Clinical Child Psychology and Psychiatry
16(1) 53–64

DOI: 10.1177/1359104509352893
ccp.sagepub.com

Outpatient psychotherapy practice with adolescents following psychiatric hospitalization for suicide ideation or a suicide attempt

Anthony Spirito,[1] Valerie Simon,[2] Mary Kathryn Cancilliere,[1] Rachel Stein,[3] Candace Norcott,[3] Katherine Loranger,[3] and Mitchell J. Prinstein[4]

Abstract

Outpatient treatment is standard care for adolescents discharged following a psychiatric hospitalization. There is little research, however, on the amount and types of psychotherapy these clients receive in the community. We examined therapy attendance and therapist report of outpatient therapy practice with adolescents discharged from psychiatric hospitalization following either a suicide attempt or severe suicidal ideation in the Northeastern USA. Therapists (n = 84) completed a packet of self-report questionnaires regarding treatment of these adolescents in the first six months after discharge from the hospital. Information on number of sessions attended, primary presenting problem, therapist orientation, therapy techniques, and therapeutic relationship was collected. The findings indicated that therapists met their clients in both private and community outpatient settings. The most common modality of treatment was individual therapy, but almost all types of therapeutic techniques were endorsed. Adolescents attended an average of 8.1 therapy sessions (SD = 4.7), with 18% terminating treatment against therapist advice within the first three months. Psychologists, psychiatrists, and social workers used cognitive-behavioral, psychodynamic, and family system techniques about equally. Social workers used humanistic techniques more than their counterparts. The variability in number of therapy sessions attended suggests that many adolescents discharged after a psychiatric hospitalization will not receive adequate care. Short-term therapy protocols designed for community practice emphasizing cognitive techniques may be useful to test in future community-based research trials based on the high percentage of adolescents attending relatively few sessions.

Keywords

adolescents, individual therapy, outpatient psychotherapy, suicide, therapist orientation

[1]Brown University, USA
[2]Wayne State University, USA
[3]Bradley Hospital, Providence, RI, USA
[4]University of North Carolina at Chapel Hill, USA

Corresponding author:
Anthony Spirito, Department of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Center for Alcohol and Addiction Studies, 121 South Main Street, Providence, RI 02912, USA.
E-mail: Anthony_Spirito@brown.edu

Over the last two decades in the United States, the length of psychiatric hospitalization for children and adolescents has shortened considerably, with the focus having shifted from comprehensive evaluation and treatment to brief intensive intervention (Daniel, Goldston, Harris, Kelly, & Palmes, 2004). Many of the service needs previously met during psychiatric hospitalization are now met after discharge (Goethe, Dornelas, & Gruman, 1999). A review of the literature (Daniel et al., 2004) concluded that approximately two thirds or more youths received at least some aftercare services after being discharged from a psychiatric hospitalization. Individual therapy was consistently the most commonly used and recommended type of psychiatric aftercare service. Pharmacotherapy and family therapy were also highly used and recommended.

Even when youths and families receive aftercare services, they often do not participate in these services for as long as recommended (Daniel et al., 2004; King, Hovey, & Brand, 1997; King, Segal, & Kaminski, 1995; Lloyd, Horan, & Borgaro, 1998). McKay and Bannon (2004) reported the average length of care in urban settings was three to four visits, with only 9% of families still attending after three months of treatment. Follow-through with recommended medication and individual therapy was substantially better than was follow-through with recommended parent guidance/family therapy. Brookman-Frazee, Haine, Gabayan, and Garland (2008) reported higher rates of attendance in a study of 170 adolescents and their families receiving publically funded outpatient mental health treatment in one of two participating community mental health clinics. Weekly visits were the standard mode of treatment, with session frequency ranging from 0 to 46 visits and a mean of 14 visits.

