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Parent Management of Attendance and Adherence in Child and Adolescent Therapy: A Conceptual and Empirical Review

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There have been impressive, recent advances in the development of efficacious treatments for child and adolescent behavior problems. However, specific methods for delivering these treatments in a way that amplifies their efficacy have not been well articulated. Although many factors may be involved, attendance and adherence to treatment are arguably the most basic necessities for effective treatment delivery. We provide a conceptual and empirical review of past research on attendance and adherence to child and adolescent therapy, with a special focus on the importance of parents/guardians in managing treatment participation. Our review demonstrates that attendance and adherence are associated with a range of significant methodological, clinical, and financial outcomes. Several pretreatment predictors of attendance and adherence have been identified; however, to date only 12 controlled, clinical trials have evaluated strategies for enhancing attendance and adherence to child therapy. We conclude with an agenda for advancing research on the prediction and enhancement of attendance and adherence to child therapy as a means of improving the efficiency and effectiveness of child treatments.

KEY WORDS: treatment attendance; adherence; parent training; child therapy.

Decades of clinical research have generated a growing armamentarium of evidence-based treatments for child and adolescent behavior problems (Kazdin & Weisz, 2003). Most of these treatments are directive, skills-based approaches that require active child and parent participation both in and out of sessions over the course of treatment. With the vast majority of resources in psychotherapy research devoted to developing effective therapeutic content, little attention has focused on identifying barriers to optimal delivery of these treatments, or on cultivating methods for delivering treatment in a way that maximizes outcomes. Although many factors may influence the transmission of psychotherapeutic content, *attendance* at and *adherence* to therapy are arguably the most basic necessities for treatment delivery, and thus serve as useful starting points for improving treatment effectiveness and efficiency.

Attendance and adherence are essential features of psychotherapy research and practice. Unfortunately, rates of treatment seeking, attendance, and adherence at child and adolescent therapy[3] are cause for great concern. Only one third of children and families in need of mental services actually receive treatment (Leaf et al., 1996; U.S. Congress Office of Technology Assessment, 1991), and approximately half of the families that receive services terminate treatment prematurely (Armbruster & Kazdin, 1994; Farley, Peterson, & Spanos, 1975; Gould, Shaffer, & Kaplan, 1985; Harpaz-Rotem, Leslie, & Rosenheck, 2004; Wierzbicki & Pekarik, 1993; Weisz, Weiss, &

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[3]Throughout this paper we us the term "child therapy" to refer broadly to psychosocial treatment aimed at improving the behavioral functioning of children and adolescents. We make specific distinctions between children and adolescents where appropriate.

Langmeyer, 1987). Despite the scope of this problem, relatively little research has focused on this issue, and only 1–2% of studies examining treatment participation have focused on child therapy (Baekeland & Lundwall, 1975; Pekarik & Stephenson, 1988). These figures suggest that as researchers and clinicians we have not yet developed adequate models for predicting or controlling client attendance and adherence—a fact that serves as the impetus for this paper.

The relative lack of scientific advancement in this area is partially a result of the many complexities associated with clearly conceptualizing participation in child therapy. For instance, the nature of treatment attendance and adherence differs markedly between adult and child therapy, particularly compared to differences in therapeutic content across these groups, which are often less dramatic. In adult therapy the client is solely responsible for managing the extent of his or her attendance and adherence to treatment. However, in child therapy the parent has primary responsibility for managing everyone's treatment participation. Indeed, children cannot attend treatment without parents' assistance (i.e., provide legal consent, transportation, and payment), and often do not do so without parental insistence. Similarly, although the amount of treatment adherence requested of the child and the parent differs depending on treatment modality, treatment orientation, and on the specific recommendations of the clinician, parents play a key role in managing their children's adherence, such as by monitoring and applying consequences for adherence both inside the session and between clinic visits. Thus, in child therapy, although the focus is often on modifying the child's behavior it is the parent who must manage treatment attendance and adherence.

Unfortunately, although parents often experience significant distress and discomfort associated with their child's behavior problems (Deater-Deckard, Dodge, Bates, & Pettit, 1998; Dumas, Wolf, Fisman, & Culligan, 1991; Nock & Kazdin, 2002), many parents enter the therapeutic setting not expecting (or wanting) to be active participants in the treatment (Nock & Kazdin, 2001). This is especially problematic in treatments that require parents to actively participate in treatment sessions, such as parent training approaches, which are among the most efficacious treatments for child and adolescent externalizing behavior problems (e.g., Parent Management Training; Forgatch & Patterson, 1989 and Parent–Child Interaction Therapy; Eyberg, 1988).

The primary purpose of this paper was to synthesize previous work on participation in child therapy and to evaluate the progression of research toward answering several key questions relevant to scientists and clinicians working in this area. Rather than providing an exhaustive review of all previous work on participation in child therapy, and in contrast to earlier reviews examining how parents' thoughts about themselves and their child may influence treatment participation (e.g., Morrissey-Kane & Prinz, 1999), we provide a focused conceptual and empirical review of research on attendance and adherence to child therapy, with an emphasis on the role that parents play and the barriers they face in managing treatment attendance and assisting in the delivery of treatment. Given the importance of parents in this regard, we concentrate only on child therapy approaches that require active parent involvement in treatment delivery, such as parent training approaches. Accordingly, we evaluate progress toward answering four fundamental research questions. First, how are treatment attendance and adherence defined in child therapy? Previous empirical studies and reviews in this area have been based on loosely defined constructs such as "engagement," "resistance," and other such terms. This paper attempts to provide clearer definitions for constructs related to participation in child therapy, namely attendance and adherence. Second, are attendance and adherence associated with clinical, methodological, or financial outcomes? An answer in the affirmative is necessary to justify additional work in this area. Third, if attendance and adherence are associated with important outcomes it would be useful to know what factors might predict or act as barriers to attendance and adherence, and why. Fourth, can researchers and clinicians enhance attendance and adherence? And if so, how? We critically review evidence addressing each of these questions and conclude by outlining an agenda for advancing research and clinical work on attendance and adherence to child therapy.

