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Pretherapy Expectations, Situational Factors, Perception of the Initial Interview and Premature Termination of Outpatient Psycho-Therapy: A Multivariate Study

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PRETHERAPY EXPECTATIONS, SITUATIONAL FACTORS, PERCEPTION
OF THE INITIAL INTERVIEW AND PREMATURE TERMINATION OF
OUTPATIENT PSYCHOTHERAPY: A MULTIVARIATE STUDY

by

Ann Marie Timothy

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

March

1981

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VITA

The author, Ann Marie Timothy, is the daughter of Ann (Roan) and Major Milton Timothy (Retired) of Carmichael, California. She was born October 25, 1948, in Sacramento, California.

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From September, 1980, to February, 1981, the author collected data for her dissertation research at Hines Veterans Administration Hospital. The title of her dissertation is "Pretherapy expectations, situational factors, perception of the initial interview and premature termination of outpatient psychotherapy: A multivariate study."

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CHAPTER I

INTRODUCTION

Premature termination constitutes a major problem in outpatient mental health facilities. Unannounced treatment terminations waste staff time and services which could potentially have benefited other patients. The time required to screen and process patients for treatment, either through intake interviews, psychological testing or pretherapy consultations, is also lost when patients decide to terminate prematurely. Hence, early treatment dropout is a critical drain on the resources of mental health treatment facilities.

To highlight the magnitude of the dropout problem, research studies which used criteria of dropout from two to five sessions were examined: rates of dropout ranged from 35% to 59% with an average of 46% across the studies (Brown & Kosterlitz, 1964; Caracena, 1965; Dodd, 1970; Fiester, Mahrer, Giambra & Ormiston, 1974; Heilbrun, 1961; Heine & Trosman, 1960; Overall & Aronson, 1963). This dropout rate did not include the sizeable number of patients who terminated prior to presenting for their first treatment session; a range of 3% to 35% pretherapy dropout rate was reported by Brandt (1965) in a review of 25 studies focusing on treatment dropout. Approximately 50% then of all patients who apply for outpatient psychotherapy drop out within five sessions while the median number of therapy sessions for patients

who begin treatment is between five and six (Garfield, 1978).

Comprehensive reviews of the psychotherapy dropout literature have been written by Baekeland and Lundwall (1975), Brandt (1965), Meltzoff and Kornreich (1970), and Garfield (1978). In their respective efforts to identify the determinants of early treatment dropout, the authors discussed the problems they encountered when attempting to summarize the data culled from the studies. Problematic to the reviewers were: the variety of criteria of dropout; the virtual nonexistence of operational definitions of treatment; the differences in the fees, types of samples, size of samples, intake procedures, selection criteria and frequency of treatment sessions; the lack of explanation of how patients are assigned to particular therapists; the absence of information specifying the time spent in treatment by the typical patient in the particular clinic (i.e., base-line data); and the differences in the variables which the studies attempted to control and/or investigate. With the diversity in methodology in the dropout research and the diversity of clients, types of therapy and staff at various settings, it is understandable that reviews of the literature have yielded inconsistent results regarding the salient features of the dropout phenomenon.

To understand and explain the premature termination of psychotherapy, the majority of research studies have concentrated upon patient characteristics including demographic data and/or personality characteristics (Baekeland & Lundwall, 1975; Brandt, 1965; Garfield, 1978; Meltzoff & Kornreich, 1970). Obviously the psychotherapeutic

relationship involves at least two persons, the patient and the therapist; it is reasonable then to assume that therapist characteristics and/or interaction variables may also affect the dropout process. Few studies have focused upon the latter (Garfield, 1978) while the former have been reported with much more frequency. Investigations of environmental factors, or situational variables, which may influence the decision to drop out are even more rare in the dropout literature (Baekeland & Lundwall, 1975; Meltzoff & Kornreich, 1970). In 1975, Baekeland and Lundwall proposed a three dimensional model to characterize psychotherapy dropout. The model included client input variables, therapist input variables and environmental or situational variables. Further, those who have prepared comprehensive reviews of the literature on psychotherapy and treatment dropout (Baekeland & Lundwall, 1975; Brandt, 1965; Garfield, 1978; Kiesler, 1971; Meltzoff & Kornreich, 1970) tend to concur in their recommendation that future investigations in the area utilize factorial designs which can account for a variety of variables.

The present study is an investigation of the joint interaction of patient input variables, therapist input variables and situational variables as related to the outcome of premature psychotherapy termination. The research on patient characteristics, therapist characteristics and situational factors as predictors of treatment continuation or dropout will be reviewed in this paper. Therapist-patient interaction variables, including studies of the similarity of and expectations of patient and therapist in relation to treatment out-

come, will also be reviewed.

CHAPTER II

REVIEW OF THE LITERATURE

Patient Characteristics

The area receiving the most extensive examination in the literature on psychotherapy dropout is alternately labeled patient characteristics or client variables. The hypothesis that a particular characteristic of the patient predetermines the length of time a patient will remain in treatment stimulates this research. Thus, if this variable were identified, treatment dropouts and remainers could be predicted before the commencement of the treatment process.

Patient characteristics which have been investigated in relation to dropout (or to duration of stay in treatment) include demographic variables such as sex, age, education, marital status, race and socioeconomic status (SES), and various other variables such as diagnosis, source of referral, whether the patient received medication in the initial phase of treatment and specific feelings of the patient (e.g., helplessness, isolation or suggestibility). In the same vein, research has focused upon psychological test data to determine if certain patterns of test scores correlated with length of time in treatment.

Much of the research in this area has led to inconsistent and/or inconclusive results; inconsistency among results may be related to the methodological differences among the studies. Patients were often

drawn from incomparable populations; the operational definition of dropout varied from study to study; intake and/or screening procedures were different across hospitals and clinics; treatment fees, when discussed, pointed to differences across studies; frequency of sessions was rarely explained; and psychotherapy per se remained undefined (Brandt, 1965; Garfield, 1978; Meltzoff & Kornreich, 1970).

The sex of the patient has generally not been an important factor in treatment dropout (Affleck & Garfield, 1961; Craig & Huffine, 1976; Fiester et al., 1974) although several studies prior to 1965 had reported that men stayed in treatment longer than women (Brown & Kosterlitz, 1964; Cartwright, 1955; Rosenthal & Frank, 1958). Nor has age been found to be a significant variable in relation to treatment dropout (Baekeland & Lundwall, 1975; Garfield, 1978; Meltzoff & Kornreich, 1970). The relationship between marital status and dropout has yielded inconsistent results. Two studies (Brown & Kosterlitz, 1964; Fiester et al., 1974) reported that marital status had no apparent influence on dropping out of treatment, while one investigation (Gottschalk, Mayerson & Gottlieb, 1967) found a higher dropout rate among patients who were divorced or separated from their spouses.

Years of formal education has also produced conflicting results in the dropout literature although careful perusal of the research lends support to the hypothesis that patients with less than a high school education tend to terminate prematurely (Brown et al., 1964; McNair, Lorr & Callahan, 1963; Dodd, 1970). Lief, Lief, Warren and Heath (1961) discovered that high school graduates were much more

likely to drop out early than college graduates. Fiester et al. (1974) concluded that better educated patients remained in treatment longer, however, the study failed to report the mean number of years of education for remainers and dropouts. Nonetheless, the literature seems to support the existence of a positive relationship between years of formal education and treatment persistence.

Socioeconomic status and its relationship to premature termination of psychotherapy has received much attention in the literature. From an historical perspective, the research on this topic has been stimulated by the work of August Hollingshead, a sociologist, and Frederick Redlich, a psychiatrist. Between 1948 and 1957, these two researchers collaborated to examine mental illness and its relation to social class (1958). Initially, Hollingshead and Redlich (1953) developed an instrument to measure social class; assigning weights to the education, occupation and place of residence in New Haven, Connecticut, was shown to provide a reliable estimate of a person's social position. Since the Three-Factor Index of Social Position was practical only for use in New Haven where residential areas had been thoroughly mapped by sociologists, and since in 1957, Hollingshead discovered that place of residence added very little to the reliability of the estimate of social class, he revised the measure by excluding place of residence (1958). The Two-Factor Index has been widely utilized by investigators who required an objective measure of SES in their research. (In 1975, Hollingshead again revised the index of SES by including sex of the patient and marital status in the computation,

hence, the measure of SES is now the Four-Factor Index of Social Status.)

Hollingshead and Redlich (1958) reported a significantly higher attrition rate from treatment of lower class patients in contrast to middle and upper class patients. Several more recent investigations have supported a relationship between low SES and early treatment termination (Dodd, 1970; Fiester & Rudestam, 1975; Gottschalk et al., 1967; Lief et al., 1961) suggesting that low SES is a predictor of psychotherapy dropout. Other studies (Albronda, Dean & Starkweather, 1964; Brown & Kosterlitz, 1964; Fiester et al., 1974; Pope, Geller & Wilkinson, 1975) failed to support the relationship between SES and dropout which may suggest that other variables may be contributing to the early dropout of low SES patients. Hollingshead and Redlich (1958) emphasized that low SES patients tended to be offered supportive psychotherapy while middle class patients were typically engaged in more intensive psychotherapy. It may be that therapists conceptualize the treatment of low SES patients as being short-term and the treatment of middle SES patients as being long-term. This finding was supported by Gundlach and Geller (1958) who posited that the kinds of personalities that therapists preferred working with might be a more crucial factor in predicting length of stay in treatment than SES. Brill and Storrow (1960) reported a significant difference in the social classes of those accepted for and rejected from treatment at their clinic even though cost of treatment was not a factor. However, once accepted for treatment, differences in the dropout rate between

social classes disappeared. Wolkon, Moriwaki and Williams (1973) found that higher class patients had a more traditional view of psychotherapy while lower class patients conceptualized treatment as a short-term process. Thus, it may be that other variables such as therapists' preferences for treatment and/or patients' orientation to treatment influenced the decision to terminate prematurely, and were being confounded with SES.

Another major patient variable which appears to be generally confounded with SES is race. In an extensive review of the literature on the effects of race of therapist, Sattler (1970) noted that most studies which discuss race of patients or therapists do not identify the racial characteristics of either. Further, though the research at this point suggests that patients fare better when they are of the same race as the therapist, Sattler (1970) emphasized that the "controlled investigation of interracial psychotherapy dynamics is only in its beginning phase (p. 155)." Hence, while it would seem that race of patient may be an important factor in relation to treatment persistence, nonetheless, there has been no substantive research in support of a relationship between race, as distinct from SES, and treatment duration.

When patient diagnosis has been examined in regard to length of stay in psychotherapy or to premature termination, most studies have found no significant differences between diagnostic classifications (Affleck & Garfield, 1961; Brown et al., 1964; Fiester et al., 1974; Pope et al., 1975). Lief et al. (1961) noted a trend in their data

suggesting that more psychotics terminated prematurely than did neurotics. To the contrary patients with the diagnoses of psychotic reaction, personality disorder or psychoneurotic have been found to remain in treatment longer than others (Craig & Huffine, 1976; Dodd, 1970). In summary, the study of patient diagnosis has shed little light on the question of treatment dropout.

The source of the patient referral has been investigated in terms of its value as a predictor of patient dropout. Fiester et al. (1974) reported that those patients who refer themselves or who are referred by other psychiatric sources tend to stay in treatment longer than all other kinds of referrals. Further, these researchers found that patients who had had previous contact with their clinic remained significantly longer in treatment than patients who had had no previous contact.

Psychological testing variables have been studied to determine their value as predictors of persistence in treatment. In addition to the problems endemic to all research in psychotherapy, the utilization of psychological testing variables ensures more variation across studies. The differences in examiners, in test settings, in testing procedures and their timing in the treatment process, the differences in scoring and analyzing the data make it a difficult process to compare results reported in this area. For this reason Garfield (1978) emphasized that research which has not been cross-validated is of questionable value.

The Rorschach has received the most attention in the area of

psychological testing and its relationship to treatment dropout. However, all of these studies were carried out in the 1950s and, therefore, will not be included in this review. Of the Rorschach variables investigated, R seemed the best predictor of treatment persistence (Garfield, 1978; Meltzoff & Kornreich, 1970). Several researchers in the 1950s also compared IQ and Rorschach scores to identify the best predictors of treatment remainers and dropouts; correlations between R, IQ and time in treatment were reported (Garfield, 1978; Meltzoff & Kornreich, 1970).

Other than the Rorschach few psychological tests have been examined in depth in order to identify predictors of treatment dropout or persistence. Studies utilizing MMPI test scales have yielded no accurate predictors of continuation in treatment (Dodd, 1970; McAdoo & Roeske, 1973; Rosenzweig & Folman, 1974). DeLoach (1977) found that a combination of moderate Hy and Pd scores in addition to a number of other psychological test results was a good predictor of self-referred college students remaining in treatment more than one month. The study has yet to be replicated.

Some research has attempted to cull data from several psychological tests in order to predict continuation in treatment. (Although the studies by Lorr and his associates may now be dated, they will be included herein as so much effort was expended by these researchers to replicate their experiments.) Rubinstein and Lorr (1956) discovered that four brief psychological tests and questionnaires were good predictors of treatment terminators and remainers. The four measures, a

39-item Behavior Disturbance scale, an 18-item Self-Rating scale, a 30-item modification of the Taylor Manifest Anxiety Scale, and a 15-item vocabulary test, were named the TR test battery. Subsequently, Lorr, Katz and Rubinstein (1958) reported that the TR battery (with the addition of a 20-item F scale) was not able to differentiate dropouts and remainers at an acceptable level of significance, however, the results obtained were in accordance with their predictions. The TR battery was again cross-validated (McNair et al., 1963) with 282 outpatients from 7 V.A. clinics. Results of this study supported the use of the TR battery as an accurate predictor of treatment dropout with veterans. Stern, Moore and Gross (1975) speculated that SES had been confounded with personality characteristics in much of the literature on treatment dropout. These researchers administered the TR test battery after the first treatment interview to 34 lower, and 34 middle class patients; a criterion of 6 sessions was established to identify remainers from dropouts. Thus, patient population, criterion of dropout and time of administering the test battery differed from the research of Lorr and his colleagues who worked with veterans, used criteria of 26 sessions (1958) and 16 sessions (1963), and administered the TR battery prior to the initial treatment session. Stern et al. (1975) reported that the TR test battery seemed to be discriminating SES rather than treatment dropout as most of the middle class patients were predicted remainers while most of the lower class patients were predicted terminators. Further, the TR battery was only able to accurately discriminate 50% of the patients who terminated and

50% of those who remained, a finding no better than chance.

Review of the literature on psychological test variables as predictors of treatment persistence leads to the conclusion that the best predictors, IQ and Rorschach R, are highly correlated. While the TR battery has shown some success as a predictor of treatment remainers and dropouts, Stern et al. (1975) raised serious doubts regarding the validity of the measure (i.e., does the battery measure what it purports to measure). In the final analysis the most critical flaw in this area of the dropout literature is that most of the research was carried out 25 to 30 years ago, which raises questions as to its applicability today.

In summary, the research to identify particular patient variables which are good predictors of continuing in, or dropping out of treatment has produced mixed results. Age, sex, marital status and diagnosis have generally not proven to be correlated with either dropout or persistence in treatment. A high school education and middle class SES have generally had a positive relationship with continuation in treatment. However, therapists' attitudes toward lower class patients, the effects of race variables and patients' expectations of treatment upon duration of treatment may be confounding the correlation between SES and continuation in psychotherapy. Patients who refer themselves, or who are referred by other psychiatric professionals, do seem to persist longer in treatment than patients referred from various clinics within the hospital setting. Finally, the best psychological test predictors and test battery, Rorschach R, IQ and the TR battery,

are probably confounded with SES.

Therapist Characteristics

Empirical studies have focused on numerous qualities and characteristics of therapists as these relate to dropping out of treatment. Other investigations pertaining to therapist characteristics were concerned with patient improvement and thus are not within the domain of the dropout literature. However, these studies have been included in this review as they highlight the importance of particular therapist characteristics on the treatment process. It is reasoned that if therapist characteristics have a potential effect upon patient improvement, they may also have an effect upon patient persistence in treatment.

Parloff, Waskow and Wolfe (1978) provided conceptually distinct categorizations of the various therapist variables, and their classification scheme will be utilized in this paper. One group of therapist variables are those which are assumed to be operating within the therapeutic alliance independent of the patient. This category includes such factors as sex, race, experience or competence, and professional discipline of the therapist. Another category of therapist qualities is more properly labeled patient-therapist interaction variables since patient and therapist presumably influence each other's expression or amount of the characteristic within the therapeutic alliance. However, these particular variables have rarely been treated in the literature as interaction variables as they are typically examined independent of the therapeutic process. These variables include therapist warmth or aloofness; therapist type; similarity of patient and therapist; thera-

pist genuineness, empathy and positive regard for the patient; and the expectations of therapist and patient. The few studies which do examine therapist-patient interaction variables within the treatment setting will be reviewed in the following section of this paper.

Reviews of psychotherapy literature which include therapist characteristics as an outcome measure (Baekeland & Lundwall, 1975; Garfield & Bergin, 1978; Meltzoff & Kornreich, 1970) contradict each other's conclusions regarding the significance of sex of the therapist. While Baekeland and Lundwall state that male therapists lose more patients than do female therapists, Meltzoff and Kornreich emphasize that research in this area has produced inconclusive results. The latter authors posit that part of the problem is methodological: the majority of studies that discuss sex of therapist do not randomly assign patients to therapists. Hence, the extent to which a patient selection bias may be affecting the data is unclear.

Several studies have purported to find differences between male and female therapists and their ability to keep patients in treatment. McNair et al. (1963) predicted that patients would either stay in treatment or drop out, and they found that sex of therapist did not affect the length of time in treatment for predicted quitters or remainers. When these two groups (predicted quitters and remainers) were combined for statistical purposes, there was a significant difference between length of time in therapy and sex of therapist: female therapists lost fewer patients than did male therapists. This conclusion is suspect given the nature of the analysis and the fact that the investigators

could not state with precision the probability with which a Type I error may have occurred. Mintz, O'Brien and Luborsky (1976) discovered that female social workers evidenced a higher rate of rehospitalization with female patients than did psychiatrists or psychiatric residents. This finding is attenuated by the fact that sex and profession were confounded in the study.

Research carried out with college students as clients has offered some support to the hypothesis that sex of therapist may affect treatment outcome. Heilbrun (1973) found that college females viewed as having a low readiness for counseling scored significantly higher ratings of self disclosure to males on a questionnaire than did females high in counseling readiness. When the students were evaluated in therapy analogue conditions, the interaction of readiness for counseling and self disclosure to male or female targets was not statistically significant. However, the pattern of females low in readiness for counseling disclosing less to females emerged again. In a study by Geer and Hurst (1976) college undergraduates identified as high in test anxiety were randomly assigned to treatment or control groups. The treatment, an accelerated massed desensitization of test anxiety, was administered in two, two-hour sessions. Students in both the female and male therapist groups achieved significant reductions in test anxiety. Female clients who had a male therapist reported much more anxiety reduction than females who had a female therapist. Hill (1975) reported that male and female patients were more satisfied with female therapists than with male therapists. Kirshner, Genack and Hauser (1978) found that male

and female patients who had female therapists produced significantly higher self ratings of improvement and satisfaction with the therapist than patients who had male therapists. In contrast other researchers (Pardes, Papernik & Winston, 1974; Saltzman, Luetgert, Roth, Creaser & Howard, 1976; Scher, 1975) have reported that sex of therapist had no effect on length of time in treatment and/or on progress ratings. In sum, sex of therapist as an outcome measure has produced much disagreement in the literature. Given the discrepancies reported in the research regarding this variable, it is possible that sex of therapist is confounded with warmth, empathy and/or use of support.

Investigations of the effects of race of therapist on the treatment process has generated some support for therapist-patient racial similarity (Sattler, 1970). Wolkon et al. (1973) contended that black undergraduates preferred a therapist of the same race, and experienced more dissatisfaction with their therapists than did white undergraduates. Yamamoto, James, Bloombaum and Hattem (1967) labeled therapists who had the least feelings about race as low in ethnocentricity. These investigators reported that therapists with low ethnocentricity spent comparable amounts of time in treatment of white and minority patients, whereas therapists high in ethnocentricity much less often treated minority patients for more than six sessions. Race of therapist and/or ethnocentricity merit further study if a determination of their respective contribution to patient attrition is to be established.

Experience or competence of the therapist has been examined in relation to psychotherapy outcome and has received some support as a

significant variable in relation to patients' persistence in treatment. Garfield, Affleck and Muffly (1963) secured judges' independent ratings of the overall effectiveness of six therapists; the judges had no knowledge of the therapists' treatment dropout rates. The most highly rated therapists had fewer patients terminate prematurely than did the least favorably rated therapists. While the difference between the treatment dropout rates of the two groups of therapists was not statistically significant, there did appear to be a relationship between lack of therapist competency and patient dropout. Baum, Felzer, D'Zmura and Shumaker (1966) reported that residents who had extensive clinical experience prior to their psychiatric residency kept patients in therapy much longer than did residents who entered psychiatry immediately after their internship program. The more clinically experienced residents had a 16% dropout rate while the less experienced residents had a 46% dropout rate. Caracena (1965) discovered that experienced therapists were much more likely to approach dependency statements of patients than were inexperienced thereapists, however, no difference was found in regard to their dropout rates. Scher (1975) reported that patients of experienced therapists had significantly better treatment outcomes than did patients of inexperienced therapists. In sum, there seems to be a trend in the literature toward a positive relation between therapist experience and the time a patient spends in psychotherapy. A cogent argument refuting the existence of a positive relationship between therapist experience and treatment outcome is found in an extensive review of the literature on therapist variables (Parloff et al., 1978). The authors

discussed the weaknesses inherent in most of the studies dealing with therapist experience, namely, the variety of definitions of experience, the use of therapist ratings in measuring outcome, and the confounding of experience with sex of therapist, type of training and personal psychotherapy. Parloff et al. (1978) concluded: "the body of data available is not sound enough to permit us to draw any firm conclusions (p. 240)." The writers excluded from their review the studies which utilized dropout rates or time spent in treatment as indicators of treatment outcome. This important exclusion accounts for some of the disagreement that these authors had with the other major reviewers (Auerbach & Johnson, 1977; Baekeland & Lundwall, 1975; Meltzoff & Kornreich, 1970) on the influence of therapist experience on treatment outcomes.

Although the professional discipline of a therapist would seem to be an important variable to be examined in relation to its influence on treatment dropout, very few studies have even mentioned the topic in their discussion sections. Meltzoff and Kornreich (1970) commented: "As far as we can determine, the question has not been answered simply because it has not been tested (p. 266)."

In summary, research of the sex of therapist in relation to dropout or time spent in treatment has generated a morass of contradictory findings. Race of therapist and/or therapist ethnocentricity has received some support as a potent influence on treatment dropout and on patient satisfaction with therapist. And while experience of the therapist has been shown to affect duration of treatment, there is much dis-

agreement about whether duration of treatment corresponds to positive therapeutic outcome (Baekeland & Lundwall, 1975; Garfield, 1978; Parloff et al., 1978). We are left with many unanswered questions regarding the various therapist characteristics, which operate independent of the patient in the treatment setting, and their relative contribution to the premature termination phenomenon.

The second category of therapist variables which are assumed to interact with patient variables but which are generally examined independent of the treatment setting will now be discussed.

