1981

Demographic Predictors of Psychotherapy Dropout: Patient and Therapist Characteristics

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DEMOGRAPHIC PREDICTORS OF PSYCHOTHERAPY DROPOUT: PATIENT AND THERAPIST CHARACTERISTICS

by

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A Thesis Submitted to the Faculty of the Graduate School of Loyola University of Chicago in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

February

1981

ACKNOWLEDGMENTS

I would like to thank the members of my committee, Al DeWolfe, Ph.D. (director) and John Shack, Ph.D., for their help in bringing this thesis to its completion.

I would also like to express my deep appreciation to Kenneth Howard, Ph.D. who has served as my mentor in psychotherapy research. His interest, support, and guidance have been invaluable to me. I also thank David Orlinsky, Ph.D. for his consultation and encouragement on my work.

I am grateful to Dr. S. Dale Loomis, Director of the Katharine Wright Clinic, and Ms. Angeline Heisler, Clinic Administrator, for their cooperation and assistance in the collection of data. I also thank Steven Tovian, Ph.D. for his assistance in this work.

Lastly, I thank my husband, Alan, for his help and support during the preparation of this thesis.

VITA

The author, Linda Papach Goodsitt, is the wife of Alan Goodsitt, M.D., and daughter of Edward Papach and Dorothy (Stilipec) Papach. She was born August 7, 1948, in South Bend, Indiana.

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TABLE OF CONTENTS

LIST OF TABLES

CONTENTS OF APPENDICES

CHAPTER I

INTRODUCTION

The label "psychotherapy dropout" has been used by mental health professionals to describe patients who terminate their treatments after relatively brief periods of time. This label carries with it the assumption that patients who stay in psychotherapy for only short periods are necessarily treatment failures.

Given the assumption of therapeutic failure, clinicians have reacted with concern to survey statistics that indicate psychotherapy dropouts comprise a relatively large percentage of their outpatient clinic populations. One concern is that limited professional manpower is being wasted on patients who will not or are unable to cooperate in the treatment process. A second concern is that of patient welfare. Specifically, following their brief psychotherapeutic exposure, psychotherapy dropouts are presumed to remain in psychological need.

A number of solutions have been proposed to reduce the incidence of patient dropout. One proposed solution has been to institute careful screening procedures in which psychotherapeutic services are offered only to those patients deemed likely to stay in and benefit from it. Pretherapy training and modifications in treatment techniques have also been proposed as possible solutions.

Underlying each of these proposals are hypotheses about the causative factors of treatment dropout, which include characteristics

specific to the patient, therapist, and treatment process. In their study of treatment dropout, the research community has investigated potential predictive and causative factors with major attention being given to demographic characteristics of patients and therapists. To date, however, little evidence has been found linking demographics to dropout.

The assumption of therapeutic failure of psychotherapy dropout has been made by clinicians and researchers alike. Yet the validity of this assumption has gone unquestioned. Research conducted to date on the dropout problem has used continuation in treatment as its sole criterion.

Given that the mental health community's target concern regarding psychotherapy dropout is that he is a therapeutic failure, it would be more scientifically precise and sound to utilize two criteria when investigating this problem area. Namely, a length of stay criterion and a therapeutic outcome criterion.

Statement of the Problem

It is the purpose of the present study to investigate the relationship between patient and therapist demographic characteristics and dropout, using the criteria of both length of stay in treatment and therapeutic outcome. As research using this two-dimensional definition of dropout has not been done before, this study is considered exploratory in nature and no formal hypotheses will be advanced.

CHAPTER II

REVIEW OF LITERATURE

This literature review has three sections. In the first section, the relation of dropout to length of stay in psychotherapy is discussed. Attention is given to the current conceptualization of psychotherapy dropout, and the mental health practitioner's concerns for and proposed solutions to the problem. The second section covers research on patient and therapist demographic characteristics related to length of stay in psychotherapy. The last section is a critique of the current operational definition of psychotherapy dropout in the research literature.

The Relation of Dropout to Length of Stay in Psychotherapy

Psychotherapy has recently been defined as an interpersonal process in which patients are offered an opportunity to modify problematic feelings, cognitions, attitudes, and behaviors, and take on new ways of feeling and behaving that are consonant with adaptive functioning and a sense of well being (Strupp, 1978). And mental health practitioners traditionally assume that patients must participate in this process for a certain length of time in order for any positive change to occur. In a review of research literature seeking to identify factors that influence the outcome of psychotherapy, Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) have concluded that the longer patients remain in psychotherapy, the more

likely will they have achieved positive therapeutic outcomes. This research finding has supported the notion that a certain amount of contact between patient and therapist is necessary for therapeutic change to take place, although the exact amount of contact has remained unspecified.

Consistent with the practitioner's assumption that the more treatment the better is a corollary assumption that patients who stay in treatment for relatively brief periods of time are necessarily unchanged or worse. Garfield (1978) has explained the rationale for this assumption as follows: "If a client discontinues therapy before the therapist believes there has been sufficient time to affect change, then such discontinuance directly influences and limits the amount of change to be expected" (p. 210). As such, patients who terminate their psychotherapy shortly after its inception have been variously labelled "discontinuers," "premature terminators," or "dropouts" and are traditionally assumed to be therapeutic failures (Garfield, 1971).

Based on these assumptions it may be that practitioners hope, expect, and/or advise their patients to continue in psychotherapy for longer versus shorter periods of time in the interest of promoting beneficial change. Yet investigations into the actual length of time patients remain in their psychotherapy has revealed that a large percentage of outpatients terminate their psychotherapy shortly after onset.

Incidence of Dropout. In an early investigation into the actual length of stay of outpatients in psychotherapy, Garfield and Kurz (1952)

reported that of 560 patients in a VA mental health center who were offered and accepted psychotherapeutic treatment, two-thirds of them received no more than 10 sessions, with a median length of stay of six sessions. Haddock and Mensh (1957) reported that two-thirds of the patients in one VA clinic and two university health settings were seen for fewer than five sessions. In an annual statistical report for psychiatric clinics in the states of New York and Maryland, Gordon (1965) reported that the majority of patients were seen for less than five sessions. Gabby and Leavitt (1970) found that of 400 clinic patients, 45% were seen for less than five interviews. Fiester and Rudestam (1975), in reviewing the records of three urban mental health centers reported that 37-45% of adult outpatients terminate their psychotherapy after the first or second visit.

In two major reviews of studies reporting on length of stay in psychotherapy, Garfield (1971, 1978) concluded that of patients who were offered and accepted psychotherapy, the median length of stay ranged from three to 12 visits, with a clustering around six sessions.

Not only has it been found that many patients stay in psychotherapy for short periods of time, but that these early terminations are frequently patient-initiated, and often without prior discussion with the therapist. In a study by Weiss and Schaie (1958), their review of 603 outpatient records revealed that 38% of the patients failed to return for treatment or disposition even though they were given a definite appointment. In the Haddock and Mensh (1957) study, more than one-half of the veterans and one-third of the students who stayed for fewer than five sessions terminated their treatment on

their own, without discussing it with their therapists. In the Gabby and Leavitt (1970) study, of the 45% of the clinic patients seen for less than five interviews, the majority were reported as simply discontinuing treatment on their own.

Eiduson (1968) in a review of premature termination studies reported that 30-65% of all patients in facilities representing every kind of psychiatric service drop out of their treatment. Baekeland and Lundwall (1975) in their review of the dropout literature reported that 20-57% of patients failed to return for a scheduled appointment after their first visit. Of the 31-56% of patients who attended no more than four sessions, four out of five dropped out of treatment on their own. Garfield (1971) has concluded that "the finding of an unplanned and premature termination from psychotherapy on the part of a large number of clients is a reasonably reliable one" (p. 276).

By juxtaposing the figures on the actual length of stay of a large number of outpatients and the practitioner's expectation regarding length of stay and positive outcome, it can be seen that dropping out of treatment constitutes a major problem in the practice of psychotherapy, from the practitioner's point of view.

Concerns for and Proposed Solutions to Dropout. A two-fold concern about this problem has been expressed. One concern is of an economic nature. Given the large demand for psychotherapeutic services and the limited professional resources available to meet this demand, it has been considered an inefficient use of professional manpower to invest time in arranging provision of services for persons who are not

going to follow through with the treatment. Most clinics are known to have waiting lists, and as such time spent on one person is time not available to another.

A second concern is that of patient welfare. As mentioned above, patients who both initiate terminations from their therapy and do so at an early stage of treatment, with or without notice to their therapists, are frequently assumed to be therapeutic failures in the sense that they have not remained long enough in their treatment to have gotten anything out of it. Baekeland and Lundwall (1975) have added that practitioners also assume that these patients get worse following their terminations.

In response to the problem of the dropout, the professional community has proposed three major solutions, as outlined by Garfield (1971): (a) the institution of screening procedures with the aim of selectively offering psychotherapy only to those patients deemed likely to follow through with the treatment; (b) the addition of pretherapy training as a means to better align patient expectations with what psychotherapy has to offer, thereby reducing patient attrition; and (c) a modification in the psychotherapy itself to better meet the needs of the dropout. Underlying each of these proposed solutions to the dropout problem are differing hypotheses about what has caused the dropout problem in the first place.

The screening procedure solution posits that there is a certain class or type of patient for whom psychotherapy will work, and a certain class or type for whom it will not work. The difference between success and failure in psychotherapy is thought to be a function of

characteristics of the patient before he enters treatment. This view is consonant with Frank's (1974) conclusion that "the most important determinant of long-term improvement lie in the patient" (p. 339). As such, patients who have certain requisite characteristics (e.g., age, income, social class, education, symptom clusters) that have been shown to respond favorably to psychotherapy in the past would be judged "suitable" candidates for psychotherapy in the present and thus offered the treatment. Those patients who do not have the necessary success-predicting characteristics would be deemed "unsuitable" and not offered psychotherapy.

This solution to the dropout problem leaves the burden of responsibility for, in effect, qualifying for treatment on the patient. Yet while it may reduce the dropout rate, thereby responding to the economic concern of making most efficient use of professional manpower, it does not respond to the concern for patient welfare. Given that psychotherapy is frequently the major and sometimes sole treatment offered at mental health clinics for emotional and behavioral problems, a large portion of the outpatient population would be left unserved.

Another problem that is attendant to the hypothesis that patient characteristics are responsible for early termination from psychotherapy is the manner by which screening choices would be made. It is well known that psychotherapists prefer working with patients who are young, psychologically sophisticated and less disturbed, and that this preference influences therapists' expectations regarding who is most likely to benefit from psychotherapy (Schofield, 1964). The mere

implementation of selection criteria, based upon practitioners' hunches, preferences, and expectations, without benefit of empirical evidence, leaves room for stereotypy and bias that all too often leads to self-fulfilling prophecies about who will or will not stay in and benefit from treatment.