The studies reviewed above examined psychiatrically hospitalized adolescents with a wide range of symptoms and diagnoses who were referred to and treated as outpatients after discharge. Outpatient treatment of adolescents following psychiatric hospitalization for suicidal ideation or a suicide attempt is of particular concern because the three month period immediately following discharge from a psychiatric hospital has been shown to be the period during which adolescents who attempt suicide are most at risk for a repeat attempt (Prinstein et al., 2008). Spirito, Plummer, and Gispert (1992) documented that 9% of adolescents who have attempted suicide initially treated in a psychiatric hospital failed to participate in any outpatient treatment after discharge and about half participated in four or fewer outpatient sessions. King, Hovey, Brand, Wilson, and Ghaziuddin (1997) found substantial variability in follow-through, with different types of outpatient treatment after adolescents were hospitalized for attempted suicide. With regard to actual therapy approaches used with adolescents in aftercare services, only a few studies have been reported. Only one study has specifically examined the treatment received by adolescents who attempted suicide. Spirito, Stanton, Donaldson, and Boergers (2002) examined treatment-as-usual in a sample of 63 adolescents who made a suicide attempt that required medical care in an emergency department of a general hospital. Therapists were contacted by mail and asked to complete a questionnaire about the type of therapy provided to these adolescents. Out of 63 therapists, 54 (85%) returned questionnaires (82% female, 85% Caucasian). Therapy was provided by mostly master's-level social workers (63%), then doctoral-level psychologists (20%), psychiatrists (6%), one clinical nurse specialist (2%), and other professionals with master's degrees (9%). Attendance ranged from 0 to 22 sessions with an average of 7.0 sessions. Fifty-two percent of the adolescents attended six or fewer sessions. Supportive psychotherapy techniques were reported by three fourths of the sample, psychodynamic and cognitive techniques by one half of the sample, and behavioral techniques by one third of the sample.

Given the relatively small amount of published data about the types of psychotherapy provided in community care, the purpose of the current study was to examine what therapists report as their

outpatient therapy practice. We specifically examine the treatment received by adolescents discharged from a psychiatric hospital in the Northeastern US following either a suicide attempt or severe suicidal ideation. The six month period following discharge is the focus of the study as it constitutes a time when these adolescents are at high risk for a repeat attempt.

Method

Participants

The sample consisted of 84 therapists (12% psychiatrists, 25% PhD-level psychologists, 44% master's-level social workers, and 19% other) ranging from 24 to 70 years old who met with an adolescent for outpatient treatment after the adolescent was discharged from a child psychiatric inpatient facility.

Of the 84 therapists, 81% were female and 98% Caucasian. Length of experience ranged from 6 months to 45 years. Many of the therapists received clinical supervision (70%). Out of the group receiving supervision, most of the therapists met for individual supervision (76%): on a weekly (59%), twice-monthly (12%), monthly (21%), or less than once per month (9%) basis.

Most of the therapists identified themselves as primarily child/adolescent therapists (69%). Others saw themselves as family therapists (19%) and adult therapists (12%). The therapists met with their clients at their private practice (36%), community health facilities (31%), hospital-based outpatient programs (18%), or other clinics (15%). The therapists reported having a caseload of between as few as three to as many as 200 clients. The most common therapy modality was individual therapy with the adolescent (77%). Collateral contacts were most common with school personnel (55%) and a psychiatrist prescribing medications (40%).

Procedure

Each therapist was mailed a packet of questionnaires referring to the treatment of their adolescent clients during the six months following the adolescent's inpatient hospitalization. A total of 164 therapists were mailed packets and 84 responded by completing the study questionnaires (51% completion rate).

The adolescents seen by the therapists were enrolled in an 18 month longitudinal study (from 2001 to 2004) examining the course of adolescents following discharge from the hospital (Prinstein et al., 2008). Psychotic clients were excluded from the study. Institutional review board approval was obtained for the original study. At the three month follow-up point, adolescents and their parents were asked for permission to contact their therapists, and consent and assent were obtained to do so. Therapists were then contacted by mail at six months.

Measures

Questionnaire. All of the therapists were asked to complete a questionnaire. The first section of the questionnaire asked the therapists to report their general demographic information, educational history, and clinical practice characteristics, including rating the degree to which four clinical orientations (psychodynamic, cognitive-behavioral, humanistic, and family systems) influenced their case conceptualization and treatment approaches or techniques.