There are several therapist characteristics which have been examined in relation to treatment dropout which have not received the attention required to support or disconfirm their importance. One of these is the therapist's responsiveness to patient dependency. Winder, Ahmad, Bandura and Rau (1962) found that when therapists approached the dependency statements of patients, the patients tended to remain in treatment, whereas patients terminated more readily with therapists who avoided dependency statements in the initial stage of treatment. On the contrary, Caracena (1965) reported no difference between patient dropout and nondropout in relation to therapist response to dependency statements. McNair et al. (1963) found that therapists who expressed interest in their patients' problems kept both predicted quitters and predicted stayers in treatment, although no other studies have reported the effects of the therapist expressing interest in the patient's communications.

Since 1954, when Whitehorn and Betz developed the concept of

Type A and B therapist as a result of their research studying therapist effectiveness in the treatment of schizophrenic patients, type of therapist has been a focus of investigation (McNair, Callahan & Lorr, 1962; McNair et al., 1963; Whitehorn & Betz, 1960). Subsequent research attempted to highlight the personality characteristics that seemed typical of the two groups of therapists (i.e., A and B). Review of a comprehensive dissertation on therapist types (Nightingale, 1975) is included here as representative of the research currently being done on A and B therapist types. Nightingale (1975) investigated personality variables which had previously been described as characteristic of A and B therapists. Two groups of subjects were studied in the research: professional therapists and college students. It was predicted that self actualization, autonomy, affiliation and nurturance would be positively correlated with Type A individuals; that there would be no differences between Types A and B in trait anxiety; that dominance, intraception and order would be positively related to Type B persons; and that the professional therapists would be more self actualized and score less trait anxiety than the students. In the group of male students, self actualization and nurturance were positively correlated to Type A, and order was positively correlated to Type B. Intraception was positively correlated only to Type B female students. No differences were found between A and B types in trait anxiety as predicted. However, professional therapists did not demonstrate less trait anxiety than the students. Indeed, the only prediction regarding professional therapists which was supported was that therapists were more self actualized than

students. As the investigator concluded, most of the research on A and B therapist types subsequent to the initial studies of Whitehorn and Betz have been carried out with students on the assumption that personality characteristics associated with the A and B types are invariant across student and therapist populations. However, this assumption does not seem to be valid given that little correspondence has been found in the research to date between student and professional therapist types. Hence, future research ought to concentrate on experienced male and female therapists and the effect of therapist type on psychotherapy.

The connection between patient-therapist similarity and its effect upon treatment dropout or treatment outcome has stimulated a variety of research investigations.

Studies concerned with therapist-patient similarity are based upon the assumption that something inherent in the dyadic relationship is the key to that which is therapeutic and that the therapeutic potential of this relationship is a direct function of the interaction of the two personalities who are partners to it. Most therapists today accept this as a truism rather than as a hypothesis subject to test (Meltzoff & Kornreich, 1970, p. 311).

Mendelsohn and Geller (1963) administered the Myers-Briggs Type Indicator (MBTI) to 72 patients at a university counseling center prior to beginning treatment, and to 10 therapists when their patients had ended treatment. The MBTI provides scores of Judgment-Perception, Thinking-Feeling, Sensation-Intuition and Extraversion-Introversion. A difference score was obtained for each therapist-patient dyad by adding the absolute differences between the scores on each of the four dimensions. It was posited that the lower the difference score between patient and therapist, the higher was their similarity. The inves-

tigators found that the more similar were the patient and therapist, the greater the number of therapy sessions. While this relationship was statistically supported on only one MBTI dimension, Judgment-Perception, nevertheless, the data suggest that there exists a connection between similarity and length of time in treatment. A replication of the study (Mendelsohn, 1966) lent further support to the previous findings. However, rather than a linear relationship existing between similarity and duration, the data suggest a mildly curvilinear relationship with moderately similar dyads having the greater number of therapy sessions. In a reexamination of the data of this study, Mendelsohn and Geller (1967) focused on early termination, missed sessions and similarity. It was reported that patients who missed one session but continued in therapy were very similar to their therapists. In contrast to this finding, the patients who were moderately similar to their therapists did not cancel appointments, whereas highly similar dyads obtained the highest number of missed sessions and remained in therapy the longest. The researchers provided an interesting explanation of the results, emphasizing the importance of the effects of interaction variables on duration of treatment:

It is clear from the data that in a surprisingly high proportion of cases the failure of a client to appear at a scheduled interview is related to events which take place in the counseling rather than to events which are external to the counseling....The occurrence of a missed session seems to reflect an ambivalent attitude toward counseling on the part of the client. If the ambivalence is resolved favorably the client is apt to make a stronger commitment to counseling than would otherwise be the case. Such ambivalence is (a) most likely to occur early in counseling when the client is still trying to evaluate the potential worth of counseling and the counselor and (b) to be stimulated by a high degree of similarity between the client and

the counselor (p. 214).

A curvilinear relationship between similarity and success in treatment had been reported earlier by Carson and Heine (1962) who utilized MMPI scales to obtain ratings of similarity between patient and therapist. However, an attempt to replicate the research failed to support a connection between successful treatment and similarity (Lichtenstein, 1966).

Related to the issue of similarity is the compatibility of patient and therapist. Sapolsky (1965) administered the Fundamental Interpersonal Relations Orientation Behavior scale (FIRO-B) to 25 female inpatients and 3 therapists, and used the obtained scores as global measures of compatibility. The therapists in the study were psychiatric residents, one of whom was female. Supervisors of the therapists provided the ratings of improvement. A significant relationship was found to exist between the global compatibility scores and improvement. Mendelsohn and Rankin (1969) investigated compatibility from FIRO-B scores in relation to treatment outcome measured by patients' ratings of improvement. Subjects in the study were 104 males and 58 females who contracted for therapy at a college counseling center. The 11 therapists (5 females, 6 males) were divided into groups in terms of their years of experience; each experience group engaged in treatment roughly the same number of patients. Investigators analyzed 10 compatibility scores from the FIRO-B, including a global measure of compatibility. Findings revealed a difference between females and males on the importance of some areas of compatibility in relation to improvement. While

female patients' improvement ratings were positively correlated with five of the compatibility scores, male patients' ratings were not related to any of the compatibility scores. However, in contradiction to Sapolsky (1965) neither the women's nor the men's global compatibility scores were significantly related to improvement.

In summary, conflicting results have been obtained on the issue of similarity and/or compatibility in relation to treatment outcome. While Mendelsohn and Geller (1963, 1966, 1967) and Carson and Heine (1962) provided some support for the existence of a curvilinear relationship between similarity and improvement, further research failed to replicate their findings (Carson & Llewellyn, 1966; Lichtenstein, 1966). Though Sapolsky (1965) reported a positive relationship between compatibility and improvement, Mendelsohn and Rankin (1969) failed to support the hypothesis. It must also be noted that the research of Mendelsohn and his colleagues utilized students seeking assistance with educational and vocational issues as well as those seeking personal counseling, and therefore, their findings may not be generalizable to clinical populations.

The work and theory of Carl Rogers has stimulated a wealth of research focusing on therapist and patient conditions requisite for therapeutic benefit. From his client-centered theory Rogers (1957) specified patient and therapist behaviors which were necessary and sufficient to bring about personality change. Rogers posited that the therapist must express an unconditional positive regard for the client; must be able to understand the client from the client's frame of

reference; must express accurate empathy for the client; and must be genuine (i.e., congruent) in relating to the client. For his/her part, the client needed to be able to perceive the therapist's "goodness" (the expressions of positive regard, empathy and genuineness) and must be somewhat anxious or vulnerable regarding his/her personal problems in living. Behavioral rating scales were developed (Bozarth & Krauft, 1972; Rogers, 1957; Truax & Carkhuff, 1967; Walker, Rablen & Rogers, 1960) to measure the frequency and levels of the therapist and patient behaviors. It must be emphasized that although this research purports to examine the therapeutic relationship, the actual variables under investigation are the therapists' interpersonal skills.

Since comprehensive reviews of the literature on client-centered therapist conditions in relation to treatment outcome have been provided (Carkhuff, 1969a, 1969b; Meltzoff & Kornreich, 1970; Mitchell, Bozarth & Krauft, 1977; Truax & Mitchell, 1971; Truax & Wargo, 1966), two experiments in clinical settings which are representative of research in this area will be presented herein.

Van der Veen (1965) tested the Rogerian conditions for positive treatment outcome by analyzing the recorded treatment sessions of three chronic hospitalized schizophrenic patients. Due to the procedure established at the hospital for obtaining treatment, the three patients had each seen the same five therapists. Patient and therapist variables were rated by using both audiotapes and transcripts of three randomly selected, consecutive, four-minute segments from the first and fourth treatment sessions. Results of the study supported

the hypotheses that patients and therapists influence each other's behavior in the therapeutic relationship, and that the levels of patient and therapist behavior are positively related to each other. Van der Veen (1967) again examined recorded interviews of hospitalized schizophrenics to measure levels of therapist and patient variables in relation to treatment outcome. Treatment benefit was defined by the summation of the means of five change measures: an estimate of change obtained from two psychologists evaluating pre- and posttreatment test batteries; the change score from the self-concept Q-sort; the change score from an anxiety scale; the change score on certain MMPI items; and the percentage of time in hospital since the beginning of the research. Van der Veen reported support of the relationship between levels of therapist and patient behavior and treatment outcome; a positive correlation was also found between patient perception of therapist behaviors and treatment outcome.

From their review of the literature on therapist empathy, warmth and genuineness, Truax and Wargo (1966) concluded that the evidence is so much in favor of these therapist conditions that psychotherapy without them could change client behavior for the worse. Mitchell et al. (1977) were much more skeptical concerning the research on therapist offered conditions. These reviewers, who like Truax and Wargo had carried out many studies themselves in this area with generally positive results, criticized earlier research for failing to consider important variables (e.g., demographic variables of both patient and therapist, and the levels of the therapists' interpersonal skills). It

was emphasized that the results of earlier studies need to be reviewed and revised. Mitchell et al. (1977) questioned the construct validity of the behavioral rating scales and pointed out that research focusing on the postulated reinforcement effects of interpersonal skills had not been performed. Additionally, the reviewers noted that an insufficient number of studies had been carried out regarding the effects of therapist training (i.e., increasing the levels of the therapists' interpersonal skills) on both the stability of the gains and on treatment outcome. Regarding future research, the reviewers suggested that the therapist skills of immediacy and confrontation be investigated, and they recommended a focus on levels of therapist conditions in relation to client changes within certain time frames in the treatment process.

Treatment Expectancies

The effect of therapist and patient expectations on treatment outcome, on treatment duration or attendance has been under examination since the mid-1950s. Underlying these studies is the belief that patient and therapist bring to the therapeutic relationship specific and/or global expectations about the process of psychotherapy, about the time treatment requires, about their respective behaviors in the process, and about what benefits the patient may attain through psychotherapy. The primary hypothesis which expectancy studies address is whether similar therapist and patient expectancies affect outcome. While these studies are not directly applicable to the question of treatment dropout, nevertheless, they seem important in terms of creating relevant hypotheses regarding psychotherapy dropout. For

this reason the results of the outcome studies regarding patient and therapist expectations about psychotherapy will be included in this review. It must be emphasized that the research of expectancies was highly stimulated in the 1960s, in an attempt to understand the increased dropout rate which was experienced when the advent of community based mental health clinics made psychotherapy available to persons who were poor and/or psychologically unsophisticated. At that time concerned professionals began to wonder whether the disconfirmation of patients' treatment expectations was influencing them to terminate prematurely.

Expectancy of therapeutic gain was originally conceptualized as a placebo effect: if the patient believes treatment will be beneficial then there is a greater likelihood that he/she will obtain favorable results from treatment. Frank (1959) contended that positive expectancy may be a necessary condition for therapeutic gain:

a patient's expectancy of benefit from treatment in itself may have enduring and profound effects on his physical and mental state. It seems plausible, furthermore, that the successful effects of all forms of psychotherapy depend in part on their ability to foster such attitudes in the patient (p. 36).

An opposing viewpoint was maintained by Cartwright and Cartwright (1958) who believed that expectation of improvement is not correlated with treatment benefit:

...we have no confidence in predicting any particular relation between degree of belief...that certain effects will result, and degree of improvement in psychotherapy (p. 175).

Rather than focusing attention on placebo effect, Cartwright and Cartwright (1958) exhorted therapists to explore "actual functional

relations between different kinds of (expectancies) and improvement in psychotherapy (p. 177)."

Rosenthal and his colleagues continued to examine the merits of placebo effects in their research. In one study (Rosenthal & Lawson, 1964) some experimenters were informed that the rats they would be observing were "bright" while others were told their rats were "dull". Experimenters observing the bright rats reported significantly higher rates of acquisition than did those observing dull rats. Rosenthal and Jacobson (1968) randomly assigned children to treatment and control groups in a school in California. Teachers were given the names of children (the experimental subjects) who the researchers identified as those children who were expected to make significant intellectual gains. This study demonstrated the profound effect that teacher expectations had upon children's achievement: children who were expected to achieve obtained significantly enhanced IQ scores in contrast to children in the control condition.

A topic related to placebo effect is the explanation of patient improvement prior to formal psychotherapy. Goldstein (1960a) argued that:

improvement taking place in control subjects be conceptualized as analogous to a placebo effect in that such improvement appears to be a partial function of these non-specific consultative interventions, by culturally defined healers, which the patient may interpret as therapeutic activity (p. 400).

Goldstein considered it fallacious to label symptom improvement without formal psychotherapy as "spontaneous improvement." The investigator found, as he had predicted, that patients who received professional

attention by means of intake interviews and psychological testing do improve prior to beginning psychotherapy. However, Goldstein maintained that this improvement is not spontaneous but rather the result of a mobilization of the patient's positive expectations of improvement through nonspecific therapy.

Various studies have attempted to ascertain patients' expectations regarding improvement in treatment, and examined the effect of such expectations upon improvement. One of the methodological issues problematic in these studies is whether to utilize patients' or therapists' assessment of patient improvement. In either case bias may be confounding the results: therapists may need to perceive patient improvement and patients may need, after their considerable investment in treatment, to perceive improvement. With this in mind we proceed to review the literature on the effect of patient expectation of improvement upon outcome. Lipkin (1954) concluded that:

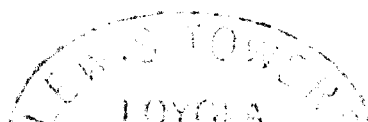
the client...who anticipates that his experience in counseling will be a successful and gratifying one undergoes more change in personality structure than does the client who has reservations about the counseling experience (p. 26).

Although Rosenthal and Frank (1956) supported Lipkin's position that a relationship existed between patient expectation of personality change and its occurrence, Goldstein (1960b) failed to support the relationship. Heller and Goldstein (1961) found that client pretherapy attraction to the therapist was positively correlated with client's movement toward independence through the treatment process. Additionally it was discovered that attracted clients reported an increasing

sense of independence even though overt behavioral measures did not corroborate the change. This discrepancy between self reports and behavioral data was discussed by the researchers in terms of the patients' attempts to please the therapists by fulfilling what patients' believed to be the therapists' expectations. However, an alternate explanation is that the patients may have been fulfilling their own expectation of treatment, namely, that through treatment they expected themselves to grow more independent. Martin, Moore, Sterne and McNairy (1977) reported a significant correlation between patients' expectations of improvement and posttreatment adjustment ratings.

Patients' expectations regarding length of treatment and the role of the therapist have also been explored. Garfield and Wolpin (1963) administered questionnaires to patients in order to ascertain patient expectations of psychotherapy. Although 62 of the 70 patients thought psychotherapy was the treatment of choice for their problems, their view of psychotherapy tended to be at odds with the traditional dynamic view of treatment held by most therapists at that time. That is to say, 73% of the patients expected improvement by the fifth session, and only 21% anticipated that treatment might last more than twenty sessions. Goin, Yamamoto and Silverman (1965) discovered that while 52% of the lower socioeconomic class patients held a traditional view of the nature of psychotherapy (i.e., that it would involve talking about their feelings and their past), 56% of these same patients believed therapy would require 10 sessions or less. Forty-eight percent of the lower class patients expected the psychiatrist to provide a solution

to their problems either in the form of advice or chemotherapy. Of the latter group of patients 21% expected treatment to last only 2 sessions, while 46% believed it would end within 10 sessions. Only 20% of the total sample of patients held the prevalent conventional view that psychotherapy would require more than 25 sessions. Dodd (1970) reported that the median number of visits for 169 new outpatients in a university psychiatric clinic was 4. This finding, coupled with a high dropout rate, led Dodd to speculate that the majority of patients who present for treatment for the first time expect brief psychotherapy. Williams, Lipman, Uhlenhuth, Rickels, Covi and Mock (1967) confirmed the results of other researchers regarding expectations of psychotherapy held by lower class patients. Administration of pre-treatment questionnaires to 587 psychiatric outpatients elicited the information that the lower class patients expect more active therapists who are supportive, medically oriented and who offer advice. A more recent study (Rapoport, 1976) contradicts that finding: a low expectation for medically oriented treatment was reported. Instead, the investigator found that patients sought therapists who would primarily listen, offer some direction and who had a more traditional psychological orientation. While socioeconomic status may once have been a reliable clue to patients' expectations of treatment, perhaps the nature of the presenting problem bears a stronger relationship to treatment expectations today. Horenstein (1975) discovered that females who presented for psychotherapy with complaints of severe physical problems expected medically oriented therapists. Patients



concerned about their own personal adjustment reported presenting problems regarding their future goals and plans, and expected psychotherapy to be dynamic and psychologically oriented. Finally, there was no significant difference found between treatment expectations and premature dropout.

Research of therapist expectancy of patient improvement and its relationship to treatment outcome has produced evidence in support of the contention that therapist expectancy may be a necessary condition for patient improvement. Goldstein (1960b) examined therapists' and patients' expectancies of improvement and subsequently compared these to their perceptions of actual improvement. Therapist expectation of patient improvement proved significant: those patients who felt they had improved during psychotherapy had had therapists who expected them to improve. Garfield and Affleck (1961) gave a group of therapists a description of prospective patients and asked them to rate the patients on numerous variables, such as, prognosis and anxiety. Patients who received good prognostic ratings remained in therapy longer than patients given low prognostic ratings. Therapist preferences and feelings for patients did not correlate with duration of stay in treatment. Sherry (1977) found that patients who were given negative prognostic ratings prior to treatment were much more likely to terminate than those patients given favorable prognostic ratings. Gelfand (1978) examined the prognostic ratings for treatment that 92 students from applied counseling programs, who themselves held middle class role expectations of the treatment process, gave to 4 simulated patients. It

was found that socioeconomic status and IQ were the two most important factors that the students paid attention to in making their prognostic ratings. Martin and Sterne (1975) utilized a multivariate research strategy and discovered that therapists' expectations of patient improvement were positively correlated with 8 of 15 outcome measures. In explaining the results of their study, the researchers posited that therapists' expectations may be multidimensional and, hence, a reflection of both knowledge of pathology and treatment as well as knowledge of the particular patient. These investigators questioned whether therapists' expectations of improvement are predictive rather than causative as other studies had suggested. Subsequently, the hypothesis that therapists' expectancies cause treatment outcomes was examined (Martin et al., 1977) by evaluating whether posttreatment expectancy-adjustment associations were stronger than pretreatment expectancy-adjustment associations. It was reasoned that if therapists' expectations are causative, the expectancies should be communicated to patients during treatment and ought to thereby increase posttreatment expectancy-associations. Results of the study rejected a causative interpretation and provided further evidence in support of a predictive interpretation of therapist expectancies.

The match between patient and therapist expectancies has been investigated in relation to patient improvement and/or treatment dropout. Heine and Trosman (1960) compared the expectations of the patients who remained in treatment for six weeks to those who had dropped out. Mutuality of expectation between the therapist and patient about the

treatment process was the most important factor for continuing treatment. Patients whose presenting problems were primarily emotional, who viewed treatment as a process in which both persons would actively collaborate, who sought treatment for advice or assistance in changing behavior, and who had a moderate to high belief that psychotherapy would help, were more likely to continue. In contrast those who presented with somatic complaints, who intended to passively cooperate in their treatment, who sought medication or diagnostic information, and who had little or no belief that treatment would help tended to discontinue treatment. When researchers (Goin et al., 1965) manipulated advice giving in treatment sessions with lower class patients who expected advice, there was no difference in length of stay between patients who were given advice and those not given advice. Disconfirmation of this specific expectancy, wanting advice, does not appear to significantly affect treatment duration. Another interesting result of this study was that 75% of the patients felt that their treatment was successful, while the therapists rated only 56% as having improved. Patients' expectations of improvement may vary greatly from therapists' expectations of patient improvement.

Levitt (1966) hypothesized a negative linear correlation between successful treatment and the confirmation of a patient's expectations.

...there is a negative correlation between the effectiveness of any psychotherapeutic intervention and the discrepancy between the patient's expectation of the nature of the therapy process and the reality of the encounter. The more the patient finds that the therapeutic situation fails to conform to his preconceptions of it, the less it is likely to affect him favorably (p. 164).

To the contrary Clemes and D'Andrea (1965) argued that high expectancy confirmation may be as detrimental to the treatment process as very low expectancy confirmation. The researchers conceptualized maximal benefits occurring when there is a moderate level of expectancy disconfirmation. Thus, they hypothesized a parabolic relationship between successful treatment and the confirmation of patient expectancies.

Overall and Aronson (1966) reported a higher treatment dropout rate for lower class patients whose expectancies of treatment were incongruent with their experiences of psychotherapy. Gulas (1974) found that clients whose expectations of psychotherapy and of their own roles in treatment were congruent with their therapists, improved much more in short-term treatment than did clients whose expectancies were dissimilar to their therapists. A study by Sandler (1975) supported the hypothesis that dissimilar client and therapist pretherapy expectations tended to end in early termination, while congruent expectations seemed to facilitate the treatment process. Rapoport (1976) examined therapists' and lower class patients' expectancies of treatment in a Mental Hygiene Clinic. Patients whose expectations were highly discrepant with their therapists' left treatment prematurely at a significantly higher rate than did patients who had therapists with congruent expectations. From their research on patient expectancies Horenstein and Houston (1976) found support for a parabolic relationship between treatment dropout and confirmation of treatment expectancies. Thus, patients who experienced a moderate degree of confirmed expectancies tended to remain in treatment, whereas patients with very low confirmed

expectancies, and patients with very high confirmed expectancies dropped out of treatment prematurely.

In summary, the match between therapist and patient treatment expectancies seems to be an important variable in relation to patients' persistence in psychotherapy. While the relationship between successful treatment and the confirmation of patient expectancies has been explained both in terms of a linear or parabolic relationship, more research is required to definitively support either explanation.

Preparation of patients for psychotherapy has been attempted by some researchers and has proven an effective means of enhancing attendance rates and/or improvement ratings. Hoehn-Saric, Frank, Imber, Nash, Stone and Battle (1964) prepared experimental psychoneurotic subjects for psychotherapy by giving them a role-induction interview. Control subjects were not given an orientation to treatment. The investigators concluded that patients receiving the role-induction interview had better attendance rates and reported more improvement with their symptoms than did control subjects. Further, therapists' ratings of patient improvement and patient therapy behavior were significantly higher for subjects who had the orientation to treatment. Strupp and Bloxom (1973) compared the effectiveness of two techniques to prepare lower class patients for psychotherapy. Subjects were divided into three groups: one group viewed a role-induction film developed by the investigators; a second group received individual role-induction interviews; and the control group watched a film on early marriage prior to beginning psychotherapy. Patients who were prepared for treatment by

either role-induction method reported considerably more benefit and satisfaction from treatment than did control subjects. Contrary to expectation, participation in role-inductions had no effect upon attendance. While patients in all groups rated themselves as having improved from treatment, there was suggestive evidence that those who viewed the role-induction film improved most.

