CONTINUANCE AND SATISFACTION IN OUTPATIENT PSYCHOTHERAPY: AN EXPLORATION OF PATIENT AND TREATMENT VARIABLES

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ABSTRACT

Continuance and Satisfaction in Outpatient Psychotherapy:
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This study explored the effects of various patient, therapist and treatment variables on continuance and treatment satisfaction at an outpatient mental health center. One hundred patients who had terminated treatment between January 1, 1987 and March 31, 1989, were selected for study by stratified proportionate random sampling on the basis of the number of attended sessions. Patient variables included sociodemographic status, fees, degree of stress at time of intake, locus of control (external vs internal) and presenting problem causal attribution type (self, self-in-situation, environmental and situational). Therapist variables included age, gender, years of experience and professional discipline. Treatment variables were comprised of the patients' perceptions of the therapists' skills, the perceived quality of the professional relationship and the perception of concurrent logistical problems. The findings indicated that four variables contributed significantly to the variance in continuance; the quality of the professional relationship, the patient's degree of stress, social class and problem causal attribution type (multiple $R^2 = .61$, $p \leq .001$). That is; patients who perceived the therapeutic relationship as a poor one, with low degrees of stress, who were from lower social classes, with problem causal attribution types of stimulus

(other) or situation, were most likely to terminate within twelve sessions. Four variables were found to contribute significantly to the variance in overall satisfaction; perception of the professional's skills, the quality of the professional relationship, perceptions of a long initial wait for service and the ability to afford the fee (multiple $R^2 = .83$, $p \leq .001$). That is; patients who perceived the professional's skills as ineffective, the quality of the professional relationship as a poor or fair one, who felt they had initially waited too long for service and paid too high a fee, were most likely to be dissatisfied with the overall treatment experience. It was hypothesized that when the relationship between continuance and satisfaction was not a linear one; i.e., patients who dropped out after one session with high degrees of satisfaction, or patients who remained beyond twenty-five sessions with low degrees of satisfaction, the combination of variables for both continuance and satisfaction accounted for this phenomenon.

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Dedication

This dissertation is dedicated to
my wonderful wife
Nicole
whose tenacious supplies of
love, devotion, patience and support over
the last fourteen years have inspired and perpetuated
my personal and professional growth.

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I will remember him always with loving appreciation.

Chapter I

Introduction to Study

The Research Problem

This dissertation is an exploratory study of psychotherapy outpatients who have begun treatment and, at some point in the process, prematurely decide to interrupt the work. Succinctly stated, this dissertation hopes to shed some light on the increasing problem of psychotherapy patient attrition rates.

I became interested in this area of study during the course of my regular responsibilities as the computer research coordinator at the Pride of Judea Mental Health Center; a private, non-profit free-standing outpatient mental center in Douglaston, Queens New York.

The agency benefited from a computerized patient tracking system in which sociodemographic and treatment data were stored on both active and closed cases. One afternoon, I was "running" checks on the data across variables of age, sex and therapist for any patterns that might emerge. Usually, any significant patterns were so subtle that they only become evident upon statistical analysis. However, during this one particular run, I noticed that the closed case file was overrepresented by senior citizens, defined age sixty and older. In fact, close to forty percent of our closed case population, at that time, consisted of seniors; however, seniors comprised less than ten percent of the active or ongoing patient population. Upon further examination, it appeared that other variables including therapist, sex and diagnosis did not mediate or explain this high percentage at all. It appeared to me that the

agency was somehow doing or not doing something that was working against the continuation of treatment by patients age sixty and older.

I pursued my interest about this phenomenon by discussing some of these findings with Professor Alex Gitterman, during one of our earlier dissertation proposal meetings. He suggested that I investigate Learning From Clients by Anthony Maluccio as a place to start in my pursuit of patient patterns, likes and dislikes in mental health facilities.

In that particular study, Maluccio attempted to delineate the variables that made social work treatment effective as perceived by the clients themselves. The population studied were clients who had completed a course of treatment with discernable beginning, middle and end phases. In social structural terms and as suggested by Alcabes and Jones (1985), he studied people who had been successfully socialized as clients from their initial statuses as applicants.

What Maluccio's work admittedly failed to do was to study the ten subjects from his original pool of forty-three who never made it past the fifth interview. However, even more striking than the twenty-three percent dropout rate, was the distribution of these rates across social class.

Table 1-1, below, represents this frequency distribution of patients who remained in treatment (the focus of Maluccio's study) compared with those who dropped out within five sessions across the dimension of social class. Ninety-four percent of those patients from the upper classes eventually remained in treatment as

oppossed to only sixty-four percent of those patients constituting the working and poor classes (Adapted from Maluccio, 1979, p.40 and Hollingshead, & Redlich, 1958; Two Factor Scale of Social Position).

Table 1-1

Evaluation of Maluccio's Sample:
'Remainers' vs Dropouts by Social Class[1]

	Social Class I,II,III %	IV, V %	Totals %
Remainers	94	64	77
Dropouts	6	36	23
Totals:	n = 18	n = 25	N = 43

Chi-Square = 5.44, df = 1, p = .02

Armed with this additional information, I re-ran my closed case data, this time controlling for the dollar amount of the ongoing fee: The correlation between age and number of attended sessions all but vanished. It appeared that, next to the medicaid population, seniors overrepresented the lowest paying fee group of all patients at this clinic. To the degree that the dollar amount of the fee was representative of ability to pay and that income is an indirect indicator of social class, it appeared that social class, not age, was the essential predictor or premature termination.

Relevance and Importance to Social Work

The severity and extent of this problem can be identified from the fact that at general psychiatric clinics, twenty to fifty-seven

[1] This table has been extrapolated from Table 3.2 in Maluccio, op.cit, p. 40. The social class designations are based on Hollingshead's Two Factor Index of Social Position, first discussed by August Hollingshead in Social Class and Mental Illness. (See Bibliography). Essentially, the Roman numerals translate to I, Upper Class-II, Upper Middle Class-III, Middle Class-IV, Working Class - V, Poor Class.

percent of that population fail to return after the first interview and thirty-one to fifty-six percent of all applicants fail to continue beyond the fourth visit (see for example Stahler, 1987; Dodd, 1971; Martin, 1988).

The problem of patient attrition has, perhaps, never been as professionally relevant as it is today with soaring treatment costs and diminishing social and economic resources. There has been an ever growing movement on the part of big business and medical insurance companies to reduce the allowable benefits for psychotherapy, particularly, for treatments exceeding ten sessions. New York State employees, for example, are allowed reimbursement at forty-eight dollars per session for the first ten psychotherapy sessions and this amount rapidly decreases to thirty dollars per session, thereafter. What this usually means is that mental health clinics are forced to bear a proportionately heavier burden in subsidizing patients with their "sliding scale fees" while the rate of subsidy from state and local governments, at best, remains the same. In addition, the intake process generally costs a clinic or hospital more in time and money, particularly when the intake is conducted by a psychiatrist (as opposed to the ongoing treatment being conducted by a social worker). Thus, the need to determine those factors that are associated with patient attrition, either immediately or shortly after the intake process, is certainly a salient and important one.

Certainly, social work's recent response has culminated in an increasing movement to tailor and focus its services to those interventions and treatments that, in fact, work for our clients.

Professional interests in short-term models of practice and especially cognitive-behavioral therapies are quite apparent in social work literature and curricula. On yet another level, this dissertation speaks to the issue of "service accessibility" with vulnerable populations such as the poor and elderly. That is, if the findings derived from Maluccio's study are representative, it would appear that certain application and treatment procedures and policies, as commonly practiced by mental health centers, have the effect of denying service to those, social work would argue, in greatest need of it.

Research Questions

The preliminary investigation of my own data as well as Maluccio's work on completed treatments generated the following research questions that guided the review of the literature.

1. Who are the applicant-patients that prematurely terminate treatment at an outpatient mental health center?
   - What are their sociodemographic characteristics?
   - In what ways do these characteristics relate to the variables of type and severity of presenting problem and initial expectations of the patient and therapist roles?
   - Are there differences in how the patient's sociodemographic status affects perception of the therapist and the ensuing working relationship?

- In what ways do these differences in sociodemographic, related characteristics and perceptions of the therapist, affect the overall level of satisfaction with the treatment and number of sessions attended?
- Are there sociodemographic and other differences between those who drop out early and those who remain for longer periods?
- In what ways do perceptions of the professionals' skills and of the relationship, effect satisfaction with psychotherapy and continuation?

2. On the basis of the questions in group number one, can locus of control and attribution theories be used as underlying or guiding theories in the exploration of psychotherapy attrition rates?
- How are differences in locus of control and related expectations associated to patient socio-demographic variables?
- Do general expectancies regarding locus of control either predict or mediate perceptions of the therapist's skills and the working relationship in regard to the number of attended sessions and overall level of satisfaction with the experience?
- If so, do varying degrees of locus of control have any impact on the patient's perception of degree of satisfaction?

- Related, does locus of control have any effect on whether the patient is more likely to attribute changes to the self or to the therapist?
- In addition, are these differences in attribution related to number of sessions attended or overall degree of satisfaction?

3. Who are the therapists of the patients to be studied?
- Are differences in overall degree of satisfaction and attrition rates related to sociodemographic differences in the therapists?
- Are differences among therapists for professional type and years of experience related to patients' overall degree of satisfaction with the experience and attrition rates?

Chapter II

Literature Review

Introduction

The literature concerning the patient[1] dropout can be categorized into three distinct areas of research endeavor. One area traditionally examines patient attrition rates as the primary consequence of patient variables; the second area explores this problem from the vantage point of the therapist and the third approach seeks to explain premature discontinuance as the result of the interaction between the therapist and the patient. Furthermore, the areas of emphasis seem to be over-represented by disciplinary differences with psychology and psychiatry (particularly psychoanalysis) leaning in the first two directions (e.g., patient attributes leading to countertransferential issues in the therapist) with social work and social psychology emphasizing the interactional and "extrapatient" variables, e.g., environmental influences.

This literature review will be organized around these three categories with an introductory section regarding some of the preliminary concepts and definitions. The format will consist of the presentation of the relevant empirical research in section one followed by an elaborate discussion of two major attribution theories in section two.

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[1]For sake of clarity, the term patient will be used in this section to include all work reviewed with either "applicant," "patient," or "client" as the primary subject focus. This reflects this study's emphasis on the psychotherapy outpatient as well as the medical model bias of referring to an individual who has been seen at least once by a "doctor" as a patient.

Section I

The Empirical Research

Defining the Dropout

In their comprehensive and critical review of the research literature on dropping out of treatment, Baekeland and Lundwall (1975) underscore the absence of definitional explicitness in most studies of treatment attrition. When you consider the general classification of all treatment dropouts, regardless of setting or treatment, three general categories of dropouts emerge: (a) the patient who fails to return where the facility has not yet completed the intake process, (b) the patient who refuses to return where the facility has taken a position that the patient "should" be in treatment, and (c) the patient who is expelled from a treatment program for lack of cooperation or poor response to treatment, etc. (page 740). Furthermore, the patient who calls for an appointment and fails to show for the initial interview has been traditionally unaccounted for in the research literature. To further complicate matters, Ripple has made the point that continuance in casework is not necessarily synonymous with 'use' of casework service and conversely, patients who prematurely terminate often report improvements. From the vantage point of outpatient psychotherapy, dropout categories (a) and (b) seem to apply; about four out of five patients who drop out do so at their own request and not with the advice or consent of the therapist. Most studies of dropping out of treatment in psychotherapy clinics have defined the dropout or terminator and the remainer in terms of the number of visits he makes, with a cutoff point that has ranged

from three to ten visits. Defining the dropout by number of visits as opposed to time spent in treatment is the more valid approach as, even within the same clinic, the same length of treatment can include different number of contacts depending on the therapist and patient. In the sixty or so articles and books reviewed by me, the cutoff point has been fairly arbitrary, often determined by median number of visits within the post-selected sample. Based on the empirical finding that there are between-group differences for patients who fail to return after one initial intake session and patients who dropout after three months, Baekeland has defined a continuum of dropouts for any given treatment program in the following way: (a) the Immediate Dropouts (one visit only), (b) Rapid Dropouts (> one visit but ≤ 1 month) and (c) Slow Dropouts (> 1 but < 6 months of treatment). Our study will seek to incorporate a similar form of this sampling criterion. From a methodological standpoint, there is a great deal to be said for dividing up the dropout population in this trichotomized way. For one thing, significant effects can either be suppressed or falsely significant for any one particular dropout group. For example, in a study of dropouts of outpatient alcoholism treatments, the variable of lower socioeconomic status (or factors related to it such as low education, income and occupational status) was only a significant predictor variable when the dropouts were divided into the three groups defined above. Thus, Baekeland found that education was a significant predictor variable with outpatient alcohol treatment programs only in the (c) slow dropout group.

Adult Patient Variables

In all but one of the articles and books reviewed, the literature on outpatient psychotherapy dropouts seems to concern itself primarily with the adult patient.[2] As the adult individual psychotherapy population is most readily available to me, I have decided to keep the focus on literature primarily addressing this population. The literature on patient variables will be reviewed across three broad groups 1) Sociodemographic or actuarial variables, 2) Psychological attributes and 3) Expectations and other variables.

.....Sociodemographic variables

A major and recurring variable in studies of premature termination has been the patient's social class. Most studies have measured this variable by using August Hollingshead's Two Factor Scale of Social Position, a weighted single score based on the subject's highest level of education and the "social value" or position of a specific occupation or profession. Most studies incorporating this index have reported varying relationships between premature termination and social class. For example, Imber, Nash and Stone (1955) found that only 57.1 percent of lower class patients remained for more than four sessions, as opposed to 88.9 percent for middle class patients (Garfield, 1978, p. 197).[3] In yet another study cited by

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[2]In fact, only the Baekeland review article was examined in the area of child or group psychotherapies. The methodological difficulties in controlling for and including parents of children patients seems to account for the relative sparcity of literature.

[3]Subsequent to the writing of this literature review, the 1986 edition of this reference was released. Careful review of the relevant chapters revealed few additional studies and, including these, the data and conclusions, as summarized here, have remained the same.

Garfield, 12 percent of the two lower social class groups remained for more than 30 sessions as compared with 42 percent of those in the highest two social class groups. In fact, all studies reviewed by me that utilized Hollingshead's index for social class did report a significant relationship between social class and treatment duration.

One of several reasons for this phenomenon, which seems to elude discussion in the literature, is the existence of "hidden treatment costs" which is felt most acutely by lower SES patients. Storrow (1962) underscores the impact of the hidden costs of treatment particularly to lower SES patients vis a vis child-care arrangements and public transportation. For example, the additional ongoing expenditure of just ten dollars per week for child-care and public transportation, can transform a moderate psychotherapy fee of twenty-five dollars into a stressful condition to the working class patient. Since this extra cost is rarely factored-in by those who set the sliding scale fee, the patient's proclamation that the "fee is too high" may be incorrectly assessed as entirely representing a "treatment issue," i.e., resistance to or ambivalence about psychotherapy. Thus, the "hidden cost" variable would appear to play a contributing role in psychotherapy attrition.

.....Other Actuarial Variables

A few studies have investigated the relationship between education and treatment duration. To the degree that education is related to Hollingshead's social class index, most studies have shown a positive predictive value of this variable. The relationship does appear to weaken, however, when the treatment setting or function is

different from that of the free-standing outpatient mental health center with psychotherapy as the primary service. For example, Weisman, et al. (1973) found an overall low attrition rate and minimal differences between educational groups for a population of depressed women receiving casework services and medication. However, Baekeland's review of treatment dropouts generally showed that the administration of medication, in all settings, increased treatment stay by all patients (1975, p. 754). Garfield's assessment of the education variable is that it is associated in a complex way with other patient attributes such as verbal ability, sophistication about psychotherapy and income, etc. and that it seems to have a significant relationship in most studies, particularly when it is below the ninth grade level (1978, p.198).

Other sociodemographic or actuarial variables that have been investigated in relation to treatment continuance include age, sex and diagnosis. In his review of the treatment dropout studies, Baekeland summarized that age was a predictor of patient attrition for the "younger person, who is less likely to have a nuclear family and community ties of relatively binding obligation to aged parents," (p. 765). However; Garfield, who investigated those studies pertaining to psychotherapy settings only, reported that age seems to have a negligible effect on continuance (p. 198). At best, the age of the adult patient (eighteen years or older), seems to have a weak effect on treatment continuance.

On the variable of sex, Baekeland reported that sex was found to be a predictor of dropping out of drug and alcohol treatment programs

only (p.763)[4] and Garfield's review essentially corroborated this assessment. Whereas sex is a predictor of who will apply for treatment it is not a predictor of who will drop out once in treatment.[5]

In regard to psychiatric diagnosis as a predictor of treatment continuance, most studies have not reported a significant finding. Some studies have reported that patients with psychoses and severe personality disorders are more likely to remain in treatment than patients with neuroses or those in situational crises (Craig and Huffine, 1976). However, since these patients were more likely to receive medication and medication treatment is in itself a predictor of continuance, the relationship appears to be weak or negligible between psychiatric diagnoses and continuance.

.....Psychological Attributes

Psychological attributes include such qualities as psychological mindedness, ego strength/weakness, motivation, manifest stress, etc. Generally these findings are based on the administration of various psychological tests such as the Rorschach, the Minnesota Multiphasic Personality Inventory (MMPI) and the Wechsler Adult Intelligence Scale (WAIS). The twenty or so articles reviewed by me in this area yielded different and, in some cases, contradictory results. A primary reason for this lies in the fact that the aforementioned psychological

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[4]Women were found to overrepresent the earlier dropout groups in both drug and alcohol treatment programs. It is hypothesized that this is due to the fact that there are less female alcoholics than male and therefore they are more likely to be socially maladaptive or sicker. In drug treatment programs, higher female dropouts may speak to sex mismatching with male only counselors.

[5]Most accounts suggest that women seek psychotherapy or counseling at a rate of 3:1 compared to men.

concepts do not readily lend themselves to operational definitions. In addition, researchers in this area often use different instruments to measure the same concept or, more commonly, measure different outcome variables resulting in different findings. However, there is one psychological construct that seemed to hold promise for this dissertation in particular; the concept of locus of control as developed by and from Rotter's social learning theory (Rotter, 1966). According to Rotter, internal locus of control refers to the disposition to attribute to oneself some control over one's reinforcements. Those who believe that their reinforcements are controlled by fate, chance, or powerful others are said to have an external locus of control. The construct is viewed as a generalized expectancy which operates across situations. That is, externals (E's) are viewed as having a negative expectancy for success to come from attempts at personal control, whereas internals (I's) have a more positive expectancy (Biondo and MacDonald, 1971). Rotter's well-known scale has received the most attention from attribution theorists over the years, particularly in the area of educational psychology which has studied students' attributions of causes of success and failure to their academic performance (see for example, Elig and Frieze, 1979). In the field of clinical psychology, Rotter's I-E scale has been used a predictor of susceptibility to Seligman's model of learned helplessness (Cohen, et. al., 1976). Although specific use of the locus of control construct as a predictor of treatment continuance could not be located, a couple of studies have used modified forms of the scale as a predictor of outcome in different treatment types. For example, Abramowitz and Roback (1974) used a modified nine item I-E scale to predict outcome in either a "relatively

directive" or "relatively nondirective" treatment. The results indicated that those patients who attribute successful outcomes to external causes such as luck, fate or powerful others did significantly better in the directive therapy, while the "internals" did far better in nondirective therapy. In a second study, female "externalizers" were far more likely to negatively correlate with therapist ratings of patient change indicating poorer psychotherapy outcomes for female (but not male) patients who attribute external causes for their own success (Garfield, 1978, p 223).

Thus, it is reasonable to deduce that externals will be more likely to attribute the causes of their presenting problems to factors outside the self or beyond their immediate control. These patients should be more likely to expect or require an active advice-giving therapist who could assume responsibility for their own problems. To this degree, locus of control is expected to act as a mediating factor between the sociodemographic variables and the dependent variables of satisfaction and continuance.

.....Expectations and Other Variables

A major area of investigation vis a vis treatment continuance has been the patients' expectancies concerning therapy; what the therapist and treatment will be like. In this area particularly, the effect of social class appears to be strong. Overall and Aronson (1962) administered questionnaires, both before and after the first session, to forty lower class patients (classes IV and V) to determine the congruency of their initial expectations to what was actually experienced. The results indicated that these patients tended to

expect a "medical-psychiatric" interview, with the therapist assuming an active supportive role. Furthermore, the patients whose expectations were generally less accurate in terms of the therapist's actual role were significantly less likely to return for subsequent sessions. These findings are consistent with other literature that suggest lower class patients are not properly socialized into the middle-class institution of psychotherapy. The only experience they can call upon in which to understand their role as "patient" within a "treatment" is the medical interview; a typically passive role in which information is given to the doctor and professional advice is then received. This point is well illustrated in a study conducted by Heine and Trosman (1960) in which the terminators tended to emphasize passive cooperation as a means of reaching their goal and sought medicine or diagnostic information. The remainers, on the other hand, emphasized active collaboration and advice or help in changing behavior. Although Heine and Trosman did not control for social class, it is likely that it accounts for the significant differences found between the treatment remainers and dropouts.

Lorion (1973), who has studied patient expectations from the perspective of problem type, has concluded that lower-class patients are more likely to present with more practical problems in living but do not differ qualitatively from the same types of problems presented by middle and upper-middle class patients. Lazare, Eisenthal, Wasserman and Harford (1975) studied the initial treatment requests, at the Massachusetts General Hospital psychiatric walk-in clinic, of over 600 low-income and minority patients over the course of several years. They categorized the presenting problems of these patients into

fifteen distinct areas and found, as did Lorion, that although lower-class patients presented with an additional set of practical problems, they did not differ qualitatively from the types of problems presented by upper-class patients. Table 2-1 illustrates these fifteen categories of presenting problems and how they compare with treatment requests by upper-class patients.

Table 2-1

Table of Presenting Problem Types for over 600 Low-Income and Minority Patients Compared with Likelihood of same problem being presented by Upper-class patients[6]

Problem Category	Definition	Also Likely as Upper-Class Problem Type?
Administrative Request	Request for help in dealing with bureaucracy, agencies, etc.	No
Advice	Request for specific expert guidance on personal to nonpersonal matters.	No
Clarification	Request for help in putting feelings, thoughts or behavior in some perspective.	Yes
Community Triage	Request for information on where in the community to get needed services.	No
Confession	Request to talk to the therapist and ease guilt feelings for something said, thought or done.	Yes
Control	Patient feels overwhelmed and wants therapist to take control of life.	Yes

[6]Adopted from Acosta, et.al, (1982) and Lazare, et.al, (1975).

Table 2-1 Continued

Problem Category	Definition	Also Likely as Upper-Class Problem Type?
Set Limits	Requests for protection by therapist setting firm and consistent limits.	No
Nothing	No Request. Patient states he is not in need of help.	No
Medical	Requests for medical treatments or cures, e.g. medication.	No
Psychodynamic Insight	Pt wants to talk about problems perceived as originating in his/her early development.	Yes
Psychological Expertise	Pt wants an explanation as to why s/he thinks, feels, or acts in a particular way.	Yes
Reality Contact	Request for help in "keeping in touch" with reality so as not "to go crazy."	Yes
Social Intervention	Requests for intervention with other people or situations which pt sees as responsible for problems.	No
Succorance	Requests for another person to be warm, caring, involved and comforting.	Yes
Ventilation	Request to tell the therapist various feelings, other than guilt, to get it "out in the open"	Yes

As table 2-1 illustrates and as discussed by Acosta, et. al. (1982, p.14), middle and upper-middle class patients are more likely to present with problems that are more congruent with the expectations of middle-class therapists; problems that center around the treatment of emotional problems. The types of requests for help with problems inherent with being poor, i.e., administrative, community triage,

nothing, medical and social intervention are generally considered to be unacceptable areas of intervention by therapists.

Related to the above, several researchers have further investigated the role of expectations in what can be broadly referred to as pre-therapy socialization studies (Hoehn-Saric, Frank, Imber, Nash, Stone and Battle, 1964; Overall and Aronson, 1962; Orne and Wender, 1968). The findings have been generally consistent that lower-class patients who are exposed to the Role Induction Interview (Orne, 1968) or to other pre-therapy training films or interviews fare significantly better in terms of continuance and selected process and outcome measures. These findings are not surprising and have confirmed other scholarly works from a role theory perspective that have delineated "applicant" status and role set, from that of "client" status and role set (Alcabes and Jones, 1985; Rosenblatt, Aaron, 1962). According to a role theory perspective, the phenomenon of premature termination is viewed as a failure of proper "client socialization" and not as a treatment failure. The client or, more accurately, the applicant who is experiencing too much stress due to an ambiguous and "hidden" role induction process, seeks to reduce further stress caused by conflict of impinging roles by "abridging his role-set" (Rosenblatt, p.12). I believe Garfield nicely summarizes the major point of this general area of study as made by Truax and Carkhuff (1967), "If psychotherapy or counseling is indeed a process of learning and re-learning, then the therapeutic process should allow for structuring what is to be learned, rather than depending on what amounts to 'incidental learning,' where the client does not have clearly in mind from the outset what it is he is supposed to learn."

(Garfield, 1978, p.202.). The following section will describe an overview of the research that explores the therapist's contribution to premature discontinuance of psychotherapy.

Therapist Variables

The research literature on therapist variables falls into two broad categories. The first class of variables include those characteristics that are considered to operate independently of any particular patient and have typically been studied outside of the treatment setting. This category consists of the therapist's personality, mental health, sex, race, social class and level of experience and, by association, age. The second category of characteristics or behaviors are viewed as contributing to the particular treatment relationship and consist primarily of therapist styles or behaviors. The therapist variables of personality and mental health fall beyond the purview of this dissertation and will not be reviewed. However, the sociodemographic or actuarial variables of sex, level of experience as well as the second category of therapist styles and behaviors will be reviewed in this following section. Race and social class have only been studied in connection with corresponding patient characteristics and will be discussed in that part of this literature review.

.....Sociodemographic and Experiential Variables

Demographic characteristics of race, sex, age and social class have generally been studied in relationship to the corresponding characteristics of their patients. However, Garfield in his review of the literature found seven studies that investigated the effects of therapist sex independent of the patients treated. In summary, there

were no significant differences in treatment outcome due to the sex of the therapist (p.236). There are no available studies on the effect of sex on treatment continuance, per se, and this variable will be included in this present study.

Age of the therapist has not been systematically studied as a predictor variable in either treatment continuance or outcome. However; level of experience, which is highly correlated with therapist age, has been studied in regard to treatment outcome. Auerbach and Johnson (1977) conducted a comprehensive literature review of all studies in this area and found thirteen studies which investigated therapist level of experience as a prospective research variable.[7] Only five out of the thirteen specified studies demonstrated significantly superior results for more experienced therapists on treatment outcome and some of these were reported as suffering from serious methodological flaws. The authors concluded that "the view that experienced therapists achieve better results, while it may be true, does not find the unequivocal support that we expected" (p. 99). In contrast, Baekeland and Lundwall (1975) reported that six out of the seven relevant studies reviewed by them did demonstrate that level of experience is positively correlated with longer stays in treatment.[8] In my personal review of some of the selected articles discussed by the above authors, it appears that level of experience may

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[7]Studies incorporating a post-hoc analysis of level of experience were not included in this review, accounting for the relatively low number of total studies discussed.

[8]A reasonable inference here is that treatment duration, beyond the first few interviews, is not necessarily or even strongly related to better results. This would confirm the point made earlier from Lilian Ripple that continuance in treatment is not the same as use of treatment.

be related to treatment continuance in the following way: Experienced therapists are more likely to be accustomed and comfortable with their role as therapists. Consequently, more experienced therapists may be less rigid in their application of any one particular technique to all patients and, as a result, would appear more receptive and approving to the patient. Thus, it may be this related level of role-comfort and concurrent self-belief in one's efficacy that is actually associated with continuance in treatment. To the degree that newcomers may naturally possess an inner sense of self assuredness and a self-belief in their ability to be helpful to others (whether justified or not), the statistical relationship between level of experience and continuance or outcome breaks down. I believe this might account for the mixed findings reported above.

The therapist variables of race and social class have been most readily studied within the context of the corresponding patient variables. Garfield reports only one empirical study that investigated the effect of the white therapist-black patient on treatment outcome utilizing actual patients (as opposed to black college students fulfilling psychology experiment requirements). The findings suggested that patients most similar to the race and social class of the therapist tended to "explore themselves most, while patients most dissimilar tended to explore themselves least" (p. 256).

Thus, therapist variables such as race, religion, social class, age and sex seem to have a predictive effect on premature termination to the degree these variables impact on the therapist's own background with corresponding expectations of the patient. As Lorion points out, therapists when confronted with low-income patients, often report a

"lack of rapport," perceiving them as hostile, suspicious and too frustrating to work with as the use of "approved" psychoanalytical techniques and procedures are misunderstood by the lower-classes (p. 344). A reasonable inference is that less experienced therapists, particularly those whose families of origin are among the upper two classes, could benefit from a clearer and less stereotypical understanding of the needs of the lower classes.