The next section inquired about the amount of contact the therapist had with the adolescent and adolescent's family during treatment over the previous three months (after inpatient treatment) as well as information including the amount of case management and collateral contact.

Treatment questions included the collection of information about the adolescent's current psychiatric diagnosis, the case conceptualization, global assessment, and treatment plan.

A 32-item list of statements asked the therapists to rate (on a 3-point scale; 0 = not significant, 1 = somewhat significant, and 2 = very significant) how important each item was as a cause of their adolescent client's problems or disorder(s).

Questions were also included regarding termination. The questions included the date of termination, who initiated termination, and whether the therapist agreed with the timing and decision to terminate treatment.

Therapy procedures checklist (TPC). The TPC is a 59-item measure of treatment procedures used in clinical practice with children and adolescents. Composite subscales for cognitive, behavioral, and psychodynamic techniques are available. Adequate to good reliability and validity data have been reported (Weersing, Weisz, & Donenberg, 2002). The original version of the TPC, which is slightly different than the 2002 published version, was used in this study.

Therapeutic Alliance Scale for Adolescents. The Therapeutic Alliance Scale for Adolescents (TASA: Shirk, Gudmundsen, Kaplinski, & McMakin, 2008) is a 12-item scale measuring adolescent and therapist perceptions of the therapy relationship. Only therapist data were collected in this study. Six items refer to the emotional bond between client and therapist, and six items refer to level of task collaboration. The TASA has been shown to have excellent internal consistency, good test-retest reliability (Creed & Kendall, 2005; DeVet, Kim, & Charlot-Swilley, 2005; Shirk & Saiz, 1992), and moderate to large associations with other measures of relationship quality (Cavell & Hughes, 2000).

Data analysis

Data was analyzed using SPSS. Frequency distributions were calculated to provide descriptive data. Chi-square analyses were used to compare psychotherapy orientation across professional disciplines. Pearson product-moment correlations were calculated to examine the relationship between therapeutic alliance and session attendance.

Results

The therapists treated 84 adolescent clients, ranging in age from 12 to 17 years (73% female, 77% Caucasian, 3% African American, 4% Hispanic). Forty-two percent of the adolescents lived with their mothers, 7% lived with their fathers, 32% lived with both, and 19% lived with someone else.

The total number of sessions each therapist had seen their adolescent client within a six-month period ranged from 2 to 60 sessions (one client in home-based care was seen up to 60 times). The median number of sessions attended was 10 and the mean was 13.4 (S.D. = 11.8). The adolescent or adolescent's family canceled or failed to attend anywhere from 1 to 9 appointments. The average number of sessions in the first three months following discharge was 8.1 (S.D. = 4.7). Fifteen of the 84 cases (18%) terminated within the first three months of treatment. Nine of these terminations were unplanned. The six planned terminations were initiated by the therapist, parents, or other individuals.

Table 1. Percentage of therapist-reported adolescent treatment issues following discharge from inpatient psychiatric hospitalization

Depression/Self esteem	38%
Suicidal thinking/Cutting	12%
Family relationships	10%
Behavioral problems	8%
Anger/Anger management	6%
School	6%
Anxiety/Fears	5%
Coping with trauma	4%
Peer relations/Social problems	4%
Substance use/Dependence	2%
Dating relationships/Sexual behaviors	1%

Note: $N = 83$; one subject excluded due to termination of treatment.

The therapist-reported primary treatment issues following the adolescent's discharge from their inpatient hospitalization are described in Table 1. These include depression and self-esteem issues as the most common, with suicidal thinking and cutting the next most common.

Eighty-one out of the 84 adolescents received a psychiatric diagnosis from their therapist. The most commonly occurring diagnoses were: depression or dysthymia (44%), bipolar disorder (11%), anxiety disorder (9%), post traumatic stress disorder (8%), adjustment disorder (6%), attention deficit hyperactivity disorder (5%), and oppositional defiant disorder and conduct disorder (5%). Many of the adolescents (58%) received more than one diagnosis.