DEFINING ATTENDANCE AND ADHERENCE

Despite the broad scope and importance of participation in child therapy, there continues to be a lack of clarity regarding how participation is conceptualized and defined. This lack of clarity hinders communication among researchers and

clinicians and slows the progression of work in this area. In this paper, we consider two distinct but related components of participation in child therapy: *treatment attendance* and parent *adherence to treatment*. By limiting our focus to these two central constructs, several important facets of participation in child therapy will not be discussed here. The process by which families come to seek treatment, the importance of the *child's* treatment adherence, and decisions about whether parents should be present in child-centered therapy sessions are all of great significance and have been reviewed in detail elsewhere (e.g., Barmish & Kendall, 2004; Hudson & Kendall, 2002; Logan & King, 2001). Of greater concern for the present discussion is treatment attendance (of both the child and parent) and parent adherence to treatment once initial contact has been made.

Treatment attendance refers to delivery of the agreed upon treatment participants (e.g., parent, child, family, etc.) to the treatment setting for scheduled appointments. Treatment setting may be defined broadly depending on the parameters of the treatment approach. For instance, although traditional psychotherapeutic approaches require attendance at an office or clinic, attendance at more recently developed treatments may entail being present for a telephone session (e.g., Miller & Weissman, 2002), or being present for a school or home visit (e.g., Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Nevertheless, given the role of the parent as the provider of legal consent, transportation, and financial support, we consider treatment attendance at child therapy under the management of the parent. Related constructs discussed in the literature include "continuation in treatment" and "premature termination" or "attrition" from treatment. Continuation in treatment is a continuous variable that refers to the number of sessions attended by a client. Conversely, premature termination and attrition are dichotomous variables denoting a client's decision to end treatment against the advice of the clinician or before the clinician-determined treatment regimen has concluded. Both are conceptualized as different aspects of treatment attendance.

Treatment adherence refers to "active, voluntary, collaborative involvement of the patient in a mutually acceptable course of behavior to produce a desired preventative or therapeutic result" (Meichenbaum & Turk, 1987, p. 20). In the context of the current discussion we are referring to the *parent's* adherence to the treatment regimen. Child adherence to treatment is undoubtedly an important factor in child therapy as well, but is beyond the scope of the present discussion. Treatment adherence in medicine and health psychology is an area of considerable research that includes both the identification of individuals who are not likely to adhere to treatment recommendations and the development and evaluation of practices aimed at increasing such adherence. Most psychological interventions also require high levels of client adherence; yet, the evaluation of this construct in psychotherapy research is surprisingly limited.

Related constructs discussed in the psychological literature include "compliance" and "resistance." The term compliance connotes obedience and acquiescence to the orders of the therapist, and is less consistent with the collaborative parent–therapist relationship desired in most psychological interventions. Similarly, the term resistance connotes active opposition or confrontation on the part of the client. Although client behaviors may be conceptualized as noncompliant or resistant, the term adherence (or its inverse "nonadherence") is preferred because of its emphasis on collaboration between involved parties. Treatment adherence typically is measured by assessing the quantity and quality of therapeutic behaviors performed by the parent within sessions (e.g., affirmative/collaborative statements, engagement in role-plays, etc.) or between sessions (e.g., completion of written homework, reported engagement in newly acquired parenting discipline skills, etc.), as prescribed by the therapist. Distinctions in how these constructs are conceptualized and measured are highlighted throughout this paper.

Given these definitions, treatment attendance and adherence are considered related but distinct constructs in child therapy. For instance, one must attend treatment, at least initially, in order to be able to adhere to the treatment regimen, so in this way treatment attendance in some form is a necessary precondition to adherence. Of course, one can continuously attend treatment sessions but not adhere to any aspects of the treatment regimen during or between sessions. Such a person is considered to be attending but not adhering to treatment. Conversely, one can stop attending treatment sessions, or attend inconsistently, but continue adhering to all other aspects of treatment. Such a person is not attending regularly (or at all) but is adhering to the treatment regimen. An understanding of whether and how much treatment attendance and adherence are

necessary for positive outcomes will greatly advance clinical research and practice.

OUTCOMES ASSOCIATED WITH ATTENDANCE AND ADHERENCE

Treatment Attendance

Countless studies comparing treatment with no treatment indicate that some level of participation in psychotherapy is associated with better outcomes than the lack of any such participation (Smith, Glass, & Miller, 1980; Weisz & Weiss, 1993; see also Kazrin, Durac, & Agteros, 1979). Moreover, there are negative outcomes associated with inconsistent treatment attendance and premature treatment termination. First, premature treatment termination creates myriad methodological problems for psychotherapy researchers. Specifically, attrition decreases the validity of the inferences that can be drawn about treatment efficacy, as it can alter random composition of groups, reduce statistical power, limit the generality of findings, and introduce sampling bias (Armbruster & Kazdin, 1994). Second, premature treatment termination has a negative financial impact on the mental health service system by decreasing cost-effectiveness, as missed and cancelled appointments decrease staff productivity and cause an increase in unit cost for services (Garfield, 1994; Larsen, Nguyen, Green, & Attkisson, 1983; Pekarik, 1985). These problems have led some to identify poor treatment attendance as the most important issue facing psychotherapy researchers (e.g., Phillips, 1985).

Although some treatment is superior to no treatment (in most cases) and lack of attendance at scheduled sessions presents multiple problems, the optimal level of treatment attendance, if there is one, remains elusive. The question of whether greater attendance at, or larger *doses* of, psychotherapy is associated with a superior treatment response remains a source of controversy in the psychotherapy literature. Several adult therapy studies have shown a strong dose-response relation (Howard, Kopta, Krause, & Orlinsky, 1986; Kopta, Howard, Lowry, & Beutler, 1994), whereas others have failed to find such an association (Smith et al., 1980). Interestingly, a more recent and more refined study of adult therapy revealed an interaction between number of sessions attended and treatment duration such that poor treatment attendance (i.e., attending few sessions) over a long period of time was predictive of worse outcome (Reardon, Cukrowicz, Reeves, & Joiner, 2002). These findings suggest consistency in treatment attendance may be more important than actual number of sessions or time in treatment.

Although fewer studies have investigated the relation between the number of sessions and treatment response for child therapy, the available evidence for children is also mixed. Some studies have reported a strong dose-response relation (Fonagy & Target, 1994), whereas others have failed to find this association (Andrade, Lambert, & Bickman, 2000), while still others have reported a reverse dose-response effect, such that those with shorter treatment duration experience more favorable outcomes (Schneider & Byrne, 1985). We were unable to find any studies evaluating the treatment attendance by duration interaction described above; however, there is evidence that at least some families benefit from small, short doses of child therapy. For instance, although treatment completion has been shown to relate strongly to therapeutic change, a sizeable percentage of families who terminate treatment prematurely (34%) *improve* significantly (Kazdin & Wassell, 1998). Thus, many families who drop out of treatment may do so because only a small dose was needed to cause therapeutic change.

