

**The influence of personal characteristics on drop out from therapy**

by

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A thesis submitted to the graduate faculty  
in partial fulfillment of the requirements for the degree of  
MASTER OF SCIENCE

Major: Human Development and Family Studies (Marriage and Family Therapy)

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2006

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This is to certify that the master's thesis of

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### Abstract

The influence of certain personality characteristics (i.e., hostility, anxiety, satisfaction with life, and self-esteem) on drop out from therapy was examined. Participants of this study consisted of individuals who sought services from the Iowa State University Marriage and Family Therapy Clinic for individual, couples, or family therapy. A total of 501 individuals began therapy in the years between 2000 and 2004; of these, 91 were reported by the respective therapists to be drop outs. Prior to the initial therapy session, all clients signed release forms indicating their assessment materials may be used for future research. Data from the Brief Symptom Inventory, Satisfaction with Life Scale, and Rosenberg Self-Esteem Scale were examined, and hypotheses were tested using chi-square tests for independence and discriminant analyses. Although the previously mentioned personality characteristics were found to have no association with likelihood to drop out from therapy, several demographic variables were found to have a statistically significant association (i.e., modality of treatment, marital status, occupation, income, and previous therapy experience.) These findings indicate that regardless of a client's disposition at the onset of therapy, he or she is not more likely to drop out of treatment based these characteristics alone.

## Introduction and Literature Review

Regardless of type or setting of practice, a common phenomenon that therapists experience is drop out from treatment. Whether it is in a community mental health center, a university training clinic, or a private practice, at one time or another every therapist experiences a client who does not return after the first few sessions, and does not report or exhibit improvement. The therapist may be left wondering, "What happened?" or, "What could have been done differently?" Unfortunately, despite numerous investigations by researchers, the answer to this question remains unclear. If there was a way to identify common characteristics of individuals who have dropped out of therapy in the past, it may be possible to predict which clients are more likely to drop out in the future and respond to them in a way that encourages engagement in therapy. This study aims to identify some of these characteristics, in hopes of alleviating some of the wonder surrounding the issue.

### *Definition of Drop out*

Drop out from therapy has been defined in a variety of ways by many different researchers. Some who have studied this phenomenon believe drop out has occurred if the client fails to attend a specified number of sessions. For example, if the client does not return after the first or second session (Allgood & Crane, 1991; Fiester & Rudestam, 1975; Heilbrun, 1961) or attends fewer than five sessions, he or she is considered an early terminator (Davis & Dhillon, 1989; Heilbrun, 1961). Baekeland and Lundwall (1975) refer to this type of termination as immediate drop out.

Drop out from therapy has also been defined using a pre-determined length of treatment (Frayn, 1992). This may occur if the therapeutic contract states clients will attend sessions for a certain number of weeks or months, and he or she fails to meet this agreement.

If clients terminate therapy before completion of the first month, they are considered “slow drop outs” (Baekeland & Lundwall, 1975). Some may argue that this is an inappropriate method of measuring early termination because clients may feel they have experienced sufficient change before the specified treatment period is completed.

There are a handful of researchers who believe drop out has occurred when clients terminate treatment without fulfilling their therapeutic goals, regardless of number of sessions or time spent in therapy (Edlund, Wang, Berglund, Katz, Lin, & Kessler, 2002; McAdoo & Roeske, 1973, as cited in Allgood & Crane, 1991). This may also be an inefficient technique of assessing drop out because it does not distinguish between clients who have been in therapy for months without seeing improvement and those who failed to return after the first session. In addition, the therapist and client may have different perceptions of the therapeutic goals. If the client feels his or her needs have been met and leaves therapy, the therapist may still label him or her as drop out.

It is important to note that although a client may be labeled as a drop out by his or her therapist, this does not mean treatment was ineffective. There are many reasons clients may fail to return after a specified number of sessions, including but not limited to: breaking up or divorcing, financial constraints, moving, and seeking services elsewhere in the community. It is also very possible that the client feels sufficient improvements have been made and does not require further sessions.

#### *Rate*

The definition of what constitutes drop out from therapy varies widely across researchers, as does the definition of rate of early termination. A recent study by Edlund et al. (2002) examined the therapy drop out rate in both the United States and Ontario. Data

was gathered for over 1,250 individuals from the general population through the United States National Comorbidity Survey and the mental health supplement to the Ontario Health Survey. They report that across modalities (e.g., psychiatry, spiritual advising, substance abuse treatment, etc.), ten percent of clients chose to terminate therapy before the fifth session.

However, this estimate is quite low compared to those of other researchers. Hoffman (1985) reported a drop out rate of 32.4 percent. This rate was found by examining characteristics of 287 clients who attended a nonprofit community mental health center between 1976 to the time of study. Hoffman's higher estimate of drop out is intriguing, given his broader definition of drop out (i.e., not returning to therapy after the first session, as opposed to the fifth).

Other research has shown the estimate of drop out to be even higher. Fiester (1974) found that between 37 and 45 percent of individuals had dropped out of treatment from community mental health centers. This, along with Hoffman's (1985) and Edlund et al.'s (2002) results, suggests that drop out rates vary across modalities and settings of treatment. If community mental health centers experience much higher rates of drop out than others do, this can explain the discrepancy in numbers. Although the reported rates vary widely, they convey the same message: early termination without symptom improvement is a common issue that therapists encounter and must manage.

#### *Demographic Characteristics*

Many researchers have tried to pinpoint certain characteristics of those who drop out from therapy, in hopes that some of the mystery can be eliminated from early termination. Baekeland and Lundwall (1975) conducted a thorough analysis of available literature

concerning drop out and suggested that demographic characteristics such as age, sex, race, education level, and income be assessed when studying early termination. In their review, Baekeland and Lundwall (1975) reported that one of the most consistent findings across studies is that clients who drop out from therapy tend to have less education and lower socioeconomic status than those who successfully complete treatment. In addition, Fiester and Rudestam (1975) found the same results through assessing characteristics of premature terminators in two mental health settings: a hospital-based center and a state clinic. They reported that more lower-class clients dropped out of therapy than middle-class individuals.

Some argue this finding results from an association between mental health problems and limited financial resources (Edlund et al., 2002). Perhaps these individuals do not have the financial means to pay for more than a few sessions, or maybe they are working more than one job and simply do not have the time to attend every week. Whatever the reason may be, it appears that socioeconomic status is significantly associated with drop out.

Age, race, and gender do not share the same consistent relationship with drop out as socioeconomic status. Young age of the client has been shown by some researchers to be related to early termination (Edlund et al., 2002), whereas others have found no such correlation (Frayn, 1992). Frayn (1992) reviewed seven years' worth of patient assessments (85 in all) from a psychotherapy clinic and found neither age nor gender can predict drop out. As described previously, Edlund et al. (2002) obtained their data from two national mental health surveys spanning multiple treatment modalities. The sample size between these studies varies drastically, which could account for the inconsistent results concerning age. Edlund et al.'s (2002) study has greater statistical power, given the large sample size.

Therefore, it is more likely that statistically significant associations are found between age and drop out in this study than in Frayn's (1992).

Race has been reported to be associated with drop out (Dodd, 1971; Edlund et al., 2002); however, these researchers did not distinguish which races were more likely than others to prematurely terminate therapy. King and Canada (2004) found that African American individuals were approximately five times more likely than those of European decent to drop out of substance abuse treatment programs. It is suggested that this finding could be explained by sociodemographic factors related to race, such as environmental stressors, low income, and greater unemployment (King & Canada, 2004)

It has been theorized that an ethnic match between therapist and client can improve therapy outcome and prevent drop out. However, through an extensive review of existing literature, Karlsson (2005) found little empirical support for ethnic matching as a predictor of drop out. There were other therapist characteristics that were reported as more important by the client than a similar ethnicity, such as the therapist's techniques, style, and language. Socioeconomic status of the client was also reported to be a better predictor of drop out than ethnic matching, which is consistent with past research (Karlsson, 2005).

These results illustrate the confusion among researchers and clinicians in attempting to determine the factors that contribute to an individual's likelihood of dropping out from therapy. With the exception of socioeconomic status, there does not seem to be a clearly distinguishable demographic variable that contributes to drop out. For this reason, many researchers have examined personality characteristics of therapy clients in hopes of determining if there are identifiable traits present in those who drop out from therapy.

### *Personality Characteristics*

It can be argued that if clinicians are aware of specific personality characteristics that have been associated with drop out, they can alter treatment to make therapy more accommodating for individuals who exhibit these characteristics. For example, Dubrin and Zastowny (1988), by using step-wise discriminant analysis in order to analyze personality characteristics of upscale clients of a private therapy practice in New York, found that those who prematurely terminate therapy exhibit higher levels of defensiveness than those who continue. This finding has important implications for practice; if a therapist is aware that his or her client is highly defensive, he or she can tailor interventions to decrease this defensiveness.

Likewise, in a substantial review of drop out literature, Baekeland and Lundwall (1975) have found that clients who drop out from therapy are more likely to exhibit aggressiveness, sociopathy, and counter-dependence (i.e., rejection of and rebelling against dependence upon another individual). As discussed below, one of the most significant predictors of success in therapy is the therapeutic alliance. It can be assumed that these three characteristics are going to drastically impede formation of the alliance, and therefore contribute to drop out.

Just as it is important to examine characteristics of those who drop out of therapy, it is just as crucial to identify the characteristics prevalent in those who continue. Clients who do not prematurely terminate treatment have been found to exhibit higher levels of dependence than those who drop out (Heilbrun, 1961; Taulbee, 1958). This result is logical, for clients who have a history of becoming dependent on others are likely to do the same to their therapists and would not want to give up on that relationship.

Heilbrun (1961) investigated personality characteristics of clients seeking counseling through a University center. Clients were divided into four groups: female non-stay, female stay, male non-stay, and male stay. Those in the stay categories were found to have more perseverance, self-dissatisfaction, and anxiety than those who dropped out. Taulbee (1958) also found clients that do not prematurely terminate therapy exhibit higher levels of anxiety—along with elevated rates of depression, sensitivity, and feelings of inferiority.

It is important to note, however, that not all researchers have found personality differences between those who drop out from therapy and those who continue (Edlund et al., 2002). Stern, Moore, and Gross (1975) assessed 68 clients in an outpatient clinic according to the Terminator-Remainer Scale and the Two-Factor Index of Social Position. They found no significant differences between those who continue in treatment and those who dropped out. However, only male outpatients were examined, making this sample unrepresentative of all individuals seeking therapy.

#### *Other Characteristics*

Presenting problems have also been associated with early termination. Hoffman (1985) found that clients that presented with interpersonal relationship issues were more likely to drop out from treatment than those with thought disorders. He reasoned that this might be because relationship problems are often situational. Couples may enter therapy during a particularly serious conflict, and quit attending sessions once the initial anger fades.

In addition to individual counseling, drop out from couples' therapy has been studied as well. Factors that are related to drop out from couples' counseling are having a male intake clinician, husband's phobic anxiety score, and a higher number of children (Allgood & Crane, 1991). As mentioned previously, no association has been found between the client's

gender and likelihood to prematurely terminate. Therefore, it is interesting that the gender of the clinician would have a significant impact in couples' therapy.

### *Alliance Overview*

There are a wide variety of theoretical approaches to therapy, and these approaches are put into action by therapists who are even more diverse. However, there seems to be a common thread holding the field together, and this is the unique relationship between the therapist and his or her clients. Bird (1993) gave an extensive description of the therapeutic alliance, as well as elaborated on terms associated with the concept and implications for therapists. She argued that the relationship must consist of trust and a balance between connectedness and detachment. Gelso and Carter (1985) went further to state the therapeutic relationship must include collaboration in setting and achieving goals, and this relationship is a common factor through all types of therapy. Pinsof and Catherall (1986) described the therapeutic alliance as the "vessel or relational context in which therapy occurs" (p. 138).

There is little debate that the therapeutic alliance is one of the most important factors that contributes to success in therapy. Many researchers have described a positive relationship between the quality of a working alliance and therapeutic outcome (Gelso & Carter, 1985; Horvath, 1994). Beginning at the onset of therapy, it is crucial to build an effective alliance. The clients must feel that their therapist shares their goals for therapy, and is structuring interventions within session that work towards these goals. Bordin (1979) identifies these two phenomena as the "task" and "goal" components of the working alliance. The third component, bond, refers to the rapport between clinician and client. Measures of these three components after the first few sessions can predict as much as much as 45 percent of the variance in therapy outcome (Horvath & Greenberg, 1989).

More support for the therapeutic alliance came from Lever and Gmeiner (2000), who conducted case studies and found that during the joining phase of therapy (the initial sessions), a lack of connectedness was most prevalent in predicting drop out. Families that were uneasy or unsure of expectations were not engaged in therapy and were more likely to terminate early. As discussed previously, early termination from therapy is a common problem that affects therapists. It can be argued that an individual's personal characteristics can greatly affect his or her ability to form an effective working alliance, therefore hindering the likelihood of successfully completing therapy.

Some researchers argue that client characteristics are not as important in predicting drop out as other process variables (Kolb, Beutler, Davis, Crago, & Shanfield, 1985, as cited in Davis & Dhillon, 1989). However, lack of an alliance has been shown to be positively associated with drop out, and other researchers have found relationships between individual characteristics and the ability to form an alliance. For example, building an alliance has been found to be more challenging with hostile, negative clients (Kokotovic & Tracey, 1990). These clients are then more likely to prematurely terminate.

