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**Exploration of the utility of the decision-process model of
consumer behavior in the understanding of the decision to
purchase outpatient mental health services**

Johnson, Edna Beeman, D.S.W.

City University of New York, 1990

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A

**Exploration of the Utility of the
Decision-Process Model of Consumer
Behavior in the Understanding of the
Decision to Purchase Out-Patient
Mental Health Services**

by

Edna Beeman Johnson

**A dissertation submitted to the Graduate Faculty
in Social Welfare in partial fulfillment of the
requirements for the degree of Doctor of Social
Welfare, The City University of New York**

1990

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This manuscript has been read and accepted for the Graduate Faculty in Social Work in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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Abstract

EXPLORATION OF THE UTILITY OF THE DECISION- PROCESS MODEL OF CONSUMER BEHAVIOR IN THE UNDERSTANDING OF THE DECISION TO PURCHASE OUT- PATIENT MENTAL HEALTH SERVICES

by

Edna Beeman Johnson

Adviser: Professor Irwin Epstein

Changes in client attitudes and societal needs, increasing public and private competition, diminishing financial resources, and the increasing policy-making role of the insurance industry, have resulted in the need to better understand how people enter into, and use, the mental health care system. This study was undertaken to determine whether consumer behavior theory is useful in understanding the decision process people use when deciding how to cope with their emotional problems. The Decision Process Model developed by Engel, Blackwell, and Miniard was used, to see if it has utility in understanding the decision process involved in deciding whether to purchase out-patient mental health services. Sampling was done from the callers to the Intake Department of a suburban psychiatric hospital who requested information regarding out-patient treatment. Eighty subjects completed a questionnaire based on the Decision Process Model. An extensive review of the literature on "dropouts" revealed that previous studies of people using mental health services have primarily

focused on the contact with a mental health agency as an act, rather than as a process.

The findings of the study indicate that the Decision Process Model is useful in understanding the process involved in deciding whether to contact, and use, outpatient mental health services. The study suggests that the concept of "dropout" is a misnomer, in that people may have left a particular agency, but have not concluded a process. Understanding this process has implications for the content of the initial contact with an outpatient mental health clinic, the structure of the screening interview, and the development of marketing strategies to attract new service users.

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Therapist: "So, what brings you here?"

Patient: "The B27 bus."

Introduction

The utilization of mental health and social work services has long been of interest to social science researchers. Numerous studies have been done of the social class, education level, age, sex, and race of service users, and the types and levels of social stressors motivating a request for service. Social networks, personality types, reference groups, and definitions of mental health and mental illness have all been areas of focus. Questions have been posed as to what treatment modality is best for whom and for what problem; how the sex of the client and/or the therapist affects the process and/or the outcome; who drops out, when and why, etc. What is missing is a sense of process, how these factors interact, influence one another, and play a dynamic role in the potential client/consumer's decision to purchase mental health services.

It is generally accepted that most people seek help when they feel themselves to be in crisis. How do they decide what form of help to pursue? How do they set priorities in terms of the value assigned to their existing resources and needs? What are the inputs to the final decision?

The recent interest in marketing theory, brought about by the changing economic and political climate in the health care field, and by the change in the perception of health care to that of a business, has brought with it a new way of viewing the human service user. For-profit hospital chains have emerged nationwide, while non-profit health care administrators increasingly focus on cost-benefit ratios, hiring experts from the business community rather than the human service field, to run various departments

("Hospitals tap," 1986; "Rasmussen brings," 1986). The client/patient has now become a consumer, one who purchases a service in the increasingly competitive health care marketplace. Seeing the patient as a consumer adds the concept of "exchange", moving the patient from a passive user of available services, to someone who influences the types of services that will be offered, someone who can make informed decisions, and someone who perceives options. Perceived wants and needs become increasingly significant in the delivery of goods and services. And like any other consumer, this one must be understood so that s/he can be courted via targeted advertising, public relations, and service development. To do this, the complementary fields of consumer behavior and consumer research have evolved out of marketing, focused on a dynamic understanding of the consumer and his/her decision process.

Ironically, many of the tools used in consumer behavior research had their origins in the social sciences, but were used for different purposes. The search for knowledge about client populations and needs was often primarily experimental and only secondarily applied toward improved services and increased utilization. Needs assessment requirements for publicly funded programs seldom found their way into program implementation (Kimmel, 1977). This was due, in part, to the fact that a seller's market was operating in health and mental health care. Changes in client attitudes and societal needs, increasing public and private competition, diminishing financial resources (Kotler, 1982), and the increasing policy making role of the insurance industry in health care, have changed the balance of power, forcing nonprofit organizations to become

less complacent and less confident of their share of the marketplace. The recent change to a buyer's market brings new meaning to knowledge about clients and new approaches and goals in information utilization, as health care facilities must now work to attract the clients they formerly took for granted.

Mental health has lagged behind in the application of techniques and strategies developed in the fields of marketing and consumer behavior. This has been due to the reluctance to openly acknowledge the business component of mental health service provision, as well as to the unique problems inherent in the problem itself, mental illness.

The following project was undertaken in an attempt to adjust to the realities of today's competitive marketplace, and in so doing to be responsive to client needs. It is an attempt to explore the decision process in the use of out-patient mental health services, using the decision-process model initially developed by Engel, Kollat, and Blackwell (1973), and later refined by Engel, Blackwell, and Miniard (1986), in the field of consumer behavior. The purpose of the project is to see if a consumer behavior approach adds to our understanding of the decision to use mental health services. The goal is to develop a knowledge base which will enhance the exchange process between an outpatient mental health clinic and potential consumers in need of mental health services.

It is proposed that an understanding of the way in which people decide to engage, or not engage, in treatment can be of help in designing strategies to increase the possibility of consumers in need finding their way to appropriate services. It is also proposed that this understanding

may also have implications for the way in which services are delivered, and for the development of the services themselves. In essence, understanding the consumer has direct relevance to the marketing mix of price, product, distribution, and promotion.

The current, highly competitive, buyer's market in health and mental health care has created a need to better understand the consumer population 1) that uses one's services, and/or 2) that it would be desirable to have use one's services. It is no longer sufficient to just "raise the flag and see who salutes". It is now necessary to know why they salute, how they salute, when they salute, and whether a different flag, in a different place, at a different time, or on a different pole would produce more salutes.

An exploration of the decision process in the mental health context may provide a variety of information relevant to the proposed goals. In general, it may provide a dynamic understanding of the interaction and salience of the numerous variables that are already known to influence the use of mental health services. For example, rather than having an "informal consensus" on who refers patients to the Hauberk Adult Outpatient Department (AOPD), the setting for this project, it may be possible to identify the significant initiators of service. What factors enhance an exchange relationship and what factors detract from it may also be identified, affording the AOPD in particular the opportunity to maximize their market position accordingly.

An understanding of what consumers are looking for when they come for help might also influence the way in which services are presented,

modify staff expectations in some situations, and influence the perception of the treatment process. As an example: In the AOPD, the moment the potential client/consumer comes for a screening, s/he is registered as a patient; if s/he decides not to follow through on treatment, or starts and drops out after a few sessions, s/he is considered to be unmotivated, not a good treatment candidate, or resistant. From a consumer behavior perspective, this potential client/consumer may only be in the search or alternative evaluation stage, and may not yet have made a purchase (the payment of money notwithstanding). A better understanding of the dynamics involved might improve the prospects of patient development.

This report is divided into six chapters:

Chapter I will discuss the nature of the problem to be explored, the political climate in which it exists, the impact of census fluctuations on the project setting, and the efforts that have been expended to date to deal with this problem.

Chapter II will look at the history of the development of consumer behavior theory, and the field of consumer behavior, within a marketing context. It will briefly examine some of the numerous models of consumer behavior, and will then focus on a detailed description of the Engel-Kollat-Blackwell, now the Engel-Blackwell-Miniard (EBM) Decision Process Model of Consumer Behavior. This is the model which will provide the framework for this project's exploration of the decision to purchase outpatient mental health services.