A second proposed solution to the dropout problem has been a call to consider pretherapy training as a means to better align patient expectations with what psychotherapy has to offer. For example, research on role-induction interviews (Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1964; Overall & Aaronson, 1963) has shown that preparing patients for psychotherapy does have some impact on their attendance and progress. Pretherapy training hypothesizes that characteristics inherent in the patient (i.e., faulty expectations) account for his early termination, as in the case with the screening procedure solution. But unlike the screening procedure solution, pretherapy training responds to both the economic and patient welfare concerns by trying to reach out to patients who would presumably otherwise drop out of treatment.

A third proposed solution to the dropout problem has been a call for modifications in traditional treatment approaches to better meet the needs of the dropout. For example, Goldstein (1973) has developed a structured learning therapy for the poor that is designed to address the special needs and issues of this class of patients. The modification of treatment solution posits that it is the treatment, and perhaps the therapist who has offered it, that has failed the patient. It suggests that the dropout stops his treatment not because he lacks

the necessary attributes, but because the psychotherapy and the therapist have not been responsive to his needs. This approach raises the question as to whether or not there are certain types of therapists or treatment variables that account for treatment dropout. It also responds to the patient welfare concern but places a greater demand upon professional manpower.

Summary. As can be seen, the incidence of early termination from psychotherapy is conceptualized as a problem that needs to be solved. In considering all three proposed solutions, it has been hypothesized that characteristics of the patient, the therapist and the treatment may be responsible for the dropout problem.

In order to gain a better understanding of this problem, and lend empirical support to any or all of these proposed solutions, a body of research has emerged with efforts aimed at identifying factors that may account for and/or predict differential lengths of stay in psychotherapy.

The Relation of Demographics to Length of Stay in Psychotherapy

Researchers have paid considerable attention to patient and therapist demographics in their study of treatment dropout. Demographics per se have been criticized on the grounds of being too simplistic and global a categorization of what is meant by therapeutically relevant characteristics in psychotherapy (Parloff, Waskow, & Wolfe, 1978). Yet they continue to be a popular subject of study given their relative ease of accessability to the researcher and the fact that demography allows for categorization on the basis of concrete and

mutually exclusive differences between people as opposed to abstract and nondiscrete categorization.

Demographics can be conceptualized as being of two major types: those that describe a person's current life situation and those that describe his background or early history. Life situational variables include descriptors such as age, race, current socioeconomic status, marital and parental status, employment status, patient diagnosis, and therapist experience level. Variables of this type have received the greatest attention in the research literature to date.

Most frequently, life situational variables have been studied independently, both within and between patients and therapists, although recently there has been a call in the literature to consider matching patients and therapists on given variables, as well as selectively combining them into meaningful "life status" categories (Berzins, 1977). The underlying rationale for matching patients and therapists on certain variables involves the idea that a certain degree of similarity between patients and therapists, particularly at the outset of psychotherapy, may facilitate therapeutic communication and process, including continuation in treatment. This similarity hypothesis has been well taken, and there has been increased investigation of the interaction between patients and therapists on particular demographic variables.

The idea behind combining select life situational variables to describe a person's life status implies that the exigencies of the current environmental situation may dramatically influence a person's expectations and orientation toward others. It seems reasonable to

assume, for example, that a female patient who is young and single will react differently to a single male therapist, and visa versa, than a patient who is female, married, and with children. There has been little research conducted to date on the influence of current life status on psychotherapeutic process, however.

Demographics that describe a person's early history include variables such as socioeconomic background, family of origin factors like family size, birth order, and incidence of early parent loss, and religious upbringing. Here it is hypothesized that a person's early socialization and developmental experiences significantly influence the manner in which he will react to others in the present, including the other in the psychotherapeutic setting. As yet, little to no systematic research has been conducted on the influence of patient and therapist background demographics, either singly or interactively.

Before turning to a review of the literature on demographics related to treatment dropout, it is important to note a common criticism of the research methodology in this area. Specifically, treatment dropout has generally been operationally defined by the number of sessions a patient remains in his psychotherapy. Yet there is no consensus among researchers as to the number of sessions that qualify a patient for dropout status. As such, there is considerably variability in the criterion number of sessions used when forming comparison groups of "dropouts" and "remainers" in psychotherapy.

Baekeland and Lundwall (1975) have reported in their review of the dropout literature that the cutoff point between the two comparison groups has ranged anywhere from three to 10 sessions. While it is

possible to circumvent the problem of choosing a cutoff point by statistically treating length of stay as a continuous variable, for a variety of reasons many researchers have treated length of stay discretely. The following literature review is comprised, therefore, of differing operational definitions of dropout and differing statistical treatments of the length of stay variable. Garfield (1971, 1978) has noted that this variability reduces the compariability of findings among these studies.

The following review of demographics related to treatment dropout, as defined by length of stay in psychotherapy, will be presented in a format which first discusses the rationale for interest in the particular variable, and second reports the findings on the variable as descriptive of (a) the patient, (b) the therapist, and (c) the patient and therapist in interaction. For demographic variables that have not been systematically investigated, only the rationale will be discussed.

Age. The variable of age as a potentially significant factor influencing psychotherapy process has most commonly been conceptualized as strictly a patient variable. And a predominant view among clinicians has been that younger adult patients are more likely to stay in treatment and benefit from it than older adults. Garfield (1978) has explained that this belief has been argued on theoretical grounds that posit the older patient as having a character structure and defenses that are entrenched and therefore less amenable to change. Psychotherapeutic intervention that has as its goal the alteration of

personality structure would therefore be met with strong resistence and likely result in lack of therapeutic effect, possibly taking the form of early termination from treatment. The fact that a number of studies have reported that some psychotherapists and clinics prefer working with younger adult patients and consider age a factor in acceptance for treatment suggests that this belief is widespread (Bailey, Warshaw, & Eichler, 1959; Gallagher, Sharaf, & Levinson, 1965; Karasu, Stein, & Charles, 1979; Marmor, 1968; Schofield, 1964).

Butler (1969) has presented an alternative view of the patient age variable. He has used the term "ageism" to describe what he considers to be prejudice and stereotypy of therapists and clinics toward older people. To expand upon Butler's view, it is the therapist's attitudes, expectations and responses to the age of the patient that may produce differential treatment processes and outcomes, and not the age of the patient per se. In line with this view, Karasu, et al. (1979) have suggested that the variable of therapist age may be a source of influence upon psychotherapeutic process and has recommended study of the interaction between the variables of patient and therapist age.

Systematic investigation of the variable of patient age has yielded both insignificant results and results that are contrary to the hypothesis that younger adult patients continue in treatment longer. For example, Garfield (1977a) concluded that patient age is not a significant factor in continuation in treatment. Baekeland and Lundwall (1975) however concluded that younger patients are more likely to drop out of treatment.

There has been little research done on the variable of therapist age in spite of the fact that cogent arguments have been presented for investigation of this variable.

The interaction effects of patient and therapist age on continuation in treatment was investigated in only one study. Karasu, et al. (1969) reported that for psychoneurotically depressed patients, the closer the age of the therapist and patient, the greater the likelihood of patients remaining in treatment.

In summary, the variable of patient age has been reported as unrelated to continuation in treatment, as well as related in a fashion contrary to common belief. That is, younger adult patients drop out of treatment more frequently than older adult patients. The variable of therapist age has not been studied, and the interaction between patient and therapist age has received attention from only one study that suggested that similarity in age was related to continuation in treatment.

Gender. In a study by Broverman, Broverman, and Clarkson (1970) sex-role stereotyping among practicing mental health professionals of both sexes was investigated. It was found that clinical judgments of optimal mental health by professionals varied with the sex of the person being judged. For example, descriptions of the mentally healthy woman included characteristics such as more submission, less independence, less aggressiveness, more emotionality, and less objectivity, as compared with descriptions of the mentally healthy man. It was also found that clinicians' descriptions of the healthy adult (sex unspeci-

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fied) were more closely matched to their descriptions of healthy men than healthy women.

This empirical demonstration of a double standard of mental health among mental health professionals, regardless of their sex, taken together with the consciousness raising efforts of the women's movement in recent years, has led clinicians and researchers alike to evaluate potential biases and discriminatory practices on the basis of sex in psychotherapy. Lerman (1978) has suggested that evaluation efforts have been further motivated by an economic concern on the part of male professionals, as a growing number of feminist therapists recommend that female patients choose only female therapists.

There have been a number of studies that have investigated the effects of patient sex on continuation in psychotherapy. Brown and Kosterlitz (1964), Cartwright (1955), Rosenthal and Frank (1958), and Weiss and Schaie (1958) reported that male as opposed to female patients more frequently continued in psychotherapy. The majority of studies, however, have reported no relationship between patient sex and continuation (Affleck & Garfield, 1961; Craig & Huffine, 1976; Frank, Gliedman, Imber, Nash, & Stone, 1957; Garfield & Affleck, 1959; Grotjahn, 1972; Koran & Costell, 1973; Noonan, 1973).

Investigations of the relationship between therapist sex and length of stay have reported findings that suggest that male therapists are more likely to lose patients from treatment than female therapists (Hiler, 1958; McNair, Lorr, Young, Roth, & Boyd, 1964). A sufficient number of studies replicating this finding have not been conducted to warrant firm conclusions at this time, however.

Several studies have been conducted on the interaction between patient and therapist sex on length of stay. Some evidence has been reported that there is a shorter length of stay for opposite sex dyads (Heilbrun, 1971, 1973; McNair, Lorr, & Callahan, 1963; Mendelsohn & Geller, 1967; Reiss, 1973). Saltzman, Luetgart, Roth, Creaser, and Howard (1976) reported however that patient and therapist gender similarity was not related to length of stay. In a more detailed investigation of dyadic sex similarity, Abramowitz, Abramowitz, Jackson, and Roback (1973) reported that there was a tendency for male therapists to see female patients for a longer period of time than female therapists with male patients.

Reviews by Garfield (1978), Parloff, et al. (1978), Berzins (1977), Lambert, Bergin, and Collins (1977), and Zeldow (1978) have all generally concluded that patient and therapist sex as a main effect have not been found to be significantly related to continuation in psychotherapy. They have further concluded that the interaction of patient and therapist sex may prove to yield significant results but as yet has not been adequately tested.

Race. The existence of and efforts to remove racial prejudice and discrimination in our society has had major impact on our social policies and practices. And the question has been raised as to whether or not racial discrimination is operative in the practice of psychotherapy. Jones (1978) has stated that there is a major controversy centering around whether white therapists can effectively treat black patients. Griffith (1977) has stated that racial dissimilarity (black

patient/white therapist) has been clinically observed to have somewhat negative effects upon psychotherapy.

Studies investigating the relationship of the variable of patient race to continuation in treatment have frequently found at least a tendency for black patients to stop their treatment relatively early. In a study by Raynes and Warren (1971), they reported that of patients who failed to keep their first appointment at the Psychiatric Outpatient Department of Boston City Hospital, blacks were significantly more likely to be in this non-attender group than whites. Other researchers (Krebs, 1971; Rosenthal & Frank, 1958; Sue, McKinney, Allen, & Hall, 1974; Yamamoto, James, & Palley, 1968) reported significant differences between black and white patients on lengths of stay in treatment, with blacks consistently staying for shorter periods of time. Gibbs (1975) however reported that for black college students in psychotherapy, their termination rates did not differ from those of other students.

