The Impact of Poverty:
Relationship Quality, Individual Symptoms,
Fee for Services, and Attrition

by

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Abstract

Psychotherapy research has acknowledged the importance of examining dropout in therapy. However, researchers consistently neglect to look to the effect of fee-for-services on therapy attrition. Addressing this gap in the literature, the current study tests the effect that therapy fees and income-level have on attrition and dropout through the lens of Maslow's Hierarchy of Needs. Drawing upon measures of income-status and fee paid, relationship quality, individual symptoms, adverse childhood experiences, this study examines the relationship between fee as a percentage of income and dropout in therapy for clients attending a southeastern university training clinic. Results provided support for hypotheses. Fee as a percentage of income was positively related to therapy dropout and negatively related to total sessions attended. Income was also related to higher relational distress and adverse experiences in specific contexts. Explanations of findings and future directions are provided.

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Introduction

Economic hardship is considered to be the most pivotal and straining of chronic stressors, as it leads to adverse outcomes and hopelessness (Kahn and Pearlin 2006). The chronic stress of poverty leads to anxiety, substance use (Pearlin and Radabaugh 1976), depression, and physical health decline (Kahn and Pearlin 2006). Conger et. al found that economic stress serves as a catalyst for emotional and behavioral problems within families (1994). It is not surprising that the web of poverty ensures that people experiencing individual negative symptoms are more likely to be impoverished (World Health Organization, 2014); likewise, an impoverished person is more liable to experience these negative symptoms as a result of financial strain.

The forty-seven million Americans living in poverty (US Census Bureau, 2014) experience stressors, traumas, and continuous economic threats is not surprising that these individuals face personal and relationship distress as well (Evans & Kim, 2013). Federal, state and local agencies focus on the most critical life sustaining needs to ensure individual survival, at little cost to the individual. While there are programs for impoverished families to ensure the basic needs of food, shelter, and education, the psychological and relationship requirements receive lower priority.

While meeting basic needs is the foundation for addressing poverty, more needs to be done if there is ever to be hope that individuals have an opportunity to overcome the effects of poverty. The theoretical framework that best describes the impact of poverty on individual's experiencing poverty is Maslow's Hierarchy of Needs (1943). Considering

Maslow's model, meeting one's most basic physiological requirements, in addition to safety and security needs, are essential before focusing on more relational needs. The theory suggests that financial concerns and limitations will take precedence over maintaining or improving the relationship when basic needs are unmet. In addition to the inability to meet needs, economic strain presents another stressor in the maintenance of relationships.

Adverse economic conditions are detrimental to relationship quality (Aseltine and Kessler, 1993), and poverty accelerates this process of marital instability (Horin, 2004). Low-income couples experience lower levels of relationship satisfaction and higher divorce rates compared to higher income couples. These couples also report fewer positive interactions (Fein, 2004) and more problems with finances, substance use, infidelity, and friends (Trail & Karney, 2012). This theoretical perspective suggests that the chronic stress of poverty is consistently a higher priority for individuals and couples than relational or emotional stability. Therefore, therapy may seem unattainable.

Over the years, the field of couples' therapy has worked towards making treatment accessible to low-income couples. Couples attending therapy presenting with financial strain have higher levels of relational distress, more difficulties in communication, and more disagreements about finances than higher income couples in the same clinic (Aniol and Snyder, 1997). There is a common misperception that low-income clients are not motivated to participate in therapy services (Koroloff and Elliot, 1994) due to laziness and ignorance. Contrary to these assertions, researchers have found that low-income clients lack commitment to therapy treatment due to obstacles that more affluent couples do not face (Grimes and McElwain, 2008), like transportation, working

multiple jobs or inconvenient hours, and lack of childcare. Edlund et. al. (2010) found that financial instability may influence drop-out rates due to the simple fact that couples had insufficient funds to pay the therapy fees.

However, community agencies and therapy clinics face a constant threat of limited funding. While community organizations and training clinics offer lower costs services, there is a necessity to remain economically viable to continue services. While the community, state and federal governments work with non-profit organizations to provide for basic life-sustaining services at low or no cost, community agencies and training clinics work to provide "lower cost" services to meet the individual higher functioning requirements outlined in Maslow's Hierarchy of Needs. Like the underprivileged individuals served, therapy clinics face chronic economic stress. The primary goal is to match the service at a low cost with the ability of the client to make nominal payments to address the higher order need; one such service is couples therapy in marriage and family therapy training clinics.

Fees are necessary to keep clinics afloat, and to use a sliding scale allows poorer couples to attend therapy while the agency can provide services. The fee percentage as it applies to income-level brings to question how to implement a fair price system without disadvantaging the poorest of the poor and advantaging those who have more resources. Few clinics have evaluated this process, but more needs to be done to measure how the fee percentage impacts therapy drop out.

Those who have limited resources report more elevated pretreatment negative symptoms, decreased relationship quality, and more childhood adverse experiences. All of these stressors impede therapeutic progress and continuance. In this study, we will

evaluate how these stressors influence lower income couples who seek relationship therapy at a marriage and family therapy training clinic offering a sliding fee scale. We will address the combined stressors of income, relationship distress, individual symptoms, adverse childhood experiences, and fee percentage as predictors of attrition and shortened attendance in treatment. Researching pre-treatment stressors of lower income clients is crucial to the field of Marriage and Family Therapy, as Principle 6.7 in the AAMFT Code of Ethics (2001) states that marriage and family therapists are required to be ‘‘concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest....’’ Therapists will only meet this expectation if we have an understanding, and client base, for low-income couples.

Review of Literature

Theoretical Background

This chapter will focus the impact of poverty on individual symptoms and relationship stress, attrition in therapy, and how fee for services might influence the poor seeking relationship therapy through the lens of Maslow's Hierarchy of Needs (1943). The chapter will conclude with hypotheses for the current study. Research on attrition and income in couples' therapy is limited, especially when addressing the role of the fee.

The fee percentage is an inconsistent parameter in evaluating symptoms, relationship quality, and adverse childhood experiences, despite the growing need for mental health in impoverished communities. The lack of research on fee percentage and income is likely due to therapy being a financial commitment. The field of marriage and family therapy needs to acknowledge the sparse literature surrounding the impact of the fee on low-income clients; this study will be followed by the research hypotheses to further the topic of poverty and therapy.

For this study, I am interested in the relationship between poverty (income per household), stress (individual symptoms, relationship satisfaction, adverse childhood experiences) and fee for therapy on attrition (one session drop-out), and length of service in couples' therapy. Additionally, there is a need to evaluate the structure used to determine the role of fee for treatment per income level (fee percentage) in determining a fee-to-income ratio, which is related to lower attrition and longer length of service.

Through the lens of Maslow's Hierarchy of Needs (1943), we attempt to determine the ability to maintain relationship satisfaction, manage chronic stress and pay

a fee for weekly therapy sessions. Maslow's theory that before relationship requirements can be addressed securing the basic needs of food or shelter are necessary. Those who are not adequately meeting basic needs are incapacitated in maintaining their relationship satisfaction, as humans must first survive. Maslow explains basic needs as:

> "If all the needs are unsatisfied, and the organism is then dominated by the physiological needs, all other needs may become simply non-existent or be pushed into the background… All capacities are put into the service of hunger-satisfaction, and the organization of these capacities is almost entirely determined by the one purpose of satisfying hunger. …Capacities that are not useful for this purpose lie dormant, or are pushed into the background….For the man who is extremely and dangerously hungry, no other interests exist but food. He dreams food, he remembers food, he thinks about food, he emotes only about food, he perceives only food and he wants only food. The more subtle determinants that ordinarily fuse with the physiological drives in organizing even feeding, drinking or sexual behavior, may now be so completely overwhelmed as to allow us to speak at this time (but only at this time) of pure hunger drive and behavior, with the one unqualified aim of relief." (Maslow, 1943)

Poverty research is vast when studying the first and second level of Maslow's Hierarchy of Needs (1943). However, when narrowed into the third level, the love needs, research is limited (Figure 1). Maslow's theory states that "if both the physiological and the safety needs are fairly well gratified, then there will emerge the love and affection and belongingness needs, and the whole cycle." Therefore, it makes sense that when physiological needs and safety needs are not met, relational needs cannot emerge.

