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A Comparison of Completers and Noncompleters of Exposure-Based Cognitive and Behavioral Treatment for Phobic and Anxiety Disorders in Youth

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This article examined sociodemographic and clinical characteristics of child treatment completers and noncompleters who received exposure-based cognitive–behavioral treatment. A total of 137 children (46% girls) and their parents (predominantly Euro-American and Hispanic/Latino) participated in this study (106 completers, 31 noncompleters). The majority of noncompleters received an average of 5 sessions. Findings were generally consistent with past research in terms of lack of differences between completers and noncompleters. Results are discussed in the context of previous child attrition research and directions for future research.

Research on treatment noncompletion in childhood psychotherapy is scarce, with most of the work conducted in the adult area. In a meta-analysis of 125 studies in which noncompletion data were reported (Wierzbicki & Pekarik, 1993), only 16 (13%) were child studies. Of these 16 studies, the mean noncompletion rate was high: 46.81%. This high rate is consistent with the small number of other studies conducted in the child area, where noncompletion rates have been found to be as high as 50 to 75% (e.g., Pekarik & Stephenson, 1988; Singh, Janes, & Schechtman, 1982; Vaile-Val, Rosenthal, Curtiss, & Marohn, 1984).

Although rates of treatment noncompletion in child psychotherapy are high, research findings are inconsistent regarding whether children and their parents who do not complete treatment differ from children and their parents who do complete treatment. In studies that have used general community-based mental health clinic samples, few or no statistically significant differences between child completers and noncompleters have been found on a wide range of variables including sociodemographics and clinical characteristics (Gould, Shaffer, & Kaplan, 1985; McAdoo & Roeske, 1973; Pekarik & Stephenson, 1988; Weisz, Weiss, & Langmeyer, 1987). In studies that have used university-based specialty conduct disorders clinic samples (e.g., Kazdin, Mazurick, & Bass, 1993; Kazdin, Mazurick, & Siegel, 1994), statistically significant differences have been found. Specifically, in conduct disorder clinics, noncompleters have been likely to be minorities, from single-parent homes, to have lower socioeconomic status, and to receive higher internalizing and externalizing scores on the Child Behavior Checklist (CBCL; Achenbach, 1991) than completers (Kazdin et al., 1993, 1994).

We are aware of only one study in the child anxiety treatment research literature that, using a university-based specialty anxiety disorders clinic sample (i.e., Kendall & Sugarman, 1997), systematically compared treatment completers ($n = 146$) and noncompleters ($n = 44$, refusers and dropouts, ages 8 to 14 years) along a number of sociodemographic (e.g., age, gender, ethnicity) and clinical (i.e., child and parent psychopathology) variables. Although there were more similarities than differences between completers and noncompleters, a small number of differences emerged. Noncompleters were more likely to be in the wait-list control condition, live in single-parent households, and be of ethnic minority status, although this latter difference did not remain statistically significant following Bonferroni adjustment. In addition, child noncompleters self-rated lower levels of anxiety symptoms than did child completers on the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978).

Given the consistent and strong empirical evidence that anxiety disorders in children can be significantly reduced using exposure-based cognitive–behavioral treatments (see Ollendick & King, 1998; Silverman & Berman, 2001), premature termination from such treatments means that children will not receive services likely to be beneficial to them. Although research directly investigating the effects of treatment noncompletion/premature termination has

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not been conducted, there is ample research showing that untreated anxiety disorders in youths generally do not spontaneously remit (e.g., Woodward & Fergusson, 2001). Furthermore, untreated anxiety disorders in youth may be a risk factor for the development of other psychopathological conditions, including other anxiety, depressive, and externalizing disorders (Flakierska-Praquin, Lindstroem, & Gillberg, 1997; Kovacs & Devlin, 1998; Last, Perrin, Hersen, & Kazdin, 1992). Research that yields comparative information about noncompleters and completers thereby has the potential to serve a preventive function in that such information could assist in identifying at-risk youths (i.e., youths who will noncomplete treatment and thus whose anxiety disorders may develop into other severe disorders).