Sloane, Cristol, Pepernik and Staples (1970) examined how therapy preparation and pretherapy suggestion of improvement within 20 sessions influenced treatment outcome and attendance. Patients were randomly assigned to senior residents who held a psychoanalytic orientation to treatment. Therapists were unaware of the nature of the research and in retrospect could not guess the variables under investigation. Patients who were prepared for psychotherapy improved more from treatment than those unprepared, but there was no difference between the groups on attendance. Patients who were given the suggestion of improvement did not improve more than others. In fact those given improvement suggestions were rated significantly less favorably by their therapists in terms of therapist liking the patient and therapist feeling he/she could help the patient. It appears that discrepant therapist and patient expectations of patient improvement may have a negative effect upon the therapeutic relationship.

Jacobs, Charles, Jacobs, Weinstein and Mann (1972) described the discrepant expectations that middle-class therapists and lower socioeconomic class patients hold toward therapy as a function of the social distance between their SES classes. "Only after patient and doctor

succeed in reducing distance and establishing some rapport can communication and the actual psychotherapeutic process begin (p. 667)." In an attempt to reduce this social distance the investigators offered both patients and therapists (psychiatry residents) a 15 minute treatment preparatory session, and hypothesized that this preparation would significantly diminish the rate of treatment dropout. Prepared therapists kept 47% of their patients in treatment more than 5 sessions, while unprepared therapists kept only 17% of their patients for the same length of time. When patients were prepared but their therapists were not, 33% of the patients were seen more than 5 times. A brief orientation to psychotherapy for both therapists and patients seems to have a significant influence upon patient attrition.

In conclusion, research on treatment preparation has produced convincing support for enhanced patient improvement ratings, although it has generally failed to affect treatment attendance. Both a role-induction interview and a role-induction film have yielded positive results and there exists some tentative support for the superiority of the latter. Also in terms of cost benefit ratio, the film would be preferable to the interview as it would not require administration by a professional staff person. While the preparation of both therapist and patient for treatment has been investigated only once, nonetheless, it merits further attention since it seems to have a significant influence upon patients' duration of stay in treatment.

The major reviewers (Baekeland & Lundwall, 1975; Meltzoff & Kornreich, 1970; Parloff et al., 1978) of psychotherapy literature or

treatment dropout literature have highlighted methodological problems characteristic of expectancy studies and have proposed further avenues of research in this area. A dissenting note has repeatedly been voiced by Wilkins (1973, 1979) whose contention is that client expectancy has not been validated as a theoretical construct, and that expectancy effects have been demonstrated only in studies wherein operational definitions of expectancy and outcome measures of improvement were suspect. Wilkins concluded that expectancy is a questionable interpretive artifact and he exhorted researchers to focus on observable manipulations in their psychotherapy investigations. Bootzin and Lick (1979) contradicted Wilkins' analysis of the literature and posited that Wilkins "confuses designs to answer questions about theoretical mechanisms with designs to demonstrate effectiveness (p. 852)." These researchers contended that expectancy is a mediating mechanism of effectiveness and they urged further research to determine precisely how, and under what circumstances, expectancy mediates patient improvement. Wilkins' position that expectancy cannot be measured deserves further attention; many studies have assessed patient expectations using a forced choice question with only two possible responses, yes or no. Utilization of an interval rating scale to measure the "amount" of patient expectancy in regard to various aspects of treatment would be one solution to this problem.

Therapist-Patient Interaction Variables

Despite the fact that major critiques of the literature on psychotherapy (Gardner, 1964; Garfield, 1971; Kiesler, 1966; Paul, 1967;

Rotter, 1960; Strupp & Luborsky, 1962) have emphasized the necessity of investigating interaction variables, few studies have examined the nature of the therapeutic relationship in terms of its effect upon treatment outcome. Much of the research on psychotherapy focuses on either the process or outcome of treatment, thus failing to take into account the differential effects of process variables on outcome. More recently Beutler (1973) proposed that each patient-therapist dyad constituted a separate treatment and that the effectiveness of the therapeutic relationship "depends not only upon the individual characteristics of patients and therapists but upon characteristics of their mutual compatibility (p. 305)." The writer stressed that psychotherapy research required a focus upon "dyadic assessment."

Parloff (1961) investigated the quality of the therapeutic relationship and its influence upon patient change and continuation in outpatient group psychotherapy. Scores for quality of the therapeutic relationship were obtained from an observer of each group who rated therapist-patient interaction on a 75-item instrument. In concert with the therapy goals of amelioration of discomfort and modification of ineffectual behavior, improvement was operationally defined in terms of degrees of discomfort and ineffectiveness; a third component of improvement was objectivity. Patients rated themselves on two measures of discomfort and rated fellow group members on a measure of ineffectiveness. Patients also rated themselves on a measure of objectivity in terms of how they predicted fellow group members might rate them. Evaluation teams, comprised of a psychiatrist, a psychologist and a

social worker, independently rated patients on measures of discomfort, ineffectiveness and objectivity. Each team subsequently discussed their ratings and arrived at a single score for each patient on each measure. One measure of discomfort, a Symptom Disability Checklist, was completed by patients prior to beginning treatment. All other measures were completed after the 4th session of treatment; the measures were again completed after the 20th session. Patients were randomly assigned to three groups run by therapists who each had at least five years of experience. The 21 patients, 10 males and 11 females, had the following diagnoses: 14 psychoneurotic disorders, 5 personality disorders, 1 psychotic disorder and 1 transient situational disorder. At the end of the study outcome measures were available on 14 patients. Parloff reported that those patients who obtained the highest improvement ratings were those who had established better relationships with their therapist. There were 14 change measures, 3 of which were positively correlated with the quality of the therapeutic relationship. Interestingly, one measure of each component of improvement (i.e., comfort, effectiveness and objectivity) attained statistical significance. Those patients who dropped out prematurely were influenced both by the quality of the therapeutic relationship and by the quality of the relationships they established with fellow group members. Thus, limited support was found for the hypothesized positive relationship between treatment outcome and the quality of the therapeutic relationship.

Garfield et al. (1963) investigated patient and therapist behav-

iors in the first treatment session and the effect these behaviors had upon time spent in psychotherapy. Subjects were 10 males and 14 females who were randomly assigned to 6 therapists who had a considerable range of experience. Patients had the following diagnoses: 10 neuroses, 11 character and personality disorders, 1 psychosis and 2 "others". The age of patients ranged from 18 to 50 years. Three judges listened to audiotapes of the first therapy sessions on each dyad, and independently rated the therapist and patient behaviors using six scales. Patients filled out one rating scale, and their therapists completed three rating scales following the first and fifth treatment sessions. Results of the research indicated that none of the judges' ratings were correlated with continuation in treatment. When patients were divided into two groups of eight patients who kept the fewest number (0-5), and the highest number (10-93) of appointments, several therapist ratings were significantly related to treatment duration. Remainders were rated higher on intelligence and achievement by their therapist and were rated more positively on the Communication-Sensitivity Scale than were terminators. Terminators received ratings that were significantly higher than continuers on the Environmental-Causation Scale (i.e., therapists' judgments that the patients were in treatment in order to obtain some manipulation of their environments). Without knowledge of the rate of patient dropout, and before the study ended, judges rated therapists on their overall effectiveness. Analysis was then carried out to determine the differences between the ratings of the three highest and lowest rated therapists.

The most favorably rated therapists had rated their patients as significantly higher on passive resistance, and lower on positive collaboration, than had the least favorably rated therapists. Judges' ratings of the patients had also determined that the patients of the most favorably rated therapists were more passively resistant, but they did not support the therapists' ratings of low positive collaboration. The concurrence of therapists' and judges' ratings on passive resistance suggests that the more effective therapists tended to have the most difficult treatment cases in the experiment despite the random assignment of patients to therapists. A trend in the data also indicated that the least favorably rated therapists tended to have more patients drop out while the more favorably rated therapists had a greater number of patients who continued in treatment.

Saltzman et al. (1976) studied the initial phase of the therapeutic relationship in order to identify predictors of treatment duration and outcome. In order to gain an understanding of the interaction variables operative in the formation of the therapeutic alliance, the investigators requested clients and therapists to complete questionnaires immediately following the first ten treatment sessions. It was found that while one patient dimension, low anxiety, discriminated terminators and remainers after the first session, by the end of the third session seven dimensions were significant discriminators of the two patient groups. Dropouts were significantly lower than remainers on respect, understanding, openness, security, uniqueness, continuity and movement. This reported dissatisfaction with the therapeutic rela-

tionship by the third session prompted the majority of dropouts to leave following the fourth or fifth sessions. These results led the researchers to conclude that "it is important to know not only what the client experiences but when he/she experiences it (p. 552)."

The therapist dimensions which discriminated the dropouts and remainers by the first session were involvement, responsibility and movement. By the third session therapists of remainers had higher scores on respect, understanding, openness, anxiety, involvement, continuity and prognosis, and lower scores on hostility than did therapists of the dropouts. While interaction variables were able to identify predictors of early termination or continuation, they were unsuccessful in predicting length of time in treatment for remainers.

In summary, the research on therapist-patient interaction variables has indicated some support for the relationship between quality of the therapeutic relationship and treatment outcome (Parloff, 1961). In addition, two studies (Garfield et al., 1963; Saltzman et al., 1976) have reported a correlation between quality of the therapeutic alliance and length of time in treatment. While the paucity of data in this area prevents the formulation of any conclusive statements, nevertheless, the positive results of this research to date point to interaction variables as holding promise for further understanding of early treatment dropout.

Situational Variables

The environment within which treatment takes place may exert its own influence upon the patient's response to treatment and the decision

to remain in or drop out of psychotherapy. Situational or environmental variables may be found both within the treatment setting (e.g., procedures of the clinic, fees, the physical facilities and their upkeep) and within the community in which the patient lives (e.g., family or social support of the patient's decision for treatment, the availability of public transportation, etc.). To date few studies have investigated situational factors, thus little is known about the role these variables may play in relation to persistence in treatment.

It has been hypothesized that the kind of treatment offered to patients (individual or group therapy) may affect persistence in treatment. Nash, Frank, Gliedman, Imber and Stone (1957) found that a significantly higher number of patients in group treatment dropped out in contrast to patients in individual psychotherapy. The investigators pointed out, however, that this result may be confounded with SES as a higher percentage of poor people were assigned to group treatment. Gallagher and Kanter (1961) reported that the majority of the 299 patients in their sample were offered group therapy (83%) and that approximately equal proportions of each SES were represented in individual and group treatment. While the data suggested that initially a higher percent of group therapy patients terminated prematurely than did individual therapy patients, the difference between the groups was not statistically significant. Further, by the 14th session the percentages of group and individual patients remaining in therapy were equal. Frank, Gliedman, Imber, Nash and Stone (1957) found that many more patients dropped out of group therapy before beginning treat-

ment than did patients in individual treatment. The authors speculated that group therapy per se is discrepant with patients' expectations of treatment, and reported that more stress is experienced by patients in relation to group treatment than in relation to individual treatment.

Treatment goals established by the therapist have been investigated to determine whether they affect treatment outcome. As part of a larger experiment in which patients were randomly assigned to twice weekly, weekly or biweekly treatment, Michaux and Lorr (1961) were concerned that in spite of the instruction to provide essentially the same kind of treatment to all patients, the therapists might conform treatment goals to the frequency with which patients engaged in treatment. Hence, Michaux and Lorr investigated the frequency of treatment, the severity of illness and the therapist's profession in relation to treatment goals; also treatment goals and their relationship to treatment outcome were studied. Four categories were utilized to classify the various treatment goals: reconstructive, whose aim was personality change through insight; supportive, which focused on shoring up the patient's defenses; relationship, whose aim was to facilitate the patient's adjustment through the development of the therapeutic relationship; and not classifiable, which included goals which were unclear or mixed in their aims. Several interesting results were reported by the investigators. First, in contrast to the traditional notion that reconstructive goals are best attained by increasing the frequency of treatment, it was found that the majority of patients with reconstructive goals were engaged in biweekly group treatment. On the

other hand patients with supportive treatment goals were typically engaged in twice weekly group psychotherapy. Second, the hypothesis that patients rated the most severely ill would obtain supportive goals whereas the less severely ill would be engaged in reconstructive treatment was supported. Third, no significant difference was found between the therapist's profession (psychology, psychiatry or social work) and the type of treatment goals. Fourth, there was no relationship between the type of treatment goals and treatment outcome. This study needs to be replicated to determine whether the important results therein would be supported in other treatment settings with similar patients and therapists.

Fee payment for psychotherapy has been examined in order to establish whether the act of paying fees or the amount of the fees affect dropout or treatment outcome. Wolff (1954) interviewed 43 leading psychotherapists and reported that 44% of them considered fee payment an integral part of the therapeutic process, while 54% stated that payment of fees was not essential to treatment. Schjelderup (1955) reviewed the case materials of 28 patients he had treated in psychoanalytic treatment. His retrospective analysis of these materials failed to support the hypothesis that a linear relationship exists between the size of the fee and therapeutic effectiveness. Ross and Lacey (1961) examined 154 cases of male patients referred to a child guidance clinic in order to determine characteristics of terminators and remainers. It was hypothesized that patients whose families paid for their treatment would remain in therapy longer than patients for whom

no fee was paid, however, this was not supported. Pope et al. (1975) studied size of treatment fee, from no fee to sliding scale fees to maximum payment either by the patient or by third parties, and its relationship to the therapeutic process. No relationship was found to exist in this study between treatment outcome and fee assessment. Though few studies have been carried out in this area the conclusion from the data that has been collected suggests that there is no correspondence between the payment of fees for therapy and treatment outcome or continuation in treatment.

Situational variables which exist outside the treatment setting and which may impinge on the therapeutic process have rarely been examined. Though the family and its influence on a family member who is seeking psychotherapy would seem to be an important factor relative to the patient's attitude toward, and perhaps persistence in treatment, few studies have focused on the relatives of patients. The majority of research studies which have been carried out regarding the effect of the family upon the treatment process are concerned with the treatment of children or with family therapy. However, one investigation utilizing an adult sample (Frank et al., 1957) reported that terminators rated themselves high in terms of opposition of their relatives to the patient's psychotherapy, and low in terms of support received from the family relative to the treatment process. Much more research is necessary to establish whether or not family support of the patient's psychotherapy is a significant variable in relation to treatment continuation or treatment outcome.

Investigation of Psychotherapy Dropout

In 1975, Baekeland and Lundwall proposed a three dimensional model to characterize psychotherapy dropout: client input variables, therapist input variables and environmental (or situational) factors were identified as those forces whose interaction accounts for remaining in or dropping out of treatment. This model of conceptualizing psychotherapy dropout is consistent with the "grid model" which Kiesler (1971) constructed as a means of discovering those characteristics of therapist and patient which, when matched with specific therapeutic interventions, lead to desired behavioral changes (i.e., effective psychotherapy). Those who have prepared comprehensive reviews of the literature on psychotherapy and treatment dropout tend to agree on the recommendation that future investigations in the area utilize factorial designs which can account for a variety of variables other than patient characteristics (Baekeland & Lundwall, 1975; Brandt, 1965; Garfield, 1971, 1978; Kiesler, 1971; Meltzoff & Kornreich, 1970).

Fiester and Rudestam (1975) performed a multivariate analysis of premature termination of individual psychotherapy at two community mental health centers. The interaction of three kinds of variables were considered in their examination of psychotherapy dropout: patient input variables, therapist input variables and data about the therapy process from the patient's perspective. Conceptually, the factors analyzed represented two of the three sets of variables considered salient by Baekeland and Lundwall (1975); the third dimension, situational factors, was not investigated. Further, one therapist in-

put variable, therapist expectancy of patient and of the therapy process, which has been demonstrated to be a significant variable in relation to psychotherapy termination (Borghi, 1968; Heine & Trosman, 1960; Levitt, 1966; Overall & Aronson, 1963) was not included in the Fiester and Rudestam research. Although the extent to which confirmation or disconfirmation of expectancies is important relative to other patient and therapist variables remains unclear (Horenstein & Houston, 1976), nevertheless, it seems an important area to consider in further early termination of psychotherapy research.

The present study expanded the research design of Fiester and Rudestam (1975) to include situational factors and therapist expectancies both of patients and of the treatment process. Thus, patient input variables (including demographic, pretherapy expectations and perspective of the treatment process); therapist input variables (including demographic, expectancy of the treatment process and perspective of the treatment process); and situational variables (including the perspectives of both the patient and therapist) which may impinge upon the treatment process and influence the decision to begin or remain in treatment will be examined. No prior attempt has been made to investigate the joint interaction of patient input variables, therapist input variables and situational variables as related to the outcome of premature psychotherapy termination.

Hypotheses

1. Drop out from psychotherapy can be predicted by the responses that the patient and therapist made regarding demographic variables,

process variables and situational variables. The primary hypothesis of this experiment is that when representative items from the three sets of variables are considered, a stable algebraic function will be generated which is superior in its ability to discriminate subjects into reasonably discrete classifications (i.e., dropout and nondropout groups) than any other function which may be produced by examining separate groups of these variables.

Specific predictions within the cluster of analyses will be further analyzed in order to fully examine those variables from the dropout literature which have demonstrated the most consistent results or have suggested the most promise for further research. Those predictions are as follows:

2. It is expected that dropouts will indicate that fewer of their pretherapy expectations about the therapist were met in the treatment session than will nondropouts.

3. It is expected that dropouts will indicate that fewer of their hopes or goals for the initial session were realized than will nondropouts.

4. It is expected that nondropouts will be more similar to their therapists in SES than will dropouts.

CHAPTER III

METHOD

Subjects

The subjects (N = 87) consisted of all veterans who presented to the Mental Hygiene Clinic (MHC) at Hines Veterans Administration Hospital (HVAH) between September, 1980, and December, 1980, and who contracted to participate in weekly treatment. Since Hines is a veterans hospital, most of the subjects were men (males = 83, females = 4). Veterans who were referred after the initial session (i.e., after intake) to other community mental health clinics, to inpatient psychiatry, to monthly individual or group psychotherapy, or who terminated at intake were eliminated from the study. Demographic information including age, sex, race, marital status, employment status, SES, and diagnosis of subjects is presented in Appendix I.

Site

HVAH is located on federal property adjacent to Maywood, IL, a suburb west of Chicago. As a VAH all services provided therein are federally funded and are available for any veteran of the armed services. Typically veterans pay no fee for psychotherapy, however, those who have health insurance may be charged for treatment. Services provided by the MHC include walk-in screening; intake evaluation and diagnosis; crisis intervention; individual, family and group psychotherapy; and individual and group hypnotherapy. The clinic staff is

comprised of one full-time and three part-time psychiatrists; three full-time clinical psychologists (Ph.D.); two full-time psychology interns (M.A.); one full-time nurse clinical specialist (R.N., M.A.); one part-time nurse in graduate clinical training (R.N.); two full-time and one part-time social workers (M.A., A.C.S.W.); and one part-time social work trainee (B.A.). One psychologist transferred during the period of the study and the position was subsequently filled, hence, there were four psychologists who were therapists in the research. Since the psychiatrists at the MHC are not scheduled for intakes, they did not participate as therapists in the study. In sum, there were 12 therapists (males = 8, females = 4), whose mean age was 38.08, and whose mean number of years of clinical experience since terminal degree was 7.06.

Patients are referred to the MHC from Admitting/Triage, from Inpatient Psychiatry, from inpatient and outpatient clinics of various medical and surgical services within the hospital, and from other VA hospitals throughout the Chicago metropolitan area. No self-referrals are accepted; patients who specifically request outpatient psychotherapy must present to the Admissions Office where they are evaluated by psychiatrists or psychiatric residents and then referred to the MHC. After business hours and on weekends patients are evaluated in the Emergency Room and referred to the appropriate service. Once the referral has been effected, the secretary of the referring service arranges the intake appointment through the MHC secretary. Staff therapists schedule five intakes per week; trainees schedule between two

four intakes weekly depending on their training goals. Therapists notify the secretary of the specific hours of the week that he/she will be available for intakes. Patients are randomly assigned to the therapists with two exceptions: 1) one psychologist typically receives referrals for hypnotherapy; and 2) if a patient has recently terminated treatment at the clinic, an attempt is made by the secretary to schedule the intake with the patient's previous therapist. During the intake interview, a tentative treatment plan is established with the patient. Usually the patients interviewed at intake become a part of the intake therapist's case load. However, a therapist may refer the patient to another therapist in the MHC or to the weekly Diagnostic Staffing Group. At the Diagnostic Staffing Group the clinic staff interviews the patient; the patient then leaves the room, the case and treatment plan are discussed, and a therapist is decided upon. Immediately following the staffing the therapist meets with the patient and establishes a treatment contract. In general, arrangements for treatment are effected during the intake as patients do not leave the clinic without a return appointment (unless they are referred to other agencies or terminated).

Procedure

As the purpose of this research was to increase our understanding of those factors which influenced a patient to terminate prematurely from psychotherapy, subjects were divided into two groups: dropouts and nondropouts. Dropout subjects ($N = 47$) were those patients who, after contracting for weekly treatment sessions, failed to

return or who discontinued treatment in five sessions or less. One exception were the patients who presented for short-term treatment (or crisis intervention) and whose charts indicated that the termination was a mutual agreement between patient and therapist; these patients were labeled nondropouts. The intake interview constituted the first treatment session even though the patient's therapist may not have been the intake therapist. If a patient attended the Diagnostic Staffing Group, that interview was considered the second treatment session. Nondropout subjects ($N = 40$) were those patients who continued treatment for six or more sessions regardless of final disposition.

Patients, when scheduled for intake, were given an appointment time which was 30 minutes preceding the actual intake session time. The investigator met each patient as he/she checked into the clinic; it was then explained that all veterans presenting to the MHC were requested to participate in the research project. A written explanation of the research project and of the veteran's right to participate or not in the research without loss of treatment benefits was given to all subjects. Those patients who agreed to participate in the research were then administered the Pre-Interview Questionnaire, and instructed to return it to the research investigator in the MHC office. Written instructions on the instrument emphasized that therapists would not see or have access to the completed questionnaires. The majority of the patients were administered the questionnaires in a large group therapy room, where the patient sat alone at a table. At times when the group therapy room was not available, patients complet-

ed the questionnaires in a smaller MHC office. Immediately following the initial session patients were given the Post-Interview Questionnaire and asked to return the completed questionnaire to the research investigator in the MHC office. On several occasions when the research investigator was not present at the MHC, one of the secretaries administered the questionnaires to the patients.

Therapists completed three kinds of questionnaires in the course of the study: 1) a pre-experiment questionnaire, 2) a post-interview questionnaire after each intake session, and 3) post-experiment questionnaires. The questionnaires were placed in the therapists' mailboxes, were completed by the therapists at their convenience and were returned to the investigator's mailbox in the MHC office.

Instruments

In order to compare the dropout and nondropout groups, data on three sets of variables relevant to the psychotherapeutic process was obtained: 1) patient input, including demographic information, pre-therapy expectations and initial perspective of the psychotherapy process; 2) therapist input, including demographic information, expectation of the treatment process and initial perspective of the therapy process; and 3) situational information from the perspectives of both patient and therapist.