Although the variable of therapist race has not been studied independently, the interaction between patient and therapist race has. Of the four possible racial pairings (black/white therapists with black/white patients), Ewing (1974) and Jones (1978) have reported no significant differences in lengths of stay between the groups.

Garfield (1978) has concluded that for the variable of patient race, research does show a tendency for blacks to terminate their treatment earlier than whites, but has further added that because this has not been shown to be a consistent finding the evidence is not conclusive. There have been no studies conducted on the variable of

therapist race as a main effect on continuation in treatment. And the few studies that have been done on the patient-therapist race interaction have reported no significant differences, although Parloff, et al. (1978) has stated that this has not been adequately tested.

It is important to note that reviewers have identified two problems in research on the race variable in psychotherapy. One concerns the possibility that there is an underrepresentation of racial biasing influences in the samples studied as voluntary participation of patients and therapists in psychotherapy research allows persons with racial prejudices to self-select themselves out of the sample (Parloff, et al. (1978). The second problem, as expressed by both Parloff, et al. (1978) and Garfield (1978) specifically concerns the variable of patient race. Because blacks make up a relatively large portion of lower class patient samples, the variable of patient race is generally confounded with patient current social class standing. Most studies investigating the patient race variable have not partialled out social class factors from their analyses.

Social Class Variables. Socioeconomic status, or social class, has generally been defined in the literature in terms of the Hollingshead Two-Factor Index of Social Position (Hollingshead, 1957) or the Warner's Index of Status Characteristics. The Hollingshead Index identifies five levels of social class ranging from Class I, the highest, to Class V, the lowest. It is based upon level of education and type of occupation. The Warner Index classifies people on the basis of occupation alone into seven categories ranging from the

upper class to the lower-lower class.

The social class of a person is thought to significantly influence his expectations, attitudes, beliefs, wants, needs, and values. The degree of difference between the classes on these factors is further thought to be directly proportional to the size of the difference between class standings. For example, using the Hollingshead Index, persons ranked in Class I are most similar to persons ranked in Class II, and least similar to persons ranked in Class V.

In a study by Brill and Storrow (1960), it was found that lower class patients were significantly more likely to have a low estimated level of intelligence, view problems as physical rather than emotional, desire symptomatic relief, lack an understanding of the process of psychotherapy, and lack a desire for psychotherapy. Frank, Eisenthal, and Lazare (1978) have stated that these differences have commonly been assumed to render lower class patients unsuitable for psychotherapy because they are not "psychologically minded."

It has been fairly well established that some psychotherapists and the clinics in which they serve prefer working with patients from middle and upper classes (e.g., Brill & Storrow, 1960; Schofield, 1964). Differential treatment assignments have also been found to be made on the basis of social class. For example, Cole, Branch, and Allison (1962) and Baker and Wagner (1966) reported that psychiatrists and psychiatric residents were more likely to see upper class patients as compared to social workers who saw more lower class patients.

A relationship between social class of patients and type of clinic has also been reported. Kadushin (1969) reported that the more

closely affiliated a clinic was with the orthodox psychoanalytic movement, the higher the social class of its applicants. Rudolph and Cummings (1962) reported that the more sophisticated a clinic's therapeutic method and the more qualified the staff, the more highly selective and higher in social status was the population of the clinic.

In contrast to the unsuitability hypothesis of lower class patients, others have suggested that biases of middle and upper class therapists prevent lower class patients from accepting and benefitting from treatment (Lambert, et al., 1977). Some studies have suggested that these biases are communicated to patients causing them to drop out of treatment (Heller, Myers, & Kline, 1963; Snyder, 1961; Wallach, 1962). It has also been suggested that middle and upper class psychotherapists are unable to gain rapport with and understand lower class patients, further contributing to the dropout problem (Parloff, et al., 1978).

The hypotheses of unsuitability of lower class patients, therapist biases, and therapist lack of understanding have been advanced because lower class patients have been consistently reported to drop out of treatment early. Imber, Nash, & Stone (1955) have reported that 42.9% of lower class patients left treatment before the fifth interview, as compared with 11.1% of middle class patients. Cole, et al. (1962) reported that 12% of the two lowest class groups of patients remained beyond 30 sessions as compared with 42% of patients in the highest two social classes. Gibby, Stotsky, Hiler, and Miller (1954) reported that middle class patients stay in therapy longer than lower class patients. Rubinstein and Lorr (1956), using a five-session cutoff, and

Sullivan, Miller, and Smelzer (1958), using a nine-session cutoff, reported that higher class patients stay significantly longer than lower class patients. One study by Albronda, Dean, and Starkweather (1964) reported no differences when using a four-session cutoff, but did find that upper class patients were slightly better at staying in treatment than lower class patients when an 11-session cutoff was used.

Educational level of the patient, which is a variable subsumed under social class, has also been found to differentiate between shorter and longer stays in psychotherapy, with higher levels correlated with lengthier treatments (Bailey, et al., 1959; McNair, et al., 1963; Rosenthal & Frank, 1958; Rosenzweig & Folman, 1974; Rubinstein & Lorr, 1956; Sullivan, et al., 1958). Three studies, however, reported no significant differences (Garfield & Affleck, 1959; Pope, Geller, & Wilkinson, 1975; Weissman, Geanakapolas, & Prusoff, 1973). In an effort to explain the lack of consistency in the results reported on educational level, Garfield (1971, 1978) has stated that it may be that education below a certain level, and not educational level in general, accounts for shorter stays in treatment. Garfield has further pointed out that education may only be one component of a larger factor which includes verbal ability, income, sophistication regarding psychotherapy, etc. As such, variability in results may be due to influences from these other components.

There has been no systematic research conducted on the current social class standing of therapists as a main effect upon continuation in treatment. The interaction between current social class standing of patients and therapists has received some attention, however. In

an analogue study by Carkhuff and Pierce (1967) it was found that the most similar dyads on race and social class showed the greatest depth of self exploration. The least similar dyads showed the least self exploration. The relation of self exploration in the psychotherapy to continuation has not been established however.

Parloff, et al. (1978) have stated that the social class backgrounds of therapists may be a significant variable in social class research. They have suggested that therapists who come from social class backgrounds that are similar to their patients may be in a position to better understand their life experiences. Henry, Sims, and Spray (1971) have reported that 48% of practicing psychotherapists surveyed in their study come from lower class and middle class backgrounds. But of this 48%, only 6% are from the lowest social class (Class V). Given that Class V patients are most often rejected from treatment, and drop out early, the question is raised as to whether dissimilarity in social class backgrounds may account for some of the variance in findings of short lengths of stay for lower class patients. Patient and therapist social class of origin has not been studied to date, and therefore no conclusions regarding the benefits or drawbacks of similarity or dissimilarity on this factor can be drawn at this time. Berzins (1977) has stated that social class similarity is currently considered to be a desireable patient-therapist match however.

In summary, the variable of patient current social class has been found to be significantly related to length of stay, with lower

class patients terminating their treatments earlier than upper class patients. This relationship holds for patient educational level as well, although the relationship is less consistent. There is some suggestion that patient and therapist similarity in current social class standing is facilitative to the psychotherapy process but whether this is true specifically for length of stay is not known. The effect of social class backgrounds of patients and therapists has not been tested. The question has been raised as to whether or not dyadic similarity/dissimilarity in social class backgrounds might not account for differential lengths of stay of lower class patients that have been reported in the literature to date.

Patient Diagnosis. Straus, Gabriel, Kokes, Ritzler, VanORD, and Tarana (1979), in their discussion of psychiatric diagnosis, have critiqued the traditional diagnostic classification system for its low reliability and inability to accurately describe the majority of patients seeking treatment. They state "For most patients, forcing the diagnostician to choose among the categories requires an arbitrary decision that may contribute to dissatisfaction in the diagnostician who recognizes how misleading diagnoses can be" (p. 105). Nonetheless, some researchers have attempted to explore for possible relationships between psychiatric diagnosis and continuation in treatment.

Frank, et al. (1957) reported that patients diagnosed with anxiety or depressive disorders had longer lengths of stay than patients in all other diagnostic categories. Dodd (1970) found that patients diagnosed with psychoneurotic and psychotic reactions re-

mained in treatment longer than patients with other diagnoses. Craig and Huffine (1976) reported that patients with psychoses or personality disorders stayed longer than patients with neuroses or transient situational disorders. Garfield (1971), in citing studies by Bailey, et al. (1959), Garfield and Affleck (1959), Lief, Lief, Warren, and Heath (1961), and Rosenthal and Frank (1958), concluded however that the majority of studies indicate that diagnosis as a means of classification has no relationship to continuation in outpatient psychotherapy. The variable of diagnosis itself is also questioned on the grounds of reliability and validity.

Patient Previous Treatment. Little research has been conducted on the effect of a patient's having had previous psychotherapeutic exposure to the length of stay of his current therapy. In considering some clinicians' and researchers' views that it is important that patients have realistic expectations about what psychotherapy is and what it can do for them, it may be hypothesized that patients who have had prior psychotherapy will be more realistically oriented toward their current therapy which will facilitate continuation in it. Baekeland and Lundwall (1975) cited two studies (Bailey, et al., 1959; Katz & Solomon, 1958) that reported a positive relationship between continuation in treatment and previous psychotherapy.

Therapist Level of Experience. Auerbach and Johnson (1977) have stated that experienced therapists differ from inexperienced ones in several ways: (a) they have seen a larger number of patients over a number of years; (b) they are older and therefore have more life

experience; and (c) they have had a greater opportunity to integrate their techniques and philosophy of therapy with their own life experiences. These differences have generally been assumed to render the experienced therapist more effective in his work with patients.

Auerbach and Johnson (1977) point out two problems in research attempting to validate the hypothesis that experienced therapists are more effective than inexperienced ones. One is that most studies have used therapist populations that are relatively inexperienced. For example, in many studies, first year psychology graduate students are compared with their peers who are only a few years ahead of them in training. This type of comparison does not seem to be an adequate test of potential differences as a function of therapist experience level.

A second problem is how therapist experience level is conceptually approached in the research literature. It is not known if therapist experience should be approached as a continuous variable where there is a direct linear relationship between number of years a therapist has practiced and a particular criterion variable, or if the relationship between therapist experience level and the criterion variable is nonlinear. If a linear relationship applies, then it makes little difference where the cutoff between experience and inexperience is set, for differential effects should be found along the continuum of experience level. If however a nonlinear relationship applies, then where the cutoff point is set for number of years of experience can make a great deal of difference. Auerbach and Johnson (1977) concluded that we do not at this time know which type of relationship

represents the true state of affairs. Gurman and Razin (1977) have recommended that at least three to four years be set as a minimum cut-off point for research in this area however.

There have been a few studies that have looked at therapist experience level and continuation in treatment. McNair, et al. (1963) found that therapists with four years or more of experience held 72% of their patients whereas therapists with less than four years held only 60% of their patients. Myers and Auld (1955) reported that experienced therapists had no premature terminations whereas inexperienced therapists had 25% of their patients prematurely terminate. A study by Saltzman, et al. (1976), however, found no differences in patient length of stay as a function of therapist experience level.