In this study we thus compared completers and noncompleters from our two previous randomized clinical trials (Silverman et al., 1999a, b). Guided by the only other attrition study conducted in the child anxiety area (i.e., Kendall & Sugarman, 1997), we compared participants along sociodemographic (e.g., child's age, child's gender, single-parent home, family income, ethnicity/race) and clinical variables (e.g., child anxiety and fear levels, child internalizing and externalizing behavior problems, parent depression levels). Given the large proportion of Hispanic/Latino participants in the two trials, we also explored for differences between Hispanic/Latino and Euro-American completers and noncompleters. We know of no previous child or adult study to make this comparison.[1] Because of the paucity of research on attrition in child anxiety treatments, particularly among Hispanic/Latino participants, we view the study as exploratory and one that might serve as a springboard for future hypothesis-driven research.

Method

Participants

Data from 137 children (ages 6 to 16 years, $M = 9.91$ years; 46% girls) and their parents (one parent for each child participant; 90% mothers) who participated in one of two clinical trials for phobic and anxiety disorders (Silverman et al., 1999a, b) were included in this study.[2] All of the participants were referred by school counselors and local health professionals or were self-referred to the Child Anxiety and Phobia Program at Florida International University in Miami. The trials' inclusion criteria were a primary *Diagnostic and Statistical Manual of Mental Disorders,* 3rd edition, revised (American Psychiatric Association, 1987) diagnosis of a phobic or anxiety disorder based on a semistructured interview (child and parent versions). Exclusion criteria were pervasive developmental disorders, psychotic symptoms, or current involvement in other psychosocial or psychopharmacological treatment for phobia or anxiety problems.

Treatment completers finished the full 10- to 12-session program including participation in the posttreatment assessment. Treatment noncompleters began attending treatment sessions but unilaterally terminated the treatment program. The majority of noncompleters received an average of five sessions. Of the 137 participants, 106 (77.4%) completed treatment and 31 (22.6%) did not complete treatment. Of the 137 participants, 52 were Hispanic/Latino. Of these, 38 (73.1%) completed treatment and 14 (26.9%) did not complete treatment. Across the two trials, participants' completion and noncompletion rates, and participants' sociodemographic characteristics, were not significantly different.

Measures and Procedures

Administration of assessment measures was conducted in two separate sessions within a 2-week period. During the first session, children and parents signed informed consents and were administered the Anxiety Disorders Interview Schedule for Children (ADIS–C/P; Silverman & Nelles, 1988). Previous research has demonstrated satisfactory test–retest reliability (e.g., 10- to 14-days retest yielded $\kappa = .76$ for the ADIS–C, $\kappa = .67$ for ADIS–P, and $\kappa = .75$) for composite diagnoses using the ADIS–C/P (Silverman & Eisen, 1992). Children also completed the RCMAS (Reynolds & Richmond, 1978) and the Revised Fear Survey Schedule for Children (FSSC–R; Ollendick, 1983). Both rating scales are widely used and have acceptable psychometric properties. The RCMAS contains 37 items describing anxiety symptoms to which children rate *Yes*/*No.* The FSSC–R contains 80 items denoting different objects and events to which children rate their fear level as *none, some,* or *a lot.* Parents completed the CBCL (Achenbach, 1991), which contains 113 items on which parents rate their child's behavior. Parents also completed the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) to assess their own depression levels. CBCL *t* scores were used in the analyses; scaled scores were used for the other questionnaires.

Children and parents enrolled in the two trials participated in time-limited (10- to 12-sessions), exposure-based psychosocial interventions that were administered using consistent and similar experimental procedures (e.g., manualized, trained therapists) at the Child Anxiety and Phobia Program. The interventions also made similar requirements on the clients (e.g., completion of forms, in-session assignments, out-of-session assignments) and required similar skill levels on the part of therapists. Details of these clinical trials, including the results, are described elsewhere (Silverman et al., 1999a, b).