In addition to the capacity to meet basic levels of needs, stress is chronically accumulated throughout the lifetime in impoverished families (Kahn and Pearlin, 2006). The intrusion of external financial pressure draws attention away from intimacy and communication concerns and narrows the focus towards financial and basic survival needs, despite having the same value for having a healthy marriage as more affluent couples (Trail & Karney, 2012). Researchers found that low-income couples reported economic instability as the largest barrier to maintaining relationship quality (Clark-Nicolas & Gray-Little, 1991) and individual functioning (Kahn and Pearlin, 2006).

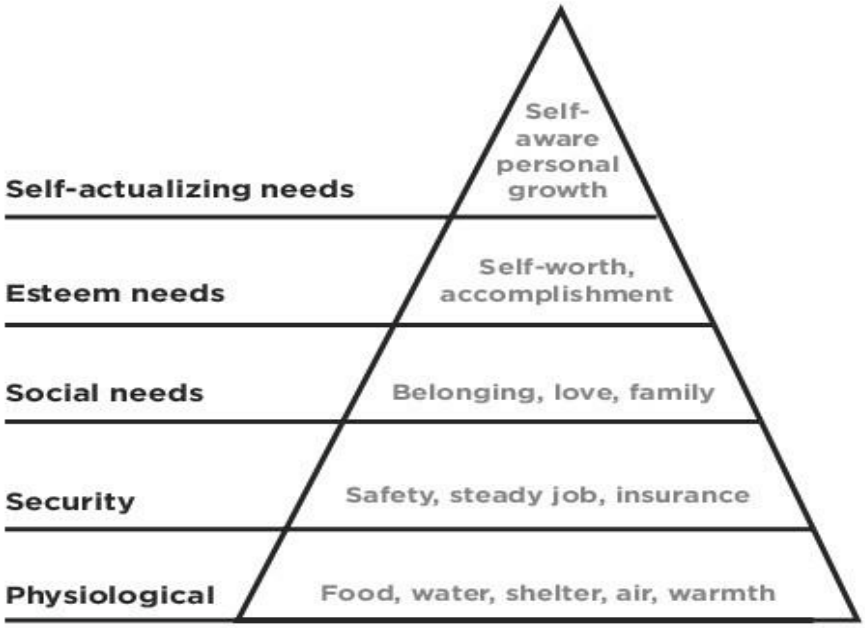

Figure 1. Maslow's Hierarchy of Needs (1943).

Research is significantly lacking in low-income relationship studies. Most of the research was done in the 1990's and has continued to remain stagnant, as seen in these articles ranging from 1990-2000. In a Midwestern study of 74 couples, Conger (1990) found that economic problems negatively affect marital quality and stability. Researchers

found that the negative fiscal problems increased negative interactions and decreased positive behaviors within the relationship (Conger, 1990). The quality of interactions was set-up by the distress of the individual, and in poverty, that was chronic. Conger et. al. (1994) developed the family stress model and completed extensive research on poverty and relationships for the past two decades.

Couple Relationship

Attrition in couples' therapy, despite income, is relevant to the research. Most studies examining pre-therapy symptomology neglect to address attrition as a variable by itself. Many studies consider pre-therapy relationship quality and attrition but may focus on a particular modality of therapy, instead of the entire field (Bartle-Haring, Glebova, and Meyere, 2007). These pre-treatment scores are assumed to be lower than those of the nonclinical population.

Couples attending therapy are expected to report low relationship quality, as most couples wait until their problems are severe to attend therapy (Doss et al., 2003). Dyadic relationship quality and individual distress must be examined because of the difference in individual and couples therapeutic outcomes. In 1996, a study found that depressive symptoms of individual partners improved in both individual and couples therapy. In addition to individual symptoms, relational distress improved more in couples' therapy (Emanuels-Zuurveen and Emmelkamp, 1996). These outcomes are consistent with therapeutic assumptions, as couples therapy targets the couple relationship. However, there is a need to address relationship quality in regards to attrition.

Individual Symptoms

In the field of marriage and family therapy, goals are created for both partners as a couple as well as individually. Individual symptoms should be considered in addition to relational distress in examining attrition. In 1991, Allgood and Crane found that presenting problems only relating to one of the partners showed a significant relationship with partner drop out. Understanding these individual symptoms has been a necessary piece of understanding attrition in couples' therapy.

The level of individual symptoms is also increasingly important in understanding attrition. A study found that those reporting lower overall functioning were more likely to drop out of therapy prematurely (Klein, Stone, Hicks, and Pritchard, 2003). They also found that self-reported symptoms were relevant in predicting attrition. Another study found that higher pre-treatment symptoms, anxiety and depression, are significantly related to higher attrition rates and poorer outcomes in therapy (Swift & Greenberg, 2012).

The Impact of Poverty on Individual and Relationship Functioning

It can be inferred that the inability to meet physiological and safety needs create stress, as noted by the previously stated theories. A study examining the effect of economic strain on mental and physical health over the lifetime (Kahn and Pearlin, 2006) found that financial pressure at any time point was detrimental to mental and physical health, especially when the stress began before age 35 and continued into adulthood. They found that the persistence of stress mattered more than episodic hardships in relationship to self-rated physical health, the quantity of health conditions, functional impairment, and depressive symptoms. A stratified random sample of 1,200 people above the age of 65 was sent assessments measuring time points of poverty and chronic stress

over the lifetime, with 1,167 respondents. The measure in this study consisted of 3 questions measuring financial strain by using a 3-point scale at four different time points in their lives, ranging from childhood to age 65. Despite the limitations of this retrospective study, researchers found ample support for the link between financial strain and chronic stress.

It is clear that individual symptoms often play a role in relational distress, but researchers found that these symptoms in the context of financial strain have a significantly stronger effect on relationship quality. Liu and Chen (2006) conducted a study within the NLSY (National Longitudinal Study of Youth), finding that impoverished women were six times more likely to suffer from depression due to their marital quality than higher-income women. They pulled 2,254 female participants who were married in the year 1992, living with their spouse, and had at least one child. They measured depressive affect, marital conflict, and marital disruption using poverty as a control variable. The results indicated a significant mean differences between groups of those in poverty ($N_1 = 213$) and those out of poverty ($N_2 = 2{,}041$) in depressive affect ($M_1 = 5.80$, $M_2 = 3.91$, $p<.001$), marital conflict ($M_1 = 21.32$, $M_2 = 19.06$, $p<.001$), and marital disruption ($M_1 = .20$, $M_2 = .06$, $p<.001$) Though demographically narrow, this study allows inference for the baseline stress and ability to maintain relationship quality in low-income couples.

Another study supporting this was conducted in 1999; 389 couples who were also parents of students attending a public school were selected to participate in a longitudinal study measuring economic pressure and emotional distress (Conger, Rueter, and Elder, 1999). Researchers found that reported economic pressure at the first wave of the study

was significantly and positively related to change in marital distress over time, emotional distress, and marital conflict. These couples were married for an average of 17.9 years with incomes ranging from indebted $61,474 to an income of $257,000 (median = $33,399). The measures were economic pressure, marital distress, marital conflict, social support, emotional distress, and effective problem solving over three years at three annual time points. These variables are related to relationship quality overall, but are not comparable with the current study's measures.

Kerkmann et al. (2000) examined relationship distress in low-income couples using similar measures as the current study. In a university sample of 218 couples living in student housing, with incomes from $10,000-$20,000 per year, they measured marital satisfaction using the RDAS. This study found that economic problems significantly influenced marital relationships, specifically by reduced warmth and increased hostility. However, this particular study came with a multitude of limitations. First and foremost, the demographics showed a very homogenous sample. All of these "low-income" couples were students, which does not directly imply poverty or SES. In this sample, 98.6% of participants were white, and 70% were female. The most concerning piece though is that these couples had a pre-therapeutic marital satisfaction of 20.4, which is higher than the non-clinical average of 19.7. These couples were previously very satisfied with their marriages, while none of the couples had been married for more than three years, a significant limitation. However, despite limitations, we can conclude that financial strain increased negative behavior and decreased positive interactions, as supported by research (Conger, 1990). These results indicate relationship distress due to outside stressors, specifically for those living in poverty.

Poverty often affects one's view of self and partner and their perceived roles in relationships. Research has well supported the concept that feelings of inadequacy lead to hostility and relational dissatisfaction for the past 50 years (Glenn and Weaver, 1978; Jorgensen, 1979). In 1991, researchers at the University of North Carolina at Chapel Hill found that perceived economic inadequacy most closely associated with negative marital quality (Clark-Nicolas & Gray-Little, 1991) compared to measures of social class, income, education, and occupation. The other variables played a role in marital satisfaction, but not nearly as significantly as economic inadequacy for wives ($F = 13.98$, $p < .001$) and husbands ($F = 6.62$, $p < .01$). Participants consisted of 75 African American couples (N = 150) living in an urban community and were polled door-to-door in neighborhoods with at least 50% black residents. Clearly, there is a limitation of sample size and limited racial demographics. This study contributes to research as another link from poverty to individual symptoms that influence relationship quality.