Kokotovic and Tracy (1990) examined personality characteristics and alliance scores of 144 clients and 15 counselors. Shortly after the first session, both the counselor and the client completed assessments about themselves and the other person, in addition to completing the WAI. Client hostility and poor quality of current and past relationships (as viewed by the counselor) were correlated with a poorly-rated working alliance.

An individual's satisfaction with life has been found to be related to the therapeutic alliance; that is, high satisfaction with life is associated with a stronger therapist-client bond (Werner-Wilson, Murphy, Cheng, Heiberger, Rice, & Green, 2005). Werner-Wilson et al.

(2005) also found high levels of depression have negative effects on the goal and task subscales of the therapeutic alliance. However, other characteristics such as gender and modality were found to have no association with formation of the alliance; therefore, the authors concluded that very little of the variance in alliance scores can be attributable to personal characteristics.

Bird (1993) explicitly described the therapeutic alliance. She reports that the therapists' personal feelings towards the client are shown to impact formation of the alliance. In addition to the therapist's personal feelings, difficulty of treatment (Gelso & Carter, 1985), and the clients' history of interpersonal relationships (Moras & Strupp, 1983) also affect the therapeutic alliance. All of these factors can be significantly altered by the client's personality characteristics (e.g. hostility, anxiety, etc.).

In summary, early termination from therapy is a problem that clinicians and researchers often face. Unfortunately, despite numerous studies on the subject, it is still not clear which variables accurately predict drop out. Most research that has examined early termination was conducted in settings other than marriage and family therapy (e.g., psychotherapy, in-patient therapy, alcohol or drug treatment, etc.) Therefore, the present study is unique in that three modalities of marriage and family therapy will be examined: individual, family, and couple.

In recent years, the majority of research that has examined therapeutic outcome of marital or family therapy has centered on the therapeutic alliance as a mediating factor. Very few studies have directly examined the relationship between an individual's personality characteristics and his or her likelihood to prematurely terminate from a marriage and family therapy setting, as this study will.

### *Hypotheses*

It is hypothesized that high levels of hostility will be associated with drop out from the therapy process. In addition, it is predicted that drop out will also be more prevalent in clients who exhibit low levels of self-esteem, anxiety, and satisfaction with life. Each of these variables play a significant role in forming the therapeutic alliance, and without proper formation of this alliance drop out is likely to occur.

*Hypothesis 1: Hostility.* Hostility is hypothesized to be positively correlated with drop out because it is likely that if an individual exhibits high levels of hostility, he or she is going to have an increasingly difficult time forming interpersonal relationships. This hypothesis is consistent with past literature; Kokotovic and Tracey (1990) found that clients with high levels of hostility experienced more difficulties forming the therapeutic alliance. As discussed previously, the alliance has been shown to be a critical mediating factor in determining successful therapy outcomes. It will be a challenge for someone who has difficulty forming relationships to build an alliance; therefore, drop out from therapy is likely.

*Hypothesis 2: Self-Esteem.* Self-esteem is predicted to impact drop out as well, for it may be associated with the client's ability to exert effort on the therapy process. Success in therapy greatly depends on the degree to which clients believe they have control over—and can change—their environment. Therefore, if an individual believes in him or herself (i.e., exhibits high self-esteem) she is more likely to keep working to remedy the situation.

*Hypothesis 3: Anxiety.* In past studies, one consistent finding is that individuals with high levels of anxiety are more likely to remain in therapy (Lorr et al, 1958). Although the

population of this study will differ from those of past research, the same result is expected.

A certain level of anxiety is needed for one to seek therapy—and to continue through it.

*Hypothesis 4: Satisfaction with Life.* Satisfaction with life is hypothesized to be negatively associated with drop out from therapy. Low satisfaction levels are to be expected, for clients would not enter therapy if these aspects were acceptable, but the lower these appraisals plunge, the likelihood of dropping out of therapy increases. A bleak view of life could affect an individual's level of hope in overcoming whatever obstacle brought him or her to therapy. In addition, Werner-Wilson, et al. (2005), found a positive association between formation of the therapeutic alliance and satisfaction with life. As discussed previously, alliance is associated with therapeutic outcome, including drop out. It can therefore be hypothesized that clients with high levels of satisfaction with life are less likely to drop out, for they have a stronger therapeutic bond with their therapist.

## Methods and Materials

### *Population/Sample*

Participants consisted of individuals who sought services from the Iowa State University Marriage and Family Therapy Clinic for individual, couples, or family therapy. A total of 501 individuals began therapy in the years between 2000 and 2004; of these, 344 attended more than five sessions (i.e., not a drop out), and 91 were reported by the respective therapists to be drop outs. An additional 66 clients attended less than five sessions, but their reason for leaving did not constitute drop out (i.e., broke-up/divorced, moved, client and/or therapist felt therapy was finished, client sought services outside of clinic, or unknown.)

### *Design*

Prior to the first therapy session, clients entering the marriage and family therapy clinic complete appropriate paperwork and a package of assessments. The first, which everyone is required to complete, obtains essential demographic information such as address, race/ethnicity, income, marital status, number of children, etc. Then, depending on modality of treatment, each client fills out appropriate assessment materials. Those seeking individual therapy complete a package that includes Satisfaction With Wife and other personal characteristic variables (e.g., depression, anxiety, etc.) Regardless of modality, clients complete the same assessment package during their fifth and termination sessions.

In addition to completing the assessment packages, clients also sign a research release, which allows the results from the assessments to be used in future research. Therefore, data for this study was obtained from the clinic archives.

### *Instrumentation*

*Satisfaction with Life Scale (SWLS)*. The SWLS is a Likert scale which is administered to clients in order to assess their own perceptions of life satisfaction. Fischer and Corcoran (1994) argue that this is important to examine because satisfaction with life is a critical aspect of mental health.

Consisting of only 5 items, scores on the SWLS can range from 5-35 with low scores suggesting lower satisfaction levels with life. Alpha levels for the SWLS are .87 for internal consistency and .82 for test-retest reliability. The SWLS is also reported to have high levels of validity; scores on this measure correlate with nine other scales of well-being and ratings of life-satisfaction among the elderly (Fischer & Corcoran, 1994).

*Rosenberg Self-Esteem Scale (RSE)*. This short (10-item) Likert instrument assesses an individual's level of self-esteem. Five of the ten items are reverse coded, so that a high score is associated with high self-esteem. Scores on the RSE have been shown to correlate with other measures of self-esteem, as well as instruments that assess depression, anxiety, and peer-group reputation. In addition, this instrument has excellent stability (test-retest correlations of .85 and .88) and internal consistency alpha level of .92 (Fischer & Corcoran, 1994, p. 518). Self-esteem of an individual is worthwhile to assess, for someone who does not believe in him or herself may not think success in therapy is possible, and drop out of treatment as a result.

*Brief Symptom Inventory (BSI)*. Hostility and anxiety will be measured in the present study using subscales of the Brief Symptom Inventory (BSI). The BSI is a condensed version of the Symptom Checklist-90 (SCL-90-R), consisting of 53 items describing possible symptoms (e.g., "feeling easily annoyed or irritated," "feeling fearful," etc.). Clients rate

each item on a five-point Likert scale, ranging from "not at all" to "extremely." The BSI consists of seven subscales measuring the following dimensions: interpersonal sensitivity, obsessive compulsiveness, depression, anxiety, hostility, paranoid ideation, and psychoticism. High scores on these scales reflect a stronger presence of the symptoms. These subscales have high internal consistency, with alpha levels ranging from .71 to .85 (Derogatis & Melisaratos, 1983).

### *Analysis*

For this study, drop out will be defined as a client who fails to return to therapy before their fifth session, yet does not report or exhibit improvement of symptoms. Upon the client's departure from the clinic, the primary therapist completes termination paperwork reporting number of sessions, a brief description of the case, and reason for termination. Response possibilities include: client felt therapy was finished, therapist felt therapy was finished, both client and therapist felt therapy was finished, client moved, therapist felt client was inappropriate for the clinic, therapist moved, client quit, and client felt clinic was inappropriate for his or her needs. Therefore, in order to distinguish clients who dropped out of therapy, these forms will be physically examined in order to assess which clients attended less than five sessions and whose therapists believed they had quit treatment.

This definition of drop out combines two of three elements that are commonly used among researchers in this domain. In the past, other researchers have defined a client as dropping out if he or she failed to return after the first session or intake interview. However, most have utilized the five-session definition, and I believe it is the most appropriate for this study. This definition was combined with another (i.e., failing to meet therapeutic goals) to control for other factors that may contribute to the client not returning to therapy (e.g.,

moving, breaking up or divorcing, seeking services elsewhere, etc.). In addition, this controls for the possibility of including individuals in the analyses that attended less than five sessions, yet felt significant improvements had been made and therapy was finished.

Another possibility concerning definition of drop out would have been to use a pre-determined length of time (e.g., six months). This definition is not appropriate for the current study. The clinic from which data will be obtained serves a diverse population of individuals. Employing a pre-determined length of therapy (e.g., six months) to measure drop out would not be appropriate, for the time spent in therapy varies drastically between clients.

As discussed previously, it is expected that there will be a significant difference between the clients who drop out from therapy and those who choose to continue in the following domains:

*Hostility.* Those who prematurely terminate therapy are likely to exhibit significantly higher levels of hostility than those who continue (Hypothesis 1).

*Self-Esteem.* Those who prematurely terminate therapy are likely to experience significantly lower levels of self-esteem than those who continue (Hypothesis 2).

*Anxiety.* Those who prematurely terminate therapy are likely to exhibit significantly lower levels of anxiety than those who continue (Hypothesis 3).

*Satisfaction with life.* Those who prematurely terminate will have significantly lower levels of satisfaction with life than those who continue (Hypothesis 4).

Because each of these hypothesis involves a continuous predictor variable (e.g., levels of anxiety, hostility, etc.) and a discrete dependent variable (i.e., drop out versus non drop out), discriminate analysis will be used to differentiate which variables are more prevalent in

the clients who choose to prematurely terminate therapy. The Wilks' lambda procedure will be utilized to determine which variables significantly contribute to the variance of drop out.

## Results

### *Rate of Drop out*

Ninety-one of 501 clients (18%) who sought therapy from the Marriage and Family Therapy Clinic between the years 2000 and 2004 dropped out prior to the fifth session, without reported or observed improvement. Reasons for leaving prior to session five, for those who attended less than five sessions but did not drop out, included: moving (1.4%), breaking up or divorcing (2.0%), client felt therapy was finished (4.6%), client and therapist felt therapy was finished (13%), client sought services outside of clinic (1.2%) and unknown (1.4%). Four hundred and ten clients (58.4%) remained in therapy through session five.

### *Modality of Treatment*

The majority of persons entering therapy were seeking couples therapy (n = 288; 57.5%). Of the 501 total clients, 119 (23.8%) sought individual and 78 (15.6%) sought family therapy. Modality was not reported for 16 cases.

### *Demographic Characteristics*

*Gender.* A greater number of women (n = 284; 56.7%) entered therapy than men (n = 195; 38.9%). Some participants chose not to report gender on the intake form from which these data were obtained; therefore, there were a total of 22 individuals (4.4%) for whom gender was not reported.

*Marital Status.* The majority of clients were either currently married (36.9%) or never married (22.8%). There were very few who were separated (3.6%), divorced (5.2%), or cohabiting (14.6%). Some clients identified their marital status as “other” (6.8%), while others chose not to report their marital status (10.2%).

*Occupation.* Client occupational category varied greatly, indicating diversity among the sample. Occupational categories included: managerial (n = 57; 11.4%), technical (n = 34; 6.8%), service (n = 35; 7.0%), precision production, craft, or repair (n = 4; 0.8%), operator, fabricator, or laborer (n = 13; 2.6%), farming, forestry, or fishing (n = 6, 1.2%), unemployed (n = 45, 9.0%), or other category (n = 235, 46.9%). Data regarding category of occupation were missing for 72 individuals.

*Ethnicity.* The majority of individuals in this sample were of Caucasian decent (n = 360; 71.9%). Twenty-one clients (4.2%) identified themselves as African-American, 25 (5.0%) as Hispanic or Latino, 16 (3.2%) as Asian, and 16 (3.2%) as other. Ethnicity was not reported for 63 (12.6%) individuals.

*Education.* Education was reported as highest level completed, with 73 (14.6%) individuals reporting a high school degree or less. A large number of individuals obtained an undergraduate degree (n = 249; 49.7%), and 85 (17%) completed a Master's or Doctorate level of education. Twenty-nine individuals (5.8%) responded as "other," and 65 (13.0%) did not report highest level of education obtained.

*Income.* Similar to occupation category, income varied across the sample, indicating some diversity. Refer to Figure 1 for a summary of reported income levels.

*Religious Preference.* The intake forms from which data for the current study were obtained offered five choices for religious preference: Catholic, Protestant, Latter-Day Saints, none, or other. Information regarding religious preference was missing for 76 individuals (15.2%). Reported religious preferences can be found in Figure 2.

