized as overarching barrier categories, into which the endorsement of 31 specific barriers from the written questionnaire was recoded. As hypothesized, Practical Obstacles barriers, Poor Alliance with the Therapist barriers, and Socioemotional barriers were the most endorsed overall when counting number of times barriers endorsement fell into these categories across the top 5 ranked by each participant. These three categories were also the most endorsed when examining just the first highest rank ordered barrier by each participant, and the second highest rank ordered barrier by each participant. (please see Figure 8).

To investigate the second aim which explores possible associations between specific clinician characteristics (ethnicity, gender, and license status) and the categories of barriers to treatment clinicians experience in their practice, quantitative analyses were conducted in SPSS.

Six chi-square tests of independence was performed on the pooled imputed complete dataset to examine the relationships between (a) clinician ethnicity and first highest endorsed barrier, (b) clinician ethnicity and second highest endorsed barrier, (c) clinician gender and first highest endorsed barrier, (d) clinician gender and second highest endorsed barrier, (e) clinician professional status and first highest endorsed barrier, and (f) clinician professional status and second highest endorsed barrier. A significant relationship was found between clinician gender and the first highest endorsed barrier, X^2 $(6, N = 36) = 38, p < .001$. According to Agresti (2007), “a[n adjusted] standardized residual having absolute value that exceeds about two when there are few cells or about three when there are many cells indicates lack of fit of Ho in that cell” (p. 38). An examination of adjusted standardized residuals revealed only one cell greater than +/- 2 (gender = other X barrier category = cultural barrier). No other cells were associated with adjusted standardized residuals greater than the cutoff criteria. Please see Table 1 for the chi-square table with residuals for gender x first highest endorsed barrier.

No relationship was found between ethnicity and the first highest endorsed barrier, X^2 (9, N = 36) = 11.48, p =.25. Similarly, no relationship was found between ethnicity and the second highest endorsed barrier, X^2 (12, N = 36) = 10.10, p =.61, or between gender and the second highest endorsed barrier, X^2 (8, N = 36) = 10.62, p =.22. No relationship was found between professional status and the first highest endorsed barrier, X^2 (3, N = 36) = 5.16, p =.16, and no relationship was found between professional status and the second highest endorsed barrier, X^2 (4, N = 36) = 2.06, p =.73.

Expanded Results with Comparison or Integration, Discussion, and Implications

In this study, we sought to enhance the literature by examining the types of barriers to treatment that clinicians experience in their practice with youth and family clients. Barriers identified in this study will help synthesize current research findings by illuminating the most common treatment barriers experienced by mental health providers in community settings. Utilizing quantitative and qualitative data, we examined clinicians' perceptions of the types of barriers to treatment and explored possible associations between ethnicity, gender, and professional status with identified categories of barriers to treatment. Based on a review of the literature (Gopalan et al., 2010; Kazdin et al., 1997; McKay & Bannon, 2004; Murdock et al., 2010), it was hypothesized that clinician participants would most often endorse the following categories of barriers: Practical Obstacles Barriers, Poor Alliance with the Therapist Barriers, and Socioemotional Barriers.

Finding 1: Poor Alliance with the Therapist Barriers

Quantitative. Twenty-seven percent of clinician participants endorsed specific barriers subsumed under the category of Poor Alliance with the Therapist Barriers (e.g., lack of communication, lack of engagement, or problems with therapeutic relationship) as their first highest endorsed barrier category, 28% of clinician participants endorsed Poor Alliance with the Therapist Barriers as their second highest endorsed barrier category, and 36% of clinician participants endorsed this category overall (i.e., from 1st to 5th highest ranked).

Qualitative. There was a shared belief across clinicians that suggest poor alliance with the therapist are problematic in treatment, such as [1]"guessing at or not knowing client's satisfaction," that "therapist is unaware of treatment obstacles," or that "client feels uncomfortable with the their therapist." This deduction is reflective of 356 out of 80 (45%) codes representing Poor Alliance with the Therapist Barriers.

Comparison or integration. Findings from both datasets support that Poor Alliance with the Therapist is a significant overarching barrier to treatment. There is a 9% difference between the qualitative responses (45%) and the quantitative endorsements (36%). Group and individuals narrative interviews may have yielded even more endorsement in this category of barriers when clinicians were asked open-ended questions to discuss barriers they encountered, in contrast to being asked to select specific barriers from a close-ended list. This provides further credence to the idea that Poor Alliance with the Therapist is a prominent barrier experienced by providers and is likely at the forefront of their minds when asked which barriers affect treatment retention.

Discussion. Consistent with the literature (Kazdin et al., 1997; Robbins et al., 2003) and as hypothesized, Poor Alliance with the Therapist is a barrier that is commonly experienced by clinicians and was elicited across both types of inquiry (self-report questionnaire and narrative interview).

Implications. Findings suggest that therapists should focus on developing therapeutic alliance to improve treatment gains for clients and to reduce premature termination of services. To further understand the barriers subsumed under Poor Alliance with the Therapist from the

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[1] Quotations in the qualitative sections are from data gathered from the participants in this study during 2012.

viewpoint of the client, it may be important to gather data about the experiences and perception of youth and parents in therapy.

Finding 2: Practical Obstacles Barriers

Quantitative. Fifty-eight percent of clinician participants endorsed specific barriers subsumed under the category of Practical Obstacles Barriers (e.g., transportation, financial, attendance, and logistical) as their first highest endorsed barrier category, 37% of clinician participants endorsed Practical Obstacles Barriers as their second highest endorsed barrier category, and 38% of clinician participants endorsed this category overall (i.e., from 1st to 5th highest ranked).

Qualitative. Several individual quotes such as “consistency with attendance,” “insurance difficulties,” “bus takes too long,” and “scheduling” support the concept groups/child codes of transportation, financial, attendance, and logistical barriers, which were subsumed under the category of Practical Obstacles Barriers. This reflected 31% percent of the data coded (246 out of 800 codes). An examination of the child codes revealed that 41% of the Practical Obstacle Barriers consisted of logistical child codes, as the most commonly endorsed concept code in this category.

Comparison or integration. The quantitative data indicates Practical Obstacles as the number one most common experienced treatment barrier by clinicians. However, qualitatively it is the second most reported treatment barrier (31%). The questionnaire may have yielded more endorsement in this category of barriers because listing specific examples of these made them more easily identifiable, in contrast to being asked open-ended questions to discuss barriers they encountered.

Discussion. Our findings support our hypothesis and are congruent with the existing literature (Garcia & Weisz, 2002; Gopalan et al., 2010) that Practical Obstacles occur frequently for youth therapy clients. Of particular note, the child code/concept group of logistical barriers (e.g., time constraints, lack of childcare, and clinic policies) were most often experienced by clinicians. With institutional support, these logistical barriers may be practically addressed to increase service access and utilization.

Implications. Targeted interventions for Practical Obstacles Barriers with emphasis on logistical barriers may decrease premature termination. Strategies to decrease logistical obstacles may include therapist flexibility (e.g., offering flexibility with weekend hours at least twice a month), clinic flexibility (e.g., sliding fee scale or allowing therapist travel to client's school or home), and increase of resources (e.g., onsite childcare).

Finding 3: Socioemotional Barriers

Quantitative. Thirteen percent of clinician participants endorsed specific barriers subsumed under the category of Socioemotional Barriers (e.g., stigma, shame, or embarrassment) as their first highest endorsed barrier category, 12% of clinician participants endorsed Socioemotional Barriers as their second highest endorsed barrier category, and 11% of clinician participants endorsed this category overall (i.e., 1st to 5th highest ranked).

Qualitative: Responses such as “fears about confidentiality,” “therapy as scary/ overwhelming if new to therapy,” and “communicating stress through emotions/emotionality” reflect the 114 out of 800 (14%) codes referring to Socioemotional Barriers. Socioemotional Barriers had code co-occurrences with three out of the four other parent themes. Code co-occurrences are frequencies for code pairing that were applied to the same excerpts, and “relatively high frequency suggests an overarching schema which includes both concepts being activated as participants formulate their responses” (Dedoose, 2014, p. 49). Co-occurrences were with parent themes of Poor Alliance with the Therapist Barriers (e.g., “conflict avoidance”), Practical Obstacles Barriers (e.g., “life stressors”) and Cultural Barriers (e.g., living in a society that doesn’t like conflict”)

Comparison or integration. Findings from both datasets reflect shared views as there was only a 3% difference between the quantitative (11%) and qualitative (14%) responses.