Chapter III looks at the literature on the utilization of mental health services, illustrating the past approaches used to understand the

utilization process. It covers how mental illness is defined, what kind of help people look for, who comes for help, and whether they remain or terminate, when and why. Attention is also paid to the "consumer approach" to service provision. This literature is placed within the context of the Decision Process component of the EBM model.

Chapter IV describes the project, the setting in which it was conducted, the process of its implementation, and the method of analysis.

Chapter V reports the results of the project.

Chapter VI discusses the significance of the findings and their implications for future service development and marketing strategies.

Given the related assumptions that people need out-patient mental health services and that out-patient mental health clinics need clients, the following project is designed to better understand how the needs of both may be mutually met.

I. DEFINING THE PROBLEM

Overview

The introduction of marketing concepts into the field of mental health has been an evolutionary process, spurred on by numerous changes in the context within which services are now delivered. Changes in Federal legislation and insurance company regulations have influenced service development, reimbursement rates, and acceptable lengths of stay for mental hospital patients. Disillusionment with the promises of psychiatry has led to decreased client/consumer demand, coupled with an increase in "do-it-yourself" books, seminars, and educational courses focused on self-help and preventive behavior. An increasingly educated consumer population is also beginning to challenge the provider-oriented and organization-oriented institutions (Donabedian, 1973), demanding a change in priorities, and taking advantage of the increasingly competitive situation by "shopping" for mental health services.

The Patient's Bill of Rights is but one example of how the consumer has had influence on how treatment will be provided, and on what terms. Hospitals reports that "consumers are more opinionated about where to get the *best* hospital care these days" ("Consumers more opinionated," 1986, p. 112). And the fact that consumers are up for grabs in their quest for health care is reflected in the fact that hospital marketing budgets were up 23%, and advertising budgets were up 46% in 1986, from their 1985 levels ("Marketing budgets," 1986).

Within this context, many non-profit organizations have been slowly forced to react to the change from a seller's to a buyer's market. Isolated attempts at needs assessments, service development, and public relations have met with mixed results, often lacking a unifying framework or theory. As a result, mental health agencies are now faced with the need to reach out to a service population whose identity, needs, and service usage patterns often have not been previously identified, in an attempt to successfully compete for potential clients/consumers. What has followed is a turn to the field of marketing to provide the tools and framework needed to survive in the business of mental health service delivery today. Within this field, the study of consumer behavior plays an indispensable role.

This Chapter will look at some of the changes that have taken place politically and ideologically in the field of mental health. It will then relate them to the setting in which this project was implemented, Hauberk Hospital. Efforts at dealing with fluctuations in census will be examined within the context of marketing theory.

Background

Political Climate

Mental health service provision has been greatly affected by numerous legislative decisions in the past 20 years, which reflect both an awareness of mental health problems in the community and the need for a planful approach to service provision, with accountability. Public Law 89-749, the Comprehensive Health Planning and Public Services Amendment of

1966, mandated local human service agencies to plan programs to meet the needs of those living in their communities. The 92nd Congress amended the Social Security Act to create Professional Standard Review Organizations (PL 92-603), which were to assess the necessity of services rendered by physicians to patients, the appropriateness of the facility within which the patient is treated, and the quality of care provided to the patient. What emerged in mental health were criteria defining ever-decreasing acceptable lengths of stay for in-patients, with guidelines by which agencies could be compared vis à vis quality and quantity of service, but with little focus on outcome. The emphasis on accountability has resulted in hospitals being held accountable to all their funding sources, as well as to the Joint Committee on Hospital Accreditation. In addition, the funders, including Federal and State governments and insurance companies, have become the makers of health care policy by virtue of their power of the purse.

In 1974, the National Health Planning and Resource Development Act (PL 93-641) created a planning process whereby state and local Health Systems Agencies evaluate an area's health care services, manpower, and facilities, developing a plan to meet identified needs and reducing documented inefficiencies. The power to approve Certificate of Need (CON) applications for new services potentially served to prevent duplication of services through the denial of funding. As a result of the recent changes in the political climate, including the reaffirmation of laissez-faire capitalism, CON legislation was lifted. The outcome has been a proliferation of competing institutions.

PL 94-63, the Community Mental Health Center Amendments of 1975 required centers to evaluate their programs to see if they were meeting the needs of those in their catchment areas. The community mental health movement reflected an awareness of the inequities in mental health service provision, which frequently discriminated in favor of verbal, middle class clients. Ongoing responsiveness to the community was stressed, but criteria for evaluation were not spelled out, nor were the mechanisms by which the evaluation should be conducted. Programs therefore remained vulnerable to legislative whims.

Reaganomics contributed to the containment and control orientation toward both health and mental health care. While not totally unwarranted, it was prompted by mixed motives, some of which may pose serious risks for today's health care consumers. The current by-product of this process has been the development of Diagnostic Related Groups (DRGs), a system by which a flat payment is made for each listed illness, based on a prescribed length of stay. Discharging a patient under the predetermined time limit makes money for the hospital: keep a patient longer and services may not be reimbursed. Following closely on the heels of the DRGs is the Prospective Payment Plan, whereby institutions will be given a flat amount of money to treat "X" number of patients (capitation), regardless of the actual cost to the institution. While such systems do not apply to mental health services yet, such a system is being studied. And for those psychiatric facilities that are connected to medical facilities, the impact in one area will ultimately be felt in the other.

Such developments have forced health and mental health facilities to give more thought to service provision in order to make it more cost-effective. They have also resulted in the need to serve more patients, each of whom will be treated for a shorter period of time, in order to sustain current levels of organizational operation. Whose needs are being met becomes a more pressing question, highlighting the frequent discrepancy between professional, organizational, and community goals.

Project Setting

Hauberk Hospital, the psychiatric division of a large, suburban Medical Center, shares many of the problems faced by other mental health facilities today. Merged with the Medical Center since 1972, it is part of a teaching medical center which is composed of the medical hospital, a specialty hospital, numerous community-based, primarily grant-funded clinics, the psychiatric hospital, and several affiliations. Struggling to cope with the problems unique to a psychiatric facility, it is further impinged upon by the financial problems and administrative bias of the Medical Center, to which it is ultimately responsible. Deficits become a shared burden, regardless of where they initiated, and without regard to the impact they may have upon the programs suddenly held accountable for them. Within this context, Hauberk nonetheless strives to provide viable, appropriate, and cost-effective psychiatric services.

The Adult Out-Patient Department (AOPD), the primary focus of this project, operates on a sliding-fee scale, with fees ranging from \$15-75 for individual treatment, \$10.50-52.50 for group therapy, with the maximum fee being paid on a gross income of \$37,000 for a single person.

Insurance coverage for all but maximum fees is assigned to the clinic. To stay current, patient fees are re-evaluated annually on the patient's anniversary date. People who pay these fees come to a facility in which little attention is paid to the physical plant, where individual office floors are seldom waxed, and where chairs are old, mismatched, and uncomfortable. The staff, on the other hand, is very experienced and extremely competent. Treatment in the AOPD is done by social workers and trainees (Third and Fourth-year Residents, Social Work and Psychology interns, etc.). Psychiatrists see patients for medication and are available for teaching and consultation.

At Hauberk, the In-Patient services are the major income producers, supplementing the ambulatory services, which routinely operate at a deficit. Decreased lengths of stay on the In-patient units, required by the state, had been further encouraged by the need to make all beds Blue Cross eligible. The resulting increase in the turnover rate has led to the consequent need for an increase in the total number of patients. Success or failure in attracting more In-Patients rebounds to the other services provided at Hauberk.

The fluctuations that have taken place in the Medical Center in the past few years reflect its vulnerability to market variations and suggest the need for a long range approach to census maintenance. Depending upon where one is in the fluctuation cycle, however, influences the felt need to engage in organized marketing. In 1986, the arrival of DRGs merely added another potential problem to an already beleaguered Medical Center. Its medical facilities were operating way below desired capacity, including

the much touted specialty hospital. Hauberk was maintaining the desired census on its In-Patient units, but its Day Hospital and Adult Out-Patient Department were below census. The AOPD had 1000 fewer visits in 1985 than in 1983. (1984 visits were skewed by a 47 day strike which closed the clinic for that period.) Over a 5 year period, the AOPD registered a 30% decline in patient visits. Admissions were down by almost 500 people from the 1980 rate. While there had also been a cut in staff, implemented during a low census period, there was no subsequent increase in the waiting list for treatment.