Figure 1  
*Client reported incomes*

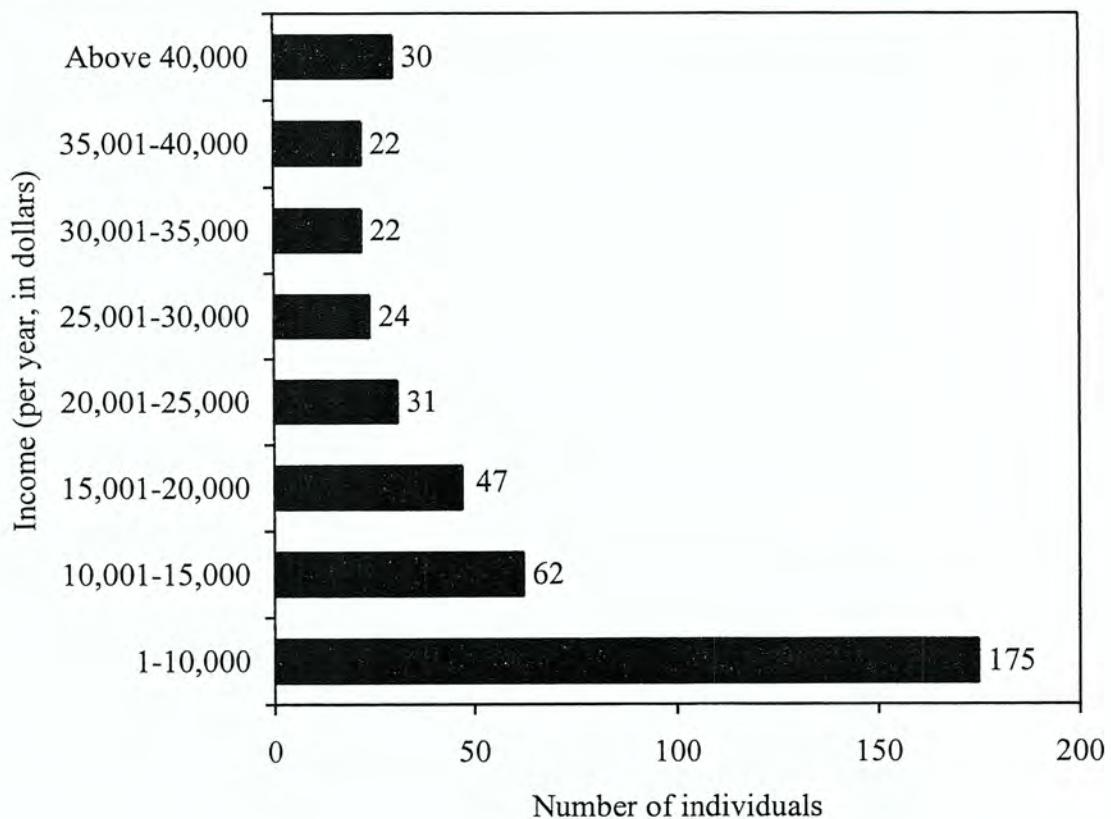
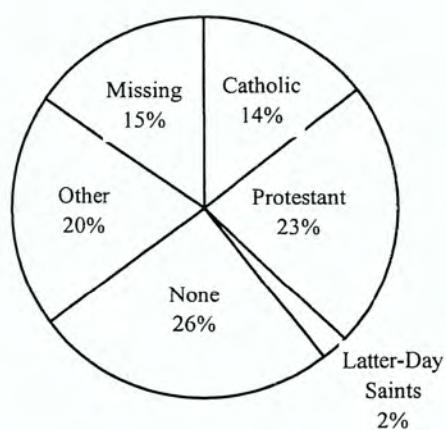


Figure 2  
*Religious Preference*



*Previous Therapy or Counseling Experience.* The majority of clients who sought therapy from the clinic utilized for this study had previous counseling experience ( $n = 298$ ; 59.5%). One hundred eighty-seven clients (37.3%) had not sought services in the past. Data were missing for 16 (3.2%) of the cases.

#### *Chi-Square Analysis*

Chi-Square analyses were used to test for associations between client demographic variables, treatment modality, and dropout. An alpha level of .05 was used for these tests.

*Modality of treatment.* Modality (i.e., couple, family, or individual) was found to have a weak association with dropout ( $\chi^2=6.502$ , df 2,  $p=.039$ ), indicating that the two variables are not independent of one another. The expected values for individual, couple, and family modalities for drop out were 22.4, 52.6, and 16.1, respectively. The corresponding observed values were 15, 63, and 13; indicating more couples and less individuals and families dropped out of treatment than expected.

*Gender.* Client gender was not found to have a statistically significant association with the client's probability of dropping out ( $\chi^2=.001$ , df 1,  $p=.974$ ). The expected and observed values for men and women were almost identical. The expected count for women who dropped out was 36.1, and 36 women actually dropped out. Likewise, the expected count for men was 51.9, and 52 men dropped out of treatment.

*Marital Status.* A strong association was found between the client's marital status and drop out ( $\chi^2=20.081$ , df 5,  $p=.001$ ). Significantly fewer individuals who have never been married dropped out than expected; likewise, cohabiting couples dropped out of therapy more than expected. Actual and expected counts for marital status can be found in Table 1.

Table 1.  
*Marital Status and Drop Out Crosstabulation.*

	Marital Status					
	Married	Separated	Divorced	Never Married	Living Together	Other
Drop Out						
Expected Value	30.6	2.9	4.1	20.0	12.0	5.4
Observed Value	34.0	5.0	5.0	7.0	20.0	4.0
Residual	3.4	2.1	.9	-13.0	8.0	-1.4
Non Drop Out						
Expected Value	127.4	12.1	16.9	83.0	50.0	22.6
Observed Value	124.0	10.0	16.0	96.0	42.0	24.0
Residual	-3.4	-2.1	-.9	13.0	-8.0	1.4

*Occupation.* Clients' category of occupation was also found to have an statistically significant association with the likelihood of dropping out ( $\chi^2=18.486$ , df 8, p=.018). A summary of expected and actual values for drop out can be found in Table 2.

Table 2.  
*Client occupation and drop out crosstabulation.*

	Occupation							
	Managerial	Technical	Service	Precision production craft or repair	Operator, fabricator, or laborer	Farming forestry or fishing	Un-employed	Other
Drop Out								
Expected	9.8	6.5	6.7	.8	1.8	1.0	8.1	40.2
Observed	13.0	7.0	13.0	0.0	4.0	0.0	8.0	30.0
Residual	3.2	.5	6.3	-.8	2.2	-1.0	-.1	-10.2
Non Drop Out								
Expected	38.2	25.5	26.3	3.2	7.2	4.0	31.9	157.8
Observed	35.0	25.0	20.0	4.0	5.0	5.0	32.0	168.0
Residual	-3.2	-.5	-6.3	.8	-2.2	1.0	0.1	10.2

*Client Ethnicity.* There is no statistically significant association between the client's predominant ethnicity and their probability of dropping out ( $\chi^2=7.453$ , df 4, p=.114), indicating ethnicity may not be a practical predictor of drop out. For a summary of expected and actual counts of drop out by ethnicity, refer to Table 3.

Table 3  
*Ethnicity and Drop Out Crosstabulation*

	White	Black	Ethnicity Hispanic	Asian	Other
Drop Out					
Expected Value	60.9	3.6	4.8	3.0	2.6
Observed Value	56.0	7.0	3.0	5.0	4.0
Residual	-4.9	3.2	-1.8	2.0	1.4
Non Drop Out					
Expected Value	246.1	15.2	19.2	12.0	10.4
Observed Value	251.0	12.0	21.0	10.0	9.0
Residual	4.9	-3.2	1.8	-2.0	-1.4

*Education.* Client education level does not have a statistically significant association with drop out ( $\chi^2=6.400$ , df 4, p=.171). Refer to Table 4 for expected and observed values for this variable.

Table 4  
*Client Education and Drop Out Crosstabulation*

	Client Education				
	1-12	Undergraduate	M.S./M.A.	Ph.D.	Other
Drop Out					
Expected Value	13.0	42.5	9.8	3.7	4.9
Observed Value	17.0	44.0	4.0	3.0	6.0
Residual	4.0	1.5	-5.8	-.7	1.1
Non Drop Out					
Expected Value	53.0	73.5	40.2	15.3	20.1
Observed Value	49.0	172.0	46.0	16.0	19.0
Residual	-4.0	-1.5	5.8	.7	-1.1

*Income.* The current income levels of clients were shown to have a statistically significant association with their probability of dropping out of therapy ( $X^2=15.642$ , df 7,  $p=.029$ ). Significantly fewer clients with incomes less than 10,000 dollars per year dropped out of therapy than expected, and significantly more clients with a current income level between 25,000 and 30,000 dollars per year dropped out. See Table 5 for observed and expected counts.

Table 5  
*Current Income Level and Drop Out Crosstabulation*

		Income							
		1- 10,000	10,001- 15,000	15,001- 20,000	20,001- 25,000	25,001- 30,000	30,001- 35,000	35,001- 40,000	Above 40,000
Drop Out	Expected Value	31.5	11.0	8.3	5.7	3.7	4.1	3.5	5.3
	Observed Value	25.0	11.0	8.0	6.0	10.0	4.0	4.0	5.0
	Residual	-6.5	.0	-.3	.3	6.3	-.1	.5	-.3
Non Drop Out	Expected Value	123.5	43.0	32.7	22.3	14.3	15.9	13.5	20.7
	Observed Value	130.0	43.0	33.0	22.0	8.0	16.0	13.0	21.0
	Residual	6.5	.0	.3	-.3	-6.3	.1	-.5	.3

*Religion.* The chi-square ( $X^2=6.299$ , df 4,  $p=.178$ ) indicates that the client's religious preference and likelihood for dropping out are independent of each other. Therefore, religion should not be utilized as a predictor for drop out. Refer to Table 6 for observed and expected values.

**Table 6**  
*Client Religious Preference and Drop Out Crosstabulation*

		Client Religious Preference				
		Catholic	Protestant	L.D.S.	None	Other
Drop Out						
Expected Value		12.0	20.5	2.2	22.3	17.0
Observed Value		14.0	15.0	0.0	24.0	21.0
Residual		2.0	-5.5	-2.2	1.7	4.0
Non Drop Out						
Expected Value		48.0	81.5	8.8	88.7	68.0
Observed Value		46.0	87.0	11.0	87.0	64.0
Residual		-2.0	5.5	2.2	-1.7	-4.0

*Previous Therapy Experience.* Whether or not the client has attended therapy or counseling in the past was shown to be a significant predictor of drop out ( $\chi^2=7.528$ , df 1,  $p=.006$ ). Individuals with no therapy or counseling experience were more likely to drop out of therapy than those with past experience. The expected values for drop out were 56.3 for those with previous therapy experience and 34.7 for those without. The actual counts of those who dropped out were 46 for those with experience and 45 for those without.

#### *Discriminant Analysis*

Hypotheses 1 (high client hostility), 2 (low self-esteem), 3 (low anxiety), and 4 (low satisfaction with life) were tested for predicting drop out using discriminant analysis. These variables were entered into a discriminant analysis equation in order to determine which of these variables significantly contribute to the variance of drop out. None of the four predictors significantly predicted drop out from therapy (Wilks' Lambda=.984,  $p=.232$ ).

#### *Scale Reliability*

*Anxiety.* The anxiety composite variable consisted of six items from the Brief Symptom Inventory (BSI). These items included: "nervousness or shakiness inside,"

“suddenly scared for no reason,” “feeling fearful,” “feeling tense or keyed up,” “spells of terror or panic,” and “feeling so restless you couldn’t sit still.” Together, these items have an internal consistency level of .781.

*Hostility.* The hostility composite variable also consisted of items from the BSI. These included: “feeling easily annoyed or irritated,” temper outbursts that you could not control,” “having urges to break or smash things,” “having urges to beat, injure, or harm someone,” and “getting into frequent arguments.” The internal consistency for hostility is .765.

*Self-Esteem.* Client self-esteem was measured using the Rosenberg Self-Esteem Scale (RSE). Five of the 10 items of the RSE were reverse coded in order to compute a composite raw score for each client. Chronbach’s alpha of the RSE for this study is .887.

*Satisfaction with Life.* Each of the five items of the Satisfaction with Life Scale (SWLS) was used to compute clients’ current satisfaction level. Internal consistency for this scale is .887.

### Discussion

The original hypotheses concerning client characteristics (i.e., hostility, anxiety, self-esteem, and satisfaction with life) were not supported by the results of this study. In addition, certain demographic variables such as gender, ethnicity, education, and religious preference were found to have no association with drop out. However, there are several variables that were found to be significantly associated with drop out through chi-square analyses: treatment modality, marital status, occupation, income, and past therapy experience.

The lack of association between client personality characteristics and drop out is surprising. There have been numerous studies completed that have demonstrated characteristics such as these as predictors of therapeutic alliance and outcome, most notably, anxiety (Allgood & Crane, 1991; Gallagher, 1953; Greenspan & Mann Kulish, 1985; and Lorr, 1958). However, Kokotovic and Tracey (1990) found that although client factors such as hostility affected the formation of a working alliance, there were no significant differences between those who dropped out and those who continued with therapy. These results suggest that although these characteristics have implications on the formation of the therapeutic alliance, they do not affect engagement in therapy.

The association between modality of treatment and drop out that was found in this study contradicts past research. Heatherington and Friedlander (1990), in their research concerning the therapeutic alliance within couple and family therapy, found no significant differences between modalities. However, it is important to note that this study concentrated on a predictor of drop out (the therapeutic alliance) and not drop out itself. This suggests that

other factors beyond the therapeutic alliance contribute to the variance of drop out between treatment modalities.