.....Therapist Styles and Behaviors

The literature on the effects of therapist styles on the treatment relationship originates from a long tradition of theorists who addressed conditions that were deemed optimal for the therapeutic relationship. Freud believed that the "working alliance" was based on the patient's recognition that the therapist was understanding and well disposed toward him/her. Freud later stressed that the therapist should provide conditions whereby the patient could experience warm and positive feelings toward him, on the grounds that such feelings effected successful results in psychoanalysis as in all other remedial methods (Freud, 1910).

Carl Rogers, in his non-directive therapy, underscored an original list of six therapist variables that were deemed "necessary and sufficient" conditions for a positive therapeutic relationship, regardless of patient type (Rogers, 1957). Following in this tradition, latter day researchers have maintained that there are three therapist conditions or traits related to treatment effectiveness: 1) Accurate Empathy, 2) Non-possessive warmth and 3) Genuineness (Truax and Mitchell, 1971). Studies on these therapist variables have produced

varying results as outcome measures have differed as well as the type of therapist rating and methods for obtaining those ratings. However, a relevant point for this dissertation is that researchers in this area have reported that "the ratings of patients tend to be consistently higher than those of the nonparticipant judges, so that the assumption that judges' ratings may be used as better or adequate representations of the patients' perceptions seems unwarranted," (Garfield, p.250).

Within this long tradition of attempting to identify the effect of critical therapist behaviors on the therapeutic relationship, Shulman investigated the function of specific skills on the working relationship or alliance. The theoretical assumption for this study, adapted from Shwartz's interactionist or mediating model, was that certain skills established a positive working relationship, other skills were helpful only after the development of the relationship and, others may be unhelpful if presented prior to the establishment of a working relationship (Shulman, 1978, p.274). In summary, Shulman found that some skills served to build a relationship as well as help the client, while other skills were helpful only in the presence of a working relationship. For example, the skill of sharing personal thoughts and feelings was both equally instrumental in establishing a relationship and in helping the client. However, the skills of 'putting client's feelings into words,' and 'clarifying roles' had r coefficients of .32 and .23 respectively. However, when a partial correlation was performed on helpfulness controlling for relationship, the correlations for these skills all but vanished at .04 and .07 respectively. This suggests that certain skills such as 'putting client's feelings into words' and 'clarifying roles' are perceived by the client as helpful only

when the client feels accepted by and safe with the therapist, i.e., once the working relationship is established. This dissertation will attempt to utilize an adapted form of Shulman's Social Worker Behavior Questionnaire as a way of determining perception of these skills on both the treatment relationship and the phenomenon of dropping out.

Subsequent and more recent studies in the area of premature termination have indirectly corroborated many of Shulman's findings. For example, Shulman found that 'putting the client's feelings into words', 'providing data' and 'partializing the client's concerns' were correlated to both helpfulness and the establishment of a relationship. Tracey (1986) in an attempt to identify interactional variables that correlated with premature termination at a university counseling center, found that the absence of "topic determination" in the earlier sessions was highly predictive of dropping out as overrepresented by "no-shows" (as opposed to telephoned cancellations). To the degree it can be reasonably inferred that the skills of 'putting the client's feelings into words', 'providing data' and 'partializing the client's concerns' are critical in developing preliminary contracts with clients, i.e., topic determination, it would seem that Tracey's findings support Shulman's interactional model of the effect of skills on the relationship. Furthermore, there is strong evidence that the absence of certain critical skills early in the relationship by the therapist is predictive of a non-relationship or dropping out. In addition, Tracey found evidence of varying "threshold levels of topic determination" and this study will further attempt to investigate the patient variables

that may predict different thresholds to either the absence or premature presence of certain therapist skills.

Section II

Discussion of Attribution Theories

The focus and intent of this section will be to elucidate the representative theoretical concepts over some of the areas just delineated in the review of the empirical research. In essence, this section will attempt to theoretically explain, by discussion of the "driving" or guiding theories of attribution, some of the quantitative findings reported on the above variables. The combination of the empirical and theoretical research will provide the basis for establishing this study's research variables, questions and hypotheses in chapter III and, finally, the research methodology and instrumentation in chapter IV.

Attribution Theory

Attribution theory is the study of how and why people explain events in their lives and how causes of behavior are understood by the ordinary person. The more general concept of perception as it relates to attribution theory is of tantamount importance to this dissertation. It becomes the underlying rationale for using the particular instruments of this study that will be discussed in chapters III and IV. Two major theories of attribution will be discussed in detail as they relate most directly to perceptions of cause and effect and motivations regarding health care treatments.

.....Kelley's theories of covariation and configuration

Kelley's theories of covariation and configuration seek to explore the types of information that people use to attribute explanations about cause and effect (Kelley, 1972). Kelley postulated that there are three different aspects of information that people use in various combinations or configurations to form causal attributions about people, stimuli or circumstances; 1) Consensus, 2) Distinctiveness and 3) Consistency. Furthermore, these three aspects work in combination to help the viewer determine how effects (outcomes) covary with different sources and whether these effects are due to factors within the person, the stimulus within the environment or the governing situation. Kelley's theory of covariation states that the effect is seen as caused by the factor with which it covaries, based on the three aspects of information stated above (Kelly, 1973). An illustration should help to clarify the use of terminology.

Peter, who has just completed a three year psychotherapy at a mental health center, tells his friend Joe, who is experiencing emotional problems, about how wonderful his experience in therapy was, what a great therapist he had and that Joe should consider seeing this same therapist. Joe's task now is to determine whether these wonderful results are due to Peter the person, the stimulus (the therapist) or to contextual circumstances for Peter over the past three years (Peter's business boomed over the past three years) independent of the therapy. In order to determine which source is related to or covaries best with the result, Joe must apply the three different aspects of his available information (consensus, distinctiveness and consistency) to this perceptual problem. First, Joe may wonder

whether he has ever heard anyone else rave about this same therapist. If he had, then there would be "high" consensus regarding the therapist and Joe would begin to perceive that good results covary with this therapist (i.e., this therapist or stimulus causes good results). Second, Joe will need to determine just how distinctive his friend's feelings are. If Peter is the type of person who says only good things about everyone, then Peter's views of his therapist lack distinctiveness, in which case his positive feelings provide little, if any, information about the therapist as a clinician. Third, Joe may consider how consistent Peter's views have been over the past three years. If Peter started out disliking or hating the therapist, then Joe would have reason to believe that it may have been something the therapist actually did that caused Peter's feelings to turn around. However in this case, Peter has always liked his therapist and this particular configuration of a high level of consistency, together with a low level of distinctiveness with no available information concerning consensus has led Joe to conclude that his friend's good feelings and positive results probably have more to due with him, as an upbeat person, then with this therapist or even with psychotherapy, in general.

Kelley's model of covariation and configuration is a powerful and critical theoretical model for explaining differences in patients' perceptions of therapists' skills. Let's consider one more general example before applying the model to patients' perceptions of psychotherapists. Allan and David are two new co-workers who seem to like each other and Allan suggests to David that they get together at his house after work. David accompanies Allan to his home later that

evening around dusk and notices that David fails to turn on any of the lights. After a minute or so, David asks Allan if he would turn on some lights. Allan says that he will, but instead of going to the nearest light switch, he nonchalantly leaves the room and exits the house without saying a word. David finds himself sitting alone in the dark feeling very peculiar about being in this strange person's house. Kelley's theories of covariation and configuration can now be applied to speculate about the types of causal attributions David will make about Allan's motivations and intentions. David self-reflects that everyone knows you must flick the light switch in order to turn on the lights: This is an expected behavior with high, if not total, consensus. David doesn't know Allan, therefore he does not possess additional information about whether this failure to turn on the lights is distinctive to his presence or whether Allan is always like this (consistently likes to sit in the dark). Therefore, David concludes that Allan is a strange person, if not rude and selfish and that he has made a mistake in trying to pursue a friendship with him. Just as David makes this causal attribution between motivation and behavior, all the lights in the house simultaneously turn on. Allan returns and makes a casual comment about what a nuisance it is to have to reset the fuse box every time his neighborhood experiences an electrical storm (as they had earlier that day) and apologizes for the inconvenience. Thus, without prior knowledge of this special set of circumstances, David made an erroneous attribution of motivation which he initially viewed as covarying with the person, Allan, as opposed to the situation surrounding the behavior (the electrical storm).

In a similar way, patients' attributions of the therapists' motivations and intentions based on the presence or absence of certain skills can be understood with the application of Kelley's model. For example, psychoanalytically trained therapists are taught not to answer the patient's personal questions directly. It is believed and I would agree, that the indiscriminate answering of personal questions without first knowing what emotional impact the answers could have on the patient, can do more harm than good (e.g, what causal attributions does the patient possess about a therapist who is divorced or single, or a member of one religion as opposed to another?). However, to make the assumption that the patient, especially one who is new to therapy, understands the good intentions of a deflective intervention or a non-response, is equivalent to leaving our friend David sitting alone in the dark. Viewed in this way, it is very clear as to why pre-therapy socialization studies (reviewed earlier in section I) are so effective in reducing dropout rates: These studies provide the potential patient with new information regarding consensus, distinctiveness and consistency that are specific to the circumstance or situational context of psychotherapy as opposed to other types of social interactions.

.....Weiner's model of achievement motivation

Another important theoretical model for explaining differences in patients' motivations for psychotherapy can be found in Weiner's attribution model for causes and predictors of success and failure. Initially, Weiner's model was developed for application in the field of education to explain why some students applied themselves and why

others did not. However, Weiner's model has since been applied to many other fields, including the application to compliance and attendance behaviors in health care treatments, as will be discussed later.

Weiner postulated that explanations regarding success and failure were found to be based on four factors; ability, effort, task difficulty and luck and that these factors varied along three dimensions; stability (over time), internality (whether situation emanates from self or environment) and control (whether person can exercise control over the situation), (Weiner, 1979). Furthermore, Weiner states that as a rule, ability is viewed as a stable, internal and uncontrollable factor; effort is unstable, internal and controllable; whereas task difficulty is external, unstable and uncontrollable and luck is external, unstable and uncontrollable. Table 2-2 summarizes the four factors and their relationships across the three dimensions.

Table 2-2

Weiner's Model of Achievement Motivation

		(The Three Dimensions)		
		Stable?	Internal?	Controllable?
The Four Factors	Ability	Yes	Yes	No
	Effort	No	Yes	Yes
	Task Difficulty	No	No	No
	Luck	No	No	No

Idiosyncratic differences in self-attributions regarding the four factors above can serve as explanations for the persistence of certain emotional disorders. For example, a patient who believes that he has been born with bad luck, necessarily views luck not as a unstable factor, but as a stable factor over time that is also not in his control. This self-perception could serve to perpetuate, if not predispose, an

endogenous depression within a person who might feel that all the therapy in the world will not change his uncontrollable, internal and stable trait of having being born with bad luck. Furthermore, people with a generalized tendency toward an external locus of control (as discussed in section I) would be more likely to attribute successful application of internal traits to the effects of others, e.g., "I do my best work (ability and effort) when I'm around successful people," or "Have you ever noticed how much prettier she looks (effort at appearance, ability to attract) when she's with her husband," etc.

Weiner's four factors involved in attributions of success and failure have direct and corresponding relevance to perceptions regarding health and mental health. In this schema, ability, being internal and stable, can be equated with genetic or metabolic factors as in schizophrenia or major affective disorders. Effort, being unstable and internal, corresponds to personal health behaviors, such as attending psychotherapy sessions. Task difficulty, being unstable, external and uncontrollable, would correspond to such factors as stress from a job or problems with the family. Luck, in this reframing, would represent a fatalistic attribution of mental illness, or related, a religious attribution regarding pre-destination, for example.

A solid attribution model for understanding how patients view their problems and whether or not they would be predisposed to attributing psychotherapy as a viable solution to their perceived problems can be constructed by combining or interweaving Kelley's model (information used to establish cause and effect) with Weiner's model (information used to establish explanations or potential for success or failure). Table 2-3, below, illustrates how the two models

can be combined to develop an attribution mental health model of behavior.

Table 2-3

Attribution Model for Explaining Patient Perceptions of problems and probable course of action*

Kelley (3 aspects of Information)	Kelley (Causal Attributions as to person, stimulus or circumstances)	Weiner (Attributions as to ability, effort, task difficulty or luck)	Patient perceptions and explanations as to causes and viable solutions
High Consensus High Distinctiveness High Consistency	Stimulus	= Task Difficulty (external, stable, uncontrollable)	My spouse is a miserable person, everyone thinks so and he has always made me miserable too. However, I'm only miserable at home with him. He needs therapy, not me.
Low Consensus Low Distinctiveness High Consistency	Person (Self)	= Ability (internal, stable, uncontrollable)	I've always been a miserable person in all types of situations and very few people feel this way in the same situation. I'm too hopeless for therapy.
High Consensus Low Distinctiveness Low Consistency	Situation	= Luck (external, unstable, uncontrollable)	I'm usually O.K. but this is a bad time right now that would bother most people. Maybe some short term therapy to get me through this rough time would be helpful.
Low Consensus High Distinctiveness Low Consistency	Person X Situation	= Effort (internal, unstable, controllable)	I find myself in a situation right now that is depressing me, but I know that most people wouldn't be depressed. I'm usually O.K. but something about who I am in this special situation is very upsetting. Therapy would help me sort this out.

*Adapted and modified from King (1983, p.180)

As can be seen in table 2-3, applicants who view their emotional problems as idiosyncratic (low consensus), in which the troubled time appears to be distinctive to a particular situation (high distinctiveness as in starting graduate school) and in which the individual has usually felt good during the past (low consistency) is most likely to attribute

his problems as emanating from within, and as unstable (not a permanent part of who he is) and controllable. These type of causal attributions would result in a classically ideal psychotherapy patient. In addition and most importantly, this type of person is less likely to attribute negative motivations on the part of the therapist when confused by a therapist's particular behavior, as he is aware, by definition, that something is specifically wrong with his perceptions of his current situation (low consensus). Conversely, an applicant who has always been unhappy with her husband in which she receives high consensus from girlfriends about how he would drive anyone crazy and who generally functions well at work or with her children, is less likely to apply for therapy or continue if she did. In this particular case, she attributes her problems as being caused by external influences that have been stable over time and are uncontrollable (i.e., "I won't leave him while the kids are still young.") However, the model would predict that if this same woman did decide to divorce her husband, once the youngest child left the house and then found herself becoming depressed, she would be far more likely to seek out therapy and to continue with it. In this new scenario her depression would be seen as having low consensus (my girlfriends think I'm crazy for being depressed, good riddance to him they say), with high distinctiveness (the divorce) and low consistency (I didn't feel this bad when I was living with all of his insanity). According to the model then, this woman would be likely to attribute her depression to some form of interaction between who she is as a person and the situation she is currently facing.

This dissertation will seek to explore the ways that perception of cause of problem together with locus of control tendencies interface with perception of therapist skills and feelings about the therapeutic relationship.

Chapter III

Definitions and Hypotheses

This chapter will provide conceptual and operational definitions of the variables to be included in this study. The variables will be organized around the theoretical assumptions as to independent, mediating and dependent function. Finally, the research hypotheses will be generated as to the expected relationships between the study's variables.

Definition of Variables

Table 3-1

List of Variables with Corresponding Conceptual and Operational Definitions

Variable	Conceptual Definition	Operational Definition
	Independent Patient Variables	
Age	Age at time of psychiatric Interview.	Calculated as integer value (date of intake - date of birth)/365.25
Gender	Sexual identity of respondent.	Male or female
Marital Status	Legal Matrimonial status at time of psychiatric intake	Self report as to marital status by respondent from married,divorced, separated, widow(er), or never married.
Social Class (SES)	Social status or position of client.	Hollingshead's 2 Factor Scale of Social Position based on weighted scores for education and occupation.
Education	Amount of formal schooling that has been completed. Used to determine SES.	Junior H.S., Partial H.S., H.S. graduate, Partial College, Standard College Degree, Graduate Degree
Occupation	Reported occupation. Used to determine SES.	Occupational grouping per Hollingshead

Table 3-1 Continued

Variable	Conceptual Definition	Operational Definition
Medicaid Status	Whether patient is recipient of AFDC	Yes or No
Religion	Religious Affiliation of Respondent	Categories include J, C, P, EO and Other
Causal Attributions of presenting problems.	Causal attribution schema based on Kelley's (1972) model.	Values include person (self), stimulus, situation or person-in-situation.
Severity of Presenting Problems	Perceived Stress Caused By Problems	Response to 4-point Likert Scale Item
Diagnostic Fee	Fee that was set by agency for psychiatric intake	Actual Dollar Value
Ongoing Fee	Fee that was set for ongoing therapy sessions	Actual Dollar Value
Recall Intake	Whether or not patients in Grps II & III recall their psychiatric intake	Yes or No
Psychiatric Quality Index (PQI)	Initial feelings about the psychiatrist for those who continued beyond the intake.	Response to 4 Item Likert Scale adapted from Truax
Follow-Up Question to PQI	An open-ended question designed to explore discrepancies in PQI and attendance behaviors	Will be asked of those who liked psychiatrist and discontinued or who disliked psychiatrist and continued
Professional Skills Index	Patient perceptions as to intake doctor/therapist skills.	7 Item 5-point Likert Scale Measure adapted from the Shulman's SWBQ
	Independent Therapist Variables	
Professional's Age	Age of Professional at time of intake or first session	Calculated as integer value (date of intake - date of birth)/365.25
Professional's Sex	Gender Identification	Male or Female
Profession	Professional Discipline	Psychiatry or Social Work

Table 3-1 Continued

Variable	Conceptual Definition	Operational Definition
Professional Experience	Years of professional experience	Years of Experience from time of Intake or First Session from time of Graduation
	Mediating Patient Variables	
Locus of Control of Behavior (LCB)	General Tendency of Respondent to attribute internal or external causes of influence over change	Measured by 8 Item Scale adapted from Craig, et al.
Logistical Problems	Degree to which practical problems interfered with treatment continuance	Six independent items testing for degree of common logistical problems, with a 5 point Likert Scale
Professional Relationship Quality Index	Degree to Which all respondents liked and felt liked by the professional	A 4 Item Scale adapted from Truax, et al. that measures therapist sincerity and warmth
	Dependent Variables	
Number of Sessions Attended	Cumulative No of Sessions Actually Seen including Intake Based on findings that there are between group differences depending on number of sessions attended	Group I Or Immediate Dropout Group = Intake Only Group II Or Rapid Dropout Group = 1 to 12 sessions Group III Or Remainers = 25 or more sessions
Client Satisfaction with overall experience	A multi-faceted concept covering perceived helpfulness, degree of improvement, effectiveness and need fulfillment	The Client Satisfaction Questionnaire-An 8 item scale with several years of use shown to be reliable and valid across cultures and settings

Summary of Variables and Hypothesized Relationships

Table 3-1 is a schematic representation of the variables that will be investigated in this study. On the patient side, the sociodemographic variables to be included are age, sex, marital status, social class (as measured by level of education and occupation) and religion. Related patient variables include diagnostic fee, ongoing fee,

medicaid status, problem causal attribution type, degree of stress at the time of intake and locus of control. Race has been excluded due to an absence of available cases. Therapist variables are comprised of age, sex, years of experience and professional discipline. Treatment variables include perceptions regarding the professionals' skills, the perceived quality of the therapeutic relationship and the perceived quality of the relationship with the psychiatrist for those who continued beyond the initial intake session (groups II and III). Furthermore, an open-ended question will be presented to those subjects in groups II and III who either liked and felt liked by the psychiatrist and abruptly discontinued therapy or who disliked the intake psychiatrist and continued in the process anyway. The study's dependent variables include number of attended sessions with three values including Group I (Intake Only), Group II (Intake + 1 to 12 sessions) or Group III (Intake + 25 or more sessions) and the Client Satisfaction Scale, a multidimensional scale as presented in appendix C. It is hypothesized that perceptions of what the therapist did will directly influence the patients' feelings about the therapeutic relationship. Furthermore, it is hypothesized that the perceived quality of the relationship will mediate other independent patient variables with the number of attended sessions and the Client Satisfaction Score. To the degree the literature is correct in this respect, I would expect to find a positive relationship between locus of control and the perceived quality of the relationship. In addition, those patients whose attribution of positive events include luck or powerful others (to the degree that therapists are perceived in this way) with causal attributions of presenting problems as due to the

effect of others (stimulus), should be less satisfied with the working relationship and the overall treatment experience.

Research Hypotheses

- Age, sex, marital status and religion of the patient should not have any direct relationship on the overall satisfaction with the treatment experience or the number of attended sessions.
- Lower social class (SES) patients are more likely to drop out of treatment than the higher social class patients.
- Higher SES patients are more likely to present with the "person" and "person-in-situation" causal attribution categories of their problems with less perceived stress than lower SES patients.
- Patient's who view their problems as having been caused by "self" or "self-in-situation" are more likely to be satisfied with the therapist and the overall treatment experience than patients who view their problems as having been caused by others ("stimulus") or just "situation."
- Lower SES patients are more likely to manifest external loci of control than higher SES patients.
- External locus of control is more likely to be associated with with poorer working relationships with higher rates of earlier attrition and low levels of patient satisfaction.

- The quality of the working relationship should mediate the effects of the Professional Skills Index on the number of attended sessions and overall patient satisfaction.
- The presence of logistical problems should be negatively associated with the number of attended sessions and the degree of overall satisfaction.
- Different matched combinations between therapist and patient on age and sex will not effect satisfaction with the treatment relationship or number of attended sessions.
- Therapist's of patients who are most satisfied with the relationship are likely to have more experience.
- Therapists successful at engaging lower SES patients are just as likely to engage higher SES patients.
- Therapists successful at engaging higher SES patients are not necessarily just as likely to engage lower SES patients.

Chapter IV

Research Design and Methodology

Introduction

The research design and methodology have been developed to satisfy the following purposes 1) to identify combinations of variables which are related to the probability of both continuance and discontinuance in an outpatient mental health center, 2) to identify patients at higher risk for premature termination of services who could otherwise still benefit from service and 3) to contribute to the empirical knowledge base of the social work profession. This chapter will present the research design, the sampling cite description and sampling process, instrument development, the methods of data collection and analysis that were utilized and limitations to the study.

Research Design

The research is conducted through a post-hoc exploratory survey design with descriptive and explanatory features. The descriptive component consists of a delineation of who terminates outpatient psychotherapy and, specifically, when this occurs in the treatment process. The explanatory component seeks to illuminate why certain patients continue in the process while others will probably not do so. This is achieved by discerning patterns of background variables, their impact on social class expectations and perceptions of therapist skills and their effects on the outcome or dependent variables. It is hoped that the findings that emanate from this study can be used to increase utilization of services for those who are at risk to prematurely terminate such requested services.

The population of interest is adult patients who have been seen at least once in a psychiatric intake and have thereafter terminated treatment at varying selected intervals. The method of data collection is a twenty minute structured telephone interview conducted by this researcher.

Description of Sampling Site

The Pride of Judea Mental Health Center is a private non-sectarian free-standing agency serving all age groups in individual, group, marital, family and parental counseling modalities. Psychotropic medication is available as an adjunct to psychotherapy only, as needed. The primary "school of thought" practiced is psychoanalytically oriented psychotherapy. The agency staffs psychiatrists, third year psychiatric residents, social workers, second year social work students, psychologists, psychology externs and one master's level psychiatric nurse. Psychiatrists are solely responsible for all intakes and medication. In a few isolated incidences, psychiatrists do provide ongoing treatment as well. Social workers are referred to as "therapists" and, for the most part, provide all ongoing treatment. Recently, the agency has begun to use psychologists in a regular treatment role, similar to social workers, in addition to their function as psychometricians. The role of the one psychiatric nurse is undistinguished from that of the social work staff.

Perspective patients can receive an application for treatment either by calling the "intake department" or, far less frequently, by walking into the agency. The complete application consists of a typical single-sided profile sheet asking for identifying information

and presenting problem and a double-sided financial information form. Upon receipt of the application, the applicant is called and an intake appointment with a psychiatrist is scheduled (usually one to three weeks from date of application). All applicants receive at least one psychiatric intake. Typically, a "patient" will be assigned to a therapist one to five weeks from the date of the psychiatric exam. In total, an applicant will usually wait two to six weeks from date of application until beginning work with an ongoing therapist.

Fees are assigned on the basis of a sliding scale contingent on the patient's gross annual income. At the time relevant to this study, fees ranged from a minimum of fifteen dollars to a maximum of seventy dollars when the patient was covered by third party major medical insurance. The minimum fee for the psychiatric intake was thirty-five dollars and the maximum, seventy dollars. The agency accepts medicaid patients who comprised about twenty percent of the active patient population. The average fee for non-medicaid patients was approximately twenty-three dollars. Fees for medication include the full value of the intake fee for the initial forty-five minute appointment and one-half of the regular ongoing fee for twenty minute monthly follow-up appointments.

The majority of patients are seen once weekly in primarily individual psychotherapy (approximately sixty-five percent) while the balance is seen twice weekly in individual therapy plus group, marital, family therapy or parental counseling. The number of active patients receiving medication was approximately twenty percent while from the time span of 1980 to 1985 it had remained below five percent. This is mostly representative of an agency policy change to accept,

even solicit, sicker patients who tend to be recipients of the fifty dollar per session medicaid program in the midst of a leaner fiscal environment.

Appendix E is an exact replica of the agency's database face sheet. All data fields on this sheet have been entered into the Pride of Judea's computerized database as of April 1st, 1988. That is, the computer system contains records on all patients who were still active on April 1st, 1988 and on all patients who subsequently stopped treatment on or after this date. Thus, all demographic variables for this study are already available on a computerized system with the exception of highest degree of education and occupation which are available on the patient's application.

Appendix F is an exact replica of the agency's closed case form. All therapists closing cases must complete this form. Thus, all closed cases and all of the variables indicated in appendix E are available on hard disk for study.

As stated earlier, the Pride of Judea Mental Health Center has agreed to cooperate in my doctoral dissertation efforts. I find myself in a uniquely advantageous position of having been the agency's computer research coordinator and the one who developed and wrote the clinical database in use. The agency chose not to sponsor (subsidize) my time actually spent on the study, so that the 'rights' to the dissertation are solely mine. They will, of course, receive a copy of the completed results.

Selection of Sample

A printout was obtained from the computerized database for all cases that had been entered into the closed case file from approximately December 1st, 1987 through March 31th, 1989. The master printout revealed 533 cases that had been entered during this time and included cases that had been entered retroactively for agency purposes, dating back to cases actually closed from January 1985. Given the format of this study called for recollection of professional skills and behaviors for possibly one attended session, it was felt that all subjects who had attended their first session prior to January 1st, 1987 should be omitted from the available pool of subjects. Next, all computerized closed-case summaries were perused and all patients who were either denied treatment or were ultimately referred elsewhere, regardless of number of sessions actually attended, were deemed necessarily inappropriate for this study. Related, a small group of patients consisted of referrals to the agency from a New York State Psychiatric Hospital Program known as RCCA, whose patients are both homeless and psychiatrically disabled: These patients too were deleted from possible study by conducting a search on the home address field containing the value "Winchester," the hospital's address. Patients who were seventeen years old and younger at the time of the initial intake session were also deleted as this study was designed for adult patients only. Finally, any patient who was known to me personally in any capacity was also deleted from the study. Table 4-1 represents the various search/selection criteria utilized and the breakdown of sample size according to group assignment.

Table 4-1

Selection of 251 Viable Subjects
From Original Pool of 483 (after stratification)

Search Criteria	Immediate (Grp I) Intake Only	Rapid (Grp II) 1-12	Remainers (Grp III) 25 or more
Without Search	155	140	188
-1st <01/01/87	-1	-2	-83
-17 and Younger	-51	-40	-26
-'Winchester'	-6	-4	-3
-Denied Tx	-9	-3	0
-Known to Me	-1	-1	0
Viable Cases	**85**	**90**	**76**

Once the appropriate cases were screened, the available pool of subjects were stratified utilizing Baekeland's criteria (1975) for group by number of attended sessions, controlling for unattended sessions and for those who were seen more than once per week, as illustrated in Table 4-1. Thus, someone who was in twice-weekly therapy for eight weeks and missed two sessions would be calculated as having attended 14 sessions for stratification purposes (8 weeks * 2 - 2 cancelled). Consequently, Study Group I coincides with Baekeland's Rapid Dropout Group and Study Group II collapses Baekeland's Immediate Dropout Group with part of his Slow Dropout Group. Study Group III represents the "continuers" or "remainers" for this study.[1] The final outcome yielded 251 possible cases for a sampling goal of 100 patients. Within each group, a contributing percentage was calculated to determine the target sample size per group, referred to as proportionate sampling (Monette,1986). Table 4-2 illustrates the

[1]The rationale for calculating, for example, four weeks of twice weekly therapy as an equilavent of eight weeks of once weekly therapy, lies in the fact that the dependent variable, on which the study group criteria are based, is "continuation," i.e., attendance behaviors. It is recognized by this author that this approach would be highly suspect if the study groups had been based on a traditional "outcome" measure, e.g., improvement. It should be recalled from chapter two that the method of selection employed by this study has a precedence of use in the prior empirical research.

following calculations of target patients to be interviewed within each group: Group I (85/251 * 100) = 34 subjects, Group II (90/251 * 100) = 36 subjects and Group III (76/251 * 100) = 30 subjects.