The 75-item Patient Pre-Interview Questionnaire (Appendix II) was the same one utilized by Fiester and Rudestam (1975) except that the present investigator included 12 items pertaining to situational variables. The questionnaire requested the following demographic in-

formation: age, sex, education (in years), occupation, previous psychotherapy experience both at other clinics and at the MHC, length of time the presenting problems have been experienced, current state of adjustment, and social class background (for identification of SES on Hollingshead's Four-Factor Index of Social Position). Two other important patient characteristics, race and marital status, were gathered on patients by reviewing the intake report written by the intake therapist; this information was then written on the questionnaire by the research investigator. Data regarding pretherapy expectations was obtained from questions patients responded to regarding: anticipated number of visits to the clinic, the sex and orientation expected of the therapist (i.e., physician, teacher, minister, friend), anticipated role behavior of the therapist (19 items), and the goals and hopes the patient holds for the initial session (14 items). The 12 items included by the investigator in order to obtain information regarding situational variables required the patient to assess the extent to which transportation (4 items), weather conditions, time of treatment, pressure from others to be in treatment, waiting for treatment to commence (3 items), and work or school commitments made treatment a difficult process in which to engage. Each patient also reported the degree of confidence he/she had that treatment would help him/her cope with problems.

Items utilized by Fiester and Rudestam (1975) regarding the role behavior of the therapist were taken from Overall and Aronson's (1963) questionnaire developed to assess lower class patients' expectations

of psychotherapy. Questions pertaining to the patient's goals and hopes for the treatment session were from Orlinsky and Howard's (1966) Therapy Session Report (TSR). Items focusing on situational variables were developed from the present investigator's review of the literature on environmental and situational variables that may affect the treatment process.

The Patient Post-Interview Questionnaire (Appendix III) was the one utilized and developed by Fiester and Rudestam (1975) to compare dropouts' and nondropouts' perspectives of the treatment process. Fiester and Rudestam included on the form: 1) the same 19 items regarding patient expectations of the therapist (Overall & Aronson, 1963) that the patient had previously answered; 2) two items regarding the patient's evaluation of the treatment experience at the clinic and the extent to which the patient anticipated the next session (Strupp, Fox & Lesser, 1969); and 3) the complete 146-item Therapy Session Report (TSR), an instrument developed by Orlinsky and Howard (1966) to obtain data pertaining to the patient's immediate impressions of the process of psychotherapy in regard to the therapist, the patient and the therapeutic process. In formulating items for the questionnaire, the authors attempted to be theoretically neutral. The questions were also written in such a way as to provide the patient with a simple means of describing the experience of therapy: the patient checks the response on an interval scale (i.e., from one to six) which corresponds to his/her impressions.

Eleven categories of information are tapped by the TSR. First,

the patient rates the quality of the therapy session. Second, the patient evaluates his/her own progress with personal problems; also included in this category are the patient's motivation for treatment and sense of well-being, items which Fiester and Rudestam placed on the pre-interview questionnaire. Third, the patient rates the understanding and helpfulness of the therapist in the session. Fourth, the patient evaluates the extent to which he/she talked about topics which are typically discussed in psychotherapy; this category accesses data on the content of the session. Fifth, the patient rates the therapist's behavioral or interpersonal participation in the session. In the sixth category further data on the content of the session is obtained from the patient's ratings of possible concerns which he/she may have experienced in the treatment session. Seventh, the patient rates the goals or hopes he/she has for the session; these items were included by Fiester and Rudestam on the pre-interview questionnaire. Eighth, the degree to which the patient's expectations of the psychotherapy session were realized are assessed by the ratings the patient makes on the items pertaining to what the patient obtained from the session. These are the same items the patient previously responded to regarding specific goals or hopes for this treatment session. Ninth, the patient rates the extent to which he/she experienced specific feelings during the session. Tenth, the patient evaluates his/her own behavioral and experiential participation in the session. Eleventh, the patient rates the extent to which the therapist expressed certain feelings in the session.

Finally, the patient questionnaires included two items regarding the extent to which the patient felt annoyed with the research questionnaires. These items were developed by Fiester and Rudestam in order to tap in some way the reactivity of the patient to the two measures.

Prior to the beginning of the study each therapist completed the Therapist Pre-Experiment Questionnaire (Appendix IV); this was the same questionnaire used by Fiester and Rudestam (1975). Data obtained from the form provided demographic information on therapists including age, sex, profession, educational and post-terminal degree experience (in years), personal therapy experience (in hours), and social class background (for identification of SES on Hollingshead's Four-Factor Index of Social Position). Additionally, therapists were administered Whitehorn and Betz's (1960) A-B therapist scale to determine their position on the scale as an A or B therapist. The questionnaire was developed by Fiester and Rudestam with the intention of including on the form those variables identified by Strupp and Bergin (1969) as the most significant therapist input variables which ought to be considered in carrying out psychotherapy research.

Subsequent to each intake interview the therapist completed a 14-item Post-Session Questionnaire (Appendix V) which furnished data regarding the therapist's expectancies of the patient and of the treatment process. The questionnaire was developed by the present investigator and modelled after the Patient Post-Interview Questionnaire. Six categories of information are represented: 1) the therapist's evalu-

ation of the patient's participation in the session; 2) the therapist's ratings of the extent to which the patient's problems interfere with five major life spheres (e.g., work, relationships, etc.) and an overall impression of the degree to which the patient's problems affect his/her life; 3) the therapist's ratings of feelings experienced in the session; 4) the expectations that the therapist has of the patient and his/her capacity to benefit from treatment; 5) the treatment plan, including expected length of treatment and treatment modality; and 6) the intake diagnosis. If the patient was referred to another therapist or to the diagnostic staffing group, the item on treatment modality was completed by the research investigator after the treatment modality had been established.

Subsequent to the termination of the research project (i.e., after all patients had been identified as dropouts or nondropouts), the therapists completed a 16-item questionnaire, the Therapist Post-Experiment Questionnaire (Appendix VI). The questionnaire was prepared by the present investigator in order to obtain information about situational variables operating in the initial interview which may have affected the treatment process. Six categories of situational variables are accessed by the questionnaire: 1) information regarding the therapist's behavior (e.g., whether the therapist smokes, writes notes, writes the intake report in the session, keeps the office neat, etc.); 2) information regarding whether the therapist allows the patient to smoke or to drink coffee during the session; 3) an item regarding the presence of uncontrolled variables (e.g., other patients knocking on

the office door); 4) two items regarding the size and location of the therapist's office; 5) one item requesting the therapist to specify his/her theoretical orientation to individual psychotherapy; and 6) one item requesting the therapist to rate the extent to which the various research questionnaires have interfered with his/her work schedule. While there was no specific source for the preceding questions, it seemed reasonable to expect that the presence of these particular situational variables within the initial session might affect the patient's experience of the treatment and/or influence the patient's decision to remain in, or dropout of psychotherapy.

Finally, the Therapist Post-Experiment Questionnaire on Groups (Appendix VII) was completed by those therapists who were group psychotherapists holding weekly group treatment sessions in the MHC. Therapists were asked to rate the "group atmosphere" of each group that they led on six items: group warmth, group support, group acceptance of new members, group expression of negative feelings, group discussion of intimate life issues and group expression of affection and warmth within the group. The group therapists were also asked to specify the theoretical orientation out of which the therapist worked in each particular group. This questionnaire was developed by the research investigator in order to gather information regarding group treatment situational or contextual variables which might affect a patient's perspective of the treatment process. While no one source was specifically drawn upon in the formulation of the items, two references which deal primarily with group psychotherapy were consulted (Egan, 1970;

Lieberman, Yalom & Miles, 1973).

CHAPTER IV

RESULTS

To test hypothesis #1 a discriminant analysis was carried out on 274 patient input, therapist input and situational variables (see Appendices II-VII for identification of the variables). Excluded from the discriminant analysis were those 13 variables (TVAR1, TVAR4, TVAR12, TRVAR18, PCVAR1, PCVAR9, PCVAR12, PCVAR16, PSES1, TIORT1, TGORT1, PMAR1, and PREF1) which were nominal type data; and those variables which were used to calculate SES (TVAR7-11 and PCVAR4-7). One categorical type variable was recoded in order to be included in the discriminant analysis; this variable (TRVAR19) pertained to patient diagnosis, and in the recoding patients were categorized as either neurotic or psychotic. The variables in the discriminant analysis were divided into 17 sets which seemed to represent distinct groups of variables as they may exist in the real world. For example, therapist demographic variables comprised one group while patient's expectations of the therapist comprised another. Discriminant analysis of each of the 17 sets of variables was carried out. Subsequently, the two variables which obtained the highest Wilks' lambda in each of the 17 analyses were combined into an 18th group for a final discriminant analysis. Stepwise discriminant analysis was used prior to each of the 18 analyses to eliminate those variables which had little discriminating power.

Results of the discriminant analyses are presented in Tables 1

to 18; included in each table are the summary table, the classification function coefficients, the standardized canonical discriminant functions evaluated at group means (group centroids) and the classification results.

The results of the discriminant analysis of the therapist demographic variables are presented in Table 1. The discriminant analysis correctly classified 60.92% of the 87 patients; 20% of the nondropout group were misclassified as dropouts while 55.3% of the dropout group were misclassified as nondropouts. The two therapist demographic variables with the highest discriminating power were sex and age: remainders tended to have male therapists who were older than the therapists of dropouts.

The results of the discriminant analysis of the therapist's perception of the patient and of the initial treatment process variables are presented in Table 2. The discriminant analysis correctly classified 68.97% of the 87 patients; 32.5% of the nondropouts and 29.8% of the dropouts were misclassified. The two most potent therapist rating variables were ratings of the extent to which the patient's problems interfered with the ability to obtain a job (remainders' problems interfered more than dropouts' problems did in this regard); and the extent to which the patient's problems interfered with the ability to maintain a satisfactory sexual relationship (dropouts' problems interfered more than remainders' problems).

Results of the discriminant analysis of patient demographic variables are presented in Table 3. This analysis yielded an algebraic

Table 1

Discriminant Analysis of Therapist Demographic Variables

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars In</u> | <u>Wilks' Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------|--------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | TVAR02 | | 1 | 0.980925 | 0.2021 |
| 2 | TVAR03 | | 2 | 0.965084 | 0.2248 |
| 3 | TVAR06 | | 3 | 0.953441 | 0.2635 |
| 4 | TVAR11 | | 4 | 0.938918 | 0.2645 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| TVAR02 | 2.5366100 | 2.0633480 |
| TVAR03 | 0.5021716 | 0.4697187 |
| TVAR06 | -0.1078836D-01 | -0.9204463D-02 |
| TVAR11 | 2.5938290 | 2.4750800 |
| (constant) | -27.4772200 | -24.4097800 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|--------|---------------|
| TVAR02 | 0.54879 |
| TVAR03 | 0.64288 |
| TVAR06 | -0.61148 |
| TVAR11 | 0.53580 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.27328 |
| Dropout | -0.23258 |

Table 1, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 32 80.0% | 8 20.0% |
| Dropout (2) | 47 | 26 55.3% | 21 44.7% |

Percent of "Grouped" Cases Correctly Classified: 60.92%

Table 2

Discriminant Analysis of the Therapist's Perception of the
Patient and the Initial Treatment Process

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars In</u> | <u>Wilks' Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------|--------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | TRVAR03 | | 1 | 0.952736 | 0.0431 |
| 2 | TRVAR08 | | 2 | 0.888097 | 0.0068 |
| 3 | TRVAR11 | | 3 | 0.870899 | 0.0091 |
| 4 | TRVAR15 | | 4 | 0.852699 | 0.0102 |
| 5 | TRVAR05 | | 5 | 0.836078 | 0.0114 |
| 6 | TRVAR06 | | 6 | 0.801241 | 0.0058 |
| 7 | TRVAR19 | | 7 | 0.788287 | 0.0071 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| TRVAR03 | -1.5912210 | -0.9158975 |
| TRVAR05 | 0.4738830 | -0.1001606 |
| TRVAR06 | -0.6119494 | -0.2060880 |
| TRVAR08 | 6.6496610 | 5.8069950 |
| TRVAR11 | 0.9157302 | 1.3637170 |
| TRVAR15 | 0.9227713 | 0.5878698 |
| TRVAR19 | 5.7105580 | 6.4736540 |
| (constant) | -19.6733600 | -18.3309500 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| TRVAR03 | 1.17724 |
| TRVAR05 | -0.84438 |
| TRVAR06 | 0.61692 |
| TRVAR08 | -0.81230 |
| TRVAR11 | 0.53994 |
| TRVAR15 | -0.48289 |
| TRVAR19 | 0.29749 |

Table 2, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.55527 |
| Dropout | 0.47257 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 27 67.5% | 13 32.5% |
| Dropout (2) | 47 | 14 29.8% | 33 70.2% |

Percent of "Grouped" Cases Correctly Classified: 68.97%

Table 3

Discriminant Analysis of Patient Demographic Variables

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PCVAR15 | | 1 | 0.973915 | 0.1350 |
| 2 | PCVAR02 | | 2 | 0.954362 | 0.1406 |
| 3 | PCVAR03 | | 3 | 0.928804 | 0.1038 |
| 4 | PCVAR10 | | 4 | 0.914381 | 0.1149 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PCVAR02 | 0.3473853 | 0.3179839 |
| PCVAR03 | 28.7217200 | 27.0741200 |
| PCVAR10 | 0.3349421D-01 | 0.2452889D-01 |
| PCVAR15 | 0.4680135D-01 | 0.2933469D-01 |
| (constant) | -24.2009400 | -21.0689400 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PCVAR02 | 0.64845 |
| PCVAR03 | 0.57051 |
| PCVAR10 | 0.43145 |
| PCVAR15 | 0.62956 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.32786 |
| Dropout | -0.27903 |

Table 3, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 19 47.5% | 21 52.5% |
| Dropout (2) | 47 | 15 31.9% | 32 68.1% |
| Percent of "Grouped" Cases Correctly Classified: 58.62% | | | |

function which correctly classified only 58.62% of the 87 patients, a result which is slightly better than chance. Of the nondropouts 52.5% were misclassified while 31.9% of the dropouts were misclassified. The two most powerful patient demographic variables were the patient's previous number of treatment sessions at the MHC (remainders had more prior contact with the clinic than did dropouts); and age (nondropouts tended to be older than dropouts).

Results of the discriminant analysis of patient ratings of present level of adjustment, motivation for therapy, expectations of the therapist's role and perspective on situational variables are presented in Table 4. This analysis successfully identified 71.26% of the patients; 25% of the nondropout group and 31% of the dropout group were misclassified. The two most potent discriminating variables in this analysis were the patient's expectations that the therapist would be like a minister and like a teacher. Dropouts expected the therapist to be more like a minister than did remainders, while remainders expected the therapist to be more like a teacher than did dropouts.

Results of the discriminant analysis of the patient's expectations of what the therapist would do in the first treatment session are presented in Table 5. The analysis correctly classified 63.22% of the patients; 35% of the nondropouts and 38.3% of the dropouts were misclassified. The two most powerful discriminating variables were the expectations that the therapist would ask about the patient's physical illnesses (dropouts expected this more than remainders) and would tell the patient what is wrong with him/her (remainders expected

Table 4

Discriminant Analysis of Present Level of Adjustment,
Motivation for Therapy, Expectations of the Therapist's Role
And Perspective on Situation Variables

Summary Table

| Step | Action | | Vars In | Wilks' Lambda | Sig. |
|------|---------|---------|------------|------------------|--------|
| | Entered | Removed | | | |
| 1 | PETRL03 | | 1 | 0.963582 | 0.0766 |
| 2 | PETRL02 | | 2 | 0.908443 | 0.0177 |
| 3 | PETRL04 | | 3 | 0.878052 | 0.0125 |
| 4 | PTRAN02 | | 4 | 0.858976 | 0.0133 |
| 5 | PEMP03 | | 5 | 0.848255 | 0.0186 |
| 6 | PEMP01 | | 6 | 0.815254 | 0.0103 |
| 7 | PWAIT01 | | 7 | 0.804648 | 0.0134 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PETRL02 | 0.5422720 | 0.2029629 |
| PETRL03 | 0.6308644 | 0.9547450 |
| PETRL04 | -0.6166124D-01 | 0.7896634D-01 |
| PTRAN02 | 0.5613502D-01 | 0.2317733 |
| PWAIT01 | 1.1097960 | 1.2824270 |
| PEMP01 | 13.1904900 | 14.3737100 |
| PEMP03 | 3.7735420 | 4.2901580 |
| (constant) | -15.6581400 | -19.1800600 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PETRL02 | -0.72991 |
| PETRL03 | 0.62869 |
| PETRL04 | 0.29898 |
| PTRAN02 | 0.31471 |
| PWAIT01 | 0.27913 |
| PEMP01 | 0.57889 |
| PEMP03 | 0.71250 |

Table 4, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.52793 |
| Dropout | 0.44930 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 30 75.0% | 10 25.0% |
| Dropout (2) | 47 | 15 31.9% | 32 68.1% |

Percent of "Grouped" Cases Correctly Classified: 71.26%

Table 5

Discriminant Analysis of Patient's Expectations of
the Therapist's Behavior

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PEXPT16 | | 1 | 0.955164 | 0.0490 |
| 2 | PEXPT03 | | 2 | 0.899152 | 0.0115 |
| 3 | PEXPT13 | | 3 | 0.863283 | 0.0065 |
| 4 | PEXPT12 | | 4 | 0.850774 | 0.0094 |
| 5 | PEXPT06 | | 5 | 0.832536 | 0.0099 |
| 6 | PEXPT01 | | 6 | 0.820728 | 0.0128 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PEXPT01 | 0.1902983 | 0.3313675 |
| PEXPT03 | 0.4105292 | -0.1903587D-01 |
| PEXPT06 | 0.7151554 | 0.9129596 |
| PEXPT12 | 0.3654426 | 0.1199199 |
| PEXPT13 | 0.5846395 | 0.8547729 |
| PEXPT16 | 0.9678548 | 1.4835880 |
| (constant) | -6.5830870 | -8.3315330 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PEXPT01 | 0.30855 |
| PEXPT03 | -0.84231 |
| PEXPT06 | 0.35604 |
| PEXPT12 | -0.49517 |
| PEXPT13 | 0.53138 |
| PEXPT16 | 0.93876 |

Table 5, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.50075 |
| Dropout | 0.42617 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|---------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 26 65.0% | 14 35.0% |
| Dropout (2) | 47 | 18 38.3% | 29 61.7% |

Percent of "Grouped" Cases Correctly Classified: 63.22%

this more than dropouts).

Results of the discriminant analysis of the patient's goals and/or hopes for the initial treatment session are presented in Table 6. This analysis correctly classified 70.11% of the patients; 22.5% of the nondropouts and 36.2% of the dropouts were misclassified. The two most potent discriminating variables in the analysis were the patient's goal to learn about how to behave in treatment (remainers expecting this more than dropouts) and the hope to obtain advice from the therapist (dropouts hoping for advice more than nondropouts).

Results of the discriminant analysis of the patient's ratings of the quality of the initial session, of the therapist's understanding and helpfulness, of progress made on problems in the session and on whether the patient would recommend treatment at the clinic to a friend are presented in Table 7. This analysis correctly identified only 57.47% of the 87 patients, a result which is only slightly better than chance. While 22.5% of the nondropouts were misclassified, 59.6% of the dropouts were misclassified. The two most powerful predictors in this analysis were whether the patient would recommend the clinic to a friend (dropouts would more readily recommend the clinic than would remainers) and the rating of the therapist's helpfulness in the session (remainers perceived the therapist as more helpful than did dropouts).

Results of the discriminant analysis of the variables regarding what was talked about in the session are presented in Table 8. This analysis successfully classified 74.71% of the patients; 27.5% of the

Table 6

Discriminant Analysis of the Patient's Goals and Hopes

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PHOPE02 | | 1 | 0.981575 | 0.2100 |
| 2 | PHOPE09 | | 2 | 0.966287 | 0.2368 |
| 3 | PHOPE11 | | 3 | 0.933548 | 0.1249 |
| 4 | PHOPE12 | | 4 | 0.912150 | 0.1061 |
| 5 | PHOPE08 | | 5 | 0.887053 | 0.0786 |
| 6 | PHOPE06 | | 6 | 0.868222 | 0.0720 |
| 7 | PHOPE10 | | 7 | 0.851372 | 0.0696 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PHOPE02 | 1.2962710 | 0.8568688 |
| PHOPE06 | -0.1755372 | 0.1450327 |
| PHOPE08 | -0.2655389 | 0.1278249 |
| PHOPE09 | -0.5025155 | 0.1254657 |
| PHOPE10 | 1.7642840 | 1.4487170 |
| PHOPE11 | 1.1397030 | 0.7966326 |
| PHOPE12 | 0.3677556 | -0.1036879 |
| (constant) | -10.1897900 | -8.8612900 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PHOPE02 | 0.96739 |
| PHOPE06 | -0.66715 |
| PHOPE08 | -0.76586 |
| PHOPE09 | -1.25571 |
| PHOPE10 | 0.55258 |
| PHOPE11 | 0.64394 |
| PHOPE12 | 1.04100 |

Table 6, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.44767 |
| Dropout | -0.38100 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 31 77.5 | 9 22.5% |
| Dropout (2) | 47 | 17 36.2% | 30 63.8% |

Percent of "Grouped" Cases Correctly Classified: 70.11%

Table 7

Discriminant Analysis of the Patient's Ratings of the
Quality of the Session, of the Therapist's Understanding,
of Progress Made in the Session and of
Patient's Recommendation of the Clinic

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | RECMD01 | | 1 | 0.959424 | 0.0614 |
| 2 | TACT02 | | 2 | 0.939337 | 0.0722 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| RECMD01 | 3.0412490 | 2.642564 |
| TACT02 | 0.9151759 | 1.105719 |
| (constant) | -10.6363100 | -9.460544 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| RECMD01 | 0.98724 |
| TACT02 | -0.61385 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.27228 |
| Dropout | -0.23173 |

Table 7, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 31 77.5% | 9 22.5% |
| Dropout (2) | 47 | 28 59.6% | 19 40.4% |

Percent of "Grouped" Cases Correctly Classified: 57.47%

Table 8

Discriminant Analysis of Content of the Session

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PTALK19 | | 1 | 0.966545 | 0.0899 |
| 2 | PTALK07 | | 2 | 0.943188 | 0.0857 |
| 3 | PTALK05 | | 3 | 0.904943 | 0.0395 |
| 4 | PTALK06 | | 4 | 0.874380 | 0.0250 |
| 5 | PTALK02 | | 5 | 0.840397 | 0.0136 |
| 6 | PTALK12 | | 6 | 0.819302 | 0.0121 |
| 7 | PTALK10 | | 7 | 0.799612 | 0.0111 |
| 8 | PTALK08 | | 8 | 0.782914 | 0.0111 |
| 9 | PTALK13 | | 9 | 0.768725 | 0.0120 |
| 10 | PTALK14 | | 10 | 0.757079 | 0.0140 |
| 11 | PTALK09 | | 11 | 0.746864 | 0.0168 |
| 12 | PTALK16 | | 12 | 0.735170 | 0.0189 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PTALK02 | 0.1264045 | 0.53188880000 |
| PTALK05 | 0.1027027 | -0.56364350000 |
| PTALK06 | -0.2432309 | 0.48961350000 |
| PTALK07 | 0.7695385 | 1.12759000000 |
| PTALK08 | 0.2118740 | -0.14955260000 |
| PTALK09 | 0.1377350 | 0.34826030000 |
| PTALK10 | 0.8160385 | 0.56277960000 |
| PTALK12 | -0.2071653 | 0.20220970000 |
| PTALK13 | 0.1788745 | -0.5887084D-01 |
| PTALK14 | 0.3380008 | 0.13675300000 |
| PTALK16 | 0.1394434 | -0.6841064D-01 |
| PTALK19 | 0.6985381 | 0.28387780000 |
| (constant) | -5.5294840 | -5.40319100000 |

Table 8, continued

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PTALK02 | -0.61118 |
| PTALK05 | 0.93613 |
| PTALK06 | -0.93871 |
| PTALK07 | -0.49868 |
| PTALK08 | 0.47379 |
| PTALK09 | -0.31980 |
| PTALK10 | 0.36960 |
| PTALK12 | -0.61437 |
| PTALK13 | 0.36919 |
| PTALK14 | 0.31297 |
| PTALK16 | 0.31045 |
| PTALK19 | 0.59658 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.64307 |
| Dropout | -0.54729 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 29 72.5% | 11 27.5% |
| Dropout (2) | 47 | 11 23.4% | 36 76.6% |

Percent of "Grouped" Cases Correctly Classified: 74.71%

nondropouts and 23.4% of the dropouts were misclassified. The two 'talk' variables which proved most salient in this analysis were (1) talking about treatment per se especially in regard to one's feelings and progress (remainders perceived themselves as talking about these issues more than did dropouts), and (2) talking about work, career or education (dropouts perceived themselves as talking about these issues more than did remainers).