Other researchers have found important differences across modalities regarding the therapeutic alliance and client gender. Werner-Wilson (1997) reported a stronger therapeutic alliance for women in couples therapy, whereas men were found to have a stronger alliance in family therapy. This could be related to the individual's ability to introduce topics within a therapy session. Women have been found to be more successful at introducing topics in marital therapy than men, whereas men are more successful than women in doing so in family therapy (Werner-Wilson, Zimmerman, & Price, 1999). Although gender was not found to be significantly associated with drop out in the present study, there were a greater number of women in the sample than men. According to the previously discussed research, it could be expected that couples in this study would be less likely to drop out than families or individuals, for women report stronger alliances in couples therapy, and the current sample is mostly women. However, this was not found. Couples were more likely to drop out of therapy than individuals or families in the present study, suggesting once again that factors beyond the therapeutic alliance contribute to drop out.

Occupation and income were also significantly associated with dropping out. These results are similar to past research (Baekeland & Lundwall, 1975; Dubrin & Zastowny, 1988; Taulbee, 1958). It is difficult to speculate on why these variables are consistently found to be associated with drop out. It is possible that the type of occupation a client holds contributes to his or her availability for sessions. In all modalities, if one or more clients have a work schedule that does not coincide with the availability of the therapist, it may be very difficult to schedule and keep appointments.

The association between income and drop out is interesting, for the clinic in which this data was collected serves clients on a sliding-fee scale. In other settings, it would be reasonable to hypothesize that clients with low-income levels drop out of treatment because of financial limitations or time constrictions resulting from the client working multiple jobs. However, given that most clients in this setting pay as little as five dollars per session, this may not be the case. Furthermore, the results of this study show that fewer individuals with incomes less than 10,000 dollars dropped out of treatment than expected, and the income level most strongly associated with drop out was the range of 25,000 and 30,000 dollars per year.

The finding that gender and religious preference have no significant association with drop out is consistent with the literature available. Client gender is often included as a demographic variable to be examined, and has not been shown to predict or be associated with drop out (Frayn, 1992; Heatherington & Friedlander, 1990). Religious preference has been shown to have no association by Hoffman (1985).

The other variables in this study that were found to have no association with drop out (i.e., ethnicity and education level) counter previous research. Both Dodd (1971) and Edlund et al. (2002) found significant associations between client ethnicity and the likelihood of dropping out. Education level has been shown repeatedly to be associated with drop out; specifically, high education level predicts continuation in treatment (Allgood, 1991; Dodd, 1971; Dubrin & Zastowny, 1988).

The drop out rate in this study was roughly 18 percent. This is higher than some previous reports (Edlund et al., 2002), yet much lower than others (Fiester, 1974; Hoffman, 1985). However, it may be inaccurate to compare rates across these studies. Edlund et al.

(2002) examined a wide range of treatment settings and modalities (i.e., psychiatry, substance abuse counseling, etc.). Fiester (1974) and Hoffman (1985) each examined community mental health centers. In addition, the drop out rate may be lower in this study because of a stricter definition of drop out. The previously mentioned studies all employ a definition of drop out with only one requirement (e.g., number of sessions). The definition utilized in this study is unique because it includes only individuals that attended less than five sessions and excludes cases in which clients report or exhibit improvement.

#### *Limitations*

A major limitation of this study is the sample size and composition. Roughly 70 percent of the sample is Caucasian, which is not representative of the general population. In addition, a large number of individuals seeking therapy from the clinic used in this study are university students. Although people from the community also seek services from this clinic, they are often referred because of the sliding fee-scale. This could indicate that individuals constituting this sample are not representative of the general population in terms of age, income, or other important demographic variables.

Size of the sample is also a potential concern. Although there are an ample number of total cases (501), there are a relatively small number of individuals that dropped out (91). If a larger sample size were to be utilized, statistical power would increase and it is possible that more significant associations could be found. The number of individuals that dropped out could have been increased with a broader definition of drop out (e.g., individuals that attended less than five sessions, regardless of goal attainment). However, this would allow for a number of confounding variables and ultimately be detrimental to the study.

### *Future Research*

The definition of drop out for this study was unique because it considered number of sessions the client attended as well as the reported reason for leaving therapy. However, this reporting was completed by therapists, not the clients themselves. Future research examining drop out could examine the client's perceptions of therapy as well, in order to obtain more accurate reports of the client's experience throughout the therapy process and upon termination. This could be done prospectively by having clients complete Session Evaluation Questionnaires after the initial sessions.

Another possibility for gaining a more accurate description of the client's experience in therapy is to analyze videos of therapy sessions. Reliable, independent researchers could compare sessions of clients who dropped out of therapy and those who remained. This method would eliminate the reliance on the therapist's report, which can be subjective or inaccurate.

### *Conclusions and Clinical Implications*

The results of this study have significant implications for therapists, counselors, and psychologists. Specifically, the lack of association between client characteristics such as anxiety, hostility, self-esteem, and satisfaction with life suggests that regardless of a client's disposition at the onset of therapy, he or she is no more likely to drop out of treatment based on these characteristics alone. If a clinician wishes to implement materials to help assess for drop out risk, these would not be appropriate screening variables.

When assessing for drop out, instead of examining personality variables such as the ones mentioned above, the clinician may be better equipped by paying attention to treatment modality, marital status, occupation, and income level of potential clients. Knowing that

these factors can predict the likelihood of dropping out of therapy, clinicians can make more efforts towards preventing drop out.

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## Appendix 1: Annotated Bibliographies

Allgood, S.M., Crane, D.R. (1991). Predicting marital therapy drop outs. *Journal of Marital and Family Therapy*, 17, 73-79.

### **Topic: Drop out, Marital Therapy, Anxiety, Presenting Problem**

**Definition of Drop out:** Couples who attended only the intake interview and first session. In the past, other researchers have used the number of sessions (Slipp, Ellis, & Kressel, 1974), the number of weeks in therapy (Reder & Tyson, 1980), the client's decision not to return (Brandt, 1965), and not completing therapeutic goals (McAdoo & Roeske, 1973) as criterion for drop out.

### **Lit Review:**

- Past evaluations of therapeutic drop out have concentrated on individual variables such as client-reported evaluations of the therapist, demographic variables, marital adjustment, and distance from the clinic (Shapiro & Budman, 1973; Gaines & Steadman, 1981; Lowman et al., 1984; Anderson et al., 1985; Cross & Warren, 1984; Ross & Lacey, 1961).
- The present study attempts to identify a comprehensive model of marital therapy drop out. The authors argue such a model is imperative because couples tend to drop out of therapy at higher rates than individuals or families (Anderson, Atilano, Bergen, Russell & Jurich, 1985; Lowman, DeLange, Roberts, & Brady, 1984; Garfield, 1986).

### **Methodology:**

- Sample. 474 couples that sought therapy at the Comprehensive Clinic at Brigham Young University from 1981-1985. The couples were married less than three years with an average of roughly three children. Most couples had never attended therapy

before, and all were Caucasian, young, and educated. All couples scored high ( $M=85.7$  &  $M=80.1$ ) on marital adjustment tests. Presenting problems for these couples were classified into: marital dissatisfaction, family-related problems, individual-related problems, and skill deficiencies. The therapists (slightly more than half of the sample saw male therapists) averaged 16.3 months of experience.

- Instruments Used
  - Marital Adjustment Test (MAT). This test is a 15 item self-report questionnaire in which total scores range from zero to 158, with higher scores indicating increased marital adjustment. Validity and internal consistency were both high for this measure (.90).
  - Marital Status Inventory (MSI). This measure is a 14-item true/false questionnaire that examines a couple's potential for divorce. Scores range from 0-14, with higher scores indicating higher divorce potential. Reliability and validity are both high in this measure as well (split-half  $r=.87$ ).
  - Symptom Check List (SCL-90). This measure is a general psychiatric screening assessment consisting of 90 items covering areas such as hostility, depression, and anxiety. This measure has adequate reliability and validity.
- Procedure. Each spouse attending therapy at BYU completed the previously mentioned measures in addition to a demographic questionnaire. 72 of the 474 couples met criteria to be considered drop outs, and from the remaining sample, 72 couples that continued in therapy were drawn at random for a control group.
- Analysis. A multiple regression procedure was used to narrow down 10 variables that predict drop out. These 10 variables were then entered into a stepwise discriminant

procedure in order to determine significance. The significant variables found from the discriminate procedure were used to develop three different models of predicting therapeutic drop out: a husband model, a wife model, and a couple model. The genders were looked at separately to determine if one spouse had more influence on terminating therapy early.

**Results:** The common variables of each model were: gender of intake clinician, having an individual vs. family-related presenting problem, number of children, SCL-90 scores, interpersonal sensitivity or phobic anxiety, education level, time married, and MSI score.

- Husbands model predictor variables (79% of those that dropped out):
  - Having a male intake clinician
  - Individual or family related presenting problem
  - Phobic anxiety score
  - Number of children
- Wives model predictor variables (79% of those that dropped out):
  - Having a male intake clinician
  - An individual related presenting problem
  - Number of children
- Couples model predictor variables (82% of those that dropped out)
  - Having a male intake clinician
  - An individual or family-related presenting problem
  - Husband's phobic anxiety
  - Number of children

Finally, an analysis of couples that did not drop out of therapy indicated that these variables identified 83% of husbands, 83% of wives, and 80% of couples

Baekland, F. & Lundwall, L. (1975). Dropping out of treatment: A critical review.

*Psychological Bulletin, 82(5), 738-783.*

This article, although not empirical in nature, provided some guidelines for conducting and reviewing research on therapeutic drop out.

### **Definitions**

- Three types of drop out: client who fails to return, client who refuses to continue, and client who is expelled from treatment.
- Immediate drop out is defined as when the client fails to return after one session; rapid drop out is defined as when the client fails to return within the first month; slow drop out is defined as when the client fails to return between the 2<sup>nd</sup> and 6<sup>th</sup> months.
- Someone who has previously dropped out of treatment is more likely to do so again than someone who is seeking therapy for the first time.

### **Patient Variables**

- Authors argue that it is important to include age, sex, race, education level, and income when doing assessments of drop out.

### **Treatment Variables**

- The authors believe that “an institutions staffing, admission procedures, and treatment methods are all factors which could induce a patient either to quit treatment or to remain in it” (p.742).

## Statistical Considerations

- “It cannot be assumed that the patient who does not show up for treatment is a total loss.”

Endicott & Endicott's (1963) results imply that as severity of symptoms increases, so does the client's likelihood of dropping out.

Bird, J. (1993). Coming out of the closet: Illuminating the therapeutic relationship. *Journal of Feminist Family Therapy*, 5(2), 47-64.

## Topics: Therapeutic Alliance

### Therapeutic Relationship

- Definition: “special relationship in that one person trusts the other with their vulnerability.” This is “given” to the therapist by the client and requires the therapist to give “energy, skill, knowledge, thoughts, actions, and care” (p.49)
- Contract: When a therapist agrees to the therapeutic contract (becomes one’s therapist), he or she releases the right to keep secrets in regards to the therapeutic relationship.
- Reflections: Therapists have a responsibility to protect clients from becoming dependent upon therapy by reflecting upon one’s self and what he or she is gaining from the therapeutic relationship. The author argues this is critical to learn in training to become a therapist.
- Past Relationships: Self-reflection can help a therapist identify themes that he or she is uncomfortable with and may possibly avoid.

- Reflection concerning client: Bird argues that therapists should identify their feelings about their clients by asking themselves questions such as “What do I think about the client? What do I feel about the client? Do I like the person I am working with?” (p.54). If these feelings interfere with the relationship, then the therapist needs to resolve them for the sake of the therapeutic relationship (by self-reflection or supervision). The author also argues that if the therapist admits to not liking his or her client, the therapeutic relationship is likely to be unsuccessful (p.56).
- Sexual/Strong Feelings: If the therapist feels any strong emotions or sexual feelings concerning his or her client, they need to be addressed immediately through supervision.

Building the relationship: A successful therapeutic relationship “consists of a balance between connectedness and detachment” (p.59). Both the client and therapist must believe the therapist is able to detach from the client’s situation.

Davis, H. & Dhillon, A.M. (1989). Prediction of early attrition from couple therapy.

*Psychological Reports, 65, 899-902.*

**Topic: Drop out, type of relationship (married vs. cohabitational)**

**Definition of Drop out:** Attending fewer than 5 sessions.

**Lit Review:**

- Baekeland & Lundwall (1975), in their review of literature, found that the following client variables are associated with treatment drop out: low socioeconomic status, aggressiveness, sociopathic personality, counter dependence and low psychological mindedness.

- Kolb, Beutler, Davis, Crago, and Shanfield (1985) reported client characteristics to be not as important in determining drop out as therapeutic process variables.

### **Methodology:**

- Sample. 45 married or cohabitating couples. 21 of the 45 prematurely terminated. The couples were together a mean of 5.3 years; the average age of the women was 29.2 and the men 30.8.
- 4 male and 9 female therapists were utilized for this study, most worked from a learning-cognitive perspective.
- The following items were collected from each client:
  - ISP class estimate
  - Number of children
  - Number of previous marital/cohabitational relationships
  - Number of different countries resided in before age 10
  - Number of separations in current relationship
  - Whether or not couple has sought out counseling in the past
- Analysis. Regression analysis

### **Results:**

- “The final regression equation...found that common-law marriage and low nonmortgage debt were statistically associated with the failure to engage in couples’ therapy” (p.901).