In the Myers and Auld (1955) study, the authors looked not only at premature termination as a function of experience level, but also investigated outcome in psychotherapy as a function of the interaction between length of stay and therapist experience. They found that for therapies less than 10 sessions in duration, there were no differential outcomes between experienced and inexperienced therapists. But for therapies greater than 10 sessions, experienced therapists had more positive outcomes.

To summarize, therapist level of experience has been found to be inconsistently related to continuation in treatment. Some reviewers have concluded a positive relationship between these variables (Baekeland and Lundwall, 1975) while others suggest no relationship but reserve judgment about this as a firm conclusion (Auerbach and Johnson, 1977).

Therapist Personal Therapy. Whether or not a psychotherapist should undergo his own personal therapy is a controversial training issue in the mental health disciplines. In discussing this issue, Garfield (1977b) has noted that some training institutions, such as psychoanalytic institutes and other post doctoral programs, require personal therapy for their students. Others, such as clinical psychology graduate programs do not require this. Garfield (1977b) has also noted that frequently psychotherapists seek out personal therapy on their own as a method to advance their training or for personal problems. A survey by Garfield and Kurtz (1974) reported that of 855 members of the Division of Clinical Psychology of the American Psychological Association, 63% had had some personal therapy.

Garfield (1977b) has stated that the recommendation or requirement of personal therapy for the therapist has received little systematic investigation. There have been some studies that have looked at the relationship between therapist personal therapy and outcome (e.g., Derner, 1960), but none have studied the relationship between personal therapy of the therapist and continuation in treatment.

Other Life Situational and Background Variables. There has been a call in the literature to consider combining select life situational variables into categories that meaningfully describe a person's life position or status (Berzins, 1977). This suggestion is based upon the idea that a person's current life situation influences his orientation and expectations toward others. In a study by Orlinsky and Howard (1976), for example, female outpatients were categorized

on the basis of age, marital status, and parental status. They found that depressed women seen by female therapists who were young and unattached (single or divorced with no children) reported their therapies as more satisfying and supportive than women in the same life situation who were seen by male therapists.

This categorization of Orlinsky and Howard represents just one of many life status configurations that could be formed from life situational variables. And each categorization can be used to describe therapists' as well as patients' life situations.

The variables of marital and parental status of patients and therapists can also be studied independently and from a dyadic matching perspective. Both life status categories and marital and parental status variables have not been studied with regard to continuation in treatment.

There has been little to no systematic research conducted on the influence of patient and therapist background demographics on length of stay in psychotherapy. This is surprising when one considers that a cornerstone of many theories of psychotherapy and personality development is the significant influence of early socialization experiences. Included in potentially significant background experiences are the variables of religious upbringing, family size, birth order, and incidence of early parent loss. These variables can be studied on the patient, the therapist, and from the dyadic matching perspective.

Insofar as demographic data on life situational and background variables is available, it behooves the demographic researcher to test whether or not they differentially influence the psychotherapeutic

process, including continuation in treatment.

Similarity Index. Berzins (1977) has commented upon the fact that most psychotherapists have found that they are able to work with some patients better than others. Theoreticians and researchers, in considering this clinical observation, have hypothesized that there may be certain types of patient and therapist pairs that by nature are "good" matches and some that are mismatches. This goodness of fit has further been hypothesized to be a function of an optimal degree of similarity between patients and therapists on various life situational and background variables. Parloff, et al. (1978) have discussed three different views on the degree of similarity that is optimal in a therapeutic relationship. One is that a therapist who is substantially similar to his patient is in a better position to empathize with and understand him. Another view emphasizes dissimilarity between a patient and therapist, for dissimilarity is thought to heighten therapist objectivity. The third view argues a curvilinear relationship between similarity and efficacy in psychotherapy. This view suggests that enough similarity must be present so that the therapist can understand his patient, but not so much that he overidentifies with the patient and looses his objectivity.

Baekeland and Lundwall (1975) have cited one study by Mendelsohn (1966) that tested the relationship between degree of patient-therapist similarity and continuation in treatment. In this study, it was found that low patient-therapist similarity was associated with short lengths of treatment.

Summary. Most reviewers of demographics have generally concluded that there is little research evidence to suggest a relationship between patient and therapist characteristics, as a main effect, and the dropout problem as defined by length of stay in psychotherapy. Notable exceptions to this are the findings on the variables of patient race and current social class standing. Explanations of these findings remain obscure, with interpretations ranging from inadequacies inherent in the patient, failures of the therapist, and natural mismatches between these types of patients and the majority of therapists to whom they have been assigned. And while there is an increased interest in the dyadic matching perspective on demographic variables, insufficient research has been conducted using this approach to warrant firm conclusions.

Given the large number of studies that have reported nonsignificant findings, one might conclude that demographics per se play a relatively minor role in early termination from treatment. As such, further investigation into the dropout problem might best be directed elsewhere.

But before abandoning demographics, it seems important to first consider the current conceptualization of what is meant by psychotherapy dropout itself. As will be discussed below, research efforts to date have failed to address a basic issue underlying the mental health professionals' concerns about the psychotherapy dropout.

A Critique of the Current Definition of Dropout

A basic assumption that underlies the concerns for and proposed

solutions to the dropout problem in psychotherapy is that the patient who terminates treatment early is necessarily unchanged or possibly worse following brief psychotherapeutic exposure. The economic concern of making most efficient use of limited professional manpower presumes that the provision of services to persons who stay in treatment for shorter versus longer periods of time is wasted effort. The patient welfare concern directly presumes that patients who terminate early have rejected psychotherapy as a means to solve their problems, yet continue to experience psychological distress. Based upon these two concerns, various solutions have been advanced to reduce the incidence of patient attrition with each proposal positing to a greater or lesser extent patient, therapist, and/or treatment characteristics as responsible for the dropout problem.

The research community, in an effort to lend empirical support to these proposed solutions, as well as seeking to understand who the dropout is and his reasons for dropping out of treatment, has undertaken studies to investigate possible relationships between a host of demographic variables and continuation in treatment. A common methodological approach has been to dichotomize patient populations into criterion categories of shorter and longer stay groups. Then using this dichotomy, the groups are statistically compared for significant differences on the "predictor" variables. Another methodological approach has been to treat length of stay as a continuous variable and look for possible correlations between length of stay and demographics.

In both of these methods, characteristics associated with shorter lengths of stay are presumed to be predictive of or related to the

dropout problem. In effect, dropping out of treatment has been operationally defined in the research literature by temporal distinction only. And this definition is consonant with the practitioner's belief that a certain amount of contact between patient and therapist is necessary for therapeutic change to occur, the amount of time needed being longer versus shorter lengths of stay.

While the research literature tends to show a positive relationship between length of treatment and positive outcome, as reported in a review of this area by Luborsky, et al. (1971), this has not been a consistent finding. For example, Rosenthal and Frank (1958) reported that among psychiatric outpatients in psychotherapy who were discharged as improved, 32.5% attended no more than five sessions. When one further considers the findings of Luborsky, Singer, and Luborsky (1975) and Gurman and Kniskern (1978) that show essentially no differences in outcome when comparing brief time limited therapy with unlimited therapy, the assumption that improvement is directly proportional to the length of treatment, with short lengths of stay effecting no therapeutic change, becomes more open to question.

The assumption regarding short lengths of stay and lack of or negative therapeutic outcome has also been criticized on conceptual and methodological grounds. For example, in the Bergin and Lambert (1978) review of therapeutic outcome studies, the authors take issue with the well known Eysenck (1952) psychotherapy outcome study which included premature dropouts in the unimproved rather than improved comparison group. While the authors argue that it is not a fair test of psychotherapeutic effectiveness to include premature terminators in

the unimproved category from the point of view that the treatment has not been fully applied to these patients, it can also be seen that the authors do not consider it methodologically sound to classify premature terminators as ipso facto treatment failures.

Further, Garfield (1978) states that while most researchers and practitioners tend to view patients who abruptly terminate their psychotherapy as failures, some view these patients as post hoc successes, assuming that they would have returned to treatment if in psychological distress.

In one of the few studies that actually investigated the fate of patients who dropped out of treatment with regard to therapeutic outcome, Straker, Devenloo, and Moll (1967) reported that at a two-year followup 17.1% of the dropouts were doing well. Of patients who dropped out after having completed at least 11 sessions, 72.7% of them reported that they were symptom free. Of patients who dropped out before 11 sessions, 50% of them reported themselves as successful outcomes.

The question remains, therefore, as to whether or not the patient who has less therapy necessarily is only slightly changed, unchanged or worse. It may be, for example, the there is a class of patients for whom very brief psychotherapeutic exposure is all that is needed at a given time to promote beneficial change, or at least to facilitate return to a comfortable and maybe even healthy psychological equilibrium. As Baekeland and Lundwall (1975) point out, while symptom relief and/or support during an acute crisis period may not be the goals of treatment from the therapist's point of view, from the patient's

viewpoint he may have initiated termination because he has gotten from psychotherapy what he wanted in the first place. If this were the case, the mental health practitioner's label of dropout, or discontinuer, or premature terminator for the person who terminates treatment relatively early, with its negative therapeutic change connotation, would not be accurate in description.

The fact that there are patients who have not improved, either from their own or their therapists' perspectives, yet terminate their treatment early, indicates that the mental health practitioner's economic and patient welfare concerns are well founded, and supports the continued investigatory efforts into this problem area. When researching factors that might be related to early therapeutic failure, however, it is antithetical to the real purpose of the investigation to include patients who have improved after brief stays in treatment in the negatively valued category of dropout.

To study the dropout problem in psychotherapy, it is therefore recommended that evaluations of outcome be included, so that patients whose needs were met through brief psychotherapeutic contact can be studied separately from patients who were unable to obtain help but remain in need. It is this latter class of patients who are of target concern to mental health practitioners, both from the economic and patient welfare points of view.

A concise operational definition of what is meant by dropout needs to be made in research methodology. In contrast to a strictly temporal definition of dropout, it has been argued on both empirical and conceptual grounds that the criterion of therapeutic outcome be

added to the length of stay criterion. It is the purpose of this study to investigate the relation of demographic variables of patients and therapists, both independently and interactively, to this newly proposed definition of psychotherapy dropout. Patients who have remained in treatment for short periods of time, and at time of termination have not shown improvement, will be compared with patients who have remained in treatment for long periods of time, regardless of therapeutic outcome. As research using this two-dimensional conception of psychotherapy dropout has not heretofore been conducted, this study is considered exploratory in nature and no formal hypotheses will be advanced.

CHAPTER III

METHOD

Subjects

Patient Sample. The patient sample consisted of 151 patients in individual outpatient psychotherapy at the Katharine Wright Clinic, Chicago, Illinois, during the period 1965-1970. Psychotherapy was generally scheduled on a once-weekly basis and sessions were normally of 45-minute duration. All patients were female, their median age was 26, 88% had at least a high school education, approximately one-half were single, and 80% were currently employed. This sample was fairly representative of an urban outpatient population (Ryan, 1969). Characteristics of the patient sample are summarized in Table 1.

