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EARLY PSYCHOTHERAPY DROPOUT

CHARACTERISTICS AT TIME OF INTAKE AND FOLLOW-UP

by

Mary Catherine Moore

A Dissertation

Submitted to the Faculty of the Graduate School

of Loyola University of Chicago in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy in Psychology

April 1984

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VITA

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INTRODUCTION

Premature psychotherapy termination, or psychotherapy dropout, has become a phenomenon of increasing importance in the psychotherapy research literature. Studies of dropout in general psychiatric clinics indicate that 20-57% of patients fail to return for further treatment after their first visit, and 31-56% attend no more than four sessions (Baekeland & Lundwall, 1975). Studies of community mental health centers typically report dropout rates of 37-45% after the first or second session (Fiester & Rudestam, 1975). Garfield (1978) indicated in his review that a majority of clinics lose 50% of their clients prior to the eighth session, while the median length of treatment in the clinics included in his review varied from 3-12 sessions.

These statistics are considered to be problematic for several reasons. Dropouts usually are considered to represent treatment failure, with the assumption that the patient was not helped by the treatment and that the patient will get worse after dropping out of treatment (Baekeland & Lundwall,1975). These assumptions are supported in some research, such as studies indicating that patients who drop out of treatment are judged to be in need of further intervention (Fiester, Mahrer, Giambra, & Ormiston, 1974) and do not get further treatment elsewhere (Fiester & Rudestam, 1975); and challenged in other studies, such as those indicating that for patients, early terminations reflect the success of a mental health center rather than the failure perceived by

therapists and administrators (Littlepage, Kosloski, Schnelle, McNees, & Gendrick, 1976).

In addition to the concern with the welfare of dropouts, researchers have begun to investigate therapist and clinic variables which contribute to high dropout rates, questionning whether services offered are of high quality (e.g., Silverman & Beech, 1979). One consistent conclusion of dropout studies, that the lower socioeconomic classes are represented in large numbers in dropout rates, has generated a good deal of concern, given that community mental health centers are mandated to provide services to this group (Fiester & Rudestam, 1975).

Finally, many clinics report long waiting lists and limited manpower, generating a concern with increasing the cost-effectiveness of services by rapidly screening out patients who are not likely to complete the treatment process (Baekeland & Lundwall, 1975; Heilbrun,1974). Given the assumption of therapeutic failure, therapists and administrators are troubled by the time and energy spent on dropouts which produce no evident positive results (Kelner, 1982).

It is evident from the above statistics that psychotherapy dropout is a phenomenon in need of further study. Based on their review of the literature, Baekeland and Lundwall (1975) identify four critical research questions to be considered when studying psychotherapy dropout: 1) What are the characteristics of the dropout, i.e. can it be predicted who will drop out of treatment? 2) What are the patient variables related to dropping out of treatment as opposed to variables related to the treatment setting, type of treatment, and therapist ability or style? 3) What is the fate of the dropout, i.e. is the dropout necessarily a treatment failure? and, 4) How can the dropout problem be solved?

The proposed study will attempt to answer two of the questions proposed by Baekeland and Lundwall (1975), namely, identification of the characteristics of the early dropout and the use of follow-up research to determine the fate of the early dropout from psychotherapy.

LITERATURE REVIEW

The following review will focus on two aspects of the psychotherapy dropout literature, namely, characteristics of the dropout patient and follow-up studies of dropouts. Attention will be given to the methodological difficulties involved in conducting research with this population.

Characteristics of the Psychotherapy Dropout

Methodological Considerations

An important methodological consideration in the study of psychotherapy dropout is the manner in which dropout is defined. The most common method of definition is a length of stay criterion; that is, dropouts are defined according to the number of sessions attended, with a cutoff point ranging from 3 to 10 sessions (Baekeland & Lundwall, 1975). The cutoff point often is chosen according to a subjective criterion, such as therapists' expectations of the number of sessions needed to effect positive treatment gains, and occasionally is chosen according to the median number of sessions at the particular facility under study (Baekeland & Lundwall, 1975).

A second strategy defines dropouts and remainers by excluding a middle range of visits from 13 to 21 sessions, dropouts attending less than 13 sessions and remainers attending more than 21 sessions (Baekeland & Lundwall, 1975). The rationale for this approach is twofold:

one, the middle zone has been called a failure zone, since some studies have shown a sharp drop in the correlation between measures of outcome and number of sessions during this interval (Cartwright,1955). Two, it is theorized that differences between dropouts and remainers will be detected more easily the greater the differences in number of sessions between them (Baekeland & Lundwall, 1975).

A third strategy involves defining dropouts as those who fail to appear for scheduled appointments and thereby withdraw from further treatment, regardless of the number of sessions attended (e.g., Fiester et al, 1974), and those patients who withdraw from treatment without therapist consent or approval. As Baekeland and Lundwall (1975) point out, this approach includes two types of dropouts: those who fail to return and those who refuse to return.

All of the above methods have drawn criticism. The use of number of sessions alone to define dropout has been criticized as imprecise, as it varies from study to study (Baekeland & Lundwall 1975); as misleading, given the confusing and conflicting findings from studies investigating the relationship between length of stay in psychotherapy and outcome of psychotherapy (e.g., Garfield, 1978; Luborsky, Singer, & Luborsky, 1975; Rosenthal & Frank,1958); and as value laden, since therapists and patients estimates of the amount of time necessary for treatment to be effective have been found to differ greatly (e.g., Silverman & Beech, 1979).

Exclusion of the middle zone of sessions to define dropouts and remainers can be criticized on all of the above grounds. In addition, this strategy appears impractical for many outpatient clinics, since the

majority of patients may have been terminated as early as the fifth session (Baekeland & Lundwall, 1975), and only a small proportion may remain long enough to be classified as nondropouts.

Unilateral termination, or patient termination without the knowledge or agreement of the therapist has drawn criticism as a method of defining psychotherapy dropout. Silverman and Beech (1979) view unilateral termination as a therapist rather than a patient concern, and argue that equating unilateral termination with treatment failure is not valid. Support for their view is provided by follow-up studies indicating that dropouts report being helped by a single interview (e.g., Bergin & Lambert, 1978; Fiester & Rudestam, 1975; Gottman & Markman, 1978) even if they do not return for further treatment. In addition, the therapists' view of patients who drop out of therapy, regardless of the number of sessions, as unfinished and in need of further treatment, is being questioned. Fiester and Rudestam (1975) have gone as far as to suggest that this therapist view may well result from feelings of having been rejected by the patient, not to mention the common training and theoretical biases toward longer term treatment and ambitious treatment goals.

It is clear that the issue of unilateral termination as a criterion for defining dropouts is complicated and most likely includes explanations other than treatment failure (Silverman & Beech, 1979). It is also evident that the length of stay criterion used in defining psychotherapy dropouts is in need of clarification. In the following section, the literature on length of stay in psychotherapy with regard to outcome will be briefly reviewed which should be considered in the definition of "dropout".

Length of Stay and Outcome of Psychotherapy

In one of the earlier large scale studies of the effects of psychotherapy, Rosenthal and Frank (1958) found that of those patients discharged as improved in treatment, 32.5% had attended no more than five sessions and more than half of those improved had attended no more than 10 sessions. Gorkin (1978) defined dropouts as attending one to seven sessions, and remainers as attending more than 24 sessions in his study of psychotherapy dropout. At the time of follow-up, 32% of the dropout sample said that they felt better after coming to the psychiatric clinic. His findings are very similar to those of Rosenthal and Frank (1958) but were used to support the view that dropouts, defined according to length of stay, are treatment failures.

In a review of the literature, Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) concluded that the longer patients remain in psychotherapy, the more likely they are to achieve positive therapeutic outcomes. However, in some studies, the positive correlation between number of sessions and positive outcome has been shown to break down with prolonged treatment. For example, Cartwright (1955) identified the failure zone from 13 to 21 interviews, during which time the correlation between outcome and number of sessions diminished, while Rosenthal and Frank (1958) found a pattern of strong positive correlation in the interval from one to five sessions, and in the interval from 11 to 20 sessions, but diminished returns in the intervals 6 to 10 sessions and more than 20 sessions.

Fiester and Rudestam (1975), in a multivariate study of early dropouts (i.e., unilateral termination following one or two sessions),

identified a sizable number of dropouts who reported receiving benefit from their brief contact, and who reportedly did not drop out of treatment because of treatment dissatisfaction. They conclude that there is no direct relationship between the length of treatment and patient improvement. In their study, the majority of dropouts reported the session to be successful and effective, which supports the idea that a subgroup of patients exists for whom brief contact satisfies treatment expectations and needs (Fiester & Rudestam, 1975). These findings were supported in a second study (Fiester, 1977).

Other studies of the relationship between treatment length and improvement show conflicting findings. Baekeland and Lundwall (1975) summarized the findings in their review of 20 studies: 10 studies found positive relationships between number of sessions and outcome, and 10 found no relationship between time in treatment and outcome. They offer the following explanation for these conflicting findings: "it seems clear that different problems may respond to treatment at different rates, so that the implications of dropping out of treatment will vary according to the symptom or problem at issue" (p. 744).

Baekeland and Lundwall (1975) also suggest that the early dropouts may have a different idea of the nature of their problems, and may leave treatment when their goals are accomplished, even though their therapist may view treatment as unfinished. Discussing studies of the failure zone in psychotherapy and studies of the nature of change in treatment for various types of problems, they conclude:

> Patients with acute situational problems may derive little benefit from extended treatment and may resist it by dropping out after they have gotten from it what they wanted in the first place, that is, symptomatic relief and support during the resolution of an acute life problem (p.744).

This conclusion is supported in a study by Johansson, Silverberg, and Lilly (1980). In their study, the average client expected to come in only for about three sessions, and the mean length of stay for the sample was 5.6 sessions. There was a strong positive correlation between improvement and number of sessions. However, the number of sessions was very small. The mean for the improved group was 4.78 and the mean for the unimproved group was 1.54 sessions. In many studies, almost all of the improved group would have been classified as dropouts according to the length of stay criterion. An intriguing finding in this study is that therapists felt dissatisfied with treatment outcome of clients who dropped out of treatment, while the dropouts themselves rated their satisfaction with therapy highly at the time of followup (Johansson, Silverberg & Lilly, 1980).

It is evident from the above studies that the relationship between number of sessions and positive outcome of psychotherapy is not a simple linear relationship, and that many factors are operative in the process of psychotherapy which complicate any attempts to define dropouts by length of stay alone. Some of the studies cited above indicate the importance of patient expectations in determining the length and outcome of psychotherapy. Others highlight the often disparate perceptions of therapists regarding the ideal length of treatment and the extent to which clients achieve therapist defined treatment goals.

The most promising approach to the definition of psychotherapy dropout appears to be a focus on the early dropout rather than on patients who drop out unilaterally at other stages of treatment. Along these lines, Baekeland and Lundwall (1975) propose that dropouts be de-

fined in three groups: (1) immediate dropout, following one visit; (2) rapid dropout, following one month of treatment; and (3) slow dropout between two and six months of treatment. Some empirical support for this definition is provided in a study of dropout by Fiester, Mahrer, Giambra, and Ormiston (1974). In their study, dropout patients were defined as those who failed to appear for scheduled appointments, regardless of the number of previous sessions and who thereby withdrew from further treatment. Nondropouts included patients whose treatment was terminated without the need for referral. The patient sample was subdivided further using the median number of sessions, three, to establish four groups: (1) dropouts with one or two sessions; (2) dropouts with three or more sessions; (3) nondropouts with one or two sessions; and (4) nondropouts with three or more sessions. In their study, the number of patients fitting the nondropout, one or two session category was small, and was omitted from analyses.

Some experimental support was provided for the above classification when the dropout and nondropout groups were compared on demographic and clinical variables. The early dropout group differed from the later dropout group, which was found to be identical to the nondropout group. The authors proposed a critical stage, occuring during the first one or two sessions. Patients who remain past the critical stage represent a homogeneous group on demographic variables while early dropouts have a unique set of characteristics (Fiester et al, 1974).

Early Dropout Characteristics

Rosenthal and Frank (1958) used the following classification in their study of psychotherapy dropout: treatment rejectors were defined as those who attended intake only, and refused treatment when it became available; treatment remainers included those patients who attended six or more sessions. No significant differences were found in sex, age, and diagnostic categories between remainers and rejectors. Social class and source of referral did differ between the two groups. Patients of the lowest income and education levels were the most likely to refuse psychotherapy, and patients who were referred by a social agency were the least likely to continue in treatment.

Patients who were referred by a psychiatrist or a psychiatric facility were the least likely to refuse therapy; the refusal rate was about the same for self-referred patients and patients referred from medical sources. Patients defined as remainers had more education and a higher income than rejectors and whites were more likely than blacks to remain in treatment. Males were more likely to remain in treatment (Rosenthal & Frank, 1958).

Variables related to either rejecting or remaining in treatment, then, were race, education, income, and source of referral.

Sullivan, Miller, and Smelser (1958) defined dropouts and remainers by using the median number of visits in their sample, nine interviews. In their study, remainers were higher on education and occupation than dropouts. On the MMPI subscales, remainers were higher on social status, ego strength, a repression measure, an intellectual efficiency measure, and the K scale. They concluded that remainers are more

educated, better integrated in life pursuits, and able to maintain their defenses against stress. Dropouts were higher on MMPI factor A, measuring anxiety and general maladjustment, and on MMPI Pa; this finding was interpreted to show greater maladjustment in the dropout group (Sullivan, Miller, & Smelser, 1958).