Dubrin, J.R., & Zastowny, T.R. (1988). Predicting early attrition from psychotherapy: An analysis of a large private practice cohort. *Psychotherapy, 25(3)*, 393-406.

**Topic: Drop out, Psychotherapy, Personality factors**

Although this study was completed in a psychotherapy clinic, it can be related to family therapy in that the researchers state the people entering long-term psychotherapy often “expect to ‘feel better,’ ‘feel more,’ and achieve personality reconstruction and characterologic change” (p. 393) These expectations are also present in marriage and family therapy.

The researchers’ rationale for this study is that “anywhere from 30-60% of clients who begin therapy will end treatment before the sixth visit” and after dropping out, many do not enter therapy at a different facility. They believed that personality and clinic measures could predict a client’s likeliness to drop out.

**Definition of Drop out:** The authors of this article provide a lengthy review of past researchers’ definitions of drop out. They provide examples in which “rapid drop outs, slow drop outs, and attenders” were defined.

**Literature Review Findings:**

- Social class, education, and race all are significant predictors of drop out (Dodd, 1971).
- Higher education level for the clients who remained in therapy (Hiler, 1956).
- African Americans tend to drop out of treatment earlier than Caucasians (Lorr et al., 1958).
- Age is not a significant predictor, according to the review of literature.
- Some “psychiatric types” correlate with staying in therapy (Lorr, et al., 1965).
- Garfied & Bergin’s (1978) review of literature revealed “little relationship between personality and clinical characteristics and leaving psychotherapy.”

- High anxiety (Lorr, et al, 1958), motivation (Wallach & Strupp, 1960) and the presence of depression (Frank et al., 1957) are related to staying in therapy.
- Sociopathic features, aggressive behavior, passive-aggressive behavior, defensiveness were found in various studies to correlate with dropping out (Altman et al., 1972; Baekeland et al., 1973; Zolik & Hollon, 1960; etc.)
- “Koss (1979) found the attrition rate in private-practice population to be consistent with that seen in clinic populations” (p. 397)

### **Methodology:**

- Sample. 306 clients from an upscale portion of New York requesting treatment from a private practice. Ages ranged from 20-63. 63.4% of clients were female.
- Procedure. The clients were given assessments to complete during the first session and returned them the second. The assessments included: which of the nine therapists they were seeing, demographic variables (sex, age, occupation, and education), MMPI variables, POI variables, and Feeling scale variables.
- Analysis. Multiple discriminant analysis, stepwise prediction

### **Results:**

- MMPI scale 1, summation of MMPI scales 1 & 3, MMPI scale 5, feeling item 3, occupation, and education were found to significantly correlate with dropping out.
- Otherwise, there is a lack of significant outcomes for this study. The researchers hypothesize this could be due to a number of factors (perhaps there are differences in private practice clients than institutional).

Edlund, M.J., Wang, P.S., Berglund, P.A., Katz, S.J., Lin, E., & Kessler, R.C. (2002).

Dropping out of mental health treatment: Patterns and predictors among epidemiological survey respondents in the United States and Ontario. *American Journal of Psychiatry*, 159(5), 845-851.

**Topics: Drop out, psychotherapy, demographics, disorders**

**Definition of Drop out:** Those who terminated treatment but do not report symptom improvement.

**Lit Review:**

- Drop out from therapy is common; the researchers hypothesize that this may be due to the lack of financial resources that individuals with mental health problems possess.
- 1<sup>st</sup> aim of current study: determine drop out rates from treatment in both the US and Ontario.
- 2<sup>nd</sup> aim of current study: examine 4 drop out predictors:
  - Clinical conditions
  - Treatment modalities
  - Negative attitudes regarding mental health treatment
  - Demographic features

**Methodology:**

- Sample. “Data for this study came from the United States National Comorbidity Survey and the Mental Health Supplement to the Ontario Health Survey” 830 respondents from the National Comorbidity Study and 432 from the Mental Health Supplement study were examined. Age range 15-54. All had self-defined problems with “emotions, nerves, mental health, or use of alcohol and drugs” (p.846).

- Variables examined (\* = researchers hypothesized this would be significant predictor):
  - Sociodemographic features\*
  - Gender
  - Family income
  - “Urbanicity”
  - Country of residence
  - Race/ethnicity
  - Type of disorder\*
  - Treatment type\*
  - Negative attitudes towards mental health professionals\*
- Measures. “Presence of DSM-III-R mental disorders...was assessed with a modified version of the World Health Organization Composite International Diagnostic Interview. Disorders examined include:
  - Major depressive episode
  - Mania
  - Dysthymia
  - Social phobia
  - Simple phobia
  - Agoraphobia
  - Generalized anxiety disorder
  - Panic disorder
  - Alcohol abuse/dependence

- Drug abuse/dependence
- Analysis. Kaplan-Meier curves; chi-square analyses “to test whether each class of predictors significantly predicted drop out in multivariable models” (p.846).

### **Results:**

10% of patients in both countries dropped out by session five.

- No significant effect was found for DSM-III-R diagnoses as predictors of drop out.
- Drop out was significantly higher for those clients seeing a spiritual advisor than any other type of provider.

Sociodemographic variables (i.e., age and race) were found to be significant while controlling for the others.

Fiester, A.R., & Rudestam, K.E. (1975). A multivariate analysis of the early drop out process. *Journal of Counseling and Clinical Psychology*, 43(4), 528-535.

### **Topics: Drop out**

#### **Review of Literature:**

- Between 37 and 45% of adult outpatients in mental health centers drop out of treatment after the first or second session (Fiester, 1974).
- Many researchers believe that once an individual drops out of therapy they are unlikely to return for treatment (Garfield, 196; Noonan, 1973; Riess & Brandt, 1965).
- Previous research consistently demonstrates that those from a lower socio-economic class drop out at a higher proportion.
- This study examines the interaction between:
  - Patient variables (e.g., demographics, expectations of therapy)

- Therapist variables (e.g., demographics)
- Therapy process from the patient's perspective.

**Definition of Drop out:** Those who did not know for a scheduled appointment and thereby withdrew from treatment (1<sup>st</sup> or 2<sup>nd</sup> session)

**Method:**

- Sample: Outpatient adults (age 18 and older) accepted at two outpatient mental health centers. Early drop out group n = 45 for hospital center and n = 26 for state clinic. Nondrop out group n = 75 and 26 for hospital and state centers, respectively.
- Instruments: Two-Factor Index of Social Position (Hollingshead & Redlich, 1958) and questionnaire containing items assessing pretherapy expectations, orientation, and role of the therapist. Researchers also collected demographic information and post-therapy questionnaire assessing therapist behavior.
- Analysis: A factor analysis was completed to isolate "alternative pathways" to drop out. (p.529). In addition, a chi-square test and t-tests were completed to determine differences between drop out and nondrop out clients regarding demographic data.

**Results:**

- Within the hospital setting, none of the variables were found to be significantly different between drop out and nondrop out participants.
- Within the clinic setting, the following variables were significantly different between drop outs and nondrop outs. Drop outs:
  - Rated their therapist as more helpful
  - Spoke less in sessions concerning feelings toward the therapist
  - Felt angry during sessions

- Reported being more attentive to therapist
- Viewed therapist as involved and serious in session.
- More lower-class participants dropped out than middle-class.
- Authors suggest early termination does not equal failure
- Results indicate that certain clients terminate prematurely for reasons other than events that occur during initial session (p.534).

Frayn, D.H. (1992). Assessment factors associated with premature psychotherapy termination. *American Journal of Psychotherapy*, 46(2), 250-261.

This study concentrates on client qualities that can be assessed by senior trainees during initial consultation, and how those qualities relate to early termination.

**Topics: Drop out, psychotherapy, client factors**

**Definition of Drop out:** Any client who left therapy before the agreed-upon nine months.

**Lit Review:**

- Negative patient alliance factors have higher correlations with outcome than positive patient alliance factors (such as motivation for insight) (Marzali, Marmar, & Krupnick, 1981).
- There is no direct relation between the therapists' professional experience and orientation (Luborski, 1976).
- Previous studies have examined the following factors and reported an association with drop out: substance abuse, axis II diagnosis, early prolonged silences, primitive defenses, preoedipal conflict, persistent transference resistance, psychosomatic or somatizing symptomatology and situational crises.

**Methodology:**

- Sample. 85 patient assessments were reviewed for this study over a seven-year period. 20 of the cases were early terminators, so the researchers randomly selected 20 cases that completed therapy to use as a comparative group.
- Measures. T.I.P. Assessment Questionnaire: contains biographical and clinical data and 16 patient qualities/dynamic factors. The qualities examined were:
  - Past Positive Transferences
  - Clinical functioning
  - Affect availability
  - Therapist alliance
  - Introspection
  - Object relatedness
  - Frustration tolerance
  - Motivation
  - Life circumstances
  - Impulse control
  - Childhood attachment
  - Past positive treatment
  - Symptom duration
  - Patient alliance
  - Work adaptation and
  - Sexual functioning

**Results:**

- Age and gender were not found to be significantly related to drop out.
- Introspection, frustration tolerance, motivation, therapist alliance, and life circumstance items were the most highly discriminated b/w the two groups (<.001).
- Impulse control, past positive transferences, and present clinical functioning were also significant, but to a lesser degree (<.01).

Greenspan, M. & Mann Kulish, N. (1985). Factors in premature termination in long-term psychotherapy. *Psychotherapy, 22(1)*, 75-82.

#### **Literature Review:**

- Redler & Tyson (1980) estimate drop out from psychotherapy to be 63% before the 16<sup>th</sup> session and 96% by the 19<sup>th</sup>.
- Drop out is influenced by three factors: therapist variables, patient variables, and interactional variables. (This study does not examine the third.)
- Lower socioeconomic classes are found to have a higher drop out rate in psychotherapy.
- McNair et al (1963) found clients who demonstrate “perseverance, social integration, suggestibility, expressed anxiety, less impulsivity, and the absence of antisocial or authoritarian attitudes have lower drop out rates.
- Goodman (1960) found that clients who paid a higher fee for therapy had lower drop out rates, but Adams (1968) and Borghi (1968) found no difference between fees.

**Definition of drop out:** The therapists' report of the mutuality of the termination of therapy, not an arbitrary length of time or number of sessions.

#### **Methodology:**

- Sample. Data was taken from 718 terminated patient records in a private psychiatric clinic in Detroit. Family and Marital therapy cases were excluded. 273 of these were found to meet criteria of “drop out” (only long term cases were considered, those who had a valid reason for leaving were excluded, etc.)
- Variables considered:
  - Age
  - Race
  - Sex
  - Marital status
  - Residence
  - Employer
  - Source of referral
  - Source of payment
  - Chief presenting complaint
  - Diagnosis

Heatherington, L. & Friedlander, M.L. (1990). Couple and family therapy alliance scales: empirical considerations. *Journal of Marital and Family Therapy*, 16 (3), 299-306.

Topics: Alliance, CTAS, FTAS, Split Alliance

#### **Review of Literature:**

- Each client’s alliance with the therapist affects each relationship within the system.

- Individual alliance: each member with therapist; subsystem alliance: marital dyad and therapist; whole system alliance: between therapist and collective. (Pinsof and Catherall, 1986).
- Couple Therapy Alliance Scale (CTAS) and Family Therapy Alliance Scale (FTAS) were each developed by Pinsof and Catherall (1986). Each contain content portions based on Bordin's alliance concept and interpersonal portions based on perceptions of alliance. Reliabilities are .79 and .83 respectively.

**Method:**

- Participants: 66 clients (32 male) and 16 therapists (12 male). Therapists consisted of psychologists, social workers, and psychiatrists with experience ranging from doctoral intern to clinician.
- Instruments
  - CTAS & FTAS
    - Interpersonal subscales
      - Self (I trust therapist)
      - Other (My partner doesn't agree with therapist)
      - Group (Therapist cares about my family)
    - Content subscales
      - Task
      - Goals
      - Bonds
  - Session Evaluation Questionnaire (SEQ): Measures both the clients and therapists' perceptions of an individual session.

- Procedure: Measures were completed between the third and sixth session.

### **Results:**

- No significant effects between scale used (modality of treatment), gender, or interaction.
- High alphas for all subscales (.7-.94), indicating high internal consistency
- Each subscale highly correlated with overall rating.

At least 14% of couples and 42% of families experience a split alliance within therapy.

Heilbrun, A.B., Jr. (1961). Client personality patterns, counselor dominance, and duration of counseling. *Psychological Reports*, 9, 15-25.

*Topics: Achievement; Deference; Autonomy; Dominance; Abatement*

### **Review of Literature:**

- Length of counseling is important because “brief exposure” can only produce negligible changes in client (p.15).
- Continuers of treatment tend to be: more educated, more intelligent, and from a higher S.E.S.
- Demographic variables important, but in clinics such as ours (on college campuses) there is a homogeneity among clientele (p.15).
- Personality wise, continuers of treatment are: more anxious, more self-dissatisfied, have “higher verbal productivity”, more persistence, and more dependency.
- Male continuers have been found to be less achieving, autonomous, and dominant and more deferent and abasing than early terminating males. Females were found to exhibit just the opposite.

- Regardless of gender, those who were early terminators conformed more closely to gender stereotypes (males who stayed in treatment were more masculine, etc.).
- Hypothesis 1): There are specified and differential sex-linked personality patterns for men and women who stay in counseling or drop out.
- Hypothesis 2): What possible interactions may exist between personality characteristics of female client and those of the counselor?