Therapists' views about the causes of their adolescent clients' difficulties varied. They included: poor problem solving skills, inadequate coping strategies, poorly-developed self regulation or self control skills, failure to internalize self-soothing capacity, irrational or maladaptive thoughts or beliefs, and immature or rigid use of self defense mechanisms. A more comprehensive list of views along with percentages of endorsement can be seen in Table 2.

Table 3 presents the clinical orientations reported by each therapist with regard to their case conceptualization and therapy approach with their specific adolescent client. Statistical analyses were conducted to compare use of therapy techniques by professional discipline. There was only one difference: social workers (43%) reported more frequent use of humanistic techniques than psychologists (15%) and psychiatrists (11%), $X^2(2, n = 59) = 6.32$, $p < .05$.

In treating their adolescent clients, the most commonly used therapy techniques included: trying to enhance the adolescent's cognitive or affective perspective-taking skills, encouraging expression of feeling, and monitoring suicidal thoughts, feelings, or behaviors. The top 20 therapy techniques can be seen in Table 4.

When asked about their therapeutic relationship with the adolescent client, most therapists felt the adolescents with whom they were working considered them to be an ally (69%) and were comfortable talking about their thoughts and feelings (62%). Sixty-five percent of the therapists thought their adolescent clients could count on them as a therapist and when in session would work on problems or issues (70%). There was a small positive correlation ($r = .26$, $p < .05$) between number of therapy sessions attended and therapist rating of therapeutic alliance on the TASA.

Table 2. Therapists' views about the causes of the adolescent's difficulties

	Not significant	Somewhat significant	Very significant
1. Poor problem solving skills/inadequate coping strategies	5%	28%	67%
2. Poorly developed self regulation or self control skills	13%	27%	60%
3. Failure to internalize self-soothing capacity	23%	31%	46%
4. Irrational or maladaptive thoughts or beliefs	20%	39%	41%
5. Immature or rigid use of self defense mechanisms	26%	34%	40%
6. Inadequate ego functioning	33%	31%	36%
7. Adolescent genetic makeup	24%	54%	22%
8. Inappropriate biased expectations	33%	50%	17%
9. Neurochemical imbalance	26%	47%	27%
10. Inherited predisposition for mental illness	32%	45%	23%
11. Maladaptive interpretation of events	21%	43%	36%
12. Parental modeling of inappropriate cognitions	21%	43%	36%
13. Dysfunctional interpersonal schemas	32%	41%	27%
14. Parents or teachers who are unskilled in behavior Management	26%	41%	33%
15. Deficient social learning experiences	39%	40%	21%

Note: $N = 84$.

Table 3. Therapy orientation rated on a 5-point scale that most influenced treatment choice with the adolescent ($N = 84$)

	Not at all/Somewhat	The most
Psychodynamic approach:		
Psychiatrists	70%	30%
Psychologists	80%	20%
Social workers	70%	30%
Cognitive behavioral approach:		
Psychiatrists	30%	70%
Psychologists	10%	90%
Social workers	14%	86%
Humanistic approach:		
Psychiatrists	89%	11%
Psychologists	85%	15%
Social workers	57%	43%
Family systems approach:		
Psychiatrists	30%	70%
Psychologists	43%	57%
Social Workers	19%	81%

Discussion

The purpose of this paper was to examine the outpatient therapy practice of therapists treating adolescents discharged from a psychiatric hospitalization in the Northeastern US due to suicidal ideation or a suicide attempt. We surveyed therapists from the community who primarily identified themselves as child/adolescent therapists and who met their clients in both private practice and community health facilities. The most common modality reported was individual therapy, endorsed

Table 4. Therapists' top 20 most commonly used psychotherapy techniques (from 59- item Therapy Procedure Checklist)