When the authors attempted to cross validate the differences between dropouts and remainers, none of the findings on the MMPI measures could be replicated. Education and occupation, however, were confirmed as variables which differentiated the two groups.

The same sample was then divided into improved and not improved patients using therapist ratings. The improved group held better positions, were employed in capacities more closely related to their level of education, and were much less disturbed on MMPI scales than the unimproved group (Sullivan, Miller, & Smelser, 1958). The authors conclude: "...those persons who are least equipped to meet life challanges are the ones who stand to gain the least from psychotherapy" (Sullivan, Miller, & Smelser, 1958, p. 7). In addition, these people were shown to be more likely to drop out of psychotherapy in their study. Because the outcome ratings were made by the therapists alone, the authors were unsure as to whether there might be some systematic bias operating on the part of the therapists leading them to rate patients of lower class or patients who drop out as less improved (Sullivan, Miller, & Smelser, 1958).

In a study by Johansson, Silverberg, and Lilly (1980), no differences were found between remainers (mutual termination) and dropouts (unilateral termination) on socioeconomic variables. Clients defined as remainers had higher degrees of discomfort than dropouts, measured by

the Hopkins Symptom Checklist (HSCL) overall score, somatization score, obsessive compulsive score, and target problem severity. Anxiety and depression scores on the HSCL did not differ between dropouts and remainers.

Gorkin (1978) defined dropouts as those patients attending between one and seven sessions and remainers as attending more than 24 sessions. Three variables were found to distinguish between dropouts and remainers. Children whose parents were in concurrent treatment were more likely to remain in treatment. Those who received a combination of individual and group therapy were most likely to remain, followed by individual, group, couple, and family therapy. Those who were self-referred as opposed to referral by others were more likely to remain in therapy (Gorkin, 1978).

Fiester, Mahrer, Giambra, and Ormiston (1974) used unilateral termination and length of stay to define dropouts in their study, forming four groups: dropouts with one or two sessions, dropouts with three or more sessions, nondropouts with one or two sessions, and nondropouts with three or more sessions. The nondropout, one or two sessions group was eliminated from analyses due to small size. In this study, dropouts with one or two sessions differed from dropouts with three or more sessions on the following variables: less previous clinic experience, less previous psychiatric care, smaller incidence of hostile acting out, greater incidence of phobias and compulsions as the primary reason for referral, and lower incidence of being judged in need of further care at the time of case closing. The comparisons were performed on 63 variables; the significant findings on the above variables were cross validated on a separate, randomly selected sample.

The dropout groups differed from the nondropout group on only one major variable, the judgement that further care is required. In addition, more nondropouts had received previous care at the clinic under study, and had received psychiatric care at other facilities prior to the current episode of care.

Dropouts did not differ from nondropouts on demographic variables. Furthermore, it was discovered that dropouts following three or more sessions were identical to nondropouts in this study. The early dropouts differed from patients attending three or more sessions by having less previous clinic contact, less previous psychiatric care, and a greater incidence of being judged in need of further care (Fiester et al, 1974).

These results were confirmed in part in a study by Monti (1978). In her study, individuals with previous inpatient treatment stayed in therapy longer than those without previous treatment. Patients of higher education and occupation levels were more likely to remain in therapy than those with lower schooling and occupation. In addition, white, English speaking patients were more likely to remain in therapy than Hispanic patients (Monti, 1978).

Kahn and Heiman (1978), in a study of a mental health center with a large Mexican-American population, found that white males were more likely to be seen for more than one session than Mexican-Americans. Age, marital status, source of referral, medication, type of problem, and therapist estimates of improvement all differentiated dropouts following one session from clients attending three or more sessions. More individuals in the age group 25-45 were in the remainer group than

younger and older clients. More divorced women were in the remainer group than were in the dropout group. Self-referred individuals were more likely to remain compared to those referred by physicians. Patients receiving medication were less likely to drop out. Dropouts were more likely to have problems related to general social and financial situation while remainers were more likely to have specific psychological problems, such as anxiety, depression, and family difficulties. Similar to other studies, therapists were more likely to rate remainers as improved as opposed to dropouts (Kahn & Heiman, 1978).

In a study of absenteeism and dropout at a community mental health center, Kosloski, Schnelle, and Littlepage (1977) found no significant relationship between dropout and the following client characteristics: marital status, number of children, income, previous psychiatric care, religious affiliation, employment status, family member present at intake, length of wait for intake, and length of wait for therapy. They concluded that absenteeism and dropout are not limited to a subgroup with unique characteristics; rather, they concluded that absenteeism and dropout occur in general throughout the clinic population (Kosloski, Schnelle, & Littlepage, 1977).

Summary of Patient Characteristics Related to Dropout

In the above studies, a number of variables were shown to distinguish between dropouts and remainers in psychotherapy: education, income, occupation, race, age, and referral source. Level of education was lower for dropouts than for remainers in four studies, but did not differ in dropouts or remainers in two studies. Level of income was

lower for dropouts than remainers in two studies, but in three studies income was not a significant predictor of dropout. Type of occupation differed between dropouts and remainers in two studies, dropouts being more likely to have lower status occupations than remainers, although this variable was not significant in a third study. Race was predictive of dropping out in three studies, Blacks and Hispanics being more likely to drop out than whites, but was nonsignificant in two studies. Age and sex were not predictive of dropping out in two studies. In one study, age was predictive of dropping out.

In three out of three studies, source of referral was found to predict dropping out or remaining in treatment. Patients who are self-referred or referred by a psychiatrist or psychiatric facility are more likely to remain in therapy than patients who are referred by a social service agency, a medical facility, or a medical doctor. The following variables failed to distinguish between dropouts and remainers in at least one study: number of children, diagnosis, religion, length of wait for intake and length of wait for therapy. Type of treatment, medication, and presenting problem severity were all found to be related to remaining in treatment in at least one study.

Several clinical variables were reported to distinguish between dropouts and remainers in more than one study. The type of symptom presented by a patient was different in dropouts and remainers in four out of four studies. Patients with previous psychiatric history were more likely to remain in therapy than to drop out in two studies, though this variable was not significant in one study. Three variables were found to be important in predicting dropout in at least one study: previous

treatment at the clinic under study, need for further treatment as rated by therapists at the time of closing, and type of psychotherapy.

In a review of studies of patient characteristics predicting dropout from adult outpatient clinics, Baekeland and Lundwall (1975) found 63 out of 65 studies identified variables which distinguished between dropouts and remainers. Variables identified in their review as predictive of dropout include: demographic variables, i.e. age, sex, source of referral, socioeconomic status and affiliation; clinical variables, i.e. diagnosis, symptoms, motivation, defense mechanisms and dependency needs; and a variety of therapist and patient-therapist match variables.

Baekeland and Lundwall (1975) conclude from their review that younger patients are more likely to drop out of brief therapy, and that patients in the age interval 30-39 years are most likely to stay in longer-term therapy; patients who are self-referred are less likely to drop out than those referred by hospitals or institutions; female patients are more likely to drop out than male patients; socioeconomic status is highly predictive of dropping out, indicated by education, occupation, and income; race is predictive of dropping out; and patients who have no affiliations are more likely to drop out of treatment than those who belong to groups, organizations, or have close family ties.

Interestingly Baekeland and Lundwall (1975) report that the predictive value of socioeconomic status in determining treatment dropout held only in studies of institutions favoring a psychoanalytically oriented approach to psychotherapy. In these facilities, lower class patients were most likely to drop out of treatment. In the studies reviewed by Baekeland and Lundwall (1975), no relationship was found

between social class or race and length of stay in non-analytic clinics. However, two of the studies reviewed above did find a significant relationship between dropping out of treatment, race, and socioeconomic factors in facilities not described as psychoanalytic in orientation (Kahn & Heiman, 1978; Monti, 1978). In fact, one of the investigators was puzzled by finding race to be predictive of dropout, since the particular clinic under study was described as oriented toward delivery of services to the Mexican-American population and as having some Mexican-Americans on staff (Kahn & Heiman, 1978). Despite this description, whites were remaining in treatment in higher proportions than Mexican-Americans. Other reviewers have also stated that lower socioeconomic class patients contribute to dropout rates in a disproportionate amount (e.g., Fiester & Rudestam, 1975), without reference to the psychoanalytic therapeutic orientation.

In nine studies of diagnosis and length of stay reviewed by Baekeland and Lundwall (1975), four found diagnosis to be related to dropout. In the remaining five, the following symptoms were related to dropping out of psychotherapy: low level of anxiety or depression, paranoid symptoms, sociopathic features, and alcoholism. In contrast to these studies, Johansson, Silverberg and Lilly (1980) found no relationship between anxiety, depression, and dropping out of treatment; Sullivan, Miller, and Smelser (1958) found that dropouts were higher on anxiety scales than remainers.

Baekeland and Lundwall (1975) offered an explanation for these conflicting findings, stating that the relationship between anxiety, depression and dropping out of treatment is not simple. They suggested

that the more severely depressed patient is likely to drop out of treatment initially due to low energy, pessimism and feelings of hostility, but that as levels of depression and anxiety decrease, he is also likely to abandon treatment. It appears that there may be two points, then, at which these symptoms are predictive of dropout: the early stage, during which the patient is being engaged in treatment, and the middle range of number of sessions, during which time symptomatic relief begins to occur.

A variety of psychological test findings have been related to dropping out of psychotherapy. Studies using the Rorschach have found dropouts to be more defensive, to have limited verbal productivity, to censor emotions, and to avoid expressing thoughts about people (Baekeland & Lundwall, 1975). Baekeland and Lundwall (1975) caution, however, that the lack of verbal productivity may be related to lower socioeconomic status in dropouts, rather than psychological factors.

Sullivan, Miller, and Smelser's (1958) study found that dropouts were higher on MMPI factor A, measuring anxiety and general maladjustment, and on MMPI Pa and they conclude that dropouts are more maladjusted and defensive than remainers. As indicated in the above review, however, these findings could not be replicated. Johansson, Silverberg, and Lilly (1980) found remainers to have higher degrees of discomfort, higher somatization scores, and higher obsessive compulsive scores than dropouts, measured with the Hopkins Symptom Checklist.

Other psychological variables found to be associated with dropping out of treatment in Baekeland and Lundwall's (1975) review include less psychological-mindedness, less suggestibility, high need for approval, less self-disclosure, and counterdependence.

Clinic, Therapist, and Patient-Therapist Factors

Fiester and Rudestam (1975) complain:

> research on the dropout phenomenon has focused almost exclusively on patient input variables...no attempt has been made to investigate the joint interaction of patient input, therapist input, and therapy process as related to the outcome of early psychotherapy termination (pp. 528-529).

Similarly, Meltzoff and Kornreich (1971) state that to approach the problem of premature termination in a more sophisticated way would mean exploring the therapist and treatment situation to which the patient may be responding. Baekeland and Lundwall (1975) also indicate that studies of psychotherapy dropout have emphasized demographic, symptomatic, and personality factors of the patient rather than extrapatient factors.

Clinic Variables

Among the clinic variables which could be related to dropout are a facility's staffing patterns, admission procedures, and treatment methods, the length of wait to begin evaluation and treatment, and the process of case assignment. Baekeland and Lundwall (1975) report that in most studies, no information is given about most of these variables. In one of the few dropout studies to include any clinic variables, Kosloski, Schnelle, and Littlepage (1977) found no relationship between length of wait for intake and length of wait for therapy and dropping out of treatment. Baekeland and Lundwall (1975), on the other hand, found three studies in which delay in assigning a patient to a therapist was associated with dropping out of treatment.

Kahn and Heiman (1978) included concurrent use of psychoactive medication and contact with the clinic between sessions as variables in

their study of dropout; both were found to be related to remaining in treatment. Similarly, Baekeland and Lundwall (1975) indicate that for lower class patients, giving medication is associated with remaining in treatment. They emphasize the importance of providing such patients with a form of treatment which agrees with their expectations and which offers rapid symptomatic relief (Baekeland & Lundwall, 1975).

Therapist Variables

More studies are available in which therapist level of experience is related to dropping out of treatment. In Baekeland and Lundwall's (1975) review, six of the seven studies which examined this variable found a strong positive relationship between therapist experience and length of stay. Sullivan, Miller, and Smelser (1958) report a trend for experienced therapists to keep patients in treatment longer, and to rate higher improvement in patients, but this finding was not significant. In their study, more experienced therapists tended to be assigned patients with better prognosis, indicated by higher educational and occupational standing. When the results were analyzed according to low-high education group by inexperienced-experienced therapist, the low education group had equally good or bad outcome regardless of therapist experience. The findings, then, had less to do with therapist experience than with the good prognosis of the patients seen by experienced therapists. Saltzman, Luetgert, Roth, Creaser, and Howard (1976) found no differences in patient length of stay as a function of therapist experience level.