By mid-1988, the medical hospital had an occupancy rate of 105%, and the specialty hospital was at full capacity. The Hauberk In-Patient units were at 98.9% capacity, and the AOPD had a modest waiting list. These figures illustrate the potential for fluctuation in service utilization.

Marketing Overview

Kotler (1982), the most prominent translator of marketing theory to the non-profit sector, defines marketing as "the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives" (p. 6). Using this definition, classical marketing, which is one function of management, is not currently practiced at the Medical Center, as the examples to follow will illustrate. The current healthy state of the Medical Center could raise question as to the need for it anyway. Nonetheless, past history has shown that being a "reactive" institution, particularly at Hauberk, contains

the potential for repeated census crises, with no clearly defined or consistent plan for their potential prevention.

Marketing includes research, planning, strategy development, public relations, fund development, community relations, patient liaison, recruitment, internal marketing, and contracting (Winston, 1986). Some of the key words to keep in focus when evaluating an organization's efforts at service provision, program development, and census maintenance are "integration" (Cooper, 1979), "coordination" (Hardy, 1986), "planning" (Kotler, 1972), and "objectives" (MacStravic, 1977). The activities of the Medical Center, where some functions are centralized, and at Hauberk, can be viewed within this context.

Analysis

Cooper (1979) defines crises as both a danger and an opportunity. The change from a seller's to a buyer's market had, in addition to the funding changes noted above, precipitated numerous changes in the former complacency of the Medical Center, and at Hauberk in particular. In 1985, the Medical Center hired a nationally known marketing firm to study its situation and to develop a marketing strategy for improving its market position. Its initial focus was on identifying the Medical Center's current image in the community, with particular focus on the then new specialty hospital. The Medical Center ultimately decided that allocating funds for formalized marketing was not a priority, and terminated the process.

At Hauberk, one of its members was asked by the CEO to develop a questionnaire to send out to doctors and other community professionals, advising them of the re-organized In-Patient services and asking which

services they might find useful. An independent firm handled the mailing. The responses to the questionnaires were never evaluated, to determine what mental health services community professionals were interested in. Respondents who requested more information were contacted. While this mailing undoubtedly served to publicize Hauberk's reorganized in-patient service, it also illustrates the hospital's ambivalence about developing a true exchange relationship with the community.

The AOPD is in a position to assess its current market situation, but has done little with available statistics regarding the people it serves, in spite of a fairly comprehensive MIS system. Reports generated on needs, usage patterns, outcomes, or demographics (to list a few of the potential data profiles available), when requested, have not been used for program expansion or development. The approaches being followed recently (e.g. the professional survey) reflect a bias against community input via either primary or secondary data, in that no organized attempts have been made to reach lay people in the community. This is particularly significant in view of the fact that the informal consensus is that between 70-75% of the people who come to the AOPD come by word of mouth.

With the proliferation of computers at Hauberk, there has been a renewed interest in collecting information which may help to stabilize patient flow. Central Intake now tracks the kinds of services being requested, referral sources, reasons for callers finding Hauberk inappropriate to their needs (e.g. fees too high, no evening hours, problems with dual diagnosis), and to where callers are referred out. Again, most of this information is being collected in relation to the In-Patient services,

although the AOPD is now beginning to receive some attention. The Director of Central Intake sees to it that every referring person to In-Patient receives a letter thanking them for their referral and advising them of the disposition. He has taken this action on his own initiative.

Planning

Programmatic change in the AOPD has frequently been initiated as a result of staff developing an interest in a particular, popular area of specialization, rather than as the result of some formal market analysis. As a result, the AOPD has a Phobia Clinic, a Human Sexuality Clinic, a PMS Clinic, and a Walk-In Clinic for immediate triage. With the increased focus on attracting new patients, the tracking of calls to the Central Intake unit gave rise to questions of expanding evening hours, and the development of an Eating Disorders Clinic, a Bereavement Clinic, and a Stress Clinic. While some of these programs were initiated, no organized effort was made to sustain them, and they eventually petered out. For the most part, the emphasis has been on program maintenance and the provision of quality service in the treatment of depression, anxiety, marital and family problems, etc.

At Hauberk, several attempts had been made to begin to address the census needs of the hospital. In late 1985, an ad hoc marketing committee, initiated by the Social Work Department and including several program administrators, was set up to discuss the need to "market" the In-Patient services to the community. This committee was expanded and was eventually chaired by the hospital's representative to the Medical Center's marketing committee. The committee was hampered in identifying a focus

for themselves by the absence of a clear mandate and conflicting goals. The committee also reflected the fact that ultimate decision-making authority rested elsewhere, with the President of the Medical Center. Nonetheless, the mere existence of the committee reflected the fact that Hauberk recognized the need to reach out to the community and had mobilized itself in that direction. A short time later, the committee disbanded, possibly as the result of a lessening of the pressure to raise the census, and because of conflicting agendas between Hauberk and the Medical Center regarding growth priorities.

Implementation

The Medical Center has always had a Community Relations Department, which has been responsible for making its services visible to the community. It has followed a fairly traditional and common approach to public relations, taking advantage of the free publicity offered via public service announcements on the radio, providing experts on talk shows, and writing press releases for new or "gimmicky" services.

Mental health has not been given much priority by the Department, nor is it viewed as exciting by the media, unless the focus is on some new area of mass interest or has a new twist. For the AOPD, the most long-term impact has resulted from coverage of some live event, such as the opening of the Walk-In Clinic, which was attended by prominent local politicians and received live press coverage. The impact from this type of exposure was felt for several months. Coverage would be instantly available if reporters were allowed to interview patients or sit in on

actual group sessions, neither of which has been allowed, because of the need for patient confidentiality.

Hauberk had developed glossy brochures to be sent to professionals in the community, and to be used during outreach with various agencies and organizations. There are general information brochures for the hospital as a whole, and for each of the individual departments. Professionals have been targeted for most of this information because they make most of the referrals to the In-Patient units. Factual and descriptive in content, they do not emphasize what may be one of the most unique aspects of Hauberk's programs, continuity of care.

Hauberk also has a community outreach person, whose job it is to market the hospital's services to the community, as well as to give feedback to the hospital regarding community needs. She promotes the continuity of care offered by Hauberk, and monitors the hospital's image in the community.

None of these efforts have been consistent, continuous, nor have they had a unifying focus or theme. Lack of coordination was illustrated when a worker read an ad in a local Pennysaver inviting people to join a group at Hauberk which had been discontinued almost a year before.

As can be seen from the above examples, there appears to have been little analysis, planning, or integration with regard to the marketing of Hauberk. This has undoubtedly stemmed from the Medical Center's ambivalence about its psychiatric component, and the consequent lack of a clear sense of direction regarding the future of Hauberk, and the role it should play within the Medical Center itself.

The most significant change that has taken place at Hauberk within the past few years has been the resignation of the Chairman of the Department of Psychiatry, and the appointment of a successor who has nationally respected expertise in research. At a presentation to the Social Work Department in 1989, he noted the absence of a clear identity for the hospital, both in the community and in the Medical Center itself. He stated that the Medical Center would not be doing any marketing in the near future, and that the priority at Hauberk was to identify our areas of expertise, to increase the comprehensiveness of our services, and to further the integration of medicine and psychiatry in an environment in which psychiatry is seen as a soft science. He seemed to be reflecting the status of hospital marketing noted in Hospitals ("Hospitals Call", 1986), wherein it was reported that health care was calling a "time out", moving back from the rush to the promotional aspect of marketing, to focus on what it is that it should be marketing.

Implications for the Hauberk AOPD

The AOPD operates in a hostile Medical Center environment because of its money-losing status. Originally conceived of as an In-Patient referral source, it has consistently "failed" in its mission by successfully treating most patients on an out-patient basis. Its current existence is ultimately dependent upon the fact that it is the primary site for resident psychiatric training, a valued program in the Medical Center.