	Never	Sometimes	Frequently
1. Trying to enhance the adolescent's cognitive or affective perspective-taking skills	5%	16%	79%
2. Encouraging expression of feeling	3%	20%	77%
3. Monitoring suicidal thoughts, feelings, or behaviors	5%	19%	76%
4. Training the adolescent to recognize and modify maladaptive thoughts	9%	31%	60%
5. Training in problems solving skills	10%	32%	58%
6. Teaching the adolescent that cognitions affect behavior and emotion, and can cause behavior problems	15%	31%	54%
7. Trying to help the adolescent gain insight into his/her feelings, motives, or conflicts	17%	30%	53%
8. Cognitive restructuring or reframing	11%	37%	52%
9. Teaching the adolescent to modify maladaptive cognitions	11%	37%	52%
10. Training the adolescent to anticipate future problems and generate alternative solutions	13%	37%	50%
11. Exploring the adolescent's understanding of the family context, family relationship and family dynamics	12%	39%	49%
12. Helping the adolescent generate alternative interpretations for events, consider other evidence, and correct misappraisals of perceived threat	16%	36%	48%
13. Trying to understand the original circumstances that led to the current problems	17%	36%	47%
14. Trying to understand the adolescent's unconscious drives, feelings, or conflicts	23%	32%	45%
15. Teaching the adolescent to monitor self-statements (or automatic thoughts) and/or behavior	29%	26%	45%
16. Working toward the development of a more adequate psychic structure	31%	25%	44%
17. Using rewards or praise	28%	29%	43%
18. Identifying and challenging irrational beliefs, attributions, or schemas	14%	43%	43%
19. Striving for an atmosphere of collaborative empiricism	27%	30%	43%
20. Trying to help the adolescent develop more effective ego functioning	20%	39%	41%

Note: N ranges from 82 to 84.

by about three quarters of the sample. Collateral contacts were common, with both school personnel and a psychiatrist prescribing medications. These out-of-session contacts in the service of clients reflect the demanding nature of treating this population. Two factors – therapy attendance and therapy approach – are of particular interest and have implications for the transfer of research findings to practice.

Number of sessions attended

The number of therapy sessions adolescents attended in this study during their six months of aftercare treatment varied greatly. The average number of sessions attended in six months (n = 13) is comparable to what Weisz, Doss, and Hawley (2005) describe as the average number of treatment sessions attended in research studies (11 sessions). Similarly, Brookman-Frazee et al. (2008) examined adolescents with a range of preexisting problems and found the mean number of treatment sessions to be 14, with a range from 0 to 46 outpatient visits, in a public sector clinic.

With respect to adolescents who attempted suicide, Spirito et al. (2002) reported an average of seven outpatient treatment sessions in the first three months after discharge from hospitalization, with a range from 0 to 22 sessions; 52% of those who attended outpatient treatment reported attending six or fewer sessions. The current study, conducted in the same community, suggests that the number of therapy sessions attended by these adolescents in the first three months following discharge over the last decade (i.e., about eight sessions) has remained about the same.

Community-based clinicians identify inconsistent attendance and difficulties in engagement as considerable challenges in providing effective care to families (Brookman-Frazee et al., 2008; Quinn, Epstein, & Cumblad, 1995). It has been documented that among families who begin outpatient mental health treatment, 40% to 60% terminate prematurely (Kazdin, 1996; Wierzbicki & Pekarik, 1993). This study also indicated that a substantial portion of adolescents will not receive an adequate course of outpatient mental health care following hospitalization for suicidality.

Consistent and sustained treatment attendance is assumed to be an important prerequisite for effective care. However, Bickman, Andrade, and Lambert (2002) looked at whether increased amounts of mental health treatment result in better client outcomes and found in their study of 125 children that children who received negligible amounts of treatment improved to a similar degree as those receiving substantial amounts of mental health treatment. Thus, short-term therapy models might not only be practical, given the large number of adolescents who drop out of therapy prematurely, but also effective. If this is true, then the type of therapy provided in the community is important to understand in order to be able to develop short-term treatments acceptable to community therapists.

Factors affecting treatment attendance

What factors might be associated with poor treatment attendance? Brookman-Frazee et al. (2008) found family socio-demographics (i.e., ethnic minority and low socioeconomic status) and clinical factors (i.e., parent stress, parent psychopathology, severe child behavioral problems and poor child functioning) to affect treatment follow-through. Kazdin, Holland, and Crowley (1997) tested the relation between parent report of barriers to treatment and premature treatment termination in a study of 242 children seen in a child psychiatry service where 10 clinicians served as therapists. The overall findings indicated that perceived barriers to treatment participation, including stressors and obstacles associated with coming to treatment, perceptions that treatment was not very relevant, and a poor relationship between the parent and the therapist, were all related to premature treatment termination.