Discussion. Consistent with the literature (Barrett, Chua, Christoph, Gibbons, & Thompson, 2008) and as hypothesized, Socioemotional is a barrier that is commonly experienced by clinicians and was elicited across both types of inquiry (self-report questionnaire and narrative interview). In addition, the results suggest that client’s emotions regarding therapy, particularly ones that were negative towards the therapy process, often co-exist with other barriers to treatment such as Poor Alliance with the Therapist and Cultural Barriers.

Implications. Socioemotional Barriers are important to recognize when exploring treatment obstacles because it provides further understanding to the complex processes involved in treatment termination and engagement. It is important that clinicians periodically and systematically check-in with their clients about their emotions and attitudes towards therapy through more formal assessments (e.g., attitudes questionnaires) or through informal inquiry undertaken as part of therapy sessions.

Finding 4: Cultural Barriers

Quantitative. Three percent of clinician participants endorsed specific barriers subsumed under the category of Cultural Barriers (e.g., negative reaction from family or friends or religious / spiritual issues specific to a cultural group) as their first highest endorsed barrier category, 7% of clinician participants endorsed Cultural Barriers as their second highest endorsed barrier category, and 8% of clinician participants endorsed this category overall (i.e., 1st to 5th highest ranked).

Qualitative. Six percent of the codes (47 out of 800) reflected Cultural Barriers and suggested that participants shared a belief that this category (e.g., “expressing barriers varies across cultures/genders,” “living in a society that doesn’t like conflict,” and “family dynamics makes therapy difficult”) contributes to premature termination.

Comparison or integration. Findings from both datasets identified Cultural Barriers as an overarching barrier. Both datasets had relatively lower proportions endorsed compared to other barrier categories. The quantitative dataset yielded 2% more endorsements (8%) compared to the qualitative dataset (6%).

Discussion. Our findings support existing literature that certain cultural attitudes, values, beliefs, and/or behaviors (such as parental acculturation levels) may act as barriers to mental health service use for youth and family clients and help explain differential mental health service use (Cauce et al., 2002; Ho, Yeh, McCabe, & Hough, 2007; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999).

Implications. Findings suggest that cultural barriers were noted by our clinician participants but not as commonly as other barrier categories. However, the existing literature points to cultural incompatibilities and cultural issues significantly impacting youth and family therapy (Ho et al., 2007). These findings suggest that perhaps the participating therapist are not directly discussing potential cultural barriers with their clients, or perhaps they do not recognize cultural concerns as barriers to treatment. Developing systematic methods to assess client's cultural beliefs as they relate to the treatment utilization process and helping clinicians to complete training on culturally competent services may help to address treatment retention problems when they relate to cultural concerns.

Finding 5: Therapist's Perceptions Barriers

Quantitative. Zero percent of clinician participants endorsed specific barriers subsumed under the category of Therapist's Perceptions Barriers (e.g., child resistance or feelings by parent that youth mental health issues should be dealt with by therapists) as their first highest endorsed barrier category, 14% of clinician participants endorsed Therapist's Perceptions Barriers as their second highest endorsed barrier category, and 7% of clinician participants endorsed this category overall (i.e., 1st to 5th highest ranked).

Qualitative. Five percent of codes (37 out of 800) reflecting content such as "narcissism in therapy profession," "low fee clients don't mind canceling because they are paying less," and “therapist’s tendency to self-defend when client’s dropout” were categorized as Therapist’s Perceptions Barriers.

Comparison or integration. Both datasets support that Therapist’s Perceptions is a smaller but still important overarching barrier to treatment.

Discussion. Our findings support existing literature (Murdock et al., 2010; Westamacott, Hunsley, Best, Rumstein-McKean, & Schindlery, 2010) that therapists were likely to attribute the premature termination of their clients more on situational or client factors than on therapist’s perception factors (e.g., “resistance with mandated clients” or “low fee clients don’t mind canceling because they are paying less”), and that clinicians are unlikely to identify client dissatisfaction with the therapist as a reason. There may be some defensiveness on the therapist’s part (e.g., not wanting to fully recognize their own role in their client’s premature termination), or it may be that clinicians are less attuned to their own contributions rather than the problems external to the therapist (e.g., transportation, client’s negative attitudes, etc.) than clients may encounter in the treatment process. Thus, it is important to recognize the potential biases and self-serving attributions that may consciously or unconsciously exist in research that is conducted from the clinician’s point of view.

Implications. Therapist may be encouraged to be more introspective about the entire treatment process from treatment initiation to treatment termination, and seek consultation to evaluate any potential biases or self-serving attributions that may contribute to problems in the treatment process.

Finding 6: Clinician Gender x First Highest Barrier Category

Quantitative. A significant relationship was found between clinician gender and the first highest endorsed barrier. Compared to male and female, clinicians who endorsed "other" gender (*N* = 1 out of 36) had a significant association with the Cultural Barrier category. The residual, a difference between the observed and expected values for a cell, was 6, and research indicates, "the larger the residual, the greater the magnitude of the resulting chi-square obtained" (Sharpe, 2015, p. 2) with an absolute value of over 2 being used as a cutoff.

Qualitative. None.

Discussion. This finding shows a relationship between gender and Cultural Barriers that may suggest individuals who identify outside of the traditional male / female gender categories are possibly able to identify cultural concerns more readily. It is possible that they are more aware of cultural differences due to the fact that they self-identify outside of traditional gender norms and mainstream culture, and therefore, may be more aware of issues relating to diversity. However, the sample for clinicians who endorsed other gender represented only 1 out of 36 participants, and this finding must be interpreted with caution. To understand the details of this finding, further exploration between variables is needed on future studies.

Limitations and Strengths

The current study has several limitations that should be considered when interpreting the findings. First, although the sample size was relatively large for a qualitative study, on the contrary, it was relatively small for a quantitative study. Quantitatively obtaining a larger sample size could offer more meaningful results as it relates to the exploratory associations. In addition to the quantitatively small sample size, it is also important to note that participants were primarily from two community-based agencies in the Los Angeles area. Thus, the results may not be as generalized to all therapists in other mental health settings and different areas of the country. Furthermore, to enhance the generalizability of the results, it is important to note that the findings represent the perspective of therapists and do not account for youth and parent client's perspectives. Given this central fact, it would be important for future studies to gather information about the clients' experiences.

Despite the aforementioned limitations, this study had a number of strengths, such as the qualitatively large sample size. The large sample size added to the to the quality of the study, given that qualitative research often consists of small sample sizes. Some existing qualitative studies include as few as two or three participants (Creswell, 2013b), and Baker, Edwards and Doidge (2012) recommend samples include at least 12 participants. Thus, the 36 participants included in the current study are triple the minimum recommendation for qualitative research, and capture richer and robust information that may not have been obtained with a smaller sample. In addition to the sample size, the study accessed a wide range of clinicians who regularly treat youth clients and their families with varying levels of educational experiences and professional status (e.g., Practicum Students, Interns, LCSW, MFT, MSW, Psy.D., and Ph.D.). Hence, the findings in this study add important information to the extant mental health literature for youth.

In conclusion, the present study identified and quantified five main barriers to treatment categories, deducted first from the qualitative dataset, then consolidated with the results of the quantitative dataset. This study also explored potential associations between clinician gender, ethnicity, and professional status (licensed versus unlicensed) and found no significant differences in the types of barriers experienced overall except for the possibility that those identifying outside of traditional gender norms may more readily identify Cultural Barriers as reasons their clients terminated treatment. These findings help to elucidate other research in this area and add to the smaller yet growing body of findings specifically relating to youth and family clients receiving mental healths services in community mental health settings. It is hoped that these findings can inform future studies in this area, specifically, ones that examine and evaluate effective engagement strategies that are designed to address each type of barrier category found to influence treatment retention for youth and family clients.