**Definition of Drop out:** 5 or less sessions beyond initial screening interview

**Method:**

- Participants divided into the following groups: non-stay (31 females and 27 males) and stay (22 females and 32 males). Non-stays were further divided between those who did not show for the initial appointment and those who dropped after the 1<sup>st</sup>. All males and females were similar in education, age, and intellectual ability.
- Number of sessions:
  - Female non-stays: 0 to 3
  - Male non-stays: 0 to 4
  - Female stays: 6 to 64
  - Male non-stays: 6 to 40.
- Instruments. Gough Adjective Check List (Need scale)
- Personality variables and predicted outcomes:
  - Achievement (Males non-stay>stay; Females stay<non-stay).
  - Deference (Males non-stay<stay; females non-stay>stay).
  - Autonomy (Males non-stay>stay; females non-stay<stay).
  - Dominance (Males non-stay>stay; females non-stay<stay).

- Abasement (Males non-stay<stay; females non-stay>stay).
- Heterosexuality (Males and females non-stay>stay.)
- Change (Males and females non-stay>stay).

## **Results**

- All predictions for males were supported at a significant level, except for autonomy, which approached significance. None of the differences between female stays and non-stays are significant. Those who continue are more deferent and abasing and less achieving, autonomous, and dominating than drop outs.

More autonomous females were more likely to continue in counseling when the counselor was highly dominant than were less autonomous females. However, females that are more autonomous dropped out of therapy with average dominance counselors, and less autonomous females continued.

Hoffman, J.J. (1985). Client factors related to premature termination of psychotherapy. *Psychotherapy, 22(1)*, 83-85

### **Topics: Drop out, client demographics**

**Definition of Drop out:** A client who does not return to therapy after either the initial contact (intake interview) or first session, against the recommendation of the therapist.

### **Lit Review:**

- “The most generally accepted estimate of early terminators is 33%” (p.83)
- Reasoning for study: early termination is not only harmful for the client, but therapist as well.

- Brandt (1965) found that “personality characteristics were found to successfully identify the two groups” (p.83).

### **Methodology:**

- Sample. “287 clients of a private nonprofit community mental health center” (p.84) who attended therapy between 1976 to the time of study.
- Variables examined:
  - Whether they were a “remainer” or “terminator”
  - Age
  - Sex
  - Income
  - Education
  - Religion
  - Marital status
  - Family size
  - Source of referral
  - Presenting problem
  - Diagnosis
  - Previous psychiatric or psychological treatment
- Analysis. Chi-square test of independence

### **Results:**

- Researchers found an overall 32.4% drop out rate (consistent with their lit review).

- The three variables that were found to be significant predictors were: previous psychiatric contact ( $p < .01$ ; more likely to remain), diagnosis ( $p < .05$ ; more likely to remain), presenting problem ( $p < .05$ ).
- Clients who presented with a thought disorder were less likely to terminate early ( $p < .02$ ). Clients who presented with an interpersonal relationship problem were more likely to terminate early ( $p < .05$ ).

Researchers' rationale for the interpersonal relationship finding is that problems of this nature are often situational. When the crisis seems to have passed, they may feel they do not need therapy anymore. "Many premature terminators are clients who have applied for counseling services for the first time" (p.85).

Kokotovic, A.M., & Tracey, T.J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology, 37*(1), 16-21.

### **Topics: Alliance**

#### **Review of Literature:**

- Alliance can be defined as "the feeling that both participants care for each other and that they can and will work productively toward a shared goal." This is extremely important in the beginning sessions (Gelso & Carter, 1985). If the alliance is not formed early, a "poor outcome is assumed to occur."
- Bordin (1979) proposed the three components of the alliance are: goal, task, and bond. These three components are highly intercorrelated (Horvath & Greenberg, 1989). Bordin also suggests that an outcome of a poor alliance is early termination.

- It is assumed that the characteristics of an individual will affect the quality of the alliance or relationship. The ability to form an alliance is related to “his or her capacity to form productive attachments to others, capacity to trust others, and willingness to take responsibility for the work of counseling” (Gelso & Carter, 1985).
- Hostile/negative clients have a more difficult time forming alliances (Gomes-Schwartz, 1978; Marziali, Marmar, & Krupnick, 1981; Strupp, 1980). Those who have a history of interpersonal relationships are able to form alliances (Moras & Strupp, 1982).
- Gelso & Carter (1985) suggest the difficulty of treatment relates to the quality of the alliance.
- Hartley & Strupp (1983) found no differences in quality of alliance between remainers and drop outs from therapy regarding predictor variables.
- This article examines the relationship between the working alliance and premature termination, and the extent to which it is affected by the client and therapist satisfaction levels with treatment. (p.17).

**Method:**

- Sample: 144 clients (57% women) and 15 counselors
- Instruments:
  - WAI (Horvath & Greenberg, 1986)
  - Interpersonal Relationship Scale (IRS)—measures hostility level, quality of interpersonal relationships, and quality of relationships with family members.
  - Problem Severity Rating Scale (PSRS)—measures severity of problem, distress level, quality of interpersonal functioning, and academic performance.

- Therapist Satisfaction Scale (TSS)—7 item scale measuring overall satisfaction with sessions
- Client Satisfaction Scale (CSS)—5 items, measuring overall satisfaction
- Self-Report Checklist (SRC)—assess rate/severity of common presenting problems.
- Counselors and clients completed appropriate measures as soon as possible after first session/interview.
- Counselor rated variables:
  - Hostility
  - Quality of family relationships
  - Quality of interpersonal relationships
  - Overall adjustment
- Client rated variables:
  - Overall adjustment
  - Educational concerns
  - Emotional arousal
  - Public speaking anxiety
  - Intimacy

### **Results:**

- Client hostility, poor quality of current and past relationships (as viewed by the counselor) were correlated with formation of the working alliance.
- Premature Termination:
  - There were 43 drop outs and 85 remainers in this study.

- There were no significant differences in characteristics between those who prematurely terminated and those who remained in therapy. “No support was yielded for the hypothesized working alliance differences between those dyads that terminated prematurely and those that did not” (p.20).

The hypothesis that interpersonal difficulties would negatively affect the therapeutic alliance was not supported.

Iverson, D.C., Jurs, S.G., & Wenger, S.S. (1976). Prediction of attrition from a therapeutic community. *Psychological Reports*, 39, 1287-1290.

### **Topics: Locus of Control; Self-Actualization**

#### **Review of Literature:**

- Past researchers have used the Personal Orientation Inventory; which is a 150-item measure that assesses development of self-actualization. This is important because those who enter therapy with a high self-actualization score may only require a minimal amount of therapy or “quickly become disenchanted with many of the treatment components which have negative effects” (p.1287).
- Hypothesis: The higher of a score a person received on the POI, the more likely they were to drop out of therapy.

#### **Definition of Drop out:**

- Less than 90 days in treatment

#### **Method**

- Sample. 75 (51 male, 24 female) drug-dependent individuals who entered treatment between October 1973 and December 1974. Age ranged from 15 to 31 years, with a

mean of 20.32. Average education = 10.8 years. Of the 75, 56 had been in jail, 30 had attempted suicide, and 30 were in the program as a result of probation.

- Procedure: Participants were divided into 5 groups: Those who remained less than 90 days ( $n = 36$ ); 90-179 days ( $n = 23$ ); 180-269 days ( $n = 6$ ); 270-359 days ( $n = 6$ ); and 360 days or more ( $n = 4$ ).
- Instruments Used: Personal Orientation Inventory (described above).
- Analysis: Stepwise Regression to predict length of stay using demographic items and POI subscales. ANOVAs were also ran to determine variance between groups.

## Results

- Overall, the POI was not an accurate predictor of length of stay. However, some of the subscales of the POI were significant.
  - Self-acceptance, Time competence, time incompetence, and spontaneity accounted for almost 20 % of variance. ( $R^2=.187$ ).
- Groups did not differ significantly from one another on the inventory subscales.
- Demographic variables (attempted suicide, incarcerated, probation) were less predictive than subscales of POI.
- “The inclusion of a measure of locus of control, a psychological diagnostic measure, and the Personal Orientation Inventory may yield the level of precision useful for more effective counseling.”

Lever, H. & Gmeiner, A. (2000). Families leaving family therapy after one or two sessions: A multiple descriptive case study. *Contemporary Family Therapy*, 22(1), 39-65.

**Topics: Drop out, Family Experiences, Therapist Experience, Reflecting Team**

**Review of Literature:**

- Of all of the factors that contribute to the therapeutic alliance, family factors, make up, and perception of the therapeutic process seem to be the most important (Duncan, Hubble, & Miller, 1997).
- Although we, as therapists, acknowledge that families are the experts on their own lives, we rarely consult with them regarding what may make therapy more useful. (Carpenter, 1994; McCollum & Beer, 1995; Wark, 1994).
- Often the opinion of a family is quite different from that of the therapist regarding therapeutic interventions and sessions. What the therapist believes was not effective, the family may have found extremely useful (Carpenter, 1994; McCollum & Beer, 1995).
- Therapy is a success when families can look at problems in new and different ways (White, 1995).
- Problem: Many families choose outside of the therapy session to not return and therapists are left with a minimal excuse/reason, if any. As a result, the research question is: What does the family, therapist, and reflecting team experience in the first or second session when the family leaves afterwards?

**Method:**

- Two therapists worked with each family, in addition to a reflecting team working from a social constructionist perspective.
- “Research followed a qualitative, exploratory, contextual, and descriptive design with the strategy of a multiple descriptive case study” (p.42).

- Two case studies were done in which the therapists, reflecting team, and families who have dropped out were consulted about their experiences with therapy using methodological, observational, personal, and theoretical field notes. Two case studies were done to increase validity/reliability and generalizability.
- Analysis: Tesch, a design in which common themes are identified. Coders did not use pre-determined categories.

**Results:**

- During the joining phase of therapy, the common theme identified was a sense of connectedness within the therapy room. If families were unsure of what was expected or uneasy they were not engaged in therapy.
- During the working phase of therapy, a lack of engagement was due to the family not feeling safe within the therapy room. The reflecting team also reported not feeling safe enough to share their views. In addition, families felt as if they did not play an active role (have power) in the therapy process.

During the termination phase of therapy, both families reported feeling as if their goals of therapy were not addressed, and leave feeling frustrated and unhelped.

Mallinckrodt, B. & Nelson, M.L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology, 38*(2), 133-138.

**Topics: Alliance, BSI, Experience level of therapist**

**Review of Literature:**

- Gelso & Carter (1985) define working alliance as “an emotional alignment between the counselor and the client that engages the self-observing rational aspects of the client and the working therapizing aspects of the counselor” (p.133)
- Bordin’s (1979) 3 components: bond, task, goal.
- 30-45% of variance in outcome can be predicted by WAI scores after 2<sup>nd</sup> or 3<sup>rd</sup> session. Task and goal dimensions were more strongly related to successful outcome than bond (Horvath & Greenberg, 1989).
- The authors argue that “the broader knowledge base and more efficient cognitive abilities of experienced counselors may account for their superior skill at case conceptualization...to formulate clearly defined goals” (p.133).
- Worthington (1984) found that case conceptualization is emphasized only in later stages of supervision and training.
- Two most abrupt increases in ability occur after first practicum semester and after internship.
- Hypothesis: Training level would impact all three dimensions of the WAI in the following order of severity (most to least): goal, task, bond.

**Method:**

- Data were collected at three counseling centers using time-limited brief therapy.
- Participants: 50 therapists (18 novice, 24 advanced, 8 experienced) and 76 clients (17 male and 41 female).
- Instruments:
  - WAI. 36 item self-report measure based on Bordin’s (1979) model of the working alliance. Each subscale (task, goal, bond) consists of 12 items.

Internal consistency for client subscales is .88 to .91 and .88 to .93 for counselor subscales (Kokotovic & Tracey, 1990).

- Pretherapy Symptoms. Clients completed the Bell Global Psychopathology Scale, and the BSI to determine baseline symptoms that could affect the therapeutic alliance.
- Analysis:
  - ANOVAs were conducted to compare clients across counselors in regards to pretherapy symptoms. No significant differences were found, leading the researchers to believe that there were no confounding variables.
  - A two-way MANOVA was also conducted to examine training level x source of WAI rating (novice, advanced, trainee x counselor, client). Main effects were significant for training level and source of rating, but the interaction was not significant.

### **Results:**

- As hypothesized, the bond subscale showed the smallest difference across levels, the goal subscale the most, and task was in-between.
- Counselors rated the working alliance significantly lower than their clients did. Clients' ratings of the working alliance were positively associated with higher training levels.
- There was a strong main effect for training level. Clients rated counselors in middle training levels (the advanced group) as more effective than the novice group. Novice therapists rated themselves higher than the advanced counselors, however. The author hypothesizes that this is because as the counselor learns more about case

management and goal setting, he or she also realizes how much more there is to learn. They begin to feel as if they are “too unskilled to perform effectively” (p.136).

Pinsof, W.M. & Catherall, D.R. (1986). The integrative psychotherapy alliance: Family, couple, and individual therapy scales. *Journal of Marital and Family Therapy*, 12(2), 137-151.