Garland, Haine, and Boxmeyer (2007) studied 143 families who received outpatient mental health care in one of two large community-based clinics. The primary aim of the study was to examine the extent to which parent and youth satisfaction with outpatient mental health care could be accounted for by a wide variety of potential determinants. Fifty-five clinicians provided treatment during the study. Their results suggested that youth satisfaction was positively associated with the therapist's years of experience and parent satisfaction was positively associated with the number of treatment sessions. In addition, higher parent satisfaction was associated with lower caregiver strain at service entry and improvement in youth-reported functional impairment. Similarly, Nock and Kazdin (2001) reported that parents who report very high or low expectations about treatment are likely to attend more sessions and are less likely to drop out of treatment.

Therapeutic alliance is another key factor associated with treatment attendance. The current study found a small, positive relationship between therapist perception of the alliance and treatment attendance. Shirk et al. (2008) found, in their study of 54 adolescents in a manual-guided,

cognitive-behavioral therapy for adolescent depression, that an early alliance between an adolescent and their therapist predicted the continuation of therapy. There was a positive association between therapist rating of alliance and the number of cognitive-behavioral treatment sessions completed as well as treatment continuation. Another study, by Hawley and Weisz (2005), found that parent ratings of their own alliance with the therapist predicted treatment completion better than youth-rated alliance. This finding suggests that parent relationship with the therapist might dictate the adolescent's treatment adherence. Shelef, Diamond, Diamond, and Liddle (2005) also found parent alliance with the therapist to predict treatment attendance.

Therapist clinical orientation

The therapists in this study endorsed a broad range of clinical orientations, i.e., psychodynamic, cognitive-behavioral, humanistic, and family system, consistent with findings that therapists employ an eclectic mix of therapy (Weersing et al., 2002). Cognitive-behavioral therapy techniques were used most often by all disciplines – psychiatrists, psychologists and social workers. Social workers reported using humanistic approaches more often than their counterparts.

Brookman-Frazee et al. (2008) reported the primary therapeutic orientation included 36% family systems, 32% eclectic, 17% dynamic, and 15% behavioral/cognitive-behavioral. Our findings differ somewhat from those reported by Brookman-Frazee et al. (2008), possibly because the mix of therapists was different in the two studies. In our sample, there were fewer marital and family therapists and psychiatrists and a larger number of social workers and psychologists than in the Brookman-Frazee et al. (2008) study. Spirito et al. (2002) also found a broad range of clinical orientations reported by the different professions. When working with adolescents who were suicidal, supportive psychotherapy techniques were reported by three fourths of the sample, psychodynamic and cognitive techniques by one half, and behavioral techniques by one third. The data in the current study suggest a shift in techniques such that therapists are now reporting greater use of cognitive and behavioral techniques when working with adolescents who are suicidal than they did in the same community about seven years earlier. Given the increasing emphasis on cognitive approaches in the field, it is possible that the finding was influenced by social desirability. Similarly, social workers might have endorsed using more humanistic techniques based on their training. Nonetheless, these findings suggest that research protocols using cognitive-behavioral approaches might eventually find their way into community care.

The most common therapist views about the causes of an adolescent's difficulties included: poor problem solving skills, inadequate coping strategies, poorly developed self regulation or self control skills, failure to internalize self-soothing capacity, irrational or maladaptive thoughts or beliefs, and immature or rigid use of self defense mechanisms. These views suggest that cognitive formulations are most common in working with these adolescents but that psychodynamic conceptualizations coexist with the cognitive formulations.