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TABLES

Table 1.

Chi-square Residuals for Clinician Gender x First Highest Barrier Category.

		Practical Obstacles	Poor Alliance with the Therapist	Socioemotional	Cultural	Marginals
Male	Count	6	4	0	0	10
	Residual	.4	.9	-1.1	-.3	
	Std. Res	.2	.5	-1.1	-.5	
	Adj. Res	.3	.8	-1.3	-.6	
Female	Count	14	7	4	0	25
	Residual	-.1	-.6	1.2	-.7	
	Std. Res	0	-.2	.7	-.8	
	Adj. Res	.1	-.5	1.4	-1.5	
Other	Count	0	0	0	1	1
	Residual	-.6	-.3	-.1	1	
	Std. Res	-.7	-.6	-.3	5.8	
	Adj. Res	-1.1	-.7	-.4	**6**	
Marginals		20	11	4	1	36

Note. Adjusted residuals in bold are those that exceed +/-2.

FIGURES

Practical Obstacles	**Poor Alliance with the therapist**	**Therapist's Perceptions**	**Socioemotional**	**Cultural**
Transportation	Therapeutic Relationship			
Financial	Lack of Communication			
Logistical	Lack of Engagement			
Attendance				

Figure 1. Inter-rater reliability barrier codes.

	ORIGINAL		POOLED	
	N	%	N	%
Ethnicity	34	94.5	36	100
White	17	47.2	18	50
AA	2	5.6	2	5.6
Latino	10	27.8	10.6	29.4
Other	5	13.9	5.4	15
Sex	34	94.5	36	100
Male	10	27.8	10.2	28.3
Female	23	63.9	24.6	68.3
Other	1	2.8	1.2	3.3
Professional Status	35	97.2	36	100
Unlicensed	21	58.3	21.2	58.9
Licensed	14	38.9	14.8	41.1

Figure 2. Original v. pooled demographic variable distributions.

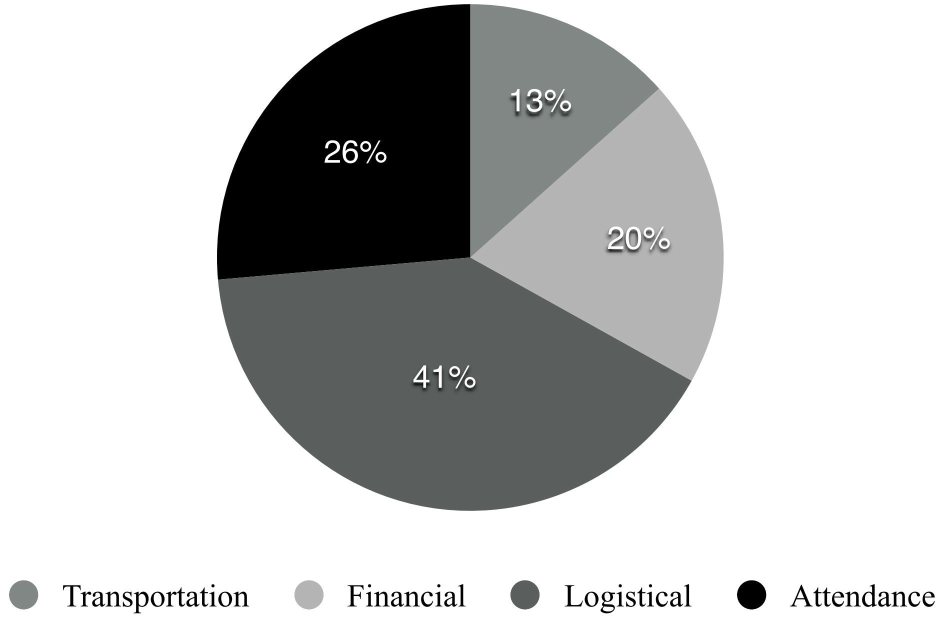

Figure 3. Percentages of each child code subsumed under the Practical Obstacles Theme.

Transportation	Financial	Attendance	Logistical
“Transportation / Client not having car”	“Lack of money for transportation/ Cost of Gas”	“Clients arriving late"	“Inflexible with clinic policies”
“Bus takes too long”	“Insurance difficulties "	"Early termination due to improvement from medication”	"Childcare Problems”
“Transportation"	"Cost of session contributes to lack of attendance”	“Canceling"	“Scheduling"
"Transportation / Car Trouble”	“Affordability"	"Clients no-showing”	"Time Constraints”

Figure 4. Data excerpts from the Practical Obstacles Barriers transcripts.

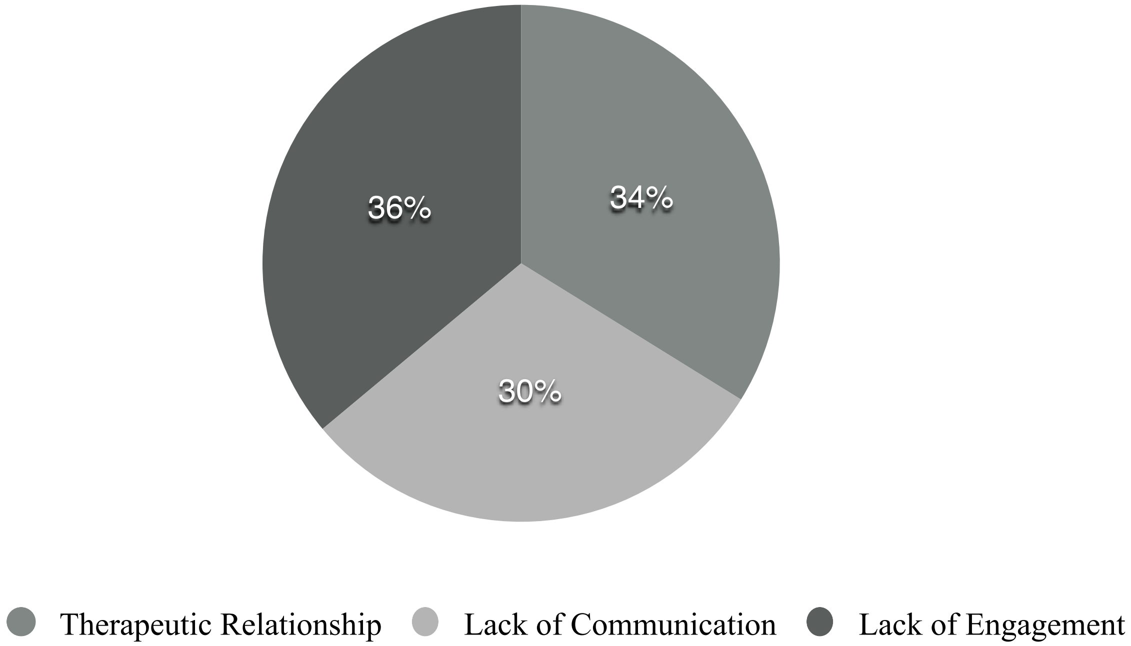

Figure 5. Percentage of each child code subsumed under the Poor Alliance with the Therapist Theme.

Lack of Engagement	Therapeutic Relationship	Lack of Communication
"Excuses and other random reasons”	"Parent disagreement about child's treatment”	“No or Lack of communication between client and therapist”
“Noncompliance"	“Parent's unrealistic expectations"	"Clients not being direct”
“Lack of Motivation"	“Lack of rapport affects attendance, motivation, interventions and overall receptivity”	“Client not knowing what the treatment obstacles are"
“Substance abuse “	“Unestablished Rapport"	“Lack of / no communication regarding termination from the client"

Figure 6. Data excerpts of the Poor Alliance with the Therapist Barriers transcripts.

Therapist’s Perception	Socioemotional	Cultural
“Guessing / assuming client is satisfied”	“Previous Forced Treatment/ Negative previous Treatment Experiences"	“Family dynamics make therapy difficult"
“Low fee clients don't mind canceling because they are paying less"	"Expressing Ambivalence"	“Cultural/ ethnicity / gender impacts the therapist relationship”
“Therapist's tendency to self-defend when client's dropout"	“Fearfulness"	“Some groups may not advocate for themselves”
"Pushing the therapist's agenda”	"Negative beliefs about therapy"	“Barriers represented differently across cultures"

Figure 7. Data excerpts of the parent themes Therapist’s Perception, Socioemotional, and Cultural Barriers.