As reflected by Maslow's theory, many couples that cannot meet basic needs are stunted in their capacity to meet relationship needs. Waldgrave (2005) acknowledges in his research that low-income couples are under-researched in our field, journals, and at conferences. It is not uncommon, however, for low-income couples to attend therapy at a university-based clinic, likely due to the reduced fee. For low-income clients attending therapy, most researchers find that they have greater dysfunction and less successful treatment outcomes than higher income clients (Dougall & Schwartz, 2011).

Adverse Childhood Experiences

Poverty is associated with adverse childhood experiences, which impede adult functioning. The Adverse Childhood Experiences (ACEs) assessment is used in clinics

around the world. The ACE measures the effect of traumatic childhood experiences on negative symptoms, particularly related to increased risk of depression across the lifespan (Felitti et al., 1998). This assessment is often related to poverty in childhood and is later addressed in detail in the following Methods chapter.

Felitti et al. (1998) found that people who had four or more categories of adverse childhood experiences were four to twelve times more likely to have adult health risks for alcoholism, drug abuse, depression, and suicide attempt. They had two to four times increased risk of smoking, poor health, more than 50 sexual intercourse partners, and sexually transmitted disease. Finally, they are 1.5 times more likely to have decreased physical activity and increased severe obesity. The seven categories of adverse childhood experiences were significantly interrelated, and persons with multiple adverse childhood experiences were more likely to have multiple adult health problems (Felitti et al. 1998). It is important to note that lower income is associated with health problems, as referenced earlier, as well as ACEs.

Bright and colleagues (2015) found that there is a significant relationship between low-income families and the prevalence of adverse childhood experiences and toxic stress. They also noted that 35% of children living below the federal poverty line had 2 or more adverse childhood experiences, compared to 10% of those living 400% above the poverty threshold. This statistic explains the relevance of looking at the possible effect of ACEs on low-income adults.

Researchers (Chapman et al., 2004) found that the number of ACEs an individual may experience is significantly related to depression in adulthood. In a retrospective study of 9,460 adults completed a survey including the ACE assessment as well as

lifetime health-related concerns. They found that the lifetime prevalence of depression was 23%, and the odds for women from emotionally abusive homes was 2.7:1 and 2.5:1 for men. Supporting these findings, Fussman & McKane (2015) found that Michigan adults reporting four or more ACES were approximately four times more likely to have depression and report higher mental health issues.

Attrition

It is crucial that attrition is continually examined in the field of marriage and family therapy because research surrounding marriage and family therapy dropout suggests that there is significantly lower attrition in couples therapy compared to medical doctors, nurses, psychologists, social workers, and professional counselors (Moore et al. 2011). Finding marriage and family therapists have a lower attrition rate is fairly standard (Crane & Payne, 2011; Hamilton, Moore, Crane, & Payne, 2011). In general, the length of the marriage and family therapy modalities are designed to be shorter than most clinical or counseling psychology modalities, so it is necessary to limit the study to the field of marriage and family therapy. Researchers have been attempting to find reasons for the length of treatment and implication of treatment dropout for the past few decades.

Historically, research suggests that 30-60% of outpatient therapy clients drop out (Baekeland and Lundwall, 1975), and less education and lower income have been overall the greatest influences in treatment dropout. This large range is due to the operationalization of "drop out", ranging from coded termination reasons, therapist reports, and a specific number of sessions attended. Swift and Greenburg (2012) reviewed varying definitions and found that in 669 studies, therapist report accounted for 63, failure to complete accounted for 314 services as determined by the therapist, and

using a particular threshold for a specific number of sessions accounted for 131 studies. The standard number of sessions systematically used to establish drop-out in the couple therapy literature is one session. Using single session drop-outs is the most objective measure of drop-out among the measurement modalities as it is free of therapy biased concerning goal completion or progress. (Allgood and Crane 1991; Fiester and Rudestam 1975; Heilbrun 1961; McCabe 2002). For the current study, measuring drop-out using the single session attendance standard was used.

A study examining factors association with premature drop out (Frayn, 1992) found that "life circumstances" was significantly related to dropout, more so than attachment, symptoms, frustration tolerance, sexual functioning, and impulse control. Frayn (1992) defined this variable as "the degree of support for therapy that present personal (age, finances) and environmental (time, family, work) circumstances can provide at this time." To further support this, Edlund et al. (2002) suggested that limited financial resources may limit clients' ability to attend therapy, and they may be more likely to drop out due to insufficient time and funds.

Psychotherapy research has found that low-income differences in attrition are more apparent than differences in outcomes. Reis and Brown (1999) conducted a review summarizing 30 studies of attrition in marriage and family therapy research, finding that low socioeconomic status and ethnicity were the only two consistent predictors of attrition. Wierzbicki and Pekarik (1993) ran a meta-analysis of 125 studies on therapy dropout, and only found significant effect sizes for education, income, and racial status. Within those demographics, less educated and lower income clients had higher dropout rates. Research examining therapy outcomes and income are slightly less clear. It appears

that in earlier studies, the outcome was evaluated using attrition itself as a measure of outcome. Most studies that assessed outcome alone found no significant differences between socioeconomic groups (Garfield, 1994).

Contrary to the current hypotheses, a 2010 study revealed that participants with incomes less than $10,000 dropped out less than predicted, and participants ranging from $25,000 and $30,000 were the most associated with drop out (Werner-Wilson and Winter, 2010). The participants attended a training clinic using a sliding-scale fee but did not outline how it was developed and contained inherent bias against one income bracket compared to another. Therefore, the structure of the sliding fee scale may have impacted the findings.

Fee in Therapy

A understudied variable in therapy research is the impact of paying a fee for services. Yates et al. (2001) conducted a review of 152 clients randomly selected in a marriage and family therapy training clinic. The findings supported the previous research as no relationship was found between clients' outcomes and paying a full fee, reduced fee, or no fee. Most studies have found no significant results (Clark and Kimberly, 2014) or that it is better to pay a fee than none at all (Aubry et al. 2000; Jensen and Lowry 2012). Other studies have examined the role of paying for services versus receiving them for free.

Researchers at the University of Texas examined the role of the fee by comparing a control, non-fee paying group to a group paying a $10 fee. Despite having identical means for pretreatment problem distress, clients in the non-fee paying group had significantly lower problem distress scores after treatment (Yoken and Berman, 1984).

The findings are limited as the authors only assessed outcomes at completion not change scores. The authors suggest that fee percentage could play a role in client outcomes.

Current Study

Despite evidence linking poverty and relational distress, there remains a need for understanding the role of couples' therapy in low-income populations. Couples attending therapy are less likely to be experiencing poverty due to their capacity to provide beyond physiological and safety needs. The research is limited in examining the role of income in relationship and symptom distress; the current study begins by examining this relationship. Though studies have linked chronic distress (Hill, 1949; Conger, 1990), symptoms (Kahn and Pearlin, 2006), and relationship dissatisfaction (Liu and Chen, 2006) with financial strain as well as dropout in therapy, little research has investigated the role of fee in this relationship. As well as the impact of poverty on pre-treatment symptom and relationship scores, the current study will conduct an analysis determining the role of fee in low-income clients' attendance in therapy.

The present study seeks to examine client factors affecting dropout rates from couple therapy by examining the relationship between income and relationship quality, individual symptoms, and adverse childhood experiences. Attrition factors pertaining to psychotherapy have been widely scrutinized, but there is gap in the literature examining attrition in low-income populations, specifically for couples. Factors in relation to the fee paid for services, percentage of weekly income, and financial distress are considered to add to the examination of attrition from couple therapy in the field of marriage and family therapy.