Results

Comparing Completers and Noncompleters

Table 1 shows proportions, means, and standard deviations for the total sample and for completers and noncompleters on sociodemographic and clinical variables. Chi-square (for categorical data) and *t* test (for continuous data) analyses revealed no statistically significant differences between treatment completers and noncompleters in terms of sociodemographic variables (child's age, child's gender, single-parent home, family income, ethnicity/race, and diagnoses). No statistically significant differences between completers and noncompleters were found in terms of participants' pretreatment scores on the RCMAS, FSSC–R, BDI, CBCL–I, (Internalizing Scale), and CBCL–E (Externalizing Scale). Chi-square analysis revealed no statistically significant differences between proportions of completers (88.1%) and noncompleters (80.0%) with pretreatment CBCL–I scores in the clinical range ($t > 70$; Achenbach, 1991).

Comparing Hispanic/Latino and Euro-American Completers and Noncompleters

We also examined whether Hispanic/Latino and Euro-American completers and noncompleters differed in terms of child's age, child's gender, single-parent home, family income, and number of

[1] We are aware of only one clinical trial that reported treatment noncompletion rates for Hispanic/Latino youth and their families: Szapocznik et al. (1989) reported a 22% noncompletion rate for 88 Hispanic boys (ages 6 to 12 years) with conduct problems.

[2] Data from families who were assigned to the education support comparison control condition in Silverman et al. (1999b) were not included because education support is not viewed as an empirically supported treatment, and so studying noncompletion in this condition holds little empirical or clinical relevance within the context of the present study.

Table 1
Means and Proportions for the Total Sample (N = 137) and for Completers (n = 106) and Noncompleters (n = 31)

	Total sample		Completers		Noncompleters		
Variable	*M (SD)*	%	*M (SD)*	%	*M (SD)*	%	*p*
Age, years	9.9 (2.84)		9.80 (2.74)		10.26 (3.17)		.43
Gender							.61
Girls		46.0		47.2		41.9	
Boys		54.0		52.8		58.1	
Ethnicity							.56
Hispanic/Latino		38.0		36.2		45.2	
Euro-American		57.7		59.0		54.8	
Other/not reported		4.3		4.8		0.0	
Single-parent home		23.4		26.0		14.3	.20
Income							.27
< $ 21,000		26.8		27.8		23.3	
$ 21,000 to 40,000		28.3		24.7		40.0	
> $ 40,000		44.9		47.5		36.7	
No. of diagnoses	2.94 (1.46)		3.00 (1.45)		2.74 (1.50)		.26
Comorbidity present		79.6		80.2		77.4	.74
Child completed measures							
RCMAS	11.23 (6.87)		11.75 (7.02)		9.45 (6.09)		.10
FSSC–R	117.66 (34.69)		118.85 (34.74)		113.61 (34.80)		.46
Parent completed measures							
CBCL–I	83.63 (13.15)		83.79 (13.80)		83.00 (10.56)		.87
CBCL–E	113.04 (15.23)		113.22 (16.20)		112.13 (9.48)		.86
BDI	7.53 (6.52)		7.76 (6.65)		6.69 (6.06)		.46

Note. RCMAS = Revised Children's Manifest Anxiety Scale; FSSC–R = Fear Survey Schedule for Children—Revised; CBCL–I = Child Behavior Checklist–Internalizing Scale; CBCL–E = Child Behavior Checklist–Externalizing Scale; BDI = Beck Depression Inventory.

diagnoses. Analysis of variance indicated a statistically significant interaction between ethnicity/race (Hispanic/Latino; Euro-American) and attrition status (completers, noncompleters) for the RCMAS total anxiety scores, $F(3, 127) = 4.76$, $p = .03$; no other significant differences were found. Single degree of freedom interaction contrast analysis (Boik, 1979; Jaccard & Guiliamo-Ramos, 2002) was used to test whether the effects of the RCMAS anxiety scores on attrition status (completer, noncompleter) differed across both levels of ethnicity/race (Hispanic/Latino and Euro-American). The single degree of freedom interaction contrast analysis was not statistically significant, $t(127) = 1.543$, $p > .05$.