It is likely that different parent, child, and treatment factors *moderate* the relation between treatment dose and therapeutic response. For instance, families with less severe problems may benefit sufficiently from smaller doses of therapy, whereas those with more severe problems may require larger doses in order to experience significant improvement, suggesting the need for stepped-care treatment models (see Haaga, 2000). Indeed, evidence suggests severity of child (Ruma, Burke, & Thompson, 1996) and parent (Cobham, Dadds, & Spence, 1998; Dumas & Wahler, 1983) psychopathology are negatively correlated with treatment responsiveness. Thus, in analyzing the relationship between treatment dose and outcome, it may be particularly important to consider the initial severity of childhood psychopathology and the presence of parental psychopathology as potential moderators of treatment efficacy.

Child age may also influence treatment attendance and ultimately affect treatment outcomes. Dishion and Patterson (1992) evaluated the influence of child age on the effectiveness of a parent training intervention and found that although there were no effects for age on treatment outcome, a

higher proportion of older children were represented among the families who dropped out of treatment. Interestingly, older children who dropped out of treatment also demonstrated lower levels of dysfunction at initial assessment, suggesting that child age and severity of dysfunction may also interact to predict treatment attendance. Although an understanding of the exact nature of the relation between attendance and positive therapeutic outcome requires further study, incorporation of such moderational models will aid in the clarification of the complex, and heretofore inconsistent, relations observed in the studies mentioned previously.

Treatment Adherence

Most child therapy packages with support for their efficacy are composed of therapeutic content based on theories of learning and assume the child, parent, or family must engage in certain behaviors (e.g., skills acquisition, behavioral exposure, self-monitoring, specific parenting practices; see Lonigan & Elbert, 1998) in order to cause change. Given this approach, one would expect greater client adherence to a behavior change plan to be associated with more positive therapeutic outcomes. Although the importance of *therapist* adherence to treatment has been widely discussed and evaluated in the research literature (e.g., Huey, Henggeler, Brondino, & Pickrel, 2000; Waltz, Addis, Koerner, & Jacobson, 1993), we are referring here to client, and particularly parent, adherence to treatment, which has received less consideration in the research literature.

Treatment adherence occupies a central theme in other subdisciplines, such as pediatric and health psychology (e.g., Lemanek, Kamps, & Chung, 2001; Meichenbaum & Turk, 1987), but is not often addressed in the child psychotherapy literature (Allen & Warzak, 2000). A notable exception is the program of research on parent treatment adherence conducted by Patterson and colleagues (see Patterson & Chamberlain, 1994 for a review). Through an impressive series of studies, Patterson and colleagues demonstrated that increases in parent adherence (referred to by this group inversely as parent "resistance") accounted for approximately 40% of the change in parent discipline practices, which were associated with subsequent improvements in child behavior. Moreover, they found nonadherent (i.e., "high resistance") parents were much more likely to terminate treatment prematurely than were adherent (i.e., "low resistance") parents (54% vs. 14%, respectively) (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984).

Interestingly, the negative outcomes associated with parent nonadherence do not seem to be limited to the child. Patterson and others (Patterson & Chamberlain, 1994; Patterson & Forgatch, 1985) also found that parent nonadherence both within and between sessions influenced *therapist* behaviors in a negative manner. More specifically, parent nonadherence was associated with less time spent teaching social learning principles, more therapist confrontation, and lower levels of therapists' liking of the parent. The authors concluded that parent nonadherence seemed to lead to the therapist being "turned off" by the parent and to spending less time trying to help the parent. These findings, although in need of replication, highlight the negative effects of parent nonadherence. Overall, given the effects of attendance and adherence on clinical, methodological, and financial outcomes, there is a clear need to identify factors that influence attendance and adherence, which may aid in the prevention or intervention of premature termination or nonadherence.

INFLUENCES ON ATTENDANCE AND ADHERENCE

Treatment Attendance

Most research on predictors of treatment attendance has focused on identifying demographic variables associated with attendance at adult therapy (e.g., distance from clinic, client age and gender); however, most of these variables fail to consistently predict attendance in child therapy (Armbruster & Kazdin, 1994; Pekarik & Stephenson, 1988). Research on predictors of attendance at child therapy has increased in recent years. However, most studies have attempted to identify predictors of treatment attendance using variables of convenience (typically those likely to appear on clinic intake forms), and have lacked theoretical perspective, limiting their usefulness. Although factors such as low socioeconomic status, ethnic minority status, parent psychopathology, and severity of child psychopathology are related to poor attendance and premature termination of treatment (Armbruster & Schwab-Stone, 1994; Gould, Shaffer, & Kaplan, 1985; Kazdin, Mazurick, & Bass, 1993; Kendall & Sugarman, 1997; McMahon, Forehand, & Griest, 1981; Wierzbicki &

Pekarik, 1993), these findings tell us little about *why* these families stop coming to treatment.

One way to conceptualize why individuals or families fail to attend or adhere to treatments is to consider *barriers* that may interfere with their doing so. As such, *barriers to treatment* models have been developed and evaluated in various areas of health care and have proven useful in explaining and predicting attendance and adherence to treatment (e.g., Alvidrez, Kaiser, & Havassy, 2004; Rockloff & Schofield, 2004; Sehgal et al., 2002). Kazdin and colleagues (Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997; Kazdin & Wassell, 1999) have developed and evaluated a barriers to treatment model specific to child therapy, which proposes that many families experience multiple obstacles or hindrances to participating in treatment, and these experiences elevate the risk for decreased treatment attendance and adherence. Rather than focusing exclusively on problems of the family, parent, or child, or conversely on aspects of the therapist or treatment, barriers to treatment are best conceptualized as developing out of an interaction between the client and the treatment.

Kazdin, Holland, and Crowley (1997) and Kazdin, Holland, Crowley, and Breton (1997) have outlined and evaluated a model of barriers to treatment that classifies barriers into four primary domains: (1) the experience of stressors and obstacles (e.g., conflict with significant other or other children about accompanying parent to treatment), (2) a poor relationship with the therapist (including perceived lack of support from, and disclosure with, the therapist), (3) perceptions that treatment is not relevant, and (4) perceptions that treatment is too demanding—each of which have been shown to contribute significantly to premature termination independent of the pretreatment family, parent, and child factors mentioned above (Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997). Moreover, among families at high risk for drop out, parent perceptions of fewer barriers to treatment attenuated the risk of attrition, suggesting that the experience of low levels of parental barriers to treatment serves a protective function against premature treatment termination (Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997).