University Training Clinic. The current study examines attrition in an MFT training clinic, which could be inconsistent with other professional fields (Callahan, Aubuchon-Endsley, Borja, & Swift, 2009). Other factors for training clinics include potential discomfort with features such as cameras and one-way mirrors, possibly affecting premature termination. However, studies also indicate that there are benefits of training clinics to be considered as well. Ward and McCollum (2005) point out that the research in training clinics have experienced, on-site supervisors and researchers who can conduct evaluations, and clients can understand that they are attending a university-based clinic focused on clinical outcome and process research. Research also suggests that though cameras and one-way mirrors may create discomfort, they are valuable resources in supervision, training, and research. Most clients adapt quickly and are made aware of the arrangement of the training clinic before beginning therapy. Clark, Robertson, Keen, and Cole (2011) found that in a training clinic setting, attrition may be affected by therapist graduation; this is expected to differ in non-training clinics, as there are much less frequent client transitions. If training clinics are the choice of low-income couples receiving therapy, more attention needs to be given to these service providers. Becoming educated about how these couple stressors impact services is an informed step towards service strategizing. The present study acknowledges the limits of the sample, but also considers understanding attrition in training clinics valuable.

Research Hypotheses. Based on this review of the literature, the following hypotheses were developed:

Hypothesis 1. Lower reported income will be related to marital distress, individual symptoms, adverse childhood experiences, and attrition, in couple therapy.

Hypothesis 2. Higher relationship distress, individual symptoms, and adverse childhood experiences will be related to attrition in couple therapy.

Hypothesis 3. Higher fee percentage will predict higher dropout, higher R-DAS scores, lower OQ scores, and more ACEs in couples' therapy clients.

Methods

Data were collected from the Auburn University Marriage and Family Therapy Center on the campus of Auburn University in Auburn, Alabama. Auburn University is an accredited program by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), providing services to residents of East Alabama.

Procedure

Quantitative data were collected from case files from males and who came as a couple for therapy at AUMFTC between January 2004 and December 2011. Before the first session of treatment, all clients received the same intake packet containing self-reported scores from the Demographic Questions, Outcome Questionnaire (OQ-45.2; Lambert et al., 1996), the Revised Dyadic Adjustment Scale (RDAS; Spanier, 1976), and Adverse Childhood Experiences Scale (ACES; Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, 1998). The questionnaires were paper-and-pen and administered by intern therapists or center staff for clinical assessment purposes, further research, and administrative records. Master's level intern therapists, treated the clients, with most sessions occurring weekly.

Measures

Demographic questions. The intake packet for all clients coming to the AUMFTC for therapy includes basic demographic questions that will be used in the analysis. These include questions of gender, race, employment, income, family-of-origin, current family size, and reasons for attending therapy. For the purpose of this study, the income and family size questions are of interest. For income, clients indicate a range of earnings from "Under $5,000" to "Over $40,000" (with a range of $5,000 between each level)

combined income with their partner as well as their past 3 pay stubs or previous year's tax return to qualify for our sliding scale, which ranges from "Under $5,000" to "Over $55,000". This study will use the upper range of each income grouping to determine fee score, as a conservative estimate.

Individual Symptoms. The OQ 45.2 (Lambert et al., 1996) is a 45-item measure including three subscales: Symptom Distress, Interpersonal Relations, and Social Role (OQ 45.2). The clients completed the OQ 45.2 before the first session, and then every fourth session after; the measure is widely used and was designed to measure client progress throughout treatment. Responses to each question are on a 5-point Likert-type scale that ranges from 0-4., with 0 indicating lower symptom distress and 4 indicating higher symptom distress. For the entire OQ 45.2 questionnaire, the cutoff is 63; scores above 63 indicate clinically significant distress (Beckstead, Hatch, Lambert, Eggett, Goates, & Vermeersch, 2003). The Symptom Distress subscale contains 25 questions used to assess for anxiety and depression. Examples of items in this subscale are: "I feel worthless," "I blame myself for things," and "I feel something is wrong with my mind." The subscale question responses are totaled to provide an overall rating of anxiety and depression. The interpersonal relationships subscale contains 11 questions used to assess for problems with interpersonal relationships. Examples of items in this subscale are: "I am concerned about family troubles," "I have an unfulfilling sex life," and "I am satisfied with my relationships with others." The social role subscale contains nine questions that are used to assess for dissatisfaction or conflict that a client is experiencing at work, school, and in leisure activities. Examples of items in this subscale are: "I feel stressed at work/school," "I have trouble at work/school because of drinking or drug use," and "I

have too many disagreements at work/school." Internal consistency ranges from .70-.91, and .78-.84 from test to re-test (Lambert et al., 1996). In recent studies, Cronbach's alpha for this measure is 0.94 for males and 0.94 for females.

Relationship Quality. The Revised Dyadic Adjustment Scale is a 14-item revised version of Spanier's (1976) 32-item Dyadic Adjustment Scale (RDAS; Busby, Christensen, Crane, & Larson, 1995). There are three subscales: Consensus, Satisfaction, and Cohesion. The ratings for these scales range from zero to five on a Likert-type scale. The Consensus subscale includes six items and measures the partner's agreement on broad issues including as religion, demonstrations of affection, making major decisions, sex relations, conventionality and proper behavior, and career decisions. Scores for these items range from "always disagree" (0) to "always agree" (5). The Satisfaction subscale contains four items which measure the partner's current satisfaction with the relationship, asking about frequency of arguments and stability of the relationship. These items are range from "all the time" (0) to "never" (5). The Cohesion subscale contains four questions measuring the partner's perception of shared activities and closeness in the relationship. Most of these items range from "never" (0) to "more often" (5) on a six-point Likert-type scale; one item ranges from "never" (0) to "every day" (4) on a five-point Likert-type scale. The score of each of the subscales can also be totaled to obtain an overall marital satisfaction score. The overall range can be from 0 to 69, with lower scores indicative of greater distress in the relationship. Forty-eight is considered to be the clinical cutoff score to distinguish distressed and non-distressed couples (Crane, Middleton, & Bean, 2000). In recent studies, Cronbach's alpha for this measure is 0.87 for males and 0.87 for females.

Adverse Childhood Experiences. The Adverse Childhood Experiences Scale is a 10-item questionnaire originally developed in 1985 for measuring reasons for drop out in an obesity clinic. Felitti (1985) found that many people reported adverse childhood experiences, like physical and sexual abuse, and revised the ACES to include questions of family-of-origin physical abuse, family member mental illness, and neglect in childhood (ACES; Felitti, 1998). The current ACES measure is a 10-item self report requiring indication of "YES" or "NO" for the following in "the family in which you now live" and "the family in which you grew up": "Alcohol, drug substance, or prescription abuse", "physical abuse or violence", "sexual abuse", "emotional abuse", "mental illness", "trouble with the law", "religious/spiritual practice", and "suicide/attempted suicide". The score of each item is created by adding one point per "YES," and a no points added for reporting "NO." The only exception was "religious/spiritual practice" where it is reverse-coded, "NO" adding 1 point to the overall score, with "YES," receiving zero points.

Total Sessions. Total sessions were examined by the number of sessions attended. The number of sessions completed was determined based on the client file case notes and billing sheet, where therapists recorded each session completed. The number of sessions completed in this study ranged from 1 to 43 (M = 7.16, SD = 6.88). The literature was reviewed in relation to expected numbers of sessions required for completion and a crosstab between therapist rating of dropout and number of sessions attended was conducted by a previous study, indicating that 61% of drop out cases completed 5 sessions or less. Therefore, in this study, six sessions were used as an estimate for therapy completion in analyses, as it has been supported by clinical literature (Crane &

Christenson, 2012). Values above 6 sessions were recoded to "6" in the data. As another measure of attrition, the clients who only attended one therapy session (n = 71, 16.1%) was used as a dichotomous variable for drop-out.

Fee percentage. The fee percentage was a variable created using reported income, family size, and fee paid. To determine this fee percentage variable, we have suggested the following equation:

(1) $Weekly\ Income = \frac{Reported\ Annual\ Income}{52\ weeks/year}$

(2) $Weekly\ Household\ Income = \frac{Weekly\ Income}{Reported\ Family\ Size}$

Weekly income is determined by dividing reported annual income by 52 (weeks per year). Weekly household income is then divided by family size, creating the per person weekly income.

(3) $Fee\ into\ Income = \frac{Average\ fee\ for\ services}{Weekly\ household\ income}$

(4) $Fee\ Percentage\ = Fee\ Into\ Income\ x\ 10\ to\ determine\ percentage$

Finally, the fee is calculated as a percentage of weekly income and identified as the "Fee percentage" variable. For example, if a participant reports an annual income of $40,000 with a family size of 2 household members, their fee would be $50. Therefore, their fee score would be 9.5%. On the other end of the spectrum, if a couple is making $20,000 with one child who pay $20 according to our sliding scale, would have a fee percentage of 15.6%.