Weisz, Weiss, Han, Granger, and Morton (1995) observed that behavioral methods were associated with more substantial therapy effects than non-behavioral methods when they controlled for treated problem, therapist training, and child age and gender. Yet, the current study found that in treating their adolescent clients, therapists' most commonly used treatment techniques were: trying to enhance the adolescent's cognitive or affective perspective-taking skills, encouraging expression of feeling, and monitoring suicidal thoughts, feelings, or behaviors. Behavioral approaches were much less likely to be used than cognitive or psychodynamic approaches. These techniques might be preferred due to the specific population studied here. However, the adolescents in this study displayed a range of suicidality from ideation to suicide attempts; the attempts themselves

ranging from parasuicidal gestures to medically serious attempts. Nonetheless, the Weisz et al. (1995) meta-analysis found that behavioral approaches were more effective regardless of the problem being treated and greater emphasis on behavioral therapy may be indicated with this population.

This study has several limitations. The data collected were on therapist perception of what they do in therapy using a broad questionnaire rather than by more objective, detailed assessments and observations of what they actually did. The accuracy of therapist recall may have been affected by such retrospective reports. Client perception of therapy was not collected either. In addition, the measures used to assess therapy techniques did not have much content on interpersonal processes, such as those found in several types of therapy. The generalizability of the findings regarding therapy practice in this community is also unknown. The system of care reported here was not integrated from inpatient to outpatient services, unlike some systems. The lack of continuity from inpatient to outpatient care may have affected some of the findings, especially those related to treatment adherence.

Conclusion

Despite its limitations, the study does shed light on the most common therapeutic techniques used and provides more in-depth information on therapist practices than typically found in the literature. The study also illustrates important points for the administration of mental health services. First, this study demonstrates how difficult it is, especially in a nonintegrated system of care, to ensure that adequate treatment is received and, if received, the type and quality of this treatment. Second, documenting the range of therapy approaches used in the community may be useful for those attempting to disseminate findings from treatment research. Given the variability in length of outpatient therapy, short-term protocols might be appropriate treatment for these clients. A skill-based protocol that could be completed in 8–12 sessions would ensure that a majority of these adolescents receive a specified course of treatment. It might also serve as the core treatment for those who remain impaired and need to continue therapy for a longer period of time.

Acknowledgement

This work was supported in part by grants from the National Institute of Mental Health (R01–MH59766).

References

Bickman, L., Andrade, A., & Lambert, E. (2002). Dose response in children and adolescent mental health services. *Mental Health Services Research*, *4*, 57–70.

Brookman-Frazee, L., Haine, R., Gabayan, E., & Garland, A. (2008). Predicting frequency of treatment visits in community-based youth psychotherapy. *Psychological Services*, *5*, 126–138.

Cavell, T., & Hughes, J. (2000). Secondary prevention as context for assessing change processes in aggressive children. *Journal of School Psychology*, *38*, 199–236.

Creed, T.A., & Kendall, P.C. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of Consulting and Clinical Psychology*, *73*, 498–505.

Daniel, S.S., Goldston, D., Harris, A., Kelley, A., & Palmes, G. (2004). Review of literature on aftercare services among children and adolescents. *Psychiatric Services*, *55*, 901–912.

DeVet, K., Kim, Y., Charlot-Swilley, D., & Ireys, H. (2005). The therapeutic relationship in child therapy: Perspectives of children and mothers. *Journal of Clinical Child and Adolescent Psychology*, *32*, 277–283.

Garland, A.F., Haine, R.A., & Boxmeyer, C.L. (2007). Determinates of youth and parent satisfaction in usual care psychotherapy. *Evaluation and Program Planning*, *30*, 45–54.

Goethe, J., Dornelas, E., & Gruman, C. (1999). Predicting service utilization after psychiatric hospitalization. *Comprehensive Psychiatry*, *40*, 192–197.

Hawley, K., & Weisz, J.R. (2005). Youth versus parent working alliance in usual clinical care: Distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology*, *34*, 117–128.

Kazdin, A.E. (1996). Dropping out of child therapy: Issues for research and implication for practice. *Clinical Child Psychology and Psychiatry*, *1*, 133–156.

Kazdin, A.E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, *65*, 453–463.

King, C., Hovey, J., & Brand, E. (1997). Prediction of positive outcomes for adolescent psychiatric inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 1434–1442.

King, C., Hovey, J., Brand, E., Wilson, R., & Ghaziuddin N. (1997). Suicidal adolescents after hospitalization: Parent and family impacts on treatment follow-through. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*, 85–93.