	N	%
Practical Obstacles Barrier Total	68.8	38
Poor Alliance with the Therapist Barrier Total	64.2	36
Therapist’s Perception Barrier Total	12.8	7
Socioemotional Barrier Total	20.6	11
Cultural Barrier Total	13.6	8
Practical Obstacles Barrier First Highest Endorsed Barrier	20.8	58
Poor Alliance with the Therapist Barrier First Highest Endorsed Barrier	9.6	27
Therapist’s Perception Barrier First Highest Endorsed Barrier	0	0
Socioemotional Barrier First Highest Endorsed Barrier	4.6	13
Cultural Barrier First Highest Endorsed Barrier	1	3
Practical Obstacles Barrier Second Highest Endorsed Barrier	13.4	37
Poor Alliance with the Therapist Barrier Second Highest Endorsed Barrier	10.6	28
Therapist’s Perception Barrier Second Highest Endorsed Barrier	5	14
Socioemotional Barrier Second Highest Endorsed Barrier	4.4	12
Cultural Barrier Second Highest Endorsed Barrier	2.6	7

Figure 8. Frequencies and percentages of total barrier categories and first and second highest ranked barrier categories by clinician report.

APPENDIX A

Review of Literature

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Andrade, A. R., Lambert, E. W. & Bickman, L. (2000)	Dose effect in child psychotherapy: Outcomes associated with negligible treatment		- No body of evidence to show that mental health treatment for children & adolescents is effective in current condition - Positive correlation between improvement & great lengths of psychoanalysis in study using Child BX Checklist
Armbruster, P., & Fallon, T. (1994)	Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic.	Failure to attend, repeated cancelations resulting in no further contact, or open refusal of recommendations for further evaluation or treatment.	- Epidemiological data reporting 2/3 of children in need of mental health services fail to receive them

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Ascher, B. H., Farmer, B. J., & Angold, A., (1996)	The Child and Adolescent Services Assessment (CASA): Description and Psychometrics.		- Child & Adolescent Services Assessment is a self- and parent-report instrument designed to assess the use of mental health services by children 8-18; collects information on whether a services was ever used and more detailed information on services in the recent past
Banerjee, A. & Chaudhury, S. (2010)	Statistics without tears: Populations and samples.		- Non-random samples: volunteers who agree to participate; limitations: larger group harder to identify, internal valid, can provide important cues for further studies based on random samples; generalization may be possible

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Baruch, G., Vrouva, I., & Fearon, P. (2009)	A follow-up study of characteristics of young people that dropout and continue psychotherapy: Service implications for a clinic in the community.		- Dropping out of psychotherapy among young people is a significant problem - Internalizing problems: relationship problems & being older increase the likelihood of dropping out - Externalizing problems: homelessness and being younger increase the likelihood of dropping out
Centers for Disease Control (2009)	National health and nutrition examination survey.		
Copeland, W. E., Miller-Johnson, S., Keeler, G., Angold, A., & Costello, E. J. (2007).	Childhood psychiatric disorders and young adult crime: A prospective, population-based study.		- 51.4% of male young adult offenders & 43.6% of female offenders had a child psychiatric history
Creswell, J. W. (2013).	Research design: Qualitative, quantitative, and mixed methods approaches.		
Cummings, J. R., Wen, H. & Druss, B. G. (2013).	Improving access to mental health services for youth in the United States.		- School-based mental health programs may remedy geographic and financial barriers

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Denzin, N. K. (2012).	Triangulation 2.0.		- Descriptions/ definitions of qualitative statistics
DeRigne, L. (2010).	What are the parent-reported reasons for unmet mental health needs in children.		- Findings regarding uninsured children - Definition of unmet needs
Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J. (2008).	Ethnic background, therapeutic alliance, and treatment retention in functional family therapy with adolescents who abuse substances.	Not completing all therapy sessions for which they were scheduled	- Latino families who did not complete therapy demonstrated more imbalanced alliances during the first session than families that completed therapy
Garcia, J. A., & Weisz, J. R. (2002).	When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment.	Clinic record information: statements that termination was ‘against therapist advice’ or ‘premature’ were used to indicate dropout. Early d.o.: five treatment sessions or less. Late d.o.: six sessions or more.	- Child and adolescent treatment ends for a variety of reasons, but little is known about the underlying factors or about whether any such factors are linked to premature dropout.

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Gonzalez, A., Weersing, V. R., Warnick, E. M., Scahill, L. D., & Woolston, J. L. (2011)	Predictors of treatment attrition among an outpatient clinic sample of youths with clinically significant anxiety.	Clinician-rated d.o. (CR) (this determined who was seen as a dropout): youths/ families who unilaterally decided to terminate and discontinued contact with clinic (terminations for reasons beyond ones control were seen as non-d.o.) The dropouts were further delineated by number of sessions ˛Phase of treatment d.o. (PT): pre-treatment (0–1 sessions), early (2–6 sessions), late (>6 sessions)	- Approximately 35-75% of children terminate services before the provider would agree that it is appropriate - The relatively small body of work on attrition from youth psychotherapy has yielded inconsistent findings and has been dominated by studies of children and adolescents with disruptive behavior disorders - Untreated, early-onset anxiety often continues into adulthood (Dadds et al., 1999; Keller et al., 1992), and predicts academic underachievement, substance dependence (Woodward & Fergusson, 2001), and the development of depression and conduct disorder

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. M. (2010).	Engaging families into child mental health treatment: Updates and special considerations.		- Not surprisingly, rates of child psychopathology in low-income inner-city settings have been found to be as high as 40% - Close to 1/3 of children and their families fail to engage at the initial face-to-face intake appointment. - It is not uncommon for length of treatment to average 3–4 sessions in urban, low-income communities - 40% to 60% of children receiving outpatient mental health services attend few sessions and drop out quickly - Found that at the end of 12 weeks, only 9% of children remained in treatment in urban inner-city clinics

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Ingoldsby, E. M. (2010).	Review of interventions to improve family engagement and retention in parents and child mental health programs.	The few interventions found to produce longterm impact on engagement and retention integrated motivational interviewing, family systems and enhanced family stress and coping support strategies at multiple points throughout treatment.	- Anywhere from 20 to 80% of families drop out prematurely, with many receiving less than half of the prescribed intervention
Kataoka, S. H., Zhang, L., & Wells, K. B. (2002).	Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status.	In a 12-month period, 2-3% of children 3-5 years old and 6-9% of children and adolescents 6-17 years old used mental health services. Of children and adolescents 6-17 years old who were defined as needing mental health services, nearly 80% did not receive mental health care. Controlling for other factors, the authors determined that the rate of unment need was greater among Latino than white children and among uninsured than publicly insured children.	