Table 4-2

Proportionate Sampling

Group	Number in Group	Percentage of 251	Multiply X Total Goal 100	Target Sample per Group
Immediate (I)	85	x .338	x 100 =	34
Rapid (II)	90	x .358	x 100 =	36
Remainers (III)	76	x .303	x 100 =	30
			Total =	100

Finally, all possible subjects within each study group were randomly assigned a number on the basis of a standardized randomization table. Any subject who refused participation in the study was recorded for later analysis and the next patient on the list was contacted until the target goal for that group had be achieved.

Development of the Instrument

The development of the final research instrument was guided by the goals of this study and was primarily derived from the research literature as discussed in chapter two. All measurements have been adapted, wholly or in part, from pre-existing measurements with precedence of use, with the only exception of the six logistical problem areas which were created by me on the basis of the literature review as a structured alternative to an open-ended question, as will be discussed later. The Dissertation Interview Schedule (appendix C) consists of essentially four sections that seek to explore the critical research variables of this study. Section I consists of all sociodemographic variables including an open-ended question and

follow-up question about presenting problems and perceived causality. A content analysis of the respondent's follow-up answer will be performed for the purpose of coding the causal attribution as to person, stimulus, circumstance or person-in-situation. Finally, perceived degree of stress caused by those problems will be measured on a four point Likert scale. Section II consists of the Professional's Behavior Questionnaire which determines the patient's perceptions of the therapist's skills and behaviors. It is preceded by an open-ended question, for study Groups II & III only, about their recollections of the psychiatric intake, their feelings about that relationship as measured by the Relationship Quality Index and the effect it may have had on their thoughts about continuing treatment or not. The Locus of Control of Behavior Scale is then presented in an attempt to secure a measurement as to the patient's internal versus external locus of control as a general expectancy and how this might mediate perception of skills with the dependent measures. Section III consists of six logistical problem areas and respondents are asked to report the degree to which they experienced each practical problem during the course of their treatment. It was directly drawn from the literature review and consists of six five-point Likert scale responses as to the relative degrees each of the logistical problems was experienced. These six areas include, 1) The Fee 2) Transportation problems, 3) Child-care difficulties, 4) Hassles with family members, 5) Conflicts between new work schedule and ongoing appointment time and 6) Waiting list was too long. Finally, Section IV consists of the Client Satisfaction Questionnaire which is designed to measure an

overall sense of the patient's general satisfaction with their experiences at the agency.

The scales adapted from pre-existing measurements include the Professional's Behavior Questionnaire (The Social Work Behavior Questionnaire, Shulman, 1978), The Relationship Quality Index (adapted from Truax, 1971), The Locus of Control of Behavior Questionnaire (Craig, 1984) and the Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves and Nguyen, 1979) which is an established, if not standardized, multi-dimensional measurement of general client satisfaction across settings and cultures (Larsen, 1979). The original and actual wording of each Likert Scale response, for each pre-established measurement, has been retained accounting for the different response items within the same interview schedule.

Data Collection

Patients selected for study were contacted in "waves" of thirty at a time, ten per study group, with an introduction/consent information letter from the researcher and an attached letter of endorsement from the agency's executive medical director (appendices A and B respectively). Approximately five to seven days later, the subjects were called during the evening hours and were asked if they had received the information explaining the research study and if they would like to participate. Those who declined participation were thanked for their time, the code of the declining subject was noted for future analysis and the next subject was called. Those who agreed were asked to make an appointment for a twenty minute time period that would be convenient for them, if the present time was not.

Subjects were asked if they had any preliminary questions or concerns and the interview was read verbatim from the Dissertation Interview Schedule (appendix C) while responses were directly recorded on the Interview Schedule Score Sheet (appendix D). Upon completion of the interview, subjects were thanked for their time and were asked if they had any questions about the study.

Data Analysis

Computer analysis was performed on the statistical software program Statview 512+ for the Macintosh Plus computer. Descriptive statistics include frequency distributions and mean, mode and median for sociodemographic characteristics of the study groups. Comparative statistics include crosstabulation tables and analysis of variance when the intent was to examine "between-group" differences on various categorical levels of the dependent variables; Pearson's r correlation coefficients and multiple regression tables were used when the intent was to illustrate the combinations of variables that best explain the variance in the dependent variables.

Results of Pilot Study

A pilot study was conducted with four subjects who closely resembled the population to be studied. A computer printout of all cases that had closed from April 1st, 1989 to June 30th, 1989 was obtained and the same selection criteria were applied. Two subjects were selected from study group I, and one each from study groups II and III. The primary purpose of the pilot study was to determine any difficulties that may exist with the administration of the research instrument and the appearance of variability of responses across

groups. The research instrument used was identical to the present version with the exception of the Locus of Control of Behavior scale which was originally seventeen items long.

The same procedure was followed for initially contacting perspective subjects. Subjects were then contacted by phone and all four were eager to participate in the study. The expressed feeling was one of being able to "be heard" and to contribute to "something important," regardless of overall satisfaction with the services.

In general, all subjects understood the questions and found the format easy to follow with the exception of the Locus of Control of Behavior scale which two out of four subjects complained was to too long and repetitious. This appeared to be related to lower SES subjects. These subjects felt the repetition was intentionally designed to "check them out for lying." With this one exception, all subjects felt the interview was "enjoyable and interesting" and there appeared to be significant variation of responses between groups. One unexpected phenomenon was the extended interest on the part of the subjects after the formal interview had been completed. Three out of four participants were eager to ask questions about the study and to expound on their previous answers without solicitation. The formal structured interview itself required an average of twenty minutes to administer with the range falling between sixteen and twenty-three minutes. The additional discussion after the end of the formal interview brought most interviews to a total of thirty minutes in duration.

Given the results of the pilot study, it was felt that the Locus of Control of Behavior scale should be shortened for the telephone

interview. The original scale was reported by the developer with a factor analysis chart which made this goal easier and less arbitrary. Seven items were selected on the basis of those that loaded in on factor one with the highest correlational coefficients. These seven items, plus factor one, resulted in an abridged eight item version of this scale as listed in appendix C.

Major Limitations of Study

.....External Validity

The issue of generalizability perhaps represents the greatest limitation of this study as is usually the case when a study is conducted by one researcher under restraint of resources, particularly time and money. In the most limited and technical sense, the findings will pertain to those psychotherapy outpatients of the Pride of Judea Mental Health Center who were first seen no earlier than January 1st, 1987 through March 31st, 1989 who also terminated treatment during this time. To the degree that screening procedures and treatment modalities and approaches have remained relatively stable over several years, the findings may truly be representative of the typical patient at the Pride of Judea. However, to the extent that the exclusive use of psychiatrists for intakes or first sessions may be idiosyncratic to the Pride, the generalizability of these findings to other patients of private free-standing mental health centers is questionable. This assumes, of course, that there are fundamental differences between psychiatrists and social workers in how this role of "intake person" is performed and, more importantly, perceived by patients. However, it should be recalled that the research literature

has generally failed to substantiate any perceived differences on the part of patients due to professional degree and training. Finally, due to the absence of a sufficient number of cases, the variable of race could not be studied. This would also raise the question of a sample that may be more homogeneous than one would typically find at an "average" outpatient mental health center. Thus, the question of generalizability to patient populations of other mental health centers, particularly those in neighboring facilities, remains open.

.....Internal Validity

The emphasis of design on a structured interview was intended to avoid the major limitations of the open-ended interview where differences in how specific research questions are presented can raise serious questions about internal validity and reliability of the instrument and the results. On the other hand, the absence of open-ended questions renders sterile results that are more descriptive than exploratory. Subsequently, the research instrument was designed to, at least, pass the test of construct validity by relying on pre-existing scales for measurement of variables. Open-ended questions have been limited to the capacity of following-up quantitative results in order to provide some depth of analysis.

.....Reliability

Threats to reliability can generally emerge from three major areas; the instruments themselves, the method of data collection and related, systematic error.

As stated earlier, the instruments used in this study have a precedented history of research use and all have been used in several

different settings and, in the case of the Client Satisfaction Questionnaire, in different cultures. All instruments have been reported in the literature with inter-item reliability coefficients that have met the statistical convention of .80. Therefore, there is no inherent reason to believe that these instruments would pose any threat to this study's reliability. To maintain the integrity of the instruments, the original likert scale responses were unaltered. In addition, original wording was retained wherever possible with the exception of substituting the word "therapist" or "doctor" for "worker".

The greatest threat to this study's reliability emanates from the specific research method itself, namely, post-hoc telephone-survey research. The major limitation involves the total reliance on voice-to-voice communications to the degree that the possibility of being able to "read" respondents from their facial expressions and "body-language" is eliminated. Consequently, the task of detecting untruthful or even conflictual responses becomes mitigated. In addition, some of the subjects in this study could potentially be responding to events that occured over a year and a half from the time of the interview, raising the issue of the reliability of their recall. However, it should be noted that the interviewer is an experienced clinical social worker and is therefore, in a manner of speaking, a professional interviewer who is extremely familiar with the content and substance of the interview. In addition, the no-risk component to this study mitigates the possibility of deliberate deception. That is, any potential respondent who is significantly uncomfortable about participating can simply decline involvement. However, the possibility of "demand

bias," or the phenomenon of subjects attempting to answer the questions on the basis of social desirability cannot be ruled out.

The problem of recollecting events that occured several months ago is lessened by the fact that this study is addressing a fairly significant event that typically generates a great deal of affect and therefore, has a greater probability of being remembered accurately. However, the consideration that peoples' initial negative reactions are often tempered by the passage of time raises the issue of systematic error due to an "under-reporting" of negative events. This, as well as some of the issues just discussed, will have to be considered during analysis of the data.

The final threat to the study's reliability emanates from systematic error due to interviewer bias and "counter-transferential" reactions to material that serve to skew the findings. Again, this issue will have to evaluated when the data are analysized, particularly in the presence of highly surprising or contradictory results.

Chapter V

Findings

Patient Sociodemographic and Related Variables

Overview: Rationale of Presentation

The study's findings will be organized across six chapters for clarity of presentation and ease of reading. Chapter five will be comprised of a description of the patients' sociodemographic and related variables through the use of frequency distribution tables and, where appropriate, means and standard deviations. A summary discussion of those patients who refused participation in the study will be included at the end of this chapter.

Chapter six will examine the univariate or one-factor relationships of the sociodemographic and related variables on the dependent variables of continuance and degree of overall satisfaction through chi-square or analysis of variance tables, depending on the type of data being discussed.

Chapter seven will include an integrative analysis and discussion of the inter-relationships and contributing strengths or effects of the patient variables in various combinations on continuance and satisfaction through the use of multiple regression analysis. All research hypotheses pertaining to the patient variables will be summarized at the end of this chapter.

Chapter eight will examine the professionals in the study along with the treatment variables. Having already introduced the dependent variables in chapters five and six, the univariate associations of the professional and treatment variables to

continuance and satisfaction will be integrated in context, for depth of discussion.

Chapter nine will explore the inter-relationships of the treatment variables as well as a multivariate analysis of the contributing strengths of those variables in various combinations on continuance and satisfaction.

Chapter ten will be comprised of an integrative multivariate analysis of the contributing effects of the most significant patient and treatment variables (as determined in chapters seven and nine, respectively) in combination on the study's dependent variables of continuance and satisfaction. The relationship between the study's two dependent variables will then be discussed on the basis of the previous findings and a conceptual model for discussing the implications will be posited. The remaining research hypotheses pertaining to the interaction of both patient and treatment variables will be summarized at the end of this chapter.

Chapter eleven will be comprised of a summary discussion of the study's major findings followed by the implications of these findings for added knowledge, social work practice and education and recommendations for future research.

Section I

Description of Patients in Study

Introduction

A total of one hundred and ten contact letters were mailed in order to secure a sufficient number of available subjects for the study, due to the following. Six letters were eventually returned by

the post-office as "unforwardable": The respondents had moved without filing their new addresses. Four of these potential subjects would have been assigned to group I (intake only) and the remaining two would have been assigned to group II (rapid dropouts; one to twelve sessions). In addition, all six potential subjects had received their psychiatric intakes within four months of the contact period which suggested that transiency played at least some role in discontinuance for these people.[1] Of the remaining one hundred and four people who were successfully contacted by mail and were eventually called, a total of four people refused participation in the study. All four potential subjects would have been assigned to group I (intake only) and an analysis of their characteristics concludes this chapter.

.....The Sociodemographic Variables

The patients in this sample will be described in terms of age, gender, marital status, religion, education, occupation and social class as a weighted index of education and occupation.

-Age-

The subjects ranged in age from eighteen years (minimum age for inclusion in this study) to eighty-three years old. The average age was approximately thirty-nine and the largest proportion of subjects or thirty-two percent, were between the ages of twenty-

[1]Upon further review of the closed case records, it was observed that not one of the subjects had indicated to the intake psychiatrist any plans to relocate. Thus, the possibility that these six subjects deliberately applied for short-term therapy around the psychosocial stressors of the impending move is nil.

were between eighteen and thirty-nine years old, inclusive, while only eleven percent were sixty-one years of age or older. Thus, this sample is generally comprised of "late-young-adults", as opposed to middle-aged and older-aged patients. Although the sample would appear to be skewed in the direction of patients under the age of fifty, age has been evaluated as a weak predictor, at best, of continuance (Garfield, p. 198). Table 5-1 contains the frequency distributions of age for the patient sample.

Table 5-1

Frequency Distributions of Age

Range	Count, (%)
18-28	27
29-39	32
40-50	18
51-61	12
62-72	6
73-83	5
Total:	100

-Gender-

The clear majority of the patients were female (sixty-seven percent) while males constituted approximately one-third or thirty-three percent of the total sample. This percentage of female to male patients (2:1) is somewhat lower than the national average of typically three women to every one man as psychotherapy outpatients (Garfield, p.763). The higher proportion of men to women, in this sample, could be accounted for by regional differences in the acceptability of psychotherapy, i.e., New York, Nassau-Queens counties as opposed to national averages. In addition, this sample does not control for the gender of the initial applicant. A woman who applied on behalf of herself and her

husband (marital therapy, for example) in which the husband was seen once in intake and terminated while his wife continued, would not be counted in the general averages (as a patient) but is included in this analysis.

-Marital Status-

Marital status was recorded along the values of never married, married, divorced, separated and widowed. Sixty-six percent of the patients were without partners in one way or another while thirty-four percent of the patients were married, at the time of the initial intake. The literature has not specified any relationship between marital status and continuance in psychotherapy and the lower incidence of widowed patients is consistent with the mean age of this sample, i.e., "late-young" and "early-middle-aged" adults. Table 5-2 provides the frequency distributions for the category of marital status.

Table 5-2

Frequency Distributions of Marital Status

Value	Count, (%)
Never Married	25
Married	34
Divorced	33
Separated	4
Widowed	4
Total:	100

-Religion-

The category of religion was recorded along the values of Jewish, Catholic, Protestant, Eastern Orthodox and Other. Almost half of the sample population is Jewish and another thirty-eight percent is comprised of Catholic patients, accounting for eighty-five

percent of the total sample. Protestant, Eastern Orthodox and Other religions constituted the remaining fifteen percent of the sample. The "other" religion value was comprised entirely of Moslem patients. Table 5-3 summarizes the frequency distributions of religion across the sample.

Table 5-3

Frequency Distributions of Religion

Value	Count, (%)
Jewish	47
Catholic	38
Protestant	10
Eastern Orthodox	1
Other (Moslem)	4
Total:	100

The distribution of religious affiliation for this sample does bear resemblance to the sociodemographic distributions for the communities that surround the Pride of Judea Mental Health Center, e.g., Great Neck, Bayside, Little Neck and Flushing. Nevertheless, Jewish patients would seem to be over-represented in this sample. An explanation for this seems to exist with the agency's historical mission and the surrounding community perception of the agency, particularly given its name. The Pride of Judea was originally an orphanage, in the early 1900's, for orphaned children of Jewish immigrants. Many of the agency's sponsoring members and board members are either grown former residents of the orphanage or relatives of former residents and hence, there has been an understandably long-standing emotional need to preserve the cultural and historic ties of the agency despite its current mission as a non-sectarian mental health center. However; religion, in and of itself, was not found to be associated

with attendance behaviors in outpatient psychotherapy. Thus, the skewed direction of the sample regarding religion would not necessarily alter the interpretation of the remaining findings.

-Education-

Education was measured across seven different levels for the eventual purpose of coding subjects on Hollingshead's Two Factor Index of Social Position (1957, p.9): graduate professional degree, standard college/university degree, partial college (less than four years but at least one year of college), high school or GED, partial high school (less than high school diploma but at least tenth grade), junior high school (completion of grades seven through nine) and less than seven years of school. There were no subjects in the study with either a graduate professional degree or with less than a tenth grade education. Fifty percent of the patients in this study have either a completed college degree or some formal college education. Forty-three percent of the sample are high school graduates while only seven percent have less than a high school diploma. In fact, these numbers under-represent the potential level of education for this sample as several of the patients (thirteen percent) were registered as either part-time or full time, albeit older, college students who could only be coded for the amount of education they had actually completed at the time of intake. In addition, the majority of the subjects with less than a high school diploma (five out of seven) were currently enrolled in a continuing education program working towards their GED diplomas, at the time of intake. Thus, the actual frequency distributions for

education as well as the subsequent social class values, do not accurately reflect the fact that this is a fairly homogeneous population from the vantage point of valuing and seeking continuing education. This is perhaps an artifact of the sampling criteria that eliminated patients on the basis of their having been denied treatment due to grave mental illness, i.e., healthier patients would tend to be better educated or, at least, have the emotional potential to seek more education. However; it may be recalled that education was found to be a significant predictor of treatment continuance only when it was below the ninth grade level (Garfield, p.198). Table 5-4 summarizes the frequency distributions for level of education.

Table 5-4

Frequency Distributions of Education

Value	Count, (%)
Graduate Prof. (1)	0
BA/BS degree (2)	24
Some College (3)	26
H.S./GED (4)	43
≥ 10th < H.S. (5)	7
≥ 7th ≤ 9th grds (6)	0
≤ 6th grade (7)	0
Total:	100

-Occupation-

The category of occupation was measured across seven broad levels as specified by Hollingshead's Two Factor Index of Social Position (1957, p.3). These categories include: 1) Higher Executives, Proprietors of Large Concerns and Major Professionals (e.g., bank presidents, brokers, physicians, university-level teachers), 2) Business Managers, Proprietors of Medium Sized Businesses (<$100,000) and Lesser Professionals (e.g., branch

managers, furniture business, chiropractors, social workers, primary-secondary level teachers), 3) Administrative Personnel, Small Independent Businesses and Minor Professionals (e.g., chief clerks, bakery owner, photographers), 4) Clerical and Sales Workers, Technicians and Owners of Small Businesses (<$6,000), (e.g., bookkeepers, timekeepers, flower shop owners), 5) Skilled Manual Employees (e.g., auto body workers, chefs, licensed barbers), 6) Machine Operators and Semi-Skilled Employees (e.g., high-service waitress, gas station attendant, taxi drivers) and 7) Unskilled Employees and Unemployed (e.g., parking lot attendants, "hash-house" waitress, garbage collector, public assistance recipients, students, "housewife").

Twenty percent of the study's sample reported occupations that included medical and small business secretarial work, department store sales and bookkeeping and were coded on level four above. Another thirty percent reported occupations that included insurance agents, sales representatives and service managers and were coded on level three above. Thus, one-half of the patients reported occupations that roughly coincided with "middle" and "lower-middle" class social statuses. Another twenty-five percent of the sample population reported occupations that would be classified as skilled or semi-skilled employment. Twenty-one percent of the patients reported current social statuses of homemaker, unemployed or full time student and were coded on level seven above while four percent reported either ownership of medium-sized businesses or business management that met the criteria for level two above. Further analysis and discussion of these

findings will be integrated with discussion of social class, below. Table 5-5 summarizes the frequency distributions for occupational status levels.

Table 5-5

Frequency Distributions of Occupation

Value	Count, (%)
Higher Executives (1)	0
Branch Managers (2)	4
Administrative (3)	30
Clerical (4)	20
Skilled Labor (5)	20
Semi-Skilled Labor (6)	5
AFDC-Student (7)	21
Total:	100

-Social Class-

The variable of social class for this study was obtained as a calculated value from the data reported for both educational and occupational levels. Each social class score was obtained by multiplying the individual score for education by a factor of four and the individual score for occupation by a factor of seven and comparing the summed value to a frequency distribution chart for social class position (see appendix G). For example, social class position for a medical secretary with a high school diploma would be calculated in the following way: High school graduates receive an educational score of four and, four times the factor weight of four is equal to sixteen. The occupation of "medical secretary" is classified under level four; clerical and sales workers, etc. Four times the factor weight of seven is equal to twenty-eight. Sixteen (weighted value for education) plus twenty-eight (weighted value for occupation) is equal to forty-four and comparing this value with the social class frequency distribution chart in appendix G yields a

social class position of IV. Thus, the social class position of a medical secretary with a high school diploma would be class IV which is roughly equivalent to a lower-middle class value. Similarly, a full time college student (level seven for occupation) who was currently in the sophomore year (level three for education) would have a combined social class position of sixty-one, classified as social class V; the poor and working poor. Calculated in this way, the vast majority or seventy-five percent of the patient population had social class values that would be equivalent to the middle-class or the lower-middle class (classes III and IV, respectively). Twenty percent of the patients in this sample had class V or poor and working-poor class statuses while only five percent fell within the frequency distributions for class II (upper-middle class). No respondents were categorized as upper-class (I) patients. Table 5-6 summarizes the frequency distributions for social class standings.

Table 5-6

Frequency Distributions of Social Class

Value	Count, (%)
Upper Class; I	0
Upper-Middle; II	5
Middle Class; III	42
Lower-Middle; IV	33
Poor Class; V	20
Total:	100

It can be observed from table 5-6 above that this study's sample is heavily skewed in the direction of a middle-class patient population. As eluded to earlier during the discussion of educational values, the frequency distribution of twenty percent for class V respondents, is misleading when you consider that more

than half of this group (thirteen percent of total population) were registered as either part-time or full time college students. According to Hollingshead, "The educational scale is premised upon the assumption that men and women who possess similar educations will tend to have similar tastes and similar attitudes and they will also tend to exhibit similar behavior patterns," (1957, p.9). It would seem that the calculated differences in social class are falsely suggesting differences that may not actually exist in reality. That is, it would appear from the educational part of the scores (which become suppressed given a smaller factor weight of four as opposed to seven for occupation) that what the differences in social class are suggesting are a group of relatively homogeneous patients who are at different developmental stages along a very similar continuum (middle class values). If this "developmental stage" interpretation is correct, then I would not expect to find powerful between-group differences (on the basis of number of attended sessions) on the variable of social class. That is, between-group differences on client satisfaction, feelings about the psychiatrist and the therapist, would not be strongly associated with this study's variable of social class, if "social class" is, in part, a measure of the developmental stage currently occupied by the respondent. Further support for this interpretation exists in the fact that this population's age distribution is skewed toward the young-adult and "late-young-adult" age groups, suggesting that respondents have not yet reached "occupational maturity." One would have greater confidence that this study's differences between social class positions were actually associated with different sets of beliefs and

attitudes if the age distribution of the sample was more evenly distributed across all age-groups. The between-group comparative analysis that follows this descriptive section will be able to test the validity of this interpretation.

Related to social class is the variable of medicaid status. This variable was collected as a corollary to the information for diagnostic and ongoing fees, i.e., medicaid recipients reported an "out-of-pocket" fee of "nothing" or zero for these values. The variable is being reported here as opposed to the next section on "related patient variables," as it is highly correlated with Hollingshead's values for social class, i.e., a medicaid recipient with a professional graduate degree or a four year college degree would be categorized under social class IV status as opposed to social class V, but this would not represent the norm. Seventeen percent of the patients studied reported being enrolled in the medicaid program as recipients of AFDC (Aid to Families with Dependent Children). These seventeen medicaid recipients almost fully comprised the social class V category (seventeen out of twenty). Of these seventeen patients, ten were enrolled in college; three on a full time basis. In addition, five out of the remaining seven were involved with an adult continuing education program, working towards completion of their high school equivalency diplomas. Fifty percent of the mothers attending college were doing so prior to applying for and receiving AFDC and, in all but two cases, the women became recipients of medicaid as a consequence of divorce, i.e., they were not able to receive or enforce child-support payments. Thus, the vast majority of respondents in the social class

V category clearly viewed their poor or lower-class status as a temporary or transitional status. I believe this, again, speaks to the relative homogeneaty of the study's patient population.

.....Related Patient Variables

This sub-section includes a descriptive analysis and discussion of diagnostic and treatment fees, related medicaid status, patients' causal attributions about their presenting problems and the degree of perceived stress due to these problems.

-Diagnostic Fee-

The fees charged for the diagnostic intake[2] and the ongoing therapy sessions were collected to determine if fee-setting was associated with treatment discontinuance. The out-of-pocket fees for the diagnostic intake ranged from zero dollars (for medicaid recipients) to seventy-five dollars. The percentage of patients paying zero dollars for the intake session also represents the total number of patients receiving medicaid (N = 17). The average diagnostic fee was approximately thirty-seven dollars and fifty-eight percent of the patients paid between fifteen and fifty-nine dollars, inclusive, for that initial intake. Another twenty-five percent of the population paid an initial diagnostic fee of sixty dollars or more. Table 5-7 summarizes the frequency distribution across diagnostic fee intervals.

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[2]The diagnostic fee is a special fee for the intake with the psychiatrist that may or may not be the same as the eventual ongoing fee.

Table 5-7

Frequency Distributions of Diagnostic Fee

Range $	Count, (%)
0-14	17
15-29	15
30-44	27
45-59	16
60-74	24
75-90	1
Total:	100

-Ongoing Fee-

The average out-of-pocket fee for the ongoing therapy sessions (for study groups II and III only) was just slightly less than the fee for the intake sessions at thirty-four dollars with a range of zero to seventy dollars. The small decrease in dollar amounts from the intake fee to the ongoing fee reflects the agency's tendency to set somewhat higher fees for the more costly psychiatric time (as opposed to ongoing therapy with the social worker). Approximately sixty-seven percent of the patients in study groups II and III (N = 66) paid ongoing fees between fifteen and fifty-nine dollars, inclusive. Comparative analyses as to between-group differences for diagnostic and ongoing fees will be offered in section II. Table 5-8 summarizes the frequency distributions for the ongoing fees.

Table 5-8

Frequency Distributions of Ongoing Fee
Groups II & III: N= 66

Range $	Count	%
0-14	9	14
15-29	20	30
30-44	14	21
45-59	10	15
60-74	13	20
Total:	66	100

-Problem Causal Attributions-

In order to determine the patients' causal attributions about their presenting problems, all patients in the study were asked the following open-ended question: "Can you tell me something about what brought you to the Pride of Judea, what kinds of difficulties you were having at that time?" Some of the respondents were asked a follow-up question, if it was felt that a clear causal attribution could not be determined from the initial response: "As you think back on it now, what was your understanding of what was causing you to have these problems?" All responses were recorded and a content analysis was performed to determine causal attributions as to 1. Person (Self), 2. Stimulus (Environment, Someone else), 3. Situation (Circumstances) or 4. Person-in-Situation (some interaction between who the respondent is and the current set of circumstances), as detailed in chapter two (pages 27-35). The following are illustrative examples of the types of responses and how they were coded for analysis.

Table 5-9

Content Analysis of Patient Responses as to Causal Attributions

a. "Can you tell me something about what brought you to the Pride of Judea, what kinds of difficulties you were having at that time?"

b. "As you think back on it now, what was your understanding of what was causing you to have these problems?"

Response	Coding
"I guess I was depressed. What caused it; well, I didn't know exactly, that's why I went into therapy--to find out."	Person

Table 5-9 continued

Response	Coding
"It was really quite stupid and a waste of time. My wife said we could go into therapy or we would get separated--So, I felt at the time that I had nothing to lose."	Stimulus
"I wanted help in dealing with my daughter. She became a different person once she reached 13. Between her boyfriends and problems at school, it was breaking up the family."	Situation
"I became very depressed, for the first time, when I was passed-over (for the new position). After 8 years in the same job, I realized I had stayed in a place that didn't care about me or my work." I guess the job had become like a bad family for me or something like that.	Person-in-Situation

In the interest of reliability, a second coding was conducted by another clinical social worker with eight years experience, who was given a separate copy of the responses along with coding definitions. In all but six cases, there was agreement as to type of coding. The discrepancy existed entirely between "Person" as opposed to "Person-in-Situation" codings, indicating that judgements as to "Situation" and "Stimulus" were fairly straightforward.[3] The six cases in dispute were discussed and consensus, as to coding type, was eventually reached. For sake of clarity, patient causal attributions that included a "self-diagnosis," e.g., depressed, anxious, moody, etc. without a specific reference to

[3]The social worker who conducted the second coding was my very talented wife, Nicole Mavrides. A second interpretation regarding the high percentage of inter-rater agreement, lies within thirteen years of marriage and a possible consensus, in general, as to how cases are perceived and assessed.

stimulus (other) or situation, were coded as a "self" causal attribution type.