Research on the therapist experience variable has been criticized by Auerbach and Johnson (1977). They point out that most studies use therapist populations that are inexperienced, comparing, for example, first year psychology students to peers only several years ahead of them. In addition, they suggest that too little is known of the relationship between therapeutic experience and criterion variables such as length of stay to make meaningful comparisons; for example, it is unclear where the cutoff point should be for number of years of experience in defining a group of experienced therapists. If the relationship between therapist experience and criterion variables was nonlinear they point out that the choice of a cutoff point could obscure any real differences (Auerbach & Johnson, 1977). In addition, dichotomizing the variables reduces the power of the statistical tests used to detect differences. Those studies which are available have conflicting results.

Several studies have investigated the influence of therapist attitudes and personality traits on dropout from psychotherapy. Baekeland and Lundwall (1975) suggest that therapists' attitudes toward their patients help determine whether patients will remain in treatment. They offer as an example the finding that higher class, younger, white female patients are more likely than others to be seen more often by an experienced therapist. The implication is that therapists feel more comfortable with this type of patient, and perhaps expect a higher degree of constuctive change. Therapists who dislike their patients or who are not interested in the type of problem presented are more likely to lose them. Similarly, therapists rated high on ethnocentricity (i.e., feeling that one's own group is superior) saw patients fewer times than therapists rated low on ethnocentricity (Baekeland & Lundwall, 1975).

Several studies have looked at patient and therapist gender as variables which are related to length of stay and dropout. Male therapists are more likely to lose their patients (Hiler, 1958; McNair, Lorr, Young, Roth, & Boyd, 1964). Betz and Schullman (1979), in a study of dropouts from a university counseling center, also found that clients, regardless of sex, were less likely to return when the intake counselor was male than when the intake counselor was female, and even less likely to return when a male intake counselor referred a client to a male assigned therapist. In their study, intake counselor experience level (defined in two categories, more than three years of experience and less than three years of experience) and type of referral (referral to same therapist as seen at intake or different therapist) were not related to client return rate following intake. As pointed out above, dichotomizing the experience variable in this way reduces the power of the statistical test used. This could account for the lack of significant results.

Krauskopf, Baumgardner, and Mandracchia (1981) attempted to replicate the above findings in a different setting. In their study, the return rates of clients to female or male intake counselors differed in the same direction as the Betz and Schullman (1979) study, but the results were not statistically significant. There were no differences in client return rate if the assigned therapist was male or female, nor if the intake counselor was experienced or inexperienced (Krauskopf et al, 1981). Epperson (1981) also tried to replicate the findings of the Betz and Schullman (1979) study. In his study, male counselors had significantly higher return rates than female counselors, regardless of the sex

of the clients, the experience of the counselor, the presenting problems of the clients or the severity of these problems. This finding is exactly opposite the findings of Betz and Schullman (1979).

Both Epperson (1981) and Krauskopf et al (1981) conclude that the utility of counselor gender as an independent variable in research on dropout is questionnable. Epperson (1981) suggests that this line of research would be more relevant if male and female counselors for whom differences in outcome have been documented were studied, rather than male and female counselors in general. It seems likely that the differences in attrition rates have more to do with variables other than counselor sex alone, such as clients' perceptions of therapists, therapists' attitudes, and client- therapist interaction variables.

Patient-Therapist Interaction Variables

Therapist-patient gender matching as a variable related to length of stay has also been studied. In some studies, opposite sex dyads were reported to have shorter length of stay than same sex dyads (Mendelsohn & Geller, 1967; Reiss, 1973). Saltzman, Luetgert, Roth, Creaser, and Howard (1976), in contrast, found that patient and therapist gender similarity was not related to length of stay. Abramovitz, Abramovitz, Jackson, and Roback (1973) reported a tendency for male therapists to see female patients for more sessions than female therapists to see male patients.

Berzins (1977) and Garfield (1978) both conclude in their reviews that patient and therapist gender are not related to continuation in psychotherapy as main effects. They suggest, however that the interac-

tion of patient and therapist gender may be related to length of stay but has not been tested adequately.

Other studies of the relationship between patient-therapist similarity and continuation in psychotherapy have investigated the variables age (Karasu, Stein, & Charles, 1979), 1979), race (Ewing, 1974; Jones, 1978), social class (Carkhuff & Pierce, 1967) and similarity index (Mendelsohn, 1966). In a study of depressed patients, patients were more likely to remain in therapy the closer the age of therapist and patient (Karasu et al, 1979). No significant differences were found in length of stay between four groups of therapist-patient racial pairings (Ewing 1974; Jones, 1978). The study of social class matching is related only marginally to dropout. Carkhuff and Pierce (1967) found that the patient-therapist dyads most similar on race and social class had the greatest depth of self-exploration, a variable thought to be related to successful psychotherapy. Berzins (1977) suggests that this variable be more thoroughly explored in relation to length of stay in psychotherapy.

In one study of the relationship between degree of patient-therapist similarity and continuation in therapy, it was found that low patient-therapist similarity was associated with short length of stay (Mendelsohn, 1966). Berzins (1977) and Parloff, Waskow, and Wolfe (1978) commented that similarity indices may be a promising approach to the study of psychotherapy dropout, but in general have not been tested adequately.

In a study by Goodsitt (1981), patients and therapists were matched on sex, age, marital status, parental status, religious background, social class background, education, birth order, and family size

to arrive at a similarity index score. In her study, dropouts were defined as those patients who attended 12 sessions or less, and whose outcome evaluations reflected no positive change in therapy. None of the patient-therapist match variables, similarity index, or patient variables alone were found to be related to dropping out of psychotherapy. Goodsitt (1981) concluded that matching on demographics is not a valuable means of investigating psychotherapy dropout; rather, she suggested that further research be directed away from global categorization on the basis of demographics and toward measurement of input characteristics such as patient and therapist expectations and cognitive styles, and toward investigation of the psychotherapeutic process itself in relation to dropout.

Fiester and Rudestam (1975) conducted one of the few studies to investigate the joint interaction of patient input, therapist input, and therapy process in relation to early psychotherapy dropout. Dropouts in their study were defined as those who terminated unilaterally after the first or second session. Data were collected on patient demographic and clinical variables, patient pretherapy expectations, therapist demographic and experience variables and patient posttherapy description of session one.

In this study, two mental health centers were used, a hospital based clinic and a state clinic. The two clinics had the same overall dropout rates but had different significant therapist input, patient input, and therapy process variables. The authors concluded that the dropout phenomenon is setting specific, and that inter-setting differences in the dropout process likely account in part for the conflicting findings of dropout studies (Fiester & Rudestam, 1975).

In the hospital based clinic, several factors were found to differentiate between dropouts and nondropouts. The first dropout factor, patient-therapist match, indicated that lower status therapists, such as technicians and students, were being assigned the most disturbed patients for the first session (Fiester & Rudestam, 1975). The more negatively patients viewed their own functioning, the greater the expectation that the therapist role will be that of a teacher offering direct, concrete advice. These same dropout patients reported a tendency to be critical of or negative toward their therapist, which Fiester and Rudestam (1975) concluded indicates dissatisfaction. Because this factor accounted for a large percentage of the variance in the dropout group, and was unique to the dropout group, Fiester and Rudestam (1975) underscore the importance of the patient-therapist match factor in early sessions.

The other three factors characterizing the dropout group all indicated a successful patient-therapist encounter (Fiester & Rudestam, 1975). The second factor, collaborative involvement, is described as a serious patient working with a therapist whom he considers close and adjusted, and also included a less disturbed patient who was able to express emotions and achieve some problem resolution in the first session. The third factor, direct effective therapist, is described as the patient's pretherapy expectation that the therapist would tell him what was wrong and would ask questions about his personal life, and the patient's view of the therapist as effective. Fiester and Rudestam (1975) interpret this finding as indicating a patient group whose need for contact is brief, who seek a direct opinion of the causes of their problem,

and who receive information from their therapist that satisfies this need.

The fourth dropout factor, intimate effective therapist, is described as a therapist viewed as close, effective, and facilitative of emotional expression, and a patient who achieves significant problem resolution. The authors concluded that patients may unilaterally terminate treatment because of reaching a decision that they are ready to handle problems without further help, and that this decision may be reached after the cathartic relief of a single session (Fiester & Rudestam, 1975).

The significant nondropout factors in the hospital based clinic group were described as collaborative involvement, patient satisfaction with intimate therapist, and attacking patient anticipating didactic therapist. The collaborative involvement factor consisted mainly of therapy process factors, i.e., the more the patient percieved himself as serious and his therapist as adjusted and effective, the less critical or negative the patient was of the therapist. Patient satisfaction with an intimate therapist included a serious patient working with a therapist described as close, who satisfied the patient's pretherapy expectation that he would find out what was wrong during the sessions. The third factor consisted of the patient's pretherapy expectation that the therapist would be directive, teaching, authoritarian, and would ask personal questions. The patient perceived himself in the session as being negative and critical of the therapist. Fiester and Rudestam view the first two factors as indicating a close sense of collaboration and involvement as well as positive outcome, which they believe would main-

tain therapy involvement. However, they were puzzled by the third factor, which would appear to be more indicative of dropout than remaining in therapy. The authors suggest that the third factor may include patients who remain in therapy because of a need to argue with an authority figure, but question whether this type of therapeutic involvement would lead to any positive gains (Fiester & Rudestam, 1975).

In the state clinic group, the above findings were not cross validated. The factor structures which differentiated between the dropout and remainer groups in the hospital clinic were not qualitatively different for these groups in the state clinic. State clinic dropout patients were lower class individuals who perceived themselves as attentive in their first visit and who described their therapists as helpful, involved, serious, and affectionate; however, they also reported feeling angrier during the sessions and talking less about feelings toward their therapist than nondropouts. Fiester and Rudestam (1975) conclude that dropout occurred more as a result of dissatisfaction with services in this setting as opposed to the factors described in the hospital clinic.

When the therapist samples in the two different settings were compared, the state clinic therapists were found to be older, more experienced, more upper-class, and more traditionally trained than hospital clinic therapists. In addition, the therapists differed in their theoretical orientation to treatment. The state clinic therapists were described as more psychodynamically oriented than the hospital clinic therapists, who had more of a here- and-now focus. These differences were supported by the patients' reports of the therapy process. There

were no differences in the patient samples on the variables of age, sex, or social class; Fiester and Rudestam (1975) suggested therefore, that the different findings concerning dropout in the two settings were mainly a function of therapist differences. They concluded, as did Baekeland and Lundwall (1975), that higher dropout rates among lower-class patients may occur only in settings which offer mainly psychodynamically oriented treatment. In addition, they underscored the importance of investigating both therapist and therapy process variables in the study of dropout, given their finding that setting differences were a function of these variables rather than patient input variables (Fiester & Rudestam, 1975).

In a second study, Fiester (1977) compared clients' perceptions of therapists divided into high-dropout-rate therapists and low-dropout-rate therapists (based on individual attrition rates being greater or less than the mean attrition rate). Dropout clients in this study did not differ from nondropouts on demographic, clinical, or pretherapy expectation variables. The two therapist groups did not differ on demographic or training related characteristics. A number of significant differences were found between the two client groups on therapy process variables. Five factors characterized clients assigned to high-dropout-rate therapists: inhibited or uninvolved client, anxious aroused therapist, ineffectual therapist with confronting client, therapist-directed interview, and cathartic relief with anxious therapist (Fiester, 1977).

Fiester (1977) offered the following conclusions: dropout cannot be equated with treatment failure in all cases; psychotherapy process variables have greater explanatory value with regard to dropout than pa-

tient characteristics; client attrition should be viewed as a multidimensional phenomenon; and the tendency of researchers to view the therapist influence as uniform and of little importance is an unfounded myth. These studies indicate the importance of patient expectations in psychotherapy as well as patient perceptions of the therapists and the psychotherapeutic process.

Follow-up Studies of Dropouts

Studies collecting follow-up data on dropouts usually focus on consumer satisfaction with treatment and outcome information about the problems for which paients originally sought treatment. Some studies of consumer satisfaction with mental health treatment fail to find differences between dropouts and remainers (e.g., Littlepage, Kosloski, Schnelle, McNees, & Gendrick, 1976). Others report small but significant differences in satisfaction between dropouts and remainers (e.g., Larsen, Attkisson, Hargreaves, & Nguyen, 1979). Studies of dropouts alone, without comparison to remainers, report high levels of patient satisfaction (e.g., Silverman & Beech, 1979). Studies of unilateral as opposed to mutual terminators indicate a higher level of satisfaction in mutual terminators (e.g., Balch, Ireland, McWilliams, & Lewis, 1977).

Outcome studies of psychotherapy dropouts report a variety of findings; some studies indicate that dropouts report receiving benefit from their short contact and report that their problems have been solved (e.g., Fiester & Rudestam, 1975; Silverman & Beech, 1979). Other studies report that dropouts do not feel better following limited contact and still complain of the problems for which they sought treatment at

the time of follow-up (e.g., Gorkin 1978). Some studies find that drop-outs actually receive treatment elsewhere (e.g., Bergin & Lambert, 1978). Others report that dropouts do not seek treatment elsewhere (e.g., Gorkin 1978). Dropouts have reported turning to friends, family, clergy, and other non-professional sources for help (Silverman & Beech, 1979). Furthermore, a change in life circumstances, such as obtaining employment or getting divorced is reported by dropouts to have alleviated the problems for which they initially sought help (Silverman & Beech, 1979).