Plan of Analysis

The purpose of the present study is to examine low-income couples in therapy. First, descriptive statistics were examined to understand sample characteristics and distributions. Linear regression analyses with a variable indicating completion based on

the number of sessions, as well as logistic regression analyses with a dichotomous variable of dropout are described. Linear regression analyses with variables of individual symptom distress, relationship quality, and adverse childhood experiences with income and attrition are examined. Finally, the variable of fee percentage examined in relationship to therapy drop out, pre-therapy relationship quality, individual symptoms, and childhood adverse experience scores and treatment attrition.

Demographics

The participants consisted of married and non-married couples in heterosexual partnerships who attended therapy at the Auburn University Marriage and Family Therapy Center (AUMFTC). These couples attended therapy from 2004 to 2011 for a variety of reasons related to relationship counseling. Three primary categories of treatment are communication problems, affairs, and mental health diagnoses. Four hundred and ninety-nine couples began therapy at AUMFTC during the sampling period (see Table 1); of the 499 couples in the study, 122 (24.4%) self-reported being in a "committed relationship," and 377 (75.6%) self-reported being married. Of the sample, 280 couples completed at least four sessions of therapy (63.6%). For the remaining couples, 71 attended only one session (15.9%), and 89 couples attended more than one but less than four sessions (20.5%). The attrition percentages are consistent with previous MFT clinical training research (Allgood & Crane, 1991). Researchers examined attrition in an MFT training clinic over a four year period with 474 couples, 15% dropped out after one session, therefore consistent with our sample.

The age range for the total sample was 17 to 99, with a mean of 32 years (Table 2). Participants reported their race, income, and education level. The data shows that

78% of males and 75% of females reported their race as White, 14.3% of males and 17.4% of females were African American, 1.3% of males and 1.7% of females were Hispanic, and 6.3% of males and 5.7% of females indicated "other" race. The reported annual household income for this sample ranged from below $5,000 to over $40,000, with a median income of $35,000. One-hundred and forty-three males (49.1%) and 119 females (42.2%) reported graduating from high school, and 109 males (37.5%) and 133 females (47.2%) reported receiving Bachelor's degrees; 30 females (10.6%) and 39 (13.4%) did not complete high school.

Missing Data

The sample including fee percentage was smaller than the total, as data was only obtained for 128 couples, 25.7% of the sample. A T-test was run to determine any significant differences between this sample and the population as a whole. There were no significant differences found at the $p < .05$ level. Therefore the models with this variable were fit as planned.

Results

Descriptive Statistics

Descriptive statistics for each of the variables were examined (see Table 3). Both males (M = 38.03) and females (M = 41.13) showed clinically significant relationship distress, with scores below the RDAS cutoff of 48. Couples who come to therapy often wait until the distress is at an intolerable level expected (Doss et al., 2003); therefore this finding was likewise expected in this study. Similarly, an OQ score of 63 indicates clinically significant individual symptoms, and on average females demonstrated clinically significant symptoms (M = 67.92), though males were just below the cutoff (M = 60.70). The average number of Adverse Childhood Experiences (ACEs) for females was 2.28 and males 2.03. Males were on average two years older than females. Finally, the couples in this sample attended an average of 7 sessions.

Bivariate correlations between variables were examined (see Table 4). Dropout, a dichotomized variable accounting for whether clients attended only one or more than one session, was significantly and positively correlated with the fee percentage score. Therefore, the fee as a proportion of weekly income increases client attrition after one session.

Also, total sessions were significantly correlated with fee percentage, indicating that the higher the fee percentage was, the fewer sessions couples' attended. It is important to note that both male and female R-DAS scores were correlated with male and female OQ scores and ACEs, which is supported by past research, indicating validation in our study (Liu and Chen, 2006). This finding is not surprising, as individual symptoms tend to be higher as relationship quality deteriorates.

Means Comparison

Paired-sample t-tests were used to examine preliminary gender differences (see Table 3). Paired-sample T-tests indicated that female participants reported significantly higher individual symptom distress than males. Relationship distress was also higher for females, with male reported dyadic adjustment scores being significantly higher. The number of male and female Adverse Childhood Experiences (ACEs) was not significantly different in this sample.

A t-test was fit to determine the difference in fee percentage paid between those living below the conservatively estimated 2011 poverty line (US Census Bureau, 2011) and those who are not (see Table 10). The poverty threshold in 2011 for a two-person household with $140 per week per person. This estimate is considered conservative not only due to the two-person income stream, but data is reported through 7 years before 2011, and the poverty threshold has only increased since 2004 ($118 per person). The creation of three groups allows for the measurement of clients below the poverty line, those living above the poverty line but below 100% of the threshold, and those living 100% above the poverty line.

Those living below the poverty threshold on average paid 18% of their weekly income, while those living 100% above the poverty line paid an average of 7.5% ($t = 5.3$, $p < .001$). This analysis is a conservative percentage, as all income levels above $50,000 are capped. Those living above poverty and below the 100% above poverty paid an average of 12.7% of weekly income in their weekly fee. Given that the most conservative estimate of poverty was evaluated, a future examination using the annual estimated poverty threshold and incorporating data on household size would reveal an

even larger gap. Other potential outcomes of this will be further explained in the following section.

Age and Education as Control Variables

The control variables in this study, age and education, were chosen due to the previous findings that they were related to attrition (Swift & Greenburg, 2012). Results in this sample support age as a predictor of total sessions, but education was not significant.

Linear Regression Analyses with Total Sessions as the Outcome Variable

Regression analyses were used to examine the relationship between the number of sessions and the fee percentage variable.

The capped total sessions were regressed onto fee percentage, relationship quality, individual symptoms, and adverse childhood experiences. In the first model of the regression, total sessions were regressed onto education and age. In the second level, fee percentage was added, and the third level included OQ, RDAS, and ACEs scores.

For males, the variables entered accounted for 17.2% of the variance in total sessions. As seen in Table 7, Model 2 best fit the data. Model 2 had the greatest and most significant change in R^2 from the original model ($\Delta R^2 = .063$). The addition of fee percentage strengthened the model and found that fee was significantly related to total sessions ($\beta = -.06$, $SE = .02$, $p < 0.05$). Male age was also found to be significantly related to total sessions ($\beta = .09$, $SE = .02$, $p < 0.01$).

For females, the variables entered accounted for 8.9% of the variance in total sessions, and again only Model 2 was significant (see Table 5). Fee percentage was the only variable significantly correlated with total sessions ($\beta = -.05$, $SE = .02$, $p < 0.05$).

Logistic Regression Analyses with Dropout as the Outcome Variable

Logistic regression analyses were fit to examine individual symptoms, relationship quality, adverse childhood experiences, and fee percentage in relation to dropout in therapy. The dichotomous dropout variable based on termination after one session was regressed onto the control variables and fee percentage in two blocks (see Table 6). For this outcome, dropout is coded as 0 for those who are attending two or more sessions and 1 for those who did not return after the initial session.

Fee percentage was a significant predictor of therapy drop out. For both males (β = .07, SE = .03, $p < 0.05$) and females (β = .06, SE = .03, $p < 0.05$), fee percentage was significantly related to dropout. Thus, the higher percentage of weekly income spent on therapy is positively related to the likelihood for clients to dropout of therapy. The odds ratio for males (e^B=1.08) indicates that those paying a higher fee percentage are 108% more likely to drop out of therapy, and 106% for females.

Additional Analyses

The 16-item Adverse Childhood Experiences (ACEs) assessment measures adverse experiences in one's family of origin as well as current household. The total ACEs for males were correlated with income, but female ACEs were not. An additional analysis of individual items was conducted to better understand the impact of income on ACEs. As seen in Table 8, some of the items were significantly correlated with income. For males, lower income was associated with current household higher substance use, domestic violence, emotional abuse, legal problems, and mental illness and suicidality both family of origin. Female ACE's scores indicated a relationship between lower income and current family violence, emotional abuse, and suicidality; both childhood

sexual abuse and childhood emotional abuse were also positively related to lower income.

There was minimal support in the original model for the effect of income on total RDAS score. The Revised Dyadic Adjustment Scale (RDAS) is a 14-item assessment used to measure adjustment in couple relationships on three sub-scales: Consensus, Satisfaction, and Cohesion. In this study, the total and individual items were examined. Female pre-treatment RDAS total scores were correlated with income, but when fitting the regression, the control variables invalidated the significant relationship. Although, when fitting additional analyses for specific subscales and items, there were multiple significant correlations for the RDAS.