The primary focus of the AOPD has been organizational survival. Now being merged with the Aftercare Department into one Ambulatory Care Center (ACC), its structure and focus may change. The renewed emphasis

on research at Hauberk, with its focus on structuring programs around diagnostically related groupings, has implications for the kinds of services that will be offered at Hauberk, and by the ACC in particular. It is at such a time of transition, taking place within the context of major funding changes, that the exchange relationship between the hospital and the community takes on increasing importance.

While Hauberk may again be developing an image for itself, it is important to step back and analyze how people have come into contact with the hospital in the past, and with the AOPD in particular. Understanding this process, and the way people make decisions about using this or any other mental health service, has implications for the development of a marketing strategy which is responsive to both the needs of the institution and the needs of potential consumer/patients in the community.

The purpose of this project is to explore the decision process as it relates to the decision to purchase mental health services, using the Hauberk AOPD applicants as a sample population. The question is whether the same decision process model used to study and understand consumer behavior in the traditional goods and services marketplace has relevance in the mental health sector. The purpose is to begin to identify the variables that influence the decision to purchase mental health services, and the process by which that decision is made, so that future marketing attempts are planful and informed, and potential clients increasingly perceive the relevance of mental health services to their needs.

From a theoretical perspective, it is proposed that the traditional approaches used by social workers and other service professionals to attract clients are only partially useful. Needs assessments, standard tools in the field, may provide valuable information when properly constructed, implemented and evaluated, but they reveal only part of the picture. Often they are used to substantiate a need which is already known to exist, to justify initial or continued funding. What they do not determine is how a perceived need goes from being passive to active, how a problem goes from recognition to resolution, and the variables that influence the outcome. This is where marketing theory, with its emphasis on consumer behavior and the decision process, has particular value, as health organizations in general, and the Hauberk AOPD in particular, strive for organizational survival via maximization of service utilization.

II. CONSUMER BEHAVIOR: THEORY AND APPLICATION

Overview

Consumer research has focused extensively on purchases made in the "for-profit" marketplace, ranging from toothpaste to automobiles. With the extension of marketing theory to the non-profit sector (Kotler and Levy, 1969; Kotler, 1972), attention has turned to the use of service institutions as areas where a marketing perspective also has relevance. Colleges, zoos, museums, public transportation, and now hospitals are but a few of the non-profit organizations looking to marketing theory for helpful tools in an era in which government money is tight and the competition is fierce for private funds. While marketing theory is becoming increasingly popular in the non-profit sector in general, its use in the health and mental health fields has been slower to develop. This is due, in part, to the reluctance to apply selling and advertising approaches to such sensitive and "non-business" organizations, and because of the stigma attached to overt competition for patients. Consumer research consequently has not previously given this field the attention that it is now beginning to command.

What follows is a brief historical overview of the field of consumer behavior, followed by a description of the significant models developed to structure and systematize thinking in this area. It should be noted that, unless otherwise specified, the description of consumer behavior is

generic to most books with that title. Information included below was culled primarily from Block and Roering (1979); Loudon and Della Bitta, (1979); Engel et al, (1973 and 1986); and Wentz and Eyrich, (1970). The Engel-Kollat-Blackwell model, now referred to as the Engel-Blackwell-Miniard model (EBM), of the consumer decision process is the one which will be used as a guide in this study, to explore the decision process in the use of mental health services. It will be described, and its components will be defined and explicated.

Background of the Development of Consumer Behavior Theory

Marketing Context

As cited before, Kotler (1982) defines marketing as "the analysis, planning, implementation, and control of carefully formulated programs designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives" (p.6). He, and others, distinguish between a marketing orientation and a sales orientation. A sales orientation holds that the main task of the organization is to stimulate the interest of potential consumers in the organization's existing products and services. A marketing orientation holds that the main task is to determine the needs and wants of target markets and to satisfy them through the design, communication, pricing and delivery of appropriate and competitively viable products and services. At present, Hauberk is a rough combination of both approaches, with sales predominating, as it begins to consider marketing concepts.

A sales orientation has been commonly used by most hospitals to date, and is the traditional basis for most public relations departments.

The change to a marketing orientation has resulted in an increased interest in those theories and "scientific" procedures which focus on consumer behavior and need identification or assessment. Needs assessments, which have long been valuable tools in the social sciences, are a significant component of the marketing process. Marketing does not stop there, however. It attempts to develop a dynamic understanding of the target population, which includes an analysis of the process whereby a potential consumer becomes an actual consumer, and of the reasons for the direction the consumption takes. The assumption is that the knowledge of the "why" of consumer behavior then offers an opportunity to influence that behavior (Wentz and Eyrich, 1970). Out of this has come a separate field of study, that of consumer behavior.

Development of Field of Consumer Behavior

The study of consumer behavior came into focus after World War II, although theories of sociology and psychology had been used to understand the consumer before then. Prior to that time production and consumption were fairly evenly matched, and consistent with the amount of money available to consumers. Production potential was greatly increased during the war, while consumers saved money that could not otherwise be spent on sparse non-combat goods. With the end of the war, industry was ready to produce and consumers were ready to spend. It then became important to know what consumers would buy, and how to help them want to buy it.

Marketing practitioners and social scientists both began to study the dynamics of consumer behavior, each using different means of study and having different orientations. Marketing practitioners were pragmatic,

focusing on attitudes and demographics, looking for information to facilitate the prediction of behavior and to aid in strategy development. The social scientists were more scientifically oriented, looking to further the level of knowledge about this special case of human behavior, and were interested in theory validation. The theories which have gradually evolved, borrowing from the behavioral scientists, are part of the unending quest for answers to the "whys" of human behavior.

Loudon and Della Bitta (1984) note that the study of human behavior draws from several disciplines. General psychology provides concepts for analyzing individual behavior. Social psychology adds an interpersonal behavioral perspective. As consumer behavior is influenced by group and human interaction, sociology, cultural and social anthropology provide valuable frameworks. Philosophy helps in the analysis of why people behave as they do, and economics addresses the choices made in the allocation of scarce resources.

Theories about consumer behavior have been influenced by such concepts as "motives", which gave rise to the field of motivation research in the early 1950's, and advocated by by Ernest Dichter (1960). Learning theory, or behaviorism, commonly associated with Pavlov and B. F. Skinner, provided the sequence of drive-cue-response-reinforcement. This approach proposes that the consumer experiences a drive to act motivated by an internal need. S/he responds to cues, internal or external stimuli, which inform a response to satisfy the drive aroused by the need state. Such response is either positively or negatively reinforced, depending upon the outcome of the response.

Psychoanalytic theory contributed ideas pertaining to the complexities of individual development and personality structure, including the notion of the unconscious and drive theory as factors in motivation. Gestalt theory focused on the person in his/her environment, with the emphasis being on the perception of that environment.

Social psychology has focused on cognitive theory, studying the organization of values, attitudes and information stored in an individual's memory. Festinger (1957) advanced the theory of cognitive dissonance, which focuses on what happens when an imbalance arises as a result of contradictory information. This produces a state of tension in the system, which will hypothetically motivate change to re-establish harmony.

Reference group theory, social class theory, and the sociology of the family, have emphasized the fact that people are influenced by others around them.

Current Consumer Behavior Theory

Consumer behavior, as defined by Engels, Kollat and Blackwell (1973), is "the acts of individuals directly involved in obtaining and using economic goods and services, including the decision processes that precede and determine these acts" (p. 5). It includes the what, where, how often, and under what conditions of the consumer process. The emphasis is on the process by which a consumer makes a purchase, which is far more involved and complex than the purchasing act itself, including both before and after variables. It is also mindful of the context within which behavior occurs, including social, individual, and institutional variables.

Block and Roering (1979) divide the approaches to the study of consumer behavior into two categories, the distributive approach and the decision-process approach. The distributive approach focuses on behavioral outcomes, seeing behavior as an act, rather than as a process. It attempts to predict the relations among various independent variables (economic, demographic, and social-psychological) and consumer decision-making outcomes. While this approach is simple and fairly inexpensive, it does not always provide the depth of information required to develop meaningful marketing strategies. In particular, it omits the psychological component of behavior, the why that connects variables. Such an approach will be illustrated in the discussion of treatment "drop-outs" in Chapter III.