- The authors argue that the alliance “may be the primary mediating variable that determines the outcome of discrete interventions. It is the vessel or relational context in which therapy occurs” (p.138).
- The alliance occurs on at least three levels: the individual (the alliance with each member of the family), the whole system (all members as a group), and the subsystem (parents, children, etc.) None of these should be considered in isolation.
- Definition of alliance: “that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (p.139). This is different than the therapeutic relationship in that this only addresses the mutual collaboration (as opposed to religious or political differences).
- Two dimensions create 3x3 matrixes for scales (tasks, goals, bonds x self-therapist, other-therapist, group-therapist). All items on scales fit into one of the cells.
- Common features of 3 scales:
  - Alliance based on individual self report
  - Scales are administered to client at the end of a session

- Format: 7-point Likert scale ratings of how much the client agrees or disagrees with a particular statement
- Individual patient scores (on all therapist levels—self, other, group)
- Conjoint scores
- Results from two studies:
  - Scales have adequate and expected rate-rerate reliability
  - All clients (individual, couple, family) are reluctant to admit to negative feelings concerning therapy or their therapist.

Stern, S.L., Moore, S.F., & Gross, S.J. (1975). Confounding of personality and social class characteristics in research on premature termination. *Journal of Consulting and Clinical Psychology*, 43(3), 341-344.

### **Topics: Outpatient Psychotherapy, Drop out**

**Definition of Drop out:** If the client did not attend six consecutive sessions, or missed more than one session without notifying the therapist.

### **Review of Literature:**

- Some researchers believe premature termination occurs with 30-60% of clients (Rubinstein & Lorr, 1956).
- Some characteristics of premature terminators include: sociopathic tendencies (i.e., poor impulse control), authoritarian attitudes, rigid perceptions of authority, and lack of anxiety (Lorr et al., 1958; McNair, Lorr, & Callahan, 1963; Rubinstein & Lorr, 1965) p.341.

- Most of the clients who drop out of therapy with these characteristics are also from a low socio-economic class. Therefore, there may be confounding between the two variables.
- Hypotheses:
  - Differences would be demonstrated between low- and middle-class patients on the Terminator-Remainer subscales.
  - Scores on the terminator-remainer scales would not differ significantly within class between premature terminators and those who remain in therapy

**Method:**

- Sample: 68 male patients at six outpatient clinics in Indiana, ages 18 and older.
- Procedure: The terminator-remainer scale was given to patients after their initial interview.
- Instruments:
  - The terminator-remainer scale consists of three subscales
    - Behavior Disturbance Scale. 40 item instrument that measures impulse control, goal persistence, and personal ties. Low scores reflect sociopathy and relate to premature termination.
    - California F Scale. 20 item instrument that assesses patient's psychological sophistication, insight, and tendency to repress conflict. Low scores relate to premature termination.
    - Taylor Manifest Anxiety Scale. 30 item instrument that measures willingness to admit anxiety.

- Two-Factor Index of Social Position. Participants were divided into four groups: lower-class terminators, lower-class remainers, middle-class terminators, and middle-class remainers.

### **Results:**

- Terminators and remainers did not differ significantly regarding personality characteristics on the behavior disturbance scale or the modified F scale.
- Significant differences did exist between the two classes regardless if they were early terminators or not.
- Results indicate that neither social class nor personality variables can sufficiently explain premature termination.

Taulbee, E.S. (1958). Relationship between certain personality variables and continuation in psychotherapy. *Journal of Counseling Psychology*, 22(2), 83-89.

**Topics: Anxiety, Defensiveness, MMPI Items, Persistence; Drop out**

### **Literature Review:**

- Past research has shown a relationship between certain personality variables and continuation in therapy, as well as socioeconomic status, education, and intelligence.
- Cartwright (1955) and Taylor (1956) found variance in continuation and improvement in therapy is more attributable to personality differences than the type of therapy employed. (This could imply that although most research is concentrated on individual psychotherapy, it is applicable to marriage and family therapy as well.)
- Higher levels in anxiety and lower levels of defensiveness are associated with continuers in therapy (Gallagher, 1953)

- In terms of improvement, those who have benefited from therapy exhibit higher IQ scores, productivity, emotional depth, responsiveness, sensitivity and energy (Rosenberg, 1954).
- Hypothesis 1) Continuers of therapy score higher on “symptom” scales of the MMPI and specific items on the Rorschach
- Hypothesis 2) Continuers are less defensive
- Hypothesis 3) Continuers are more persistent
- Hypothesis 4) Continuers resemble “normal” participants moreso than early terminators.

**Definition of Drop out:** Those who terminate treatment before the 13<sup>th</sup> session.

### **Methodology**

- Sample. 85 patients who were “veterans” in a mental hygiene clinic who were previously diagnosed with a psychoneurotic disorder without organic complications.
  - “Attritors”: N = 40; Mean age= 33.45, Mean education = 10.3 years. No descriptions of gender.
  - “Continuers”: N = 45; Mean age=33.6, Mean education = 10.93 years.
  - “Normal subjects”: N = 50; Mean age=35.62. Residents of a small Midwestern community in close proximity to the mental hospital.
- Instruments Used:
  - Rorschach: Scored according to the Beck system and checked by a second person.
  - MMPI

- Procedures: Chi Square to determine differences between “normal” subjects and continuers. An Objective Configural Analysis was also applied to the MMPI items.

## Results

- Hypothesis 1) Continuers exhibited greater scores on the symptom scales (hs, D, Pa, Pt, and Sc) of the MMPI.
- Hypothesis 2) Continuers rejected fewer cards, meaning they are less defensive
- Hypothesis 3) Continuers were found to be more persistent (gave more S responses and total responses)
- Hypothesis 4) Continuers were more like “normal” subjects.
- Overall: Continuers are more emotionally responsive, anxious, sensitive, dependent, self-doubting, and have increased feelings of inadequacy, inferiority, and depression.

## Appendix 2: Survey Instruments

### RSE

Please record the appropriate answer for each item, depending on whether you strongly agree, agree, disagree, or strongly disagree with it.

1 = Strongly agree

2 = Agree

3 = Disagree

4 = Strongly disagree

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I'm a person of worth.
8. I wish I could have more respect for myself.
9. All in all, I am inclined to think that I am a failure.
10. I take a positive attitude toward myself.

## SWLS

Below are five statements with which you may agree or disagree. Using the scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Slightly disagree
- 4 = Neither agree or disagree
- 5 = Slightly agree
- 6 = Agree
- 7 = Strongly agree

- 1. In most ways my life is close to ideal
- 2. The conditions of my life are excellent.
- 3. I am satisfied with my life.
- 4. So far I have gotten the important things I want in life.
- 5. If I could live my life over again, I would change almost nothing.

## Appendix 3: Human Subjects Research Form

*Revised* *9/12/05*

Review Date:	12/22/05	IRB ID:	DS-580 05-574
Approval Date:		Length of Approval:	
Approval Expiration Date:		FULL Committee Review:	
EXEMPT per 45 CFR 46.101(b):	4	Minimal Risk:	
EXPEDITED per 45 CFR 46.110(b):		More than Minimal Risk:	
Category	Letter	Project Closed Date:	

## ISU NEW HUMAN SUBJECTS RESEARCH FORM

*IRB*

## SECTION I: GENERAL INFORMATION

*DEC - 7 2005*

Principal Investigator (PI): Abbie L. Heiberger	Phone: 294-8899	Fax:
Degrees: BA, Psychology & Family Services	Correspondence Address: 63 LeBaron Hall, Iowa State University	
Department: Human Development and Family Studies	Email Address: abbieh@iastate.edu	
Center/Institute:	College: Consumer and Family Sciences	
PI Level: <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Postdoctoral <input checked="" type="checkbox"/> Graduate Student <input type="checkbox"/> Undergraduate Student		

Title of Project: The Influence of Client Characteristics on Premature Termination from Therapy.
Project Period (Include Start and End Date): [mm/dd/yy][10/30/05] to [mm/yy/dd][07/01/05]

FOR STUDENT PROJECTS			
Name of Major Professor/Supervising Faculty: Ron Werner-Wilson	Signature of Major Professor/Supervising Faculty: <i>Ron Werner-Wilson</i>		
Phone: 294-8671	Campus Address: 4380 Palmer		
Department: Human Development and Family Studies	Email Address: rwwilson@iastate.edu		
Type of Project: (check all that apply)			
<input type="checkbox"/> Research	<input checked="" type="checkbox"/> Thesis	<input type="checkbox"/> Dissertation	<input type="checkbox"/> Class project
<input type="checkbox"/> Independent Study (490, 590, Honors project)	<input type="checkbox"/> Other. Please specify:		

## KEY PERSONNEL

List all members and relevant experience of the project personnel. This information is intended to inform the committee of the training and background related to the specific procedures that each person will perform on the project.

NAME & DEGREE(S)	SPECIFIC DUTIES ON PROJECT	TRAINING & EXPERIENCE RELATED TO PROCEDURES PERFORMED, DATE OF TRAINING
1. Abbie Heiberger, B.A	Graduate Student	ISU Human Subject Training, 08/16/2004
2. Ronald Werner-Wilson, PhD	Associate Professor	09/19/2000

Add New Row

## FUNDING INFORMATION

Internally funded, please provide account number: N/A
Externally funded, please provide funding source and account number: N/A
Funding is pending please provide OSPA Record ID on GoldSheet: N/A

Title on GoldSheet if Different Than Above: N/A
---

Other: e.g., funding will be applied for later. N/A
---

#### **SCIENTIFIC REVIEW**

Although the compliance committees are not intended to conduct peer review of research proposals, the federal regulations include language such as "consistent with sound research design," "rationale for involving animals or humans" and "scientifically valuable research," which requires that the committees consider in their review the general scientific relevance of a research study. Proposals that do not meet these basic tests are not justifiable and cannot be approved. If a compliance review committee(s) has concerns about the scientific merit of a project and the project was not competitively funded by peer review or was funded by corporate sponsors, the project may be referred to a scientific review committee. The scientific review committee will be ad hoc and will consist of your ISU peers and outside experts as needed. If this situation arises, the PI will be contacted and given the option of agreeing that a consultant may be contacted or withdrawing the proposal from consideration.

Yes  No Has or will this project receive peer review?

If the answer is "yes," please indicate who did or will conduct the review: N/A

If a review was conducted, please indicate the outcome of the review: N/A

#### **NOTE: RESPONSE CELLS WILL EXPAND AS YOU TYPE AND PROVIDE SUFFICIENT SPACE FOR YOUR RESPONSE.**

#### **COLLECTION OR RECEIPT OF SAMPLES**

Will you be: (Please check all that apply.)

Yes  No Receiving samples from outside of ISU? See examples below.  
 Yes  No Sending samples outside of ISU? See examples below.

Examples include: genetically modified organisms, body fluids, tissue samples, blood samples, pathogens.

If you will be receiving samples from or sending samples outside of ISU, please identify the name of the outside organization(s) and the identity of the samples you will be sending or receiving outside of ISU:

N/A
-----

Please note that some samples may require a USDA Animal Plant Health Inspection Service (APHIS) permit, a USPHS Centers for Disease Control and Prevention (CDC) Import Permit for Etiologic Agents, a Registration for Select Agents, High Consequence Livestock Pathogens and Toxins or Listed Plant Pathogens, or a Material Transfer Agreement (MTA) (<http://www.ehs.iastate.edu/bs/shipping.htm> ).

#### **SECTION II: APPLICATION FOR INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL**

Yes  No Does this project involve human research participants? If the answer "no" is checked, you will automatically move to a question regarding the involvement of radiation producing devices in your project.

#### **SECTION III: ENVIRONMENTAL HEALTH AND SAFETY INFORMATION (EH&S)**

Yes  No Does this project involve laboratory chemicals, human cell lines or tissue culture (primary OR immortalized), or human blood components, body fluid or tissues? If the answer is "no" is checked you

will automatically move to a question regarding the involvement of human research participants in your project.

#### ASSURANCE

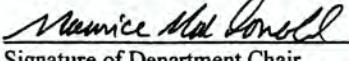
- I certify that the information provided in this application is complete and accurate and consistent with any proposal(s) submitted to external funding agencies.
- I agree to provide proper surveillance of this project to ensure that the rights and welfare of the human subject or welfare of animal subjects are protected. I will report any problems to the appropriate compliance review committee(s).
- I agree that I will not begin this project until receipt of official approval from all appropriate committee(s).
- I agree that modifications to the originally approved project will not take place without prior review and approval by the appropriate committee(s), and that all activities will be performed in accordance with all applicable federal, state, local and Iowa State University policies.

#### CONFLICT OF INTEREST

A conflict of interest can be defined as a set of conditions in which an investigator's or key personnel's judgment regarding a project (including human or animal subject welfare, integrity of the research) may be influenced by a secondary interest (e.g., the proposed project and/or a relationship with the sponsor). ISU's Conflict of Interest Policy requires that investigators and key personnel disclose any significant financial interests or relationships that may present an actual or potential conflict of interest. By signing this form below, you are certifying that all members of the research team, including yourself, have read and understand ISU's Conflict of Interest policy as addressed by the ISU Faculty Handbook (<http://www.provost.iastate.edu/faculty>) and have made all required disclosures.

- Yes  No Do you or any member of your research team have an actual or potential conflict of interest?  
 Yes  No If yes, have the appropriate disclosure form(s) been completed?
- 

#### SIGNATURES

	<u>12/7/05</u>
Signature of Principal Investigator	Date
	<u>12/7/05</u>
Signature of Department Chair	Date

**PLEASE NOTE:** Any changes to an approved protocol must be submitted to the appropriate committee(s) before the changes may be implemented.