Therapist Sample. The patients were in treatment with 26 therapists (16 males, 10 females). Each therapist saw anywhere from one to 16 patients, with a median of four patients per therapist. The therapists had a median of six years of experience in the practice of psychotherapy. Their median age was 36, and 54% were currently married. They had been trained in psychiatry, clinical psychology, or psychiatric social work, and 62% had undergone personal therapy. Their theoretical orientation was dynamic-eclectic. The therapist sample was fairly representative of the national sample of psychotherapists studied by Henry, Sims, and Spray (1971). Characteristics of the therapist sample are summarized in Table 1.

Table 1

SUMMARY OF SAMPLE CHARACTERISTICS

Characteristic	Patient Sample (N = 151)	Therapist Sample (N = 26)
Current Life Status		
Age		
range	18-64	29-78
median	26	36
Marital Status		
single	51%	27%
married	26%	54%
separated/divorced	23%	19%
Parental Status		
no children	59%	54%
parents	41%	46%
Employment Status		
currently employed	80%	100%
currently unemployed	20%	-
Sociocultural Status		
Social Class of Origin		
upper and upper middle	9%	20%
middle	19%	44%
lower middle	23%	28%
upper lower	29%	8%
lower and lower lower	20%	-
Education		
some high school or less	12%	-
completed high school	24%	-
some college	40%	-
completed college	16%	-
graduate school	8%	100%
Race		
black	19%	-
white	81%	100%

Table 1--Continued

Characteristic	Patient Sample (N = 151)	Therapist Sample (N = 26)
Personal and Family Background		
Sex		
female	100%	38%
male	-	62%
Religious Background		
Protestant	38%	32%
Catholic	46%	27%
Jewish	16%	41%
Family Size		
only child	8%	20%
1 sib	25%	20%
2 sibs	23%	36%
3 sibs	18%	12%
4-5 sibs	15%	8%
6-12 sibs	11%	4%
Birth Order		
only	7%	20%
oldest	32%	24%
middle	35%	28%
youngest	26%	28%
Age at Family Disruption		
under 5 years	14%	
6-10 years	5%	
11-15 years	11%	
16+ years	19%	
home never broken	51%	
Patient Therapeutic Status		
Previous Psychotherapy		
yes	52%	
no	48%	

Table 1--Continued

Characteristic	Patient Sample (N = 151)	Therapist Sample (N = 26)
Diagnosis		
depressive reaction	46%	
anxiety reaction	14%	
personality disorder	23%	
schizophrenic (schizoid)	16%	
other	1%	
Therapist Professional Status		
Profession		
psychiatrist		65%
psychologist		16%
psychiatric social worker		19%
Years of Experience		
range		2-22
median		6
Personal Psychotherapy		
yes		62%
no		38%

Measures

Two measures were developed to evaluate therapeutic outcome for the Psychotherapy Session Project (Tovian, Howard, & Orlinsky, Note 1): (a) an Evaluation of Symptom Change from Treatment Summaries form; and (b) an Outcome Ratings of Therapist Closing Notes form. They are reproduced in Appendix A.

The development of these measures was tailored to the specific policy of recordkeeping at the clinic. Clinic policy required each therapist to write a treatment summary on each of her or his patients every month. The therapist was further required to write a closing note at termination of the psychotherapy which summarized the course of treatment and assessed the progress made.

The Outcome Ratings of Therapist Closing Notes form delineated nine scales focusing on therapist identification of patient-relevant parameters of therapy outcome. Two judges independently rated these scales, based upon therapist closing notes.

The Evaluation of Symptom Change from Treatment Summaries form required judges to independently identify specific problems to be changed in the course of treatment. This information was taken from the therapist initial treatment summary and allowed for the identification of a maximum of five problems. An independent rating of the amount of change effected for each problem over the course of treatment was then made by the judges based solely upon the therapist closing note.

In collaboration with Howard and Orlinsky (Note 2), five specific scales were selected from these two measures to form the basis of

the clinical outcome evaluation used in the present study. Only those scales that allowed for both positive and negative change to be rated were included. Table 2 lists these scales. The number of scales used for any one patient-therapist pair varied depending upon the number of target problems identified by the raters. Also, only those problems agreed upon by both raters were included.

To obtain a numerical score of outcome for a given patient-therapist pair, the two raters' scores for each outcome scale were combined to form a single score. Next, all scores that rated specific problems were summed and divided by the number of problems rated. The score of "patient's condition at closing" and the mean score of the problems were next added together and divided by two. The possible score for any given patient on outcome ranged from 2 to 14, with a score of 2 indicating the greatest amount of negative change and a score of 14 indicating the greatest amount of positive change.

Inter-rater reliability of these measures was analyzed in a study by Tovian (1977). Tovian found that substantial inter-rater agreement was obtained on all scales used in the present study, with correlations ranging from .96 to .74.

Procedure

For a period of 20 months, beginning August, 1965, patients and therapists at the Katharine Wright Clinic participated in the Psychotherapy Session Project. This project was originally designed to explore patient and therapist experiences in psychotherapy. During this 20-month phase, 151 patient-therapist pairs participated. Parti-

Table 2

CLINICAL OUTCOME EVALUATION SCALES

1. Patient's condition at closing[a]:

(1) Considerably worse	_____
(2) Moderately worse	_____
(3) Slightly worse	_____
(4) No change	_____
(5) Slightly improved	_____
(6) Moderately improved	_____
(7) Considerably improved	_____

2. Rating of Problem Change at Closing[b]:

(1) Considerably worse	_____
(2) Moderately worse	_____
(3) Slightly worse	_____
(4) No change	_____
(5) Slightly improved	_____
(6) Moderately improved	_____
(7) Considerably improved	_____

[a]This scale is taken from the Outcome Ratings of Therapist Closing Notes.

[b]This scale is taken from the Evaluation of Symptom Change from Treatment Summaries. A maximum of five problems could be rated.

cipants filled out demographic data sheets at the onset of their participation. Then, immediately following each psychotherapy session, patients and therapists filled out parallel questionnaires describing their experiences in the session just completed. A detailed description of the instruments and procedures used in this phase of the Project has been presented elsewhere (Orlinsky & Howard, 1975).

An evaluation of outcome for each patient-therapist pair was made in the second phase of the Project, and was based upon patient protocols kept at the clinic. This was necessarily conducted following termination of the treatments. For all 151 participants, terminations had been effected at the time of outcome evaluation.

Evaluations of outcome were independently made by two graduate students in psychology using the evaluation forms previously described. Code numbers were assigned to all patients and therapists at the beginning of the Project and used throughout data collection and analysis. At time of termination, the length of stay, defined by number of psychotherapy sessions attended, was also calculated for each patient-therapist pair.

Selection of Demographic Data. With the exception of the variable of patient diagnosis, the selection of demographic variables for this study was taken from information collected on the demographic data sheets of patients and therapists. The demographic data sheets are reproduced in Appendix B.

For the purposes of data analysis, the raw data for most of these variables were recategorized to form either natural or theoreti-

cally based subgroups that allowed for a relatively equal number of subjects in each subgroup, while keeping the number of subgroups to a minimum.

An example of a categorization based upon natural subgrouping is patient education. On the patient demographic data sheet, education was classified in six subgroups ranging from group 1, grammar school or less, to group 6, graduate school. This raw data was reclassified into three groups, ranging from group 1, completed high school or less, to group 3, completed college or more.

An example of a theoretically based recategorization is the variable of patient age at family disruption. On the patient demographic data sheet, patients were asked to specify how old they were when and if their parental home was broken by events such as parent separation, divorce, or death. This raw data was categorized into age groups of five years or less, 6-10 years, 11-15 years, and 16+ years and never. These age groups are consonant with psychoanalytic theory of the pre-Oedipal and Oedipal, latency, and genital phases of development.

For some variables, there were few if any responses to a particular subgroup on the demographic sheet. If this subgroup could not be naturally subsumed under another category, the cases in it were eliminated from the analysis. This occurred for example in the case of the variables of patient and therapist religious background. The demographic sheet allowed subjects to select from six subgroups (Protestant, Roman Catholic, Jewish, Other, None, and Mixed). As only two patients and four therapists described themselves as having a religious background of Other, None, or Mixed, these subgroups and

the cases in them were dropped.

The variables of patient and therapist social class backgrounds were determined by rating the subject's father's occupation. This rating was based upon an adaptation of Warner's Index of Status Characteristics.

The variable of patient diagnosis at intake was obtained from the patient's chart following termination of treatment. Clinic procedure required each patient to have a psychiatric evaluation before entering treatment at which time a DSM-II diagnosis was given. These diagnoses were classified, for purposes of data analysis, in four major groups (Depressive Reactions; Anxiety Reactions; Personality Disorders, excluding Schizoid Personality; and Schizophrenia, including Schizoid Personality). For cases that were given both a symptomatic diagnosis and a character diagnosis (e.g., Depressive Reaction in a Passive-Aggressive Personality), the case was classified on the basis of the symptomatic diagnosis.

Patient and therapist match variables were classified on the basis of similarity/dissimilarity on a given variable. For example, for the patient-therapist match variable of parental status, if patients and therapists had the same status (either both were or were not parents), the case was classified in the "same" group. All other combinations were classified in the "different" group.

The similarity index variable is comprised of the patient-therapist match variables of sex, age, marital status, parental status, religious background, social class background, education, birth order, and family size. A given patient-therapist pair could be assigned a

score that ranged from 0 to 9. A score of 0 indicated that the pair was dissimilar on all of the above variables, and a score of 9 indicated that the pair was similar on all variables.

The variable of patient life status is a combination of age, parental and marital status. In considering these variables as they describe significant aspects of the patient's current life situation, the following classification schema was developed. Single Women described patients who were between 18 and 25 years of age, unattached, with no parental responsibilities. Older Single Women described patients who were 26 years of age or older, unattached, with no children. Single Parents described patients who regardless of their age were unattached and responsible for at least one child. Family Women described patients who regardless of their age were married with children.

The therapist life status variable was comprised of the demographics of sex, parental and marital status. The category of Independent Men described therapists who were not currently married, with no children. Married Men described therapists who were married and had no children. Family Men represented the group who were married and with children. Independent Women were therapists who were not married and had no children. Family Women were therapists who were married with children.