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Kazdin, A. E., & Weisz, J. R. (2003).	Evidence-based psychotherapies for children and adolescents.		
Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997).	A qualitative analysis of client perceptions on therapist self-disclosure in long-term therapy.		
Lindsey, M., Brandt, N., Becker, K., Lee, B., Barth, R., Daleiden, E. & Chorpita, B. (2013).	Identifying the common elements of treatment engagements interventions in children's mental health services.		- Engagement interventions were most frequently delivered in the clinic setting (62.9 %), followed by the client's home (44.9 %), and other settings (e.g., schools; 7.9 %)

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
McKay, M. M. & Bannon, W. M. (2004).	Engaging families in child mental health services		-Studies have identified several concrete obstacles (eg, insufficient time, lack of transportation), contextual obstacles (eg, community violence), and agency obstacles (eg, time spent on a waiting list) experienced by the family that interfere with use of services. - Recent findings support the influence of perceptual barriers as being significantly more salient to understanding engagement in services than logistical barriers

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
McKay ,M. M., Lynn, C. J., & Bannon, W. M.(2005).	Understanding inner city child mental health need and trauma exposure: Implications for preparing urban service providers.		- An ecological perspective of mental health need guides the presentation of issues and stressors that occur at the level of the individual child; within the family, school, and community; and within the larger service system context. - Results reveal low rates of ongoing service involvement despite multiple, complex presenting mental health issues and significant levels of trauma exposure.
Merikangas, K. et al., (2010)	Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication-adolescent supplement (NCS-A).		- Total rates of specific disorders were 8.6% for ADHD - 2.1% for conduct disorder, 0.7% for anxiety disorders - 0.1% for eating disorders (0.1% for anorexia and 0.1% for bulimia), and 3.7% for mood disorders

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Merikangas, K. R., He, J., Brody, D., Fisher, P. W., Bourdon, K., & Kortez, D. S. (2010)	Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES.		- The overall prevalence of disorders with severe impairment and/or distress was 22.2% - Nearly one in three adolescents (31.9%) met criteria for an anxiety disorder, with rates for individual disorders ranging from 2.2% for GAD to 19.3% for specific phobia - Severe anxiety disorders were present in 8.3% - The prevalence of ADHD was 8.7% - ODD was present in 12.6% - 6.8% met criteria for CD - Substance use disorders were present in 11.4%
Miller, R. L. & Brewer, J. (Eds). (2003).	The A-Z of social research: A dictionary of key social science research concepts.		

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Miller, L. M., Southam-Gerow, M. A., & Allin, R. B., Jr. (2008).	Who stays in treatment? Child and family predictors of youth client retention in a public mental health agency.		- The lion's share of research on attrition with child and adolescent research-clinic based samples has occurred in randomized clinical trial (RCT studies) and most of this has focused on youth with externalizing behavior problems, though a few studies of children with internalizing disorders have been conducted. Even fewer studies have occurred in non-research clinical service settings like community mental health centers or private practice settings where treatment endpoints are rarely predetermined
New Freedom Commission on Mental Health (2003).	Achieving the promise: Transforming mental health care in America.		

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
O'Connell, M. E., Boat, T., & Warner, K. E.(Eds.). National Research Council and Institute of Medicine. (2009).	Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.		- Associations have been demonstrated between MEB disorders and a number of chronic diseases. For example, one study showed that 16 percent of asthmatic youth ages 11-17 demonstrated criteria for anxiety and depressive disorders (McCauly, Katon, et al., 2007). Health professionals in both sectors contribute to the maintenance of good physical and good mental health. - The health status of young people has a significant influence on the trajectory of health into adulthood

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Onwuegbuzie, A. J., & Leech, N. L. (2006).	Linking research questions to mixed methods data analysis procedures.		- Conducting mixed methods research involves collecting, analyzing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon. - “its logic of inquiry includes the use of induction (or discovery of patterns), deduction (testing of theories and hypotheses), and abduction (uncovering and relying on the best of a set of explanations for understanding one’s results) - Providing a bridge between the qualitative and quantitative paradigms, an increasing number of researchers are utilizing mixed methods research to undertake their studies.

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Perou, R., Bitsko, R. H., Blumberg, S. J., Pastor, R. M., Ghandour, R. M., Gfroerer, J. C., … Huang, L. N., Centers for Disease Control and Prevention (CDC) (2013).	Mental health surveillance among children —United States, 2005-2011.		- A total of 13%–20% of children living in the United States experience a mental disorder in a given year - Rate of hospital stays among children for mood disorders increased 80% during 1997–2010, from 10 to 17 stays per 10,000 population - Mental disorders might result in serious difficulties at home, with peer relationships, and in school (*17–19*). These disorders also can be associated with substance use, criminal behavior, and other risk-taking behaviors

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Podell, J. L., Gosch, E. A., Albano, A., Rynn, M. A., Sherrill, J. T., Birmaher, B.,… Piacentini, J. C. (2013).	Therapist factors and outcomes in CBT for anxiety in youth.		- Research indicates that most anxiety disorders do not abate with time, and if left un- treated, youth are at a greater risk for anxiety disorders in adulthood (Pine, Cohen, Gurley, Brook, & Ma, 1998), future depression (Bie- derman, Faraone, Mick, & Lelon, 1995), and potential substance abuse

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003)	Alliance and dropout in family therapy for adolescents with behavior problems: Individual and systemic effects.	Attending less than eight sessions and being identified by the therapist as unsuccessful termination	- Results demonstrated that individual parent and adolescent alliances did not predict retention. However, as hypothesized, dropout cases had significantly higher unbalanced alliances - These findings highlight the importance of alliances in functional family therapy and suggest that how the alliance operates in conjoint family therapy may be a function of systemic rather than of individual processes.

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Russell, L. (2010).	Mental health care services in primary care: Tackling the issues in the context of health care reform.		- Mental health workforce shortages and maldistribution problems - The ability of the primary care workforce to diagnose and treat mental health disorders - Insurance and financial barriers for patients seeking treatment for mental health disorders - Patients' perceptions and fears that are barriers to accessing effective and appropriate treatments for mental health disorders - Racial and ethnic disparities in mental health services
Tambling, R. B., Johnson, L. N., Templeton, G. B., & Melton, M. S. (2007).	Using web-based technology to facilitate client engagement.		- Results indicated that the use of a web-based scheduling system significantly reduced the number of days clients waited for a first appointment and increased the number of kept appointments.

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Tashakkori, A., & Creswell, J. W. (2007)	Editorial: Exploring the Nature of Research Questions in Mixed Methods Research.		- A strong mixed methods study starts with a strong mixed methods research question or objective. - when a project explores mixed research questions with interconnected qualitative and quantitative components or aspects (e.g., questions including "what and how" or "what and why"), end product of the study (conclusions and inferences) will also include both approaches
U.S. Department of Health and Human Services, (1999).	Mental health: A report of the surgeon general.		- 21% of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associate with at least minimum impairment

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
U.S. Department of Health and Human Services, (2001).	U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.		- In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment. Yet, in any given year, it is estimated that about one in five children receive mental health services. Unmet need for services remains as high now as it was 20 years ago.

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Warnick, E. M., Gonzalez, A., Weersing, V. R., Scahill, L. D., & Woolston, J. L. (2012).	Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition.	Three definitions 1. Clinician judgment: youths were classified as dropouts based on the clinician coded reason for discharge 2. Missed last appointment: youths were classified as dropouts if they did not attend their last scheduled appointment 3. Dose: attending less than 12 sessions within 4 months	- In line with previous findings, our a priori hypotheses stated that ethnic minorities, single caregiver families, families with state-funded insurance coverage for low-income families, and families where the identified child was referred for externalizing behaviors would be at higher risk of dropping out. - Based on two of the definitions evaluated, clinician-rated dropout and missed last appointment, attrition rates in this sample (63.1% and 56.6%, respectively) were similar to rates reported in other outpatient settings

Author	Title	Definition of Drop-Out	Important Miscellaneous Info.
Zhang, Y., & Wildemuth, B. M. (2009)	Qualitative analysis in content		- Defining the coding unit is one of your most fundamental and important decisions - Qualitative content analysis usually uses individual themes as the unit for analysis, rather than the physical linguistic units

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APPENDIX B

Clinician Questionnaire Interview/Focus Groups

P.A.R.T.Y.

Clinician Questionnaire
Interview/Focus Groups

For the questions below think about the experiences you have had counseling youth and/or family therapy clients.

1. In your experience as a clinician with youth clients and/or family therapy clients, which of the following barriers have affected client attendance and adherence? Rank them from most to least common [1 = most common, 2 = 2nd most common, etc.] You only need to rank up to 5 of the most common barriers.

rank	Item	rank	Item	rank	Item
	Transportation problems		Insurance inadequacies		Financial burden
	Bureaucratic Delay		Clinic refusal to treat		Time constraints
	Language Problems		Lack of motivation		Fear for safety
	Child Resistance		Parent resistance		Unrealistic goals
	Unrealistic Expectations		Mental health condition		Life stressors
	Treatment lasts too long		Treatment is not effective		Lack of information
	Treatment is too difficult		Access to child care		Situation improved
	Previous negative experience		Stigma, shame embarassment		Poor client-clinician relationship
	Negative beliefs about therapy		Lack of support from family		Anticipated fear of loss of parental rights
	Feelings by parents or youth that mental illness can be overcome independently		Negative reaction from family and/or friends		Religious/spiritual issues
	Feelings by parent that youth mental health issues should be dealt with by therapists		Other Stressors or Obstacles: Please indicate ___________ ______________________ __		

For the questions below, please continue to think about the experiences you have had counseling youth and/or family therapy clients. We will record your verbal responses using a digital recorder, so we can make sure that we get all the information you are telling us as accurately as possible. (Research Associate: Please start recorder when participant is ready)

2. Do you choose to discuss potential barriers to treatment with clients in the initial session or when obstacles arise? How do you discuss barriers with your clients? Please explain.