The decision-process models provide an integrative-comprehensive approach. They attempt to describe how a decision is made and assess the impact of various influences on the purchase process, focusing on the procedure an individual uses in reaching a decision. This approach starts at the point at which a problem is recognized and continues through to the evaluation of the problem-related decision. Such a framework extends the study of consumer decisions to both before and after the actual decision is made. In this way, it provides more extensive information that may be helpful in the development of a product and a marketing approach. It is important to remember, however, that no framework can completely account for the multitude and variety of complex interactions that may be involved in any one decision.

Models of Consumer Behavior

There are numerous ways to categorize the variety of approaches used to understand the behavior of consumers. A few of them are included here to illustrate the existing diversity. A brief description of some models, significant for their contributions to the development of the decision-process approach, will be followed by a detailed outline of the EBM model.

Economic

Economics was the first field to develop models of consumer behavior, providing information regarding one aspect of the process. Macroeconomics has focused on aggregate economic activity, looking at total consumption patterns and the consumption of broad categories of goods. This school developed such concepts as the relative income hypothesis, which states that consumption rates are influenced by reference groups and not absolute levels of income (Duesenberg, 1949); and the permanent income hypothesis, which states that consumers develop some long-term standard of wealth to determine the extent of immediate consumption (Friedman, 1957). Initially, little attention was paid to the psychological factors influencing consumer expenditures, although work in this area has begun. Katona (1975), for example, has found that future expectations influence present expenditures.

Microeconomics focuses on the behavior of individual consumers, studying the purchasing act, what consumers would buy and how much. Out of this came the concepts of the cost/benefit ratio and marginal utility. The consumer was seen as being a totally rational individual who will

always get the most benefit for money spent. This perspective does not consider the before and after factors which are considered to be an integral part of the buying process. Nor does it take into consideration the social and psychological influences on the otherwise "rational" consumer (Loudon and Della Bitta, 1984).

Motivation Research

This field was the first to bring together theories from the psychoanalytic literature and theories and techniques from general, experimental, and applied psychology, with social and economic theories. It was concerned with identifying the motives behind consumer purchases. Using such tools as projective techniques, word association tests, sentence-completion tests, and TATs, it attempted to "see beneath rational layers of buying, beneath the customary responses to the inquiry into buying behavior, and to understand the basic motives, the personality needs, the emotional impulses which attract people to one product and not to another" (Westing and Albaum, 1964, p. 346).

Motivation research relied heavily on psychoanalytic theory, frequently drawing conclusions which could not be empirically validated. The field fell into disrepute with the publication of Vance Packard's The Hidden Persuaders (1957), which advanced the premise that people could be manipulated without their conscious awareness.

Miscellaneous models

Wentz (1979) identifies several models of consumer behavior. Aside from Freudian, Pavlovian, and Marshallian, described elsewhere, he

includes the Veblenian model, wherein society dictates consumption and behavior patterns, and the Hobbesian model, which defines man as a political consumer. From social psychology he cites the McClelland model focused on achievement motivation, the Goffman model presenting the consumer as a role player, and the Riesman model which defines consumers as tradition-directed, inner-directed, or outer-directed.

Decision-process models

Nicosia Model of Buyer Behavior

Francisco Nicosia (1966) proposed one of the first models to conceptualize consumer behavior as a decision process. It is a four field model, which sees the consumer as purposive, moving from generalizations to specific, final solutions. It flows from Field One, which consists of an advertising message which provides input into a consumer's space, which is made up of psychological attributes. The outcome is the formation of an attitude, which activates Field Two, the pre-action stage. Here there is a search for, and evaluation of, alternatives. If motivation to purchase develops, decision and purchasing action follow. This is Field Three. Field Four encompasses the consequences of the action, including feedback to the suppliers, and memory of the consequences stored by the consumer.

The most significant problem with the model is that there are some consumer behaviors which do not involve a decision (Woods, 1981). Routine purchases or brand preferences, after the initial decision process, do not follow the same routine in subsequent consumer actions. If, for example, a consumer has found Colgate toothpaste to be acceptable, when it is used up, the consumer may buy more without giving thought to any

other brands. Field Two has an already formed attitude, immune from stimuli other than need, and Field Three is unnecessary. Nonetheless, Nicosia pioneered the way for subsequent models.

Howard-Sheth Model of Buyer Behavior

The model developed by Howard (1963), and later refined by Howard and Sheth (1969), utilized learning theory, and was primarily an attempt to explain brand choice over time. Howard distinguished between extensive problem-solving, limited problem-solving, and automatic response behavior. An assumption was that consumers attempt to make logical decisions, given their abilities and resources.

They divide the decision-process into input variables, hypothetical constructs (perceptual and learning), output variables, and exogenous variables. They indicate that input has several levels, significant (objective), symbolic, and social. Significant stimuli come from the actual product or service. Symbolic stimuli come from its representation by the producer in symbolic form, as in advertising. Social stimuli come from family and reference groups.

Once attention is gained, in the form of stimulus ambiguity, a search for further information may ensue. The information obtained will be affected by perceptual and learning constructs. Perceptual constructs include sensitivity to information, perceptual bias, and the search for information. Learning constructs include motives, brand potential of the evoked set (will the brand considered meet the defined need), decision mediators (criteria for selection), predisposition, inhibitors (price, time,

e.g.), and satisfaction (does it meet expectations afterwards). Such information may then serve to activate consumer action.

Output variables are the consumer's observable responses to the input variables, and include attention, comprehension, attitude, intention, and purchase behavior.

The major contribution of the Howard-Sheth model was its linkage of a multiplicity of variables. The fact that not all of them were measurable, however, has been generally thought to cause unnecessary confusion and complexity (Block and Roering, 1979). In particular, exogenous variables are not well defined, or distinguished from other variables. Research on the model has shown that the amount of variation explained by the model, while in the predicted direction, is quite low.

Engel, Blackwell, and Miniard's Consumer Decision Process Model

The EBM model (1986), shown in Figure 1, is the model used in this project. It was chosen because it is the model which is the most accessible and understandable to someone who is not a student of consumer behavior. It extends the knowledge gained from the other models, in an attempt to develop a framework which is more scientifically rigorous, and in which the relationship between variables can be more systematically determined. It is composed of four interdependent segments: Input, Information Processing, Decision Process, and Variables Influencing the Decision Process.