Results of the discriminant analysis of patient's ratings of what the therapist actually did in the initial treatment session are presented in Table 9. Discriminant analysis of these variables identified correctly 65.52% of the 87 patients; 27.5% of the nondropouts and 40.4% of the dropouts were misclassified. The two variables with the highest discriminating power were (1) the therapist told me ways to solve problems (remainders scored this higher than dropouts), and (2) the therapist tried to get my mind off my troubles (dropouts scored this higher than remainers).

Results of the discriminant analysis of the variables regarding the therapist's participation and involvement in the initial session as rated by the patient are presented in Table 10. The analysis successfully classified 63.22% of the patients; 30% of the nondropouts and 42.6% of the dropouts were misclassified. The two most salient variables in this analysis were the extent to which the therapist took the initiative in talking (dropouts rated therapists higher in initiative taking than did remainers), and the extent to which the therapist seemed negative or critical (remainders rated their therapists

Table 9

Discriminant Analysis of Patient's Ratings of Therapist's Behavior

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PFTHA09 | | 1 | 0.964337 | 0.0798 |
| 2 | PFTHA13 | | 2 | 0.928716 | 0.0448 |
| 3 | PFTHA02 | | 3 | 0.903616 | 0.0374 |
| 4 | PFTHA14 | | 4 | 0.882903 | 0.0352 |
| 5 | PFTHA08 | | 5 | 0.857824 | 0.0269 |
| 6 | PFTHA10 | | 6 | 0.840209 | 0.0268 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PFTHA02 | 1.27961000 | 0.9304664 |
| PFTHA08 | 0.11163140 | 0.3435053 |
| PFTHA09 | 0.90282150 | 0.3037727 |
| PFTHA10 | | 1.3176920 |
| PFTHA13 | -0.17754480 | 0.1517505 |
| PFTHA14 | -0.9497344D-01 | 0.1893339 |
| (constant) | -7.89774300 | -6.4434550 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PFTHA02 | 0.71301 |
| PFTHA08 | -0.51930 |
| PFTHA09 | 1.32720 |
| PFTHA10 | 0.37137 |
| PFTHA13 | -0.66125 |
| PFTHA14 | -0.63214 |

Table 9, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.46725 |
| Dropout | -0.39766 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 29 72.5% | 11 27.5% |
| Dropout (2) | 47 | 19 40.4% | 28 59.6% |

Percent of "Grouped" Cases Correctly Classified: 65.52%

Table 10

Discriminant Analysis of Patient's Ratings of Therapist's

Participation and Involvement

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | TPAR03 | | 1 | 0.976343 | 0.1549 |
| 2 | PTAR05 | | 2 | 0.953320 | 0.1343 |
| 3 | TPAR04 | | 3 | 0.933153 | 0.1230 |
| 4 | TPAR07 | | 4 | 0.919039 | 0.1356 |
| 5 | | TPAR03 | 3 | 0.927472 | 0.0985 |

Classification Function Coefficients

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| TPAR04 | 0.9070589 | 1.1389930 |
| TPAR05 | 0.9648386 | 0.7391599 |
| TPAR07 | 5.1138810 | 5.5113200 |
| (constant) | -16.9154400 | -18.4821500 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|--------|---------------|
| TPAR04 | 0.62861 |
| TPAR05 | -0.69162 |
| TPAR07 | 0.71015 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.29962 |
| Dropout | 0.25500 |

Table 10, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 28 70.0% | 12 30.0% |
| Dropout (2) | 47 | 20 42.6% | 27 57.4% |

Percent of "Grouped" Cases Correctly Classified: 63.22%

higher in criticalness than did dropouts).

Results of the discriminant analysis of variables regarding the patient's concerns in the initial session are presented in Table 11. The analysis correctly classified 66.67% of the 87 patients; 35% of the nondropouts and 31.9% of the dropouts were misclassified. The two most potent discriminating variables in the analysis were concern about angry feelings or behavior (remainders were more concerned about angry feelings than were dropouts), and concern about sexual feelings or sexual experiences (dropouts were more concerned about sexual feelings than were remainders).

Results of the discriminant analysis of variables which referred to what the patient actually obtained from the first session are presented in Table 12. The analysis correctly classified 73.56% of the patients in the study; 27.5% of the nondropouts and 25.5% of the dropouts were misclassified. The two most powerful predictors of group membership in this analysis were responses to, "I feel that I got nothing in particular: I feel the same as I did before the session" (dropouts scored higher on this variable than did nondropouts), and to, "I feel that I got knowledge about what to do in therapy" (remainders scored higher on this variable than did dropouts).

Results of the discriminant analysis of the variables which refer to patient's feelings during the session are presented in Table 13. The analysis correctly identified 72.41% of the 87 patients; 25% of the nondropouts and 29.8% of the dropouts were misclassified. The two most potent discriminating variables were feelings of hopefulness (remainders

Table 11

Discriminant Analysis of Patient's Concerns

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PCONC08 | | 1 | 0.951480 | 0.0404 |
| 2 | PCONC06 | | 2 | 0.928234 | 0.0438 |
| 3 | PCONC02 | | 3 | 0.891215 | 0.0221 |
| 4 | PCONC07 | | 4 | 0.874610 | 0.0253 |
| 5 | PCONC03 | | 5 | 0.863118 | 0.0329 |
| 6 | PCONC04 | | 6 | 0.845722 | 0.0328 |
| 7 | | PCONC07 | 5 | 0.854501 | 0.0237 |
| 8 | PCONC12 | | 6 | 0.839756 | 0.0263 |
| 9 | PCONC13 | | 7 | 0.823695 | 0.0271 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PCONC02 | 0.8483495 | 0.55997210 |
| PCONC03 | 0.1671419 | 0.40526940 |
| PCONC04 | 0.4577485 | 0.20784100 |
| PCONC06 | -0.2241215 | 0.5612434D-01 |
| PCONC08 | 0.7727144 | 0.54360120 |
| PCONC12 | 0.4945487 | 0.24527700 |
| PCONC13 | -0.2661555 | -0.5189573D-02 |
| (constant) | -5.0119700 | -3.57695300 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PCONC02 | 0.64684 |
| PCONC03 | -0.50780 |
| PCONC04 | 0.55493 |
| PCONC06 | -0.54881 |
| PCONC08 | 0.48457 |
| PCONC12 | 0.60170 |
| PCONC13 | -0.43588 |

Table 11, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.49570 |
| Dropout | -0.42187 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout | 40 | 26 65.0% | 14 35.0% |
| Dropout | 47 | 15 31.9% | 32 68.1% |

Percent of "Grouped" Cases Correctly Classified: 66.67%

Table 12

Discriminant Analysis of What Patient Obtained from Session

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | NOGOT01 | | 1 | 0.943920 | 0.0272 |
| 2 | AHOPE02 | | 2 | 0.906904 | 0.0165 |
| 3 | AHOPE06 | | 3 | 0.840308 | 0.0023 |
| 4 | AHOPE11 | | 4 | 0.755855 | 0.0001 |
| 5 | AHOPE04 | | 5 | 0.730732 | 0.0001 |
| 6 | AHOPE01 | | 6 | 0.715275 | 0.0001 |
| 7 | AHOPE13 | | 7 | 0.702965 | 0.0002 |
| 8 | AHOPE08 | | 8 | 0.692702 | 0.0002 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| AHOPE01 | 1.32596000 | 1.09681300 |
| AHOPE02 | 1.22351700 | 0.65904590 |
| AHOPE04 | -0.72882000 | -0.31131350 |
| AHOPE06 | -0.68373320 | 0.16397510 |
| AHOPE08 | 0.1015987D-01 | 0.28215430 |
| AHOPE11 | 1.06936800 | 0.8088359D-01 |
| AHOPE13 | 0.67107170 | 0.48726220 |
| NOGOT01 | 0.92450370 | 1.34056600 |
| (constant) | -8.31662800 | -7.61368000 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| AHOPE01 | -0.31186 |
| AHOPE02 | -0.74214 |
| AHOPE04 | 0.60630 |
| AHOPE06 | 1.19166 |
| AHOPE08 | 0.39533 |
| AHOPE11 | -1.33673 |
| AHOPE13 | -0.27373 |
| NOGOT01 | 0.58603 |

Table 12, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.71363 |
| Dropout | 0.60735 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 29 72.5% | 11 27.5% |
| Dropout (2) | 47 | 12 25.5% | 35 74.5% |

Percent of "Grouped" Cases Correctly Classified: 73.56%

Table 13

Discriminant Analysis of Patient's Feelings

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | PFEEL29 | | 1 | 0.918615 | 0.0074 |
| 2 | PFEEL17 | | 2 | 0.867677 | 0.0026 |
| 3 | PFEEL16 | | 3 | 0.846385 | 0.0030 |
| 4 | PFEEL12 | | 4 | 0.829024 | 0.0037 |
| 5 | PFEEL19 | | 5 | 0.801868 | 0.0027 |
| 6 | PFEEL09 | | 6 | 0.787462 | 0.0033 |
| 7 | PFEEL30 | | 7 | 0.767896 | 0.0031 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| PFEEL09 | 2.0632130 | 1.5647000 |
| PFEEL12 | 2.3848630 | 1.9716860 |
| PFEEL16 | -0.7115891 | -0.1045721 |
| PFEEL17 | 2.1262800 | 1.4997980 |
| PFEEL19 | 6.2207220 | 5.5211460 |
| PFEEL29 | 2.9514460 | 2.3708410 |
| PFEEL30 | -1.4881730 | -1.0756240 |
| (constant) | -21.9393700 | -16.4997300 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| PFEEL09 | 0.47845 |
| PFEEL12 | 0.34553 |
| PFEEL16 | -0.58459 |
| PFEEL17 | 0.68144 |
| PFEEL19 | 0.51846 |
| PFEEL29 | 0.52441 |
| PFEEL30 | -0.42027 |

Table 13, continued

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.58906 |
| Dropout | -0.50133 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 30 75.0% | 10 25.0% |
| Dropout (2) | 47 | 14 29.8% | 33 70.2% |

Percent of "Grouped" Cases Correctly Classified: 72.41%

(remainers were more hopeful than dropouts) and depression (the remainers were more depressed than the dropouts).

Results of the discriminant analysis of the variables regarding the patient's involvement and participation in the session as rated by the patient are presented in Table 14. Discriminant analysis of the patient participation variables correctly identified only 56.32% of the patients in the study; 40% of the nondropouts and 46.8% of the dropouts were misclassified. The two most potent discriminating variables were amount of patient talking (remainers rated themselves higher than dropouts), and extent to which the patient took initiative in bringing up subjects to discuss in the session (dropouts rated themselves higher than remainers).

Results of the discriminant analysis of variables regarding the therapist's feelings during the session as rated by the patient are presented in Table 15. The analysis successfully identified 74.71% of the 87 patients; 25% of the nondropouts and 25.5% of the dropouts were misclassified. The two most powerful predictors of group membership in the analysis were perceiving the therapist as feeling embarrassed (dropouts scored therapists higher in embarrassment than did remainers) and perceiving the therapist as feeling apprehensive (remainers scored therapists higher in apprehension than did dropouts).

Results of the discriminant analysis of the situational variables which may be operating in the initial session as rated by the therapist are presented in Table 16. Discriminant analysis correctly classified 65.52% of the patients. The discriminating power of the func-

Table 14

Discriminant Analysis of Patient's Involvement and Participation

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | ACT01 | | 1 | 0.981200 | 0.2054 |
| 2 | ACT03 | | 2 | 0.967421 | 0.2488 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| ACT01 | 2.6089500 | 2.3118180 |
| ACT03 | 0.7874505 | 0.9489988 |
| (constant) | -8.4839900 | -7.7931150 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|-------|---------------|
| ACT01 | 1.02818 |
| ACT03 | -0.71137 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.19662 |
| Dropout | -0.16734 |

Classification Results

| <u>Actual Group</u> | <u>No. of</u> <u>Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 24 60.0% | 16 40.0% |
| Dropout (2) | 47 | 22 46.8% | 25 53.2% |

Percent of "Grouped" Cases Correctly Classified: 56.32%

Table 15

Discriminant Analysis of Therapist's Feelings

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | TFELT15 | | 1 | 0.949546 | 0.0365 |
| 2 | TFELT11 | | 2 | 0.890538 | 0.0077 |
| 3 | TFELT07 | | 3 | 0.854225 | 0.0043 |
| 4 | TFELT27 | | 4 | 0.816634 | 0.0021 |
| 5 | TFELT34 | | 5 | 0.781324 | 0.0011 |
| 6 | TFELT10 | | 6 | 0.755593 | 0.0008 |
| 7 | TFELT08 | | 7 | 0.740112 | 0.0009 |
| 8 | TFELT19 | | 8 | 0.720853 | 0.0009 |
| 9 | QBOTH01 | | 9 | 0.706871 | 0.0010 |
| 10 | TFELT33 | | 10 | 0.686061 | 0.0008 |

Classification Function Coefficients

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| TFELT07 | 0.77705600 | 1.9054240 |
| TFELT08 | 1.89029800 | 2.4908840 |
| TFELT10 | -0.50837410 | -1.1490060 |
| TFELT11 | -0.8573785D-01 | -1.0315030 |
| TFELT15 | 1.70345600 | 2.8938370 |
| TFELT19 | 4.25702600 | 3.7543370 |
| TFELT27 | 0.29337830 | 0.8863066 |
| TFELT33 | 11.86980000 | 13.2835800 |
| TFELT34 | 3.64168600 | 3.0818130 |
| QBOTH01 | -0.44867080 | -0.8783620 |
| (constant) | -24.94864000 | -25.3429000 |

Table 15, continued

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| TFELT07 | 0.69978 |
| TFELT08 | 0.47335 |
| TFELT10 | -0.53977 |
| TFELT11 | -0.79720 |
| TFELT15 | 0.57087 |
| TFELT19 | -0.29813 |
| TFELT27 | 0.46723 |
| TFELT33 | 0.37445 |
| TFELT34 | -0.37051 |
| QBOTH01 | -0.46417 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.72479 |
| Dropout | 0.61684 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 30 75.0% | 10 25.0% |
| Dropout (2) | 47 | 12 25.5% | 35 74.5% |

Percent of "Grouped" Cases Correctly Classified: 74.71%

Table 16

Discriminant Analysis of Therapist Rated Situational Variables

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | TSIT01 | | 1 | 0.908642 | 0.0044 |
| 2 | TWRIT01 | | 2 | 0.894506 | 0.0093 |
| 3 | TROBH02 | | 3 | 0.882481 | 0.0152 |
| 4 | TOFFC01 | | 4 | 0.868971 | 0.0201 |
| 5 | TCPBH01 | | 5 | 0.849409 | 0.0194 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| TCPBH01 | 2.7319910 | 3.0158960 |
| TROBH02 | 4.6060180 | 4.9316720 |
| TWRIT01 | 0.5941311 | 0.7746256 |
| TOFFC01 | 5.8963580 | 6.3295190 |
| TSIT01 | 9.8572140 | 8.8316740 |
| (constant) | -36.8297700 | -37.1720200 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| TCPBH01 | 0.70971 |
| TROBH02 | 0.65013 |
| TWRIT01 | 0.43014 |
| TOFFC01 | 0.75022 |
| TSIT01 | -0.87356 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | -0.45114 |
| Dropout | 0.38395 |

Table 16, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 29 72.5% | 11 27.5% |
| Dropout (2) | 47 | 19 40.4% | 28 59.6% |

Percent of "Grouped" Cases Correctly Classified: 65.52%

was much better in identifying nondropouts (only 27.5% misclassified) than dropouts (40.4% misclassified). The two most potent discriminating variables in the analysis were the distance the therapist sat from the patient (therapists of dropouts sat closer to the patients than did therapists of remainers) and writing intake reports during the session (therapists of remainers wrote intake reports during the session more often than did therapists of dropouts).

Results of the discriminant analysis of the environmental variables operating in group treatment sessions as rated by the therapist are presented in Table 17. The analysis correctly identified 67.82% of the patients; 67.5% of the nondropouts were misclassified while only 2.1% of the dropouts were misclassified. The two best predictors of group membership in this analysis were the group's acceptance of new members (therapists of remainers rated groups as more accepting of new members than did therapists of dropouts), and group intimacy (therapists of remainers rated groups as dealing with more issues of intimacy than did therapists of dropouts).

In summary, discriminant analyses of six of the groups of variables generated algebraic functions which correctly classified 70% or more of the 87 patients in the study. The best rate of classification (74.71% correct) was attained by two groups of variables, those pertaining to what was talked about in the session as rated by the patient, and those pertaining to what the therapist felt in the session as rated by the patient. In contrast the set of variables which produced the least successful rate of classification (only 56.32% cor-

Table 17

Discriminant Analysis of Group Environmental Variables

Summary Table

| <u>Step</u> | <u>Action</u> | | <u>Vars</u> <u>In</u> | <u>Wilks'</u> <u>Lambda</u> | <u>Sig.</u> |
|-------------|----------------|----------------|--------------------------|--------------------------------|-------------|
| | <u>Entered</u> | <u>Removed</u> | | | |
| 1 | GRPATO3 | | 1 | 0.869240 | 0.0006 |
| 2 | GRPATO5 | | 2 | 0.852779 | 0.0012 |
| 3 | GRPATO1 | | 3 | 0.810531 | 0.0005 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| GRPATO1 | 0.9885278 | -0.5103056 |
| GRPATO3 | 0.6226392 | -0.3224129 |
| GRPATO5 | -1.3437400 | 1.1140650 |
| (constant) | -1.1545990 | -0.7389162 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| GRPATO1 | 2.85097 |
| GRPATO3 | 1.75009 |
| GRPATO5 | -3.80078 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.51803 |
| Dropout | -0.44088 |

Table 17, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | 1 | 2 |
| Nondropout (1) | 40 | 13 32.5% | 27 67.5% |
| Dropout (2) | 47 | 01 2.1% | 46 97.9% |

Percent of "Grouped" Cases Correctly Classified: 67.82%

rect) was the group of variables regarding the patient's participation in the session. On the basis of the 17 analyses, 34 variables were identified as having the most power to discriminate dropouts and non-dropouts: TVAR2, TVAR3, TRVAR8, PCVAR15, PCVAR2, PETRL3, PETRL2, PEXPT16, PEXPT3, PHOPE2, PHOPE9, RECMD1, TACT2, PTALK19, PTALK7, PFTHA9, PFTHA13, TPAR5, TPAR4, PCONC8, PCONC6, NOGOT1, AHOPE2, PFEEL29, PFEEL17, ACT1, ACT3, TFELT15, TFELT11, TSIT1, TWRIT1, GRPAT3 and GRPAT5.

Results of the discriminant analysis of the 34 variables identified in the previous 17 analyses as the best predictors of group membership are presented in Table 18. In fact the stepwise criterion eliminated 16 of the variables prior to the discriminant analysis, thus only 18 variables were involved in the final analysis. The discriminant analysis correctly classified 91.95% of the patients; only 10% of the nondropouts and 6.4% of the dropouts were misclassified. Of the three dropouts misclassified as remainers, two terminated after the initial session and the third dropped out after the third session of therapy. Comparison of the classification results of this 18th analysis with the best classification results of any of the preceding analyses (i.e., 74.71% correct) was carried out by chi-square analysis; the results of this analysis are presented in Table 19. Chi-square analysis indicated that the algebraic function generated in the 18th analysis was superior to any other function generated by preceding analyses at a level which was statistically significant ($\chi^2 = 9.292$, $df = 1$, $p = < .01$). Hence, evidence was obtained to support the primary hy-

Table 18

Discriminant Analysis of the Best Predictor Variables

Summary Table

| Step | Action | | Vars In | Wilks' Lambda | Sig. |
|------|---------|---------|------------|------------------|--------|
| | Entered | Removed | | | |
| 1 | GRPAT03 | | 1 | 0.869240 | 0.0006 |
| 2 | TSIT01 | | 2 | 0.799077 | 0.0001 |
| 3 | NOGOT01 | | 3 | 0.751032 | 0.0000 |
| 4 | TACT02 | | 4 | 0.695059 | 0.0000 |
| 5 | PTALK19 | | 5 | 0.646418 | 0.0000 |
| 6 | TRVAR03 | | 6 | 0.613256 | 0.0000 |
| 7 | TRVAR08 | | 7 | 0.567295 | 0.0000 |
| 8 | PFEEL17 | | 8 | 0.540554 | 0.0000 |
| 9 | PCONC06 | | 9 | 0.505533 | 0.0000 |
| 10 | PFEEL29 | | 10 | 0.468758 | 0.0000 |
| 11 | ACT01 | | 11 | 0.448030 | 0.0000 |
| 12 | PCONC08 | | 12 | 0.429569 | 0.0000 |
| 13 | PCVAR15 | | 13 | 0.411744 | 0.0000 |
| 14 | | GRPAT03 | 12 | 0.417311 | 0.0000 |
| 15 | TVAR02 | | 13 | 0.403385 | 0.0000 |
| 16 | TFELT11 | | 14 | 0.394377 | 0.0000 |
| 17 | TFELT15 | | 15 | 0.385123 | 0.0000 |
| 18 | PEXPT16 | | 16 | 0.374525 | 0.0000 |
| 19 | PEXPT03 | | 17 | 0.357671 | 0.0000 |
| 20 | PETRL03 | | 18 | 0.350881 | 0.0000 |

Classification Function Coefficients
(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|---------|-------------------|----------------|
| TVAR02 | 5.5660450 | 4.5708870 |
| TRVAR03 | -4.4366590 | -3.2008320 |
| TRVAR08 | 11.4631100 | 9.9888120 |
| PCVAR15 | 0.1164495 | 0.8655360D-01 |
| PETRL03 | 0.4544626 | 0.7332961 |
| PEXPT03 | 1.3142700 | 0.8116121 |
| PEXPT16 | 0.4408145 | 1.1227420 |
| TACT02 | 1.2516850 | 2.2167450 |
| PTALK19 | -0.2432822 | -1.2465740 |
| PCONC06 | -2.0620430 | -0.8829835 |
| PCONC08 | 2.4710450 | 2.0502630 |
| NOGOT01 | 0.6039149 | 1.1601700 |
| PFEEL17 | 2.6008760 | 1.5636470 |
| PFEEL29 | 3.5284700 | 2.3941910 |

Table 18, continued

Classification Function Coefficients, continued

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| ACT01 | 6.3566770 | 5.8414010 |
| TFELT11 | 2.0791650 | 1.1432330 |
| TFELT15 | 8.7861270 | 9.8439620 |
| TSIT01 | 11.0344700 | 9.0266310 |
| (constant) | -86.2089800 | -73.2489700 |

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| TVAR02 | 0.21640 |
| TRVAR03 | -0.82084 |
| TRVAR08 | 0.54150 |
| PCVAR15 | 0.24242 |
| PETRL03 | -0.19607 |
| PEXPT03 | 0.33868 |
| PEXPT16 | -0.42652 |
| TACT02 | -0.58089 |
| PTALK19 | 0.63695 |
| PCONC06 | -0.78539 |
| PCONC08 | 0.30271 |
| NOGOT01 | -0.38367 |
| PFEEL17 | 0.45604 |
| PFEEL29 | 0.41411 |
| ACT01 | 0.24057 |
| TFELT11 | 0.39236 |
| TFELT15 | -0.25231 |
| TSIT01 | 0.52945 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 1.45731 |
| Dropout | -1.24026 |

Table 18, continued

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 36 90.0% | 04 10.0% |
| Dropout (2) | 47 | 03 06.4% | 44 93.6% |

Percent of "Grouped" Cases Correctly Classified: 91.95%

Table 19

Comparison of Classification Results

Generated by the 18th and 15th Discriminant Analyses

| <u>Set of Variables</u> | <u>Patients Correctly Classified</u> | <u>Patients Incorrectly Classified</u> | <u>df</u> | <u>χ^2</u> |
|-----------------------------|--|--|-----------|----------------------------|
| Group 18 | 80 | 07 | | |
| | | | 1 | 9.292** |
| Group 15 | 65 | 22 | | |

** $p < .01$

pothesis of this experiment: a stable algebraic function was generated by utilizing items representative of those sets of variables which have been conceptualized as operative in the process of psychotherapy, and this function was superior in its ability to discriminate subjects into reasonably discrete classifications (i.e., nondropouts and dropouts) to any other function generated by utilizing separate groups of these variables.