3. What strategies seem to be effective in maintaining client attendance despite barriers? Please explain.

4. How do you overcome logistical barriers with clients, including but not limited to: lack of money, lack of time, no transportation, no childcare, etc?

5. How do you overcome therapeutic barriers with clients, including but not limited to: lack of motivation, unrealistic expectations, unrealistic goals, slow/no improvement, etc?

6. In your experience, do your clients verbally communicate the stress of treatment obstacles? How do they communicate them?

7. In your experience, do your clients verbally communicate the desire to prematurely terminate treatment? How do they do so?

8. What questions do you believe are important to ask clients at the start of therapy to determine how you can best engage and motivate them throughout the treatment process?

9. How do you adequately gauge clients’ satisfaction with treatment?

10. How important is rapport with clients to overcoming potential barriers to therapy?

11. Discuss some ways in which you build rapport with clients.

Thank you for participating!

APPENDIX C

Demographic Questionnaire

P.A.R.T.Y.

DEMOGRAPHIC QUESTIONNAIRE

We would like to start by asking for some background information about you and your family. Your answers will be kept confidential so please try to be as truthful as possible.

1. BACKGROUND

1a. Age__________
1b. Sex: M F None/Prefer Not To Say

2. FAMILY MEMBERS AND MARITAL STATUS

2a. What is your marital status?
c Single, never married
c Separated
c Divorced
c In a relationship but living apart
c Married
c Widowed
c Living together

2b. How many children live in your household? ___________
2c. How many adults (including you)? ______________

3. INCOME

3a. Which category best describes your total household yearly income?
c Less than $10,000
c $20,000 - $29,999
c $40,000 - $49,999
c $60,000 - $69,999
c More than $80,000
c $10,000 - $19,999
c $30,000 - $39,999
c $50,000 - $59,999
c $70,000 - $79,999

4. DEMOGRAPHICS

4a. Ethnicity:
c White, non-Hispanic
c Hispanic
c Native American
c African-American
c Asian-Pacific Islander
c Other (please specify)__________________

4b. Language Preference:______________
4c. Language Spoken at Home:______________
4d. Years you have resided in the United States:______________

4e. Education
Highest level of education completed:
c Less than High School
c High School/GED
c Some College
c 2 - Year College Degree (Associates Degree)
c 4 – Year College Degree (BA,BS)
c Master’s Degree
c Doctoral Degree
c Professional Degree (MD,JD)

4f. Please indicate your current professional status or the type of professional credential or license you currently hold.
c Practicum Student (practicing under licensed clinician)
c Intern (practicing under licensed clinician)
c LCSW
c MFT
c MSW
c MD
c PsyD
c PhD
c Other: Please describe ____

4g. How many years have you been working in counseling/mental health (including training)?

____

4h. What type of practice setting do you currently work in?
c Private Practice
c Medical Group
c Community Mental Health Clinic
c School or University Based Counseling Center
c Social Services Agency
c Outpatient Hospital
c Residential Treatment Center
c Inpatient Hospital
c Other: Please describe ____

THANK YOU VERY MUCH FOR YOUR COOPERATION, WE GREATLY APPRECIATE YOUR TIME.

APPENDIX D

Transcription Template

Name of Audio Clip:
Transcriber #1:
Transcriber #2:
Final Sign-Off by Lab Manager:

APPENDIX E

Qualitative Data Preparation and Transcription Protocol

Qualitative Data Preparation and Transcription Protocol

TEXT FORMATTING

General Instructions

The **transcriber** shall transcribe all individual and focus group interviews using the following formatting:

1. Arial 10-point face-font
2. One-inch top, bottom, right, and left margins
3. All text shall begin at the left-hand margin (no indents)
4. Entire document shall be left justified

Labeling Focus Group Transcripts

Individual interview transcript shall include the following labeling information at the top of the document:

Example:
Focus Group Location:
Cadre:
Date:
Number of Attendees (if known):
Name of Transcriber:
Number of Tapes:

Audiotape Changes

The transcriber shall indicate when the interview is recorded on a new tape and include information verifying that the second side of the audiotape is blank as well as the total number of audiotapes associated with the focus group. This information shall be typed in uppercase letters.

Example:
END OF TAPE 1 (3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 1 IS BLANK
START OF TAPE 2 (3 TAPES TOTAL)
END OF TAPE 2 (3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 2 IS BLANK

Documenting Comments

Comments or questions by the Interviewer or Facilitator should be labeled with by typing **I:** at the left margin and then indenting the question or comment.

Any comments or responses from participants should be labeled with **P:** at the left margin with the response indented. A response or comment from a different participant should be separated by a return and than a new **P:** at the left margin.

Example

I: OK, before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand that your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at anytime.

P: Yes, I had read it and understand this.

P: I also understand it, thank you.

I: Do you have questions before we proceed?

End of Interview

In addition, the transcriber shall indicate when the interview session has reached completion by typing END OF INTERVIEW in uppercase letters on the last line of the transcript along with information regarding the total number of audiotapes associate with the interview and verification that the second side of the tape is blank. A double space should precede this information.

Example:

I: Is there anything else that you would like to add?

P: Nope, I think that about covers it.

I: Well, thanks for taking the time to talk with me today. I really appreciate it.

END OF INTERVIEW—(3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 2 IS BLANK

CONTENT

Audiotapes shall be transcribed verbatim (i.e., recorded word for word, exactly as said), including any nonverbal or background sounds (e.g., laughter, sighs, coughs, claps, snaps fingers, pen clicking, and car horn).

- Nonverbal sounds shall be typed in parentheses, for example, (short sharp laugh), (group laughter), (police siren in background).
- If interviewers or interviewees mispronounce words, these words shall be transcribed as the individual said them. The transcript shall not be "cleaned up" by removing foul language, slang, grammatical errors, or misuse of words or concepts.
- If an incorrect or unexpected pronunciation results in difficulties with comprehension of the text, the correct word shall be typed in square brackets. A forward slash shall be placed immediately behind the open square bracket and another in front of the closed square bracket.

Example:
P: I thought that was pretty pacific [/specific/], but they disagreed.

Filler words such as *hm*, *huh*, *mm*, *mhm*, *uh huh*, *um*, *mkay*, *yeah*, *yuhuh*, *nah huh*, *ugh*, *whoa*, *uh oh*, *ah*, and *ahah* shall be transcribed.

Inaudible Information

The transcriber shall identify portions of the audiotape that are inaudible or difficult to decipher. If a relatively small segment of the tape (a word or short sentence) is partially unintelligible, the transcriber shall type the phrase "inaudible segment." This information shall appear in square brackets.

Example:
The process of identifying missing words in an audiotaped interview of poor quality is [inaudible segment].

If a lengthy segment of the tape is inaudible, unintelligible, or is "dead air" where no one is speaking, the transcriber shall record this information in square brackets. In addition, the transcriber shall provide a time estimate for information that could not be transcribed.

Example:
[Inaudible: 2 minutes of interview missing]

Overlapping Speech

If individuals are speaking at the same time (i.e., overlapping speech) and it is not possible to distinguish what each person is saying, the transcriber shall place the phrase "cross talk" in square brackets immediately after the last identifiable speaker's text and pick up with the next audible speaker.

Example:
P: Turn taking may not always occur. People may simultaneously contribute to the conversation; hence, making it difficult to differentiate between one person's statement [cross talk]. This results

in loss of some information.

