NOTE TO USERS

The Outcome of Children in Day Treatment: Behavioral Trends and Predictors of Success

Brett Elizabeth Maher, MS.Ed.

A Doctoral Project Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology in the Department of Psychology at Pace University

New York

2005

INFORMATION TO USERS

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleed-through, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

UMI®

UMI Microform 3162529

ProQuest Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

PSY.D PROJECT FINAL APPROVAL FORM

NAME: Brett Maher, M.S.Ed.

TITLE OF PROJECT: The Outcome of Children's Day Treatment:

Behavioral Trends and Prediction of Success

DOCTORAL PROJECT COMMITTEE:

PROJECT ADVISOR: John Stokes, Ph.D.
Name

Professor of Psychology, Pace University
Title Affiliation

PROJECT CONSULTANT: Alfred Ward, Ph.D.
Name
Associate Professor of Psychology, Pace University
Title Affiliation

FINAL APPROVAL OF COMPLETED PROJECT:

I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Clinical Child Psychology.

Project Advisor's Signature — 4/1/05 Date

Project Consultant's Signature — 4/6/05 Date

ACKNOWLEDGEMENTS

There are so many people to thank for their guidance and support on this project, which took me far too long to begin (and it felt like even longer to finish!) But I will try my best to recognize them all.

To begin, I need to give my utmost thanks and respect to my advisor, Dr. John Stokes. I cannot begin to describe the ways in which he helped me find my way with this project and whose consistent support and encouragement throughout graduate school, as well as on this project, have truly helped shaped me into the psychologist that I have become. His high standards and commitment to the field have helped me come to strive for excellence in my own practice.

I also would like to thank my consultant, Dr. Alfred Ward for his collaboration and statistical guidance in this project. I would also like to note my 'behind the scenes' consultant, supervisor, ally and friend, Dr. Gilian Goldman for helping me remain calm during this strenuous process. I would like to recognize Dr. Rodney DiMotta, the program director at the Astor Day Treatment

program, for his support and input on this project as well as my top notch fellow researchers (and soon to be Doctors) Rachel Hoina and Amanda Bernstein for their contributions, insights, support and hours of grueling data collection.

Finally, I would like to thank my family; my mother and father, Kerrie and William Liedy, whose love, support, and caring have made it possible for me to get to this point. Without you believing in me, I never would have believed in myself. I would also like to thank my brother, Bill for not only being the best brother in the world, but a good friend.

And to my husband, John: you, my love, are my inspiration and my greatest support. Your kindness and generosity are unmatched and I truly don't know where I would be without you. Thank you for ALWAYS being there for me and helping me in ways that you don't even know. When I began this project, I never thought there could be anything that would feel more important than finishing it. But this is nothing compared to our "little project" we are working on right now! Sweet pea, you are my most favoritest thing in this world and I can't wait to meet

the newest member of our family. Thank you for that, which is the greatest gift of all.

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

The following is an outcome study in a day treatment program using archival data. Demographic data, IQ scores, an intake Child Behavior Check List and Identifying Behavior Checklist (at 4 points) were collected in an archival study of 70 children, during their 1st grade year in a day treatment program in order to predict outcome, as measured by a treatment team decision to place the child in a less restrictive setting.

IQ was not correlated with a successful outcome, ($r(70) = .00$, $p=.486$). Broadband scores on the CBCL did not predict membership in the good outcome group, (Wilks' lambda $=.891$, approximated $F(2,66) = 2.69$, and $p=.053$). Narrowband scores on the CBCL did not predict membership in the good outcome group, (Wilks' lambda $=.813$, approximated $F(8,61) = 1.75$, and $p=.104$). One-way ANOVAs indicated that three narrowband scales were associated with good outcome: Somatic complaints ($F(8,61) = 6.18$, $p<.05$), Anxious/Depressed ($F(8,61) = 9.03$, $p<.05$) and Thought Problems ($F(8,61) = 7.49$, $p<.05$).

Two areas on the IBC predicted membership in the good outcome group: social skills ($F(2,65)= 6.33$, $p=.014$) and task completion ($F(2,65)=4.24$, $p=.043$). Implications for School-Clinical Psychology are discussed.

CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

Many studies seek to examine the variables that predict success for children in different treatment modalities; outpatient (Kazdin & Mazurick, 1994, Target & Fonagy, 1994, and Pelkonen, Martutunen, Laippala, & Lonnqvist, 2000), day treatment (Milin, Coupland, Walker, & Fisherbloom, 2000, Byrnes, Hansen, Malloy, Carter, & Curry, 1999 and Gabel, Swanson, & Shindledecker, 1990), and inpatient or residential settings (Prentice-Dunn, Wilson, & Lyman, 1981, Pfeiffer & Strzelecki, 1990, and Gold, Shera & Clarkson, 1993). Factors often studied and cited seek to examine the predictive value of variables such as, number of family sessions, intelligence, socioeconomic factors and diagnosis.

While this focus on factors that predict success for certain groups of children is useful, it offers little insight toward treating clients who do not fit the

pattern of success. Moreover, many of the factors that have been associated with positive outcome are not factors that can easily be modified. Many outcome studies focus only on the variables inherent in the program, family or child, when addressing clients with lowered functioning in several areas but few studies also address the actual course of treatment.

Often in a day treatment population, the severity of emotional disturbance is so great, that there are several areas that need to be assessed and treated. Often the area with the lowest functioning is targeted and addressed, initially, especially in behaviorally based programs. While common sense dictates alleviating the most problematic symptomatology first, is this the most efficacious treatment? Is there some pattern or order to treatment that would best ensure optimal functioning for the individual client? As stated by Harkness and Lilienfeld (1997), treatment planning is best undertaken when the clinician utilizes all the scientific knowledge and individual factors at hand, especially when utilizing individual psychology to know where to focus change efforts, have realistic expectations, match treatment to personality, and work at development of self.