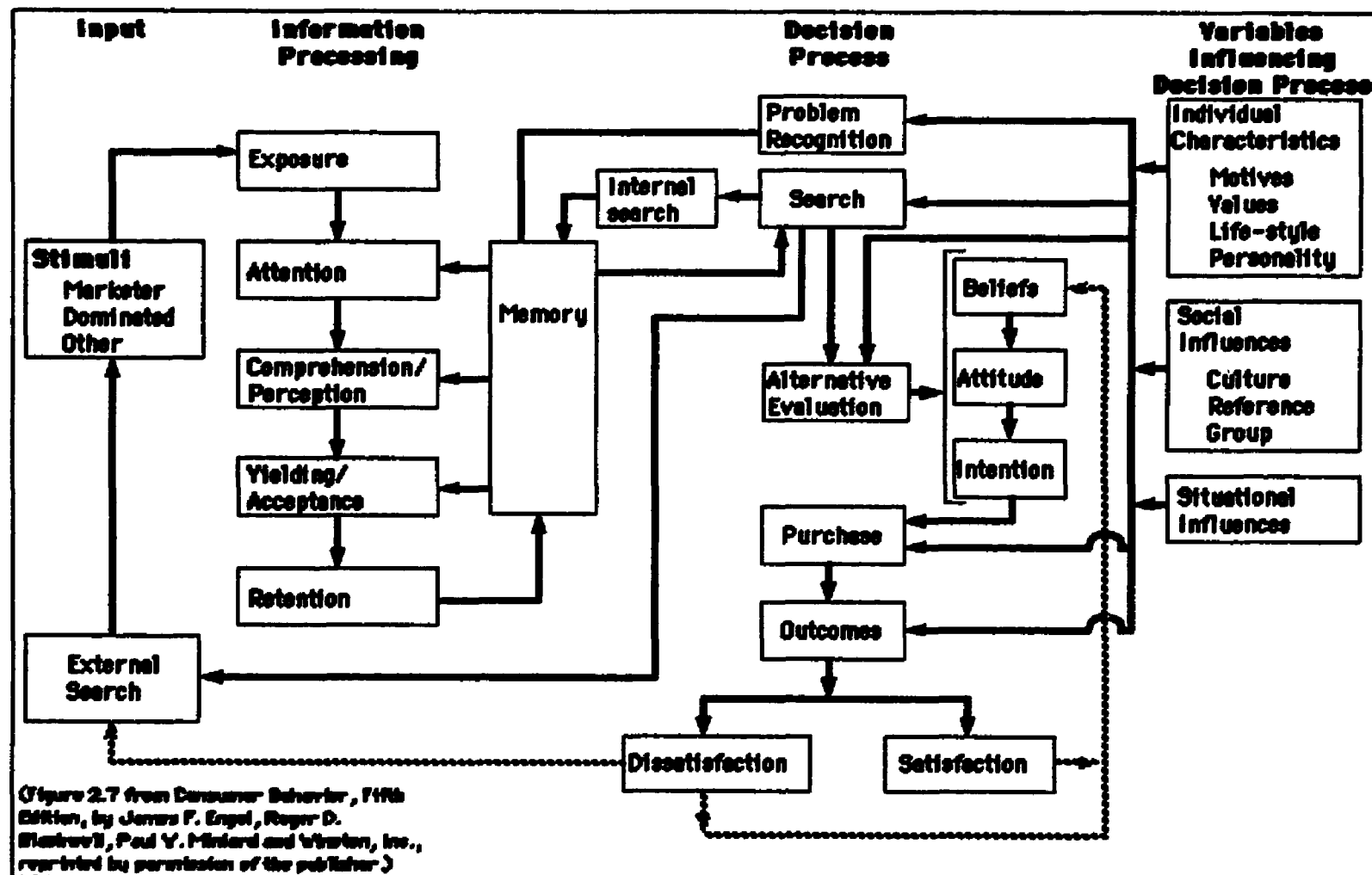


Figure 1. The Complete Decision Process Model.

Input, which will not be further elaborated, include stimuli, frequently in the form of advertising, or information obtained in the process of external search. Information processing includes such concepts as exposure, attention, comprehension/perception, yielding/acceptance, retention, and memory. The decision process includes problem recognition, search, alternative evaluation, which also relates to beliefs, attitudes, and intention, purchase, and outcome, which includes satisfaction and/or dissatisfaction. Variables influencing the decision process include individual characteristics such as motives, values, life-style and personality; social influences such as culture, reference group, and family; and situational influences.

In the next section, the components of the model will be defined and described. Literature testing the various components and concepts of the model will be cited as they attempt to further define the intricate process of consumer behavior.

Description of the EBM Model Components

Decision Process

The core of the model, the decision process segment, includes problem recognition, internal and external search, alternative evaluation, purchase, and outcome. Not every stage is active in every decision. Payne (1982) emphasizes the contingent nature of decision making, depending upon the particular task at hand. For example, habitual decisions, such as what coffee to buy, will go from internal search to choice, assuming past experience has been positive. Buying a car, on the other hand, might include problem recognition (current car doesn't run), internal search (this

model never ran well), external search (reading Consumer's), and alternative evaluation (test driving different models, comparing prices, interest rates, cost of repairing current car, etc.).

Punj and Stewart (1983) stress the importance of considering not only the task and the individual, but the interaction between the two. They indicate that task characteristics might include the number of available alternatives, decision uncertainty, frequency of decision, decision importance, the number of attributes per alternative, attribute commonality, information format and form, information source, time pressures, and cooperation characteristics (p.184). Individual characteristics might include, among others, personal values, prior knowledge and experience, need for cognitive clarity, need for self-esteem, ability to process information, beliefs, tolerance for ambiguity, etc. (p. 189). Some people with a positive previous treatment experience at Hauberk may automatically contact the hospital during another period of stress, whereas other people with problems may try anything to avoid acknowledging the need for professional help. These same people may, however, differ in the ease with which they decide what to have for dinner or where to go on vacation.

Problem recognition occurs when an individual perceives a difference between an ideal and an actual state. This can result through need activation, which causes an individual to become alert, responsive, and vigilant because of the resulting feeling of discomfort. External and internal stimuli can provide activating stimuli. The recognition of a problem will not automatically lead to problem-oriented activity,

however. The problem must provide a sufficient state of tension to motivate action, and it must occur in a context within which action toward a solution is possible. If a car breaks down and the owner is broke, the car does not get fixed until the necessary money is available, even though the owner will now have trouble getting around. A person who wants help with emotional problems may not get it if they feel they cannot afford the fee.

Many factors contribute to problem recognition, including motives, and other individual characteristics, social influences, situational influences, and information and experience (from memory). A motive is an enduring predisposition to strive to attain specified goals, to maintain the "ideal" homeostasis of the individual. It is an inner state that mobilizes bodily energy, directing it selectively toward goals usually located in the external environment (Loudon and Della Bitta, 1979). Motives can be aroused by physiological conditions, environmental stimuli, or cognitive activity. Motives also influence the development of the evaluative criteria used to assess particular products or services.

Motives have been classified into numerous categories. Some of the major ones include physiological versus psychogenic, primary versus selective, rational versus emotional, conscious versus unconscious, and positive versus negative. Psychogenic motives have been subdivided into affectional, ego-defensive, and ego-bolstering. All three types are learned. Primary motives direct action toward a general category (food, clothing, e.g.) whereas selective motives focus on the more specific

aspects of a purchase (e.g. pizza or Burger King, Calvin Klein or Gloria Vanderbilt jeans).

While categories can be helpful in designing promotional strategies, it should be obvious in looking at the categories that none are mutually exclusive. In addition, behaviors may be motivated by a variety of motives, not all of which may be directly observable, or even in the conscious awareness of the consumer.

There are many variables contributing to the ideal state of the individual. They include personality characteristics, attitudes, values, and evaluative criteria. These, in turn, are influenced by culture, subculture, social class, family and reference groups. Changes in reference groups, changes brought about by other decisions, financial circumstances, and stages in the family life cycle may also influence the definition of the ideal state. Advertising and the mass media have an enormous influence on what is considered ideal.

Product expectations also influence what is ideal. A consumer may expect better service from a private physician than from a doctor in a clinic. The introduction of new information, such as the recent emphasis on patient's rights, may change the definition of the ideal state, thereby activating problem recognition and the decision process.

There are different types of problems, resulting in differing levels of problem recognition: simple problem-recognition, somewhat complicated problem-recognition, and highly complex problem-recognition (Block and Roering, 1979, p. 372) Simple problem-recognition refers to those strongly learned, highly programmed, and automatic processes. These type

of problems occur regularly in daily life, resulting, for example, in those weekly trips to the grocery store to replace depleted supplies. A chronic patient may also have to give little thought to the fact that, when symptoms return, it is time to call the usual hospital.

A somewhat complicated problem-recognition process involves more time, more influencing factors, and more intense consumer attitudes. A person who has agoraphobia may have accepted this as a way of life and made adjustments accordingly. Over time she may read articles in popular magazines discussing the phobia and discussing current treatments. She may find out that a friend or neighbor had a similar problem and received help. She may also see a treating person from her local hospital interviewed on the Donohue show. Gradually, a previously accepted and perhaps not consciously recognized problem becomes less acceptable, in that awareness of alternatives now exists.