Consideration of the barriers to treatment model can serve to organize much of the previous research on attendance and adherence at child therapy, and may also be useful for guiding future research in this area. More specifically, previous work has evaluated similar constructs that overlap with, or map on well to, the barriers to treatment model. For instance, the experience of *stressors or obstacles* to participating in treatment—the first component of the barriers model—has been reported by multiple research groups in the form of "parent stressors" and "logistical difficulties" (Cunningham et al., 2000; Webster-Stratton & Hammond, 1990), which are predictive of attendance at child therapy. Similarly, *therapeutic relationship* factors also have been shown to be related to attendance at child therapy (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Garcia & Weisz, 2002).

Barriers related to perceptions of *treatment irrelevance* match closely with previous work on the discrepancies that often exist between parent expectancies for therapy and the actual properties of treatment. Such discrepancies have been shown to predict poor attendance or premature termination from treatment (Day & Reznikoff, 1980; Furey & Basili, 1988; Plunkett, 1984). The role of parents' beliefs about themselves, their children, and the relevance of treatment have been reviewed in detail elsewhere (Morrissey-Kane & Prinz, 1999); however, one recent finding warrants specific comment. Although most previous studies have shown that parents who have stronger beliefs that therapy will be effective (i.e., is more relevant for their problems) attend more therapy sessions, Nock and Kazdin (2001) reported a significant curvilinear relation between expectancies and treatment attendance—such that parents with expectancies that were either very high *or* very low were most likely to complete treatment. This finding not only adds to the literature highlighting the importance of parent beliefs about the relevance of treatment, but also suggests a more complex relation among these constructs than previously assumed.

The final component of the barriers model, perceptions that *treatment is too demanding*, corresponds with an area that has received much attention in the adult therapy literature—a lack of motivation for therapy. Motivation for therapy has been defined in many different ways in the psychological literature and refers broadly to a state of "readiness" or "eagerness" to perform the tasks required in order to change one's behavior. Beliefs that what is required in treatment exceeds what one is prepared to do can be thought of as perceptions that treatment is too demanding (e.g., too costly, too long, too difficult, etc.). Clients' self-reported motivation to change has been shown to predict participation and outcome in adult therapy (see Frank & Frank, 1991; Garfield,

1994; Miller & Rollnick, 2002; Walitzer, Dermen, & Connors, 1999 for reviews). Interestingly, one early study found a curvilinear relation similar to that reported above, such that those with high *or* low motivation were most likely to accept a referral to therapy and more likely to improve in treatment (Rosenthal & Frank, 1958). These findings suggest pretreatment measurement of motivation for treatment may provide useful information about future participation and outcome. Surprisingly, however, we could not find a single study that systematically measured and evaluated the role of parent motivation for child therapy—suggesting this is an area in great need of attention.

Examining parent attendance using the barriers to treatment model may also have important implications for understanding how variables such as severity of child psychopathology, parent psychopathology, and other consistent predictors of treatment attendance may contribute to premature termination. In particular, child and parent variables, such as parental stress and psychopathology, severity of child dysfunction, and child age may not themselves contribute directly to treatment attendance. Instead, these variables may influence parents' experiences of barriers to treatment, which then predict treatment attendance. For instance, it may be the case that parents of children with more severe behavioral or emotional problems have reduced expectancies regarding the ability of treatment to effect change (i.e., low treatment relevance). Additionally, parental psychopathology may both decrease a parent's motivation to fully engage in the treatment of his child's illness and increase the likelihood that he perceives the particular treatment as very demanding. Similarly, parents may perceive treatment that involves active parent participation to be less relevant in the treatment of adolescents who have already begun to depend less on their families as a primary source of support.

Nock and Kazdin (2001) found support for the links between several of these parent and child variables and specific expectations about treatment effectiveness. High parental stress and child dysfunction, as well as older child age were specifically associated with low expectations for child improvement. Moreover, high levels of parent depression were associated with expectations of low treatment credibility. The curvilinear relationship between expectations and treatment attendance suggests that parent expectations may mediate the relationship between these parent and child variables and treatment attendance. Unlike variables such as child age and severity of child and parent psychopathology, perceptions of barriers to treatment represent potentially malleable targets for interventions designed to increase attendance in child therapy.

Finally, it is important to consider how parent perceptions of barriers to treatment may impact different aspects of treatment and may differ across treatment modalities and settings (see Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Morrissey-Kane & Prinz, 1999 for reviews). As an example, a recent review by Chronis et al. (2004) suggested that families who had children with more severe behavioral problems were more likely to utilize group, rather than individual behavioral parent training approaches. It is possible that families attempting to manage a severe child behavioral disorder perceive fewer barriers to participating in group therapy given the social support offered in group settings. Additionally, Chronis et al. (2004) reviewed evidence suggesting that treatment setting may moderate treatment attendance, particularly for low-income and minority families. Treatment attendance for such families was particularly reduced in medical, as opposed to neighborhood, settings. The authors suggested that the increased obstacles, such as transportation and childcare, associated with conducting treatment in a clinical setting may account for the poor treatment attendance, underscoring potential differences in the experience of barriers to treatment among different treatment settings.

Together, these findings indicate that parent and child variables, such as parental psychopathology, child age, and treatment modality and setting may interact to influence parent perceptions of barriers to treatment and, ultimately, attendance at child therapy. Importantly, most of the evidence cited above is from studies focusing on the treatment of child externalizing disorders. It is possible that parental perceptions of barriers to treatment vary according to child diagnosis. For instance, parents of children with internalizing disorders may be less likely to seek the social support of other parents because the child disorder is less stigmatizing and disruptive to the family environment. Such questions follow directly from the studies cited and represent important areas for future study.