On the basis of this content analysis, thirty-two percent of the respondents felt that some stimulus or environmental factor was the "cause" of their problems and was responsible for their application for therapy. Another thirty-one percent, felt that some transient situation (typically a developmental phase of life) was the cause of the presenting problem and that they would not have applied for help had it not been for this situation. Nineteen percent of the respondents felt that they were depressed, anxious or angry and that this was not attributable to anything specific in their lives while the remaining eighteen percent of the patients felt their problems were the effect of their own inability to handle a situation that "normal" people would be expected to deal with; the person-in-situation category. Table 5-10 summarizes the frequency distributions of causal attributions of presenting problems.

Table 5-10

Frequency Distributions of Causal Attributions of Presenting Problems

Value	Count, (%)
Person	19
Stimulus	32
Situation	31
P-in-Situation	18
Total:	100

When you consider the primary function of the agency in the study, psychodynamically oriented psychotherapy, the frequency distributions of the causal attributions as to presenting problems are not surprising. The literature has discussed a clear relationship between presenting problem type and psychotherapy attrition

(Acosta, et. al., 1982; Lorion,1973). Problem types associated with environmental problems or transitory situations in which the patient does not view him/herself as personally responsible for the current problem set, seem to lend themselves to role-set conflicts and discrepancies between therapist-patient expectations for the type of help that can be offered (Rosenbiatt,1962; Garfield, 1978, p. 202). Thus, it is not surprising that sixty-three percent of the patients in this study's sample presented with either "stimulus" or "situation" type causations of presenting problems. Furthermore, I should expect to find between-group differences between length of stay and problem causation, in section II.

-Degree of Stress-

Finally, respondents were asked to report the degree of stress that was caused by the presenting problems at the time of application. The majority of the patients or fifty-three percent, reported experiencing "some stress" as a result of their presenting problems. No one in the sample reported the absence of stress at the time of application. Twenty-three percent, of the patients reported feeling a "little stress" at the time of intake, while the remaining twenty-four percent reported experiencing a "great deal of stress," as a result of the presenting problems. Although psychological factors associated with motivation were beyond the scope of this dissertation, it would seem that degree of stress is associated with motivation for treatment and that degree of stress would be associated with psychotherapy attrition. Viewed in this way, it is not surprising that twenty-three percent of the patients,

in this sample, reported experiencing a minimal degree of stress at the time of intake. Table 5-11 summarizes the frequency distributions of the reported degree of stress at the time of intake.

Table 5-11

Frequency Distributions of
Perceived Degree of Stress at time of Intake

Value	Count, (%)
No Stress	0
Little Stress	23
Some Stress	53
Great Deal of Stress	24
Total:	100

-Locus of Control Of Behavior-

The locus of control of behavior scale, is an eight item likert-scale type instrument, that was administered to all one-hundred subjects. The purpose of this instrument was to eventually determine to what degree an internal or external general psychological expectancy was associated with social class, the perceived quality of the working relationship, attrition and overall satisfaction with the experience.

A correlation table was generated in order to determine the relationship of each item to the total summed index value. Each item was correlated to summed index by at least a coefficient of .801, suggesting that the summed value is a statistically sound index of the "activity" on each of the eight items. The eight items will not be repeated in text as the summed index is the critical factor for discussion (the locus of control of behavior instrument can be found in appendix C).

The values from the locus of control of behavior index (the LCB) ranged from eight to forty-six, where the lower values represented an internal locus of control (i.e., where the patient feels responsible for changes in one's life) and the higher values, an external locus of control (i.e., where the patient feels powerful others or luck are responsible for changes in one's life). For ease of discussion, the LCB index values were recoded across three nominal levels, so that the lower values would be representative of an internal locus of control, the higher values indicative of an external locus of control and, the middle-range values representative of a general expectancy that was neither internal or external.[4] Viewed in this way, forty-five percent of the study's sample have general expectancies that can be categorized as internal. Twenty-seven percent of patients possess an external locus of control, while the remaining twenty-eight percent responded in a way that suggests neither an internal nor an external locus of control. These findings were not surprising given the modal distribution of middle-class respondents in this study and the empirical relationship between higher social classes and internal loci of control (Garfield, 1978, p 223). Table 5-12 summarizes the frequency distributions for the locus of control of behavior values.

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[4]The procedure that was employed for recoding interval data is as follows: The observed range was distributed across intervals of equal width based on the number of points used to measure the data on the likert scale. In the case of the LCB scale, the six point-likert scale was further collapsed to three levels given the relatively small N of 100.

Table 5-12

Frequency Distributions of Locus of Control of Behavior

Value	Count, (%)
Internal	45
Neither	28
External	27
Total:	100

Section II

Patients Who Refused Participation in Study

The four respondents who refused participation in the study were examined across the relevant variables that were available from the clinical database. These variables included age, gender, marital status, religion, diagnostic fee, medicaid status and the age, sex and experience level of the intake psychiatrist. As occupation and level of education were not available, SES could not be obtained as well as information regarding problem cause and degree of stress at time of application. The Mann-Whitney U test was employed to determine if the four "refusals" differed significantly from their counterparts in Group I (the group the four patients would have been assigned to if they had agreed to participate). A critical value of U was obtained for N1 = 4 and N2 = 34 (number of respondents in group I) at the .05 level of probability for a two-tailed test, i.e., the hypothesis that the two groups did not differ on the observed variables. At a critical value of Ucr =16, no significant differences were found to exist on any of the available variables, i.e., in every case the observed values far exceeded the critical value. It is reasonable to conclude that the present patient sample is not "biased" by virtue of certain "types" of people agreeing to participate

over others. Appendix H summarizes the available descriptive statistics for the four patients who refused participation in this study.

Synopsis of Findings: Chapter V

The implications of the patient findings on the sociodemographic and related variables have already been discussed in context: For sake of clarity, the major findings will be re-stated here.

The patients ranged in age from eighteen to eighty-three years old, at an average age of about thirty-nine, where the largest proportion of patients or thirty-two percent were between the ages of twenty-nine and thirty-nine.

Sixty-seven percent of the patients were women which was found to be somewhat higher than the national ratio for outpatient psychotherapy patients at about three women to every man. The observed differences were attributed to regional differences in attitudes about psychotherapy and the fact that this study, by definition, included men who were no longer active patients.

The frequency distributions on marital status were essentially bi-modal at thirty-four percent married and thirty-three percent divorced.

The religious breakdown was represented by Jewish patients at forty-seven percent where Catholic and Protestant respondents accounted for an additional forty-eight percent of the sample studied. The higher percentage of Jewish patients was primarily

attributed to the surrounding communities' perceptions of the Pride of Judea as a sectarian agency.

Forty-two percent of the people studied would be categorized as "middle-class" where forty-three percent have completed high school and are working in, what would be categorized as, "white-collar" administrative occupations.

Related, seventeen patients were receiving AFDC during the period studied. The average diagnostic and ongoing fees paid were approximately thirty-seven and thirty-four dollars, respectively.

The frequency distributions for problem causal attribution type was essentially bi-modal at thirty-two percent for "stimulus" and another thirty-one percent for "situation." Thus the majority of patients attributed the causes of their problems to either someone else or to a transitory period or crisis in their lives.

Fifty-three percent of the people interviewed indicated that they had experienced "some stress" as a result of their problems.

Forty-five percent of the respondents answered the locus of control of behavior questionnaire in such a way as to suggest they viewed themselves as the principal agents responsible for changes in their lives, i.e., internal locus of control.

Finally, the four potential subjects who refused participation in the study were examined for any differences between them and the study group they would have been assigned to. The findings indicated that there were no significant differences on the sociodemographic, related or therapist variables that were available for comparison. This suggested an absence of sample bias across the variables studied.

Next, chapter six will explore the univariate effects of the sociodemographic and related variables on continuance and satisfaction.

Chapter VI

Findings:

One-Factor Effects of the Patient Variables

Introduction

This chapter will seek to explore the univariate effects of the patients' sociodemographic and related variables on continuance and satisfaction. For ease of discussion, the statistical associations to the dependent variable of continuance will be presented first, followed by a discussion of the findings for satisfaction.

.....Association of Sociodemographic and Related Variables to Continuance

The sociodemographic and related variables, just discussed, were examined across the study's group selection criterion of number of attended sessions where group I, the Immediate dropout group, represents one intake session only; group II, the Rapid dropout dropout group, represents one through twelve sessions and group three, the Remainers, represent twenty-five or more attended sessions. On that basis, there were no between-group differences found on age, gender, marital status, religion, education, occupation or social class. Restated, there are no univariate relationships between the sociodemographic variables and length of stay at the agency for the patients in this study. The related patient variables were also examined for between-group differences: These variables included diagnostic fee, ongoing fee, medicaid status, problem causal attributions, perceived stress at time of intake and locus of control. There were no between-group

differences on diagnostic fee, ongoing fee and medicaid status at the .05 level or lower. Thus, the patients in this study were fairly homogeneous by group on the sociodemographic variables as well as on type and amount of payment, in regard to treatment continuance. However, there were striking one-factor between-group differences on problem causal attribution type and degree of stress at time of intake; both below the .001 level of significance and a less powerful but statistically significant difference was found to exist on the basis of locus of control.

Patients were far more likely to attribute the cause of their problems to self (person) or to person-in-situation as number of attended sessions increased. Over eighty-three percent of the patients in the Remainer group (twenty-five or more sessions) reported either Person or Person-in-Situation problem causal attributions, as opposed to eight percent of the patients in the Intake Only group. Conversely, over ninety-one percent of the patients in group I (intake only) reported either Stimulus or Situation problem causal attributions, as opposed to about sixteen percent of the patients in the Remainer group. Table 6-1 summarizes the observed percentages of problem causal attribution type by group assignment.

Table 6-1

Observed Percentages of Problem Causal Attributions By Group Assignment

	Immediate %	Rapid %	Remainers %	Totals %
Person	6	11	44	19
Stimulus	53	36	3	32
Situation	38	39	13	31
P-in-S	3	14	40	18
Totals	n = 34	n = 36	n = 30	N = 100

Chi-square = 43.17; df = 6, $p \leq .001$

As stated earlier in chapter five, similar findings have been reported in the literature and are typically explained as resulting from discrepant expectations vis a vis the type of help being sought by the patient and the type of help deemed professionally appropriate by the helping person. In summary, the patient's perception as to cause of presenting problem was found to be highly associated with the length of stay in treatment: Patients who dropped out after only one intake session were far more likely to attribute their problems to environmental factors independent of self or to what was typically reported as life transitional problems where the respondent felt otherwise "healthy" in his/her day-to-day functioning.

Perceived degree of stress caused by the presenting problem(s) was also found to vary in a striking way by length of stay in treatment. Length of treatment was found to be highly and positively associated with perceived degree of stress at the time of intake. Approximately sixty-eight percent of the respondents who dropped out after the initial intake reported a little stress as opposed to zero percent for those who remained beyond the twenty-fifth session. Conversely, about sixty-three percent of the remainers reported experiencing a great deal of stress, at the time of intake, as opposed to only three percent of those who dropped out immediately. Related, there were no patients in the rapid dropout group (those who dropped out between the first through twelfth session) who reported experiencing just a little stress: The vast majority of these patients experienced at least some degree of stress. This finding is consistent with the literature and can be

explained by some studies that have reported that patients with psychoses and severe personality disorders are more likely to remain in treatment than patients with neuroses or those in situational crises (Craig and Huffine, 1976). Table 6-2 summarizes the distribution of reported degree of stress by study group assignment.

Table 6-2

Observed Percentages of Perceived Degree of Stress By Group Assignment

	Immediate %	Rapid %	Remainers %	Totals %
Little Stress	68	0	0	23
Some Stress	29	89	37	53
Great Deal	3	11	63	24
Totals	n = 34	n = 36	n = 30	N = 100

Chi-square = 86.59; df = 4, $p \leq .001$

The specific psychological influences of perceived stress on the decision to continue or discontinue with treatment is beyond the scope of this dissertation. However, it is reasonable to assume that degree of stress does play a role in "treatment motivation" and that this variable as well as problem causal type will have to be analyzed for contributing effects when discussing the treatment variables: This will be discussed more fully in chapter six.

The total between-group differences for locus of control by length of stay was statistically significant at the .03 level. Most of the between-group variance is accounted for by the difference in locus of control between the immediate dropout group (intake only) and the remainers (twenty-five sessions or more). Table 6-3 summarizes the observed frequencies of locus of control by group.

Table 6-3

Observed Percentages of Locus of Control of Behavior
By Group Assignment

	Immediate %	Rapid %	Remainers %	Totals %
Internal	41	44	50	45
Neither	24	20	43	28
External	35	36	7	27
Totals	n = 34	n = 36	n = 30	N = 100

Chi-square = 10.55; df = 4, p ≤ .05

Table 6-3 illustrates that only about seven percent or two of the patients in the remainers group possess loci of control that could be categorized as external as opposed to about thirty-five percent of the respondents in group I, intake only. To some degree, the more likely a person is to attribute significant changes to the influences of other people or events external to oneself, the less likely that person is to continue beyond the twenty-fifth session.

Tables 6-4 and 6-5 summarize the univariate statistical associations of each of the patient sociodemographic and related variables with continuance.

Table 6-4

Univariate Analysis of Variance Summary Table:
Association of Demographic and Related Variables
to the three levels of Continuance.
Interval Data

Variable	Mean Std.Dev	Immediate Intake Only	Rapid 1 - 12	Remainers 25+	DF	F-test†
Age	mean	37.88	42.08	38.17	99	.79
	std.dev	14.75	17.95	13.24		
Diagnostic Fee	mean	39.12	36.39	36.23	99	.18
	std.dev	24.88	20.02	21.07		
Ongoing Fee	mean	--	32.78	36.1	65	.41
	std.dev	--	20.89	21.45		

†* p≤.05, ** p≤.01, *** p≤.001

Table 6-5

Chi-Square Summary Table:
Association of Demographic and Related Variables
to the three levels of Continuance.
Nominal Data

Variable	X^2	DF	Sig. Level†
Gender	3.68	2	N.S.
Religion	1.68	2	N.S.
Marital Status	3.31	4	N.S.
Education	3.78	6	N.S.
Occupation	4.16	10	N.S.
Social Class	.46	4	N.S.
Problem Cause	43.17	6	***
Degree Stress	86.59	4	***
Locus of Control	10.55	4	*
Medicaid Recip	1.56	2	N.S.

†* p≤.05, ** p≤.01, *** p≤.001

.....Overall Patient Satisfaction

The overall level of satisfaction was measured by a standardized multi-faceted eight item, four point Likert-type instrument (Larsen, Attkisson, Hargreaves and Nguyen, 1979; see appendix C). The summed index value was highly correlated (minimum correlation was .893) with each of the eight items suggesting that the summed index value was a statistically representative measure of the responses on all eight items. The indexed values ranged from eight to thirty-two with a mean score of 17.91. In order to discuss the scores in nominal terms, the indexed values were recoded across the following values; Mostly Dissatisfied, Dissatisfied, Satisfied and Totally Satisfied. On this basis, forty-seven percent of the patients responded to the eight items with values that would suggest they were "mostly dissatisfied" with the overall experience. Twenty patients could be categorized as being just "dissatisfied." In other words, the majority of patients in this sample, or sixty-seven percent, were dissatisfied to some degree with the service they

received. Twenty-two percent of the patients responded with values that could be categorized as "satisfied," while the remaining eleven percent would be categorized as having been "totally satisfied" with their treatment experience at the Pride of Judea. In summary, of the one hundred patients who were randomly selected from the closed case files for use in this study (using the selection criteria discussed in chapter four) the majority, or sixty-seven percent, were dissatisfied to some degree with the overall service while the remaining thirty-three percent were satisfied to varying degrees. Table 6-6 summarizes these findings across level of satisfaction.

Table 6-6

Frequency Distributions and Re-Coded Values
For the Client Satisfaction Questionnaire

Range	Value	Count, (%)
8-15	Mostly Dissatisfied	47
16-23	Dissatisfied	20
24-31	Satisfied	22
32-39	Totally Satisfied	11
	Total:	100

.....Satisfaction and The Sociodemographic and Related Variables

The sociodemographic variables of age, gender, marital status, religion, education, occupation and social class were analyzed for any statistical univariate associations to degree of satisfaction. Gender, age, marital status and religion were not found to be significantly associated with satisfaction. However; education, occupation and social class were all found to have varying degrees of associations with overall degree of satisfaction. As the values for education and occupation were used to calculate the patients' social

class position, only social class will be used for analysis and discussion.

Approximately fifty-one percent of the patients categorized as upper-middle class and middle class expressed some degree of satisfaction with the overall treatment experience. This was strikingly contrasted with the degrees of satisfaction of working and poor class patients: Only seventeen percent of the working class and poor patients reported some degree of satisfaction while the clear majority of these patients, or about eighty-three percent, were dissatisfied to some degree. Restated, upper-middle class and middle class patients were found to be far more likely to report some degree of satisfaction than those patients of the lower social classes. Table 6-7 summarizes the findings for degree of satisfaction by social class.[1]

Table 6-7

Observed Percentages of Degree of Satisfaction
By Collapsed Values for Social Class

Degree of Satisfaction	Upper-Mid & Middle %	Working & Poor %	Totals %
Mostly Dissatisfied	26	66	47
Dissatisfied	23	17	20
Satisfied	30	15	22
Totally Satisfied	21	2	11
Totals	n = 47	n = 53	N = 100

Chi-square = 20.17; df = 3, $p \leq .001$

These findings, in and of themselves, are not surprising and would be predicted by the literature on patient expectations

[1]In order to avoid the statistical contra-indication of using a Chi-square analysis when more than twenty percent of the expected cell values are less than five (in a table greater than 2 x 2), wherever possible, polar levels of either one or both categorical variables will be collapsed and the data will be reported accordingly.

particularly in regard to role-set expectations and social class (see, for example, Overall and Aronson,1962; Heine and Trosman,1960 and Rosenblatt, 1962). However; that social class is associated with degree of satisfaction but is not associated with continuance, strongly suggests that social class, solely, is contributing in sufficient strength to satisfaction but is operating in association with other variables when considering continuance: This will be analyzed fully in chapter seven.

The following related patient variables were examined for differences on degree of satisfaction; diagnostic fee, ongoing fee, medicaid status, problem causal attributions, perceived degree of stress and locus of control of behavior. There were no between-level differences found for problem causal attribution type or degree of stress on degree of satisfaction. The diagnostic fee, ongoing fee, medicaid status and locus of control of behavior were each found to be associated with satisfaction. The three variables associated with ability to pay (fees and medicaid status) were also highly associated with one's social class, which has already been discussed. On this basis, locus of control of behavior will be discussed here and the related patient variables associated with social class will be discussed later in chapter seven.

Sixty percent of the respondents who could be categorized as possessing an internal locus of control reported some degree of satisfaction. However, approximately ninety-six percent of the patients with an external locus of control reported some degree of dissatisfaction with the overall treatment experience. Interestingly, about eighty-two percent of those patients whose

locus of control scores fell somewhere in the middle ranges and were categorized as "neither" internal nor external were also likely to report some degree of dissatisfaction. Restated, patients who did not possess a general psychological expectancy that placed contingencies of events as emanating from within themselves were most likely to report some degree of dissatisfaction with the overall experience. Table 6-8 summarizes these results.

Table 6-8

Observed Percentages of Degree of Satisfaction
By Locus of Control of Behavior

Degree of Satisfaction	Internal %	Neither %	External %	Totals %
Mostly Dissatisfied & Dissatisfied	40	82	96	67
Satisfied & Totally Satisfied	60	18	4	33
Totals	n = 45	n = 28	n = 27	N = 100

Chi-square = 38.96; df = 2, p ≤ .001

Tables 6-9 and 6-10 summarize the statistical associations between the patients' sociodemographic and related variables with overall degree of satisfaction.

Table 6-9

Univariate Analysis of Variance Summary Table:
Association of Demographic and Related Variables
to the four levels of Satisfaction
Interval Data

Variable	Mean Std.Dev	Mostly Dissatisfd	Dissatisfd	Satisfied	Totally Satisfied	DF	F-test†
Age	mean	41.11	35.40	41.23	36.46	99	.86
	std.dev	17.04	12.42	16.80	10.41		
Diagnostic Fee	mean	30.32	38.50	41.37	56.55	99	5.31*
	std.dev	23.30	19.61	16.92	15.69		
Ongoing Fee	mean	28.20	30.33	36.83	55.00	65	4.04*
	std.dev	21.93	18.07	19.22	15.35		

†* p≤.05, ** p≤.01, *** p≤.001

Table 6-10

Chi-Square Summary Table:
Association of Demographic and Related Variables
to the four levels of Satisfaction
Nominal Data

Variable	X^2	DF	Sig. Level†
Gender	1.22	3	N.S.
Religion	15.94	9	N.S.
Marital Status	13.74	12	N.S.
Education	41.36	9	***
Occupation	30.78	9	**
Social Class	23.11	9	*
Problem Cause	8.29	9	N.S.
Degree Stress	20.17	3	***
Locus of Control	38.96	2	***
Medicaid Recip	10.81	3	*

†* p≤.05, ** p≤.01, *** p≤.001

Synopsis of Findings: Chapter VI

.....One-Factor Effects on Continuance

The patients' causal attribution type was found to be highly associated with length of stay in treatment at the .001 level. Ninety-one percent of those who dropped out of treatment immediately after the intake session attributed the causes of their presenting problems to either a "significant other" or a transitory situational crisis. This finding was in sharp contrast with those who remained for at least twenty-five sessions: Only seventeen percent of the remainers presented with stimulus or situational causal attribution types.

The perceived degree of stress was also found to be highly associated with continuance: Sixty-eight percent of those who dropped out immediately reported that they had initially experienced "a little stress" as a result of their problems as opposed to zero percent of the rapid dropouts and treatment remainers ($p \leq .001$).

The patients' general psychological tendencies as to locus of control were also found to be significantly associated with psychotherapy attrition. Thirty-five percent of those who dropped out immediately presented with an external locus of control; the tendency to perceive "powerful others" or luck as the primary "agents" responsible for significant changes in their lives. This finding was in contrast with those patients who comprised the remainer group: Only seven percent of those patients who remained for twenty-five sessions or more presented with an external locus of control ($p \leq .05$).

.....One-Factor Effects on Satisfaction

Social class as well as those variables thought to be associated with it; fees, medicaid status, education and occupation, were all found to be significantly associated with degree of overall satisfaction. Approximately fifty percent of those patients categorized as upper-middle and middle class reported some degree of satisfaction. This was in contrast with only seventeen percent of the working or poor class patients who reported some degree of satisfaction.

Locus of control was also found to be associated with satisfaction: ninety-six percent of those patients with an external locus of control were dissatisfied to some degree while sixty percent of those with an internal locus of control were satisfied to some degree.

Finally, degree of stress was found to be positively associated with the degree of overall satisfaction such that those patients with

greater degrees of initial stress were more likely to report higher degrees of satisfaction with the overall treatment experience.

Next, chapter seven will attempt to explore the inter-relationships and combined contributing effects of the variables that were found to have univariate significance on continuance and satisfaction.

Chapter VII

Findings:

Multivariate Analysis of the Patient Variables

Introduction

Chapter seven will begin by determining if the four sociodemographic variables of age, gender, marital status and religion have significant combined effects on the dependent variables. Second, those variables that were found to have significant univariate associations to continuance and satisfaction will be analyzed for their combined contributing effects. Finally, those research hypotheses pertaining to the patient variables will be summarized at the end of this chapter.

.....The Combined Effects of the Sociodemographic Variables

It was demonstrated earlier in chapter six, that the sociodemographic variables of age, gender, marital status and religion did not have significant one-factor effects on the study's dependent variables. The remaining question was whether or not these variables in combination would have sufficient or significant contributing effects on continuance or overall satisfaction. In order to determine this a multiple regression analysis was conducted by regressing age, gender, marital status and religion on continuance and then satisfaction. The findings indicated that these four sociodemographic variables, in combination, still lacked sufficient strength in accounting for a significant proportion of the variance. I can conclude with greater confidence that the four patient variables, just described, were not associated in any manner with

either continuance or satisfaction (multiple $R^2 = .05$, $p = .88$; multiple $R^2 = .08$, $p = .68$, respectively).

.....Inter-relationships and Combined Effects of Variables Associated With Continuance.

Three variables were found to be associated, to varying degrees, with continuance; the problem causal attribution type, the perceived degree of stress and locus of control. A multiple regression analysis on continuance by these three variables indicated that degree of stress and problem causal attribution type, in that order, accounted for most of the variance while locus of control contributed at the ≤.05 level of significance as illustrated in Table 7-1.

Table 7-1

Contributing Effects of Problem Causal Attribution Type, Degree of Stress and Locus of Control to Continuance
Multiple $R^2 = .448$, $p \leq .001$

	Std. Values	Significance Level
Problem Causal Type	-.297	.0046
Degree of Stress	.455	.0001
Locus Of Control	-.215	.027

Thus patients with a problem causal attribution type involving some aspect of "self" with a higher degree of stress and an internal locus of control (to some extent) were most likely to continue with the treatment.

A curious finding in chapter six was the absence of a univariate association between social class and continuance. Considering the possibility that the categorization of the actual number of attended sessions into three distinct study groups may have suppressed significant effects, social class was regressed on the actual number

of sessions, as opposed to the three goups levels constituting continuance. The results indicated that about five percent of the change in the actual number of sessions was in fact significantly associated with a change in social class (R^2 = .054, p = .02). In order to investigate the contributing effects of this variable, social class was added to the multiple regression analysis above to determine how the contributing effects of each might change. The total amount of variance in number of attended sessions did increase by about six percent when social class was added to problem causal attribution type, degree of stress and locus of control and this increase is significant at the .001 level. What is most noteworthy is how the contributing effects of locus of control change. Locus of control was found to contribute the least amount to the variance in continuance when combined with degree of stress and problem causal attribution type. However, when social class was factored in, the contributing effects of locus of control increased to a .0001 level of significance from the previous .027 level. In addition, the combined contributing effect of social class diminished slightly from its previous univariate effect. This suggested that social class and locus of control might be statistically associated. A simple regression analysis was conducted and indicated that social class did account for eleven percent of the variance in the patients' locus of control (R^2 = .11, p = .003). Table 7-2 illustrates the contributing effects of these four variables combined, on continuance.

Table 7-2

Contributing Effects of Problem Causal Attribution Type, Degree of Stress and Locus of Control with Social Class on Continuance
Multiple R^2 = .505, $p \leq .001$

	Std. Values	Significance Level
Problem Causal Type	-.297	.0079
Degree of Stress	.455	.0001
Locus Of Control	-.215	.0007
Social Class	.341	.0102

Related, the patient's degree of stress at the time of intake was found to be strongly related to the type of causal attributions made about the problem ($r = .513$, $p \leq .001$) in the following way: Patients with either a person or person-in-situation causal attribution were more likely to report a greater degree of stress than those patients with either a situational or stimulus (other) type of causal attribution. However, a simple regression analysis of problem causal type with social class suggested that these two variables are not statistically related: How a patient "framed" the cause of the problem was independent of his/her social class position ($r = .014$, $p = .88$). This finding was consistent with previous research in this area which has found the presenting problems of lower class patients to be qualitatively similar to those of upper class patients (Lazare, Eisenthal, Wasserman and Harford, 1975). In addition, social class was not found to be associated with the patients' degree of stress at the time of intake.

In summary then and in order of significance, degree of stress, locus of control, problem causal attribution type and social class were found to account for about fifty-one percent of the variance in the number of attended sessions.

.....Inter-relationships and Combined Effects of Variables Associated With Satisfaction.

In chapter six it was found that several variables, given a one-factor analysis, were associated with degrees of overall satisfaction; for example, the fees, medicaid status, education and occupation. It was hypothesized at that time that these variables were probably associated to satisfaction to the degree that they are additional indicators of social class. To test for this, the four variables thought to be related to social class were regressed on satisfaction together with social class. The findings indicated that these five variables "shared" so much of the same variance on satisfaction, that not one of them contributed to satisfaction in a unique way when combined. Table 7-3 illustrates the beta values of the five variables that are all essentially measuring some aspects of social class.