Multiple individual RDAS items were correlated with income level (see Table 9). Male scores indicated a correlation between lower income and less conventionality (correct or proper behavior), less communication about career decisions, more frequent rating of "getting on each other's nerves", and less frequent stimulating discussions of ideas. For females, lower income was correlated with less conventionality, more frequent discussion of divorce, more frequent quarreling, higher ratings of regret for marrying partner, and more frequent rating of "getting on each other's nerves".

Discussion

Much of the previous research related to the cost-effectiveness of marriage and family therapy has examined how couple therapy impacts financial benefits external to therapy such as lowered healthcare costs or legal fees (e.g. Carr, 2014; Crane & Christenson, 2012). However, the relationship of the cost of therapy *directly* to therapeutic outcomes in and of themselves has received much less attention and is often neglected due to the difficulty of defining measurements (Yates, 2001). It is expected that the cost of therapy would be directly related to the completion of therapy, particularly as prohibitive costs would be expected to be related to other key treatment factors such as length of treatment.

Previous research has likewise indicated that therapy drop out is a widespread issue in the field of psychotherapy and is related to adverse financial circumstances including ineffective use of finances and considerably lower cost-effectiveness for dropouts (Barrett et al. 2008, Reis & Brown, 2006; Masi et al., 2003). Similarly, it has previously been shown that individual symptoms and couple distress are predictive of outcomes in therapy (Kilmann & Vendemia 2013; Lebow et al. 2013). Additionally, it has been understood that the number of Adverse Childhood Experiences (ACEs) may play a role in adult outcomes and dropout in therapy (Chapman et al., 2004). Though these certainly impact therapeutic outcomes, the relationship between these factors and therapy fees has also been widely neglected, though all of these are expected to be worse for clients with lower socioeconomic status. Therefore, this study was initiated to examine the impact of fees, particularly in relation to the overall burden from the percentage of fees in relation to household income, to better understand the impact on

therapy services. The study sought to understand particularly this regarding low-income clients and fees paid given the expected relation of financial struggles and attrition.

Although these variables have been studied in the context of individual therapy, there is not nearly as much attention on couple therapy. Recent research has indicated that there are differences in scoring on individual distress and relationship quality for couple and individual therapy clients (Knerr et al, 2011). This study examined individual symptoms and relational distress in relation to fee percentage and therapy drop out.

Hypothesis 1. *Lower reported income will be related to marital distress, individual symptoms, adverse childhood experiences, and attrition, in couple therapy.*

For couples presenting to treatment at a training clinic, it is not abnormal to find that almost 60% of participants reported an annual income of below $35,000. The median household income in the United States in 2014 was $53,657, which accounts for less than 25% of our sample. This is not uncommon, as training clinics are less expensive attracting lower-income couple clients who can afford services (Allgood & Crane, 1991).

Research has shown that impoverished and low-income families are more likely to have multiple ACEs than those living above the poverty threshold (Bright et al, 2015). Additional analyses examining individual ACEs indicated that there is a relationship between income level and adverse experiences, in both current households and family-of-origins. In addition to adverse experiences, individual RDAS scores indicated that lower income is predicted to increase relational distress for specific items in both males and females.

This is not surprising, as couples' with more financial strain are less likely to find relational distress tolerable. Maslow's Hierarchy of Needs (1943) supports this finding. As previously stated, relational needs are not accessible for those attempting to meet basic needs. Conventionality and frequency of getting on each other's nerves were found to be correlated for both males and females. Irritability with partner and disapproval of appropriate behavior (conventionality) could easily be related to day-to-day stress and inability to care for the other person. Variables like sex, religion, participating in activities together, and affection are not related to stress outside of the relationship or financial strain, therefore none of which were found to be significant.

Our findings indicate emotional stress in relation to economic instability, therefore are supported by the family stress model and research addressing the effect of financial strain (Conger 1990; Conger, Rueter, & Elder, 1999).

Hypothesis 2. *Higher relationship distress, individual symptoms, and adverse childhood experiences will be related to attrition in couple therapy.*

The results indicate partial support for Hypothesis 2 (higher symptoms, relationship quality, and ACEs will be related to attrition). Males who reported more ACEs were more likely to drop out of therapy. Also, both males and female RDAS scores were negatively related to total sessions, which was similar to previous findings suggesting the two are related (Gordon, Friendman, Miller, and Gaertner, 2005; Lebow et al, 2012). This indicates that the relationship between lower relationship quality and attending fewer sessions is significant in our sample. Those who present with less desire to change their relationship are naturally less likely to continue therapy past the first few sessions.

ACEs scores were related not only to total sessions but also to income in males. As previously stated, adverse experiences often lead to financial strain and relationship distress. For clinical couples, ACEs are another battle to confront when it comes to attending and affording therapy. The ability to cope and face their stressors at home and cope with childhood experiences, treatment attendance often falls low in priorities. Bright and colleagues labeled it "toxic stress" when two or more ACEs are reported, therefore those with more reported ACEs are less likely to maintain a consistent therapy attendance.

Hypothesis 3. *Higher fee percentage will predict higher dropout, relational distress, individual symptoms, and ACEs in couples' therapy.*

Results indicated overall support for the impact of fee as a percentage of income on treatment dropout. The most relevant piece of this study is the relationship between fee percentage and drop out. The regression indicated that the higher fee percentage paid, the more likely clients are to drop out of therapy after only one session. Our study represents one of the only indications in clinical MFT research that the therapy fee has an effect on dropout. Many training clinics are attempting to stay afloat by charging a substantial fee for therapy sessions. However, when a fee is too large of a fraction of one's income, there are fewer sessions attended, therefore less money made.

In addition to this, we found that the fee is substantially higher for the poorest of our clients. Those struggling to provide food and shelter, maintaining physiological needs, are paying 17% of their weekly income to attend weekly couples' therapy. This finding implies that the sliding-scale is structured like a regressive tax. That is to say, the rate decreases as the income increases, therefore making it more difficult for the poorer

clients. This finding brings light to the issue of understanding the AAMFT Code of Ethics Principle 6.7 (2001), we must be continuing to "develop regulations that serve the public interest". One solution would be to adjust the fees across the income categories to ensure that the fee to income percentage is similar for all income groups. More of a burden, much less an equal burden, needs to be placed on higher earning clients.

Limitations and Future Directions

As noted in Table 3, there were significant differences in male and female reports of relationship distress and individual symptoms, which research has found to indicate difficulty in therapeutic outcomes (Bartle-Haring et al, 2012). Therefore, an explanation of any non-findings is addressed, as well as future directions to better the research.

The sample could explain the lack of significant relationships between attrition and pre-treatment symptoms (OQ); all participants came in for couples' therapy, not individual. Since neither dropout nor total sessions were related to individual symptoms, it is not surprising that these couples' may have been more focused on improving relational quality as a deciding factor in attending therapy. This finding is not uncommon in couple therapy (Knerr et al, 2011). Future research should evaluate the primary reason for attending couples' therapy, comparing those who attend for relational distress versus those with individual diagnostic symptoms.

Our sample is inconsistent with the general population; further research is necessary to indicate generalizability beyond those receiving treatment at the AUMFTC. With a wider range of participants and data, future researchers in community-based clinics should examine the generalizability to the population.

Defining Dropout. Drop out is not easily defined in attrition research. Though this study used a research-based definition of drop out, only attending one session of therapy, there are valid alternatives in measuring drop out, i.e. using therapist rating of drop out and understanding of therapist-recommended termination versus clients not returning to treatment. An important factor in total sessions and attrition that this study does not measure is therapeutic alliance, but the clinic data only measures that after four sessions, therefore it would not meet our need for dropout measurements.

Training Clinic. An apparent limitation of this study is that the OQ, R-DAS, and ACEs are all self-report measures. Though self-report is an accepted method of data collection; it runs the risk of additional error in the results. The standard error in the report may represent the issue of self-report in the data. A future study could look at income and with additional variables and examine those findings. Another limitation is the income report, due to the reported income in the paperwork being a multiple-choice range, with the highest report being $40,000+. Because the most conservative measure of aggregating income based on self-report data was used, there is possibility that using exact figures could have been provided more support for our hypotheses. Finally, though clients are aware they are attending a clinic to receive therapy from a training therapist, it may make clients more likely to become nervous and lead to higher attrition rates due to the mirrors, cameras, and explanation of supervision (Ward & McCollum, 2005).

Conclusion

The study found that though using a sliding scale for fee payment, the percentage of fee paid by clients not only is unequal, but it is related to therapy drop out for those paying more. This study intended to examine the impact of the fees, and distress in couples' therapy on attrition and length of therapy services. In understanding the effect of fee on drop out, clinics will be better situated to address issues of fee and be aware of potential attrition.