Highly complex problem-recognition processes are those which are infrequent and unprogrammed, involving a considerable period of time, strongly held attitudes, and are affected by many factors. The situation described above can be extended into this category. The woman discusses treatment with her husband, who is strongly opposed to it for both financial and emotional reasons. Over time their financial situation improves, but the increased demands of his job make his wife's dependency more of a burden to him. He hears other men discuss with pride the competency of their wives. More people he knows also discuss therapy more casually and with greater acceptance. He gradually begins to view

his situation differently and joins his wife in the perception of an existing problem.

Search is the process whereby information is gathered with a focus on perceived need satisfaction-problem resolution. The search process may be influenced by such factors as the uniqueness of the object sought, the strength of the precipitating motivation, previous similar search experiences, prior knowledge (Punj and Staelin, 1983), and the consumer's general predisposition toward searching (Locander, 1979). Time is also a factor in the search process (Jacoby, Szybillo, and Berning, 1976; Wright and Weitz, 1977).

Internal search occurs unconsciously, and involves a self-inventory of current attitudes and evaluative criteria. If there is enough information already available in memory, evaluation and/or decision will take place. If there is not sufficient information, external search will take place, wherein the individual will look to other sources (friends, experts, written material, e.g.) to provide sufficient information on which to base a decision. Purchase behavior may or may not occur after this stage.

The degree of external search conducted by the individual is influenced by such factors as the sense of immediacy experienced, the degree of tension, the nature of the product under consideration, and the degree of perceived risk involved. External search usually begins with broad considerations which are gradually narrowed down to a final conclusion.

Of particular interest to marketing strategists is knowing how and where to place information so that it will be found by a targeted consumer engaged in the external search process. Schaninger and Sciglimpaglia (1981), using display boards, found that depth-of-information search criteria were significantly related to the type of product (common, frequently purchased versus expensive infrequently purchased) as well as to differences in individual demographics and cognitive personality traits. Housewives, for example, who were "younger, earlier in the family life cycle, more educated, of higher social class, and nonhomeowners examined more cues and alternatives for all decisions" (p.215). More attributes and cues were examined for durable goods than for convenience and more familiar goods. This increased examination was also found to be related to tolerance for ambiguity, higher self-esteem, and having a need for cognitive clarity.

Most consumers engage in only minimal information search, with decisions frequently based on passive reasoning (Engel, Blackwell, and Miniard, 1986, p. 89).

Alternative evaluation is the process by which consumers evaluate alternatives to make a choice. It includes evaluative criteria, beliefs, attitude, and intention. Evaluative criteria are the specifications used by a consumer to compare alternatives, such as products and brands, and are concrete manifestations of personality, stored information, and various social influences. They are the standards and guidelines used to judge and compare products. One of the more common evaluative criteria is brand reputation.

Different numbers of evaluative criteria may be used in each decision, depending primarily upon the degree of involvement, but usually number around six or less (Engel, Blackwell, and Miniard, 1986, p. 95). Criteria also vary in their degree of influence on the decision process, with some having greater salience than others. Benefit segmentation, dividing the market on the basis of benefits sought by the consumer, is one of the strategies resulting from a thorough understanding of evaluative criteria.

Beliefs, a component of alternative evaluation, reflect the degree to which the consumer estimates that the product or service under consideration meets the evaluative criteria. Consumers develop a "brand image", or organized picture of the product or service, which then influences behavior. Understanding these beliefs, which are the foundation upon which consumers base their attitudes and intentions, enables one to identify a product or service's strengths and weaknesses from the consumer's perspective.

Attitude is a mental and neural state of readiness to respond, which is organized through experience, and exerts a directive and/or dynamic influence on behavior (Allport, 1935). An attitude toward a product develops as a result of using the evaluative criteria stored in memory. Attitude is a function of information and experience and evaluative criteria. It is the basic orientation for or against various alternative products, services, etc. Fishbein (1968) developed one of the more influential models of attitudes. Ahtola (1975) is one of the many investigators who attempted to refine Fishbein's approach.

According to the classical definition, attitudes are divided into three basic components: cognitive, affective, and behavioral. The cognitive component includes the beliefs and information a consumer has about a particular product or service. The affective component includes the feelings the consumer has, whether s/he likes or dislikes the product or service. The affective and cognitive components have been found to have a high correlation with one another. The behavioral component relates to intention, the consumer's action or expected behavior.

In advertising, this construct led to the hierarchy of effects hypothesis, explaining how advertising works. It was hypothesized that the three components are arranged in a particular order, as described above, and cover a process consisting of unawareness, awareness, knowledge, liking, preference, conviction, purchase (Block and Roering, 1979).

Attitudes are considered to serve four functions: the adjustment function, the ego-defensive function, the value-expressive function, and the knowledge function. The adjustment function relates to the adaptive tendency of the consumer. Attitudes give direction to behavior that will provide satisfaction, accomodating to the environment in which the behavior occurs. Attitudes perform ego-defensive functions in that they adjust to support the consumer's ego and self-image. A negative attitude toward psychotherapy might change if a consumer realizes that his/her role models or reference group think that therapy is a good thing. Similarly, if "being in analysis" is the "in thing", the consumer is then

enhancing his/her self-image by being in analysis, demonstrating an attitude which is value expressive.

The knowledge function served by attitudes is in providing a stable frame of reference for understanding, organizing, and coping with a chaotic world. It enables the consumer to decrease the number of active decisions that would otherwise need to be made everyday, by developing an overall frame of reference that covers broad categories of choice. If Anacin is the best pain-killer, the consumer need not deliberate over which brand to buy each time a headache requires relief. This is also a factor in the problem of attitude change.

Sirgy (1982) suggests that exploration of self-concept as it relates to consumer behavior should be an integral part of attitude research. He notes the various definitions of self: actual, ideal and social self, and the existence of two self-concept motives: self-esteem and self-consistency. He proposes the use of self-concept/product image congruity models as well as multi-attribute attitude models to increase the prediction of consumer behavior.

Multi-attribute attitude models, which have been developed to explain the formation of consumer beliefs and attitudes, have been classified as compensatory or noncompensatory. Compensatory models are those in which a weakness of one attribute may be compensated for by strengths of another attribute. The AOPD may not be much to look at, but the staff is friendly and competent. Noncompensatory models are those models in which a weakness of one attribute is not compensated for by the

strength of another attribute. No matter how good the staff is, the environment makes the AOPD unacceptable.

Compensatory models include expectancy-value models and attribute adequacy models. The former assumes that each alternative will be evaluated on more than one attribute, with judgement being made by beliefs as to whether each alternative has those attributes. Evaluations on each attribute are totalled, and the alternative with the highest total is selected. This model has had the greatest impact on research in consumer attitudes, and has been developed at length by Fishbein (1967) and Rosenberg (1977). Fishbein focuses on beliefs and the affective evaluation of the beliefs, whereas Rosenberg focuses on values and perceived instrumentality. Most marketing applications of these models have utilized modified versions. The expectancy value model was eventually extended to include situational influences, group and family influences, and anticipated and unanticipated circumstances, with the intention of improving the predictive value of the model.

The attribute adequacy model is similar to the expectancy value model, but it makes a distinction between the ideal and actual level of the attributes under consideration.

The "halo effect" has been raised as a concern with these models. It is suggested that individuals bias their indicated beliefs by their overall attitudes. If a consumer has a positive attitude toward an object, s/he will tend to believe that its various attributes should be rated positively. Beckwith and Lehmann (1975, 1976) and Johansson, MacLachlan and Yalch (1976) debate the significance of this effect.

The noncompensatory models include such models as the conjunctive model, the disjunctive model, and the lexicographic model. The conjunctive model sets a minimum standard that each attribute of the alternatives must meet. Failure to meet the minimum standard on a single attribute will eliminate that alternative from further consideration. The disjunctive model proposes that consumers decide that one or more attributes have the most importance. A decision will be made only between those alternatives which meet or exceed the minimum criteria on those selected attributes, regardless of the other attributes.

The lexicographic model suggests that consumers rank attributes from most important to least important. Whichever alternative dominates the first criterion is selected. If more than one qualifies, the next attribute is considered, until one comes out ahead.

Wright (1975), Peter and Tarpey (1975), Park (1976), and Jaccard, Brinberg, and Ackerman (1986) demonstrate a variety of approaches used to further understand how attributes are processed in the search for a consumer decision.