The above findings indicate that it is critical to conduct follow-up research on dropouts to determine how many actually receive treatment elsewhere, non-professional help elsewhere, experience a beneficial change in life circumstances, or experience relief from their problems despite the brief nature of their treatment contacts.

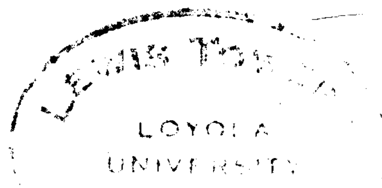
Consumer Satisfaction Studies

Methodological Problems. Several researchers have pointed out a variety of methodological flaws in consumer satisfaction studies (e.g., Larsen, Attkisson, Hargreaves & Nguyen, 1979; Lebow, 1982; Levois, Nguyen, & Atkisson, 1981; Tanner, 1981). These flaws often include lack of information about the reliability of the satisfaction indices used (Lebow,1982), and various threats to validity such as sampling bias, sources of distortion in consumer responses, lack of precise meaning for terms used in questionnaires, and the inclusion of items which do not focus on satisfaction (Lebow, 1982). In addition, Tanner (1981) points out that most studies look at the relationship between satisfaction and

a large number of variables, increasing the probability that significant findings will occur by chance.

Furthermore, most studies of consumer satisfaction report high levels of satisfaction (Tanner, 1981). Levois, Nguyen, and Attkisson (1981) point out that these findings could be the result of social psychological artifacts; for example, social desirability response bias, the Hawthorne effect, experimenter bias, expectation for positive reinforcement on the part of the client, and cognitive consistency theory.

Sampling bias is present in most studies of consumer satisfaction from the simple fact that an average of only 54% of consumers respond to surveys (Sorenson, Kantor, Margolis & Galano, 1979). In Lebow's (1982) review, he found return rates to range from 21% to 100% in the 31 studies reviewed. Since a large percentage of consumers contacted fail to respond, it is critical to investigate the extent to which respondents are representative of the mental health population in general. Lebow (1982) concluded that respondents are actually different from nonrespondents in ways which are likely to affect satisfaction reports. For example, respondents are more likely to be mutually terminated from therapy than nonrespondents, to have longer length of stay, and to have treatment judged to be more successful by therapists. Lebow (1982) also cited a study by Ellsworth (1979), which found that respondent and nonrespondent groups were similar in posttreatment functioning but differed in satisfaction with treatment. Finally, demographic differences have not been found between respondents and nonrespondents (e.g., Silverman & Beech, 1979). Lebow (1982) concluded that studies should focus on differences in treatment characteristics and outcome rather than demograph-



ics when attempting to show that a sample of respondents is representative.

Lebow (1982) suggested that researchers be more explicit about the methods followed during data collection in order to make results from different studies more comparable. In addition, he suggested that social-psychological artifacts be reduced by varying the favorableness of statements about satisfaction within scales, by separating survey collection from clinical staff duties, by ensuring anonymity, and by reassuring respondents that the emphasis of the survey is on group rather than individual data. He underscored the necessity of the removal of such artifacts by pointing out that it is the studies with the highest reactivity which produce the highest rates of satisfaction.

Larsen, Attkisson, Hargreaves, and Nguyen (1979) argue that the high baseline of consumer satisfaction reduces the value of these data. Lack of variability can result in a nonnormal distribution, making statistical analyses meaningless (Lebow, 1982); furthermore, the validity of the satisfaction measure becomes suspect when other signs, such as dropout, may indicate problems with treatment. Lebow (1982) points out, however, that the belief that all consumer satisfaction studies result in a high level of satisfaction is not necessarily accurate. In his review, eight studies of consumer satisfaction found levels of reported satisfaction below 70% (Lebow 1982). In addition, when responses of 'very satisfied', the highest level of satisfaction are examined, the median rate is found to be 49% (Lebow, 1982). Most studies combine 'satisfied' and 'very satisfied' categories in their summary statistics, which has the effect of making the results seem much more positive.

In addition to the problem of high baseline in satisfaction surveys, Lebow (1982) points out the lack of a baseline level of satisfaction to which programs can be compared. Comparison of data is further complicated by the failure of mental health centers to use standard scales of satisfaction (Larsen et al, 1979). Furthermore, satisfaction measures do not indicate which treatments are satisfying to which clients; rather, global summary statements are provided in which treatment, client, and therapist variables are ignored (Lebow, 1982).

A final methodological flaw in consumer satisfaction research is method variance (Lebow, 1982). Studies use different questionnaires with different formats (e.g., interview vs. questionnaire), assess satisfaction at different times in the treatment process, use different methods of contacting subjects, (e.g., phone, mail, in person), and differ in the procedures and statements used to present the questionnaire (Lebow, 1982). Larsen et al (1979) developed one of the few consumer satisfaction scales for which data on reliability and validity is available; their scale has also been tested for method variance (Levois, Nguyen, & Attkisson, 1981).

One study investigated the effects of follow-up procedures on the results of a survey (Roth, Klassen, & Luben, 1980). In this study, the results on a depression checklist were compared with four different procedures: mailed questionnaire, personal interview, questionnaire given personally to the respondent at the first visit, and a telephone interview. Roth et al (1980) found that telephone interviews produced significantly lower scores on the depression scale than the personal visit and mail procedure. They suggested that the social desirability re-

sponse bias would lead respondents to minimize feelings such as depression. They concluded that the greater the impersonality of the procedure used, the more likely it is that socially undesirable responses will be produced. However, more impersonal procedures such as the mailed questionnaire were found to have a much lower return rate than the more reactive telephone interview.

Larsen et al (1979) make several suggestions for increasing the usefulness of data on consumer satisfaction. They suggest a focus on dissatisfied clients, to attempt to identify subgroups of clients, aspects of service delivery with which clients are less satisfied, and differences in satisfaction among clients in different treatment modalities. However, such a focus could be seen as threatening to the staff and management of a facility. In addition, they offer the time series design as a strategy for examining the impact of programmatic changes on client satisfaction. It is suggested that clients' expectations about services prior to starting treatment be related to satisfaction, with the assumption that unfulfilled expectations may lead to greater dissatisfaction. Larsen et al (1979) caution, however, that client expectations may be unrealistic, and that the utilization of the satisfaction data may then need to focus on ways of altering client expectations rather than on ways of rectifying service problems. A final suggestion for making satisfaction data more useful is to use multiple rather then single measures of satisfaction; that is, to use both self-report and behavioral indices.

Findings of Consumer Satisfaction Studies. In a study by Flynn, Balch, Lewis, and Katz (1981), questionnaires were sent to 1000 consecu-

tively discharged patients from a community mental health center. Items on the questionnaire included level of satisfaction with the location of the center, the fees, the therapist and the therapeutic relationship, and extent of personal and social improvement. Two hundred twenty questionnaires were returned, a response rate of 22%. The authors reported that their results show a highly favorable overall evaluation by clients (Flynn et al, 1981); however, close inspection of their results indicated a more moderate interpretation. On three indices, general improvement, confidence in therapist, and satisfaction with the relationship, clients were asked to respond 'not at all', 'a little', 'some', 'quite a lot', and 'a lot'. Depending upon which response categories are summed to arrive at overall satisfaction levels, the results can be interpreted quite differently. For example, if the 'quite a lot' and 'a lot' categories were combined, 49% of the sample reported general improvement, 68% reported confidence in their therapist, and 63% reported satisfaction with the relationship. These figures could certainly be improved, and hardly suggest an interpretation of highly favorable overall evaluation.

Fifty-four percent of clients reported that they terminated treatment becaue of improvement in their problems, 13% terminated because their problems worsened, and 21% discontinued because they could no longer afford the fee. Sixty-eight percent of clients attributed improvements in their problems to their treatment, 43% said that they would return to the clinic if they experienced problems in the future, and 84% would recommend the center to a friend.

When respondents and nonrespondents were compared on both demographic and treatment variables, no differences were found for sex, ethnicity, marital status, previous treatment, education, occupation, age, income, type of discharge, previous admission, and number of individual and family sessions. Differences were found for family size, type of insurance, percent of fee reduction, and length of stay. It was not clear how number of sessions differs from length of stay, nor did the authors indicate the direction of the above differences between respondents and nonrespondents.

Multiple regression was used to compute predicted improvement for nonrespondents and no differences were found between that estimate and reported improvement by respondents. The authors used this analysis to conclude that no self-selection bias occured in their sample, and suggested that respondent-nonrespondent differences be assessed whenever possible. In their study, clients stayed in therapy longer who had confidence in the therapist and the therapeutic relationship; these clients were also more likely to report high satisfaction. Clients who dropped out tended to lack confidence in the therapist and to be dissatisfied with the therapeutic relationship and treatment in general. Interestingly, older clients expressed more dissatisfaction than younger clients, and expressed a preference for a therapist of their own age group. Eighty-nine percent of these clients had younger therapists, indicating a mismatch which the authors believe may have made the development of a therapeutic alliance and satisfaction with treatment less likely (Flynn et al, 1981).

Balch, Ireland, McWilliams, and Lewis (1977) used a telephone survey to evaluate satisfaction and outcome in clients discharged from a community mental health center. Of the 256 discharged clients in a 7-month period, 108 were contacted, or 40% of the sample. Respondents did not differ from nonrespondents on the variables of sex, social class, number of sessions attended, or mutual vs unilateral termination. Respondents were more often married and older than the nonrespondent group. Seventy-nine percent of respondents were satisfied with their clinic experience, 75% perceived that therapy was helpful to them, 75% said that their problem was improved at the time of follow-up, and 77% reported that they were somewhat more able to handle personal problems in general. Sixty percent of the respondents said that the help they received was consistent with what they expected.

When asked why they stopped coming, 38% of respondents said that they stopped because their problems had improved, 11% because their problems had not improved, and 51% gave reasons unrelated to problems. Sixty-four percent of the clients would return to the center if needed, 85% would recommend the center to others, and 75% had not sought further treatment. When the discharge was mutual as opposed to unilateral termination, clients were more likely to see their therapy as helpful and to be more positive about their ability to handle personal problems. Client age, sex, marital status and social class were not related to satisfaction or improvement in therapy (Balch et al, 1977).

Littlepage, Kosloski, Schnelle, McNees, and Gendrick (1976) used a telephone interview to collect client evaluation of services, hypothesizing that clients who drop out of therapy would evaluate services

more negatively than clients who complete therapy. Out of a sample of 349 clients, 108 or 37% of the sample were contacted. In their study, clients whose treatment ended after limited contact evaluated the services as highly as clients with extended contacts. Dropouts, defined as clients who terminated unilaterally, did not evaluate services any differently than nondropouts. The authors state that the assumption that clients leave therapy because of dissatisfaction is not supported by their results; however, they point out that the question of whether such clients achieve resolution of their problems is left unanswered, and that client evaluation of services cannot be considered the only meaningful criterion of successful therapy.

Silverman and Beech (1979) also used a telephone survey to obtain information from dropouts in four categories: satisfaction, problem solution, service expectations and center impact. Out of 184 clients who attended only one session at a community mental health center, 44 clients were contacted. The authors argue that the sample is representative because contacted subjects did not differ from noncontacted subjects on demographic characteristics. As indicated above, however, demographics are not considered to be the crucial variables in deciding on the representativeness of a follow-up sample (e.g., Lebow, 1982). The study is compromised further by the lack of a comparison group; that is, data were collected for dropouts alone.

In their study, 70% of respondents expressed satisfaction with the service they received, 79% of clients reported that their problems had been solved, 49% attributed this change to the center. Forty-six percent of respondents reported receiving help from friends, family and

other non-professionals and 38% reported that a change in their life situation helped them. When clients were asked about their pretherapy expectations, confirmation of their expectations was found to be related to satisfaction and to the perceived helpfulness of the center, but not to problem solution (Silverman & Beech, 1979).

One interesting finding of the study indicated that clients perceived the center to be more effective if they had entered the system following a visit to the emergency room crisis service than if they had entered the system by a regular outpatient appointment. The authors suggested that for dropouts, crisis intervention may be the most appropriate and effective service (Silverman & Beech, 1979).

Tanner (1981) reviewed 38 studies which examined the relationship of a large number of variables to client satisfaction. He used a statistical technique to arrive at an overall summary significance level for each variable by combining the findings from multiple studies and indicated how many studies would be needed to make the findings nonsignificant. The number of studies needed to make the findings nonsignificant represents either nonsignificant studies filed in researchers desks or new, contradictory studies.

On the basis of his review, Tanner (1981) concluded that no client or therapist demographic variable (i.e., sex, race, age, therapist experience, marital status, socioeconomic status, income, education, occupation, employment status, therapist profession, previous treatment) has been demonstrated to affect client satisfaction. Therapist behaviors, on the other hand, were related significantly to client satisfaction; clients appeared to be more satisfied with therapists described as ac-

tive, warm, empathic and interested in them. Tanner indicated that two nonsignificant studies would be needed to make the therapist activity variable lose its overall significance; 13 nonsupportive studies would be needed for therapist empathy to lose significance; seven nonsupportive studies for therapist interest; and two nonsupportive studies for therapist warmth. Tanner (1981) cautioned that all of the studies used patients' report of the above therapist behaviors, and it was not clear if the findings indicated an actual, perceived or simply reported therapist behavior.