Future researchers should include other analyses to measure differences in low-income clients, including measuring the effect of an intake fee as a barrier to services. Clinics, in an effort to increase income and decrease costs, may institute intake fees to offset one session dropouts. The impact of the intake fee should be assessed as a contributor to dropout and therapy attendance.

Literature on fees and therapy attendance is often broad and primarily focused on other variables. Researchers have controlled for the variable of income and fees paid, neglecting to examine the effect financial distress may have on clients. Contrary to the literature on fee as a variable (Yates, 2001), our study found that fee is correlated with attrition when accounting for percentage of weekly income. Researchers have not previously examined the fee as a percentage of income. The current research advances the literature by demonstrating that percentage of weekly income paid predicts therapy drop out, an important clinical implication for MFT training clinics. It is especially important in relation to symptom distress and relationship quality, as many clients presenting to therapy are facing relational and symptom distress, financial strain could play a large role in their ability to attend therapy. Improving therapy outcomes and

reducing attrition is an important clinical application for the psychotherapy field (Lambert, Harmon, Slade, Whipple, & Hawkins, 2004). Future psychotherapy research needs to continue examining the impact of fee on low-income clients and the factors leading to attrition in therapy.

An important clinical implication of this research study is the evaluation of sliding-scale fee structure in training clinics. As noted, if the fee charged to lower-income clients is more distressing than the therapy itself is worth, clients will drop out of therapy. As lower-income was found to be related to substance abuse, domestic violence, legal problems, and suicide attempts in participants' current families, we cannot ignore the stressors and adversities that increase as clients move closer to the poverty threshold. In addition to these elements, elements of relational distress are related to lower-income. Through the lens of Maslow's Hierarchy of Needs, these findings indicate a need for support for those living in low-income households. The high percentage of fee paid for those having more financial strain is no relief for these negative symptoms of both individual and relational distress. Is it worth it to attend a training clinic when the fee is creating high distress for the primary population served? Our study reveals that those living below the poverty threshold are paying significantly higher fee percentages and subsequently dropping out of therapy prior to their second session. Training clinics everywhere could consider these results to further examine and adjust their fee for services.

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Appendix

Table 1. *Demographic Information*

Length of Treatment	
Completed 4+ Sessions	280 (63.6%)
Completed 2 or 3 Sessions	89 (20.5%)
Completed 1 session	71 (15.9%)
Relationship Status	
In a committed relationship	122 (24.4%)
Married	377 (75.6%)
Average Household Income	
Under $5,000	42 (9.5%)
$5,001-10,000	29 (6.6%)
$10,001-15,000	41 (9.3%)
$15,001-20,000	49 (11.0%)
$20,001-25,000	35 (7.9%)
$25,001-30,000	31 (7.0%)
$30,001-35,000	42 (9.5%)
$35,001-40,000	47 (10.7%)
Over $40,000	125 (28.3%)

Table 2. *Demographic Information*

	Male	**Female**
Age		
18-25	26.9%	36.3%
26-35	48.1%	44.4%
36-45	16.7%	13.3%
46-55	6.0%	4.2%
55+	2.3%	1.8%
Race		
White	78%	75%
African American	14.4%	17.6%
Hispanic	1.3%	1.7%
Other	6.3%	5.7%
Education		
Did not complete high school	13.4%	10.6%
Completed High School	37.5%	47.2%
Completed Bachelor's Degree	49.1%	42.2%

Table 3. *Paired sample t-tests.*

	N	Mean		Mean Difference	*t*	*df*
		Males	Females			
OQ	466	60.59	67.52	-6.93	-5.53***	465
RDAS	457	41.22	37.94	3.28	7.66***	456
ACES	462	2	2.25	-.25	-2.32**	461
Age	479	31.82	29.91	1.919	7.6***	478
Education	468	5.88	6.16	-.278	-2.72***	467

Note: **p<.01, ***p<.001

Table 4. *Correlations Between All Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. male age	1	.144**	.302**	.806**	.044	.027	.126	-.013	.029	.002	.105*	-.027	.127**	-.06
2. male education	.144**	1	.298**	.053	.364**	-.080	-.125	.050	.000	-.110*	-.109*	.216**	-.050	.098
3. yearly income	.302**	.298**	1	.277**	.310**	-.089	-.171	-.023	.104*	-.082	-.026	.106*	.000	.01
4 .female age	.806**	.053	.277**	1	.064	.069	.189*	-.022	.080	.017	.150**	-.056	.072	-.07
5. female education	.044	.364**	.310**	.064	1	-.157**	-.148	.064	-.009	-.146**	-.103*	.253**	-.089	.172*
6. female OQ	.027	-.080	-.089	.069	-.157**	1	-.046	.018	-.016	.307**	.109*	-.478**	.315**	-.316*
7. fee percentage	.126	-.125	-.171	.189*	-.148	-.046	1	-.137	.189*	.044	-.149	-.053	-.027	.04
8. total sessions	-.013	.050	-.023	-.022	.064	.018	-.137	1	-.717**	.050	-.134**	.082	-.046	.05
9. dropout	.029	.000	.104*	.080	-.009	-.016	.189*	-.717**	1	-.076	.130**	-.058	-.020	-.04
10. female ACES	.002	-.110*	-.082	.017	-.146**	.307**	.044	.050	-.076	1	.202**	-.065	.118*	-.122*
11. male ACES	.105*	-.109*	-.026	.150**	-.103*	.109*	-.149	-.134**	.130**	.202**	1	-.069	.190**	-.092
12. female RDAS	-.027	.216**	.106*	-.056	.253**	-.478**	-.053	.082	-.058	-.065	-.069	1	-.308**	.597*
13. male OQ	.127**	-.050	.000	.072	-.089	.315**	-.027	-.046	-.020	.118*	.190**	-.308**	1	-.459*
14. male RDAS	-.060	.098*	.010	-.071	.172**	-.316**	.046	.054	-.046	-.122**	-.092*	.597**	-.459**	

Note: **p < .001, *p < .05

Table 5. *Male Variables Regressed onto Total Sessions*

	Model 1			Model 2			Model 3		
Variable	*B*	*SE*	β	*B*	*SE*	β	*B*	*SE*	β
Constant	1.58*	.92		1.90**	.90		1.59	1.4	
Age	.07**	.02	.28	.09***	.02	.34	.09***	.03	.35
Education	.10	.09	.11	.07	.09	.08	.04	.09	.04
Fee %				-.06**	.02	-.26	-.06**	.02	-.27
RDAS							.02	.02	.09
OQ							-.002	.01	-.02
ACES							-.11	.12	-.09
R^2		.093			.156			.172	
ΔR^2		.093			.063			.017	

Note. The dependent variable, total sessions, was capped at 6 sessions, so that the number of sessions completed was coded as 6 for any client attending 6 or more sessions. * $p < .10$, ** $p < .05$., *** $p < .001$

Table 6. *Females Variables Regressed onto Total Sessions*

	Model 1			Model 2			Model 3		
Variable	*B*	*SE*	β	*B*	*SE*	β	*B*	*SE*	β
Constant	2.95**	.93		3.32***	.93		1.72	1.62	
Age	.02	.02	.10	.04	.03	.15	.04*	.03	.18
Education	.11	.10	.11	.07	.10	.07	.01	.11	.01
Fee %				-.05**	.02	-.21	-.05*	.02	-.20
RDAS							.04	.02	.21
OQ							-.01	.01	.02
ACES							-.01	.11	-.01
R^2		.024			.064			.089	
ΔR^2		.024			.041			.025	

Note. The dependent variable, total sessions, was capped at 6 sessions, so that the number of sessions completed was coded as 6 for any client attending 6 or more sessions. *$p < .10$, **$p < .05$, ***$p < .01$.