Table 7-3

Combined Contributing Effects of Variables found to be Associated in a Univariate Analysis to Satisfaction
Multiple R^2 = .03, p = .76

	Std. Values	Significance Level
Diagnostic Fee	-.221	.3835
Medicaid Status	-.087	.6763
Education	-.01	.9698
Occupation	-.084	.6897
Social Class	-.007	.9814

It is reasonable to conclude then, that some aspects of "social class" are associated with the final degree of overall satisfaction. For further analysis, only the variable of social class will be used.

In addition to social class, degree of stress and locus of control were found to be associated to satisfaction in a one-factor analysis. To determine the combined contributing effects of these variables, two multiple regressions were conducted; one without social class

and the other, with social class factored in with degree of stress and locus of control.

The contributing effects of degree of stress on satisfaction vanish when you factor in the effects of locus of control as well. Thus, the unique effects of locus of control on degree of satisfaction far outweigh the effects of degree of stress, when the mutual variance is controlled for. Table 7-4 illustrates the contributing beta values.

Table 7-4

Contributing Effects of Degree of Stress and Locus of Control on Satisfaction
Multiple $R^2 = .318$, $p \leq .001$

	Std. Values	Significance Level
Degree of Stress	.155	.1421
Locus Of Control	-.532	.0001

When you regress social class with degree of stress and locus of control on satisfaction, the overall variance increases by a negligible .006, which is not significant. In addition, the effects of social class are completely absorbed by locus of control, such that the contributing effects of locus of control decrease considerably but are still uniquely significant at the .01 level. Thus, it appears reasonable to conclude that of all the variables found to be associated with satisfaction, only one contributes uniquely when all other inter-relationships are controlled for; locus of control of behavior. Table 7-5, below, summarizes the beta values of the three patient variables in question.

Table 7-5

Contributing Effects of Degree of Stress, Locus of Control and Social Class on Satisfaction
Multiple R^2 = .324, $p \leq .001$

	Std. Values	Significance Level
Degree of Stress	.174	.1116
Locus Of Control	-.455	.003
Social Class	-.11	.4582

Synopsis of Findings: Chapter VII

The four sociodemographic variables of age, gender, marital status and religion were not found to contribute to the variance in number of attended sessions or satisfaction when the four variables were combined. Thus, it is reasonable to conclude that a patient's age, gender, marital status and religious affiliation are not associated with the dependent variables of study.

Four patient variables were found to contribute to number of attended sessions when combined in a multiple regression analysis. These variables are in order of significance; degree of stress, locus of control, problem causal attribution type and social class, all essentially at or below the .01 level of significance.

Of the eight variables found to be associated with satisfaction in a one-factor analysis, only one variable proved to have significant effects on satisfaction when combined with the other variables. This variable was locus of control of behavior which was found to retain its significance below the .001 level.

.....Summary Discussion of the Relevant Research Hypotheses

The research hypotheses that have been addressed in chapters five through seven and pertain to the patient variables will now be summarized.

Hypothesis:

- Age, sex, marital status and religion of the patient should not have any direct relationship on the overall satisfaction with the treatment experience or the number of attended sessions.

Findings:

These sociodemographic aspects of the patient were not associated with the number of attended sessions or the degree of overall satisfaction. These findings are consistent with the previous empirical work reported in chapter two.

Conclusion: The (null) Hypothesis is accepted.

Hypothesis:

- Lower social class (SES) patients are more likely to drop out of treatment than the higher social class patients.

Findings:

Social class was found to be associated with treatment continuance when the actual number of sessions was analyzed as opposed to the three "collapsed" study groups, which were suppressing the moderate effects. However, the statistical significance of social class, as a factor in continuance, was found to

be the weakest of the four variables studied suggesting that the relationship between social class and continuance was not as profound as was expected from the empirical studies discussed in chapter two.

Conclusion: The hypothesis is accepted.

Hypothesis:

- Higher SES patients are more likely to present with the "person "and "person-in-situation" causal attribution categories of their problems with less perceived stress than lower SES patients.

Findings:

An interesting finding was the absence of a relationship between social class and problem causal attribution type. This finding is actually inferred by the literature which suggests that lower class patients do not differ qualitatively in the nature of their presenting problems from those of upper class patients. Related, social class was not found to be associated with degree of stress.

Conclusion: This hypothesis is rejected.

Hypothesis:

- Patient's who view their problems as having been caused by "self" or "self-in-situation" are more likely to be satisfied with the overall treatment experience than patients who view their problems as having been caused by others ("stimulus") or just "situation."

Findings:

Problem causal type was not found to be associated with the degree of overall satisfaction although it was significantly associated with continuance. It was found that once a patient "made it through" the first few sessions, it was the patient's locus of control, not the problem causal attribution type, that accounted for the overall degree of satisfaction.

Conclusion: Hypothesis is rejected.

Hypothesis:

- Lower SES patients are more likely to manifest external loci of control than higher SES patients.

Findings:

There was a strong and clear relationship between social class and locus of control in the direction stated by the hypothesis ($r = .67$, $p \leq .001$).

Conclusion: Hypothesis is accepted.

Chapter eight will examine the professional and treatment variables as well as any univariate associations to continuance or satisfaction.

Chapter VIII

Findings:

Description and Univariate Analysis of the Professionals and Treatment Variables

Introduction

Chapter eight will be comprised of an integrative analysis and discussion of the Professionals, the Professional Skills Index (perceived skills of psychiatrist for the intake only group and perceived skills of the social worker for the rapid dropouts and remainers), the Relationship Quality Index (perceived quality of professional relationship for all subjects) and the Psychiatric Quality Index (perceived quality of relationship with intake psychiatrist for the rapid dropouts and remainers) and the logistical problem areas. For depth of discussion, the univariate association of each variable to satisfaction and continuance will be analyzed and discussed for each variable.

Description of the Professionals

.....Description of the Psychiatrists

Data was collected for psychiatrists and social workers on the variables of age, gender and years of experience from the time of graduation (M.D. or M.S.W.). Eleven different psychiatrists conducted the psychiatric intakes for the one-hundred respondents in the study. The psychiatrists ranged in age from thirty to forty years old, with a mean age of about thirty-four. Forty-five percent of the intake doctors were men and fifty-five percent

were female. Years of experience, from the time of graduation from medical school, ranged from two to eleven years, with the average representing about five and a half years. A univariate analysis of variance on the doctor's age, gender and years of experience failed to produce significant differences on either number of attended sessions or degrees of overall satisfaction. Thus, no specific doctor(s) was associated with either patient attrition or overall satisfaction. Table 8-1 summarizes the descriptive findings for the intake psychiatrists.

Table 8-1

Statistical Description of Psychiatrists in Study
(At Time of Intake)
N = 11

Variable	Value Range	Mean	Std.Dev.	Category Freqs
Age	30 -40 yrs	34.44	3.67	--
Gender	Male	--	--	M: 45% (5)
	Female			F: 55% (6)
Experience*	2-11 yrs	5.56	3.35	

*From time of Graduation from Medical School

.....Description of the Social Workers

Fifteen different social workers provided the ongoing therapy for the sixty-four respondents in groups II and III: None of the psychiatrists were involved in ongoing treatment. Six, more experienced social workers were over-represented in the study; having provided more than seventy percent of the treatment for the patients in groups II and III. The social workers ranged in age from twenty-five to fifty-six years old, with the average representing about forty years of age. Sixty-seven percent of the therapists were female and thirty-four percent, male. Years of experience, from the

time of graduation from social work school, ranged from zero (reflecting the use of second year social work students) to thirty years, with the average being about fifteen years of experience. A univariate analysis of variance on the social worker's age, gender and years of experience failed to produce significant differences on either number of attended sessions or degrees of overall satisfaction. Thus, no specific social worker was associated with either patient attrition or overall satisfaction. Table 8-2 summarizes the descriptive findings for the social workers in this study.

Table 8-2

Statistical Description of Social Workers in Study
(At Time of Intake)
N = 15

Variable	Value Range	Mean	Std.Dev.	Category Freqs
Age	25 -56 yrs	40.48	9.37	--
Gender	Male Female	--	--	M: 33% (5) F: 67% (10)
Experience*	0-30 yrs	15.77	11.05	

*From time of Graduation, School of Social Work

.....Summary Discussion of Professionals

In comparison, the intake doctors tended to be younger males with less post-degree experience than the clinical social workers, who were more likely to be represented by older, more experienced females. However, no significant one-factor "between-group" relationships were found to exist between the dependent variables and the professionals' age, gender or years of experience. These findings are similar to those of the empirical studies discussed in chapter two (Baekeland, 1975; Garfield, 1978).

Next, I will look at the patients' perceptions of the skills and behaviors of the professionals just discussed.

The Professional Behavior Scale

The Professional Behavior Scale, a seven item likert-scale measurement adapted from Shulman's Social Work Behavior Questionnaire (1978), was administered to all subjects. It should be recalled that for subjects in group I (intake only) the responses refer to the psychiatrist, while the subjects in group II (rapid dropouts; one to twelve sessions) and group III (remainers; twenty-five or more sessions) are responding to their sessions with the social worker. In order to determine the reliability of using the summed index value as a representative measure of the activity of each of the seven items; the simple correlations of each item to the summed index value with corresponding levels of significance were derived: the results of which can be found in appendix I. The correlations ranged in value from .505 to .86 with levels of significance all found to be below the .001 level: Thus, it was determined that the summed index value could be used as a representative measure of the Professional Behavior Scale.

The summed index value for the Professional Behavior Scale ranged from seven to thirty-five. For clarity of presentation, the values of the frequency distributions were re-coded to represent five different levels of perception about the professionals' skills: Mostly Effective, Effective, Adequate, Ineffective and Mostly Ineffective. Viewed in this way, twenty-five percent of the respondents perceived the professionals as "mostly ineffective"

while another twenty-seven percent of the patients perceived the professionals as "ineffective". Nineteen percent of the patients perceived the professionals as just "adequate." Frequency distributions for perceptions of the professionals that could be categorized as "effective" and "mostly effective" were seventeen and twelve percent, respectively. Thus; the majority of patients questioned, or fifty-two percent, perceived the skills of their professionals as being ineffective to some degree while only thirty-one percent of the respondents perceived the skills of their professionals as being effective to some degree. Table 8-3 summarizes the frequency distributions with corresponding nominal values for the Professional Behavior Scale.

Table 8-3

Frequency Distributions and Re-Coded Values For the Professional Behaviors Scale

Range	Value	Count (%)
7-12	Mostly Ineffective	25
13-18	Ineffective	27
19-24	Adequate	19
25-30	Effective	17
31-36	Mostly Effective	14
	Total:	100

Length of stay was found to be highly associated with the patients' perceptions of their professionals' skills. Approximately seventy-four percent of the patients who dropped out immediately after the intake session perceived the skills of the intake psychiatrists as being ineffective for their needs, to some degree. No one in this immediate dropout group felt the skills were effective to any degree. This finding was significantly contrasted with those who remained with the social worker for twenty-five or

more sessions: Seventy percent of these patients did feel the professionals were effective to varying degrees ($p \leq .001$). Table 8-4 summarizes these findings.

Table 8-4

Observed Percentages of Professional Behavior Scale By Group Assignment

Prof. Behaviors	Immediate Intake Only %	Rapid 1-12 %	Remainers 25 or More %	Totals %
Mostly Ineffective	45	21	7	25
Ineffective	29	39	10	27
Adequate	26	17	13	19
Effective	0	17	37	17
Mostly Effective	0 *	6 *	33 *	12
Totals	n = 34	n = 36	n = 30	N = 100

*Expected values < 5 Chi-square = 42.20; df = 8, $p \leq .001$

Degree of overall satisfaction was also found to be highly associated with the change in the level of perception of the professionals' behaviors. Approximately seventy-five percent of those patients who were dissatisfied to some degree reported perceptions of the professionals' skills that were ineffective to some degree. Conversely; of those patients who were satisfied to some degree, about seventy-six percent felt the professionals' skills were, at least, effective ($p \leq .001$). Table 8-5, below, illustrates the relationship of the degrees of perceptions of the professionals' behaviors by collapsed degree of overall satisfaction.

Table 8-5

Observed Percentages of Professional Behavior Scale By Degrees of Overall Satisfaction

	Dissatisfied Mostly Dissatisfd	Satisfied Totally Satisfd	Totals
Prof. Behaviors	%	%	%
Mostly Ineffective	37	0	25
Ineffective	37	6	27
Adequate	20	18	19
Effective	6	40	17
Mostly Effective	0	36 *	12
Totals	n = 67	n = 33	N = 100

*Expected values < 5 Chi-square = 59.22; df = 4, $p \leq .001$

The associations between the patients' perceptions of the professionals' skills with continuance and degree of satisfaction were found to be highly significant as expected. It may be recalled from chapter three, it was hypothesized that perceptions of what the professional actually did would directly influence the patients' feelings about the quality of the professional relationship and that the relationship would actually mediate the effects of the professional behavior scale on the dependent variables. The professional behaviors most associated with the quality of the professional relationship, as well as the mediating effects of the relationship, will be explored fully in chapter nine. Next, I will examine the findings for the perceived quality of the professional relationship itself.

The Professional Relationship Quality Index

The perceived quality of the relationship was measured by a four items where the patient could respond on a five-point likert scale to each item. For clarity of discussion, the items will be

presented here (all items have been converted to positive statements for ease of discussion).

1. I felt the doctor/therapist was a warm and caring person.
2. I felt the doctor/therapist got to know me as a real person.
3. The doctor/therapist was a sincere person,. truly dedicated to helping people.
4. I felt the doctor/therapist liked me as a real person.

The Professional Relationship Quality scale was derived from the literature review as discussed in chapters two and four. In order to determine if in fact the four items constituted a "scale," a correlation matrix of the partial and multiple correlations was generated. Then, Bartlett's test of sphericity (1951) was applied on the basis of Guttman's assumptions that partial correlations should approach zero with large multiple correlations if the composite of variables is logically homogeneous, i.e., measuring the same universe of content (Guttman, 1954). The results of the measures of variable sampling adequacy with the chi-square value for the Bartlett test of sphericity can be found in appendix J. In summary, the four items were found to be highly homogeneous leading to the conclusion that each item was measuring a similar, if not the same, concept. In addition, the four items were highly correlated to the summed index value, suggesting that the summed value was representative of the activity on the four items and therefore could be used for analysis of the professional relationship scale (see appendix J, as well).

The summed index value for the professional relationship quality scale ranged from four to twenty. For clarity of presentation, the values of the frequency distribution were re-coded to represent five different levels of perceptions about the relationship; Excellent, Good, Mediocre, Fair and Poor. Table 8-6 summarizes the frequency distributions for these values.

Table 8-6

Frequency Distributions and Re-Coded Values
For the Professional Relationship Quality Scale

Range	Value	Count (%)
0-4	Poor	17
5-9	Fair	27
10-14	Mediocre	19
15-19	Good	23
20-24	Excellent	14
	Total:	100

Thirty-seven percent of the respondents perceived the quality of their relationship with the professional as either excellent or good, while another forty-four percent of the patients perceived the relationship as either a poor one or fair one, at best. Nineteen percent of the patients were primarily "undecided" as to the quality of the relationship, in what might best be categorized as a "mediocre" feeling. As expected, the total between-group differences on the basis of length of stay and perceived quality of relationship was highly significant ($r = .459$, $p \leq .001$). That is, the perceived quality of the relationship was more likely to increase with the number of attended sessions. However, this was not true for all groups. There was no significant between-group difference in perceived quality of relationship for the respondents in groups I and II: Most of the between-group variance was accounted for between group III and groups I and II. Thus, whether a patient

dropped out after one intake only or after one to twelve sessions with a social worker, the patient was unlikely to report a significant difference in the perceived quality of the relationship. A contingency table was generated on the basis of initial group assignment and the re-coded nominal values for the perceived relationship. Table 8-7 summarizes the observed findings.

Table 8-7

Observed Percentages of Professional Relationship Quality By Group Assignment

Relationship	Immediate Intake Only %	Rapid 1-12 %	Remainers 25 or More %	Totals %
Poor	24	25	0	17
Fair	31	36	10	27
Mediocre	12	20	27	19
Good	15	19	37	23
Excellent	18 *	0	26 *	14
Totals	n = 34	n = 36	n = 30	N = 100

*Expected values < 5 Chi-square = 26.31; df = 8, p ≤ .001

What is most interesting to note is that approximately thirty-three percent of the respondents in group I reported relationships with the intake psychiatrist that were perceived as either good or excellent. Just as interesting, is the finding that approximately twenty-six percent of the respondents in group III, who remained for at least twenty-five sessions with the social worker, reported relationships that were either fair or mediocre. What is most striking, is that patients who remained in the relationship, for at least twenty-five sessions, were more likely to report a "good" relationship as opposed to an "excellent" one. This may not be as surprising when you consider the previous finding on degree of stress, reported in chapter five, and length of stay: That is, degree

of stress contributed greatly to the changes in length of stay. It may appear then, that these psychotherapy patients may have had the tendency to "hold onto" a relationship they were not entirely pleased with, in the context of having felt "a great deal of stress."

The perceived quality of the relationship was found to be powerfully associated with the degree of overall satisfaction, as expected. One hundred percent of those patients who perceived the quality of their professional relationships to be poor or fair were dissatisfied to some degree with the overall experience. Conversely, the vast majority of patients who perceived the quality of their professional relationships to be good or excellent were satisfied to some degree with the overall experience. Table 8-8 illustrates the distribution of the quality of relationship values by degree of satisfaction.

Table 8-8

Observed Percentages of Degree of Satisfaction
By Perceived Quality of the Relationship

Degree of Satisfaction	Poor %	Fair %	Mediocre %	Good %	Excellent %	Totals %
Mostly Dissatisfied	100	100	88	17	14	67
Dissatisfied						
Satisfied	0	0	12	83	86 *	33
Totally Satisfied						
Totals	n = 17	n = 27	n = 19	n = 23	n = 14	N = 100

*Expected values < 5 Chi-square = 86.87; df = 4, $p \leq .001$

It can be seen from Table 8-8 that the degree of overall satisfaction increased with the quality of the professional relationship: One hundred percent of the respondents who perceived the quality of the relationship as either poor or fair reported some degree of overall dissatisfaction. Conversely, about

eighty-six percent of those who reported excellent relationships and about eighty-three percent of those who reported good relationships felt some degree of satisfaction with the overall treatment experience.

Summary Discussion of the Professional Relationship Quality Scale

Patients who remained with their social work therapists for at least twenty-five sessions, had a tendency to feel considerably better about their professional relationships than did those patients who attended for twelve sessions or less and this quality of the relationship was highly and positively associated with overall satisfaction with the treatment experience. However, there was no statistical difference in the perceived quality of the relationship between those patients who dropped out after one session and those who dropped out between one to twelve sessions. A surprising finding was that patients who did remain past the twenty-fifth session, were somewhat more likely to perceive the relationship as a "good" one, as opposed to an "excellent" one. This suggested that the degree of stress, as discussed earlier in chapter five, played a role in patients remaining in therapeutic relationships that they were not entirely satisfied with. Another surprising finding, was that about thirty-three percent of the patients, who dropped out after one visit with the psychiatrist, perceived the quality of that relationship as either "good" or "excellent" and were, in fact, satisfied with the overall albeit brief experience. Some additional light will be shed on this finding when the association between the perceived quality of the relationship and the degree of

overall satisfaction with the experience is examined. It may be that more is not necessarily better in the context of outpatient psychotherapy. Restated; it appears that those patients who dropped out after one visit, and who also liked and felt liked by the psychiatrist, clearly felt that one visit was sufficient to meet their needs. This type of scenario is best illustrated by the following vignette taken from an interview I had with one of the older woman in the study, who was having difficulties with her grown, married son, over the issue of her independence:

> "Well, I guess my problems started when my apartment building went 'co-op' five years ago. I lived in that apartment for twenty years with my husband, who died eight years ago, and there was no way I was going to give it up. Besides, I got a great deal on it with the 'insiders' price. But there was a big fight with my son about it, who wanted to sell my option and have me go move in with him and T__(his wife). Anyway, one year ago my older sister died and I guess it was more than I could handle. I cried a lot and, well, maybe I called my son and daughter-in-law too much of the time also. But, what started the whole thing was the problems I was having with my memory. I would go to the store for milk and, then, come home with everything but milk. Or, I would walk all the way down to the car and realize I had forgotten to take my car keys from the key rack. Well, anyway, I was getting more and more upset about this, you know, because of all you hear about Alzheimer's disease and I made the terrible mistake of telling my daughter-in-law about the problems I was having with my memory and how depressed I was feeling. Now, that's when the big fights really started. My son got hysterical--he ordered me to sell the apartment and to come move in with him--so, of course, I refused. Well, this went on for about a month and then my son said to me that I was never to call him again unless I was ready to sell the apartment and move in, like 'a sensible person.' You see, he really believed that I was going senile, but the worse part was, I thought so too; you know like Alzheimer's disease. It was never like me to forget things ever before. My memory has always been

> excellent, so I guess we were all worried. So finally my daughter-in-law, 'who is one of the sweetest girls who'll ever meet; my son doesn't really deserve such a nice girl,' negotiated a deal between me and my son. The deal was that I would go see a doctor and if he said that I wasn't going senile then I would keep the apartment, but if he said I was in the early stages, or whatever, of Alzheimer's that I would have to sell the apartment. So I agreed, mainly because my son wasn't talking to me at that point. My daughter-in-law had heard about the Pride of Judea and when I found out it was a 'mental clinic,' first I said 'no way,' but then, I said to myself, 'Doris, stop fighting and besides, with a Jewish name like that, how bad could they be?' So I finally got to see this very sweet doctor; she wasn't Jewish, but that didn't matter to me. She was really very warm and understanding for a doctor, although I guess, maybe psychiatrists are nicer people anyway, you know, for doctors. I explained everything to her and it was remarkable: It was as if she had known me all of my life. I would begin to say something, she would nod and know exactly how I was feeling. And, at first, I wasn't going to say anything, you know, about the Alzheimer's, but finally I did. And, I am so glad that I did. She put my mind to rest about it once and for all. What I liked most about her, besides the fact that she was warm and friendly, not like a doctor at all, was that she made me feel that I was perfectly sane! I couldn't wait to tell my son. Anyway, the more I thought about the session, the more I felt I really didn't need more therapy. A private joke that _____(intake doctor) and I had together was that maybe my son should be in therapy. My son wasn't happy that I wasn't moving afterall, but he had no other choice but to accept it, since it was their idea to begin with.

"Doris" was totally satisfied with her overall experience at the Pride, based primarily on the rapport or "excellent" quality of the relationship she had with the intake doctor. It is interesting to note the emergence of the professional behaviors eluded to in this vignette; "She really understood me," "She understood my feelings without my having to put them into words" and "She was able to help me talk about things that were tough to talk about," (fear of Alzheimer's Disease) as will be discussed in chapter nine.

The Psychiatric Relationship Quality Scale

The psychiatric relationship quality scale was comprised of the same four items as the professional relationship quality scale and was administered to the sixty-six subjects who continued beyond the initial intake session. It was administered to determine what effects, if any, the patient's feelings about the psychiatric intake might have had on the ensuing relationship with the social worker, perhaps independently of who the social worker was as a person or a therapist. The procedure employed was to ask every patient, assigned to groups II and III, if they remembered their very first interview with the psychiatrist. Second, it was planned that any incongruities between feelings about the psychiatrist and attendance behaviors would be explored. Thus, if a patient responded with very positive comments about the psychiatrist and immediately dropped out or if he/she responded negatively and still continued on to the social worker, the plan was to explore this further with the patient. In every case, the psychiatric interview was recalled. Incongruities that developed will be discussed later in the context of this section's summary analysis.

The majority, or approximately fifty-one percent, of the patients who continued beyond the intake session, reported feeling either "good" or "excellent" about the relationship with the psychiatrist. No one in groups II or III felt the relationship was a "poor" one, while about forty-nine percent of these patients reported values that could be categorized as suggesting "fair" or "mediocre" relationships with the psychiatrist. Table 8-9

summarizes the frequency distributions of the relationship values for the sixty-six patients who continued beyond the intake session.

Table 8-9

Frequency Distributions and Re-coded Values For the Psychiatric Relationship Quality Scale

Range of Index	Value	Count	%
0-4	Poor	0	0
5-9	Fair	11	17
10-14	Mediocre	21	32
15-19	Good	32	48
20-24	Excellent	2	3
	Totals:	66	100

Summary Discussion of Psychiatric Relationship

There were powerful differences in both the degrees of continuance and satisfaction associated with the perceived quality of the psychiatric interview. That is, about seventy-three percent of those patients who remained in treatment for twenty-five sessions or more, reported either good or excellent relationships with the psychiatrist. Conversely, the majority of patients, or about sixty-seven percent, who dropped out by the twelfth session reported feelings about the psychiatric relationship that could be categorized as either fair or mediocre. No one who continued past the intake session perceived the psychiatric relationship as poor. Thus, it appears that the very first feelings the patient had about the psychiatrist were highly associated with continuance later on with the social worker and, ultimately, the final degree of overall satisfaction with the total experience. Analysis of these findings will be enhanced by examining the effects of the perceived relationship with the psychiatrist on the ensuing relationship with the social worker, for those patients who continued beyond the

initial intake, only (groups II and III). Table 8-10 summarizes the observed percentages of "relationship type" by length of stay for those who continued beyond the psychiatric intake.

Table 8-10

Observed Percentages of Psychiatric Relationship Quality By Group Assignment

Relationship	Rapid 1-12 %	Remainers 25 or More %	Totals %
Fair Mediocre	67	27	48
Good Excellent	33	73	52
Totals	n = 36	n = 30	N = 100

Chi-square = 10.48; df = 1, $p \leq .01$

The initial set of feelings about the psychiatric intake was highly associated to the final degree of overall satisfaction: Over eighty-four percent of those patients who perceived the quality of the initial psychiatric relationship as either fair or mediocre ultimately experienced some degree of overall dissatisfaction. Conversely, over sixty-one percent of those respondents who felt either good or excellent about the psychiatric relationship experienced some final degree of satisfaction. Table 8-11 illustrates the relationship between the final degree of overall satisfaction by the perceived quality of the initial psychiatric intake.

Table 8-11

Observed Percentages of Degree of Satisfaction By Perceived Quality of the Psychiatric Relationship

Degrees of Satisfaction	Fair & Mediocre %	Good & Excellent %	Totals %
Mostly Dissatisfied	84	39	60
Dissatisfied Satisfied Totally Satisfied	16	61	40
Totals	n = 32	n = 34	N = 66

Chi-square = 14.86; df = 1, $p \leq .001$

Eleven patients in the rapid dropout group (one through twelve sessions) reported psychiatric relationship values that could be categorized as fair and these eleven patients were essentially asked to disclose their thinking about continuing with the work after having had such a "difficult" experience with the psychiatrist. One response from the interview with "Dan," a forty-two year old married man nicely summarizes the findings:

> "Well, that's a good question. As I told you earlier, it wasn't my idea to be there to begin with--this was one of my wife's brilliant ideas. Like I said, I didn't have any problems with the marriage--my wife did. And, so, I kept on telling this lady doctor that it was my wife's idea and she kept right on asking me what I saw as the problem and I said, 'well, my wife is unhappy. She's unhappy all the time.' Then Doctor_____ would say to me, 'But, what do <u>you</u> think is wrong with the marriage," and I would say right back, 'Nothing, it's my wife who thinks something is wrong with the marriage--Why don't you ask her?' Well this went back, like this, back and forth the whole time--It was like an Abbott and Costello routine. I got sick of it after awhile, and to be honest with you, she became down right nasty. I mean there was no mistake about it--this lady did not like me at all. I got the feeling from her that she wanted me to admit my wife was unhappy because of me. But I wasn't going to do that. My wife is basically an unhappy person. That's who she is. If she wasn't so much into analyzing everything, she probably wouldn't be so miserable. This psychological business is just too much sometimes--I mean, my wife was an unhappy person when I married her--I mean, she cried during our honeymoon together--can you believe it?--all because she missed her mother's long-distance call to her--Actually, that's my wife's biggest problem-her mother. She and her mother analyze every God-damned thing together--I'm not kidding, it would make any guy wanna vomit. I should have told Doctor_____ that my mother-in-law was the big problem in the marriage--she would have loved that."

There is a pause and I say, "O.K. This is great stuff and I follow you. But yet you decided to continue on anyway, for two more sessions, I think."

"Yea, that's right; two more sessions for me--my wife still sees the therapist you know, after all this time.--Well, I figured I had promised my wife, who had been making me miserable, and said she would feel better if I tried out this marital therapy. It would have been more aggravation at home to stop at that point. Now, if the therapist would have been this lady doctor, O.K., that's a different story--all the crying in the world wouldn't have gotten me to go--but I knew we would be seeing a different person for that, a man this time, so I figured, what the hell, let me see what the new guy was like.

"So you and your wife saw this new guy and then your wife continued but you stopped after two sessions."