Other variables found to achieve overall significance in Tanner's (1981) review were type of termination, length of stay, and client reported outcome. Patients who self-terminate are apparently less satisfied than those who remain in treatment; it would require 12 nonsupportive studies for this variable to lose overall significance. Satisfaction is related positively to length of stay, a finding which would lose significance with two nonconfirmatory studies. Clients' reports of the effectiveness of treatment have a very strong positive relationship to level of satisfaction, requiring 30 nonsignificant studies before this variable would lose overall significance. Interestingly, therapist evaluation of outcome and independent judge evaluation of outcome were not related to client satisfaction.

Tanner (1981) concluded that client satisfaction is not affected by the personality of the client or the therapist; rather, it is affected by what the therapist does and how effectively the client rates the treatment. Satisfaction is also related to length of stay, as Tanner (1981) stated:

> The satisfied client is likely to have been in treatment a long time and terminated with the agreement of the therapist. Such a client describes the therapist as active, warm, empathic and showing interest, and the treatment as helpful. The dissatisfied client is more likely to have dropped out after only brief treatment. The client describes the therapist as passive, aloof, not caring, and not understanding, and the treatment as ineffective (p.284).

Tanner (1981) cautioned that the role of social desirability bias is unclear in these findings, and suggested that future studies should use multidimensional assessment of satisfaction to confirm these findings.

Lebow (1982) also conducted a large scale review of the literature on client satisfaction. Similar to Tanner (1981), he suggested demographic characteristics are not good predictors of client satisfaction. In addition he cited studies which indicate that satisfaction is lower for drug abusers (Ciarlo & Reihman, 1977; Getz, Fujita, & Allen, 1975), suicidal clients (Richman & Charles, 1976) psychotic clients (Getz et al, 1975) and clients with poor prognosis (Woodward, Santa-Barbara, Levin, & Epstein, 1978). Client satisfaction was found to be related to the fulfillment of client expectations in several studies (Lebow, 1982).

In contrast to Tanner's (1981) review, Lebow (1982) concluded that satisfaction is unrelated to length of treatment. The difference in conclusions regarding length of stay is probably accounted for by Lebow's failure to include the studies reviewed by Tanner which indicated a significant positive relationship between length of stay and client satisfaction (Brown & Manela, 1977; Frank, Saltzman, & Fergus, 1977). Similar to Tanner (1981), Lebow (1982) concluded that clients who terminate mutually are more satisfied than unilateral terminators.

With regard to the relationship of client satisfaction to outcome meaures, Lebow (1982) concluded that satisfaction is highly related to

therapists' assessment of client satisfaction and to clients' global assessment of their success in treatment; that satisfaction is related less strongly to therapists' satisfaction with treatment, to specific assessment of clients' outcome, and to dropouts, and that clients' satisfaction is only partially related to therapists' assessment of outcome.

Lebow (1982) indicated that the consumer satisfaction literature is lacking in studies of the interaction between client satisfaction and specific types of treatment. He cited a study by Hargreaves, Showstack, Flohr, Brady, and Harris (1974) to exemplify the importance of examining such interactions. In this study, clients were assigned to individual therapy, group therapy, or a minimal contact group. Shy, upset clients were most satisfied with the minimal contact group, unmotivated clients were most satisfied with individual therapy, and verbal, outgoing clients were most satisfied with group therapy. Lebow (1982) suggested that this type of research could lead to better client-therapist matching, as well as to identifying what types of treatment are most satisfying to which types of clients.

Lebow (1982) concurs with Tanner (1981) on the need for multidimensional assessment of client satisfaction. He stated that the research literature is unclear as to the dimensionality of client satisfaction (Lebow, 1982). In Larsen, Attkisson, Hargreaves, and Nguyen's (1979) development of the client satisfaction questionnaire, factor analysis showed only one factor in response to a broad range of items. Lebow (1982) cited four factor-analytic studies, on the other hand, which found satisfaction to be multidimensional. He suggested that such

findings will have implications for further research; if client satisfaction is multidimensional, longer, more specific scales are essential, while short global scales would be more appropriate if client satisfaction is unidimensional (Lebow, 1982).

Summary of Literature Review

Several categories of variables with potential for predicting dropout from psychotherapy were reviewed in the above literature review, including patient characteristics, clinic, therapist, patient- therapist factors, and consumer satisfaction studies. Patient variables which have been found to be related to dropout in more than one study include education, income, occupation, race, age, and referral source. The following variables failed to distinguish between dropouts and remainers in at least one study: number of children, diagnosis, and religion.

Several clinical variables were reported to distinguish between dropouts and remainers in more than one study: type of symptom presented, previous psychiatric history, previous treatment at the clinic under study, and need for treatment as rated by therapists at the time of case closing. In Baekeland and Lundwall's (1975) review, the patient most likely to drop out is described as follows:

> unaffiliated, lower socioeconomic class female who may have either paranoid or sociopathic features and enters treatment with low levels of anxiety and/or depression. Poorly motivated, she is not very psychologically minded, tends to use a high degree of denial, and has problems in the area of dependent strivings which may take the form of either overt behavioral dependence or counterdependence (p.759).

With regard to the impact of clinic variables on psychotherapy dropout, the literature is more sparse. Delay in assigning a patient to a thera-

pist was found to be related to dropout in several studies. Baekeland and Lundwall (1975) pointed out that these variables in addition to family attitude toward treatment, other life stress, transportation problems and the cost of treatment are usually neglected in the psychotherapy dropout literature but could be among the more important variables.

Concerning therapist variables, therapist level of experience has been shown to be positively related to length of stay in a number of studies. However, as pointed out by Sullivan, Miller, and Smelser (1958) and Auerbach and Johnson (1977), most studies confound the experience factor with the patient's initial level of functioning and prognosis, making interpretation difficult. Findings on therapist gender and therapist personality factors in relation to dropout, as well as findings on patient-therapist demographic matching are inconclusive. Baekeland and Lundwall (1975), on the basis of their review, describe the therapist most likely to lose his patient as follows:

> experienced, more ethnocentric, dislikes his patient or finds him boring, and does not give lower socioeconomic status patients medication. Male therapists are particularly likely to lose very unproductive patients, and female therapists, those who are highly productive (p. 759).

The most interesting approach to investigating the joint interaction of patient input, therapist input, and therapy process in relation to early psychotherapy dropout is the studies of Fiester and Rudestam (1975, 1977). In these studies, psychotherapy process variables, patient pretherapy expectations, and patient perceptions of therapist behaviors were found to have greater explanatory value with regard to dropout than patient characteristics. These studies indicate the critical importance of patient expectations in psychotherapy as well as patient perceptions of the therapist and the psychotherapeutic process.

Consumer satisfaction studies indicate that client satisfaction has a strong positive relationship to length of stay, mutual termination, and outcome of psychotherapy (Tanner, 1981). In Tanner's (1981) review, client and therapist demographic variables were not related to consumer satisfaction; therapist behaviors, as reported by the patient, were highly related to consumer satisfaction. In Lebow's (1982) review, client satisfaction was found to be related to fulfillment of client expectations in several studies, as well as to clients' global assessments of their success in treatment, but less highly related to therapist satisfaction with treatment, specific assessment of client outcome, and therapist assessment of outcome.

Lebow (1982) and Tanner (1981) both conclude that client satisfaction research should address in the future the interaction between satisfaction and more specific types of treatment. As in the research on early dropout characteristics, an important area for future studies appears to be an emphasis on patient pretherapy expectations, psychotherapeutic process variables, and patients' perceptions of the therapist.

Rationale for The Study

In the above review, it is apparent that many factors complicate the study of early dropout from psychotherapy. An important methodological consideration is the manner in which dropout is defined, i.e., by length of stay, by unilateral termination, or by outcome. It is clear that the relationship between number of sessions and positive outcome of psychotherapy is not a simple linear relationship, and that many factors are operative in the process of psychotherapy which complicate any at-

tempts to define dropouts by length of stay alone. Some of the studies cited above indicate the importance of patient expectations in determining the length and outcome of psychotherapy; others highlight the often disparate perceptions of therapists regarding the ideal length of treatment and the extent to which clients achieve therapist defined goals.

The most promising approach to defining psychotherapy dropout appears to be a focus on the early dropout rather than on patients who drop out unilaterally at other stages of treatment. Baekeland and Lundwall's (1975) review and the studies by Fiester et al (1974), Fiester and Rudestam (1975) and Fiester (1977) provide evidence for the idea of a critical stage in psychotherapy during the first one or two sessions. Fiester et al (1974) suggested that patients who remain past this critical stage are homogeneous with respect to demographic and clinical variables.

This study focuses on early dropouts, i.e., patients who drop out after only one or two sessions, since the frequency of dropout is so high during this early period and since research findings suggest that patients who drop out early in the treatment process represent a distinctly different group from later dropouts. These early dropouts will be contrasted to patients remaining in treatment for three or more sessions.

The study was conducted in two parts: the first part utilized archival data to attempt to identify factors distinguishing early dropouts from remainers at Ravenswood Hospital Community Mental Health Center. The second part utilized a follow-up survey in order to obtain satisfaction and outcome data for three patient groups: dropouts following the

first intake session, dropouts following two sessions, and patients remaining in treatment for three or more sessions.

On the basis of the literature review, it is expected that dropouts differ from remainers on the following variables: education, income, occupation, race, age, referral source, type of symptomatology, previous psychiatric history, presenting problem severity, and need for further treatment. It is also expected that the three groups differ on their responses to the consumer satisfaction questionnaire (Larsen et al, 1979). Specifically it is expected that dropouts are less satisfied than remainers with their experience at the mental health center.

There is evidence to indicate that patients attending only one session find this contact to be satisfying and effective, and do not feel the need to follow the intake therapist's recommendation for psychotherapy. It may be that patients who drop out after two sessions, having accepted a referral for psychotherapy following the intake session, and having made an initial commitment, experience more frustration and dissatisfaction with treatment. It is expected that session two dropouts express more dissatisfaction with the therapist and the therapy than session one dropouts and remainers.

METHOD

Subjects

Patient Sample

Data for this study were obtained from the Adult Outpatient Program of Ravenswood Hospital Community Mental Health Center which offers comprehensive mental health services to a catchment area of approximately 90,000 people. The patient sample was selected from all patients accepted for treatment in the adult outpatient program between November 1, 1981, and August 31, 1982 (*N*=488). The follow-up sample was selected from those patients from the larger sample who had given written consent to be involved in follow-up research (*N*=302). The demographic characteristics of the samples are presented in Table 1.

As seen in Table 1, most of the sample fall in the age range 18-44, are Caucasian, not living with a spouse, have one or two dependents and have a fairly low income level. The sample is evenly distributed on the variables of occupation, sex, education, and employment status.

Adult Outpatient Selection Criteria

All patients calling the center to request services are asked several questions in order to direct them to an intake interview in the most appropriate treatment program. Each program has clearly specified criteria for admission.

TABLE 1

Demographic Characteristics of the Sample

Variable	Whole Sample	Follow-up Sample
Age		
Under 18	0.8%	0.3%
18-24	23.0%	23.5%
25-34	42.4%	46.0%
35-44	18.2%	16.9%
45-59	11.1%	18.9%
60+	4.5%	4.3%
Marital Status		
single	40.1%	41.2%
married	34.4%	32.6%
separated/divorced	22.5%	22.7%
widowed	3.0%	3.4%
Sex		
male	38.3%	36.8%
female	61.7%	63.2%
Ndependents		
1	50.2%	54.3%
2	20.7%	20.2%
3	13.7%	11.9%
4	11.3%	08.9%
5	2.7%	3.6%
6	1.4%	1.0%
Income		
$0-499	36.7%	37.7%
$5000-9999	14.3%	14.9%
$10000-14999	17.8%	17.2%
$15000-19999	11.9%	10.6%
$20000-24999	4.1%	5.3%
more than $25000	15.2%	14.2%

TABLE 1

Demographic Characteristics (continued)

Variable	Whole Sample	Follow-up Sample
Ethnic Group		
Caucasian	87.7%	88.7%
Black	2.3%	2.6%
Hispanic	6.1%	5.3%
Oriental	2.0%	2.3%
American Indian	0.2%	0.3%
Greek	0.4%	0.0%
other	0.2%	0.7%
Religion		
Protestant	6.6%	8.1%
Catholic	38.6%	39.6%
Jewish	5.6%	4.7%
other	21.8%	19.1%
none	27.4%	28.5%
education		
some high school/less	19.2%	18.3%
completed high school	41.8%	44.1%
some college	19.3%	20.7%
college graduate	10.2%	11.4%
graduate school	1.9%	1.0%
employment status		
employed	60.1%	62.6%
unemployed	39.9%	37.4%
occupation		
professional/technical	15.0%	17.1%
mgmt/sales	9.0	9.6%
craftsman	9.5%	9.6%
clerical	21.0%	20.0%
unskilled labor	9.0%	8.2%
service	5.8%	6.4%
student/housewife	14.8%	13.5%
other	15.9%	15.4%

During the time period sampled, 560 patients were seen for an intake interview in the adult outpatient program. Of those 560 patients, 488 were accepted for treatment in the adult outpatient program, 13 were referred to the child and adolescent program, 18 to the aftercare program, 12 to crisis intervention, 11 to the community connnection program, 7 to extended intake, 2 to inpatient treatment, one to emergency services, and 9 to the day treatment program.