Treatment Adherence

The few studies that have evaluated predictors of parent treatment adherence have demonstrated factors such as social disadvantage, parent

psychopathology and stress, and older child age are associated with parent nonadherence (see Patterson & Chamberlain, 1994). Theories explaining *how* these pretreatment factors might interact with aspects of the treatment setting or therapist to influence parent adherence have been forwarded, but are not well developed or evaluated. Discrepancies between parent and therapist explanations of the child's behavior problems have been associated with nonadherence (Patterson & Chamberlain). In addition, the number of barriers to treatment perceived by the parent has been shown to predict adherence to initial treatment recommendations made by psychologists (MacNaughton & Rodrigue, 2001); although, in this study adherence was defined as following a recommendation to seek treatment, rather than as engaging in ongoing, collaborative behavior change strategies. Thus, the influence of perceived barriers on adherence to an ongoing treatment regimen awaits evaluation.

It deserves mention that all of these constructs have been studied cross-sectionally. The direction and magnitude of *change* in the experience of barriers to treatment has not been examined, and may help explain the complex relations observed in previous studies. For example, the curvilinear relation between pretreatment parent expectancies and subsequent treatment attendance may exist because parents with very low pretreatment expectancies are likely to encounter direct evidence that contradicts their previous beliefs about the relevance of treatment and thus might experience a positive change in their expectancies and continue in treatment. The repeated measurement of these variables over time is likely to provide rich information about the therapeutic process. Deepening our understanding of how these dynamic constructs vary over time will aid in the development of treatment strategies aimed at increasing parent participation in child therapy.

ENHANCING ATTENDANCE AND ADHERENCE

The previous section outlined several potential explanations for why parents fail to participate in child therapy. Intervention strategies can be extended naturally from each of these theoretical models. For instance, it is possible that increasing parent motivation and reducing barriers to treatment will enhance attendance and adherence to child therapy. In order to evaluate progress toward the development of efficacious strategies for increasing attendance at and parent adherence to child therapy, we conducted a thorough review of the literature in this area. We searched the MEDLINE and PsychInfo databases to identify controlled trials aimed at increasing attendance and/or adherence among child therapies using a parent training approach or in which parents were asked to be active participants. Using the search terms: "child, adolescent, therapy, parent training, parent management training, parent attendance, attendance, parent adherence, adherence, parent interventions, parent participation, child psychopathology, child interventions" and scanning the reference sections of the identified articles for other studies of this type, we identified a final list of only 12 controlled studies meeting these criteria, which are summarized in Table I and reviewed in more detail below. The theories guiding these interventions vary widely; yet, the application of these interventions can be conceptualized as being in one of two groups: those that implement enhancement strategies only in the initial stages of treatment, and those that do so throughout the entire course of treatment.

Preparatory Enhancement Strategies

Drawing on the theory that parents stop participating in therapy because it does not match with their pretreatment expectancies, several interventions have aimed at modifying parents' pretreatment expectancies by providing information about the structure and content of therapy and the role of the parent, child, and therapist within the therapeutic context with some success. Bonner and Everett (1986) reported that parents and children randomly assigned to a condition receiving an audiotape description of what to expect in therapy (i.e., roles, outcomes, structure, and content) reported increased knowledge of therapy, higher receptivity of therapy, and more favorable outcome expectancies than those assigned to a control condition who heard only a brief introduction audiotape. This study supports the usefulness of therapy preparation strategies for changing parent and child perceptions of therapy; however, the rates of subsequent therapy participation were not reported, limiting the inferences that can be drawn about the actual efficacy of this approach.

Overcoming this limitation, several clinical studies have demonstrated the usefulness of a brief, pretreatment parent/child orientation videotape (Day

Table I. Controlled Studies Evaluating Interventions Designed to Increase Attendance and Adherence to Child Psychotherapy

Type of intervention	Investigators	Sample and study design	Outcome measures	Summary of results
Preparatory enhancement strategies	Bonner and Everett, 1986	$N = 38$ children (6–12 years) and their parents recruited from child guidance clinics *Design* = RCT (2 conditions)	Parent and child knowledge of therapy, outcome expectancies, and attraction-receptivity to therapist and treatment	A preparatory audiotape, compared to a control audiotape, was associated with greater knowledge of therapy, attraction-receptivity to therapist and treatment, and expectancies for therapeutic outcome.
	Day and Reznikoff, 1980	$N = 42$ boys (7–12 years) and their parents referred to a children's outpatient clinic *Design* = 2 group comparison	Parent and child expectancies at sessions 1 and 6; Cancelled and missed appointments; Rate of premature termination	A preparatory interview, compared to no interview, was associated with more accurate expectancies at session 1 (but not 6) and fewer cancelled and missed appointments (but not less premature termination).
	Wenning and King, 1995	$N = 747$ families referred to a children's outpatient clinic *Design* = 2 group comparison of consecutive admissions	Attendance at intake and therapy sessions	A parent group orientation meeting, compared to no meeting, was associated with better attendance at intake, but not therapy sessions.
	Kourany et al., 1990	$N = 111$ families referred to a children's outpatient clinic *Design* = RCT (4 conditions)	Rate of cancelled and missed intake appointments	Any contact (telephone call or letter) in days before appointment was associated with better attendance at intake than no-contact condition.
	Szapocznik et al., 1988	$N = 108$ Hispanic families referred to an outpatient adolescent substance abuse clinic *Design* = RCT (2 conditions)	Attendance at intake; Therapeutic outcome	A "strategic structural systems enhancement" (SSSE) intervention, compared to treatment as usual, was associated with better attendance at intake and less premature termination. There was no difference in therapeutic outcome.
	Santisteban et al., 1996	$N = 193$ Hispanic families referred to an outpatient adolescent substance abuse clinic *Design* = RCT (2 conditions)	Attendance at intake	Replication of association between SSSE intervention and increased attendance at intake. Also, increased effectiveness for Cuban Hispanics.
	Rotheram-Borus et al., 1996a, 1996b, 2000	$N = 140$ Latina adolescent (12–18 years) suicide attempters and their mothers seen in an emergency room setting	Attendance at therapy sessions; Clinical symptoms (e.g., depression)	A videotape, therapy session, and staff training intervention, compared to treatment-as-usual, was associated with increased attendance at therapy sessions for adolescents, but not for mothers. Child depression scores were lower immediately following the intervention.