"Yea, that's right; two sessions for me. Well, I got to admit I thought he was pretty good myself. Nice guy actually. He said to me, 'Listen, you don't really want to be here, right? How would you feel if your wife and I just worked together?' I swear, I almost kissed this guy for that. I give him a lot of credit for realizing who the real patient was, to begin with. So, I look at it this way Greg--If fifty bucks a week will stop my wife from crying all the time, it's money well spent on my own personal mental health--(patient laughs)-- ya know what I mean?"

The above vignette clearly illustrates what was found to be true across all eleven patients; their prior knowledge that the person conducting the intake would not be the same person conducting the therapy. Thus, all eleven patients were able to put their feelings about the psychiatrist "on hold," and suspended their final judgements about therapy until after meeting the "real" therapist. What is also noteworthy about the vignette with "Dan" is the manner in which the professional behavior of "displaying feelings" was perceived. "Dan" strongly agreed with the presence of this

professional behavior and yet, it was perceived as an entirely negative event.

Related, "Ben," a thirty-two year old man, who had never been married, attended for a total of twenty-six sessions and was totally dissatisfied with the overall experience. From the following vignette, it is clear that Ben felt too confronted too soon and that his resulting heightened defenses, primarily of projection, carried forth well into his relationship with the social worker.

> "Well, I figured that I wasn't a kid anymore and maybe there was something wrong with me, you know, because I had never been married. So when I told this to the psychiatrist, he asked me if I ever had 'homosexual thoughts' and I hit the ceiling, except I kept it inside which is what I usually do when I'm angry. I was furious but I didn't say anything about it, although, I know he knew I was angry. After that comment though, there were a lot of things that I wouldn't tell him. I couldn't imagine what he would come up with next. After that session, to tell you the truth, I wasn't going to come back. But, I figured I shouldn't make a hasty decision since it wasn't going to be him that I had to see anyway. They gave me a male therapist, like I asked for, and I figured I would try it out, except the fee was really too high--I thought they would just take my insurance, you know. Anyway, this new guy wasn't much better either. He was actually unfriendly and if you ask me, I think he was afraid that I was a homosexual or something because of that other doctor's report. Anyway, I tried it out for exactly six months and made my decision then to stop. Since we weren't getting anywhere I decided to stop. If you ask me what I think, I was totally dissatisfied with everything: They should know how to treat people better than that.

Thus; in all eleven cases explored (where there was an incongruity between feelings about the psychiatrist and attendance behaviors), the decision to continue was based on first, the

recognition that the ongoing therapist would be a different person and second, the hope that the relationship with the primary therapist would be better. Finally, those patients who perceived the quality of the psychiatric relationship as good or excellent and then stopped, generally did so because they were satisfied with the amount of service they had received as was illustrated by the case of "Doris," earlier.

-Logistical Problem Areas-

In an attempt to account for the degree to which difficulties with practical problems were associated with continuance and satisfaction, all subjects were asked to respond to what degree they had experienced problems with the following during their treatment experience; the length of the waiting list, affording the fee, transportation problems, child-care arrangements, hassles with family members and time-scheduling conflicts between work and appointment hours. For each problem area, the level of agreement was eventually analyzed for its univariate association to the number of attended sessions and degree of overall satisfaction. All statements have been converted to positive ones for ease of discussion.

Problem Area I:

The length of the initial waiting list was too long for me.

Sixty percent of the patients did not feel that the length of their initial wait was too long. However, thirty-three percent of the patients either did agree or strongly agreed with this statement.

Seven respondents were undecided. The "strongly agree" response was comprised entirely of patients in the immediate and rapid dropout groups and thus, the differences on length of stay and degree of satisfaction, were both highly significant ($p \leq .01$). An interesting finding was that the two patients who "agreed" with this statement were in the remainer group. This suggested to me that the frustration some of the patients felt, by having to wait for an assignment to a therapist, lingered on beyond twenty-five sessions: This will be explored later in chapter nine. Table 8-12 summarizes the frequency distributions across this problem area.

Table 8-12

"Waiting List Too Long"

Value	Count (%)
Strongly Agree-5	26
Agree-4	7
Undecided-3	7
Disagree-2	3
Strongly Disagree-1	57
Total:	100

Problem Area II:

Affording the fee was a problem for me.

Forty-four percent of the patients either agreed or strongly agreed that affording the fee was a problem during the course of their treatments. However, fifty-two percent of the respondents did not feel the fee was an issue, while four people were undecided. Level of agreement in this area was not associated with length of stay as was expected (to the degree that the amount of the diagnostic and ongoing fees were not found to be associated with attrition). However, level of agreement in this area was highly

associated with the overall degree of satisfaction ($p \leq .001$). This discrepant finding suggests that although a fee perceived as too high was not sufficient cause for interruption of the work, it did play a role in the feelings about the therapeutic relationship and consequently, overall satisfaction. Table 8-13 summarizes the the frequency distributions of "affording the fee" as a problem area.

Table 8-13

"Affording the Fee was a Problem"

Value	Count (%)
Strongly Agree-5	33
Agree-4	11
Undecided-3	4
Disagree-2	1
Strongly Disagree-1	51
Total:	100

Problem Area III:

Travel arrangements were a problem for me.

Seventy-eight percent of the patients did not feel transportation problems were a factor during their treatment experience. However, sixteen percent of the respondents either agreed or strongly agreed that they had difficulties with transportation arrangements. In addition, the presence of transportation problems was highly and significantly associated with early attrition: Patients who either relied on public transportation or did not have access to the family's only car (at the time of the appointment) were highly likely to drop out by the twelfth session ($p = .005$). However, the presence of transportation problems was only moderately associated with overall satisfaction ($p = .04$) indicating that patients did not hold their therapists

accountable for this problem, as was the case with fees. Table 8-14 illustrates the degree transportation problems were a factor for the patients in this study.

Table 8-14

"Transportation Problems were a Problem"

Value	Count (%)
Strongly Agree-5	8
Agree-4	8
Undecided-3	6
Disagree-2	0
Strongly Disagree-1	78
Total:	100

Problem Area IV:

Making the proper child-care arrangements was a problem.

The vast majority, or eighty-eight percent, of the patients did not experience problems in child-care arrangements and one person was undecided. However, eleven patients did either agree or strongly agree with this statement. Problems with child-care arrangements were not associated with length of stay or the degree of overall satisfaction. Table 8-15 summarizes the frequency distributions for the degree child-care arrangements were a problem for this patient population.

Table 8-15

"Child-care Arrangements" were an Issue"

Value	Count (%)
Strongly Agree-5	7
Agree-4	4
Undecided-3	1
Disagree-2	2
Strongly Disagree-1	86
Total:	100

Problem Area V:

Hassles with family members about going all the time were a problem for me.

Eighty-two percent of the patients did not report family conflicts about being in therapy as a problem. Fifteen patients felt that it was an issue and another three were undecided. The affirmative report of "hassles with family members," as a perceived problem, was not associated with attrition or the degree of overall satisfaction. Table 8-16 illustrates the frequency distributions for the degree "family conflicts" were perceived as an intervening problem.

Table 8-16

"Hassles with Family Members" were an Issue"

Value	Count (%)
Strongly Agree-5	8
Agree-4	7
Undecided-3	3
Disagree-2	1
Strongly Disagree-1	81
Total:	100

Problem Area VI:

Conflicts between my work hours and the available appointment time were a problem for me.

Eighty-one percent of the respondents did not feel that time-conflicts were a problem. Three patients were undecided, while sixteen percent of the patients either agreed or strongly agreed that they did experience scheduling conflicts with their therapists. Affirmative reports about scheduling conflicts were not associated

with number of attended sessions or the degree of overall patient satisfaction. In all sixteen cases, this conflict was due to a sudden time change in the patient's schedule (typically due to a new job or job change) that could not be accommodated by the social worker. Table 8-17 summarizes the degree to which conflicts in scheduling were a problem.

Table 8-17

"Conflicts in Scheduling" were an Issue"

Value	Count (%)
Strongly Agree-5	13
Agree-4	3
Undecided-3	3
Disagree-2	0
Strongly Disagree-1	81
Total:	100

Summary of Logistical Problem Areas

In summary, of the six problem areas that were explored, the perception of a long waiting list and transportation problems were significantly associated with the number of attended sessions and degree of satisfaction. Additionally, "problems with affording the fee," was not found to be associated with attendance but was highly associated with degree of overall satisfaction. It is suspected that these problems areas were related to the final degree of satisfaction such that the relationships suffered and poor to fair relationships with the professionals were highly associated with lower levels of satisfaction, as I will explore further in chapter nine. The problem areas of "hassles with family members," and "conflicts in scheduling," were not found to be significantly associated with either attrition or the degree of overall satisfaction.

Synopsis of Findings: Chapter VIII

There were eleven different psychiatrists in the study; five were men and six were women. The average age was approximately thirty-four years old with an average of about six years of experience. Fifteen social workers comprised the remainder of the professionals, where ten were women and five were men. The average age was approximately forty with an average of about sixteen years of experience. No univariate effects were found to exist on the dependent variables as a result of the professionals' gender, age, years of experience or professional type.

Fifty-two percent of the patients perceived the skills of the professionals as ineffective to some degree, while another thirty-one percent perceived the professionals' behaviors as effective to some degree. The remaining nineteen patients perceived the professionals' skills as neither effective nor ineffective, in what was termed just "adequate." The degree of the perceived effectiveness of the professionals' behaviors was strongly associated with continuance and satisfaction as anticipated. That is, patients who perceived the professionals as being "mostly effective" and "effective" were far more likely to remain in treatment with greater degrees of satisfaction than those who felt the professionals were inadequate.

The four items constituting the Professional Relationship Quality Scale were found to be statistically homogeneous and did appear to capture the same concept being measured. Forty-four percent of the respondents felt the quality of the relationship was

either poor or fair. Thirty-seven percent perceived the quality of the professional relationship as either good or excellent, while the remaining nineteen patients perceived the relationship as "mediocre," (somewhere between fair and good). Feelings about the professional relationship were found to be associated with both continuance and degree of overall satisfaction: The better the patients felt about the relationship, the more likely they were to continue with greater degrees of satisfaction.

Of the sixty-six patients comprising the rapid and remainer study groups, approximately forty-nine percent of these patients perceived the quality of the initial psychiatric relationship as being fair or mediocre. Almost half of these patients felt the initial psychiatric relationship was a good one while two people (about three percent) perceived it as excellent. It was interesting to note that none of the patients who continued beyond the initial intake session, perceived that initial relationship as poor. This suggested which proved to be the case, that the initial feelings about the psychiatric relationship were highly associated with both continuance and degree of overall satisfaction.

Of the six logistical problem areas explored, the perception of the initial waiting list as having been too long and transportation problems were negatively associated with both the length of stay and overall satisfaction. In addition, "problems with affording the fee" was found to be negatively associated with the degree of overall satisfaction.

Next, in chapter nine, I will explore the inter-relationships of the most salient treatment variables as well as the contributing effects of these variables when examined in various combinations on the dependent variables of continuance and satisfaction.

Chapter IX

Findings:

Multivariate Analysis of the Professional and Treatment Variables

Introduction

In this chapter I will attempt to find the most economical combination of professional and treatment variables that best explain the greatest amount of variance in continuance and satisfaction. First, the professional variables will be explored for possible combined effects that were not found on an univariate basis. Second, I will focus on specific combinations of professional behaviors that best explain the variance in the dependent variables. This will be followed by an examination of the effect of the professional relationship quality index combined with the specific skills. Related, the combined effects of the psychiatric relationship with the social work skills and professional relationship indexes will be explored in order to answer the question, "To what degree does the initial psychiatric intake effect the subsequent relationship with and perception of the social worker?" Finally, the combined effects of the logistical problem areas found to be significant on a univariate basis will be factored in to the equation along with the professional relationship quality index. I will attempt to determine to what degree concurrent logistical problems affect the perception of the treatment relationship when measured on continuance and degrees of overall satisfaction.

.....Professional Sociodemographic and Related Variables

The univariate analysis of the professionals' variables of age, gender and years of experience, in chapter eight, indicated that each variable was not related to length of stay or satisfaction as expected. The remaining question was whether or not the combined effects of all three variables would contribute significantly to the changes in continuance and satisfaction. A multiple regression analysis was conducted for the three variables for psychiatrists and social workers, separately. The findings indicated that none of the three variables, either individually or in combination, contributed to the variance in either continuance or overall satisfaction. As stated earlier, these results were hypothesized from the literature review in chapter two. Thus; it is reasonable to conclude, on this basis, that there were no effects of the professionals' age, gender, years of experience or professional type on either continuance or degree of overall satisfaction.

Next, I will turn to the combined effects of the perceived professional behaviors on the dependent variables.

.....Inter-relationships and Combined Contributing Effects of the Professional Behavior Items

It was seen earlier in chapter eight that the patients' perceptions of their professionals' skills were highly associated with both continuance and satisfaction. However, in order to assess how the different professional behaviors comparatively contributed to the dependent variables, it is necessary to examine their combined effects. There is an insufficient sample size in which to

examine all seven behaviors in a multiple regression analysis.[1] Given this, the five professional behaviors with the highest correlations to the summed index value were chosen (the correlation matrix for the seven items and the summed index value can be found in appendix I). These include; "Shared Personal Thoughts and Feelings with me," "Felt the Therapist Really Understood Me," "Understood Me Without Having to Put into Words," "Gave suggestions about the things we discussed" and "Helped me to talk about things that were difficult." These five behaviors were examined for the combined contributing effects to continuance and overall satisfaction. An analysis of the multiple regression of these five variables indicated that only one professional behavior was significant, at the .05 level, in contributing to the overall variance in continuance when considered in combination with the other behaviors; "Gave suggestions about things we discussed." Thus, the patient's perception of having received sufficient feedback was the most significant factor, of the five examined, in whether or not the patient would continue beyond the intake session. It would seem that, within the confines of this analysis, patients expected the psychiatrist and social worker to understand them and their feelings so that the presence of these behaviors did not significantly alter a patient's decision to continue. In addition, the perceived absence of sufficient feedback, perhaps early in the first session,

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[1]This is based on the statistical convention of one regression variable per twenty cases in order to retain the integrity of the multiple r square.

may have suggested to the patient that it would not be wise, safe or appropriate to talk about "taboo" areas to someone who had not already provided some feedback. The absence of a significant contributing effect of "Shared Personal Thoughts and Feelings," particularly given the important role of feedback, suggests that many of the patients may have expected to receive "advice" during the initial sessions and not personal thoughts and feelings. Table 9-1 summarizes the contributing beta values and level of significance for the five behaviors that were examined.

Table 9-1

Contributing Effects of Professional Behaviors to Continuance
Multiple $R^2 = .322$, $p \leq .001$

Professional Behaviors	Std. Values	Level of Sig.
Shared Personal Thoughts, Feelings	.223	.0754
Really Understood Me	.174	.3864
Understood Feelings Without Words	-.173	.4177
Gave Suggestions	.266	.0365
Helped To Talk About Taboo Areas	.158	.396

Three of the five professional behaviors contributed significantly to the degree of overall satisfaction, when considered in combination. These included, in order of significance; "Really Understood Me," "Gave Suggestions about the things we discussed" and "Shared Personal Thoughts and Feelings With Me." In addition, it should be noted that these five professional behaviors, in combination, accounted for over seventy-six percent of the variance in satisfaction as opposed to thirty-two percent of the variance in number of attended sessions. It is also interesting to note that the perception of sufficient feedback is important not only to continuance, but to a patient's degree of satisfaction as well. Thus; once a patient made the decision to continue, it was the presence

of feeling understood by the therapist and having had the therapist share personal thoughts and feelings that contributed to the overall degree of satisfaction. Table 9-2 summarizes these findings.

Table 9-2

Contributing Effects of Professional Behaviors to Satisfaction
Multiple R^2 = .763, $p \leq .001$

Professional Behaviors	Std. Values	Level of Sig.
Shared Personal Thoughts, Feelings	.152	.0414
Really Understood Me	.324	.0075
Understood Feelings Without Words	.236	.0634
Gave Suggestions	.166	.0273
Helped To Talk About Taboo Areas	.141	.2028

.....Combined Contributing Effects of Skills with the Professional Relationship Quality Index

In chapter three it was hypothesized that the professional behaviors would be associated to continuance and satisfaction through their association with the quality of the therapeutic relationship. In order to test for this, the four behaviors that contributed the greatest degree each to continuance and satisfaction were selected so that the therapist quality index could be regressed along with these four corresponding professional behaviors.

The findings indicated that the professional behavior of providing feedback remains statistically important in its contribution to the total number of attended sessions. Next to this behavior, the perceived quality of the therapeutic relationship contributed to the overall variance in number of attended sessions, followed by the professional behavior of sharing personal thoughts and feelings. It is interesting to note that the contributing strength

of sharing personal thoughts and feelings diminishes somewhat when you factor in the relationship quality index (from .223 to .18) suggesting that some of this skill's contribution to the overall variance is accounted for by the quality of the professional relationship, as suspected. In addition, the contributing effects of "Helped to Talk about Taboo Areas," essentially vanishes suggesting that this skill's variance is almost entirely accounted for by the quality of the relationship. Related, the standardized beta value for the skill of providing feedback increases slightly (from .223 to .290) when you factor in the quality of the relationship, suggesting that this skill is contributing to the variance in continuance aside from its association to the professional relationship. A reasonable albeit cautious conclusion, is that patients feel that they are "getting something" when the professional, particularly the intake person, provides immediate feedback for their consideration. It would appear that the perception of having received something tangible, for your time, money and effort, is more important than liking the therapist or feeling liked by the therapist when considering whether to continue or not. Table 9-3 summarizes these findings.

Table 9-3

Contributing Effects of Professional Behaviors With Relationship Quality Index to Number of Attended Sessions
Multiple $R^2 = .34$, $p \leq .001$

Four Behaviors with Relationship	Std. Values	Level of Sig.
Shared Personal Thoughts, Feelings	.18	.1506
Really Understood Me	-.145	.4717
Gave Suggestions	.29	.0218
Helped To Talk About Taboo Areas	-.011	.9475
Relationship Quality Index	.358	.0759

The quality of the therapeutic relationship when combined with the four top contributing professional behaviors accounts for

an additional three percent of the variance in the values for overall satisfaction. In addition, the therapeutic relationship represents the greatest contributing variable to the patient's degree of overall satisfaction, as expected. What is most noteworthy is how the contributing effects of the skills change. The combined contributing effects of the three behaviors of "sharing personal thoughts and feelings," "really understood me," and "understood feelings without words," are completely explained through their association to the quality of the relationship. However, the professional behavior of providing feedback increases in its relative combined strength (from .166 to .198), when considered together with the quality of the relationship, in explaining the change in patient satisfaction. This strongly suggests that there is something unique about having received feedback, that is not explained by the quality of the therapeutic relationship, when considering continuance and satisfaction in outpatient psychotherapy. Thus; in order of significance, the perceived quality of the professional relationship together with the skill of providing feedback, accounted for most of the variance in the patients' degrees of overall satisfaction with the treatment experience. Table 9-4 summarizes the combined contributing effects of the four professional behaviors with the quality of the professional relationship.

Table 9-4

Contributing Effects of Professional Behaviors With Relationship Quality Index to Degree of Overall Satisfaction
Multiple R^2 = .795, $p \leq .001$

Four Behaviors with Relationship	Std. Values	Level of Sig.
Shared Personal Thoughts, Feelings	.102	.144
Really Understood Me	.161	.1734
Understood Feelings Without Words	.077	.5173
Gave Suggestions	.198	.0041
Relationship Quality Index	.486	.0001

.....Combined Contributing Effects of the Professional Behavior Index, Social Work Relationship Index and the Psychiatric Relationship Index

So far, the data have been analyzed and discussed in aggregate form for all one hundred subjects. However, in order to examine the effects of the initial psychiatric intake on the ensuing relationship with and the perception of the social worker, I need to focus our attention on the sixty-six patients who continued beyond the psychiatric intake session (groups II and III). The first task is to examine the combined contributing effects of the professional behavior index and the (social work) professional relationship quality index on each of the dependent variables.

When you examine the professional behaviors as a whole, that is, as an index of the seven behaviors combined and add the effects of the quality of the professional relationship into the multiple regression equation, the results are startling. Approximately thirty-six percent of the change in continuance can be attributed to these two variables in which the quality of the professional relationship with the social worker significantly accounts for most of the variance. In other words, the effects of the social workers' skills on continuance can be virtually explained by the quality of the social

work relationship. (A curious finding was the occurrence of a negative slope in regard to the skills which will be addressed later when I factor in the effects of the psychiatric relationship on continuance.) Table 9-5 illustrates these findings.

Table 9-5

Contributing Effects of Professional Behaviors With Relationship Quality Index to Number of Attended Sessions
Multiple $R^2 = .356$, $p \leq .001$, $N = 66$

Social Work Skills and Relationship	Std. Values	Level of Sig.
Social Work Professional Behaviors	-.316	.144
Social Work Relationship	.856	.0002

These findings become clearer when I observe the combined effects of the social workers' professional skills and relationship quality index on the dependent variable of satisfaction. A very interesting phenomenon occurs: Now both the professional skills and the professional relationship contribute equally and powerfully to the variance in overall satisfaction. I believe the interpretation of these findings are clear. The initial feelings a patient has for a therapist are critical in determining whether or not that patient will continue beyond the first few sessions. Once the decision to continue has been made, the quality of that relationship is no longer a sufficient condition in determining future patient satisfaction with the service: The patient must feel that the social worker has actually done something (feedback, reframing, offering suggestions, etc.) that has been helpful in affecting a change in the presenting problems. Table 9-6 illustrates the dramatic change in the combined contributing effects on satisfaction.

Table 9-6

Contributing Effects of Professional Behaviors and Relationship Quality Index on Overall Satisfaction
Multiple R^2 = .856, $p \leq .001$, N = 66

Social Work Skills and Relationship	Std. Values	Level of Sig.
Social Work Professional Behaviors	.471	.0001
Social Work Relationship	.488	.0001

Now I will examine any significant changes of the contributing effects of the "social worker" variables on continuance and satisfaction when the contributing effects of the initial psychiatric relationship are factored in.

It may be recalled from chapter eight that the patients' initial feelings about the psychiatric relationship were highly associated with continuance and satisfaction for the patients who continued beyond the first session. Those findings can now be better explained. When you examine the contributing effects of the social workers' skills and the social work relationship along with the quality of the psychiatric relationship something very curious happens. The contributing strength of the social work relationship diminishes, what she actually did now becomes very salient in a paradoxical way and the effects of the initial intake increase the proportion of the variance on continuance by about three and half percent. That is, when you factor in the contributing effects of the psychiatric relationship, the social workers skills become significant at the .04 level but in a negative way: Lower levels of agreement on the presence of professional behaviors becomes significantly associated with a greater number of attended sessions! I believe I can offer an interpretation of these findings on the basis

of having worked at the Pride for many years as a social work psychotherapist.

The idiosyncratic procedure at the Pride of seeing one person (a psychiatrist) for an intake and another (social worker) for the "ongoing treatment" can have a very disruptive effect on the patient's course of treatment, particularly (but not only) when the initial relationship with the intake psychiatrist was perceived as a very rewarding one. In this instance, when the patient has had a very positive intake experience, it is essential for the social work practitioner to treat the initial "therapy sessions" as if the patient was a "transfer case." In other words, the social worker must be sensitive to certain transitory feelings of loss, or of being cheated (where the social worker is viewed as a "lower-level" therapist), or of being passed on, etc. when the relationship with the psychiatrist has been a particularly good one. Such sensitivity might reflect itself in "doing" (speaking) less and listening more. That is, it would appear that very active participation on the part of the social work psychotherapist, when the psychiatric relationship has been a particularly "close" one, is viewed as intrusive and heightens the patient's sense of loss. I would think that this would be especially true for those patients who would be diagnosed as "borderline personality disorder," who have a proclivity toward what Masterson and others have referred to as "instant intimacy," (Masterson, 1981). Table 9-7 illustrates the contributing beta weights for the variables just discussed.

Table 9-7

Contributing Effects of Professional Behaviors, Relationship Quality Index with Psychiatric Relationship to Number of Attended Sessions
Multiple R^2 = .39, $p \leq .001$, N = 66

S.W. Skills, S.W. Rel, MD Rel	Std. Values	Level of Sig.
Social Work Professional Behaviors	-.445	.0484
Social Work Relationship	.79	.0004
Psychiatric Relationship	.265	.0678

When you factor in the contributing effects of the psychiatric relationship when considering the changes in overall satisfaction, essentially nothing happens: The contributing strengths of the social workers' professional behaviors and relationships with the patients remain equally strong in accounting for about eighty-six percent of the variance in satisfaction. Thus, the powerfully significant univariate association of the psychiatric relationship with satisfaction is entirely mitigated or mediated by the intervening effects of the social workers' skills and abilities to develop sound working relationship with the patients. Table 9-8 summarizes these findings.

Table 9-8

Contributing Effects of Professional Behaviors, Relationship Quality Index with Psychiatric Relationship to Overall Satisfaction.
Multiple R^2 = .866, $p \leq .001$, N = 66

S.W. Skills, S.W. Rel., MD Rel.	Std. Values	Level of Sig.
Social Work Professional Behaviors	.441	.0484
Social Work Relationship	.443	.0004
Psychiatric Relationship	.061	.3667

.....Combined Contributing Effects of the Logistical Problem Areas with Relationship Quality Index on Continuance and Satisfaction.

It was discussed earlier, in chapter eight, that two logistical problem areas were found to be associated with both continuance and satisfaction; the perception of a long waiting list and difficulties with travel or transportation arrangements. Additionally, problems with affording the fee were highly associated with overall satisfaction, but not with number of attended sessions. Therefore, the plan is to examine the combined contributing effects of the problem areas and treatment variables known to be significantly associated with continuance or satisfaction.

Earlier in this chapter I discovered that the quality of the professional relationship was the prime factor contributing to the patients' number of attended sessions. The question then, is how will the impact of the professional relationship change when the patients' concurrent practical problems are factored in? In order to test for this, the quality of the professional relationship was regressed along with the problems of the waiting list and problems with transportation arrangements. The findings proved to be more profound than expected: Perceived problems with the waiting list superseded the quality of the professional relationship in contributing to the overall variance in continuance. What is also interesting to note, is that the univariate significance of "transportation problems" problems becomes entirely "absorbed" by the mutual variance shared among "problems with the waiting list" and the professional relationship. That is, the amount of change in

continuance due to transportation problems can be entirely accounted for by feelings regarding the waiting list and the professional relationship. Table 9-9 illustrates these findings.

Table 9-9

Contributing Effects of Logistical Problems with Professional Relationship on Number of Attended Sessions
Multiple R^2 = .271, $p \leq .001$

Problems with Prof. Relationship	Std. Values	Level of Sig.
"Waiting List Too Long"	-.29	.0071
"Transportation Problems"	-.018	.8522
Professional Relationship	.291	.009

The fact that the contributing effects of the professional relationship on continuance diminished when considered along with concurrent practical problems, made me curious about how the effects of the professionals' behaviors would change in the context of these new findings. In order to determine this, the professional behavior index was regressed along with the other three variables, above. Viewed in this way the contributing effects of each of the variables changes dramatically. The strength of the professional relationship diminishes entirely and the increased change in the variance on continuance can now be explained by what the professional actually did (in a positive way this time). This suggests that antagonistic feelings about concurrent logistical problems were highly mediated by how the professionals responded to the patients. In other words, it appears that these problems are primarily important to and remembered by patients (in retrospect) when there is concomitant dissatisfaction with the professionals' level of perceived effectiveness, as if to suggest, "I

can't believe I waited so long for this!" Table 9-10 summarizes these findings.

Table 9-10

Contributing Effects of Logistical Problems with Professional Relationship and Professional Behaviors on Number of Attended Sessions
Multiple $R^2 = .316$, $p \leq .001$

Problems, Relationship, Skills	Std. Values	Level of Sig.
"Waiting List Too Long"	-.231	.0316
"Transportation Problems"	.026	.7836
Professional Relationship	.027	.86
Professional Skills	.386	.0143

In regard to the degree of overall satisfaction, the logistical problem of affording the fee, which was also found to be highly associated with satisfaction in a one-factor analysis, was factored into the equation along with the four variables just discussed to ascertain the combined contributing strengths of each.

The findings indicated that the contributing effects of both the professionals' behaviors and the perceived quality of the professional relationship accounted for most of the variance in degree of overall satisfaction. However, the patients' initial frustrations over the waiting list coupled with the perception of the ongoing fee as unaffordable did contribute significantly to the increase in the overall variance in satisfaction (both at the .05 level). In other words, aside from the associations to feelings about the professionals' skills and the therapeutic relationships, patients who felt they waited too long and were paying more than they should have, tended to be less satisfied with the overall treatment experience. Table 9-11 summarizes these findings.