To have been accepted for adult outpatient treatment, patients had to be age 18 or older and had to have received a level of functioning rating of 5 or above on a scale from 1-9. Exclusions are based on: suicide/ homicide ratings of "extreme"; primary problem of child management; recent hospitalization or chronic history of hospitalization; primary diagnosis of alcohol or drug abuse; primary diagnosis of mental retardation, except if the patient is involved concurrently in a mental retardation facility. Those patients excluded according to the above criteria are referred to an appropriate treatment program. In cases in which the patient is not motivated to enter the appropriate program, the adult outpatient program may offer a short-term assessment contract of four sessions, for the purpose of reconciling the discrepancy between the clinic and the patient's perception of appropriate treatment. The clinical characteristics of the outpatient sample are presented in Table 2.

TABLE 2

Clinical Characteristics of the Samples

Variable	Whole Sample	Follow-Up Sample
Level of Functioning		
3	0.2%	0.0%
4	1.2%	1.0%
5	19.1%	16.6%
6	40.9%	45.5%
7	35.3%	35.2%
8	3.3%	1.7%
Suicide Risk		
none	87.5%	88.6%
minimal	11.6%	10.7%
moderate	0.8%	0.7%
Homicide Risk		
none	95.6%	95.0%
minimal	11.6%	4.0%
moderate	0.6%	1.0%
Need for Service		
very mild	0.2%	0.3%
mild	5.9%	4.6%
moderate	80.5%	84.1%
great	13.3%	10.9%
Previous Inpatient Treatment		
yes	21.9%	13.2%
no	84.8%	85.1%

TABLE 2

Clinical Characteristics (continued)

Variable	Whole Sample	Follow-up Sample
Previous Outpatient Tx *		
yes	52.9%	51.0%
no	44.9%	47.4%
DSM III Diagnosis Axis I		
organic mental disorder	0.4%	0.0%
schizophrenic disorder	0.6%	0.0%
major affective disorder	7.4%	0.3%
paranoid disorder	0.6%	0.3%
neurotic disorder	24.6%	7.0%
personality disorder	2.9%	0.3%
psychosexual disorder	3.7%	1.3%
substance use disorder	1.2%	2.0%
eating & movement disorder	2.0%	1.3%
adjustment disorder	11.3%	2.0%
conduct disorder	0.2%	0.0%
disorder of impulse control	1.2%	1.3%
V codes **	35.0%	8.9%
other	8.8%	75.2%
DSM III Diagnosis Axis II		
personality disorder	39.8%	44.0%
psychosexual disorder	0.2%	0.0%
substance use disorder	0.4%	0.0%
anxiety & other disorders	0.2%	0.3%
none	59.0%	55.6%

* Treatment

** Problems which are the focus of treatment but which are not attributable to a mental disorder

Length of Stay Data

Treatment in the adult outpatient program is short term, with the expectation that therapy will be successfully terminated after 20 sessions. Patients who meet certain criteria may continue beyond 20 sessions, if benefit from more outpatient psychotherapy can be demonstrated. Length of stay data is presented in Table 3.

As seen in Table 3, during the time period 11-1-81 to 8-31-82, 88 patients or 18% of those accepted for treatment in the adult outpatient program attended intake only and did not continue treatment. Forty-six patients, or 9% of accepted patients attended only one session after intake. A total of 27% of accepted patients, then, dropped out of or were terminated from treatment after one or two sessions. Forty-five percent (N=219) of patients had terminated treatment by the end of the fifth session; 60% (N=292) discontinued treatment by the end of the tenth session; and 74% (N=360) by the twentieth session. The remaining patients (N=44) were seen for 21 sessions or longer, and 84 were still in treatment at the time of data collection. The number of sessions attended by these 84 patients is unknown.

Definition of the Dropout Group

The patient sample was divided into three groups, as suggested by Fiester and Rudestam (1975): dropout following intake (N=88), dropout following two sessions (N=46), and continuation for three or more sessions (N=270). To be classified as a dropout, patients had to have attended one or two sessions only (N=134). The 84 patients for whom number of sessions is unknown were excluded from the sample at this point.

TABLE 3

Length of Stay Distribution

Variable	Whole Sample	Follow-up Sample
Number of Sessions		
1(intake)	18% (88)	16% (47)
2	9% (46)	10% (29)
3-5	17% (85)	17% (51)
6-10	15% (73)	15% (45)
11-15	8% (37)	9% (28)
16-20	6% (31)	5% (16)
>20	9% (44)	9% (28)
unknown	17% (84)	19% (58)
Mean	9.8	10.5
Median	4.9	5.2

In addition, termination must have been classified as unilateral, or without therapist agreement. The follow up sample was divided into the same three groups: dropout following one session (intake) (N=47), dropout following two sessions (N=29), and continuation for three or more sessions (N=168). Fifty-eight of the patients in the follow up sample had unknown numbers of sessions.

Therapist Sample

All therapists who had at least one contact with a patient in the sample were included in the study. Therapists in the adult outpatient program included PhD psychologists (N=2), MA psychologists (N=2), MSW social workers (N=4), psychology interns (N=6), and MSW students (N=4). The time period for data collection was chosen according to the starting dates for new interns and students, in order to minimize effects due to staff heterogeneity and turnover.

The therapist who interviews the patient at the time of intake is usually not assigned as the patient's primary therapist. Following intake, the adult outpatient program director assigns patients to therapists according to various unspecified criteria. Case assignment cannot be considered to be random.

Measures

Intake Data

Data collected at the time of intake included: (1) demographic information, i.e., age, gender, marital status, ethnicity, religion, education, number in household, employment, occupation, and residential stability;

(2) financial information, i.e., income, number of dependents, and source of payment; and (3) clinical data, i.e., problem list and problem severity, DSM III diagnosis, level of functioning, suicide risk, homicide risk, priority of need for service, disposition, previous inpatient treatment, previous outpatient treatment, SCL 90 score, and source of referral.

Level of functioning was rated on a scale from one to nine on the basis of four areas: personal self care, vocational capability, ability to function in the family, and degree of symptomatology. A score of one indicates that the patient is dysfunctional in all four areas and is almost totally dependent upon others to provide a supportive protective environment. A score of nine means that the patient is functioning well in all four areas and no treatment is needed.

Suicide and homicide risk were rated on a scale from zero to three, i.e., none, minimal, moderate, extreme. The problem list was obtained by choosing the first two problems listed for each patient from the Ravenswood Hospital Community Mental Health Center Computerized Problem List. The problem list covers problems in 13 general areas, ranging from problems in affective functioning to financial and legal problems. Each problem is rated in severity on a scale from one to five (i.e., mild to very severe) by the intake worker at the time of intake.

The SCL-90 is a standardized 90 item symptom checklist on a self-report form (Derogatis, 1977). Three global scores and ten symptom cluster scores are derived from the checklist: a global severity index (GSI), a positive symptom distress index (PSDI), the positive symptom total (PST), and cluster scores for somatization, obsessive-compulsive

symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation , psychoticism, and an additional depression cluster.

Outcome Data

Outcome data was obtained in two steps, outcome as rated by the therapist at the time of case closing and outcome as rated by the patient at the time of follow-up contact. Therapist ratings include level of functioning at the time of closing, extent of need for further service, and disposition of the case, i.e., patient withdrew, patient transferred, or clinic terminated.

Follow-up Data

Patients in the follow-up sample were asked to complete a telephone interview covering satisfaction and outcome. The client satisfaction questionnaire (CSQ), developed by Larsen et al (1979) was used for this purpose, since it is well-constructed and information is provided as to internal consistency, reliability, and validity. The CSQ was developed initially through a literature review of client satisfaction studies, which yielded nine categories of determinants of satisfaction. Each category contained nine items; these items were then ranked by professionals to create an item pool. The preliminary version of the scale was administered to 248 clients in five mental health centers, with a variety of treatment modalities and a variety of lengths of stay. In the preliminary analysis, only one factor was found to account for most of the variance. The final scale was constructed from those items which

loaded highly on this factor, arriving at an eight item general satisfaction scale. The final scale was tested in two independent samples; a high degree of internal consistency was found (coefficient alpha=.93). In these studies, satisfaction as measured by the CSQ was not related to education, income, marital status, amount of service, age, social class, or previous treatment. Nonwhite clients, unemployed clients, and clients with previous treatment episodes were less satisfied; clients still in treatment and clients paying a partial fee were more satisfied than clients who had left or clients paying a full fee or no fee. A second validation study used the CSQ in an outcome study of psychotherapy; clients who dropped out of therapy in the first month were less satisfied than those still in treatment (Larsen et al, 1979). The CSQ scores also correlated significantly with global improvement on the SCL-90 at the time of follow-up; but correlated negatively with two of the more specific subscales, depression and hostility. Therapists' ratings of their satisfaction in their work with clients were correlated positively to CSQ scores; in addition, therapists' estimates of client satisfaction were highly correlated with CSQ scores. These findings provide some degree of concurrent validity for the scale (Larsen et al, 1979).

In a third study, Levois, Nguyen, and Attkisson (1981) investigated three possible sources of artifact on the CSQ: mode of administration, clients' level of general life satisfaction, and degree of psychiatric impairment. The authors used a counterbalanced design to compare the effects of two parallel forms of the CSQ, the effect of written vs. oral administration, and correlates of the CSQ in 92 clients of a day

treatment program. The two forms of the CSQ were found to be equivalent; while the oral administration of the CSQ produced a mean about 10% higher than written administration. The oral form in addition produced fewer unanswered items than the written mode. The CSQ was found to be correlated highly with two other scales of satisfaction, the Ladder of Life Satisfaction and the Ladder of Service Satisfaction. The CSQ was correlated negatively with five SCL-90 subscales and SCL-90 overall symptom total. The authors concluded that oral administration is a likely alternative to written administration, but suggested that oral results be adjusted down by 10% if compared to written results. They also suggested that the effect of symptoms be controlled statistically in analyzing client satisfaction data, since symptoms were found to be correlated negatively with the CSQ.

Procedure

Data were collected in two phases: the first phase utilized archival data collected by therapists at the time of intake and at the time of case closing; the second part utilized a follow-up telephone survey of patients in the study, conducted by psychology interns at the center. Each patient went through the standard intake procedure, which consists of assessment and referral by the intake worker on duty. All assessment/referral data are recorded on computerized forms and stored in the Ravenswood Hospital Community Mental Health Center data bank. Patients are asked at the time of intake to sign an informed consent form giving the center permission to contact them for the purposes of case follow-up during and after their treatment.

Of the 488 patients in the adult outpatient program, 302 had signed follow-up consent forms. These 302 patients served as subjects for the follow-up phase of the study. Each patient was called during the month of October, 1983, by an interviewer. Patients who could not be reached following two attempts were excluded from the study. Sixty-nine of the sample of 302 patients were contacted, or 23% of the sample. Eighty-five patients were not reached after two attempts, 51 patients were excluded due to wrong numbers, 41 had disconnected phones, 41 had no phone, and 15 patients refused to participate. If the patient was available when the interviewer attempted to call, the interviewer identified him/herself as working for the research department of RHCMHC, reminded the patient that he/she had consented to be contacted for the purposes of case follow-up and asked the client if he/she would be willing to answer some questions about their experience at the center. The patients were assured that their statements would be kept confidential, that their therapists would not see this information, that the focus of the study was on group rather than individual responses, and that criticism would be just as helpful as compliments. Those patients who consented to participate were administered an 18-item version of the CSQ (Levois et al, 1981).

RESULTS

Dropout Characteristics

Discriminant Analysis

It was hypothesized that dropouts differ from remainers on the following variables: education, income, occupation, race, age, referral source, type of symptomatology, previous psychiatric history, presenting problem severity, and need for further treatment. To test this hypothesis, several analyses were used. For variables measured at the interval level, discriminant analysis was used; for variables measured at the nominal level, chi-square analysis was used. In the first discriminant analysis, three groups were used, dropout following intake(N=87), dropout following two sessions (N=39), and remainers for three or more sessions (N=262). The total number of cases was 388. One hundred cases were excluded from the analysis. Eighty-four of these cases had unknown numbers of sessions. The remaining 16 had other missing data. Variables included in the analysis were level of functioning, suicide risk, homicide risk, need for service, income, number of dependents, education, number in household, employment, age, previous inpatient treatment, previous outpatient treatment, level of functioning at time of case closing, length at residence, SCL-90 global severity index, SCL-90 positive symptom total, SCL-90 positive symptom distress index, SCL-90 subscales measuring somatization, obsessive compulsive behavior, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoia, psychoticism, and an additional depression subscale.

The method of discriminant analysis was stepwise Wilk's analysis; i.e., variables which minimized Wilk's lambda were selected for inclusion. The sample distribution of cases was taken as an estimate of the population distribution; the prior probabilities were then set at 0.22 (probability of dropping out following one session), 0.10 (probability of dropping out following two sessions), and 0.66 (probability of remaining for three or more sessions), rather than assuming equal likelihood of belonging to either group.