Table I. Continued

Type of intervention	Investigators	Sample and study design	Outcome measures	Summary of results
		Design = 2 group comparison of consecutive admissions		
	Shuman and Shapiro, 2002	*N* = 149 children (3–10 years) and parents or primary caretakers referred to a community mental health center for children and families	7 attendance. variables, accuracy of parent expectations about treatment	Combination of brochure and videotape, compared to brochure alone and treatment-as-usual, was associated with increased accuracy of parent expectations, but the preparation procedures did not improve parent attendance
		Design: Nonrandomized controlled trial (3 conditions)		
Continuous Enhancement Strategies	Aragona et al., 1975	*N* = 15 overweight girls (5–11 years) and their mothers referred to an outpatient clinic	Attendance at therapy sessions; Child weight loss	A deposit and reimbursement intervention was associated with no attrition and greater child weight loss than no-treatment.
		Design = RCT (3 conditions)		
	Eyberg and Johnson, 1974	*N* = 17 children (4–11 years) with conduct problems and their parents referred to a child therapy clinic	Completion of assignments; Therapist rating of parent cooperation; Number of child problems treated; Child therapeutic outcome	A deposit/reimbursement, and parent contingency contracting intervention, compared with treatment as usual, was associated with a greater number of completed assignments, more problems addressed, and more cooperation, but no difference in therapeutic outcome.
		Design = RCT (2 conditions)		
	Fleischman, 1979	*N* = 17 children (3–12 years) with conduct problems and their parents referred to a child therapy clinic	Therapist report of "cooperation"; Attendance at therapy sessions	A "parenting salary" ($1/day for adherence) was associated with better cooperation and less attrition.
		Design = RCT (2 conditions)		
	Prinz and Miller, 1994	*N* = 147 children (4–9 years) with conduct problems and their parents referred to a child therapy clinic	Rate of premature termination	The addition of a treatment component involving frequent supportive discussions of adult issues was associated with lower rates of premature termination, particularly in high adversity families.
		Design = RCT (2 conditions)		

Note. RCT: Randomized controlled trial.

& Reznikoff, 1980) or informational parent group meeting at the clinic (Wenning & King, 1995) for increasing attendance at child therapy. The former study reported more accurate parent and child expectancies for therapy as well as greater and more consistent attendance at subsequent therapy sessions, whereas the latter study reported increased attendance at intake appointments, but no difference in attendance at subsequent therapy sessions. Another study compared the effectiveness of several minimal intervention strategies (i.e., random assignment to a brief reminder phone call 1–2 days before the first appointment, an orientation letter describing what to expect in the first appointment, or both) with no intervention, and found that any pretreatment contact (i.e., any of the three conditions) was associated with a significantly lower "no show" rate at the initial treatment appointment (12.9%) compared to the no-contact condition (34.6%; Kourany, Garber, & Tornusciolo, 1990). However, in a separate study Shuman and Shapiro (2002) found that although a brief intervention involving a brochure and videotape increased the accuracy of parent expectations for treatment, accurate expectations, in turn, did not correspond to increased treatment attendance. These findings underscore the importance of expanding the definition of treatment expectations to include parent perceptions of relevance and credibility, and suggest that interventions specifically designed to target expectancies may not be adequate to increase attendance over the course of treatment.

In addition to these relatively simple interventions, more intensive pretreatment strategies have been evaluated in other outpatient settings. Szapoznik and colleagues (Santisteban et al., 1996; Szapocznik et al., 1988) developed and evaluated an intervention designed to increase attendance at an initial intake session (referred to as "engagement" by these authors) in families referred to an outpatient clinic for adolescent substance use. The intervention involved increased efforts to "join and restructure" the family (which included increased contact, inquiries, feedback, establishment of alliance, etc.) between initial telephone contact and attendance at intake. The authors reported families randomly assigned to the treatment condition had a significantly higher attendance rate at the initial intake session, as well as a higher rate of treatment completion (Szapocznik et al., 1988). These results were replicated in a subsequent study, which also examined potential moderators of the intervention effects and found that initial attendance was lowest in Cuban (compared to other Hispanic) families, and when parents (rather than the adolescent or other family members) were unwilling to be involved in treatment (Santisteban et al., 1996).

The interventions described above were evaluated in outpatient settings where the parent was initially seeking treatment for their child. Participation enhancement strategies will likely need to be more comprehensive or intensive to increase participation in cases where treatment was not planned or may not be desired. As an example, Rotheram-Borus and colleagues (Rotheram-Borus et al., 1996a, 1996b; Rotheram-Borus, Piacentini, Cantwell, Belin, & Song, 2000) developed and evaluated a comprehensive treatment preparation intervention for adolescent suicide attempters treated in an urban emergency room setting, a group known to have low rates of treatment attendance (Piacentini et al., 1995; Trautman, Stewart, & Morishima, 1993). This intervention included a videotape describing what families should expect during treatment and involved intensive staff training and a therapy session with the adolescent and parent, all of which occurred at one time point during the initial therapeutic contact. Compared to individuals receiving standard emergency room care, those receiving this intervention were significantly more likely to attend a subsequent therapy session and reported fewer depressive symptoms shortly after the intervention (Rotheram-Borus et al., 1996b). An 18-month follow-up evaluation revealed adolescents receiving the intervention attended a significantly greater number of therapy sessions; however, mothers involved in this intervention were not more likely to be involved in sessions than mothers in the standard care condition (Rotheram-Borus et al., 2000). The development and evaluation of this multiple-component intervention provides encouraging evidence for the efficacy of participation enhancement strategies in increasing adolescent treatment attendance, but seemed to have a limited effect on parent attendance at subsequent treatment sessions.

In summary, these studies provide evidence for the efficacy of brief (i.e., 30 s to approximately 1 hr) treatment preparation techniques, primarily focused on modifying parent expectancies, for increasing attendance at initial appointments and in some cases at subsequent therapy sessions. Given the brevity and simplicity of these interventions, they can easily be added to existing treatment protocols in a wide variety of treatment modalities, settings, and across myriad clinical populations. Most of these intervention

programs demonstrated increased attendance at an *initial* appointment; however, the inability of some of these programs to demonstrate increased attendance at subsequent therapy sessions suggests the need for more enduring participation enhancement strategies.

Continuous Enhancement Strategies

Several clinical researchers have woven participation enhancement techniques into the treatment model. These approaches have not drawn directly from the parent participation literature reviewed above, but are all based on testable, theoretical models of parent participation. In addition to the extended delivery of these interventions, they can be further classified according to whether they use an active/directive approach to enhancing parent participation, or a more supportive/indirect approach.