Table 7. *Logistic Regression with Dropout as the Outcome Variable*

	Males			Females		
	B	*SE*	e^B	*B*	*SE*	e^B
Block 1:						
Age	-.05	.02	1.02	-.03	.04	.97
Education	.03	.07	.93	-.04	.14	.96
Constant	-1.81	.62	.16	-.57	1.34	.57
Block 2:						
Age	.003	.02	1	-.05	.04	.95
Education	-.08	.08	.92	.03	.15	1.03
Fee %	.07**	.03	1.08	.06**	.03	1.06
Constant	-1.21	1.12	.3	-1.25	1.40	.29

Note. The dependent variable, therapy dropout, is coded so that 1 = therapy dropout (clients attended only 1 session) and 0 = non dropout (clients attended 2 sessions or more). *$p < .10$, **$p < .05$, ***$p < .01$

Table 8. *Correlations between ACEs items and Income*

	Female ACES and Yearly Income	Male ACES and Yearly Income
Current Family Substance Abuse	-.054	-.093*
Family of Origin Substance Abuse	-.052	-.008
Current Family Violence	-.198**	-.214**
Family of Origin Violence	-.042	-.080
Current Family Sexual Abuse	-.054	-.023
Family of Origin Sexual Abuse	-.103*	.002
Current Family Emotional Abuse	-.105*	-.112*
Family of Origin Emotional Abuse	-.131**	.003
Current Family Mental Illness	-.085	-.052
Family of Origin Mental Illness	-.018	.109*
Current Family Legal Problems	-.086	-.150**
Family of Origin Legal Problems	-.058	-.076
Current Family Religious Practice	.079	.038
Family of Origin Religious Practice	-.071	-.033
Current Family Suicidality	-.123*	-.032
Family of Origin Suicidality	-.076	-.096*

Note: *$p < .05$, **$p < .01$

Table 9. *Correlation between RDAS items and income*

	Female RDAS and Income	Male RDAS and Income
religious matters	.004	-.01
demonstrations of affection	-.03	.06
making major decisions	-.08	-.09
sex relations	-.03	.06
conventionality	-.14**	-.12*
career decisions	-.09	-.11*
frequency of considering divorce	.13**	.06
frequency of quarrels	.13**	.08
regret that you married	.13**	.003
frequency of getting on each other's nerves	.12*	.10*
engage in outside interests together	.03	.03
stimulating exchange of ideas	-.01	-.14**
work together on a project	-.06	-.09
calmly discuss something	.08	.003

Note: *$p < .05$, **$p < .01$

Table 10. *Mean Comparison between those living 100% above and those living below the poverty threshold*

	t	df	Sig. (2-tailed)	Mean Difference
Fee Percentage	5.3	71	.000	10.5

Appendix of Measures

Demographic Information

Please provide the following personal information. If a question does not apply to you write NA for Not Applicable. All information is confidential.

1. Your age: _____ 2. Your Sex: _____

3. Your current relationship/marital status is:

A. Single/Never Married B. Married C. Divorced D. Separated

E. Widowed F. Significant Other—Heterosexual G. Significant Other—Homosexual H. Significant Other—Bisexual

4. If you are married or living together, how long have you been with your current partner? _____.

5. If you have children, please provide the following information. Use the back of this page if more space is needed.

Child	Sex	Age	Race	Name	Stepchild, adopted, biological	Who does this child live with?		
1st	M F	___	_____	_____	_____	You	Other parent/ guardian	On their own
2nd	M F	___	_____	_____	_____	You	Other parent/ guardian	On their own
3rd	M F	___	_____	_____	_____	You	Other parent/ guardian	On their own

6. What is your racial/ethnic group? _____ (Please Specify)

7. What is your current occupation? _____ (Please Specify)

8. What is the highest level of education you attained?

A. Grade School B. Junior High School C. GED

D. High School E. Vocational/Technical School F. Associate Degree/2 years

G. Bachelor degree H. Master's degree I. Other _ (Specify)

9. Your yearly income is: (Please indicate your combined income with your partner)

A. Under $5,000 B. $5,000 to $10,000 C. $10,001 to $15,000

D. $15,001 to $20,000 E. $20,001 to $25,000 F. $25,001 to $30,000

G. $30,001 to $35,000 H. $35,001 to $40,000 I. Over $40,001

10. What is your current religious/spiritual preference? _____

11. Do you have current or previous experiences with counseling or therapy? YES NO

12. List any current physical health problems _____

13. List any medication you are currently taking _____

Relationship Dyadic Adjustment Scale

Most persons have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

	Always agree	Almost Always Agree	Occasionally Agree	Frequently Disagree	Almost Always Disagree	Always Disagree
1. Religious matters	____	____	____	____	____	
2. Demonstrations of affection	____	____	____	____	____	
3. Making major decisions	____	____	____	____	____	
4. Sex relations	____	____	____	____	____	
5. Conventionality-correct/proper behavior	____	____	____	____	____	____
6. Career decisions	____	____	____	____	____	

	All the time	Most of the time	More often than not	Occa-sionally	Rarely	Never
7. How often do you discuss or have you considered divorce, separation, or terminating your relationship?	____	____	____	____	____	____
8. How often do you and your partner quarrel?	____	____	____	____		
9. Do you ever regret that you married (or live together)?	____	____	____	____		____
10. How often do you and your mate "get on each other's nerves"?	____	____	____	____		____

	Every Day	Almost Every Day	Occasionally	Rarely	Never
11. Do you and your mate engage in outside interests together?	____	____	____	____	____

How often would you say the following events occur between you and your mate?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
12. Have a stimulating exchange of ideas	____	____	____	____		
13. Work together on a project	____	____	____	____		____
14. Calmly discuss something	____	____	____	____	____	

Outcome Questionnaire

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name:_____ Age:__ yrs.

Sex

ID# ___ _____ MD FD

(Session #_____ Date / /

	Never	Rarely	Sometimes	Frequently	Always
1. I get along well with others.	04	03	02	01	00
2. I tire quickly.	00	01	02	03	04
3. I feel no interest in things.	00	01	02	03	04
4. I feel stressed at work/school.	00	01	02	03	04
5. I blame myself for things.	00	01	02	03	04
6. I feel irritated.	00	01	02	03	04
7. I feel unhappy in my marriage/significant relationship.	00	01	02	03	04
8. I have thoughts of ending my life.	00	01	02	03	04
9. I feel weak.	00	01	02	03	04
10. I feel fearful.	00	01	02	03	04
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	00	01	02	03	04
12. I find my work/school satisfying.	04	03	02	01	00
13. I am a happy person.	04	03	02	01	00
14. I work/study too much.	00	01	02	03	04
15. I feel worthless.	00	01	02	03	04
16. I am concerned about family troubles.	00	01	02	03	04
17. I have an unfulfilling sex life.	00	01	02	03	04
18. I feel lonely.	00	01	02	03	04
19. I have frequent arguments.	00	01	02	03	04
20. I feel loved and wanted.	00	01	02	03	04
21. I enjoy my spare time.	04	03	02	01	00
22. I have difficulty concentrating.	00	01	02	03	04
23. I feel hopeless about the future.	00	01	02	03	04
24. I like myself.	04	03	02	01	00
25. Disturbing thoughts come into my mind that I cannot get rid of.	00	01	02	03	04
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	00	01	02	03	04
27. I have an upset stomach.	00	01	02	03	04
28. I am not working/studying as well as I used to.	00	01	02	03	04
29. My heart pounds too much.	00	01	02	03	04
30. I have trouble getting along with friends and close acquaintances.	00	01	02	03	04
31. I am satisfied with my life.	04	03	02	01	00
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	00	01	02	03	04
33. I feel that something bad is going to happen.	00	01	02	03	04
34. I have sore muscles.	00	01	02	03	04
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	00	01	02	03	04
36. I feel nervous.	00	01	02	03	04
37. I feel my love relationships are full and complete.	04	03	02	01	00
38. I feel that I am not doing well at work/school.	00	01	02	03	04
39. I have too many disagreements at work/school.	00	01	02	03	04
40. I feel something is wrong with my mind.	00	01	02	03	04
41. I have trouble falling asleep or staying asleep.	00	01	02	03	04
42. I feel blue.	00	01	02	03	04
43. I am satisfied with my relationships with others.	04	03	02	01	00
44. I feel angry enough at work/school to do something I might regret.	00	01	02	03	04
45. I have headaches.	00	01	02	03	04

SD IR SR

+ +

Total

Adverse Childhood Experiences Score

14. Please answer questions for the **family in which you now live** and the **family in which you grew up**.

In your family were/are there problems with	In the family in which you now live		In the family in which you grew up	
A. Alcohol, drug substance, or prescription abuse	YES	NO	YES	NO
B. Physical abuse or violence	YES	NO	YES	NO
C. Sexual abuse	YES	NO	YES	NO
D. Emotional abuse	YES	NO	YES	NO
E. Mental illness	YES	NO	YES	NO
F. Trouble with the law	YES	NO	YES	NO
G. Religious/spiritual practice	YES	NO	YES	NO
H. Suicide/attempted suicide	YES	NO	YES	NO