Table 9-11

Contributing Effects of Logistical Problems with Professional Relationship and Professional Behaviors on Overall Satisfaction
Multiple $R^2 = .833$, $p \leq .001$

Problems, Relationship, Skills	Std. Values	Level of Sig.
Professional Skills	.425	.0001
Professional Relationship	.381	.0001
"Affording The Fee"	-.117	.0202
"Transportation Problems"	-.035	.4769
"Waiting List Too Long"	-.133	.0155

Synopsis of Findings: Chapter IX

The professional variables of age, gender, years of experience and professional type were not found to contribute to either continuance or satisfaction whether taken separately or in combination.

Of the five skills examined in combination, one was found to significantly contribute to the variance in both continuance and satisfaction; the perception of having received feedback from the professionals. In addition, the perception of the professional having shared thoughts and feelings as well as feeling really understood by the professional contributed significantly to the overall variance in satisfaction.

However; when the perceived quality of the relationship was factored into the analysis, only one professional skill proved to contribute significantly to either continuance or satisfaction; the perception of having received sufficient feedback. The other two professional skills were significant only in their association to the quality of the professional relationship, where overall satisfaction was concerned.

The surprisingly large multiple R^2 values of .763 and higher, when satisfaction was the dependent variable of study, led me to wonder to what degree the items used to measure patient satisfaction might be related to the independent measures that were used in this study. In order to determine this, a factor analysis was conducted for the professional behaviors index, the relationship quality index and the patient satisfaction index. The results indicated that this composite of variables was actually logically homogeneous, i.e., measuring the same universe of content (the total matrix sampling adequacy value is .612). It is reasonable to conclude that all three indexes are measuring the global concept of "patient satisfaction with psychotherapy." These findings are summarized in appendix L and will be discussed further in chapter eleven under "implications for future research."

For the sixty-six patients studied who continued beyond the initial intake session, it was found that the ensuing social work relationship was primary in accounting for variance in the number of attended sessions. In addition, although not significant, the contributing effects of the social workers' skills were found to be negative. This curious finding was clarified once the contributing effects of the initial psychiatric relationship were factored in, resulting in a statistically significant and negative impact of the social workers' skills. That is; it was speculated that those patients who felt immediately close to the psychiatrist were more likely to feel a sense of loss, if the social worker attempted to actively engage them too quickly. This heightened sense of loss or anger over having been "transferred" may have been associated with early

dropout rates. However, the initial effects of the psychiatric relationship, which were first found to be highly associated with satisfaction in an one-factor analysis, proved to be insignificant in contributing to the overall changes in satisfaction with the subsequent social work psychotherapist.

Finally; the patients' initial feelings about the waiting list being too long, coupled with the perceptions of what the professional actually did (once off the waiting list), accounted for most of the variance in the number of attended sessions. It is interesting to note here, that when the patients entered the treatment with a resentment over the waiting list, the "relationship" apparently did not "get off the ground" until the professional actually engaged the patient, perhaps on that very issue of the waiting list, with specific skills.

A more distressing finding, perhaps, was that patients' initial feelings about the waiting list being too long coupled with ongoing feelings about being asked to pay a fee perceived as too high, did contribute significantly (although not primarily) to the final degree of overall satisfaction with the entire treatment experience.

Next, I will turn our attention to the combination of both patient and treatment variables (based on chapters seven and nine) that can be used to best explain changes in continuance and degrees of overall satisfaction in outpatient psychotherapy services.

Chapter X

Findings:

Multivariate Analysis of the Patient and Treatment Variables

Introduction

This chapter will attempt to integrate the multivariate findings on both the patient and treatment variables. In essence, I will attempt to explain the greatest proportions of variance in continuance and satisfaction with the least amount of patient and treatment variables. Towards this goal, the most significant multivariate findings from chapters seven and ten, on the patient and treatment variables, respectively, will be used as an initial guideline. Once achieved, the statistical and conceptual relationship between the study's dependent variables of continuance and satisfaction will be discussed, as derived and inferred from the previous findings.

Finally, the remaining research hypotheses pertaining to both patient and treatment variables, as addressed in chapters five through ten, will be summarized.

.....Combined Contributing Effects of the Patient and Treatment Variables on Continuance

Earlier in chapter seven, it was found that four patient variables, in combination, explained about fifty percent of the variance in continuance: In order of significance these were; degree of stress, locus of control, problem causal attribution type and, to a much lesser but significant degree, social class.

It may also be recalled that in chapter nine I discovered that the quality of the professional relationship, particularly for those who continued beyond the initial intake session, was a major factor in accounting for most of the variance in the number of attended sessions.

The remaining questions to be answered are first; how would the inclusion of the professional relationship quality index along with the patient variables affect the overall variance in attendance and second, how would the contributing effects of each variable change, if at all? In order to answer these questions, the professional relationship quality index was regressed along with degree of stress, locus of control, problem causal attribution type and social class.

The overall variance in continuance increased by a highly significant sixteen percent! However, what was most interesting was the manner in which the contributing effects of each of the variables changed. It may be recalled that locus of control, when combined with the other patient variables, was highly significant at the .0007 level. When you factor-in the quality of the professional relationship, the contributing effects of locus of control diminish to the point of being insignificant in adding to the proportion of the variance ($p = .14$). This can be explained by a very strong association between locus of control and the quality of the professional relationship, in which thirty-two percent of the change in the professional relationship index scores are associated with a change in locus of control ($R^2 = .32$, $p \leq .001$). That is to say, patients leaning toward an external locus of control were far more

likely to report poorer relationships with the professionals. Another interesting finding was the manner in which the contributing strength of social class significantly increases when the mutual variance with locus of control is negated or controlled for by the quality of the professional relationship. This suggests that completely aside from their feelings about the professional relationship or their general locus of control, lower class patients do appear to be at greater risk for earlier attrition in psychotherapy. In addition, this finding is not mediated by problem causal attribution type or degree of stress. Table 10-1 summarizes these findings.

Table 10-1

Contributing Effects of Patient Variables With Relationship Quality Index to Number of Attended Sessions
Multiple $R^2 = .615$, $p \leq .001$

Patient Variables with Relationship	Std. Values	Level of Sig.
Social Class	.295	.001
Problem Causal Attribution Type	-.257	.0009
Degree of Stress	.409	.0001
Locus of Control	-.076	.4421
Relationship Quality Index	.442	.0001

In summary then; of the five variables examined, two explain the greatest proportion of variance in continuance; the initial feelings about the professional relationship (especially including the psychiatric relationship for those who dropped out immediately) and degree of stress. That is, patients who did not experience a rapport with the psychiatrists or with the social workers early on in the work, with lower degrees of stress, were at extremely high risk for psychotherapy attrition, in which these two variables together produced the highest F-Ratio accounting for fifty-one percent of the variance in continuance! The third and forth variables to contribute

almost equally to the variance in continuance would be social class and problem causal attribution type which explain an additional five percent each in the changes in attendance behaviors.

Finally, the one other "treatment" variable that was found to significantly contribute to the changes in number of attended sessions was "problems with the waiting list being too long." It occurred to me that the variable of problem causal attribution type might, in fact, mediate this earlier finding. In order to test for this, the variable of locus of control was removed from the previous equation and this problem area was factored in. As suspected, the contributing effects of problem causal attribution type increases slightly and mediates or explains the previous contributing effects of "problems with the waiting list." That is to say, those patients who attributed the causes of their problems to either "environmental" or "situational" factors were the ones most affected by a long waiting list. Thus; I believe it can be clearly argued that one of the latent and major effects of a psychotherapy outpatient waiting list (at least for the agency of study) is to eventually suppress the number of ongoing patients who do not present with explanations of their problems that involve some aspect of "self." Table 10-2, below, summarizes the beta values for these findings.

Table 10-2

Contributing Effects of Patient Variables With Relationship Quality Index to Number of Attended Sessions
Multiple R^2 = .665, $p \leq .001$

Patient Variables with Relationship	Std. Values	Level of Sig.
Social Class	.245	.0043
Problem Causal Attribution Type	-.252	.0027
Degree of Stress	.313	.0004
"Waiting List Too Long"	-.148	.1006
Relationship Quality Index	.484	.0001

.....Combined Contributing Effects of the Patient and Treatment Variables on Satisfaction

The findings from chapter seven indicated that only one patient variable significantly contributed, in a multivariate analysis, to the overall variance in satisfaction; locus of control. Related, two treatment variables were found to contribute very significantly to the variance in satisfaction; perception of the professionals' behaviors and the quality of the professional relationship. Consequently, these three variables were regressed on satisfaction in order to observe the combined effects.

The findings indicated that the patient variable of locus of control does not contribute, essentially at all, to the overall variance in satisfaction. The quality of the professional relationship apparently accounts, entirely, for the variance due to locus of control previously found on satisfaction. The two treatment variables of the quality of the professional relationship and perception of the professionals' behaviors (in that order) account for eighty-one percent of the variance in the satisfaction scores. Table 10-3 illustrates these findings.

Table 10-3

Contributing Effects of Professional Behaviors, Relationship Quality Index and Locus of Control to Satisfaction
Multiple $R^2 = .805$, $p \leq .001$

Prof. Skills , Relationship , LCB	Std. Values	Level of Sig.
Professional Behaviors	.472	.0001
Professional Relationship	.488	.0001
Locus of Control	.002	.9725

Finally; an attempt was made to further analyze the finding in chapter nine that, perceptions of the waiting list as too long and problems affording the fee contributed significantly to the variance

in satisfaction. All patient variables were regressed along with the professional behavior index, the professional relationship quality index and the two logistical problem areas of "waiting list too long" and "affording the fee," one at a time, on the dependent variable of overall satisfaction. Not one patient variable was found to significantly mediate or shift the combined contributing effects of the four treatment variables mentioned. Conclusion of these findings suggests that four treatment variables explain the changes in the patients' degrees of overall satisfaction, in order of significance; the professionals' skills, the quality of the professional relationship, initial perceptions of the waiting list being too long and difficulties in affording the fee.

-The Association Between Continuance and Satisfaction-

It has been found that different sets of variables were responsible for explaining the changes in continuance and satisfaction. The reason for these differences can be best explained by the finding that length of stay and degree of satisfaction were not one in the same. Table 10-4 illustrates the statistical association between "dropout group" and degree of satisfaction.

Table 10-4

Observed Percentages of Degree of Satisfaction By Group Assignment

Degree of Satisfaction	Immediate Intake Only %	Rapid 1-12 %	Remainers 25 or More %	Totals %
Mostly Dissatisfied	72	78	40	67
Dissatisfied Satisfied Totally Satisfied	28	22	60	33
Totals	n = 34	n = 36	n = 30	N = 100

Chi-square = 25.87; df = 2, $p \leq .001$

It can be observed in the table above that over one-forth of the patients studied, who dropped out of the process immediately after the psychiatric intake, were in fact satisfied to some degree with what they received, as was illustrated by the case of Doris. Similarly, forty percent of the thirty patients who remained for at least twenty-five sessions were dissatisfied to some degree, as was illustrated by Ben's vignette. However, for the majority of the patients, there was a direct relationship between immediate satisfaction and continuing with the treatment. What this chapter has essentially demonstrated is that the set of variables accounting for immediate satisfaction (and thus the decision to continue further) are quite different in accounting for the overall degree of satisfaction over time.

The association between satisfaction and continuance, such that initial satisfaction with the professionals led to further continuance in the process, suggests that the set of variables accounting for the variance in "continuance" are essentially indicators of immediate satisfaction, whereas the set of variables accounting for the variance in the dependent variable of "satisfaction" are essentially indicators of continued or long-term satisfaction. In other words, for those patients who dropped out immediately with low degrees of satisfaction, the set of variables accounting for "continuance" best explain this type of outcome. Related, for those patients who continued beyond twenty-five sessions with high degrees of satisfaction, the variables accounting for "satisfaction" would seem to best explain this type of outcome.

However, when the relationship between satisfaction and continuance is not a linear one, i.e., patients who dropped out earlier with high degrees of satisfaction and patients who remained longer with low degrees of satisfaction, then the combination of variables accounting for both continuance and satisfaction are required to explain both of these non-linear types of outcomes. This will be the conceptual framework used in discussing the implications of these findings in chapter eleven.

Synopsis of Findings: Chapter X

Four variables, in combination, were found to contribute sigificantly to the proportionate variance in continuance. In order of contributing strength these were; the quality of the professional relationship, the patients' degree of stress, social class and problem causal attribution type. The amount of variance contributed by the patient variable of locus of control, as discussed earlier in chapter seven, was found to be completely explained by the quality of the professional relationship. That is, aside from its association to the quality of the professional relationship, locus of control did not contribute uniquely to the changes in attendance behaviors.

An integrative analysis of the patient and treatment variables could not account for any additional variance in overall satisfaction already found to exist on the four treatment variables discussed in chapter nine. These were, in order of contributing strength; the professionals' perceived behaviors, the quality of the professional relationship and to much lesser degrees, problems with the length of the waiting list and affording the ongoing fee.

Finally, a conceptual framework for understanding the different sets of contributing variables was posited on the basis of the earlier findings and a chi-square analysis of the association between satisfaction and continuance. Namely, that the dependent variable of "continuance" is indicative of immediate patient satisfaction and the dependent variable of satisfaction is indicative of long-term satisfaction when the association between satisfaction and continuance is linear. In addition, it was suggested that when the association between satisfaction and continuance was non-linear, then both sets of independent variables accounting for the variance in both continuance and satisfaction should be used in explaining the various outcomes.

Here I will summarize the findings on the study's remaining research hypotheses that have been addressed in chapters eight through ten.

.....Summary Discussion of the Relevant Research Hypotheses

Hypotheses Related to Therapist Variables:

- Different matched combinations between therapist and patient on age and sex will not effect satisfaction with the treatment relationship or number of attended sessions.
- Therapist's of patients who are most satisfied with the relationship are likely to have more experience.
- Therapists successful at engaging lower SES patients are just as likely to engage higher SES patients.

- Therapists successful at engaging higher SES patients are not necessarily just as likely to engage lower SES patients.

Findings:

The therapist's sex, age and level of experience as well as type of professional degree were not found to be associated with length of stay or degree of overall satisfaction. Thus, any hypotheses stating associations between therapist variables and patient continuance and degree of satisfaction would have to be rejected.

Conclusion: The null hypothesis is accepted in all cases.

Hypothesis:

- External locus of control is more likely to be associated with poorer working relationships with higher rates of earlier attrition and low levels of patient satisfaction.

Findings:

Thirty-two percent of the differences in the patients' perceptions of the quality of the working relationship could be explained by the patients' locus of control and this finding was highly significant. To the degree that the quality of the professional relationship mediated the effects of locus of control on both the dependent variables of continuance and satisfaction, I would have to accept this hypothesis as stated.

Conclusion: Hypothesis are accepted as stated.

Hypothesis:

- The quality of the working relationship should mediate the effects of the Professional Skills Index on the number of attended sessions and overall patient satisfaction.

Findings:

The quality of the professional relationship was found to mediate the effects of the professionals' skills on length of stay. However, perception of the professionals' skills was just as important in explaining the changes in the patients' overall satisfaction.

Conclusion: Hypothesis is rejected as stated.

Hypothesis:

- The presence of logistical problems should be negatively associated with the number of attended sessions and the degree of overall satisfaction.

Findings:

It was found that patients with environmental and situational problem causal attribution types were significantly affected by the perception of a long waiting list when considering the variance in continuance. In addition, patients who peceived the waiting list as too long and perceived the fee as unaffordable were significantly and negatively affected in their degree of overall satisfaction.

Conclusion: Hypothesis is accepted as stated.

Chapter XI

Implications of the Study

Introduction

Chapter eleven will begin by highlighting the study's major findings. This overview will then be used to discuss the implications for social work practice, education, empirical and theoretical knowledge building and, finally, future research endeavors.

.....Overview of the Major Findings

It was found in the earlier chapters that particular sociodemographic characteristics of the both the patients and the professionals do not have any significant effects on, what I will refer to as, short-term and long-term degrees of overall satisfaction with outpatient psychotherapy services. Consequently, knowing a patient's age, marital status, gender or religion as well as the therapist's age, gender, years of experience or professional degree does not tell us anything about whether the patient will be satisfied, dissatisfied, continue or discontinue with the treatment process. This finding was not surprising as it was predicted by previous empirical research.

This study did, however, underscore some very important pieces of information one should know when attempting to understand attendance behaviors, degrees of satisfaction and, perhaps more critically, the association between a patient's degree of satisfaction and the decision to continue or not.

First of all, we need to know not just how the patient felt about the person who conducted the intake, but how the patient perceived the intake person's feelings about him or her. This proved to be the

foremost critical factor in determining immediate satisfaction and, for most of the subjects studied, continuance as well. This variable proved to be so important that any patient who perceived the mutual quality of this initial relationship as a poor one, never returned to the agency again. It appeared from both the statistical analyses and my impressions during the interviews, that this initial intake session served to set the tone, a certain mindset, if you will, on the part of the patient as to what could be expected from the duration of the services. A more surprising although related finding and one that has direct implications for social work practice, was the effect of a very positive intake psychiatric relationship on the subsequent work with the social work psychotherapist. The findings strongly suggested that when the relationship with the intake psychiatrist was a particularly satisfying one, the subsequent attendance behaviors, over the course of the following twelve sessions, was directly related to the perceived absence of specific social work behaviors. The point, for the time being, is that the initial intake session clearly has profound effects on the patient's decision to continue with the process.

The patient's perceived degree of stress, as caused by the presenting problems, was another highly critical variable associated with immediate satisfaction and, again, the decision to continue. At first glance it would appear, as suggested throughout this study, that degree of stress served as some partial measure of "treatment motivation" and as such the findings on this variable were not surprising. But, there is another aspect of this finding that has not been addressed because this study did not measure the professionals' perceptions of the patients' degrees of stress. Psychoanalytically

trained therapists would have a tendency to view a patient's degree of stress as both an indicator of intra-psychic conflict and self-awareness. Thus; patients who presented with low degrees of stress, particularly when the examiner might have perceived this as a sign of denial, resistance or just plain "inappropriateness for treatment," may have received a non-verbal communication from the examiner that was not reflected by the quality of the relationship index. In other words, it may not only be that more distressed patients are more motivated to continue, but that less distressed patients are responded to as if to suggest they should not continue. This seems to speak to a psychotherapeutic bias towards patients who are clearly more distressed about their problems. This finding also has important practice implications, as will be discussed shortly, particularly when you consider that a patient's degree of stress was not associated with overall or long-term satisfaction with the services received.

Related to degree of stress, at least in interpretation, was the finding that a patient's causal attribution type also contributed to immediate satisfaction as measured by the variable continuance. We, as "therapists," if not clinical social workers, prefer patients who attribute some aspect of "self" as the cause of their problems. We perceive them as healthier for doing so and they receive better prognoses for change. We feel more on an equal plane; that the patient's agenda and our's are one in the same. It may occur to us and to the patient, if he hasn't already been "told so," that he might have come to the wrong place for help. Of course, what we really believe is that the patient with environmental or situational problems really does need our help, but just isn't able or willing to accept responsibility for

personal change. Perhaps, those of us who pride ourselves on our "clinical training and expertise," become anxious when faced with problems that do not lend themselves well to the "talking cure," in which we may fear professional impotence. I am reminded of a schizoid-schizoaffective former patient of mine whose life, in a word, was in shambles. He was constantly disheveled and unshaven, he was forever on the verge of being evicted from his apartment and life for him and his two troubled sons was a constant fight for survival. After several months of painstaking work and feeling as if absolutely nothing was changing, I looked up at him during one of our sessions and, in a somewhat frustrated, pleading, exasperated tone asked him if he knew what it was we were doing together. He looked back at me with some concern at first, then smiled while he straightened himself up in his chair, combed his uncut and matted hair back with the palm of his hand and said, "It's called 'maintenance,'.....why, didn't you know that?" I never again questioned the validity and salience of our sessions together.

The patient's position of social class also proved to be a significant indicator of continuance in psychotherapy, although not to the degree expected from previous empirical research. What was most interesting about the finding was that social class was significant when the quality of the relationship, the degree of stress and problem causal attribution type were, essentially, controlled for. This means that aside from the mutual associations social class has with the other variables mentioned, there is something intrinsic about being poor and working class that weighs against the probability of continuing for more than twelve sessions of therapy. The literature, as discussed in

chapter two, primarily explains this empirical finding on the basis of "socialization." Namely, that poor patients who come from working class and poor families are not socialized to conceptually appreciate how "just talking" about a problem can make it better. These patients are "action oriented," where talk is considered "cheap." I believe the reason this study's findings were not nearly as dramatic as some of the other's reported earlier, is that the "poor" patients in this study had middle-class families of origin in which their transitory poverty was primarily induced by divorce.

Two variables were found to account for most of the variance in long-term satisfaction; the actual skills of the social worker and the quality of that therapeutic relationship. It was interesting to observe that each variable contributed uniquely to the changes in long-term satisfaction. That is, completely aside from the fact that certain skills help to establish the therapeutic relationship, certain skills lead to overall satisfaction independent of the relationship. One skill, of the five that were separately examined, significantly contributed to the variance in long-term satisfaction; the professional behavior of offering suggestions about the material discussed. The practice implications of this finding will be discussed later in the chapter.

Perhaps the most disquieting finding of all was that the patients' initial feelings about the waiting list being too long and being charged a fee that was perceived as causing financial problems, significantly contributed to the variance in long-term overall satisfaction with the services received. This has profound implications for social work practice which will be addressed in the following section.

.....Implications for Social Work Practice[1]

The general practice concept of "starting where the client is," seems to get lost when we define the goal of the work as psychoanalytically oriented psychotherapy. Under this rubric, we expect the patients to start where we are and, apparently, for most of the patients studied, this approach does not work.

The principal practice implication that clearly emanates from this study is the need to be more flexible in defining what constitutes a legitimate psychotherapy patient and, related, what professional behaviors and skills constitute psychotherapeutic technique. I do not see the potential technical harm in working with a mother of an acting-out adolescent girl, where the mother's pathology is not *initially* made the focus of the work. To the degree the mother may become aware, perhaps for the first time, of her own inability to follow through on what she knows she must do, then and perhaps only then, should the focus of the work shift to understanding the nature of the mother's resistance in affecting change at home. Too often the therapists, in this study, skipped the step and skill of "offering suggestions" based on the initial complaint (that is, perceptions of the cause) and went directly to working on the patient's pathology (because *we* knew that ultimately this would prove to be more effective for the patient). And, to the degree the patient felt negated or misunderstood, or disapproved of, he or she became dissatisfied and interrupted the work. It is interesting to note here, that the patient discussed earlier

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[1]This section does not necessarily pertain to the Pride of Judea Mental Health Center. The implications for practice are based on the prototype of the free-standing outpatient mental health clinic that provides psychotherapy and operates on a fee-for-service basis.

who was totally satisfied with the one intake session she had with the psychiatrist (and thus didn't care to return), reported being given specific advice on how to deal with her son's concerns about her living alone.

As discussed earlier, patients who presented with "environmental" and situational problem causal attribution types were most likely to drop out by the twelfth session with low degrees of satisfaction. One explanation for this finding lies in the understanding of the interaction between agency policy and the professional tasks inherent in effective practice with patients who present with situational crises. Patients who are less functional or who present with multiple problems or crises, necessarily require more time, energy and resources from the therapist *and agency*. Without sufficient agency support and sanction, social workers may feel caught, somewhere between a rock and a hard place, when faced with patients who require any services beyond the constraints of the weekly, forty-five minute office visit. Lower functioning and multiple-problem patients do require more contact time and energy in the form of between-visit telephone interventions, inter-agency contacts, letter writing, additional staff meetings and, often, inquiries to other agencies regarding available community resources; that is, case management. Social work psychotherapists faced with agency demands and differential reward systems based on the retention of ongoing cases and the maintenance of a fixed number of patient visits per week, would necessarily (I believe) view the more troubled, multi-problem patient as an anathema. To the degree this interpretation is correct, this feeling, on the part of the therapist, would have to be

communicated to the patient on some level, early in the work. This, alone, would account for the poorer qualities of the professional relationships found in patients with stimulus and situational causal attributional types and, also, in patients with an external locus of control (to the degree these patients expected change as a consequence of the therapist's actions). An essential practice implication then, is the need for agency administrators to realize that not all caseloads, as stipulated numerically, are equal in the amount of work, time and energy required of the therapist. Therapists might be more able and willing to work with "difficult," crisis-laden patients, if agencies were willing (and able) to support and sanction practice with a broader range of patients by, for example, "weighting" caseloads on the basis of the anticipated amount and type of work.

Additional contaminating or intervening effects, of the professional or agency agenda, can be located in the initial psychiatric examination. The explicit agenda for that initial intake session is the assessment of the patient's current mental status and, subsequently, the determination of the patient's appropriateness for treatment. It would appear from the data that the format and questions inherent in a mental status examination are not conducive to "relationship-building." Related and perhaps more to the point, it may be that relatively inexperienced psychiatrists are not sufficiently skilled in the sophisticated integration of the mental status examination into the "natural" flow of the patient's material. Thus, many patients would appear to feel cut-off, discounted or negated when the examiner attempted to re-direct their material back to the agency's agenda at hand. Viewed in this way, the powerful effects of the perceived quality

of the initial professional relationship on continuance or short-term satisfaction becomes self-apparent.

Another practice implication that directly emanates from both the findings and the above discussion, is the critical need for the social work therapists to become more aware of the patients' feelings about the initial psychiatric session, whether positive or negative. It was found and discussed earlier in chapter ten that when the psychiatric relationship was perceived as a particularly good or close one, there was reason to suspect feelings of loss, anger, or being cheated when the patient necessarily had to leave that beginning relationship and start a new one with the social worker. In not one case, of the sixty-six patients questioned, did the social work psychotherapist even ask about how the intake session went.

On the basis of these findings and interpretations, it would appear to be far less disruptive to the patients and their subsequent treatments with the social workers, if one clinician could conduct both the intake and the treatment. For example, the first session or two, with the social work psychotherapist could be defined as the "intake process" for agency purposes. If a psychiatrist is needed (whether for department of mental health requirements or medication, etc.), the attrition rates at outpatient mental health centers could be significantly reduced by introducing the psychiatrist after the patient has already had a few sessions with the social worker, to the degree that the initial intake session with the psychiatrist proved to be critically and negatively associated with continuance and long-term satisfaction.

An additional practice implication pertains to an agency's or administrator's procedures and policies regarding waiting lists and fees. The initial effect of the waiting list was to essentially screen out those patients whose immediate concerns were related to crises around relationships and life-cycle types of transitions, e.g., divorce, death of a spouse, adolescent children, etc. Each agency needs to consider this phenomenon, this natural consequence of a waiting list and determine whether or not this is a desired outcome. If not, agencies should then begin to consider ways of reducing the total waiting list time.[2] Patients who reported having problems with the waiting list clearly felt that their needs or request for service had been given a low priority. However; what seemed to bother patients the most, was the fact that no one took the time to address the issue with them. The effects here are similar to being kept waiting for two hours in a doctor's waiting room, in which the doctor then greets you in a matter of fact way, never addressing the fact that she inconvenienced you. This speaks to the earlier practice implication; namely, that professionals need to be more sensitive to and aware of how issues we consider to be "routine," affect patients' attitudes and feelings about treatment, one way or the other.

A related issue was one involving patients' feelings about being charged a fee they considered to be exorbitant for a community mental health center. One has to wonder what it means when a patient who can afford a fee of sixty or seventy dollars per week, applies to a

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[2]It should be noted here, that subsequent to the time period covered by this study, the agency involved, i.e., Pride of Judea underwent some major changes in regard to admission procedures that had the effect of significantly reducing the waiting list time.

"sliding scale" mental health center. Exploration of the "treatment issues" inherent in this type of scenario (e.g., patient does not value himself enough to seek private treatment) would be self-defeating on the part of an agency that relies heavily on patient fees. The treatment issues that are explored pertain to the potential hazards inherent in charging patients less than they should be reasonably able to afford. The psychoanalytic argument generally holds that under-charging a patient is equivalent to fostering pathology around unreasonable and infantile demands that the world be responsible for his or her welfare. This researcher is not insensitive to these issues and generally espouses the merit inherent in setting viable treatment parameters. However, application of these principles can be misused and the potential harm to the resolution of the transference neurosis is critical only when considering "a psychoanalysis proper," which outpatient psychotherapy centers do not offer. Social work practitioners and administrators alike need to consider that certain patients, as a consequence of their very character pathology, cannot tolerate fees that are perceived as intrusive and/or over-demanding. In these cases it would seem more beneficial, to all concerned, to "under-charge" the patient, by a few dollars, until such time he or she can tolerate more realistic demands from the environment. You cannot deal with the fee as a treatment issue if you do not have a patient as a consequence of perceived narcissistic injury or by "realistically" becoming representative of the "withholding" or bad part-object relation unit (in the case of a borderline patient).

.....Implications for Social Work Education

The implications of the study's findings for social work education emanate directly from the implications of the data discussed in the section on social work practice.