Table 3 lists all of the patient, therapist, and patient-therapist match variables analyzed in the present study, and details the manner in which they were categorized. Sample sizes differed for each variable because of missing data as well as elimination of cases due to manner of classification. Where possible, all available data were

Table 3

CLASSIFICATION OF DEMOGRAPHIC VARIABLES FOR ANALYSIS

	n
Patient Age (N = 151)	
18-22 years	32
23-36 years	48
27-33 years	31
34-45 years	27
46+ years	13
Patient Employment Status (N = 151)	
Employed	121
Unemployed	30
Patient Education (N = 151)	
High school or less	54
Some college	60
College grad or more	37
Patient Marital Status (N = 151)	
Single/Engaged	77
Married	39
Formerly Married	35
Patient Parental Status (N = 151)	
No children	89
Mothers	62
Patient Life Status (N = 145)	
Single Younger (18-25 years, single/engaged)	55
Single Older (26+ years, single/engaged)	28
Single Parents (formerly married, with children)	29
Family Women (married, with children)	33

Table 3--Continued

	n
Patient Race (N = 151)	
White	122
Black	29
Patient Social Class of Origin (N = 140)	
Upper and Upper Middle	13
Middle	27
Lower Middle	32
Upper Lower	40
Lower and Lower Lower	28
Patient Religious Background (N = 149)	
Protestant	57
Catholic	69
Jewish	23
Patient Family Size (N = 148)	
No sibs	11
1 sib	37
2 sibs	34
3 sibs	27
4-5 sibs	22
6-12 sibs	17
Patient Birth Order (N = 148)	
Only child	11
Oldest child	47
Middle child	51
Youngest child	39
Patient Age at Family Disruption (N = 148)	
16+ years or never	104
11-15 years	16
6-10 years	7
Under 5 years	21

Table 3--Continued

	n
Patient Diagnosis at Intake (N = 149)	
Depressive Reaction	69
Anxiety Reaction	21
Personality Disorder	35
Schizophrenic (includes Schizoid)	24
Patient Previous Psychotherapy (N = 151)	
Yes	78
No	73
Therapist Sex (N = 151)[a]	
Men	94
Women	57
Therapist Age (N = 151)	
29-35 years	69
36+ years	82
Therapist Marital Status (N = 151)	
Single/Engaged	42
Married	77
Formerly Married	32
Therapist Parental Status (N = 151)	
No children	79
Parents	81
Therapist Life Status (N = 138)	
Independent Men (single/engaged)	21
Married Men (married, no children)	25
Family Men (married, with children)	48
Independent Women (single/engaged)	35
Family Women (single or married, with children)	9

[a]All analyses of therapist variables are based upon patient-therapist pairs. As such, some therapists are included more than once.

Table 3--Continued

	n
Therapist Social Class of Origin (N = 149)	
Upper Middle	35
Middle	65
Lower Middle	41
Upper Lower	8
Therapist Religious Background (N = 120)	
Protestant	38
Catholic	28
Jewish	54
Therapist Family Size (N = 149)	
No sibs	20
1 sib	33
2 sibs	46
3 sibs	28
4 sibs	16
11 sibs	6
Therapist Birth Order (N = 149)	
Only child	20
Oldest child	48
Middle child	47
Youngest child	34
Therapist Profession (N = 151)	
Psychiatrist	97
Psychologist	34
Psychiatric Social Worker	20
Therapist Experience Level (N = 151)	
0-5 years	60
6+ years	91
Therapist Personal Therapy (N = 151)	
Yes	102
No	49

Table 3--Continued

	n
Patient-Therapist Age Match (N = 151)	
Different (greater than ± 10 years)	80
Same (within ± 10 years)	71
Patient-Therapist Marital Status Match (N = 151)	
Different	104
Same	47
Patient-Therapist Parental Status Match (N = 151)	
Different	72
Same	79
Patient-Therapist Education Match (N = 151)	
Different (patient has some college or less)	114
Same	37
Patient-Therapist Social Class of Origin Match (N = 138)	
Different	111
Same	27
Patient-Therapist Religious Background Match (N = 151)	
Different	115
Same	36
Patient-Therapist Family Size Match (N = 146)	
Different	102
Same	44
Patient-Therapist Birth Order Match (N = 146)	
Different	101
Same	45

Table 3--Continued

	n
Patient-Therapist Similarity Index (N = 138)	
(Number of matches on the variables of age, sex, education, religious background, social class of origin, family size, birth order, parental status, and marital status; 0 = none matched, 9 = all matched.)	
0 variables	3
1 variable	13
2 variables	25
3 variables	31
4 variables	36
5 variables	20
6 variables	8
7 variables	2
8 variables	0
9 variables	0

used.

Selection of Criteria for Dropout Status. Two criteria were used to define dropout: an outcome evaluation that reflected no positive change during the course of treatment, and a short length of stay in psychotherapy.

The criterion of clinical outcome in the sample ranged from a score of 3 to 14, with a median of 11 ($\overline{X}$ = 10.86; S.D. = 2.59). A score of 9 or less was used as the cutoff for lack of or negative therapeutic effect. This cutoff point ensured that no case would be classified in the dropout group if both raters agreed that on the average at least slight improvement had occurred.

The criterion of length of stay was defined by number of psychotherapy sessions attended. For the 151 patient-therapist pairs, length of stay ranged from 1 to 189 sessions, with a median stay of 33 sessions ($\overline{X}$ = 47.75; S.D. = 42.02). A cutoff of 12 sessions or less was used to classify patients in the dropout group. Given that many patients participated in relatively lengthy treatments, the 12-session cutoff was selected to ensure that a sufficient number of subjects could be classified in the dropout group to allow for statistical comparison. A 12-session cutoff, which in most cases described at most a two and one-half to three-month psychotherapy, also seemed reasonable given that the model of treatment practiced at this clinic at the time of data collection was traditional long-term treatment. As such, therapies terminated within a three-month period were considered brief.

Patient-therapist pairs who had clinical outcomes of 9 or less, and lengths of stay of 12 sessions or less, were classified in the dropout group (N = 20). All other cases were classified in the comparison group (N = 131).

Method of Outcome Ratings. Two graduate students in psychology were the outcome raters for all 151 cases. Ratings were made independently. The Outcome Ratings of Therapist Closing Notes form was rated first for all cases. The ratings using the Evaluation of Symptom Change form were rated last.

CHAPTER IV

RESULTS

Table 4 shows the distribution of subjects among the levels of the two criterion groups. 20.5% of the sample (N = 31) had psychotherapies of 12 sessions or less. Of these, 64.6% were unimproved treatment cases.

A chi-square statistic was used to assess the predictive relationship between each demographic variable and the dropout group. None of the chi-square analyses obtained significance at the .05 level. Results of the analyses for each demographic are reproduced in Appendix C.

A strictly descriptive approach to the data was taken using a 10-percentage point deviation from the expected cell frequency to describe variables that were overrepresented and underrepresented in the dropout group.

For the variable of patient age, the youngest (18-22 years) and the oldest (46+ years) were overrepresented in the dropout group. For patient age at family disruption, patients in the 11-15 year range were also found to be overrepresented. Patients who had no siblings were found to be underrepresented. All remaining patient variables (employment status, marital status, educational level, parental status, social class of origin, race, previous treatment, life status, religious background, and intake diagnosis) were not differentially represented among

Table 4

DISTRIBUTION OF SUBJECTS AMONG THE DROPOUT CRITERIA

Outcome	Length of Stay			
	12 sessions or less		13 sessions or more	
	n	% of N	n	% of N
Improved	11 (35%)	7.3%	100	66.3%
Unimproved	20 (65%)	13.2%	20	13.2%

Note. Of the 31 cases traditionally classified as dropouts, 35% were short-term therapeutic successes.

the two comparison groups.

Among therapist variables, Independent Men were overrepresented. Therapists who were psychiatric social workers by training, as well as therapists who came from lower socioeconomic backgrounds, were underrepresented. All remaining therapist variables (experience level, personal therapy, age, sex, marital status, parental status, family size, birth order, and religious background) were not differentially represented.

For patient-therapist match variables, there was no overrepresentation or underrepresentation. The similarity index did show a curvilinear pattern, with a middle amount of similarity being least represented in the dropout group, but the 10% deviation criterion was not obtained at any one level of similarity.

Although no single variable was able to discriminate between the groups, the possibility remained that some combination of variables might discriminate between them. This possibility was explored using a step-wise discriminant function analysis. All continuous variables were selected for analysis (patient age, educational level, social class of origin, family size and age at family disruption; therapist age, social class of origin, family size and experience level). Three inclusion criteria were used: (a) Wilks' Lambda; (b) RAO's V; and (c) Change in V. In no case were the groups discriminated at better than $p = .19$. No combination of variables significantly discriminated between the groups. These results are presented in Table 5.

Table 5

SUMMARY TABLE OF DISCRIMINANT FUNCTION ANALYSES

Step	Variable Removed	Wilks' Lambda	Significance Level	RAO's V	Significance Level	Change in V	Significance Level
1	Therapist Experience Level	.988	.19	1.712	.19	1.712	.19
2	Patient Educational Level	.976	.20	3.315	.19	1.603	.21

Note. After removal of the first two variables in all cases, analyses stopped because the size of the indicator statistics were insufficient for computation.

CHAPTER V

DISCUSSION

None of the patient, therapist, and patient-therapist match variables analyzed in this study were found to be significantly related to the dropout problem in psychotherapy, as defined by lack of or negative therapeutic outcome and short length of stay. With the exception of the variable of patient race, these nonsignificant findings are consistent with the conclusions drawn in major reviews of patient and therapist demographics related to treatment dropout. A number of reviewers have expressed interest in a dyadic matching approach to demographics, and have not drawn conclusions given insufficient amount of attention in the research literature to this approach. The findings of this study do not support matching on demographics as a potentially valuable means of investigating psychotherapy dropout.

A question of prime importance is why there were no demographic variables differentially related to dropout. There are several plausible explanations for this.

One explanation is statistical in nature. Given that this study was a naturalistic investigation, as opposed to a controlled experiment, the formation of the comparison groups of dropout and all others produced an unbalanced distribution of 13.2% and 86.8%, respectively. With this distribution, a demographic would either: (a) have to account for a major portion of the variance in treatment dropout in

order to obtain statistical significance; or (b) the sample size would have to be very large in order for a statistic to pick up small differences that were a function of the demographic. Add to this the fact that the distributions of some demographics were also naturalistically unbalanced and the probability of obtaining significance becomes even more unlikely.

As distributions found in naturalistic investigations are unfavorable, it may be argued that controlled experiments are the next logical step in testing hypotheses concerning the relation of demographics to dropout. Yet the adviseability and fruitfulness of pursuing this may be questioned in light of the large number of studies that have yielded nonsignificant results in this area. There is also the question of lack of applicability as well as generalization of findings to naturalistic settings.

The relative consistency with which nonsignificant results have been reported suggests an alternative explanation for why no demographics in this study were found to be significant. Namely, both individually and in combination, they account for minor if any portions of the variance in dropout.

In considering the findings of the descriptive approach to the data which looked at deviations in percentage points from the expected cell frequencies for a demographic, it was found that the majority of demographics were evenly distributed among the comparison groups. These findings suggest a total lack of relationship between demographics and dropout. For the demographics that did show at least a 10% deviation, it cannot be determined whether or not these findings

reflect a chance distribution or reflect trends that under more controlled investigation would be found significantly related to dropout. While chance distribution is plausible, it also seems reasonable to consider that these variables are related to dropout. For this reason a brief discussion of them will follow.