Several participation enhancement interventions have drawn heavily from the behavior therapy literature with impressive results. Aragona, Cassady, and Drabman (1975) tested an intervention that included response cost (i.e., failure to receive previously deposited sums of money) for missed therapy sessions or incomplete homework for parents participating in treatment for their overweight children. These authors reported individuals assigned to conditions including this contingency had a 100% therapy completion rate and lost significantly more weight than those in the no-treatment condition. Similarly, Eyberg and Johnson (1974) found that random assignment to a treatment condition with a similar response cost contingency along with telephone communications and therapy sessions contingent upon homework completion by parents of children with conduct problems was associated with better parent adherence to treatment (operationalized as the rate of homework completion and therapist ratings of parent cooperative behavior).

Given many families entering treatment cannot afford to provide (and possibly lose) a monetary deposit of any significance, the development of less financially demanding programs would be useful. As an example of such a program, Fleischman (1979) evaluated the efficacy of using "parent salaries," in the form of $1 for each day of treatment adherence (i.e., implementing a point program, using time-out, etc.) for parents of children with conduct problems. The use of this contingency was associated with significantly increased attendance and parent adherence to the treatment program, especially for low income families. Taken together, these findings provide convincing support for the use of contingency contracting to increase attendance and parent adherence throughout the course of child therapy. However, parent (or clinician) financial restrictions may prohibit or limit the use of these strategies in clinical practice.

Supportive and facilitative communications with parents and other family members have also been used as a means of increasing attendance and adherence to treatment. Prinz and Miller (1994) evaluated the efficacy of adding a treatment component involving supportive discussions with parents of children with conduct problems that focused on issues not directly related to the intervention or child problems (e.g., personal concerns, health problems, job stress, etc.). This intervention was associated with a significantly lower rate of premature termination, especially for high-adversity families, and is an excellent demonstration of how cost-effective, easily implemented strategies can be incorporated into treatment and can increase participation in child therapy for those families who need it most.

In summary, several interventions have been shown to increase attendance and parent adherence to child therapy. These interventions are based on different theories of parent participation, are characterized by differing levels of intensity, and vary somewhat in the extent of the evidence for their efficacy. Nevertheless, all of the controlled studies identified in the literature yielded some degree of favorable evidence for these treatment strategies.

SUMMARY AND RESEARCH DIRECTIONS

Attendance and adherence to treatment are among the most fundamental aspects of psychotherapy research and practice, particularly among the skills-based approaches that require active client engagement within and between treatment sessions. Despite the enormous significance of attendance and adherence, only a fraction of psychotherapy research has focused on these issues. This is particularly true if one considers child and adolescent therapy. In the previous sections of this paper, we evaluated current progress toward answering several fundamental research questions related to attendance and adherence to child therapy. We now offer specific recommendations to facilitate scientific advancement in this area.

Despite the lack of attention to issues related to attendance and adherence by psychotherapy researchers, these topics have been the focus of

significant research by those in the medical and health psychology fields. These other research domains provide useful information about factors associated with client participation and about how clinicians and researchers can influence such participation. The utility of developing hypotheses for future work based on influences and research findings from related subdisciplines has been demonstrated previously (Detweiler & Whisman, 1999; Sternberg, 1999), and a similar approach will be used in this paper. A summary of related research findings and testable hypotheses specific to attendance and adherence to child psychotherapy is presented in Table II. This list and the topics discussed below are by no means exhaustive, but offer potential points of departure for future investigations in this area.

Defining Treatment Participation in Child Therapy

The broadness of the construct of treatment participation, along with the complexities introduced when considering the inclusion of parents and families in treatment have contributed to the definitional confusion that characterizes this research area. Our review focused on attendance and adherence to treatment; however, other related constructs were not discussed and also represent important areas for future research. Previous work has described the processes through which parents initiate child and adolescent mental health services (Logan & King, 2001). Treatment initiation occurs prior to ongoing participation in the chain of service utilization; however, these two processes may influence, and be affected by, similar constructs. Similarly, decisions regarding how much to involve the parent or family in a child's treatment can impact treatment participation and treatment outcomes (Barmish & Kendall, 2004). Another issue apparent from our review was the need for theoretically based, psychometrically sound measures of several key constructs involved in treatment participation. Perhaps because of the limited work on this topic to date, there are no standard measures for assessing central constructs such as treatment adherence and treatment motivation in child therapy. The development of basic assessment tools represents a practical and necessary goal before subsequent questions can be adequately addressed.

Outcomes Associated with Treatment Participation

At the most basic level, one must be exposed to a treatment in order to benefit from that treatment (although not all interventions are beneficial), and failing to participate in treatment in the form of missed sessions and premature termination is associated with negative clinical, methodological, and financial outcomes. However, the relationship between participation and outcome is not simple and linear in all cases. The continued evaluation of interaction effects and other complex relationships is likely to provide useful information about how treatment is best delivered. Most of the studies reviewed addressing this question appeared to be secondary analyses of studies designed to test treatment efficacy. Such studies are useful for generating and testing hypotheses about the relations between treatment participation and outcome. As more information about this relation is revealed, the next generation of studies in this area should aim to test different methods and schedules of treatment delivery using experimental designs in order to isolate key variables and demonstrate the causal role of these delivery methods.

Influences on Treatment Participation

Research on factors that predict treatment participation has focused primarily on demographic variables that statistically predict attendance or drop-out rates, but have not been theoretically linked with participation. More recently, however, theories explaining *why* some families stop participating in treatment have been developed and evaluated. Most notably, Kazdin and colleagues' (1997a, 1997b) barriers to treatment model describes multiple factors that can, and do, hinder treatment participation. In the future, investigations of how *changes* in perceived barriers to treatment influence participation over time, as well as how patterns of attendance and adherence may change during treatment must be performed. The evaluation of such questions can be incorporated into existing studies with relatively little additional effort, but are likely to yield useful data for improving treatment delivery methods.