Pauses

If an individual pauses briefly between statements or trails off at the end of a statement, the transcriber shall use three ellipses. A brief pause is defined as a two- to five second break in speech.

Example:

P: Sometimes, a participant briefly loses . . . a train of thought or . . . pauses after making a poignant remark. Other times, they end their statements with a clause such as but then . . . .

If a substantial speech delay occurs at either beginning or the continuing a statement occurs (more than two or three seconds), the transcriber shall use “long pause” in parentheses.

Example:

P: Sometimes the individual may require additional time to construct a response. (Long pause) other times, he or she is waiting for additional instructions or probes.

Questionable Text

If the transcriber is unsure of the accuracy of a statement made by a speaker, this statement shall be placed inside parentheses and a question mark is placed in front of the open parenthesis and behind the close parenthesis.

Example:

P: I wanted to switch to ?(Kibuli Hospital)? if they have a job available for me because I think the conditions would be better.

Sensitive Information

If an individual uses his or her own name during the discussion, the transcriber shall replace this information with the appropriate interviewee identification label/naming convention.

Example:

P: My supervisor said to me, “P1, think about things before you open your mouth.”

P: I agree with P1; I hear the same thing from mine all the time.

If an individual provides others’ names, locations, organizations, and so on, the transcriber shall enter an equal sign immediately before and after the named information. Analysts will use this labeling information to easily identify sensitive information that may require substitution.

Example:

P: My colleague =John Doe = was very unhappy in his job so he started talking to the hospital administrator at = Kagadi Hospital = about a different job.

REVIEWING FOR ACCURACY

The transcriber/proofreader shall check (proofread) all transcriptions against the audiotape and revise the transcript file accordingly. The transcriber/proofreader shall adopt a three-pass-per-tape policy whereby each tape is listened to three times against the transcript before it is submitted. All transcripts shall be audited for accuracy by the interviewer who conducted the interview or by the study data manager.

SAVING TRANSCRIPTS

The transcriber shall save each transcript as a text file rich text file with an .rtf extension.
For focus groups, the title should include the location of the focus group and the cadre.

APPENDIX F

P.A.R.T.Y. Informed Consent

P.A.R.T.Y.

P.A.R.T.Y. Survey Project

Promoting **A**ttendance and **R**etention in **T**reatment for **Y**outh

INFORMED CONSENT FOR CLINICIAN PARTICIPATION IN RESEARCH ACTIVITIES (INTEVIEW/FOCUS GROUPS)

Participant (Print Name):

Principal Investigator: Judy Ho, Ph.D., ABPP, Assistant Professor of Psychology, Pepperdine University

Title of Project: **P**romoting **A**ttendance and **R**etention in **T**herapy for **Y**outh (PARTY)

1) I, ______________________________, agree to participate in the research study under the direction of Dr. Judy Ho. I understand that while the study will be under the supervision of Dr. Judy Ho, other personnel who work with her may be designated to assist or act in her behalf. I understand that my participation in this study is strictly voluntary, and that I may withdraw my participation at any time.

2) PURPOSE OF STUDY: The objective of this research study is to examine the types of emotional, cultural, therapeutic, and logistical barriers that youth and families experience in mental health treatment and counseling. Furthermore, the study investigates strategies utilized by clinicians, clients, and agencies to overcome emotional, cultural, therapeutic, and logistical barriers to improve treatment retention and reduce treatment dropout. Clinicians/counselors will be asked to report barriers to treatment that have been and are most pervasive in their treatment and referral experiences as well as strategies most effective in increasing attendance, retention, and engagement in therapy.

3) MY TASKS FOR THIS STUDY: I will be asked to complete a questionnaire that will provide information regarding my clinical experience. I will also be asked open-ended questions to consider clinical strategies and problems confronted in my clinical experience, and my answers will be recorded via audiotape by the research associate to ensure accurate transcription. However, no identifying information will be recorded on this audiotape, and only research associates will have access to these tapes. I will not be asked to provide identifying or specific information about clients. The interview or focus group will require approximately 30-45 minutes total to complete. This study will be conducted at a location and time convenient to me. I can elect to participate in this study via an individual interview (one-on-one with the research associate) or to participate within a small focus group format (with a few other clinicians and 2-3 research associates). The format of the participation will be up to me.

4) POTENTIAL BENEFITS OF THIS STUDY: I understand that there are no direct benefits to me for participating in this study. I understand that my participation may benefit society and the field of psychological research by increasing understanding and knowledge of potential barriers to mental health treatment and strategies for overcoming these barriers. The data collected may be used to help attain funding to continue this type of research at no cost to mental health clinics, and/or used in research manuscripts or textbooks to help increase public awareness of the barriers to motivation and engagement in youth and family therapy.

5) POTENTIAL RISKS OF THIS STUDY: There are no anticipated significant risks for my

participation, but some minimal risks include boredom and fatigue while completing the aforementioned questionnaires. If I become bored or fatigued, I understand that I can take breaks at any time. Also possible are some uneasy feelings that may arise when asked to answer questions about my clinical work. If I experience such unease, I may speak with the researcher immediately, or I can contact the principal investigator by phone at (310) 568-5604 following the session. I understand that I may discontinue the study at any time.

6) CONFIDENTIALITY: I understand that the principal investigator and her research associates will take all reasonable measures to protect the confidentiality of my records, and my identity will not be revealed in any publication that may result from this project. Only the principal investigator and her research associates will have access to my data, and the data is not linked to any identifying information. Recorded audio will be uploaded onto a secure server, and the audio file will be password protected, and only research associates will have access to the password and the data, stored on official research lab laptop computers in a secured facility at Pepperdine University Graduate School of Psychology, West Los Angeles campus. The hard copy data (written material and audio recordings) may be kept in these locked facilities for 5 years, and will be destroyed when it is no longer required for research purposes. In addition, the information collected will be entered into a computer data analysis program for research purposes. The computer data will be completely de-identified.. The findings of this study may be published in research manuscripts, textbooks, or presented at professional conferences. However, data from this study will only be reported in the aggregate, which ensures my anonymity.

The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. In the above cases, the researchers are mandated by law to report these issues to the proper authorities, including but not limited to the police department, child protective services, or elder protective services.

If I decide to participate within a small focus group format, all of the above confidentiality considerations apply. In addition, participating clinicians, including myself, will sign an additional form stating that we will keep the information revealed within the focus group confidential.

7) COMPENSATION: As incentive for my participation in this project, I will be compensated a $35 Target gift card. Furthermore, I will receive compensation even if I decide not to participate once I hear more about the study or if I decide not to answer all the questions or complete the survey in its entirety.

8) QUESTIONS AND CONCERNS: I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Judy Ho, Ph.D. at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045 and/or (310) 568-5604 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact Jean Kang, Manager of the Graduate and Professional Schools Institutional Review Board, Pepperdine University at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045 and/or (310) 568-5753.

9) UNDERSTANDING OF THIS CONSENT DOCUMENT: I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form, which I have read and understand. I hereby consent to participate in the research described above.

____________________________________ ____________________________________
Participant’s Signature Printed Name

____
Date

I have explained and defined in detail the research procedure in which the subject has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person’s consent.