The demographics of patient age, age at family disruption, family size, and birth order were found to deviate from expectation. The therapist variables of life status and profession were also found to deviate. As it was not the purpose of this study to investigate any one demographic intensively, its research design does not allow for causative interpretation. What can be said is that the possibility of a predictive relationship may exist. To illustrate, the variable of patient age will be used.

It was found that the youngest (18-22 years) and the oldest (46+ years) patients were overrepresented in the dropout group. The finding that younger patients were overrepresented could be taken as supportive of Baekelund and Lundwall's (1975) conclusion that the younger the patient, the higher the incidence of dropout. The finding that older patients are overrepresented could be taken as supportive of Butler's (1969) hypothesis of prejudice against older patients which promotes treatment dropout in this age group. The fact that the variables of therapist age and patient-therapist match age were not abnormally distributed suggests that it is the age of the patient per se that is the potentially relevant factor. This does not mean that patient age, as it describes something intrinsic about him (e.g., malleability of character structure) is a causative factor in dropout.

It may be, for example, that therapists' preconceived notions of patient age set the stage for a self-fulfilling prophecy. What can be concluded is that the possibility of a relationship exists. For the investigator interested in the predictive power of patient age for dropout, a controlled nomothetic experiment might follow. If interest in the causative relationship between dropout and patient age were of primary interest, ideographic research might be pursued.

The literature has reported somewhat consistently that black patients have a higher incidence of dropout than white patients. Yet the findings in this study do not show any differential effect as a function of patient race. As applies to all of the results in this study, it may be that the criteria used for defining dropout have nullified previously found differences. For example, the use of a 12-session cutoff, which when compared to other studies of dropout is at the lengthier end of the continuum for dropout status, may have obscured the fact that blacks more frequently drop out after one or two sessions as compared to their white counterparts who may stay in treatment for perhaps a month or two longer. It may also be that the elimination of cases that had positive outcomes from dropout status also nullified the race effect. Another consideration is the fact that the patient sample in this study was entirely female. This limits the comparability of the present findings to those of other studies in this area.

The fact that approximately one-third of the sample that had short therapies were rated as having at least slight improvement speaks to the importance of including an outcome evaluation in research on dropout. As discussed in Chapter II, practitioners' concerns regard-

ing psychotherapy dropout have been predicated upon the assumption that dropouts are necessarily treatment failures. By utilizing the criteria of both length of stay and outcome in the definition of dropout, precision of measurement can be obtained while at the same time being more directly responsive to the target concerns of the clinical community.

Parloff, et al. (1978) have expressed the view that demographics per se are too simplistic a conception of what is meant by therapeutically relevant characteristics in psychotherapy. In elaborating this point they stated that the mechanisms in the psychotherapy process that do effect differential results are most likely so embedded in these molar constructs to render them lost to meaningful analysis. The results of this study support this argument.

Given this position, one of two avenues of investigation can be taken. One would be to refine measurement of what has been referred to as "input" characteristics (Howard & Orlinsky, 1972) of patients and therapists. Input characteristics refer to characteristics that exist outside of the treatment process. They include demographics as well as factors such as expectations, cognitive styles, etc. For example, patient expectations of psychotherapy before entering treatment could be classified on the basis of how realistic they were, and tested for their differential effects on the incidence of dropout. A problem with this approach, as with all input variable data, is that it presumes that what is characteristic of a patient and therapist before entering treatment is active and influential in the process of the treatment.

A second avenue of investigation that seems more empirically sound and direct, although more difficult to research, is looking at

what actually occurs in the process of treatment between and within patients and therapists. Measurement of therapeutic process has been undertaken from a variety of different theoretical positions with differing methodologies. To date, no systematic research has been conducted on psychotherapy process and dropping out of treatment.

Limitations of the current study include such factors as representativeness of the sample, unbalanced distributions unfavorable to finding significant results, and method of outcome evaluation.

Regarding sample representation, while characteristics of patients and therapists were found to be similar to national surveys of outpatient clinic populations, the patient sample was entirely female and as such generalization must be limited to this population.

The outcome evaluation, based solely upon judgements of therapist views of what occurred during the course of treatment, is limited to evaluations from this perspective. Whether or not patients would concur with therapists' evaluations is open to question. Future research using outcome as one criterion of dropout status might include evaluation from the patient's perspective.

In summary, demographic characteristics of patients and therapists, both independently, from a dyadic matching perspective, and in other combinations, were not found to differentially relate to treatment dropout. Future research should be directed away from global categorization on the basis of demographics and toward either more refined measure of input characteristics or toward measurement on the basis of actual therapeutic process. The addition of the criterion of therapeutic outcome to the length of stay criterion is recommended on

grounds of measurement precision as well as alignment of research efforts with the clinical community's expressed concerns with the short-term therapeutic failure. Consideration of the patient's view of outcome should also be taken.

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APPENDICES

APPENDIX A

OUTCOME MEASURES

Patient Code_____

Therapist Code_____

OUTCOME RATINGS OF THERAPIST CLOSING NOTES

1. Patient's condition at closing:

   (1) Considerably worse _____

   (2) Moderately worse _____

   (3) Slightly worse _____

   (4) No change _____

   (5) Slightly improved _____

   (6) Moderately improved _____

   (7) Considerably improved _____

2. Prognosis: further treatment needed:

   (1) Yes _____

   (2) Suspected _____

   (3) No _____

3. Disposition or Referral Recommendation:

   (1) Therapist terminated with referral _____

   (2) Patient withdrew from therapy _____

   (3) Therapist terminated without referral _____

4. Degree to which patient achieved understanding of problem or insight:

   (1) (2) (3) (4) (5) (6) (7)

   ___ ___ ___ ___ ___ ___ ___ ___

   Little or none — Maximally — Insufficient Data

5. Degree to which patient achieved relief from emotional distress:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Little or none						Maximally	Insufficient Data

6. Degree of patient's personal integration:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Highly disorganized or defensively organized					Optimally integrated		Insufficient Data

7. Quality of patient's interpersonal relationships:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Unrealistic, immature, inappropriate patterns of relationships					Realistic, mature, age-appropriate patterns of relationships		Insufficient Data

8. Estimate of therapist's feelings toward patient:

(1)	(2)	(3)	(4)	(5)	(6)	(7)	
Strong dislike					Strong liking or respect		Insufficient Data

9. Therapist's outcome rating: patient's condition at closing and prognosis copied from the Therapist Closing Form;

	Further care needed	Further care suspected	No further care
Unimproved	(1)	(2)	(3)
Improved	(4)	(5)	(6)
Recovered	(7)	(8)	(9)

EVALUATION OF SYMPTOM CHANGE FROM TREATMENT SUMMARIES

Diangosis:

Symptoms (assessed at intake):

A.

B.

C.

D.

E.

Specific Problems to be Changed (assessed at initial stages of therapy):

A.

B.

C.

D.

E.

Changes (assessed at termination of treatment):

A.

B.

C.

D.

E.

Rating of Problem Change at Closing:

	A	B	C	D	E
(1) Considerably worse	____	____	____	____	____
(2) Moderately worse	____	____	____	____	____
(3) Slightly worse	____	____	____	____	____
(4) No change	____	____	____	____	____
(5) Slightly improved	____	____	____	____	____
(6) Moderately improved	____	____	____	____	____
(7) Considerably improved	____	____	____	____	____

Additional Comments:

APPENDIX B

DEMOGRAPHIC DATA SHEETS

PATIENT BACKGROUND

Please fill in the following information.

Personal Background

1,2 Age:_____years

3. Sex: 1___Female
2___Male

4. Education:

1___Grammar school or less
2___Some high school
3___Completed high school
4___Some college
5___Completed college
6___Graduate school

5. Occupation -- Are you employed?_____

6. If "yes," what is your job?

_____

7. Marital Status:

1___Single
2___Engaged
3___First marriage
4___Second or more marriage
5___Separated
6___Divorced
7___Widowed

8. If married, what is your husband's (wife's) job?

_____

9. How many children do you have?

1___None
2___One
3___Two
4___Three or more

Family Background

10. How many older brothers did you have? ___

11. How many older sisters did you have? ___

12. How many younger brothers did you have? ___

13. How many younger sisters did you have? ___

14. What is the marital status of your parents?

1___Living together
2___Separated
3___Divorced
4___One parent widowed
5___Both deceased

15. If your parental home was broken while you were growing up (by separation, divorce or death) how old were you at the time when this first happened?

___

16. What is (or was) your father's occupation?

_____

Cultural Background

17. Racial background:

1___White
2___Negro
3___Other

18. What is your father's nationality background?

_____

19. What is your mother's nationality background?

_____

20. What is your religious background?

1___Protestant
2___Roman Catholic
3___Jewish
4___Other
5___None
6___Mixed

21. How big is your "home town" (the place where you grew up)?

1___Large city (over 1,000,000)
2___City (under 1,000,000)
3___Suburb
4___Town
5___Rural

Identification_____

Today's date_____

Psychotherapy Background

22. Have you ever had psychotherapy before?

1___Yes
2___No

If "yes,"

23,4 (a) How long a time were you in therapy?

___months

25,6 (b) On the average, how many times a month did you meet with your therapist?

___sessions a month

THERAPIST BACKGROUND

As a coordinate part of the program of therapy research being conducted at this clinic, we are making a survey of all therapists. Please fill in the following information and return this form to Mr. Miller. Thank you for your cooperation.

Name: _____

Professional Background

1. Profession:

   1___Psychiatrist
   2___Psychologist
   3___Psychiatric social worker
   4___Other (specify)

   _____

2,3. How many years of experience have you had as a psychotherapist?

   ___years

Which of the following people or schools of thought have significantly influenced your approach to psychotherapy? (Check as many as apply.)