Since Fiester and Rudestam (1975) had performed t-tests on all the variables in their experiment (with the exclusion of nominal type variables) and subsequently carried out a discriminant analysis of the variables identified by the t-tests as statistically significant, it was of interest to the present investigator to compare their method of analyzing the data to that used in the present study. Hence, t-tests were carried out on all the variables in the study (excluding nominal type variables) and those which reached statistical significance comprised the group of variables on which the 19th discriminant analysis was carried out. The 15 variables ($p < .05$) in the 19th analysis were: TRVAR03, PEXPT16, PCONC08, AHOPE02, NOGOT01, PFEEL29, TFELT07, TFELT15, TSIT01, and GRPAT01-06. Results of the discriminant analysis of these variables are presented in Table 20. The analysis correctly classified 80.46% of the 87 patients; while only 14.9% of the dropouts were misclassified, 25% of the nondropouts were misclassified. Comparison of the classification results produced by the 18th and 19th analyses was carried out by chi-square analysis; the results of this comparison are presented in Table 21. Chi-square analysis indicated that the function

Table 20

Discriminant Analysis of Significant Variables

Generated by t-tests

Summary Table

| Step | Action | | Vars In | Wilks' Lambda | Sig. |
|------|---------|---------|------------|------------------|--------|
| | Entered | Removed | | | |
| 1 | GRPAT03 | | 1 | 0.869240 | 0.0006 |
| 2 | TSIT01 | | 2 | 0.799077 | 0.0001 |
| 3 | NOGOT01 | | 3 | 0.751032 | 0.0000 |
| 4 | PCONC08 | | 4 | 0.703543 | 0.0000 |
| 5 | PEXPT16 | | 5 | 0.673400 | 0.0000 |
| 6 | AHOPE02 | | 6 | 0.649037 | 0.0000 |
| 7 | TFELT07 | | 7 | 0.632449 | 0.0000 |
| 8 | GRPAT05 | | 8 | 0.615737 | 0.0000 |
| 9 | GRPAT01 | | 9 | 0.573305 | 0.0000 |
| 10 | TRVAR03 | | 10 | 0.559374 | 0.0000 |
| 11 | PFEEL29 | | 11 | 0.545926 | 0.0000 |

Classification Function Coefficients

(Fisher's Linear Discriminant Functions)

| | <u>Nondropout</u> | <u>Dropout</u> |
|------------|-------------------|----------------|
| TRVAR03 | 0.8606765 | 1.1509070 |
| PEXPT16 | 1.4171470 | 1.7403300 |
| PCONC08 | 1.6625760 | 1.2000740 |
| AHOPE02 | 0.6631102 | 0.3829512 |
| NOGOT01 | 1.0407130 | 1.4128520 |
| PFEEL29 | 2.2643230 | 1.7919280 |
| TFELT07 | 1.3551390 | 1.8568560 |
| TSIT01 | 7.6418780 | 6.8573770 |
| GRPAT01 | 2.1356080 | -0.4165667 |
| GRPAT03 | -0.7376808 | -1.8728840 |
| GRPAT05 | -1.2043030 | 2.8472400 |
| (constant) | -29.7281200 | -27.1058900 |

Table 20, continued

Standardized Canonical Discriminant Function Coefficients

| | <u>Func 1</u> |
|---------|---------------|
| TRVAR03 | -0.28750 |
| PEXPT16 | -0.30147 |
| PCONC08 | 0.49621 |
| AHOPE02 | 0.26901 |
| NOGOT01 | -0.38280 |
| PFEEL29 | 0.25721 |
| TFELT07 | -0.23079 |
| TSIT01 | 0.30852 |
| GRPAT01 | 2.57358 |
| GRPAT03 | 1.11446 |
| GRPAT05 | -3.32150 |

Canonical Discriminant Functions Evaluated at Group Means

| <u>Group</u> | <u>Func 1</u> |
|--------------|---------------|
| Nondropout | 0.97716 |
| Dropout | -0.83162 |

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|-------------------------|-----------------------------------|-------------|
| | | <u>1</u> | <u>2</u> |
| Nondropout (1) | 40 | 30 75.0% | 10 25.0% |
| Dropout (2) | 47 | 07 14.9% | 40 85.1% |

Percent of "Grouped" Cases Correctly Classified: 80.46%

Table 21

Comparison of Classification Results

Generated by the 18th and 20th Discriminant Analyses

| <u>Set of Variables</u> | <u>Patients Correctly Classified</u> | <u>Patients Incorrectly Classified</u> | <u>df</u> | <u>x²</u> |
|-----------------------------|--|--|-----------|----------------------|
| Group 18 | 80 | 07 | | |
| | | | 1 | 7.499** |
| Group 20 | 70 | 17 | | |

** $p < .01$

generated in the 18th analysis was superior to that generated in the 19th analysis at a level which attained statistical significance ($\chi^2 = 7.499$, $df = 1$, $p < .01$).

In an attempt to replicate the results obtained in this experiment two further discriminant analyses were carried out by randomly assigning half of the dropouts and nondropouts to one analysis ($N = 44$), and the remaining dropouts and remainers to another analysis ($N = 43$). Both of these discriminant analyses used the variables from the 18th analysis in order to ascertain whether these analyses could classify the patients as well as the discriminant function in the 18th analysis did (i.e., 91.95% correct). The classification results of these discriminant analyses are presented in Table 22. The levels of significance reached in both these analyses were similar and both of the analyses produced very high rates of classification: 93.35% and 97.73% correct.

To test whether any of the variables excluded from the discriminant analyses were able to discriminate group membership, the 12 variables were evaluated by chi-square analysis. (One variable, TVAR01, was excluded due to the fact that all the therapists were White thus making the variable a constant.) Results of these analyses are presented in Table 23; none of the chi-square values reached statistical significance.

Hypothesis #2 predicted that dropouts would indicate that fewer of their pretherapy expectations about the therapist were met than would remainers. Overall group differences between responses on the

Table 22

Classification Results of A Split Group Approach
to Cross-Validation

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|---------------------|-----------------------------------|-------------|
| | | 1 | 2 |
| Nondropout (1) | 20 | 20 100.0% | 00 0.0% |
| Dropout (2) | 24 | 01 4.2% | 23 95.8% |

Percent of "Grouped" Cases Correctly Classified: 97.73%

Classification Results

| <u>Actual Group</u> | <u>No. of Cases</u> | <u>Predicted Group Membership</u> | |
|---------------------|---------------------|-----------------------------------|-------------|
| | | 1 | 2 |
| Nondropout (1) | 20 | 20 100.0% | 00 0.0% |
| Dropout (2) | 23 | 02 8.7% | 21 91.3% |

Percent of "Grouped" Cases Correctly Classified: 95.35%

Table 23

Comparison of Dropouts and Nondropouts on Variables

Representing Categorical Type Data

TVAR04

Therapist's Profession

Dropout^aNondropout^a

| | | |
|---------------------------|----|----|
| Psychologist | 21 | 16 |
| Social Worker | 11 | 12 |
| Nurse Clinical Specialist | 04 | 05 |
| Psychology Intern | 10 | 03 |
| Social Work Intern | 01 | 03 |
| Nurse Clinical Intern | 00 | 01 |

TRVAR18

Treatment Modality

| | | |
|-------------------|----|----|
| Individual | 28 | 24 |
| Group | 03 | 13 |
| Family or Marital | 01 | 03 |
| Undetermined | 15 | 00 |

PCVAR01

Patient Race

| | | |
|----------|----|----|
| White | 40 | 36 |
| Black | 07 | 03 |
| Hispanic | 00 | 01 |

PCVAR09

Previous Treatment Facility

| | | |
|--------------------------------------|----|----|
| Private Hospital in Chicago | 03 | 03 |
| Community MHC in Chicago | 01 | 03 |
| Private Psychologist or Psychiatrist | 03 | 02 |
| Illinois VAH | 07 | 02 |
| Out of State VAH | 00 | 01 |
| Community MHC not in Chicago | 04 | 02 |
| Federal Hospital | 03 | 03 |

^aEntries are frequencies

Table 23, continued

| PCVAR12 | <u>Dropout</u> ^a | <u>Nondropout</u> ^a |
|---|-----------------------------|--------------------------------|
| What led to previous termination? | | |
| Patient Terminated | 09 | 11 |
| Therapist Terminated | 08 | 04 |
| Mutual Termination | 04 | 02 |
| No Response | 26 | 23 |
| PCVAR16 | | |
| What led to previous termination of treatment at Hines MHC? | | |
| Patient Terminated | 05 | 05 |
| Therapist Terminated | 03 | 04 |
| Mutual Termination | 04 | 02 |
| No Prior Treatment at Hines | 35 | 29 |
| PSES01 | | |
| Patient Social Class Position | | |
| I | 03 | 01 |
| II | 08 | 13 |
| III | 18 | 13 |
| IV | 17 | 12 |
| V | 01 | 01 |
| TIORT01 | | |
| Therapist's Typical Theoretical Orientation to Individual Treatment | | |
| Communication Skills | 01 | 03 |
| Interactional | 04 | 06 |
| Intrapsychic/Psychoanalytic | 10 | 03 |
| Adlerian and Interactional | 02 | 06 |
| Rational Emotive and Hypnotherapy | 01 | 01 |
| Psychoanalytic and Hypnotherapy | 03 | 01 |
| Adlerian and Hypnotherapy | 11 | 13 |
| Interactional and Reality Therapy | 09 | 06 |
| Adlerian, Hypnotherapy and Interactional | 06 | 01 |

^aEntries are frequencies

Table 23, continued

| TGORT01 | <u>Dropout^a</u> | <u>Nondropout^a</u> |
|--|----------------------------|-------------------------------|
| Therapist's Typical Theoretical Orientation to Group Treatment | | |
| Interactional | 00 | 09 |
| Adlerian and Hypnotherapy | 01 | 03 |
| Interactional and Social Learning | 01 | 00 |
| Communication Skills and Interactional | 00 | 01 |
| Adlerian, Interactional and Communi- cation Skills | 01 | 00 |
| Not in Group Treatment | 44 | 27 |
| PMAR01 | | |
| Patient Marital Status | | |
| Married | 23 | 18 |
| Divorced | 07 | 12 |
| Separated | 03 | 02 |
| Single | 13 | 07 |
| Widower/Widow | 01 | 01 |
| PREF01 | | |
| Referral to Diagnostic Staffing Group | | |
| Patient Not Referred | 29 | 31 |
| Referred and Kept Appointment | 03 | 09 |
| Failed Appointment | 15 | 00 |

^aEntries are frequencies

pre- and post-treatment expectation items pertaining to the therapist's behavior (PEXPT01-19 and PFTHA01-19) were compared by using a t-test to determine whether the dropout and nondropout groups were significantly different. Results of the analysis of the expectations of the therapist are presented in Table 24; the t-value was not statistically significant.

In order to cross-validate a result that Fiester and Rudestam (1975) reported, that is that 16 of the 19 pre- and post-treatment expectation of therapist items were significant within groups, the expectation items were submitted to a further statistical analysis. The results of this analysis (see Appendix VIII) supported Fiester and Rudestam's (1975) results as 15 of the 19 therapist expectation items were significant within groups. One of the items previously reported nonsignificant was also found to be nonsignificant in this study: the expectation that the therapist would listen more than talk. While the previous investigators indicated that patients' post-treatment scores were higher than their pre-treatment scores on the expectation items, in this study all post-treatment scores were lower than the pre-treatment scores. However, the implication in both studies is that patient expectations about the therapist are being frustrated in both nondropout and dropout groups.

Hypothesis #3 predicted that dropouts would indicate that fewer of their hopes or goals for the initial session were realized than would remainers. Overall group differences between responses on the pre- and post-treatment questionnaires pertaining to hopes or goals for

Table 24

Comparison of Group Means Between Dropouts and Nondropouts
 on Pre-Post Expectations of the Therapist Using
 Pooled Variance Estimate Approach

| <u>Group</u> | <u>N</u> | <u>x</u> | <u>s.d.</u> | <u>df</u> | <u>t</u> | <u>p</u> |
|-------------------------|----------|----------|-------------|-----------|----------|----------|
| Nondropout, pre | 40 | 79.4250 | 16.787 | 85 | -1.06 | n.s. |
| Dropout, pre | 47 | 83.1277 | 15.761 | | | |
| Nondropout, post | 40 | 63.5250 | 18.017 | 85 | 0.51 | n.s. |
| Dropout, post | 47 | 61.6170 | 17.143 | | | |
| Nondropout, pre-post | 40 | 15.9000 | 18.319 | 85 | -1.50 | n.s. |
| Dropout, pre-post | 47 | 21.5106 | 16.446 | | | |

the first session (PHOPE01-14 and AHOPE01-14) were compared by using a t-test to determine whether the dropout and nondropout groups were significantly different. Results of the analysis of the hopes for the first session are presented in Table 25; the t-value did not attain statistical significance.

Since Fiester and Rudestam (1975) also reported that 13 of 14 expectations regarding hopes or goals for the first session were significant within groups, these items in the present study were submitted to a further statistical analysis. The results of this analysis (see Appendix IX) supported Fiester and Rudestam's findings as 12 of the hopes or goals were significant within groups. One of the items previously reported nonsignificant was identified as nonsignificant in the present study: the chance to get things off my chest during the session. This research also supports the conclusion of Fiester and Rudestam (1975): both the nondropout and dropout patients' hopes for the first session are being frustrated.

Hypothesis #4 predicted that nondropouts would be more similar to their therapists in SES than would dropouts. Overall group differences between patient and therapist SES were compared by using a t-test to determine whether the nondropout and dropout groups would be statistically different. Results of this analysis are presented in Table 26; the t-value did not attain statistical significance.

Nondropout and dropout patients' responses to the items designed to tap patient reactivity to the measures (i.e., "To what extent were you bothered by answering the items in this questionnaire?") were not significantly different. The pre-treatment group means on the item

Table 25

Comparison of Group Means Between Dropouts and Nondropouts

on Pre-Post Goals or Hopes Items

Using Pooled Variance Estimate Approach

| <u>Group</u> | <u>N</u> | <u>x</u> | <u>s.d.</u> | <u>df</u> | <u>t</u> | <u>p</u> |
|-------------------------|----------|----------|-------------|-----------|----------|----------|
| Nondropout, pre | 40 | 67.9250 | 14.239 | 85 | 0.79 | n.s. |
| Dropout, pre | 47 | 65.1915 | 17.497 | | | |
| Nondropout, post | 40 | 49.8500 | 18.946 | 85 | 0.67 | n.s |
| Dropout, post | 47 | 47.1702 | 18.158 | | | |
| Nondropout, pre-post | 40 | 18.0750 | 19.499 | 85 | 0.01 | n.s. |
| Dropout, pre-post | 47 | 18.0213 | 24.832 | | | |

Table 26

Comparison of Group Means Between Dropouts and Nondropouts
on Therapist-Patient SES Scores

Using Pooled Variance Estimate Approach

| <u>Group</u> | <u>N</u> | <u>\bar{x}</u> | <u>s.d.</u> | <u>df</u> | <u>t</u> | <u>p</u> |
|--------------|----------|-----------------------------|-------------|-----------|----------|----------|
| Nondropout | 40 | 1.9750 | 0.920 | | | |
| | | | | 85 | -0.66 | n.s. |
| Dropout | 47 | 2.1064 | 0.938 | | | |

were 1.66 for the dropout group and 1.72 for the nondropout group ($t = 0.23$, $df = 85$, n.s.). Post-treatment group means on the item were 1.74 for the dropout group and 1.9 for the nondropout group ($t = 0.50$, $df = 85$, n.s.).

Responses to the item designed to tap therapist reactivity to the questionnaires was also unable to discriminate the groups. The group means on the item were 1.81 for the dropout group and 2.12 for the nondropout group ($t = 1.82$, $df = 85$, n.s.).

CHAPTER V

DISCUSSION

The results of this study indicate that representative items from the three sets of variables inherent in the psychotherapeutic relationship (i.e., demographic, process and situational variables from the patient's and therapist's perspectives) can generate a stable algebraic function which is capable of discriminating dropouts and nondropouts at a high level of success. Discriminant analysis of specific groups of variables which operate in psychotherapy (such as patient's expectations of the therapist or therapist's perspective of the therapy process) was inferior to the discriminant analysis of representative items in classifying patients into dropout and nondropout groups. Further, submitting representative items from the three sets of variables to discriminant analysis in order to obtain a stable discriminant function was superior to utilizing those items in the discriminant analysis which in two sample t-tests of all the variables had significantly differentiated the groups. Thus, it appears that the best predictors of dropout are to be found by considering all the factors which impinge upon the process of psychotherapy rather than isolating any one group of variables for investigation.

The hypothesis that stimulates the empirical investigation of the psychotherapy dropout phenomenon is that dropouts and remainers are essentially different, and that if research can discriminate their

crucial differences, reliable predictions can be made concerning those persons most likely to terminate prematurely. While the present study lends support to the hypothesis that dropouts and remainers differ on certain variables, it has also found that those discriminating factors are not to be isolated in neat, easily visible, unidimensional characteristics. To date research in the area has tended to focus on a "part" of the process of psychotherapy (generally the patient's characteristics) while ignoring other elements which were of no particular interest to the investigator (usually process or situational variables). The results of the present study argue for an alternate approach to the study of psychotherapy dropout, namely, that the total treatment process including all variables which may influence the psychotherapeutic relationship ought to be taken into account in the research design.

A common sense explanation of dropout that has been prevalent in the field is that dropouts terminated prematurely because they did not obtain something they hoped to receive. Results of the present study suggest some support for that position as one of the most potent discriminators of the groups was the dropout's conclusion that nothing was gained from the session. While the focus of the initial session at Hines MHC tends to be on gathering pertinent information about the patient and his/her current problems in living, nevertheless, the remainers felt they had made some progress in the session while the dropouts did not. Perhaps those who have had little or no contact with the clinic expect to make much more progress at the outset of treatment

than do those who are more familiar with the clinic treatment procedures. The fact that another of the most potent discriminating variables was that remainers had had more previous contact with the clinic lends further credence to that explanation of dropout (i.e., remainers, familiar with the clinic, have lowered their hope for immediate progress and are thus more satisfied with what is in fact accomplished). It seems evident that if we are to decrease the rate of patient dropout, which in this study was highest (49%) following the first session, we are going to have to restructure the initial session and address the patient's hope for immediate progress. Additionally, some amelioration of the noxious aspects of gathering information ought to be considered.

Review of the literature on psychotherapy leads one to the tentative conclusion that the area of most promise for future research is that of treatment expectancy. The present study examined the differences between dropouts and nondropouts on their pre- and post-treatment ratings of expectancy items. The results of the study concurred with those of Fiester and Rudestam (1975): while no significant differences were found between groups on these items, the vast majority of expectation items were found to attain statistical significance within groups. It seems that both the dropout and nondropout come to psychotherapy with particular expectations of the therapist and of the treatment process that are not being met. Since it is the case that both patient groups are being frustrated in their expectations, it is clear that consideration of expectancy items alone does not provide an

alternative explanation of why patients terminate prematurely. However, as the expectancy data was collected before and after the first session alone, we have no way of knowing if the nondropout and dropout groups differ on these items after subsequent treatment sessions. It is recommended that future research in this area explore the effects of early treatment expectations on persistence in treatment. Further, it is recommended that therapists attempt to clarify the patient's expectations of the therapist and of the treatment process in the early stages of the development of the therapeutic relationship.

Perhaps the most consistent finding reported in the literature on psychotherapy dropout is that the discrepancy between patient and therapist social class position contributes to the premature termination of treatment. The present study found no significant differences between the dropout and nondropout group on the variable of social class discrepancy. It must be pointed out, however, that the relatively high SES scores obtained by patients in the study raises questions regarding the validity of the Hollingshead Four-Factor Index of Social Status. Considering the fact that veterans typically present to a VAH because they do not have the financial resources or medical health benefits to obtain services in private hospitals, and that 65.5% of all the patients in the study were unemployed, it seems inconsistent to find that 28.7% of the patients received SES ratings of I or II while only 35% received ratings of IV or V. While the Hollingshead Index has been highly practical for research purposes given the relative ease with which requisite information can be obtained, nevertheless, the real

financial issues which seem pertinent to the designation of SES are being overlooked by the measure. Specifically, actual income and/or financial resources are ignored. Also, the score for employment is given on the basis of past employment (regardless of how much time has passed since the patient was employed) or on the basis of the Father's occupation (regardless of whether the patient has ever been gainfully employed). It seems that the Hollingshead Index predicts the SES a patient ought to have reached rather than yielding the actual position a person has attained. The exclusion of information pertaining to real income and potential for employment in the computation of SES tends to inflate the patient's SES and thereby masks true differences in social class position between patient and therapist. Hence, the hypothesis that discrepancy in social class standing contributes to early treatment dropout remains untested in this experiment as we did not have a measure which could gauge the actual social class positions of the subjects.

While the present investigator is tempted to sketch portraits of the typical dropout and remainder in the study, gleaned from perusal of the 18 most potent discriminating variables, it would be highly misleading to do so. In fact the methodological approach taken in this research leads only to the conclusion --albeit an important one-- that remainders and dropouts can be discriminated at a high rate of success when representative items from the three sets of variables (demographic, process and situational variables from patient and therapist perspectives) involved in the process of psychotherapy are considered.

Fiester and Rudestam (1975) discovered that the results of their experiment were not replicated at another setting, thus leading to the implication that the discriminant weights yielded in the present study may also be setting specific. Replication of the experiment is necessary in order to determine whether the discriminant function generated herein will yield the same high rate of correct group classification at another treatment setting. Further, the 18 most potent predictor variables identified in the study ought to be cross-validated on successive samples of patients at HMHC. If these 18 variables are found to be stable across patient samples, the discriminant weights generated in the discriminant analysis can be utilized after the first treatment session in order to identify those patients who are most likely to terminate prematurely. Since patients at the MHC are amenable to involvement in research (only 6% of all the patients who presented for intake refused to participate in the study), and since the administration of the patient questionnaires requires little staff time (approximately five minutes), it is argued that the development of stable predictive indices of patient dropout is worthy of future investigation.