Table 4 summarizes the results of the discriminant analysis, showing Wilk's lambda and significance levels for variables selected by stepwise analysis. The criterion used for selecting variables was Wilk's lambda, a measure of group discrimination. Variables were selected in order of their ability to discriminate between the three groups, i.e., minimize Willk's lambda. From Table 4, it can be seen that 15 of the original 27 variables were selected before subtractions from Wilk's lambda became nonsignificant. Of the 15 variables, income, level of functioning at time of closing, interpersonal sensitivity, paranoia, and age had more discriminating power than psychoticism, positive symptom distress index, need for service, suicide risk, phobic anxiety, hostility, somatization, number in household, previous outpatient treatment, and homicide risk. The latter variables added little discriminating power to the function, as shown by the very small changes in Wilk's lambda at their entry.

Table 5 shows the discriminating power of the two functions derived from the discriminant analysis. As seen in Table 5, the two functions produce a small degree of separation between the three groups, in-

TABLE 4

Summary Table of Stepwise Wilk's Discriminant Analysis

Step	Wilk's lambda	Significance level
1. Income	0.92	0.001
2. Level of functioning (closing)	0.88	0.001
3. Interpersonal sensitivity	0.85	0.001
4. Paranoia	0.83	0.001
5. Age	0.80	0.001
6. Psychoticism	0.79	0.001
7. Positive symptom distress index	0.78	0.001
8. Need for service	0.77	0.001
9. Suicide risk	0.76	0.001
10. Phobic anxiety	0.76	0.001
11. Hostility	0.75	0.001
12. Somatization	0.74	0.001
13. Number in household	0.74	0.001
14. Previous outpatient treatment	0.73	0.001
15. Homicide risk	0.73	0.001

dicated by the eigenvalues of 0.23 and 0.20, and canonical correlations of 0.43 and 0.33 for the functions. Before any functions were removed, lambda was 0.73, indicating that the variables used in the analysis had some discriminating power. The associated chi-square ($x^2(30)=119.67$, $p<.001$) indicates that the amount of discriminating power in the variables is statistically significant. After some of this discriminating power was removed by placing it in the first function, lambda increased to 0.89, but the associated chi-square ($x^2(14)=42.73$, $p<.001$) indicates that a statistically significant amount of discriminating power still exists. Because there were three groups, no more than two functions could be derived.

Table 6 shows the standardized discriminant function coefficients for the variables which best discriminated between the three groups. As shown in Table 6, the variables which contribute most to the first function are psychoticism, phobic anxiety, interpersonal sensitivity, somatization and income. Psychoticism is about twice as important as somatization and income, while phobic anxiety and interpersonal sensitivity fall in between. The variables which contribute most to the second function are paranoia, interpersonal sensitivity, hostility, and somatization. Paranoia and interpersonal sensitivity are about twice as important in the second function as hostility, while somatization has the same relative contribution in the first and second function. The first function could be described as composed primarily of overt psychiatric symptomatology such as thought disorder and phobias. The second function could be described as composed of difficult interpersonal issues such as paranoid thoughts, sensitivity, and hostility.

TABLE 5

Discriminating Power of the Two Functions

Function	Eigenvalue	Variance	Canonical Correlation
1	0.23	65.34%	0.43
2	0.20	34.66%	0.33

Wilk's lambda	chi-square	df	significance
0.73	119.64	30	0.001
0.89	42.73	14	0.001

TABLE 6

Standardized Canonical Discriminant Function Coefficients

Variable	Function 1	Function 2
Suicide risk	-0.02	0.34
Homicide risk	0.17	0.08
Need for service	0.17	-0.25
Income	-0.86	0.01
Number in household	-0.05	-0.30
Age	0.41	-0.04
Previous OPT*	-0.17	-0.03
Level of functioning	0.52	0.10
Symptom distress index	0.47	0.64
Somatization	-0.96	0.91
Interpersonal sensitivity	-1.16	-2.25
Hostility	-0.13	-1.32
Phobic anxiety	1.17	0.53
Paranoia	-0.21	2.46
Psychoticism	1.73	-0.26

* Outpatient treatment

Table 7 shows the means and standard deviations for each group on the discriminating variables. As shown in Table 7, remainers were younger than dropouts following intake and dropouts following two sessions. Dropouts following intake had lower levels of functioning at the time of case closing than dropouts following two sessions or remainers. Dropouts following intake and remainers had higher scores than dropouts following two sessions on several variables: SCL-90 interpersonal sensitivity, paranoia, psychoticism, phobic anxiety, hostility and somatization subscales; need for service; and number in household. Dropouts following two sessions had higher scores than dropouts following intake and remainers one the SCL-90 positive symptom distress index, suicide risk, and homicide risk. Remainers had a lower incidence of previous outpatient treatment than both dropout groups.

Chi-square analysis

Chi-square analysis was also utilized to determine how strongly the clinical and demographic variables were related to dropout, since not all of the variables in the study met the criterion for discriminant analysis, i.e. measurement at the interval level. Because of the unequal sample sizes in the three groups, the following variables were excluded from the analysis due to cell size violations: primary DSM III diagnosis, secondary DSM III diagnosis, insurance, ethnicity, intake worker, therapist, and referral source. Type of occupation ($x^2(16)=22.57$, $p<0.13$), sex ($x^2(2)= 0.19$, $p<0.91$), and marital status ($x^2(8)=8.97$, $p<0.34$) did not differ in the three groups. Religion ($x^2(8)=21.47$, $p<0.04$) was significantly different in the three groups.

TABLE 7

Means and Standard Deviations for Discriminating Variables

Variable	Intake Dropouts	Two Session Dropouts	Remainers (>3 Sessions)	S.D.
income	3.59	3.49	2.44	1.81
level of functioning	6.11	6.41	6.47	1.10
interpersonal sensitivity	7.17	5.15	6.85	3.01
paranoia	6.92	5.61	6.75	3.09
age	2.99	3.05	3.35	1.11
psychoticism	6.63	4.74	6.56	3.34
symptom distress index	17.17	31.95	18.91	25.25
need for service	3.06	2.95	3.07	0.44
suicide risk	1.09	1.18	1.09	0.37
phobic anxiety	6.37	4.49	6.45	3.54
hostility	6.90	5.08	6.72	3.18
somaticism	6.61	4.87	6.54	3.36
number in household	1.85	1.61	1.79	0.74
previous OPT*	0.57	0.56	0.51	0.50
homicide risk	1.02	1.08	1.03	0.28

* Outpatient Treatment

Catholic, Protestant, and Jewish patients were more likely to remain in treatment than to drop out, while patients in the 'other' or 'none' categories of religion were more likely to drop out of treatment.

Follow-up Results

Frequency Data

Frequency data were obtained from the consumer satisfaction questionnaire (CSQ) which was completed by 69 patients. The questions can be grouped into several categories: questions dealing with satisfaction with the quality and type of services provided, questions dealing with the outcome of the services, questions addressing clinic variables, and questions having to do with the therapist.

Satisfaction with Quality and Type of services. Table 8 shows the frequency data for responses to CSQ items about satisfaction with the quality and type of services received. The responses are fairly consistent if broken into two categories instead of four. For example, for each question, between 53 and 55 subjects (77-80%) are satisfied and 14-16 (20-23%) are dissatisfied with the quality and type of services. Patients responded more positively to questions about the quality of service, recommending the program to a friend, and returning than about overall satisfaction, satisfaction with the amount and kind of service received, and not receiving other needed services. Patients were most negative about returning, with 20 saying that they would not return as opposed to the 14-16 range of dissatisfied responses on other items.

TABLE 8

Satisfaction with Quality and Type of Services

Overall General Satisfaction	
very satisfied	23.2% (16)
mostly satisfied	56.5% (39)
mildly dissatisfied	10.1% (7)
very dissatisfied	10.1% (7)
Quality of Service	
excellent	46.4% (32)
good	30.4% (21)
fair	15.9% (11)
poor	7.2% (5)
Received Kind of Service Wanted	
yes, definitely	26.1% (18)
yes, generally	53.6% (37)
no, not really	11.6% (8)
no, definitely not	8.7% (6)
Satisfied with Amount of Help Received	
very satisfied	30.4% (21)
mostly satisfied	47.5% (33)
mildly dissatisfied	14.5% (10)
quite dissatisfied	7.2% (5)

TABLE 8

Satisfaction with Quality of Services (continued)

Other Services Needed But Not Received	
definitely not	22.1% (15)
don't think so	55.9% (38)
think so	13.2% (9)
definitely were	8.8% (6)
Would Recommend Program to a Friend	
definitely yes	62.3% (43)
think so	17.4% (12)
think not	14.5% (10)
definitely not	5.8% (4)
Would Return if Needed Help	
yes, definitely	44.9% (31)
think yes	26.1% (18)
think no	15.9% (11)
no, definitely	13.0% (9)

Satisfaction with the Clinic. Table 9 shows frequency data for responses to CSQ items about aspects of the clinic itself. Again, responses were consistent, 55-58 (80-84%) of responses indicating satisfaction and 11-14 (16-20%) indicating dissatisfaction. Fewer people (N=11) expressed dissatisfaction with the fee as opposed to promptness (N=14) or friendliness of staff (N=14).

Satisfaction with the Therapist. Table 10 shows frequency data for responses to CSQ items addressing satisfaction with the therapist. Responses in this category were much more variable than in the other CSQ categories. Forty-five to sixty-two patients (74-90%) expressed satisfaction on the four therapist questions, while eight to twenty-four patients (20-35%) expressed dissatisfaction. Patients reported feeling closely listened to and thinking that their therapist was competent, but were less positive about their therapist's interest in helping them and the therapist's understanding of their problem.

Outcome of Services. Table 11 shows frequency data for responses to CSQ items addressing the outcome of services. The number of patients indicating positive change varied from 49-54 (71-78%) and 15-20 of patients (22-29%) indicated that there was no change or a worsening of their problem. These responses are not as positive as those to the CSQ general satisfaction items or satisfaction with the clinic.

TABLE 9

Satisfaction with Aspects of the Clinic

Item	Percent (n)
Receptionists and Secretaries Seemed Friendly	
yes, definitely	52.2% (36)
yes, most of the time	27.5% (19)
sometimes not	8.7% (6)
often not	11.6% (8)
Seen as Promptly as Necessary	
very promptly	52.5% (36)
promptly	27.5% (19)
some delay	14.5% (10)
took forever	5.8% (4)
Satisfied with Fee	
very satisfied	53.6% (37)
mostly satisfied	30.4% (21)
mildly dissatisfied	7.2% (5)
quite dissatisfied	8.7% (6)

TABLE 10

Satisfaction with the Therapist

How Interested Was the Therapist in Helping You?	
very interested	42.0% (29)
interested	32.2% (10)
somewhat interested	14.5% (10)
very uninterested	20.3% (14)
How Closely Did the Therapist Listen?	
very closely	73.9% (51)
fairly closely	14.5% (10)
not too closely	7.2% (5)
not at all closely	4.3% (3)
How Clearly Did the Therapist Understand Problems?	
very clearly	53.6% (37)
clearly	26.1% (18)
somewhat unclearly	15.9% (11)
very unclearly	4.3% (3)
Therapist Competence and Knowledge	
highly competent	49.3% (34)
competent	40.6% (28)
only of average ability	7.2% (5)
poor abilities at best	2.9% (2)

TABLE 11

Outcome of Services

How are Problems Now?	
great deal better	39.7% (28)
somewhat better	35.3% (24)
no change	14.7% (10)
worse or much worse	10.3% (7)
Did Services Lead to Changes in Problems or Self?	
yes, a great deal of change	18.8% (13)
some change for the better	52.2% (36)
no noticeable change	24.6% (17)
changes for the worse	4.3% (3)
Did Services Help Deal More Effectively with Problems?	
helped a great deal	30.4% (21)
helped somewhat	47.8% (33)
didn't help	15.9% (11)
made things worse	5.8% (4)

Analysis of Variance

It was hypothesized that dropouts are less satisfied than remainers with their experience at the mental health center. To test this hypothesis, a one-way analysis of variance was used. The three groups, dropouts following intake (N=10), dropouts following two sessions (N=5), and remainers for three or more sessions (N=39) were compared on the 18 CSQ items and a global satisfaction score, derived by summing the responses to the 18 items. Fifteen subjects were dropped from the analysis because the number of sessions was unknown. Table 12 summarizes the significant results of the one-way analysis of variance in the three dropout groups.