____________________________________ ____________________________________
Researcher’s Signature Printed Name

____
Date

APPENDIX G

IRB Certification

Protecting Human Subject Research Participants

Certificate of Completion

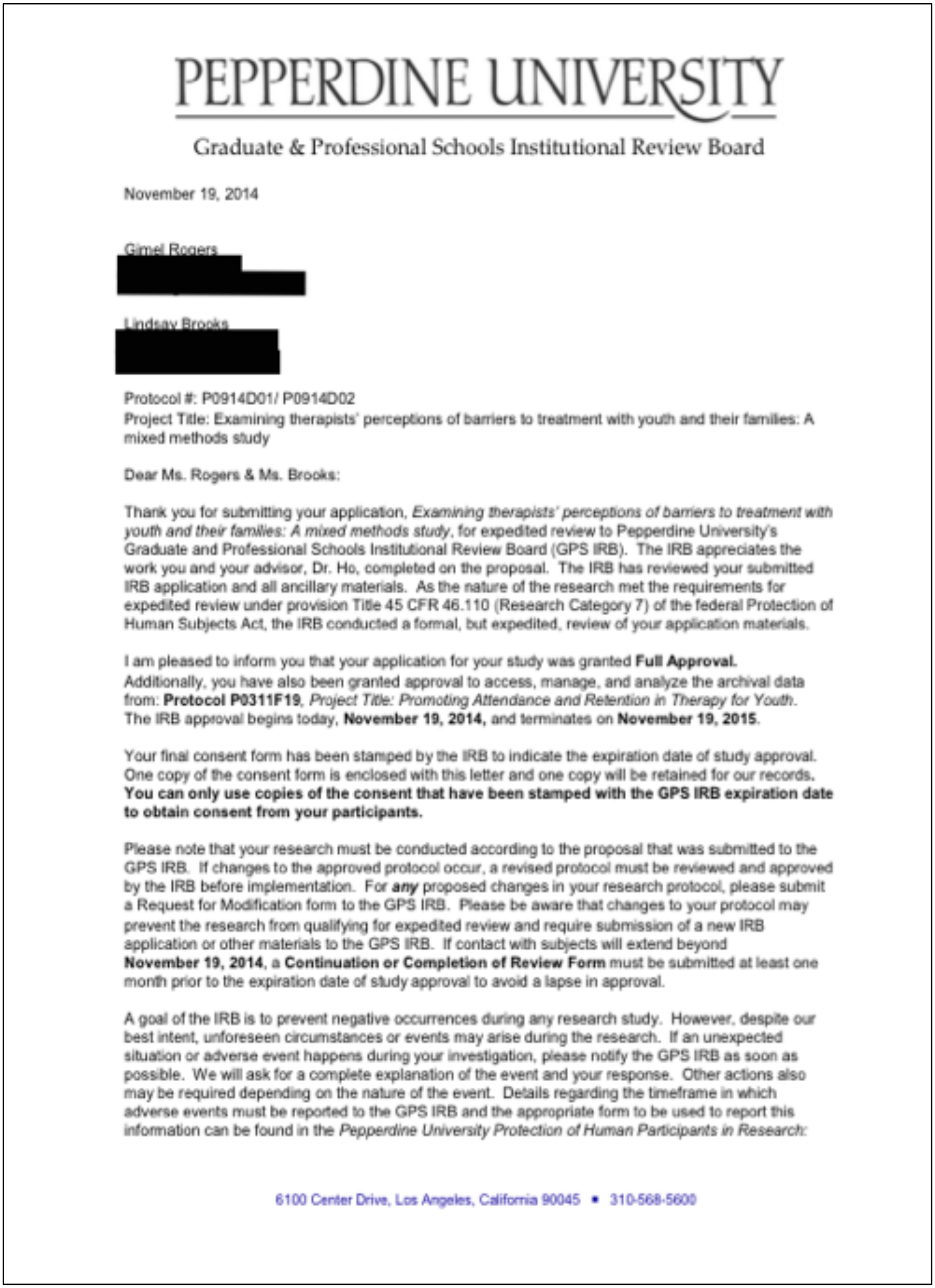
The National Institutes of Health (NIH) Office of Extramural Research certifies that **Gimel Rogers** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 02/10/2012

Certification Number: 864718

APPENDIX H

IRB Approval Notice



PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

November 19, 2014

Gimel Rogers
[redacted]

Lindsay Brooks
[redacted]

Protocol #: P0914D01/ P0914D02
Project Title: Examining therapists' perceptions of barriers to treatment with youth and their families: A mixed methods study

Dear Ms. Rogers & Ms. Brooks:

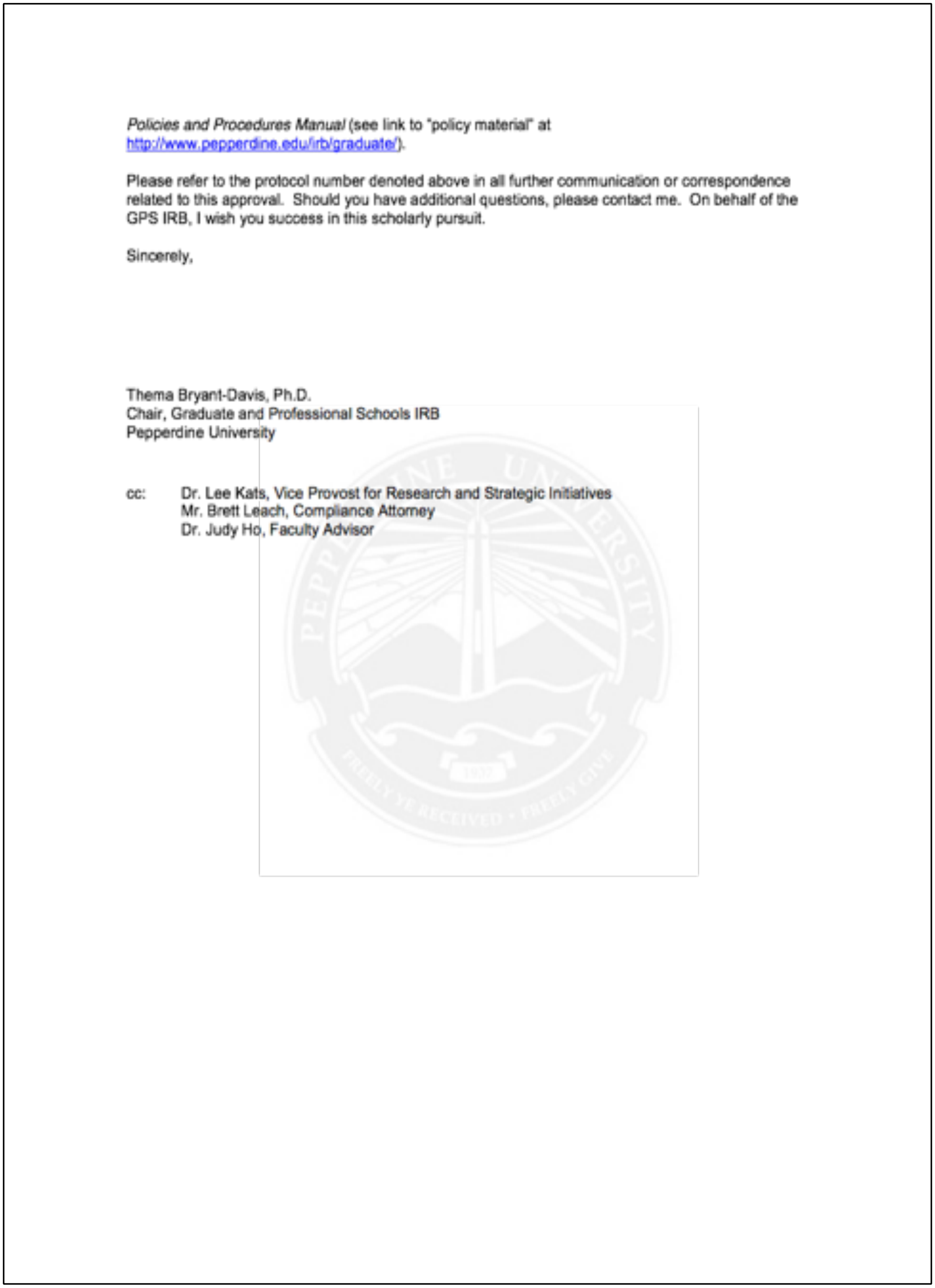
Thank you for submitting your application, *Examining therapists' perceptions of barriers to treatment with youth and their families: A mixed methods study*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Ho, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval.** Additionally, you have also been granted approval to access, manage, and analyze the archival data from: **Protocol P0311F19**, *Project Title: Promoting Attendance and Retention in Therapy for Youth*. The IRB approval begins today, **November 19, 2014,** and terminates on **November 19, 2015**.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For ***any*** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **November 19, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research:*



Policies and Procedures Manual (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Thema Bryant-Davis, Ph.D.
Chair, Graduate and Professional Schools IRB
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Judy Ho, Faculty Advisor