The importance and difficulty of targeting symptoms when planning treatment is highlighted in a study by Hawley and Weisz (2003). These investigators sought to find the level of agreement between therapists, children, and parents in an outpatient clinic regarding problem domain. They sampled 315 families of children, aged 7-17 years, who had come to an outpatient clinic. Using the Brief Symptom Inventory, asking the caregiver to identify "the major problems for which you feel your child needs help", and asking the child "the major problems for which you feel you need help", the investigators determined how much agreement was present on symptom targeting. First, they found that therapists, parents, and children were all most likely to report externalizing problems. They also found that therapists agreed with parents more than with children on the need to focus on externalizing and internalizing problems of the child, but that also the therapists agreed with children more than parents on the need for a focus family and environmental problems. This one study, of only outpatient clinic clients, highlights the difficulty of focusing treatment when working with children and families, and points to the possibility that lack of agreement may undermine therapy.

This study barely scratches the surface of the many conflicting symptom reduction needs expressed in a day treatment setting. In a day treatment setting, the clinician must formulate a treatment plan that will meet the needs of the child, parent, teacher, and culture of the school. Often each member of the team feels that a different area of concern is most pressing, leading a clinician to wonder, where do I start? What is most important? Is there a systematic way to address all of these issues in an efficacious temporal sequence? Will an immediate reduction in one area aid in a reduction in another? Which symptoms must be addressed immediately to ensure future success?

This study seeks to (1) analyze the trend of symptom changes in latency age children with Disruptive Behavior Disorders in a Day treatment population and (2) assess what factors predict success in this population, as measured by a discharge to a less restrictive setting.

Day Treatment Programs

This section will address the history and theory of day treatment, outline advantages over other treatment settings, and review the general findings in the

literature with regard to the outcome studies of day treatment.

History and Theory of Day Treatment

Day treatment for children with severe emotional disturbance has been an option for over 50 years (Gabel, Finn, & Ahmad, 1988). Its beginning dates back to 1943 and during the first 20 years there was little growth in the small number of day treatment clinics operating throughout the country (Zimet, & Farley, 1985). But despite its auspicious beginnings, day treatment was soon recognized as being "the most significant innovation in clinical care in this century" (Joint Commission on Mental Illness and Health, 1961).

In 1961, there were only 10 day treatment programs for children in the United States, but by 1972, there was an increase to 90, and they have continued to proliferate, with 353 such facilities by 1981 (Zimet & Farley, 1985). The development of day treatment was largely impacted by legislation in several states which mandated health insurance coverage for children placed in day treatment, due to its proven cost-effective nature, ranging from one quarter to one half the cost of residential care (Zimet & Farley, 1985).

The nation began to realize the need for a more intensive therapeutic daytime environment for many children who were not responding to other community settings and by 1990, almost 20,000 children and adolescents were in residential psychiatric treatment centers (Pfeiffer & Strzelecki, 1990). The need to keep these children with their families, and within the community, while providing financially feasible and therapeutically effective treatment was recognized. Hence, the development of day treatment programs began, which fall between the least restrictive setting of outpatient or private therapy and the most restrictive environment of psychiatric hospitalization (Zimet & Farley, 1985). Day treatment has the ability to offer the advantages of both more and less restrictive settings and avoid some of the drawbacks of each.

Throughout the years, day treatment, or partial hospitalization has been used to represent a variety of treatment approaches including intensive treatment, several hours a day, without necessitating hospitalization (Kettlewell, Jones, & Jones, 1985).

Children in day treatment programs suffer from such emotional disorders as psychoses, developmental

disabilities, organic syndromes, personality disorders, severe and moderate mood disorders, pervasive developmental disorders and disruptive behavior disorders. There is generally a history of school failure and an inability to function in less restrictive school programs. These children require comprehensive, interdisciplinary management, and often have academic and behavioral disabilities (Zimet & Farley, 1985). Children for whom day treatment is contraindicated have been described as (a) those who are a danger to themselves or others; (b) those who are best suited to a less restrictive, outpatient setting; (c) those whose caretakers are themselves severely disturbed, dangerous, and abusive; and (d) those with physical illness or handicap that requires round-the-clock care (Herz, Endicott, Spitzer, & Mesnikoff, 1971).

There is generally an extensive intake process to assess the goodness of fit between the child and the program, and once enrolled, a child can remain as long as one month to several years, depending upon the orientation of the program, the severity of the disturbance, and whether or not day treatment is used as a transition point, as a stabilizing experience, or as

the primary psychotherapeutic experience (Zimet & Farly, 1985). Schools and other non-mental health sources make the majority of referrals to child and adolescent partial or day programs and when examining 10 programs for both children and adolescents, the average length of stay is 143.07 treatment days, with 90.68% of children discharged in a planned fashion (Kiser, Culhane, & Hadley, 1995).

The average day treatment program is generally 6-8 hours per day, five days per week and its components usually consist of individual and/or group therapy, family therapy and parenting skill building, and pharmacological intervention as indicated. Survey of programs by Kiser, et. al (1995), showed that the averaged daily census is 19 patients and the most common modality of treatment is group therapy, which is provided for an average of 7.5 hours per week. In a day treatment setting, the children attend a school program, with special education services, which is often similar to regular school settings, but with a more intense focus on behavioral and emotional support and remediation. In addition, crisis workers are onsite to help children who lose control or require emergency interventions.