Moreover, although treatment attendance and adherence are best conceptualized as a function of the interactive processes between client and therapist, most existing models of these outcomes assume a unidirectional, linear relation between client factors or therapist factors and treatment participation. The development and evaluation of more sophisticated models that build on the barriers to treatment model and take into account the bi-directional

Table II. Research Agenda: Recommendations for Future Research on Parent Participation in Child Psychotherapy

Aspect of parent participation	Related research findings	Questions/hypotheses for future research
Definition and measurement	Involving parents in child-focused therapy is associated with more favorable outcomes in some domains (Barmish & Kendall, 2004).	Should parents be involved in child-centered therapy? What factors moderate the benefits of such involvement (e.g., child diagnosis, parent diagnosis, child developmental level)?
	Motivation and adherence are important constructs in adult psychotherapy research (Detweiler & Whisman, 1999; Miller & Rollnick, 2002).	How are parent motivation and treatment adherence best operationalized and measured in child therapy?
Outcomes of treatment participation	More consistent attendance is related to positive clinical outcomes among adults (Reardon et al., 2002).	Do experimental, parametric studies varying treatment attendance demonstrate a causal relation between attendance and clinical outcome?
Influences on treatment participation	Parent perceptions of therapy (i.e., expectancies, motivation, barriers) are related to client characteristics and also to parent participation (Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997; Nock & Kazdin, 2001).	Do parent perceptions of therapy mediate/moderate the relation between client characteristics and parent participation?
	Previous research predicting parent participation has used static measurement of different constructs at pretreatment.	Are *changes* in parent perceptions associated with subsequent treatment attendance and adherence?
	Barriers to treatment are associated with attendance and treatment outcome measures (Kazdin & Wassell, 1998).	Do barriers to treatment also influence parent treatment *adherence*? Also, how do factors such as child age and clinical severity influence barriers to treatment participation?
Interventions for enhancing treatment participation	Barriers to treatment participation are associated with less favorable attendance and treatment outcome (Kazdin, Holland, & Crowley, 1997; Kazdin, Holland, Crowley, & Breton, 1997).	What is the effect of interventions aimed at reducing barriers to treatment on subsequent participation and treatment outcome?
	Motivational enhancement techniques are associated with more favorable participation and treatment outcomes among adults (Miller & Rollnick, 2002).	What is the effect of interventions aimed at changing parent motivation for treatment participation on participation and treatment outcome?
	Behavioral strategies (visual prompts, phone calls, etc.) have been useful at increasing attendance and adherence in adult psychotherapy and pediatric psychology (Lemanek et al., 2001).	What is the effect of using such behavioral strategies aimed at increasing parent attendance and adherence?
	Child therapy preparation techniques have been shown to increase treatment attendance in one study (Holmes & Urie, 1975).	Is this finding replicable? If so, what is the mechanism through which a child-directed intervention influences treatment attendance?

relation between client and treatment are likely to provide significant advances in this area.

In addition, future work on factors that influence treatment participation must begin to unravel the complex relations between child factors and participation in treatment. Factors such as the nature of a child's disorder and child age may have a significant impact on treatment participation. It is possible that the child's developmental level and the nature and severity of the child's disorder have an influence on the experience of barriers to treatment and on subsequent participation. Indeed, we reviewed evidence that older child age and less severe child psychopathology are associated with poorer participation. However, there is also evidence in the opposite direction, thus the nature of these relations are not completely clear. Several different theoretical explanations can be tested. It is possible that children with more severe symptoms are brought to treatment more consistently given the disruption or

distress caused by the symptoms, or to the contrary, symptoms causing more distress or disruption create additional barriers to treatment attendance and lead to decreased participation. Clearly, the relations among these potential moderators are complex and require careful evaluation and special attention to differences in psychopathology and developmental level.

Enhancement of Treatment Participation

Perhaps the area most in need of further investigation is the development and evaluation of intervention programs designed to enhance participation in child therapy. The interventions evaluated have generally demonstrated positive results and warrant continued development and evaluation. However, advancement in this area may be greatly facilitated if interventions draw more heavily on theoretical and empirical work describing factors that influence treatment participation. For instance, the barriers to treatment model suggests parents stop participating in treatment when they experience specific hindrances or obstacles. Thus, interventions aimed at reducing parents' perceived barriers to treatment should increase attendance and adherence to treatment. The barriers to treatment model has been elaborated in the literature and has received empirical support; however, to date no interventions using this model have been developed or evaluated.

Similarly, interventions designed to increase parent participation in child therapy may benefit from drawing on advances in participation enhancement among adult clients. For example, there is preliminary support for the role of motivation in therapy participation in the adult literature (e.g., Rosenthal & Frank, 1958) where motivational enhancement therapies have been developed and shown to be efficacious in increasing therapeutic change (see Miller & Rollnick, 2002). These techniques favor expressing empathy and eliciting motivational self-statements over the challenging and confrontational approaches sometimes associated with cognitive-behavioral therapies. Likewise, there is evidence to suggest in working with parents, in session nonadherence actually decreases after "facilitative/supportive" behaviors by the therapist and increases following therapists' use of "teaching/confronting" (Patterson & Forgatch, 1985). These findings are consistent with the motivational enhancement literature, and suggest these techniques may be useful for increasing parent motivation and participation in child therapy.

In addition to the previously mentioned success associated with using behavior therapy techniques to increase parent participation in child therapy, a range of other behavioral techniques have been implemented successfully in the areas of adult therapy and pediatric psychology to increase patient adherence to treatment regimens, such as the use of visual prompts and frequent telephone calls requesting adherence (see Burgoyne, Acosta, & Yamamoto, 1983; Lemanek et al., 2001; Turner & Vernon, 1976). These interventions provide direct examples of techniques that could be easily transported to and evaluated in the child psychotherapy setting. Also, another distinct but related consideration is the role of the *child* in influencing attendance and parent adherence, or the influence of child adherence to treatment on therapeutic outcomes. Interestingly, one early study (Holmes & Urie, 1975) reported that assignment to a child therapy preparation interview was not associated with therapeutic change, but was associated with a significantly lower rate of premature termination (25% vs. 37.4%). Although it is unclear from this study whether parents were also exposed to preparatory information, these findings suggest interventions aimed at the child may also be useful in increasing participation in child psychotherapy. Each of these alternate areas represent separate but related facets of treatment participation and provide avenues for contributing to the progression of work in this area.

Our primary aim was to provide a conceptual and empirical review of the extant literature on attendance and adherence to child therapy. Our review of this work reveals that progress has been slow toward operationalizing key constructs, providing a comprehensive explanation of the central predictors of treatment participation, and developing and evaluating strategies aimed at increasing participation in child therapy. Through a synthesis of past work in this area and related fields, we outlined several paths for additional research on participation in child therapy. Increased research on this topic is likely to benefit not only researchers and clinicians, but most importantly the children and families in need of mental health services. We hope the research and proposed agenda for future studies on participation in child therapy will facilitate progress in this developing area of psychotherapy research.

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