SUMMARY

Premature termination of psychotherapy constitutes a major problem for mental health clinics. Early treatment dropouts waste staff time and services which could have potentially benefited other patients. The fact that approximately 50% of all patients who contract for outpatient services drop out within five sessions serves to highlight the magnitude of the drain on the resources of outpatient mental health facilities.

The present study was an investigation of the joint interaction of patient input variables (including demographic information, pre-therapy expectations and initial perspective of the psychotherapy process), therapist input variables (including demographic information, expectancy of the treatment process and initial perspective of the psychotherapy process), and situational variables (including the perspectives of both patient and therapist) as these related to the outcome of premature psychotherapy termination. Dropout patients were those individuals who, after committing themselves to psychotherapy on a weekly basis, failed to return or unilaterally discontinued treatment in five sessions or less. Nondropouts were those patients who remained in treatment for six sessions or more regardless of final disposition.

Subjects were 87 veterans who presented for outpatient treatment to a Mental Hygiene Clinic; 10 therapists were also involved in the experiment. Patient data consisted of responses given on pre- and post-interview questionnaires. The patient pre-interview questionnaire

included items pertaining to demographic information, situational information, expectations of the therapist, expectations of the treatment process and hopes for the first session. The post-interview patient questionnaire consisted of a modified version of Orlinsky and Howard's (1966) Therapy Session Report. Therapist data included responses given on pre- and post-experiment questionnaires, as well as responses on post-initial interview questionnaires. The therapist pre-experiment questionnaire requested demographic information and included the A-B Therapist Scale of Whitehorn and Betz (1960). Two therapist post-experiment questionnaires requested information regarding situational factors which might have been operating in individual or group treatment sessions respectively. The therapist post-interview questionnaire pertained to the therapist's expectations of the patient and of the treatment process.

The primary purpose of the experiment was to increase our understanding of those factors which jointly influence a patient to dropout of treatment, hence, emphasis was placed upon process and situational variables which have typically been ignored in the research on psychotherapy dropout. In an effort to demonstrate that treating representative items from the three sets of variables (demographic, process and situational) pertinent to the process of psychotherapy is superior to considering only some of those variables (e.g., a specific subset such as patient characteristics), a multivariate strategy was utilized. Further purposes included examination of those particular variables from the dropout literature which have demonstrated the most consistent

results or have suggested the most promise for further research: patient expectancy items regarding the therapist and hopes for the session, and the effect of the discrepancy between patient and therapist social class position on treatment dropout.

Results of the experiment indicated that the best predictors of dropout are to be found by considering all the factors which impinge upon the process of psychotherapy. Discriminant analysis of representative items from the three sets of variables inherent in the psychotherapeutic relationship generated a stable algebraic function which was capable of discriminating dropouts and nondropouts at a high level of success (91% correct). Additionally, it was found that frustrated patient expectations of the therapist or of the treatment per se were not in themselves the cause of premature termination as both remainers and dropouts experienced unfulfilled expectancies at levels which were statistically significant. Finally, while the study failed to confirm the hypothesis that the social distance between patient and therapist constitutes a reason for premature termination, it was pointed out that the use of Hollingshead's (1975) Four Factor Index of Social Position may not have provided an accurate gauge of the true SES of the patient.

The findings of this study indicated that those factors which discriminate treatment dropouts and remainers are not unidimensional characteristics but rather a set of highly correlated interacting variables. Hence, it was argued that future research in the area ought to include in the design all the variables which may influence the psychotherapeutic relationship.

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APPENDIX I

APPENDIX I

DESCRIPTIVE DATA FOR SUBJECTS

| <u>Variable</u> | <u>Nondropouts</u> | <u>Dropouts</u> | |
|-------------------|--------------------|-----------------|---------|
| Age (years) | | | |
| 18-20 | 00 | 01 | (1.1%) |
| 21-29 | 05 | 11 | (18.4%) |
| 30-39 | 13 | 13 | (29.9%) |
| 40-49 | 05 | 08 | (14.9%) |
| 50-59 | 12 | 09 | (24.1%) |
| 60-69 | 05 | 05 | (11.5%) |
| Sex | | | |
| Male | 37 | 46 | (95.4%) |
| Female | 03 | 01 | (4.6%) |
| Race | | | |
| White | 36 | 40 | (87.4%) |
| Black | 03 | 07 | (11.5%) |
| Hispanic | 01 | 00 | (1.1%) |
| Marital Status | | | |
| Married | 18 | 23 | (47.1%) |
| Divorced | 12 | 07 | (21.8%) |
| Separated | 02 | 03 | (5.7%) |
| Single | 07 | 13 | (23.0%) |
| Widow/Widower | 01 | 01 | (2.3%) |
| Employment Status | | | |
| Employed | 16 | 14 | (34.5%) |
| Unemployed | 24 | 33 | (65.5%) |
| SES | | | |
| I | 01 | 03 | (4.6%) |
| II | 13 | 08 | (24.1%) |
| III | 13 | 18 | (35.6%) |
| IV | 12 | 17 | (33.3%) |
| V | 01 | 01 | (2.3%) |

APPENDIX I, continued

| <u>Variable</u> | <u>Nondropouts</u> | <u>Dropouts</u> | |
|--|--------------------|-----------------|---------|
| Diagnosis | | | |
| Adjustment Reaction | 6 | 7 | (14.9%) |
| Personality Disorder | 3 | 8 | (12.6%) |
| Organic Brain Syndrome | 0 | 1 | (1.2%) |
| Psychosis | 7 | 9 | (18.4%) |
| Mood Disorder | 5 | 4 | (10.4%) |
| Addiction | 1 | 1 | (2.3%) |
| Psychological Factors Under- lying Physical Illness | 9 | 8 | (19.5%) |
| Neurosis | 9 | 6 | (17.2%) |
| Diagnosis Deferred | 0 | 3 | (3.5%) |

APPENDIX II

APPENDIX II

PATIENT PRE-INTERVIEW QUESTIONNAIRE

Instructions: Read each of the statements and check the one space which comes closest to describing your answer to the question. The therapist you see here will not see your answers.

Name _____ Date _____

- PCVAR01) Race: White ____ Black ____ Hispanic ____
- PCVAR02) Age _____
- PCVAR03) Sex (circle one): Male Female
- PCVAR04) Education (state the highest grade level completed): _____
- PCVAR05) Education of the Head of Household--if you are NOT the Head of Household (state the highest grade level completed): _____
- PCVAR06) Occupation (if presently unemployed, name last job held): _____
- PCVAR07) Occupation of Head of Household--if you are NOT the Head of Household (if presently unemployed, name last job held): _____
- PCVAR08) Have you ever gone anywhere else for professional help for the same or other problems (example: another clinic, mental hospital, private psychologist, psychiatrist, social worker, etc.):
(circle one): Yes No
- PCVAR09) If you answered "yes," where did you last go for treatment? _____
- PCVAR10) How many times were you seen there for individual treatment? _____
- PCVAR11) How many times were you seen there for group treatment? _____
- PCVAR12) What led to your ending treatment there? (check one)
 _____ I decided to stop going.
 _____ My therapist decided to end treatment.
 _____ My therapist and I decided together to end treatment.
- PCVAR13) How much did you benefit from your visits there? (check one)
 Very much _____: _____: _____: _____: _____ Not at all
- PCVAR14) Have you ever come to Hines Mental Hygiene Clinic before?
 (circle one): Yes No
 If you answered "yes," please answer the questions below:
- PCVAR15) How many times were you seen here? _____

PCVAR16) What led to your ending treatment here? (check one)

I decided to stop coming.

My therapist decided to end treatment.

My therapist and I decided together to end treatment.

PCVAR17) How many visits here do you think it will take to get over
your problems? visits

PCVAR18) How long before coming here have you felt in need of professional help for your problems? (check one)

One week.

One month

Several months

— About one year

Longer than one year

I EXPECT THE PERSON I SEE HERE TO BE LIKE A: (check one for each)

PETRL01) Medical doctor Not at all : : : : : Very much

PETRL02) Teacher

PETRL03) Minister-Pastor

PETRL04) Good Friend Not at all : : : : : Very much

PRADJ01) How well do you feel that you are getting along at this time? I am getting along: (check one)

Quite poorly : : : : : Very well

PMOT01) To what extent were you looking forward to coming today?

I was looking forward to coming: (check one)

Very much : : : : : Not at all

PFAM01) Did other family members know you were coming to our clinic today? Circle one: Yes No

PFAM02) If you answered "yes," then to what degree were these other family members in agreement that you should come here today?
(check one)

Complete agreement Complete agreement that
that I should come : : : : I should not come

PETX01) I would like the therapist I see here to be a: (circle one)
Man Woman

PSES01) SES of Patient

PTRAN01) Did you find it difficult to arrange transportation to and from our clinic? (check one)

Very much : : : : Not at all

PTRAN02) Do physical disabilities make it difficult for you to use public transportation? (check one)

Not at all : : : : : Very much

PTRAN03) Is the cost of transportation to our clinic hard to manage?

Very much : : : : Not at all

- PTRAN04) Is the location of your apartment or house near public transportation?
Very near __:__:__:__:__ Not at all near
- PWEAT01) To what extent do you think weather conditions might interfere with your ability to come to our clinic?
Not at all __:__:__:__:__ Very much
- PTIME01) Will the time your treatment takes at our clinic interfere with your work or with your studies?
Not at all __:__:__:__:__ Very much
- PPRES01) To what extent did you feel pressured by others into coming to our clinic for treatment?
Very much __:__:__:__:__ Not at all
- PWAIT01) Approximately how long did you wait between being referred to our clinic and coming here today? (check one)
____ Less than a week
____ One week
____ Two weeks
____ Three weeks
____ Four weeks or more
- PWAIT02) How much progress do you feel you made in dealing with your problems during that waiting period? (check one)
None at all __:__:__:__:__ Very much
- PWAIT03) To what extent did waiting for treatment bother you?
Very much __:__:__:__:__ Not at all
- PCONF01) How much confidence do you have that with treatment you can learn to cope better with your problems? (check one)
None at all __:__:__:__:__ Very much
- PEMP01) Are you presently working? (circle one): Yes No
If you answered "yes," please answer the questions below.
- PEMP02) How difficult was it for you to arrange time for treatment with your employer?
Very difficult __:__:__:__:__ Not at all difficult
- PEMP03) Do you expect your employer to treat you differently at work now that you will be coming for treatment?
Not at all __:__:__:__:__ Very much
- PEMP04) To what extent do you think fellow workers may treat you differently if they know you are coming for treatment?
Very much __:__:__:__:__ Not at all

WHAT DO YOU THINK THE PERSON YOU SEE HERE WILL DO?

- | | Definitely | | Definitely |
|--|------------|----------------|------------|
| PEXPT01) Give you medicine? | will | __:__:__:__:__ | will not |
| PEXPT02) Ask questions about your personal life? | | __:__:__:__:__ | |
| PEXPT03) Tell you what is wrong with you? | | __:__:__:__:__ | |

WHAT DO YOU THINK THE PERSON YOU SEE HERE WILL DO?

- | | | Definitely | | Definitely |
|----------|---|------------|-------|------------|
| | | will | _____ | will not |
| PEXPT04) | Try and cheer you up? | | _____ | |
| PEXPT05) | Listen more than he/she talks? | | _____ | |
| PEXPT06) | Avoid subjects which might upset you? | | _____ | |
| PEXPT07) | Want to know about your thoughts and feelings? | | _____ | |
| PEXPT08) | Want to know how well you get along with others? | | _____ | |
| PEXPT09) | Tell you ways to solve your problems? | | _____ | |
| PEXPT10) | Expect you to do most of the talking? | | _____ | |
| PEXPT11) | Be interested in knowing if some things make you afraid or nervous? | | _____ | |
| PEXPT12) | Be particularly interested in your aches and pains? | | _____ | |
| PEXPT13) | Try to get your mind off your troubles? | | _____ | |
| PEXPT14) | Tell you what is wrong with you? | | _____ | |
| PEXPT15) | Listen to your troubles? | | _____ | |
| PEXPT16) | Ask you to describe the physical illnesses you have had? | | _____ | |
| PEXPT17) | Want to know what things make you unhappy? | | _____ | |
| PEXPT18) | Give you definite rules to follow? | | _____ | |
| PEXPT19) | Talk to your spouse or other family members? | Definitely | _____ | Definitely |
| | | will | _____ | will not |

WHAT DO YOU WANT OR HOPE TO GET OUT OF THIS SESSION?
(For each item check the answer that best applies.)

THIS SESSION I HOPE OR WANT TO:

- | | | Definitely | | Definitely |
|----------|--|------------|-------|------------|
| | | Not | _____ | Yes |
| PHOPE01) | Get a chance to let go and get things off my chest. | | _____ | |
| PHOPE02) | Learn about what to do in therapy: what to expect from it. | | _____ | |

THIS SESSION I HOPE OR WANT TO:

- | | | Definitely | | Definitely |
|----------|---|--------------------------|--------------------------|------------|
| | | Not | _____ | Yes |
| PHOPE03) | Get help in talking about what is really troubling me. | | ____:____:____:____:____ | |
| PHOPE04) | Get relief from tensions or unpleasant feelings. | | ____:____:____:____:____ | |
| PHOPE05) | Understand the reasons behind my feelings and behavior. | | ____:____:____:____:____ | |
| PHOPE06) | Get some reassurance about how I'm doing. | | ____:____:____:____:____ | |
| PHOPE07) | Get confidence to try new things, to be a different kind of person. | | ____:____:____:____:____ | |
| PHOPE08) | Find out what my feelings really are, and what I really want. | | ____:____:____:____:____ | |
| PHOPE09) | Get advice on how to deal with my life and with other people. | | ____:____:____:____:____ | |
| PHOPE10) | Have my therapist respond to me on a person-to-person basis. | | ____:____:____:____:____ | |
| PHOPE11) | Get better self control. | | ____:____:____:____:____ | |
| PHOPE12) | Get straight on which things I think and feel are real and which are mostly in my mind. | | ____:____:____:____:____ | |
| PHOPE13) | Work out a particular problem that's been bothering me. | | ____:____:____:____:____ | |
| PHOPE14) | Get my therapist to say what he/she thinks. | Definitely | _____ | Definitely |
| | | Not | ____:____:____:____:____ | Yes |
| PBOTH01) | TO WHAT EXTENT WERE YOU BOTHERED BY ANSWERING THE ITEMS IN THIS QUESTIONNAIRE? | | | |
| | Very much | ____:____:____:____:____ | Not at all | |

THANK YOU FOR YOUR COOPERATION IN THIS RESEARCH PROJECT!

APPENDIX III

APPENDIX III

PATIENT POST-INTERVIEW QUESTIONNAIRE

Name _____ Date _____

INSTRUCTIONS: For each of the following questions, check the one answer which best applies. Your responses to these questions will remain confidential. None of the staff members here at the Mental Hygiene Clinic will see or read your responses.

SQUAL01) How do you feel about the session which you have just completed? This session was:

Excellent ___:___:___:___:___ Very poor

LKFOR01) To what extent are you looking forward to your next session?

Not at all ___:___:___:___:___ Very much

RECMD01) How strongly would you recommend to a close friend with problems to come to our clinic?

Would strongly recommend it ___:___:___:___:___ Would advise against it

SPROG01) How much progress do you feel you made in dealing with your problems this session?

Very much progress ___:___:___:___:___ No progress

TACT01) How well did your therapist seem to understand what you were feeling or thinking?

My therapist

Understood exactly how I thought and felt ___:___:___:___:___ Misunderstood how I thought and felt

TACT02) How helpful do you feel your therapist was to you this session?

Not at all helpful ___:___:___:___:___ Very helpful

WHAT SUBJECTS DID YOU TALK ABOUT DURING THIS SESSION?
(Check the answer which best applies for each.)

DURING THIS SESSION I TALKED ABOUT:

| | | | | |
|----------|-----------|--------|---------------------|------|
| | | Not | | Very |
| PTALK01) | My mother | at all | ___:___:___:___:___ | much |
| PTALK02) | My father | | ___:___:___:___:___ | |

DURING THIS SESSION I TALKED ABOUT:

| | Not at all | : | : | : | : | : | : | Very much |
|---|---------------|-----|-----|-----|-----|-----|-----|--------------|
| PTALK03) My brothers and sisters | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK04) My childhood | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK05) My adolescence | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK06) Religious feelings, activities or experiences | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK07) Work, career, or education | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK08) Relations with others of the same sex | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK09) Relations with the opposite sex | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK10) Financial resources or problems with money | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK11) Feelings about spouse or about being married | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK12) Household responsibilities or activities | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK13) Feelings about children or about being a parent | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK14) Body functions, symptoms, or appearance | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK15) Strange or unusual ideas and experiences | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK16) Hopes or fears about the future | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK17) Dreams or fantasies | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK18) Attitudes or feelings towards my therapist | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PTALK19) Therapy: feelings and progress as a patient | Not at all | ___ | : | ___ | : | ___ | : | Very much |

DID THE PERSON YOU SAW HERE: (check one for each)

| | Definitely Yes | : | : | : | : | : | : | Definitely Not |
|--|-------------------|-----|-----|-----|-----|-----|-----|-------------------|
| PFTHA01) Give you medicine? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA02) Ask questions about your personal life? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA03) Tell you what is wrong with you? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA04) Try and cheer you up? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA05) Listen more than he/she talked? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA06) Avoid topics which may have upset you? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA07) Want to know about your thoughts and feelings? | ___ | : | ___ | : | ___ | : | ___ | ___ |
| PFTHA08) Want to know how well you get along with others? | Definitely Yes | ___ | : | ___ | : | ___ | : | Definitely Not |

DID THE PERSON YOU SAW HERE: (check one for each)

- | | Definitely | | Definitely |
|--|----------------------|-------|----------------------|
| | Yes | _____ | Not |
| PFTHA09) Tell you ways to solve your problems? | _____ | _____ | _____ |
| PFTHA10) Expect you to do most of the talking? | _____ | _____ | _____ |
| PFTHA11) Show interest in knowing if some things make you afraid or nervous? | _____ | _____ | _____ |
| PFTHA12) Show particular interest in your aches and pains? | _____ | _____ | _____ |
| PFTHA13) Try to get your mind off your troubles? | _____ | _____ | _____ |
| PFTHA14) Tell you what is wrong with you? | _____ | _____ | _____ |
| PFTHA15) Listen to your troubles? | _____ | _____ | _____ |
| PFTHA16) Ask you to describe the physical illnesses you have had? | _____ | _____ | _____ |
| PFTHA17) Want to know what things make you unhappy? | _____ | _____ | _____ |
| PFTHA18) Give you definite rules to follow? | _____ | _____ | _____ |
| PFTHA19) Tell you he/she would talk to your spouse of other family members? | Definitely Yes _____ | _____ | Definitely Not _____ |

DURING THIS SESSION, HOW MUCH:

- | | | |
|---|------------------------------|-----------------|
| TPAR01) Did your therapist talk? | Slightly or not at all _____ | Very much _____ |
| TPAR02) Was your therapist attentive to what you were trying to get across? | Not at all _____ | Very much _____ |
| TPAR03) Did your therapist tend to accept or agree with your ideas and point of view? | Not at all _____ | Very much _____ |
| TPAR04) Was your therapist negative or critical towards you? | Not at all _____ | Very much _____ |
| TPAR05) Did your therapist take initiative in bringing up things to talk about? | Not at all _____ | Very much _____ |

DURING THIS SESSION, HOW MUCH:

TPAR06) Did your therapist try to get you to change your point of view or way of doing things?

Not at all : : : : : Very much

TPAR07) Was your therapist friendly and warm towards you?

Not at all : : : : : Very much

Remember the therapist you saw here today will not see your responses.

WHAT PROBLEMS OR FEELINGS WERE YOU CONCERNED ABOUT THIS SESSION? (For each item, check the answer which best applies.)

DURING THIS SESSION I WAS CONCERNED ABOUT:

| | | Not | | | | | |
|----------|--|-------|---|-----|---|-----|------------|
| | | A lot | : | : | : | : | at all |
| PCONC01) | Being dependent on others. | ___ | : | ___ | : | ___ | : |
| PCONC02) | Meeting my obligations and responsibilities. | ___ | : | ___ | : | ___ | : |
| PCONC03) | Being assertive or competitive. | ___ | : | ___ | : | ___ | : |
| PCONC04) | Living up to my conscience: shameful or guilty feelings. | ___ | : | ___ | : | ___ | : |
| PCONC05) | Being lonely or isolated. | ___ | : | ___ | : | ___ | : |
| PCONC06) | Sexual feelings and experiences. | ___ | : | ___ | : | ___ | : |
| PCONC07) | Loving: being able to give of myself. | ___ | : | ___ | : | ___ | : |
| PCONC08) | Angry feelings or behavior. | ___ | : | ___ | : | ___ | : |
| PCONC09) | Who I am and what I want. | ___ | : | ___ | : | ___ | : |
| PCONC10) | Fearful or panicky experiences. | ___ | : | ___ | : | ___ | : |
| PCONC11) | Meaning little or nothing to others: being worthless or unlovable. | ___ | : | ___ | : | ___ | : |
| PCONC12) | Other: _____ | ___ | : | ___ | : | ___ | : |
| PCONC13) | Other: _____ | ___ | : | ___ | : | ___ | : |
| | | A lot | : | : | : | : | Not at all |

WHAT DO YOU FEEL THAT YOU GOT OUT OF THIS SESSION?
(Check the answer which best applies for each item.)

I FEEL THAT I GOT:

AHOPE01) A chance to let go and get Not Very
things off my chest. at all : : : : much

WHAT DO YOU FEEL THAT YOU GOT OUT OF THIS SESSION?
(Check the answer which best applies for each item.)

I FEEL THAT I GOT:

- | | | Not
at all | : | : | : | : | : | : | Very
much |
|----------|---|---------------|---|-----|---|-----|---|-----|--------------|
| AHOPE02) | Knowledge about what to do in therapy and what to expect from it. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE03) | Help in talking about what was really troubling me. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE04) | Relief from tensions and unpleasant feelings. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE05) | More understanding of the reasons behind my behavior and feelings. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE06) | Reassurance and encouragement about how I'm doing. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE07) | Confidence to try to do things differently. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE08) | More ability to feel my feelings, to know what I really want. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE09) | Ideas for better ways of dealing with people and problems. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE10) | More of a person-to-person relationship with my therapist. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE11) | Better self control. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE12) | Straight on which things I think and feel are real and which are mostly in my mind. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE13) | A chance to begin working out a problem that's been bothering me. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| AHOPE14) | My therapist to say what he/she really thinks. | ___ | : | ___ | : | ___ | : | ___ | ___ |
| NOGOT01) | Nothing in particular: I feel the same as I did before the session. | Not at all | : | ___ | : | ___ | : | ___ | Very much |

WHAT WERE YOUR FEELINGS DURING THIS SESSION?
(For each feeling, check the answer which best applies.)