Discussion

The findings indicated that children and parents who did not complete exposure-based cognitive–behavioral treatment programs were very similar to children and parents who completed the programs. Finding more similarities than differences between completers and noncompleters is consistent with results obtained using general community-based mental health clinic samples (Gould et al., 1985; Weisz et al., 1987), which have found no statistically significant differences, as well as university-based childhood anxiety disorders specialty clinics, which have found only few differences (Kendall & Sugarman, 1997). Although null results could be attributed to low statistical power, several of the previous studies (e.g., Gould et al., 1985; Weisz et al., 1987) had substantial samples.

In light of the repeated and consistent pattern of null findings that have been observed across studies, it continues to be premature to offer recommendations about how to identify cases that are most likely to terminate early, and how to promote completion among children and parents enrolled in treatment programs for anxiety disorders, in particular, as well as for other psychopathological conditions. Although in the conduct disorders area statistically significant differences have been observed between completers and noncompleters (Kazdin et al., 1993, 1994), it is important to further examine the robustness of these findings using independent samples drawn from different clinics, before recommendations are offered. Similarly, although null findings emerged in exploring for differences between Hispanic/Latino and Euro-American completers and noncompleters, because this is the first study to compare these ethnic/racial groups, additional research is needed to determine the robustness of these findings as well, before explanations or recommendations are offered.

Perhaps what the repeated and consistent pattern of null findings underscores most is the need for future research to move beyond the types of sociodemographic and clinical variables that were selected for examination in this and past attrition studies (e.g., Armbruster & Fallon, 1994; Gaines & Stedman, 1981; Gould et al., 1985; Kendall & Sugarman, 1997; Pekarik, 1992; Weisz et al., 1987). Although these variables were reasonable ones to initially select, especially given that the first generation of child clinical trials was designed mainly to evaluate whether positive outcome could be produced, the next generation of child clinical trials is well posed to evaluate other issues. This would include whether other variables might relate to attrition using recently developed measures (Garcia & Weisz, 2002; Kazdin, Holland, Crowley, & Breton, 1997). These variables include stressors and obstacles that compete with treatment attendance, treatment demands and issues, perceived relevance of treatment, relationship with therapist, time and effort concerns, and money issues as potential influences on child attrition. Although further development and refinement of these measures are needed, particularly in terms of making avail-

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able versions for use with children, they represent the beginning armamentaria needed for future studies on attrition.

Finding that noncompletion rates were lower in the Silverman et al. (1999a, b) and Kendall and Sugarman (1997) studies (i.e., 22–27% and 23%, respectively) relative to rates reported in past community-based studies (around 50%; Wierzbicki & Pekarik, 1993) may also have implications in terms of variables relating to treatment completion/noncompletion. Perhaps characteristics of clinical trials such as their time-limited nature, manualization, and emphasis on therapist prescription of specific activities (e.g., exposure tasks) are associated with lower noncompletion rates as clients, especially children, may respond favorably to this type of structure within a therapeutic context (see May, 1991). This possibility waits further empirical testing.

Also worthy of future study would be to attempt to contact noncompleters at specified posttreatment follow-up points and assess their reasons for dropping out. A tentative hypothesis is that noncompleters with lower levels of anxiety attained satisfactory levels of improvement prior to the end of the treatment program. Conversely, noncompleters with higher levels of anxiety might have not experienced treatment gains early in the interventions and terminated prematurely, due in part to a sense of frustration or hopelessness.[3] Although this hypothesis requires further empirical evaluation, obtaining follow-up data from children and parents who did not even complete the posttreatment assessment of the program would seem to hold formidable challenges. Perhaps the challenges could be met by providing families with substantial financial incentives for participation in follow-up assessments.

The present study is limited in that completion/noncompletion status was examined only among Euro-Americans and Hispanic/Latino families. We did not have a comparable group of African American families or other ethnic groups. The present study is limited also in that despite the large proportion of Hispanic/Latino ethnic minorities in the sample, all of the families were generally acculturated. Thus, the extent to which this study's findings apply to other Hispanic/Latino children and families remains an empirical question. Last, the present study is limited in that findings are based on self-reports only. Despite the limitations, it is important that further research be conducted on comparing treatment noncompleters and completers to help lead to early identification of at-risk youths, that is, youths who may not complete treatment and thus whose anxiety disorders may develop into other severe disorders.

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