On items pertaining to satisfaction with the quality and kind of of services received, the three groups did not differ in their satisfaction with the quality of services received, with the amount of services received, in their opinion of whether other services were needed but not received, whether they would recommend the center to a friend, or whether they would return for help themselves. The three groups did differ in their response to the overall satisfaction item; remainers were somewhat more satisfied than the two dropout groups with the services received ($F=3.19$, $df=2,51$, $p<.05$). When the group differences were probed using Newman-Keuls analysis, however, no two groups differed from each other at the 0.05 level of significance. In addition, remainers had a higher global satisfaction score than dropouts following two sessions, while dropouts following intake were similar to remainers ($F=5.04$, $df=2,51$, $p<.01$). Similarly, dropouts following two sessions rated the quality of the services received much lower than remainers and

TABLE 12

One-way Anova for Three Dropout Groups

Overall general satisfaction with services

Source	df	SS	MS	F	p
Between groups	2	5.00	2.50	3.192	0.05
Within groups	51	39.98	0.78		
Total	53	44.98			

Global satisfaction

Source	df	SS	MS	F	p
Between groups	2	1037.54	518.77	5.044	0.01
Within groups	51	5245.50	102.85		
Total	53	62.83			

Rating of quality of service received

Source	df	SS	MS	F	p
Between groups	2	7.29	3.65	4.560	0.01
Within groups	51	40.80	0.80		
Total	53	40.09			

Receive kind of service wanted

Source	df	SS	MS	F	p
between groups	2	4.54	2.27	3.216	0.04
within groups	51	36.00	0.71		
total	53	40.54			

TABLE 12

One-way Anova (continued)

Services help to deal with problem more effectively

source	df	SS	MS	F	p
between groups	2	8.76	4.38	6.526	0.003
within groups	51	34.22	0.67		
total	53	42.98			

How closely did therapist listen

source	df	SS	MS	F	p
between groups	2	9.22	40.61	10.18	0.000
within groups	51	23.10	0.45		
total	53	32.31			

How clearly did therapist understand

source	df	SS	MS	F	p
between groups	2	6.56	3.28	4.153	0.02
within groups	51	40.27	0.79		
total	53	46.83			

Therapist competence and knowledge

source	df	SS	MS	F	p
between groups	2	7.06	3.53	7.316	0.001
within groups	51	24.59	0.48		
total	53	31.65			

dropouts following intake (F=4.56, df=2,51, p<.01). Dropouts following intake were more likely than remainers to state that they didn't receive the kind of service that they wanted, while dropouts following two sessions were similar to remainers on this question (F=3.30, df=2,51, p<.04). Newman-Keuls analysis of the above differences indicated that the group differences were significant at the 0.05 level.

Concerning the outcome of the services, the three groups did not differ in their responses to the question of how their problems were now or if the services received led to any changes in their problems or themselves. The groups did differ, however, in their responses to the question of whether the services helped them deal more effectively with their problem. Newman-Keuls analysis indicated that remainers were more likely to say that the services had helped than both of the dropout groups (F=6.60, df=2,51, p<.003).

Responses to therapist items were different in the three groups. Newman-Keuls analysis indicated that the difference was in dropouts following two sessions, who did not feel closely listened to by their therapists, compared to remainers and dropouts following intake, who felt very closely listened to (F=10.18, df=2,51, p<.002). Similarly, dropouts following two sessions did not feel understood by their therapist, compared to the other two groups who felt very clearly understood (F=4.15, df=2,51, p<.02). Again, dropouts following two sessions saw their therapists as less competent and knowledgeable than the other two groups, who rated their therapists highly in this respect (F=7.32, df=2,51, p<.0016). The only therapist item on which the groups did not differ was the therapist's interest in helping them.

With regard to clinic variables, the three groups did not differ in their satisfaction with the fee, in their satisfaction with the promptness with which they were seen, or in their perceptions of the receptionists as friendly and comfortable.

DISCUSSION

Variables Predictive of Dropout

The studies reviewed in the literature review provided evidence for patient input, therapist input, and psychotherapeutic process variables as predictors of dropout from psychotherapy. Patient demographic variables related to dropout include education, income, occupation, race, age, and referral source. Clinical variables related to dropout include type of presenting symptomatology, such as anxiety, depression, paranoid and sociopathic features, previous psychiatric history, need for treatment at the time of case closing, and psychological factors such as defensiveness, degree of denial, dependency, psychological mindedness, and motivation. Therapist variables related to dropout include level of experience and gender, although these findings are inconclusive. Despite the presence of statistically significant relationships between the above variables and dropout, the major conclusion of the literature review was that most studies fail to predict much of the variance in the dropout variable, for a variety of methodological and conceptual reasons.

The most informative area of the psychotherapy research literature is those studies investigating the joint impact of patient input, therapist input, and psychotherapeutic process variables, which find that patient pretherapy expectations, patient's perceptions of therapist behaviors, and psychotherapy process variables have the greatest predictive power with regard to psychotherapy dropout, compared to studies of patient characteristics alone.

In this study, it was hypothesized that patient demographic and clinical variables shown to be related to dropout in the literature review would also differ in the three patient groups used in this study. That is, dropouts differ from remainers on the demographic variables education, income, age, race, and occupation and on the clinical variables type of symptomatology, previous psychiatric history, presenting problem severity, and need for further treatment. The results of this study provide some support for this hypothesis. Variables which best discriminated among dropouts following intake, dropouts following two sessions, and remainers for three or more sessions were the demographic variables income, age, and number in household and the clinical variables level of functioning at time of case closing, SCL-90 subscales interpersonal sensitivity, paranoia, psychoticism, symptom distress index, phobic anxiety, hostility, and somatization as well as suicide risk, homicide risk, need for service, and previous outpatient treatment.

In this study, dropouts in general differed from remainers in having higher levels of income and being younger. Dropouts following intake differed from dropouts following two sessions by having a lower level of functioning at time of case closing, being more anxious around people, more paranoid, more psychotic, more phobic, more hostile, more likely to have somatic complaints, and more likely to live alone. Dropouts following intake were very similar to remainers on all of the above variables. Dropouts following two sessions had higher symptom distress indices, higher suicide risk, and higher homicide risk than intake dropouts or remainers. Dropouts following two sessions and remainers were similar in having more outpatient experience, higher closing levels of functioning, and more members in their households.

At the two points of high risk for dropout, the intake interview and the second interview with the assigned therapist, then, a different pattern of results emerges. Both dropout groups had higher levels of income than remainers, suggesting a variety of interpretations. It could be that these patients had the financial resources to afford to look for treatment elsewhere, if dissatisfied, and that remainers represent a more captive population for the mental health center. Alternatively, these findings could be indicative of more stability in the dropout groups. Interestingly, this result is in the opposite direction of that based upon the literature review. Most studies of socioeconomic status of the dropout found that lower socioeconomic status patients were more likely to drop out of treatment (Baekeland & Lundwall, 1975).

The two dropout groups differed in a number of interesting ways. Compared to the second dropout group, dropouts following intake reported more interpersonal anxiety, more hostility, more somatic complaints, more statements indicative of psychotic behavior, and more paranoia than dropouts following two sessions. These symptoms have been viewed as making it difficult for a therapist to engage a patient in psychotherapy (e.g., Baekeland & Lundwall, 1975). From this study, however, it appears that once the tense, mistrustful, hostile patient makes a decision to start psychotherapy (e.g., continues past intake), he or she is more likely to remain than patients who are less symptomatic.

Interestingly, dropouts following two sessions were higher on suicide risk, homicide risk, and overall symptom distress index, suggesting that the problems for which they sought treatment could have been more incapacitating than those of the other dropout group and remainers.

To summarize, then, dropouts in this study would be described as having higher income levels than remainers. This socioeconomic difference may lead them to seek treatment elsewhere if dissatisfied, since they have the financial resources to do so. These patients do not exhibit life-threatening symptomatology such as high suicide or homicide risk. However, they are more likely to report symptomatology suggesting that they would be more difficult to engage in the treatment process. Patients who attend only intake and who do not follow through with psychotherapy experience more anxiety, more hostility, and more interpersonal sensitivity, which probably interferes with their engagement in the treatment process. However, once these patients meet their therapist, they are more likely than others to continue. Patients who drop out following two sessions have problems which are more incapacitating than intake dropouts or remainers. It appears clear that the use of an instrument such as the SCL-90 adds to the ability to discriminate between three clinical groups such as these.

The two functions derived from discriminant analysis differed somewhat in composition. The first function could be described as composed primarily of overt psychiatric symptomatology such as thought disorder and phobias. The second function could be described as composed primarily of difficult interpersonal problems such as anxiety, excessive sensitivity, and hostility. Although the results of the discriminant analysis are statistically significant, the functions derived in the analysis do not have much discriminating power. The first function accounted for only about 20% of the variance in the groups; the second function, about four percent. Although the observed patterns are inter-

esting, the detected differences are so small that they have little clinical utility, that is, could not be used to screen out high risk clients prior to dropout. In addition, several of the variables, such as level of functioning at closing and need for further service could not function as predictors in the clinical setting. In fact, the validity of these measures has been questioned by some researchers, who believe that lower ratings reflect the negative bias of therapists toward patients who drop out (e.g., Fiester & Rudestam, 1975).

Chi-square analysis indicated that religion differed in the three groups. The finding on religion is difficult to interpet; Catholic, Protestant and Jewish patients were more likely to remain in treatment than to drop out, while patients in the "other" or "none" category for religion were more likely to drop out. It is possible that patients adhering to a particular religion are more acquiescent to authority, making them more likely to remain in treatment. Alternatively, these people may be more connected with the community and more stable than other groups. As indicated in Baekeland and Lundwall's (1975) review, patients who have no affiliations are more likely to drop out of treatment than those who belong to groups, organizations, or have close family ties.

The finding of no difference in many of the variables in the study between the three groups on the analyses suggests, again, that patient demographic and clinical variables are not the most important predictors of psychotherapy dropout and that there is no simple way to screen out patients who are at high risk for dropout at the time of intake. Rather, measures such as the SCL-90 may have more utility in predicting early dropout from psychotherapy.

Follow-up Results

In the literature review, consumer satisfaction studies indicated that client satisfaction had a strong positive relationship to length of stay, mutual termination, and outcome of psychotherapy. Therapist behaviors were highly related to consumer satisfaction but client and therapist demographic variables were not (Tanner, 1981). Client satisfaction was also found to be highly related to fulfillment of client expectations, to clients' global assessment of their success in treatment, but less strongly related to therapist satisfaction with treatment, specific assessment of client outcome, and therapist assessment of outcome.

In this study, it was hypothesized that dropouts are less satisfied on the consumer satisfaction questionnaire than remainers. The three groups did differ in their response to the overall satisfaction item; remainers were more satisfied than the dropout groups, providing some support for this hypothesis. Remainers were also more likely to say that the services helped them to deal more effectively with their problems. The three groups did not differ in their satisfaction with the quality and amount of services received, in their opinion of whether services were needed and not received, in their willingness to recommend the center to a friend or to return for treatment themselves, or their responses to the question of how their problems were now or if the services received led to any changes in their problems or themselves.

It was also hypothesized that dropouts following two sessions are more dissatisfied with the therapy and the therapist than dropouts following intake or remainers. Some support for this hypothesis was provided in this study. Dropouts following two sessions had lower global

satisfaction scores than dropouts following intake and remainers, and rated the quality of the services much lower. In addition, dropouts following two sessions did not feel listened to closely by their therapists compared to remainers and dropouts following intake, did not feel understood by their therapists, and saw their therapists as less competent and knowledgeable. The only therapist item on which the groups did not differ was the therapist's interest in helping them.

The hypothesis was not supported by the finding that dropouts following one session were more likely to state that they didn't receive the kind of services that they wanted than the other two groups.

It appears that patients may be more likely to drop out at intake when the services offered are not congruent with the services they expect, while patients are more likely to drop out following the second session when they perceive their therapists as not listening, not understanding, and lacking in competence and knowledge. These results suggest that the patient's perception of the therapist is of critical importance in determining whether or not a patient will remain in therapy. These findings concur with those of Fiester and Rudestam (1975,1977) and indicate that at the two high risk points for dropout, intake and session two, two different processes may be operating. Patients' pretherapy expectations about the kind of services they expect to receive appear to be more important in determining dropout following intake, while patients' perceptions of therapists' behaviors are more important in determining dropout following two sessions.

Methodological Problems

The above conclusions need to be tempered by the methodological flaws in this study. The small sample of patients who could be reached for follow-up cannot be considered to be a representative sample of the population under study, making the generalizability and validity of the results suspect. It would be more beneficial to attempt to contact patients, as some studies do, as soon as two weeks to one month following the intake interview, in order to maximize the likelihood of reaching a good sample. The patients in this study were contacted one year to two years following their intake interview; although some were still in treatment at the time of follow-up contact, there was a great deal of attrition due to changed phone numbers and moving.

An additional concern is the manner in which dropouts were defined. As indicated in the literature review, the criteria used for defining dropout vary tremendously from study to study. It is thus difficult to compare the results of this study to any other psychotherapy dropout study. Given that differences were found in this study between groups differing by only one session, it appears even more important to work toward a uniform dropout definition so that the research literature becomes more informative.

Finally, the common approach to the study of dropout, which was also employed in this study, involves taking a large amount of readily available data and subjecting it to analysis in the hopes of finding practical predictor variables. It seems clear that no study has identified any one consistent pattern of predictors of dropout, and that perhaps this approach should be abandoned. The findings from the consumer

satisfaction questionnaire and the SCL-90 appear to offer more relevant information about the various dropout groups than the findings from the intake data. However, these data are more difficult to obtain. The findings of this study and the findings of Fiester and Rudestam (1975) also highlight the importance of patient pretherapy expectations, perceptions of the therapist, and therapy process variables. Unfortunately, these measures require a good deal of effort, staff cooperation, and intrusiveness into the psychotherapeutic process to implement, so that they are rarely studied in natural settings. It appears clear, however, that these are the variables which hold the most promise for understanding the phenomenon of psychotherapy dropout.

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APPROVAL SHEET

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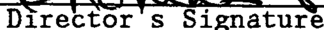
The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

4/16/84

Date



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