King, C., Segal, H., & Kaminski, K. (1995). A prospective study of adolescent suicidal behavior following hospitalization. *Suicide and Life-Threatening Behavior*, *25*, 327–338.

Lloyd, A., Horan, W., & Borgaro, S. (1998). Predictors of medication compliance after hospital discharge in adolescent psychiatry patients. *Journal of Child and Adolescent Psychopharmacology*, *8*, 133–141.

McKay, M.M., & Bannon, W.M. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America Special Issue: Evidence-Based Practice, Pt. 1: Research Update*, *13*, 905–921.

Nock, M.K., & Kazdin, A.E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, *10*, 155–180.

Prinstein, M.J., Nock, M.K., Simon, V., Aikins, J., Wargo, C., Charissa, S. L., & Spirito, A. (2008). Longitudinal trajectories and predictors of adolescent suicidal ideation and attempts following inpatient hospitalization. *Journal of Consulting and Clinical Psychology*, *76*, 92–103.

Quinn, K., Epstein, M., & Cumblad, C. (1995). Developing comprehensive, individualized community-based services for children and youth with emotional and behavioral disorders: Direct service providers' perspectives. *Journal of Child and Family Studies*, *4*, 19–42.

Shelef, K., Diamond, G.M., Diamond, G.S., & Liddle, H.A. (2005). Adolescent and parent alliance and treatment outcome in multidimensional family therapy. *Journal of Consulting and Clinical Psychology*, *73*, 689–698.

Shirk, S.R., Gudmundsen, G., Kaplinski, H.C., & McMakin, D.L. (2008). Alliance and outcome in cognitive-behavioral therapy for adolescent depression. *Journal of Clinical Child & Adolescent Psychology*, *37*, 631–639.

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

Spirito, A., Plummer, B., & Gispert, M. (1992). Adolescent suicide attempts: Outcomes at follow-up. *American Journal of Orthopsychiatry*, *62*, 464–468.

Spirito, A., Stanton, C., Donaldson, D., & Boergers, J. (2002). Treatment-as-usual for adolescent suicide attempters: Implications for the choice of comparison groups in psychotherapy research. *Journal of Clinical Child Psychology*, *31*, 41–47.

Weersing, V.R., Weisz, J.R., & Donenberg, G.R. (2002). Development of the therapy procedures checklist: A therapist-report measure of technique use in child and adolescent treatment. *Journal of Clinical Child and Adolescent Psychology*, *31*, 168–180.

Weisz, J., Doss, A., & Hawley, K. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, *56*, 337–363.

Weisz, J.R., Weiss, B., Han, S.S., Granger, D.A., & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies. *Psychological Bulletin*, *117*, 450–468.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, *24*, 190–195.

Author biographies

Rachel Stein, Candance Norcutt, and Katherine Loranger were research assistants at the time that this study was conducted and were instrumental in the collection of the data. Dr. Rachel Stein is currently in a psychiatry residency program at University of Massachusetts Medical Center in Worcester, MA. Candace Norcutt is in graduate school in clinical psychology at the University of Connecticut; and Katherine Loranger is a physical therapist in North Carolina.

Valerie Simon, Ph.D., is Assistant Professor at the Merrill Palmer Institute and in the Department of Psychology at Wayne State University. Dr. Simon's research focuses on investigating the implications of inter-parental conflict and childhood sexual abuse on adolescents' romantic development. Other interest areas include family and peer processes in development and psychopathology, marital relationships and child adjustment, and adolescent depression.

Mitchell Prinstein is Professor and Director of Clinical Psychology Training at the University of North Carolina. His research interests include cognitive-interpersonal models of adolescent depression and self-injury/suicidality as well as peer influence and adolescent health risk behavior.

Anthony Spirito is Professor of Psychiatry and Human Behavior at Brown University. His research focuses on the treatment of adolescent depression, suicidality and substance abuse.

Mary Kathryn Cancilliere is a project coordinator at Brown University's Center for Alcohol and Addiction Studies. She has an interest in adolescent substance use and mental health treatments for adolescents.