Educators need to emphasize the critical importance and role of the "intake" session vis a vis relationship-building with patients. The data clearly suggested that the first few sessions were crucial in establishing both immediate and long-term patient satisfaction with the service received. Students and beginning workers, influenced by the agency's needs, may have a tendency to perceive the intake session as superfluous to the future quality of the working relationship, that is, as being a separate component of the "real" work. However; we need to sensitize students to the fact that for any patient or client who has applied for help, the first session is the most critical part of the real work. This session is used by the patient to determine whether or not the agency or professional can be potentially helpful.

Toward this goal of being helpful and of establishing a sound basis for a working relationship, certain specific skills emerged as being critically important. The patient needs to believe, from the very first contact, that the therapist understands both the manifest content of the material being discussed, as well as the underlying affectual components that have not quite been put into words. Related, the worker must be able to facilitate discussion of material that is perceived by the patient as sensitive or "taboo." Students need to be taught that "client feedback" doesn't necessarily translate into a sophisticated "interpretation" of unconscious or latent processes. Sometimes, telling a patient or client that we "don't have the answers,

but there is a lot here we need to talk more about, to figure out *together*," is exactly the type of "feedback" that reassures patients that we are "on their side" and are motivated and interested in helping them. Students and beginning workers often make the mistake of believing it is their professional responsibility to provide immediate "answers," in order to justify their role as the "helping person." A common practice error, particularly on the part of students, is to deflect the material back to the patient when an answer is not apparent. This often produces paradoxical results by inducing greater feelings of isolation and hopelessness. I think we need to teach our students that sometimes it is not only appropriate, but preferable, to say to a patient "I don't know." Ultimately, it's *how* you say it that counts.

Related, students need to be sensitized to the fact that there is a tendency on the part of practitioners to socialize patients according to agency function, particularly when the presenting complaints are incongruous with agency purpose, rather than to focus on the perceived needs of the patient. This approach had deleterious effects on the quality of the professional relationship and on both short and long term degrees of satisfaction. A sounder, if not kinder approach, would be to offer the patient the degree of relevant service sanctioned by the agency and then to refer elsewhere, if necessary, in order to meet the remaining needs of the patient. This essentially speaks to the need for students of social work to be sensitized to the intervening and powerful effects of agency function and purpose on professional practice and values.

In addition, the two year social work curriculum should include some material on the issues inherent to inter-disciplinary practice, particularly when the agency agenda is established by psychiatry and psychology. Related, it would appear that social work values and norms succumb to the professional norms, values and agendas of the higher status professions, particularly when the social worker's role is identified as "psychotherapist;" as it is in many agencies across the country. One hypothesis for this phenomenon exists in the identification of an apparent "cognitive dissonance" that is inadvertently induced by social work education itself, when we "teach" students that they are not "therapists." Subsequently, the "would-be therapist" students seem to resolve this cognitive dissonance by viewing "social work" practice and "psychotherapy" as polar entities, so that a future professional integration of the two "perspectives" becomes very difficult, if not impossible. Social work educators and schools may need to re-evaluate their role in this schism and further assess ways of integrating, if not sanctioning, the practice of "social work psychotherapy."

.....Implications for Knowledge and Theory Building

This dissertation has dealt with three theoretical concepts, in particular, that I believe have been embellished by the study's findings: These include; attribution theory, locus of control and the "qualities" of a therapeutic working relationship.

Kelly's and Weiner's theories of attribution have been combined and an integrative model, that was empirically tested during this study, has been posited for establishing the predictive causal

attributions of psychotherapy outpatients. Thus, it was demonstrated that attribution theory can become a viable, useful tool for understanding the types of explanations our clients have about their presenting problems. It was further demonstrated that these four causal attribution types have significant implications for service delivery, degrees of immediate patient satisfaction and, subsequently, the decision to continue or not with service.

A patient's general locus of control as to internal or external contingencies of change, was found to have profound implications for the quality of the professional relationship. Thus, it was statistically established that the effects of locus of control of behavior on attendance in psychotherapy, is mediated or explained by the impact a patient's locus of control has on the ensuing relationship. Patients with an external locus of control possessed expectations of the therapeutic relationship that proved to be incongruous with what they encountered. Therefore, the significance of a patient's locus of control in understanding psychotherapy attrition lies within the direct effects it has on the professional relationship.

Finally, this study attempted to measure and capture the essential aspects of the professional relationship and, apparently, was successful in doing that. It was statistically demonstrated that the four items designed for the "scale" were highly homogeneous, i.e., they were measuring the same concept. These four items were 1. I felt the doctor was warm and caring person, 2. I felt the doctor got to know me as a real person, 3. The doctor was a sincere person, truly dedicated to helping people and 4. I felt the doctor liked me as a real person. Although it was not the purpose of this dissertation to design

a "relationship quality scale," it does appear that these four items hold promise for an abbreviated measure of the quality of a psychotherapeutic relationship.

.....Implications for Future Research

It was stated in chapter four that one of the greatest threats to this study's reliability emanated from the research design itself; namely, the use of a post-hoc survey design where respondents are asked to report on events that occurred as long as several months earlier.

The use of this design raises the question of the reliability of the respondents' answers, to the degree that one has no way of controlling for the effects of the treatment experience itself. In other words, is it actually true that a respondent experienced only a "little stress" at the time of intake, or have the effects of treatment mitigated the intensity of the memory of the precipitating events for the patient? There is no clear way to determine this with the use of a post-hoc research design.

A related concern has to do with the findings on the problem causal attribution types. To the degree that most of the patients who remained in treatment reported at least "good" relationships with the social workers, it is difficult to determine if the problem causal attribution type being suggested was the way the problem was originally perceived or if the current recollection was the effect of having been successfully indoctrinated by the therapist's biases. In other words, is problem causal attribution type a "cause" of sound therapeutic alliance and patient satisfaction, or is it really a dependent measure of a successful outcome? It would be useful to conduct

similar studies with a prospective research design to determine if a patient's causal attribution type changes over the course of therapy. Related, why are some patients able to change their perspectives with high degrees of satisfaction while others drop out having been very dissatisfied? What are the characteristics of the patient and therapist that account for this? Is problem causal attribution type another measure of a different aspect of the relationship or are some therapeutic relationships more conducive to helping patients alter their perceptions of themselves and others?

Earlier, in chapter nine, it was demonstrated that the items comprising the client satisfaction questionnaire were logically homogeneous with the professional behavior items and the professional relationship quality scale. The implication seems to be that the patient's feelings about the professional's skills and the therapeutic relationship are, in fact, another way of measuring satisfaction with the treatment experience (as opposed to being "independently" associated with the "dependent" variable of satisfaction). Future research endeavors should explore this phenomenon more thoroughly.

In addition, this study failed to control for treatment modality type and whether or not the administration of medication was a part of the treatment experience. Inclusion of these variables might have yielded more reliable results.[3]

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[3]This point is mentioned here for the sake of methodological accuracy although, for the study at hand, the primary treatment modality at the Pride of Judea Mental Health Center is individual psychotherapy. However, it was not controlled for in this study and this does constitute a methodological error although its effects on the present findings would be negligible.

Future research in this area should be prospective, so as to account for the actual effects of treatment and, perhaps, should include some measurements of the therapists' attitudes toward their patients. It is possible that greater tolerance on the part of therapists for different "types" of patients may have a great deal to do with patient satisfaction with the relationship and ultimately, the motivation for change.

-Concluding Remarks-

This dissertation attempted to hone in, just a little bit more, on the manner in which patient perceptions of themselves and their therapists effect their decision to continue as well as their degrees of satisfaction with the services rendered. A model was proposed for understanding the relationship between continuance in psychotherapy and overall satisfaction. It was suggested that the patient's immediate feelings about the professional relationship, the degree of reported stress, the way the patient explained the cause of the problems and the patient's social class can all be used to explain the patient's immediate or short-term level of satisfaction. If at this point, the patient is mostly dissatisfied, he or she will most likely interrupt the work. Long-term satisfaction was explained by what the therapist actually did, the feelings about the therapeutic relationship and the patient's residual feelings about the waiting list and the ongoing fee being charged. It was proposed that patients who dropped out early with high degrees of satisfaction could be explained by a combination of variables accounting for both continuance and satisfaction; namely, the patient perceived the therapist as having done something very

effective in addition to having liked the therapist, generally with low degrees of stress, involving a problem causal attribution type of "environment" or "situation."

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Appendix A

Cover Letter/Consent to Patients

Dear_____:

I am presently a doctoral candidate at the Columbia University School of Social Work and the former Coordinator of Computer Research at the Pride of Judea Mental Health Center. Your name has been randomly selected from a computer generated list of all clients who have stopped treatment from January 1st, 1987 through March 31st, 1989 at the Pride.

I am currently conducting a research study that is concerned with clients' perceptions of their treatment experience at the agency and how this impacts on their decision to either continue or discontinue the process.

I will be calling you over the next few days to ask you for your participation in this study which will require about fifteen minutes or so of your time on the telephone. The telephone interview will be scheduled at your convenience and will consist of a series of questions concerning your experiences with the agency, the intake doctor and the therapist (if applicable).

This study has been approved by the Columbia University School of Social Work and has been endorsed by the Pride's Executive Medical Director, from whom a letter is enclosed. However, the Pride is not affiliated at all with this study.

This study is strictly confidential. No one but myself knows the names of the people who have been selected to participate. At no time will individual responses or anonymity be disclosed to anyone. There is no risk to you in either participating or declining to participate. And, you may terminate the interview at anytime.

The benefits to you include the opportunity to personally evaluate and share your opinions about professional services in the hope that agencies like the Pride can improve their services to others. Upon being called, you may offer your consent to participate or you may simply decline to participate and you will not be called again.

If you have any questions you would like answered either before or after I call you, you may always contact me at the above number: Simply leave your name and number and I will get back to you as soon as possible.

I am looking forward to speaking with you and hope that you will agree to contribute your very important thoughts, opinions and experience to this study.

Sincerely yours,

Gregory Mavrides, Doctoral Candidate
Columbia University School of Social Work

Encl.

Appendix B

Endorsement Letter to Patients*

Dear _____:

Because our agency is interested in improving its services, we are cooperating with our research coordinator, Mr. Gregory Mavrides, on an independent study he is conducting through the Columbia University School of Social Work.

He will be calling you within the next few days to ask if you could help by spending some of your time sharing your opinions and views about your experiences here.

I want to assure you that any information you provide will be treated in strictest confidence. Your name will not be used in any way, nor will anyone at the agency or anywhere else be able to connect your name with anything you might say.

I hope that you will be able to help us with this study and I thank you very much in advance for your cooperation.

Sincerely,

Melvin A. Scharfman, MD
Executive Medical Director

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* Adapted in part from Maluccio (1978) and Mayer and Timms (1970)

Appendix C

Dissertation Interview Schedule

Introduction to Patient-Thanking them for participation-Can Stop anytime-Confidentiality-Honest answers even if negative, etc.

I would like to first go over some preliminary background information:

SECTION I Identifying Information (From Database)--Ask Pt for purposes of verification:

Pt Code_____ Intake Doctor_____ Therapist (if applicable)_____

Number of Attended Sessions (Including Intake) _____

Group Assignment (I. II. III)_____ Fee for Diagnostic Intake $____

Fee for Ongoing Sessions (if applicable) $____

May I please have your

a. D.O.B.:_____ b. Sex: M F c. Marital Status (S M D Sep W)

d. Religion (J C P EO Other) e. Highest Grade Completed_____

f. Occupation_____

g. Causal Attributions of Presenting Problem

a. Can you tell me something about what brought you to the Pride of Judea, what kinds of difficulties you were having at that time?

Then:

b. As you think back on it now, what was your understanding of what was causing you to have these problems?

h. Perceived Degree of Stress

How much stress would you say you experienced as a result of the problems we just discussed?

1. No stress at all 2. A little bit of stress 3. Some stress 4. A Great Deal of Stress

SECTION II Professional's Behavior Questionnaire

For Groups II and III ONLY

Do you recall the very first appointment you had at the Pride with the intake psychiatrist?

Yes___ Do Not Recall___

If yes, I'd like to ask you just a few questions about it. O.K.?

1. I felt the doctor was a warm and caring person.
5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

2. I did not feel the doctor got to know me as a real person.
   1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

3. The doctor was a sincere person, truly dedicated to helping people.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

4. I felt the doctor liked me as a real person.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

Sum of 1 - 4: Relationship Quality Index____

*If positive responses to above, (15 or better) and did not continue past 4 sessions, ask

You know, you seemed to feel pretty good about your session with the intake psychiatrist and yet you stopped attending the Pride after x sessions. Can you tell me something about your thoughts on this at that time?

*If negative responses, (9 or less), and continued pass the 4th session, ask

You know, it seems that you weren't all that comfortable with the intake psychiatrist and yet you decided to stick it out anyway? Can you tell me something about your thoughts on this at that time?

(*For Groups II and III, substitute 'therapist' for intake psychiatrist)

a. Now, I am going to read a list of different behaviors and skills that the intake psychiatrist(or therapist) may or may not have done during your intake (therapy) session(s). For each skill or behavior choose whether you Strongly Agree, Agree, Disagree, Strongly Disagree or are Undecided.

1. The doctor shared his personal thoughts and feelings feelings with me.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

2. When I told the doctor how I felt, he never really seemed to understand.
   1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

3. At the beginning of my intake with the psychiatrist, (s)he never explained what we would be doing and why.
   1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

4. The doctor let me know his/her feelings about the situations we discussed.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

5. The doctor seemed to understand how I felt without my having to put it into words.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

6. The doctor gave suggestions about the things we discussed.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

7. The doctor was unable to help me talk about subjects that were tough for me to talk about.
   1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

Sum of Items 1 - 7: Behavior Assessment Index____

8. I felt the doctor was a warm and caring person.
   5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

9. I did not feel the doctor got to know me as a real person.
   1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

10. The doctor was a sincere person, truly dedicated to helping people.
    5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

11. I felt the doctor liked me as a real person.
5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

Sum of 8 - 11: Relationship Quality Index____

b. (Locus of Control of Behavior Scale)
The following set of statements are about how various topics affect your personal beliefs. There are no right or wrong answers. For every item there are a large number of people who agree and disagree. For each statement could you tell me whether you Strongly Agree, Agree, Undecided, Disagree or Strongly Disagree.

2. I can anticipate difficulties and take action to avoid them.
1. Strongly Agree 2. Generally Agree 3. Somewhat Agree 4. Somewhat Disagree
5. Generally Disagree 6. Strongly Disagree

3. My problems will dominate me all my life.
6. Strongly Agree 5. Generally Agree 4. Somewhat Agree 3. Somewhat Disagree
2. Generally Disagree 1. Strongly Diasgree

4. My life is controlled by outside actions and events.
6. Strongly Agree 5. Generally Agree 4. Somewhat Agree 3. Somewhat Disagree
2. Generally Disagree 1. Strongly Disagree

5. I am confident of being able to deal successfully with future problems.
1. Strongly Agree 2. Generally Agree 3. Somewhat Agree 4. Somewhat Disagree
5. Generally Disagree 6. Strongly Diasagree

6. People are victims of circumstance beyond their control.
6. Strongly Agree 5. Generally Agree 4. Somewhat Agree 3. Somewhat Disagree
2. Generally Disagree 1. Strongly Disagree

6. When I am under stress, the tightness in my muscles is due to things outside my control.
6. Strongly Agree 5. Generally Agree 4. Somewhat Agree 3. Somewhat Disagree
2. Generally Disagree 1. Strongly Disagree

7. It is impossible to control my fast breathing when I am having difficulties.
6. StronglyAgree 5. Generally Agree 4. Somewhat Agree 3. Somewhat Disagree
2. Generally Disagree 1. Strongly Disagree

8. In my case maintaining control over my problems is due mostly to luck.
6. Strongly Agree 5. Generally Agree 4. Somewhat Agree 3. Somewhat Disagree
2. Generally Disagree 1. Strongly Disagree

Sum of 1 - 8: Locus of Control of Behavior Index:_____

SECTION III (Logistical Problem Areas)

I am going to read a list of problems that some people may have while they are going for help.. For each problem, I would like you to tell me how much you agree or disagree with whether or not this was a problem for you

1. Affording the fee was a problem for me.
5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

2. Transportation problems were not a problem for me.
1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

3. I had problems with child-care arrangements
1. Strongly Agree 2. Agree 3. Undecided 4. Disagree 5. Strongly Disagree

4. Hassles with family members about going all the time were a problem.
5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

5. Conflicts between my work hours and the available appointment time were a problem.
5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

6. The length of the waiting list was a problem.
5. Strongly Agree 4. Agree 3. Undecided 2. Disagree 1. Strongly Disagree

Section IV The Client Satisfaction Questionnaire (CSQ-8)

Next, I will ask you some questions about your feelings about the service you received at the Pride. For each question I will read five possible answers for you to choose from. O.K.?

1. How would you rate the quality of service you received?
4. Excellent 3. Good 2. Fair 1. Poor
2. Did you get the kind of service you wanted?
1. No, Definitely Not 2. No, Not Really 3. Yes, Generally 4. Yes, Definitely

3. To what extent has the Pride met your needs?
4. Almost all of my needs were met 3. Most of my needs were met
2. Only a Few of my needs were met 1. None of my needs were met

4. If a friend were in need of similar help, would you recommend the Pride to him/her?
1. No, Definitely Not 2. No, I don't think so 3. Yes, I think so 4. Yes, Definitely

5. How satisfied are you with the amount of help you received?
4. Quite dissatisfied 3. Mildly Dissatisfied 2. Mostly Satisfied 1. Very Satisfied

6. Have the services you received helped you to deal more effectively with your problems?
4. Yes, they helped a great deal 3. Yes, they helped somewhat 2. No, they really didn't help
1. No, they seemed to make things worse

7. In an overall, general sense, how satisfied were you with the service you received?
4. Very satisfied 3. Mostly Satisfied 2. Midly Dissatisfied 1. Quite Dissatisfied

8. If you were to seek help again, would you go back to the Pride of Judea?
1. No, Definitely Not 2. No, I don't think so 3. Yes, I think so 4. Yes, Definitely

Sum of 1 - 8: Client Satisfaction Index_____

Appendix D

Dissertation Interview Score Sheet

Date of Interview ____/____/89 Time Started ____ Pt Code____ Intake Doctor_____

Therapist (if applc.)_____ No Sess. (Including Intake) _____ Group (I, II, III)_____

Fee for Diag. $____ Fee for Ong Sess. (if applicable) $____

a. D.O.B.:_____ b. Sex M F c. Marital Status (S M D Sep W)

d. Religion (J C P EO Other) e. Highest Grade _____ f. Occupation____ (SES No____)

g. Causal Attribution: Person (Self), Stimulus (Other), Situation, Person-in-Situation

Stress Caused By Problem:___ (1-4)

For Groups II & III Only: Recall Psychiatrist?: Yes (1)___ No(0)___

Perceived Relationship with Psychiatrist:

Item 1___ Item 2___ Item 3___ Item 4___ Sum = Psychiatric Quality Index____

Follow up with open-ended question to qualify Above:

•For Group I- Refers to Psychiatrist Only--For Groups II & III-Refers to Social Worker

Professional Behavior Scores:
Item 1___ Item 2___ Item 3___ Item 4___ Item 5___ Item 6___ Item 7___
Sum Index____

Relationship Quality Scores
Item 8___ Item 9___ Item 10___ Item 11___ Sum = Relationship Quality Index____

Locus of Control of Behavior Scores:
Item 1___ Item 2___ Item 3___ Item 4___ Item 5___ Item 6___ Item 7___ Item 8___

Sum = Locus of Control of Behavior____
(Minimum; 8 = Extreme Internal Locus of Control, Max; 48 = External Locus of Control)

Logistical Problems Scores
Item 1___ Item 2___ Item 3___ Item 4___ Item 5___ Item 6___

Client Satisfaction Scores

Item 1___ Item 2___ Item 3___ Item 4___ Item 5___ Item 6___ Item 7___ Item 8___

Sum = Client Satisfaction Index____

Appendix E

Pride of Judea Mental Health Center
Database Information FaceSheet

(Check One) **First Time Entry** * **Edit Pre-existing Data** *

Pt's First Name_____Last:_____Cs No:_____

Street_____

City:_____St____Zip_____

Telephone # ( )-_____-_____

Diagnostic Fee:$_____ Ongoing Fee:$_____Dt Fee Last.Set__/__/__

D.O.B.____/____/____ Sex: (M F) Marital Stat: (S M Rem Sep D W)

A Medicaid?: (Y N)

B. Referral Source (Circle One that Best Applies)

1 Self 2 School 3 Professional/Clergy 4 Hospital/Day Trtmnt 5 Relative

6 Friend/Non-Pride Pt. 7 Other Pride Pt 8 Legal 9 Advertisement

C. Case Status : 1 New 2 Transfer 3 Re-Application 4 Consult/Evaluation*

*Use Case Status #4 for planned short-term/time-limited cases, e.g., Gifted I.Q., Forensic Consult, etc..If status number 4 is used then treatment code must be #700, Consult/Brief Evaluation, etc
(Note: When Transferring from one therapist to another or from two treatments to one, this is a transfer case. Cross out 'New' and circle '#2' for editing. Then cross out below the name of the therapist no longer involved)
Nothing else changes, i.e, Date Opened and Date First Seen will now remain the same!!!

D. Date of Application: __/__/__ E. Date of Mental Status: __/__/__

F. Date Contacted=Opened: __/__/__ G. Date First Seen: __/__/__

H. Treatment Modality Codes: (Use the following codes for H.1-H.3)

(100 Ind 200 Group 300 Marital 400 Family 500 Counsing 600 Meds 700 Consult/I.Q. test)

H.1 Primary Therapist_____ Tx 1:#_____

H.2 2nd Therapist_____ Tx 2:#_____

H.3 3rd Therapist_____ Tx 3:#_____

I. Diagnoses: Use DSM III-R or ICD-9 Codes only

I.1 Principle Dx: Code: _ _ _ . _ _ Desc: _____
I.2. Secondary Dx: Code:_ _ _ . _ _ Desc: _____

(Indicate Diagnosis Code to appear on Insurance Statements, if different from #1.1):
I.3 Insurance Dx: Code:_ _ _ . _ _ Desc: _____

J. Reg. Major Medical Ins? (Y N) Medicare? (Y N) Is Ins Payable to Pride (Y N)
If Payable to Pride, at what rate?$_____ (If not payable to Pride, insurance fee = ong. fee)
J. Billing Party and Address if different From Above:
C/O
Addr City ST Zip

Appendix F

Closing Summary

(Must be completed for every case with a blue database sheet)

Patient's Full Name_____ Case No._____

Therapist's Name_____

Today's Date:___/___/____

==========

Indicate Reason that Case was Closed
(Circle one that best applies)

1 Planned Termination **2 Thp. Interrupted***

3 Adult Pt Interrupted **4 Parent Interrupted**

5 Pt Never Seen for 1st Sess. **6 Consult/Testing Completed**

***For example, Therapist leaves the agency, or decides treatment is not indicated.**

Estimate Outcome of Treatment
(Circle One that best applies)

1 Little/No Improvement **2 Some Improvement**

3 Marked Improvement **4 Pt Never Seen for 1st Sess.**

5 Consult/Testing Completed (not applicable)

==========

Closing Comments
(Brief Description of treatment closing that relates to above responses)

Date of Last Session:___/___/____

Closing Balance: $_____ **_____**
Therapist's Signature

Appendix G

Frequency Distribution Table of Hollingshead's Two Factor Scale of Social Position

Table of Class Postion By Range of Scores

Social Class	Range of Scores
I	11-17
II	18-27
III	28-43
IV	44-60
V	61-77

Appendix H

Mann-Whitney U Table:

Those Who Refused Participation in Study

Descriptive Statistics and Mann-Whitney U Table for Patients Who Refused Participation in Study Against Study Group I (n1= 4, n2 = 34, Ucr = 16 at p ≤.05)

Variable	Value Range	Mean	Std.Dev.	Frequency	U observed
Age	28-67 yrs	40.5	17.97	--	U = 61.5
Gender	M-F Categories	--	--	Male: 50% Female: 50%	U = 62
Religion	4 Categories	--	--	Jewish: 50% Catholic:50%	U = 60
Marital Status	5 Categories	--	--	Single: 50% Married:25% Divorced:25%	U = 55
Diag. Fee	15-75	31.25	23.93	--	U = 51
Medicaid	Yes/No	--	--	Yes: 25% No: 75%	U = 67.6
Doctor Age	30-38 yrs	32.88	3.43	--	U = 63.6
Doctor Gender	M-F	--	--	Male: 50% Female: 50%	U = 58
Doctor Exp	2-8 yrs	3.02	2.89	--	U = 61.5

Appendix I

Correlations of the Professional Behavior Items To Summed Index

Correlation Table: Professional Behavior Scale to Summed Index Value, $p \leq .001$

Professional Behaviors	Corr to Summed Index
Shared Thoughts and Feelings-#1	.788
Really Understood Me-#2	.841
Explained What and Why-#3	.695
Displayed Feelings-#4	.505
Understood without Words-#5	.832
Gave Suggestions-#6	.805
Helped Discuss Taboo Areas-#7	.86

Appendix J

The Professional Relationship Quality Scale:

Simple Correlations, Partial Correlations and Squared Multiple R,

Variable Sampling Adequacy

Simple Correlation Matrix:
Relationship Quality Items to Summed Index Value

Relationship Characteristics	#1	#2	#3	#4
"Was a warm and caring person"-#1	1			
"Got to know me as a real person"-#2	.845	1		
"Was a sincere, dedicated person"-#3	.963	.828	1	
"Liked me as a real person"-#4	.855	.978	.827	1
Summed Index Value:	.958	.957	.946	.959

Correlation Matix:
Partials in off-diagonals; Squared Multiple R in diagonals

Relationship Characteristics	#1	#2	#3	#4
"Was a warm and caring person"-#1	.939			
"Got to know me as a real person"-#2	-.133	.958		
"Was a sincere, dedicated person"-#3	.878	.193	1	
"Liked me as a real person"-#4	.271	.923	-.168	.96

Measure of Variable Sampling Adequacy
Total Matrix Sampling Adequacy = .725*

Relationship Quality Scale Items	S.A.
"Was a warm and caring person"-#1	.733
"Got to know me as a real person"-#2	.722
"Was a sincere, dedicated person"-#3	.733
"Liked me as a real person"-#4	.713

Bartlett Test of Sphericity: DF = 9, Chi-Square = 710.067, $p \leq .0001$

*The total matrix sampling adequacy (MSA) sould be greater than .500 in order to assume that Guttman's assumptions have been minimally met.

Appendix K

Correlation of Each Professional Behavior to Summed Relationship Index Value

Correlation of Each Professional Behavior to the Summed Professional Relationship Quality Index
For Each Correlation, $p \leq .001$

Professional Behaviors	Relationship Quality Index
Shared Thoughts and Feelings-#1	.542
Really Understood Me-#2	.891
Explained What and Why-#3	.447
Displayed Feelings-#4	.183
Understood without Words-#5	.895
Gave Suggestions-#6	.491
Helped Discuss Taboo Areas-#7	.836

Appendix L

Factor Analysis Statistics for Relationship Quality Index, Professional Behaviors Index and Client Satisfaction Index

Simple Correlation Matrix:
Relationship Quality Index, Prof. Behaviors Index, Satisfaction Index

	#1	#2	#3
Relationship Quality Index#1	1		
Professional Behaviors Index#2	..491	1	
Satisfaction Index#3	.851	.626	1

Correlation Matix:
Partials in off-diagonals; Squared Multiple R in diagonals

Relationship Characteristics	#1	#2	#3
Relationship Quality Index#1	.728		
Professional Behaviors Index#2	-.104	.398	
Satisfaction Index#3	.801	.456	.782

Measure of Variable Sampling Adequacy
Total Matrix Sampling Adequacy = .612

	SA
Relationship Quality Index#1	.597
Professional Behaviors Index#2	.743
Satisfaction Index#3	.568

Bartlett Test of Sphericity: DF = 5, Chi-Square = 179.85, $p \leq .0001$

ABSTRACT

Continuance and Satisfaction in Outpatient Psychotherapy:
An Exploration of Patient and Treatment Variables

Gregory Mavrides

This study explored the effects of various patient, therapist and treatment variables on continuance and treatment satisfaction at an outpatient mental health center. One hundred patients who had terminated treatment between January 1, 1987 and March 31, 1989, were selected for study by stratified proportionate random sampling on the basis of the number of attended sessions. Patient variables included sociodemographic status, fees, degree of stress at time of intake, locus of control (external vs internal) and presenting problem causal attribution type (self, self-in-situation, environmental and situational). Therapist variables included age, gender, years of experience and professional discipline. Treatment variables were comprised of the patients' perceptions of the therapists' skills, the perceived quality of the professional relationship and the perception of concurrent logistical problems. The findings indicated that four variables contributed significantly to the variance in continuance; the quality of the professional relationship, the patient's degree of stress, social class and problem causal attribution type (multiple $R^2 = .61$, $p \leq .001$). That is; patients who perceived the therapeutic relationship as a poor one, with low degrees of stress, who were from lower social classes, with problem causal attribution types of stimulus