DURING THIS SESSION I FELT:

- | | | Not
at all | : | : | : | : | : | Very
much |
|----------|-------------|---------------|---|-----|---|-----|---|--------------|
| PFEEL01) | Confident | ___ | : | ___ | : | ___ | : | ___ |
| PFEEL02) | Embarrassed | ___ | : | ___ | : | ___ | : | ___ |
| PFEEL03) | Relaxed | ___ | : | ___ | : | ___ | : | ___ |
| PFEEL04) | Withdrawn | ___ | : | ___ | : | ___ | : | ___ |
| PFEEL05) | Helpless | ___ | : | ___ | : | ___ | : | ___ |
| PFEEL06) | Determined | ___ | : | ___ | : | ___ | : | ___ |

DURING THIS SESSION I FELT:

| | | Not | | | | Very |
|----------|--------------|--------|---|-------|---|-------|
| | | at all | : | : | : | much |
| PFEEL07) | Grateful | _____ | : | _____ | : | _____ |
| PFEEL08) | Relieved | _____ | : | _____ | : | _____ |
| PFEEL09) | Fearful | _____ | : | _____ | : | _____ |
| PFEEL10) | Close | _____ | : | _____ | : | _____ |
| PFEEL11) | Impatient | _____ | : | _____ | : | _____ |
| PFEEL12) | GUILTY | _____ | : | _____ | : | _____ |
| PFEEL13) | Strange | _____ | : | _____ | : | _____ |
| PFEEL14) | Inadequate | _____ | : | _____ | : | _____ |
| PFEEL15) | Likeable | _____ | : | _____ | : | _____ |
| PFEEL16) | Hurt | _____ | : | _____ | : | _____ |
| PFEEL17) | Depressed | _____ | : | _____ | : | _____ |
| PFEEL18) | Affectionate | _____ | : | _____ | : | _____ |
| PFEEL19) | Serious | _____ | : | _____ | : | _____ |
| PFEEL20) | Anxious | _____ | : | _____ | : | _____ |
| PFEEL21) | Angry | _____ | : | _____ | : | _____ |
| PFEEL22) | Pleased | _____ | : | _____ | : | _____ |
| PFEEL23) | Inhibited | _____ | : | _____ | : | _____ |
| PFEEL24) | Confused | _____ | : | _____ | : | _____ |
| PFEEL25) | Discouraged | _____ | : | _____ | : | _____ |
| PFEEL26) | Accepted | _____ | : | _____ | : | _____ |
| PFEEL27) | Cautious | _____ | : | _____ | : | _____ |
| PFEEL28) | Frustrated | _____ | : | _____ | : | _____ |
| PFEEL29) | Hopeful | _____ | : | _____ | : | _____ |
| PFEEL30) | Tired | _____ | : | _____ | : | _____ |
| PFEEL31) | Bored | _____ | : | _____ | : | _____ |
| PFEEL32) | Playful | _____ | : | _____ | : | _____ |
| PFEEL33) | Attracted | _____ | : | _____ | : | _____ |
| | Other: _____ | Not | | | | Very |
| | Other: _____ | at all | : | : | : | much |

DURING THIS SESSION, HOW MUCH: (Check one for each item.)

ACT01) Did you talk?
Slightly or Very
not at all __:__:__:__:__ much

ACT02) Were you able to focus on what was of real concern to you?
Not at all __:__:__:__:__ Very much

ACT03) Did you take initiative in bringing up the subjects that
were talked about?
Not at all __:__:__:__:__ Very much

ACT04) Were your emotions or feelings stirred up?
Not at all __:__:__:__:__ Very much

ACT05) Did you talk about what you were feeling?
Not at all : : : : : Very much

DURING THIS SESSION, HOW MUCH:

- ACT06) Were you angry towards yourself?
Not at all__:_:_:_:_:_: Very much
- ACT07) Did you have difficulty thinking of things to talk about?
Not at all__:_:_:_:_:_: Very much
- ACT08) Friendliness or respect did you show towards your therapist?
Not at all__:_:_:_:_:_: Very much
- ACT09) Were you free and spontaneous in expressing yourself?
Not at all__:_:_:_:_:_: Very much
- ACT10) Were you attentive to what your therapist was trying to get across to you?
Not at all__:_:_:_:_:_: Very much
- ACT11) Did you tend to accept or agree with what your therapist said?
Not at all__:_:_:_:_:_: Very much
- ACT12) Did you have a sense of control over your feelings and behavior?
Not at all__:_:_:_:_:_: Very much
- ACT13) Were you negative or critical towards your therapist?
Not at all__:_:_:_:_:_: Very much
- ACT14) Were you satisfied or pleased with your own behavior?
Not at all__:_:_:_:_:_: Very much

HOW DID YOUR THERAPIST SEEM TO FEEL DURING THE SESSION?
(Check the answer which best applies for each item.)

MY THERAPIST SEEMED:

- | | | | |
|-----------------------|-------|-------------|------------|
| TFELT01) Pleased | A lot | :_:_:_:_:_: | Not at all |
| TFELT02) Thoughtful | | :_:_:_:_:_: | |
| TFELT03) Annoyed | | :_:_:_:_:_: | |
| TFELT04) Bored | | :_:_:_:_:_: | |
| TFELT05) Sympathetic | | :_:_:_:_:_: | |
| TFELT06) Cheerful | | :_:_:_:_:_: | |
| TFELT07) Frustrated | | :_:_:_:_:_: | |
| TFELT08) Involved | | :_:_:_:_:_: | |
| TFELT09) Playful | | :_:_:_:_:_: | |
| TFELT10) Demanding | | :_:_:_:_:_: | |
| TFELT11) Apprehensive | | :_:_:_:_:_: | |
| TFELT12) Effective | | :_:_:_:_:_: | |
| TFELT13) Confused | A lot | :_:_:_:_:_: | Not at all |

MY THERAPIST SEEMED:

| | | | | | | | |
|----------|--------------|-------|----|----|----|----|------------|
| TFELT14) | Detached | A lot | __ | __ | __ | __ | Not at all |
| TFELT15) | Embarrassed | | __ | __ | __ | __ | |
| TFELT16) | Withdrawn | | __ | __ | __ | __ | |
| TFELT17) | Determined | | __ | __ | __ | __ | |
| TFELT18) | Impatient | | __ | __ | __ | __ | |
| TFELT19) | Likeable | | __ | __ | __ | __ | |
| TFELT20) | Attracted | | __ | __ | __ | __ | |
| TFELT21) | Confident | | __ | __ | __ | __ | |
| TFELT22) | Relaxed | | __ | __ | __ | __ | |
| TFELT23) | Interested | | __ | __ | __ | __ | |
| TFELT24) | Unsure | | __ | __ | __ | __ | |
| TFELT25) | Hopeful | | __ | __ | __ | __ | |
| TFELT26) | Distracted | | __ | __ | __ | __ | |
| TFELT27) | Affectionate | | __ | __ | __ | __ | |
| TFELT28) | Alert | | __ | __ | __ | __ | |
| TFELT29) | Close | | __ | __ | __ | __ | |
| TFELT30) | Tired | | __ | __ | __ | __ | |
| TFELT31) | Serious | | __ | __ | __ | __ | |
| TFELT32) | Anxious | | __ | __ | __ | __ | |
| TFELT33) | Angry | | __ | __ | __ | __ | |
| TFELT34) | Adjusted | | __ | __ | __ | __ | |
| TFELT35) | Depressed | | __ | __ | __ | __ | |
| TFELT36) | Guilty | | __ | __ | __ | __ | |
| | Other: _____ | A lot | __ | __ | __ | __ | Not at all |

QBOTH01) TO WHAT EXTENT DID ANSWERING THE ITEMS IN THIS QUESTIONNAIRE BOTHER YOU?

Very much __:__:__:__:__ Not at all

Additional Comments: Please use the rest of this page for any additional comments you wish to write.

APPENDIX IV

APPENDIX IV

THERAPIST PRE-EXPERIMENT QUESTIONNAIRE

Name: _____ Date _____

TVAR01) Race: White Black Hispanic

TVAR02) Sex: Male Female

TVAR03) Age:

TVAR04) Profession: _____

_____ Social Worker

_____ Psychologist

_____ Nurse Clinical Specialist

_____ Other (please specify, e.g., student, trainee, para-professional)

TVAR05) Number of years of psychotherapeutic experience (full time equivalent) since receiving terminal degree: _____ years

TVAR06) How many hours of personal therapy have you had (either on your own or as part of your training): _____ hours

TVAR07) Occupation of your Mother during the majority of the time when you were growing up:

Please specify: _____

TVAR08) Occupation of your Father during the majority of the time when you were growing up:

Please specify: _____

TVAR09) Education level attained by your Father (please specify grade level and make some indication of technical training if appropriate):

TVAR10) Education level attained by your Mother (please specify grade level and make some indication of technical training if appropriate):

TVAR11: Therapist A or B Type

INTERESTS:

A) Indicate after each occupation or activity listed below whether you would like that kind of work or not. Disregard considerations of salary, social standing, future advancement, etc. Consider only whether or not you would like to do what is involved in the occupation. You are not asked if you would like to take up the occupation permanently, but merely whether or not you would enjoy that kind of work or activity, regardless of any necessary skills, abilities, or training which you may or may not possess.

Work rapidly. Your first impressions are desired here.

Draw a circle around L if you like that kind of work or activity. Draw a circle around I if you are indifferent. Draw a circle around D if you dislike that kind of work.

- | | | | |
|---|---|---|---|
| 1) Building contractor | L | I | D |
| 2) Carpenter | L | I | D |
| 3) Marine engineer | L | I | D |
| 4) Mechanical engineer | L | I | D |
| 5) Photoengraver | L | I | D |
| 6) Ship officer | L | I | D |
| 7) Specialty salesperson | L | I | D |
| 8) Toolmaker | L | I | D |
| 9) Manual training | L | I | D |
| 10) Mechanical drawing | L | I | D |
| 11) Drilling in a company | L | I | D |
| 12) Making a radio set | L | I | D |
| 13) Adjusting a carburetor | L | I | D |
| 14) Cabinet making | L | I | D |
| 15) Entertaining others | L | I | D |
| 16) Looking at shop windows | L | I | D |
| 17) Interest public in a new machine through public addresses | L | I | D |
| 18) President of a society or club | L | I | D |
| 19) Many women friends | L | I | D |

INTERESTS, continued

B) Rating of Present Abilities and Characteristics: Indicate below what kind of a person you are right now and what you have done. Circle "Yes" if the item describes you, "No" if the item does not describe you, and "?" if you are not sure.

- | | | | | |
|-----|--|-----|---|----|
| 1) | Win friends easily | YES | ? | NO |
| 2) | Am quite sure of myself | YES | ? | NO |
| 3) | Discuss my ideas with others | YES | ? | NO |
| 4) | Accept just criticism without getting sore | YES | ? | NO |
| 5) | Have mechanical ingenuity | YES | ? | NO |
| 6) | Can correct others without giving offense | YES | ? | NO |
| 7) | Follow up subordinates effectively | YES | ? | NO |
| 8) | Plan my work in detail | YES | ? | NO |
| 9) | Show firmness without being easy | YES | ? | NO |
| 10) | Win confidence and loyalty | YES | ? | NO |

TVAR12: Therapist SES

APPENDIX V

APPENDIX V

THERAPIST POST-SESSION QUESTIONNAIRE

Therapist _____ Date _____

Patient _____

TRVAR01) How much initiative did the patient take in bringing up subjects to talk about? (check one)

Very much __:__:__:__:__ Not at all

TRVAR02) Did the patient have difficulty thinking of things to talk about?

Not at all __:__:__:__:__ Very much

To what extent do you think the patient's problems interfere with his/her ability to:

| | | | |
|------------------------|--------|----------------|------|
| | Not | | Very |
| TRVAR03) obtain a job? | at all | __:__:__:__:__ | much |

| | |
|--------------------------|----------------|
| TRVAR04) remain at work? | __:__:__:__:__ |
|--------------------------|----------------|

| | |
|--|----------------|
| TRVAR05) establish a satisfying sexual relationship? | __:__:__:__:__ |
|--|----------------|

| | |
|--|----------------|
| TRVAR06) establish relationships with peers? | __:__:__:__:__ |
|--|----------------|

| | |
|---|----------------|
| TRVAR07) establish or maintain satisfying relationships with relatives? | __:__:__:__:__ |
|---|----------------|

TRVAR08) Overall, how seriously do you think the patient's problems affect his/her life?

Not at all __:__:__:__:__ Very much

TRVAR09) In this first session how much friendliness or respect did you show the patient?

Very much __:__:__:__:__ Not at all

TRVAR10) Do you think that you communicated to the patient that you understood him/her?

Not at all __:__:__:__:__ Very much

TRVAR11) Were you aware of feeling critical of the patient?

Not at all __:__:__:__:__ Very much

TRVAR12) To what extent do you think the patient will actively work on his/her problems between sessions?

Very much __:__:__:__:__ Not at all

TRVAR13) To what extent do you think the patient will benefit from treatment?

Very much__:_:_:_:_:_:Not at all

TRVAR14) How much confidence do you have that the patient will continue in treatment until you mutually decide on termination?

Not much__:_:_:_:_:_:Very much

TRVAR15) Did you get the impression that the patient would continue treatment for the express purpose of obtaining medication?

Not at all__:_:_:_:_:_:Very much

TRVAR16) Did you get the impression that the patient is coming for treatment only because others (e.g., family, the court, physicians, etc.) have pressured him/her to seek treatment?

Not at all__:_:_:_:_:_:Very much

Treatment you are planning for the patient at this time:

TRVAR17) Time: _____ short term treatment (8 sessions or less)
_____ long term treatment (9 sessions or more)

TRVAR18) Modality: _____ individual therapy
_____ group therapy (on a weekly basis)
_____ couple's group therapy
_____ family therapy or marital counseling
_____ socialization group (on a monthly basis)
_____ other: _____
(please specify)

TRVAR19) Intake Diagnosis _____

APPENDIX VI

APPENDIX VI

THERAPIST POST-EXPERIMENT QUESTIONNAIRE

Name _____ Date _____

INSTRUCTIONS: For each item check the response which best applies. Your responses to this questionnaire will remain confidential.

DURING THE INTAKE INTERVIEW I TYPICALLY:

- TCPBH01) allow the patient to smoke Usually ____:____:____:____:____ Rarely
 TCPBH02) allow the patient to drink coffee or tea ____:____:____:____:____
 TROBH01) smoke ____:____:____:____:____
 TROBH02) drink coffee or tea ____:____:____:____:____
 UNCI01) am interrupted (e.g., by phone calls, knocking at the door, etc.) ____:____:____:____:____
 TREPT01) take notes on the presenting problem, symptoms, and other information the patient shares ____:____:____:____:____
 TLIST01) audio-tape the interview ____:____:____:____:____
 TWRIT01) write the intake report ____:____:____:____:____
 TDRESS01) In general I dress very casually ____:____:____:____:____ very formally
 TOFFC01) Compared to other offices in the MHC, how far is your office from the waiting room? much farther from ____:____:____:____:____ much closer to waiting room ____:____:____:____:____ the waiting room
 TOFFC02) Compared to the size of other offices at the MHC, my office is: larger than ____:____:____:____:____ smaller than most others ____:____:____:____:____ most others
 TOFFC03) Compared to the neatness with which others keep their offices at the MHC, my office is: less neat than ____:____:____:____:____ more neat than most others ____:____:____:____:____ most others
 TSIT01) Approximately how far away from the patient do you usually sit? _____ feet
 TPRES01) Have you arranged with the secretaries to hold phone calls and messages while you are with a patient? (circle one)
 NO YES
 TBOTH01) To what extent did answering the various questionnaires in this research project interfere with your work schedule?
 very much ____:____:____:____:____ not at all

TIORT01) Which of the following represents the theoretical orientation you typically ascribe during individual psychotherapy? (check one)

☐ Adlerian; ☐ Behavioral; ☐ Communication Skills Approach; ☐ Gestalt; ☐ Hypnotherapy; ☐ Interactional or Systems; ☐ Intrapsychic/Psychoanalytic; ☐ Rational Emotive/Cognitive; ☐ Reality; ☐ Social Learning;

☐ Other: _____
(please specify)

APPENDIX VII

APPENDIX VII

THERAPIST POST-EXPERIMENT QUESTIONNAIRE ON GROUPS

Therapist _____

Day/Time Group Meets _____

INSTRUCTIONS: Please think about the members of this group at the present time and consider how they typically interact with each other in the group. The following questions are aimed at obtaining your best estimate of the "group atmosphere".

TO WHAT EXTENT DO YOU THINK THE MEMBERS OF YOUR GROUP:

| | | Not at | Very |
|----------|--|---------------------|------|
| | | all | much |
| | | ___:___:___:___:___ | ___ |
| GRPATO1) | Feel a sense of warmth in the group? | ___:___:___:___:___ | ___ |
| GRPATO2) | Experience a sense of support and/or encouragement in the group? | ___:___:___:___:___ | ___ |
| GRPATO3) | Seem accepting of a new member to the group? | ___:___:___:___:___ | ___ |
| GRPATO4) | Express their feelings of irritation, annoyance or anger? | ___:___:___:___:___ | ___ |
| GRPATO5) | Talk about the intimate issues of their lives? | ___:___:___:___:___ | ___ |
| GRPATO6) | Express their feelings or warmth, support or affection? | ___:___:___:___:___ | ___ |

WHICH OF THE FOLLOWING REPRESENTS OR IS MOST SIMILAR TO THE THEORETICAL APPROACH YOU TAKE IN THIS GROUP? (check one only)

___ Adlerian; ___ Behavioral; ___ Communication Skills Approach; ___ Gestalt; ___ Hypnotherapy; ___ Interactional or Systems; ___ Intrapsychic/Psychoanalytic; ___ Rational Emotive/Cognitive; ___ Reality; ___ Social Learning; ___ Other: _____

The following questions were included by the research investigator from information taken from the intake report of the patient:

PMAR01) Patient's Marital Status

PREF01) Was patient referred to Diagnostic Staffing Group? _____

Did the patient keep the DX group appointment? _____

RQ) Did the patient remain in treatment for six or more sessions? _____

APPENDIX VIII

APPENDIX VIII

PRE-POST DIFFERENCES ON EXPECTATION OF THERAPIST ITEMS
 COMBINED SAMPLE
 (N = 87)

| <u>Variables</u> | <u>\bar{x} Pre</u> | <u>\bar{x} Post</u> | <u>p</u> | <u>Fiester's p</u> |
|---|---------------------------------|----------------------------------|----------|------------------------|
| PEXPT01-PFTHA01 Give You Medicine | 3.3333 | 1.6092 | .001 | .001 |
| PEXPT02-PFTHA02 Ask Questions about Your Personal Life | 5.4023 | 4.5287 | n.s. | .001 |
| PEXPT03-PFTHA03 Tell You What Is Wrong With You | 3.9310 | 2.7586 | .001 | .001 |
| PEXPT04-PFTHA04 Cheer You Up | 3.6897 | 3.0575 | .007 | .001 |
| PEXPT05-PFTHA05 Listen More Than He/She Talks | 4.4138 | 4.1609 | n.s. | n.s. |
| PEXPT06-PFTHA06 Avoid Upsetting Topics | 2.5057 | 2.0230 | .016 | n.s. |
| PEXPT07-PFTHA07 Want to Know Your Thoughts and Feelings | 5.3218 | 4.6207 | .001 | n.s. |
| PEXPT08-PFTHA08 Want to Know How Well You Get Along With Others | 5.2069 | 3.6782 | .001 | .001 |
| PEXPT09-PFTHA09 Tell You Ways to Solve Your Problems | 4.3678 | 2.6552 | .001 | .001 |
| PEXPT10-PFTHA10 Expect You to Do Most of The Talking | 4.3908 | 3.6437 | .001 | .01 |

| <u>Variables</u> | <u>\bar{x} Pre</u> | <u>\bar{x} Post</u> | <u>p</u> | <u>Fiestler's p</u> |
|--|---------------------------------|----------------------------------|----------|-------------------------|
| PEXPT11-PFTHA11 Be Interested in What Things Make You Afraid or Nervous | 5.2529 | 3.8851 | .001 | .01 |
| PEXPT12-PFTHA12 Be Interested in Your Aches And Pains | 4.1494 | 3.3333 | .001 | .001 |
| PEXPT13-PFTHA13 Try to Get Your Mind Off Your Troubles | 4.1379 | 2.6552 | .001 | .001 |
| PEXPT14-PFTHA14 Tell You What Is Wrong With You | 4.0575 | 2.6897 | .001 | .001 |
| PEXPT15-PFTHA15 Listen to Your Troubles | 4.8851 | 4.6667 | n.s. | .025 |
| PEXPT16-PFTHA16 Ask You to Describe the Physical Illnesses You've Had | 4.6667 | 4.3563 | n.s. | .001 |
| PEXPT17-PFTHA17 Want to Know What Things Make You Unhappy | 4.8621 | 3.3218 | .001 | .001 |
| PEXPT18-PFTHA18 Give You Definite Rules to Follow | 3.9425 | 2.4598 | .001 | .001 |
| PEXPT19-PFTHA19 Talk to Your Spouse Or Other Family Members | 2.9080 | 2.3908 | .013 | .038 |

APPENDIX IX

APPENDIX IX

PRE-POST DIFFERENCES ON EXPECTATION ITEMS REGARDING

GOALS OR HOPES FOR THE INITIAL SESSION

COMBINED SAMPLE

(N = 87)

| <u>Variables</u> | <u>\bar{x} Pre</u> | <u>\bar{x} Post</u> | <u>p</u> | <u>Fiester's p</u> |
|---|---------------------------------|----------------------------------|----------|------------------------|
| PHOPE01-AHOPE01 Get A Chance To Let Go And Get Things Off My Chest | 4.4023 | 3.9540 | n.s. | n.s. |
| PHOPE02-AHOPE02 Learn About What to Do in Therapy: What to Expect From It | 4.6322 | 3.9080 | .01 | .001 |
| PHOPE03-AHOPE03 Get Help in Talking About What Is Really Troubling Me | 4.6207 | 4.1264 | n.s. | .001 |
| PHOPE04-AHOPE04 Get Relief From Tensions Or Unpleasant Feelings | 4.4023 | 3.1839 | .001 | .001 |
| PHOPE05-AHOPE05 Understand the Reasons Behind My Feelings And Behavior | 4.8621 | 3.3218 | .001 | .001 |
| PHOPE06-AHOPE06 Get Some Reassurance About How I'm Doing | 4.5862 | 3.2069 | .001 | .001 |
| PHOPE07-AHOPE07 Get Confidence to Try New Things, to Be A Different Kind of Person | 4.6437 | 3.2989 | .001 | .001 |
| PHOPE08-AHOPE08 Find Out What My Feelings Really Are, And What I Really Want | 4.7701 | 3.2759 | .001 | .001 |

| <u>Variables</u> | <u>\bar{x} Pre</u> | <u>\bar{x} Post</u> | <u>p</u> | <u>Fiestter's p</u> |
|--|---------------------------------|----------------------------------|----------|-------------------------|
| PHOPE09-AHOPE09 Get Advice on How to Deal With My Life And With Other People | 4.6322 | 2.8391 | .001 | .001 |
| PHOPE10-AHOPE10 Have My Therapist Respond to Me On A Person-to-Person Basis | 5.1034 | 3.8046 | .001 | .001 |
| PHOPE11-AHOPE11 Get Better Self Control | 5.0805 | 3.0920 | .001 | .001 |
| PHOPE12-AHOPE12 Get Straight On Which Things I Think And Feel Are Real And Which Are Mostly In My Mind | 4.5977 | 2.8851 | .001 | .001 |
| PHOPE13-AHOPE13 Work Out A Particular Problem That's Been Bothering Me | 4.8391 | 3.9080 | .001 | .001 |
| PHOPE14-AHOPE14 Get My Therapist to Say What He/She Really Thinks | 5.2759 | 3.5977 | .001 | .001 |

APPROVAL SHEET

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

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

Date

4/10/81

Director's Signature

Michael J. O'Brien