Please proceed to SECTION II.

## SECTION II: IRB SECTION - STUDY SPECIFIC INFORMATION

### STUDY OBJECTIVES

Briefly explain in language understandable to a layperson the specific aim(s) of the study.

The relationship between the client and therapist (therapeutic alliance) has been shown to be predictive of the client's premature termination from therapy. A client's individual characteristics can influence his or her ability to form this therapeutic relationship. This research will explore the characteristics of the client that influence his or her likelihood to prematurely terminate from therapy.

### BENEFIT

Explain in language understandable to a layperson how the information gained in this study will benefit participants or the advancement of knowledge, and/or serve the good of society.

The results of this study have implications for training and therapeutic practices.

### PART A: PROJECT INVOLVEMENT

- 1)  Yes  No Is this project part of a Training, Center, Program Project Grant?  
Director Name: Overall IRB ID:
- 2)  Yes  No Is the purpose of this project to develop survey instruments?
- 3)  Yes  No Does this project involve an investigational new drug (IND)? Number:
- 4)  Yes  No Does this project involve an investigational device exemption (IDE)? Number:
- 5)  Yes  No Does this project involve existing data or records?
- 6)  Yes  No Does this project involve secondary analysis?
- 7)  Yes  No Does this project involve pathology or diagnostic specimens?
- 8)  Yes  No Does this project require approval from another institution? Please attach letters of approval.
- 9)  Yes  No Does this project involve DEXA/CT scans or X-rays?

### PART B: MEDICAL HEALTH INFORMATION OR RECORDS

- 1)  Yes  No Does your project require the use of a health care provider's records concerning past, present, or future physical, dental, or mental health information about a subject? The Health Insurance Portability and Accountability Act established the conditions under which protected health information may be used or disclosed for research purposes. If your project will involve the use of any past or present clinical information about someone, or if you will add clinical information to someone's treatment record (electronic or paper) during the study you must complete and submit the Application for Use of Protected Health Information.

### PART C: ANTICIPATED ENROLLMENT

**Estimated number of subjects contacted to reach required enrollment:** Unknown—this study will use secondary data.

<b>Number of subjects to be enrolled in the study</b>	Total: 200	Males: 100	Females: 100
---	------------	------------	--------------

Check if any enrolled subjects are:	Check below if this project involves either:
<input type="checkbox"/> Minors (Under 18) Age Range of Minors: <input type="checkbox"/> Pregnant Women/Fetuses <input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> Prisoners	<input checked="" type="checkbox"/> Adults, non-students <input type="checkbox"/> Minor ISU students <input checked="" type="checkbox"/> ISU students 18 and older <input type="checkbox"/> Other (explain)
<b>List estimated percent of the anticipated enrollment that will be minorities <i>if known</i>:</b>	
American Indian: 0	Alaskan Native: 0
Asian or Pacific Islander: 2.5%	Black or African American: 3%
Latino or Hispanic: 6%	

#### PART D: SUBJECT SELECTION

**Please use additional space as necessary to adequately answer each question.**

11. Explain the procedures for selecting subjects including any inclusion/exclusion criteria (*i.e., Where will the names come from? Will a sample be purchased, will ads, fliers, word of mouth, email list, etc. be used?*).

All individuals seeking individual or couples therapy from the Iowa State University Marriage and Family Therapy clinic, who are 18 years of age or older, and have signed a Research Release Form will be participants in this study. Any individuals who did not sign a Research Release Form will be excluded from this study.  
 Data will be examined from all qualifying participants (e.g. who are 18 years of age or older, have requested services from the Iowa State University Marriage and Family Therapy Clinic, and have signed a Research Release Form.)

12. Attach a copy of any recruitment telephone scripts or materials such as ad, fliers, e-mail messages, etc. Recruitment material must include a statement of the voluntary and confidential nature of the research. Do not include the amount of compensation, (e.g., compensation available).

**Note:** Please answer each question. If the question does not pertain to this study, please type not applicable (N/A).

#### PART E: RESEARCH PLAN

Include sufficient detail for IRB review of this project independent of the grant, protocol, or other documents.

13. Describe the flow of events used in this research protocol. Include information from the first contact with the volunteers to the end of the study. Use a diagram or flow chart if appropriate. Also, include a description of the study procedures or tasks that participants will be exposed to or asked to complete. This information is intended to inform the committee of the procedures used in the study and their potential risk. Please do not respond with "see attached" or "not applicable."

Prior to their initial session, clients at the Iowa State University Marriage and Family Therapy clinic complete consent forms (including a research release and Client's Rights & Agreement) and assessment materials. This data is then entered into clinic records. For this study, this data will be analyzed in order to determine the relationship between an individual's characteristics and his or her likelihood to prematurely terminate the therapy process.

14. For studies involving pathology/diagnostic specimens, indicate whether specimens will be collected prospectively and/or already exist "on the shelf" at the time of submission of this review form. If prospective, describe specimen procurement procedures; indicate whether any additional medical information about the subject is being gathered, and whether specimens are linked at any time by code number to the subject's identity. If this question is not applicable, please type N/A in the response cell.

N/A

15. For studies involving deception, please justify the deception and indicate the debriefing procedure, including the timing and information to be presented to subjects. If this question is not applicable, please type N/A in the response cell.

N/A

#### PART F: CONSENT PROCESS

16. Describe the consent process for participants who are age 18 and older. *If the consent process does not include documented consent, a waiver of documentation of consent must be requested.*

Clients requesting services at the Iowa State University Marriage and Family Therapy Clinic sign a Research Release Form prior to therapy, which acknowledges that the data they provide can be used for research.

17. If your study involves minors, please explain how parental consent will be obtained prior to enrollment of the minor(s).

Minor participants will not be included in this study.

18. Please explain how assent will be obtained from minors (younger than 18 years of age), prior to their enrollment. Also, please explain if the assent process will be documented (*e.g., a simplified version of the consent form, combined with the parental informed consent document*). According to the federal regulations assent "...means a child's affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent."

Minor participants will not be included in this study.

#### PART G: DATA ANALYSIS

19. Describe how the data will be analyzed (*e.g. statistical methodology, statistical evaluation, statistical measures used to evaluate results*)

Discriminate Analysis techniques will be used in order to investigate the relationship between an individual's personality traits and the occurrence of premature termination from therapy. Personality traits and relationship satisfaction will be examined using the Brief Symptom Inventory (BSI), the Internal Control Index (ICI), the Satisfaction with Life Scale (SWLS), the Rosenberg Self-Esteem Scale (RSE), and the Dyadic Adjustment Scale (DAS). Clients complete each of these measures before the first therapy session.

20. If applicable, please indicate the anticipated date that identifiers will be removed from completed survey instruments and/or audio or visual tapes will be erased:

All identifiers were previously eliminated from the secondary data that will be examined for this study.

#### PART H: BENEFITS

21. Describe the benefit to the volunteer from participating in this study, *if any*, and the benefit to society that will be gained from the study. Please note that monetary compensation is not considered a benefit.

The benefit of this study will be to future clients as therapists gain a better understanding of client

characteristics that influence premature termination from therapy. There is no direct benefit to the participant.

#### PART I: RISKS

The concept of risk goes beyond physical risk and includes risks to subjects' dignity and self-respect as well as psychological, emotional, legal, social or financial risk.

22.  Yes  No Is the *probability* of the harm or discomfort anticipated in the proposed research greater than that encountered ordinarily in daily life or during the performance of routine physical or psychological examinations or tests?
23.  Yes  No Is the *magnitude* of the harm or discomfort greater than that encountered ordinarily in daily life, or during the performance of routine physical or psychological examinations or tests?
24. Describe any risks or discomforts to the subjects and how they will be minimized and precautions taken. Do *not* respond with N/A. If you believe that there will not be risk or discomfort to subjects you must explain why.

There will be no risk or discomfort to participants. Previously collected data will be utilized for this study.

25. If this study involves vulnerable populations, including minors, pregnant women, prisoners, educationally or economically disadvantaged, what additional protections will be provided to minimize risks?

N/A

#### PART J: COMPENSATION

26.  Yes  No Will subjects receive compensation for their participation? If yes, please explain.

Do not make the payment an inducement, only a compensation for expenses and inconvenience. If a person is to receive money or another token of appreciation for their participation, explain when it will be given and any conditions of full or partial payment. (E.g., volunteers will receive \$5.00 for each of the five visits in the study or a total of \$25.00 if he/she completes the study. If a participant withdraws from participation, they will receive \$5.00 for each of the visits completed.) It is considered undue influence to make completion of the study the basis for compensation.

#### PART K: CONFIDENTIALITY

27. Describe below the methods that will be used to ensure the confidentiality of data obtained. For example,, who has access to the data, where the data will be stored, security measures for web-based surveys and computer storage, how long data (specimens) will be retained, etc.)

A confidentiality statement is signed at beginning of the therapeutic relationship and prior to services being rendered. Data collected is stored in a locked office in a locked filing cabinet and is accessible only to those who work at the Iowa State University Marriage and Family Therapy Clinic.

#### PART L: REGISTRY PROJECTS

To be considered a registry: (1) the individuals must have a common condition or demonstrate common responses to questions; (2) the individuals in the registry might be contacted in the future; and (3) the names/data of the individuals in the registry might be used by investigators other than the one maintaining the registry.

Yes  No Does this project establish a registry?

If "yes," please provide the registry name below.

N/A

#### Checklist for Attachments

The following are attached (please check ones that are applicable):

- A copy of the informed consent document OR  Letter of introduction to subjects containing the elements of consent
- A copy of the assent form if minors will be enrolled
- Letter of approval from cooperating organizations or institutions allowing you to conduct research at their facility
- Data-gathering instruments (including surveys)
- Recruitment fliers, phone scripts, or any other documents or materials the subjects will see

Two sets of materials should be submitted for each project – the original signed copy of the application form and one copy and two sets of accompanying materials. **Federal regulations require that one copy of the grant application or proposal be submitted for comparison with the application for approval.**

#### FOR IRB USE ONLY:

Initial action by the Institutional Review Board (IRB):

- Project approved. Date: 05-574 12/22/05
- Pending further review. Date: \_\_\_\_\_
- Project not approved. Date: \_\_\_\_\_

Follow-up action by the IRB:

Dianne Andrus  
IRB Approval Signature

12/22/05  
Date

#### SECTION III: ENVIRONMENTAL HEALTH AND SAFETY INFORMATION

- Yes  No Does this project involve human cell or tissue cultures (primary OR immortalized), or human blood components, body fluids or tissues? If the answer is "no", please proceed to SECTION III: APPLICATION FOR IRB APPROVAL. If the answer is "yes," please proceed to Part A: Human Cell Lines.

#### PART A: HUMAN CELL LINES

- Yes  No Does this project involve human cell or tissue cultures (primary OR immortalized cell lines/strains) that have been documented to be free of bloodborne pathogens? If the answer is "yes," please attach copies of the documentation. If the answer is "no," please answer question 1 below.

- 1) Please list the specific cell lines/strains to be used, their source and description of use.

CELL LINE	SOURCE	DESCRIPTION OF USE
N/A		

Add New Row

- 2) Please refer to the ISU "Bloodborne Pathogens Manual," which contains the requirements of the OSHA Bloodborne Pathogens Standard. Please list the specific precautions to be followed for this project below (e.g., retractable needles used for blood draws):

N/A

Anyone working with human cell lines/strains that have not been documented to be free of bloodborne pathogens is required to have Bloodborne Pathogen Training annually. Current Bloodborne Pathogen Training dates must be listed in Section I for all Key Personnel. Please contact Environmental Health and Safety (294-5359) if you need to sign up for training and/or to get a copy of the Bloodborne Pathogens Manual (<http://www.ehs.iastate.edu/bs/bbp.htm> ).

#### PART B: HUMAN BLOOD COMPONENTS, BODY FLUIDS OR TISSUES

- Yes  No Does this project involve human blood components, body fluids or tissues? If "yes", please answer all of the questions in the "Human Blood Components, Body Fluids or Tissues" section.

- 1) Please list the specific human substances used, their source, amount and description of use.

SUBSTANCE	SOURCE	AMOUNT	DESCRIPTION OF USE
E.g., Blood	Normal healthy volunteers	2 ml	Approximate quantity, assays to be done.
N/A			

Add New Row

- 2) Please refer to the ISU "Bloodborne Pathogens Manual," which contains the requirements of the OSHA Bloodborne Pathogens Standard. Specific sections to be followed for this project are:

N/A

Anyone working with human blood components, body fluids or tissues is required to have Bloodborne Pathogen Training annually. Current Bloodborne Pathogen Training dates must be listed in Section I for all Key Personnel. Please contact Environmental Health and Safety (294-5359) if you need to sign up for training and/or to get a copy of the Bloodborne Pathogens Manual (<http://www.ehs.iastate.edu/bs/bbp.htm> ).

---

Signature of Biological Safety Officer

---

Date

### Acknowledgements

I would like to thank my major professor, Dr. Ronald Werner-Wilson for his continuing guidance and support throughout the thesis writing process and my career as a graduate student. I would also like to express gratitude for my committee members, Dr. Megan Murphy and Dr. Meifen Wei, for their contributions have made this paper complete. Finally, I would like to thank my fellow Marriage and Family Therapy students, who have become my best friends and support system throughout the past two years.