4.___Freud
5.___Sullivan
6.___Adler
7.___Rank
8.___Jung
9.___Rogers
10.___Existentialism
11.___Other (specify)_____
_____
_____
_____
_____

12. Have you had personal therapy?

   1___Yes
   2___No

Personal Data

13,14. Age:_____years

15. Sex: 1_____Male
   2_____Female

16. Marital Status:

   1___Single
   2___Engaged
   3___First marriage
   4___Second or more marriage
   5___Separated
   6___Divorced
   7___Widowed

17. Do you have any children?

1___Yes
2___No

Cultural Background

18. What is your father's nationality background?

_____

19. What is your mother's nationality background?

_____

20. What is your religious background?

1___Protestant
2___Roman Catholic
3___Jewish
4___Other
5___None

21. Racial background:

1___White
2___Negro
3___Other

22. How large is your "home town" (the place where you grew up)?

1___Large city (over 1,000,000)
2___City (under 1,000,000)
3___Suburb
4___Town
5___Rural

Family Background

23. What is (or was) your father's occupation?

_____

24. How many older brothers did you have? ___

25. How many older sisters did you have? ___

26. How many younger brothers did you have? ___

27. How many younger sisters did you have? ___

APPENDIX C

CHI-SQUARE ANALYSES

PATIENT AGE

	18-22	23-36	27-33	34-45	46+	n	%
Dropout	25.0%	8.3%	9.7%	7.4%	23.1%	20	13.2%
All Others	75.0%	91.7%	90.3%	92.6%	76.9%	131	86.8%
n	32	48	31	27	13	151	

$X^2(4) = 7.09$, $p > .05$

PATIENT EMPLOYMENT STATUS

	Employed	Unemployed	n	%
Dropout	13.2%	13.3%	20	13.2%
All Others	86.8%	86.7%	131	86.8%
n	121	30	151	

$X^2(1) = 0.0$, $p > .05$

PATIENT EDUCATION

	High School or less	Some College	College Grad or more	n	%
Dropout	14.8%	16.7%	5.4%	20	13.2%
All Others	85.2%	83.3%	94.6%	131	86.8%
n	54	60	37	151	

$X^2(2) = 2.71$, $p > .05$

PATIENT MARITAL STATUS

	Single/ Engaged	Married	Formerly Married	n	%
Dropout	11.7%	10.3%	20.0%	20	13.2%
All Others	88.3%	89.7%	80.0%	131	86.8%
n	77	39	35	151	

$X^2(2) = 1.86$, $p > .05$

PATIENT PARENTAL STATUS

	No Children	Mothers	n	%
Dropout	13.5%	12.9%	20	13.2%
All Others	86.5%	87.1%	131	86.8%
n	89	62	151	

$X^2(1) = .01$, $p > .05$

PATIENT LIFE STATUS

	Single Younger	Single Older	Single Parents	Family Women	n	%
Dropout	12.7%	14.3%	17.2%	9.1%	19	13.1%
All Others	87.3%	85.7%	82.8%	90.9%	126	86.9%
n	55	28	29	33	145	

$X^2(3) = .94$, $p > .05$

PATIENT RACE

	White	Black	n	%
Dropout	13.9%	10.3%	20	13.2%
All Others	86.1%	89.7%	131	86.8%
n	122	29	151	

$X^2(1) = .26$, $p > .05$

PATIENT SOCIAL CLASS OF ORIGIN

	Upper and Upper Middle	Middle	Lower Middle	Upper Lower	Lower and Lower Lower	n	%
Dropout	7.7%	11.1%	18.8%	10.0%	10.7%	17	12.1%
All Others	92.3%	88.9%	81.3%	90.0%	89.3%	123	87.9%
n	13	27	32	40	28	140	

$X^2(4) = 1.80$, $p > .05$

PATIENT RELIGIOUS BACKGROUND

	Protestant	Catholic	Jewish	n	%
Dropout	8.8%	13.0%	21.7%	19	12.8%
All Others	91.2%	87.0%	78.3%	130	87.2%
n	57	69	23	149	

$X^2(2) = 2.49$, $p > .05$

PATIENT FAMILY SIZE

	None	1 Sib	2 Sibs	3 Sibs	4-5 Sibs	6-12 Sibs	n	%
Dropout	-	21.6%	11.8%	11.1%	9.1%	11.8%	19	12.8%
All Others	100%	78.4%	88.2%	88.9%	90.9%	88.2%	129	87.2%
n	11	37	34	27	22	17	148	

$X^2(5) = 4.57$, $p > .05$

PATIENT BIRTH ORDER

	Only	Oldest	Middle	Youngest	n	%
Dropout	-	21.3%	7.8%	12.8%	19	12.8%
All Others	100%	78.7%	92.2%	87.2%	129	87.2%
n	11	47	51	39	148	

$X^2(3) = 5.75$, $p > .05$

PATIENT AGE AT FAMILY DISRUPTION

	16+ or Never	Under 5	6-10	11-15	n	%
Dropout	12.5%	4.8%	14.3%	25.0%	19	12.8%
All Others	87.5%	95.2%	85.7%	75.0%	129	87.2%
n	104	21	7	16	148	

$X^2(3) = 3.36$, $p > .05$

PATIENT DIAGNOSIS AT INTAKE

	Depressive Reaction	Anxiety Reaction	Personality Disorder	Schizophrenic (Schizoid)	n	%
Dropout	13.0%	14.3%	5.7%	25.0%	20	13.4%
All Others	87.0%	85.7%	94.3%	75.0%	129	86.6%
n	69	21	35	24	149	

$X^2(3) = 4.58$, $p > .05$

PATIENT PREVIOUS PSYCHOTHERAPY

	Yes	No	n	%
Dropout	11.5%	15.1%	20	13.2%
All Others	88.5%	84.9%	131	86.8%
n	78	73	151	

$X^2(1) = .41$, $p > .05$

THERAPIST SEX

	Men	Women	n	%
Dropout	16.0%	8.8%	20	13.2%
All Others	84.0%	91.2%	131	86.8%
n	94	57	151	

$X^2(1) = 1.59$, $p > .05$

THERAPIST AGE

	29-35	36+	n	%
Dropout	11.6%	14.6%	20	13.2%
All Others	88.4%	85.4%	131	86.8%
n	69	82	151	

$X^2(1) = .30$, $p > .05$

THERAPIST MARITAL STATUS

	Single/ Engaged	Married	Formerly Married	n	%
Dropout	16.7%	13.0%	9.4%	20	13.2%
All Others	83.3%	87.0%	90.6%	131	86.8%
n	42	77	32	151	

$X^2(2) = .85$, $p > .05$

THERAPIST PARENTAL STATUS

	Parents	No Children	n	%
Dropout	11.4%	14.8%	20	13.2%
All Others	88.6%	85.2%	131	86.8%
n	70	81	151	

$X^2(1) = .37$, $p > .05$

THERAPIST LIFE STATUS

	Independent Men	Married Men	Family Men	Independent Women	Family Women	n	%
Dropout	23.8%	20.0%	10.4%	5.7%	11.1%	18	13.0%
All Others	76.2%	80.0%	89.6%	94.3%	88.9%	120	87.0%
n	21	25	48	35	9	138	

$X^2(4) = 5.19$, $p > .05$

THERAPIST SOCIAL CLASS OF ORIGIN

	Upper Middle	Middle	Lower Middle	Upper Lower	n	%
Dropout	20.0%	9.2%	14.6%	-	19	12.8%
All Others	80.0%	90.8%	85.4%	100%	130	87.2%
n	35	65	41	8	149	

$X^2(3) = 3.68$, $p > .05$

THERAPIST RELIGIOUS BACKGROUND

	Protestant	Catholic	Jewish	n	%
Dropout	10.5%	14.3%	9.3%	13	10.8%
All Others	89.5%	85.7%	90.7%	107	89.2%
n	38	28	54	120	

$X^2(2) = .49$, $p > .05$

THERAPIST FAMILY SIZE

	None	1 Sib	2 Sibs	3 Sibs	4 Sibs	11 Sibs	n	%
Dropout	20.0%	12.1%	8.7%	14.3%	12.5%	16.7%	19	12.8%
All Others	80.0%	87.9%	91.3%	85.7%	87.5%	83.3%	130	87.2%
n	20	33	46	28	16	6	149	

$X^2(5) = 1.78$, $p > .05$

THERAPIST BIRTH ORDER

	Only	Oldest	Middle	Youngest	n	%
Dropout	20.0%	10.4%	10.6%	14.7%	19	12.8%
All Others	80.0%	89.6%	89.4%	85.3%	130	87.2%
n	20	48	47	34	149	

$X^2(3) = 1.49$, $p > .05$

THERAPIST PROFESSION

	Psychia-trist	Psycholo-gist	Psychiatric Social Worker	n	%
Dropout	17.5%	8.8%	-	20	13.2%
All Others	82.5%	91.2%	100%	131	86.8%
n	97	34	20	151	

$X^2(2) = 5.18$, $p > .05$

THERAPIST EXPERIENCE LEVEL

	0-5 years	6+ years	n	%
Dropout	13.3%	13.2%	20	13.2%
All Others	86.7%	86.8%	131	86.8%
n	60	91	151	

$X^2(1) = 0.0$, $p > .05$

THERAPIST PERSONAL THERAPY

	Yes	No	n	%
Dropout	11.8%	16.3%	20	13.2%
All Others	88.2%	83.7%	131	86.8%
n	102	49	151	

$X^2(1) = .60$, $p > .05$

PATIENT-THERAPIST AGE MATCH

(within $\pm$ 10 years)

	Different	Same	n	%
Dropout	13.8%	12.7%	20	13.2%
All Others	86.2%	87.3%	131	86.8%
n	80	71	151	

$X^2(1) = .04$, $p > .05$

PATIENT-THERAPIST MARITAL STATUS MATCH

	Different	Same	n	%
Dropout	14.4%	10.6%	20	13.2%
All Others	85.6%	89.4%	131	86.8%
n	104	47	151	

$X^2(1) = .40$, $p > .05$

PATIENT-THERAPIST PARENTAL STATUS MATCH

	Different	Same	n	%
Dropout	13.9%	12.7%	20	13.2%
All Others	86.1%	87.3%	131	86.8%
n	72	79	151	

$X^2(1) = .05$, $p > .05$

PATIENT-THERAPIST EDUCATION MATCH

	Different	Same	n	%
Dropout	15.8%	5.4%	20	13.2%
All Others	84.2%	94.6%	131	86.8%
n	114	37	151	

$X^2(1) = 2.62$, $p > .05$

PATIENT-THERAPIST SOCIAL CLASS OF ORIGIN MATCH

	Different	Same	n	%
Dropout	11.7%	11.1%	16	11.6%
All Others	88.3%	88.9%	122	88.4%
n	111	27	138	

$X^2(1) = .01$, $p > .05$

PATIENT-THERAPIST RELIGIOUS BACKGROUND MATCH

	Different	Same	n	%
Dropout	13.0%	13.9%	20	13.2%
All Others	87.0%	86.1%	131	86.8%
n	115	36	151	

$X^2(1) = .02$, $p > .05$

PATIENT-THERAPIST FAMILY SIZE MATCH

	Different	Same	n	%
Dropout	11.8%	13.6%	18	12.3%
All Others	88.2%	86.4%	128	87.7%
n	102	44	146	

$X^2(1) = .10$, $p > .05$

PATIENT-THERAPIST BIRTH ORDER MATCH

	Different	Same	n	%
Dropout	13.9%	8.9%	18	12.3%
All Others	86.1%	91.1%	128	87.7%
n	101	45	146	

$X^2(1) = .71$, $p > .05$

PATIENT-THERAPIST SIMILARITY INDEX

	0	1	2	3	4	5	6	7	n	%
Dropout	11.1%	17.6%	19.2%	8.6%	3.4%	18.8%	-	-	16	11.6%
All Others	88.9%	82.4%	80.8%	91.4%	96.6%	81.3%	100%	100%	122	88.4%
n	9	17	26	35	29	16	4	2	138	

$X^2(7) = 5.86$, $p > .05$

APPROVAL SHEET

The thesis submitted by Linda Papach Goodsitt has been read and approved by the following committee:

Dr. Al DeWolfe, Director
Professor, Psychology, Loyola

Dr. John Shack
Associate Professor, Psychology, Loyola

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

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

2/20/81
Date

Alan S. DeWolfe
Director's Signature