Intention is the subjective probability that beliefs and attitudes will be acted upon, and is the immediate determinant of actual purchase. Intention is affected by situational influences, such as changes in finances and the appearance of new options. Fishbein (1967) and Fishbein and Ajzen (1975) developed and elaborated on this variable, which is a function of attitude and social norms. Ryan (1982) further explores this concept, finding a stronger relationship between attitudes and social norms than originally proposed.

Purchase includes where to buy and how to buy it. (Even hospitals now take credit cards!) Purchase is a function of buying intentions and situational influences. Situational influences may include physical surroundings, social surroundings, task definition, temporal perspective, and antecedent conditions (Belk, 1974). These may be part of the explanation as to why people come to a mental health clinic, go through a screening process, but then do not follow through on treatment.

Outcome involves the postpurchase evaluation of the choice made. Dissonance occurs when the individual questions the rightness of his/her choice, and may be alleviated by finding reassuring information or opinions to support the choice. Problems with the chosen item or service may lead to a revision of the evaluative criteria such that similar mistakes are not made in the future. Satisfaction with the choice made reinforces the attitudes and evaluative criteria that influenced the choice, and increases the likelihood of a similar choice being made in the future (Cohen and Goldberg, 1970; Donnelly and Ivancevich, 1970; Anderson, 1973).

Information Processing

The information processing component is activated by stimuli that pass through the psychological filter. It consists of five distinct phases: exposure, attention, comprehension/perception, yielding, acceptance, and retention, not all of which necessarily become operationalized. It is the process whereby a sensory input is transformed, reduced, elaborated, stored, recovered and used by an individual.

Exposure is simply the act of receiving stimuli by the five senses in the form of a physical sensation, from either physical or social sources.

This could range from seeing advertisements or hearing commercials, to being told how to behave by family members or reference groups. There is a difference of opinion as to whether a certain threshold must be met before the stimulus has an impact on the person.

Processing of the stimuli begins with the activation of attention, which is defined as "the taking of possession by the mind, in clear and vivid form, of one out of what seems several simultaneously possible objects or trains of thought" (Block and Roering, 1979, p. 53). Attention is highly selective, and will give preference to those stimuli which relate to the current need state. These stimuli are usually consistent with the consumer's values and do not produce cognitive dissonance. It is here where the stimuli moves into conscious active memory.

Comprehension/perception may or may not occur, influenced in part by the psychological filter, which may distort incoming information. It consists of the interpretation of the stimulus, and involves a four-stage classification process: primitive categorization, cue check, confirmation check, and confirmation completion. Each stage involves an increasingly refined perceptual process. Attention is a necessary pre-condition for comprehension, but does not guarantee that an individual will correctly understand the intended message. Applicants to the Hauberk AOPD clearly comprehend what their fee will be, but frequently fail to "hear" that they have assigned their insurance reimbursement to the clinic and therefore are not entitled to file for it themselves.

Yielding/acceptance has to do with the degree to which a person accepts what s/he perceives, resulting in the creation of new beliefs and

attitudes or the modification of existing beliefs and attitudes. S/he may understand a message perfectly, but not agree with it. Cognitive responses during information processing activities, either favorable or unfavorable, are thought to be the critical determinants of subsequent yielding (Engel, Blackwell, and Miniard, 1986).

Retention is the transfer of the stimulus input into long-term memory. It does not always occur, again because selectivity is a factor. An individual tends to retain information most consonant with his/her beliefs, values, and attitudes. Retention is also influenced by the order in which information is received, its organization, and the delivery time.

Memory is the basic foundation for consumer information processing. Active memory stores information temporarily, and brings new input together with information stored in long-term memory. In active memory, information can be assessed and put into a proper category. Learning from experience can lead to consistent and predictable ways of responding to stimuli, as a result of categorization. What information is stored in long-term memory is influenced by the individual's intelligence, maturity, education, social class, personality, familiarity with the subject, and relevance of the subject.

Variables Influencing the Decision Process

There are innumerable variables influencing the decision process. Broad categories include individual characteristics, social influences, and situational influences. These areas have received considerable attention in the social sciences, and are the subject of numerous studies, as they

relate to the use of mental health services. An extensive review of the mental health literature will be found in Chapter III.

Individual characteristics include motives, values, life-style, and personality. Motives have already been discussed in an earlier part of this chapter. Rokeach (1973) defines values as enduring beliefs that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence. Personal values may be measured as instrumental or terminal. Instrumental values include such concepts as ambitious, helpful, independent, and self-controlled, while terminal values include freedom, happiness, self-respect, and a comfortable life. Values are learned through socialization and acculturation, and are passed on from one generation to another, and within groups. Families, religious institutions and schools are the primary transmitters of values, which are then influenced by early lifetime experiences.

Life-styles is a concept which adds color, texture, and dimensionality to otherwise demographically similar groups (Loudon and Della Bitta, 1984). Life-styles have to do with the patterns defined by the ways people live, spend time and money, in the pursuit and expression of personal goals. People with similar incomes, e.g., may do very different things with their time and money. Out of the study of life-styles has come the concept of psychographics. Psychographics is the technique by which life-style can be researched in measurable terms. (Wells, 1975 and Kinnear and Taylor, 1976 provide critical reviews of this concept.)

Personality, while lacking a precise definition, can be understood from a consumer behavior perspective to refer to the basic or general patterns of behavior of an individual, the "consistent responses to external stimuli" (Kassarjian, 1971, p. 409). There are numerous theories of personality. Psychoanalytic theory, developed most prominently by Freud, posits the existence of the id, ego, and super-ego, which may be in frequent unconscious conflict. Motivation research used the theory of the unconscious in attempting to understand the behavior of consumers. Defense mechanisms play an important role in the mediation of the tension induced by the conflict between the three personality components. Marketing strategies based on this theory attempt to placate all of the competing intra-psychic interests. Engel, Blackwell and Miniard (1986) give examples of sexually suggestive ads, which are "neutralized" by the visibility of wedding bands on the models (p. 499).

Another personality theory can be labeled the social-psychological theory. This theory focuses on the interdependence of the individual and society, with emphasis on social rather than biological variables. People are influenced by early childhood experiences, which affect their feelings of security, self-esteem, and need for love. Behavior becomes directed toward maximizing positive feelings in each of these areas, and coping with the anxieties produced by their absence. Loudon and Della Bitta (1984) list Adler, Fromm, Sullivan, and Horney as proponents of this theory. Horney's identification of 10 basic needs was later used by Cohen (1967) to develop the CAD (Compliant, Aggressive, Detached) instrument,

used in a consumer context to relate personality to specific consumer choices.

Stimulus-Response theories propose that personality results from habitual responses to specific and generalized cues. Based in learning theory developed by such theorists as Hull, Pavlov and Skinner, there have been few studies to date relating this concept of personality to consumer behavior.

Trait and factor theories of personality are the ones used most often in the study of consumer behavior. Traits, general and relatively stable personality characteristics which influence tendencies to behave, presume three propositions: "that individuals possess relatively stable behavioral tendencies; that people differ in the degree to which they possess these tendencies; and that when identified and measured, these relative differences between individuals are useful in characterizing their personalities" (Loudon and Della Bitta, 1984, p. 502).

Factor theories use the quantitative technique of factor analysis. The interrelationship between various personality measures across a large number of individuals is studied in this approach. When subgroups of measures form, a trait or factor is identified. Such tests as the California Psychological Inventory and the Edwards Personal Preference Scale are examples of this type of test. Used for clinical purposes, these tests have been modified for the consumer clientele. While innumerable studies have been done, attempting to correlate personality traits with buyer behavior, Kassarian (1971) concludes, after a review of 200 studies, that the results are equivocal.

Social influences include culture, reference groups, and family.

Culture is the underlying determinant of human decision-making, explaining why some choices are preferred over others. While there are many definitions of culture, the one commonly used by writers on consumer behavior is: "the complex of values, ideas, attitudes, and other meaningful symbols that serve humans to communicate, interpret, and evaluate as members of society...[and] are transmitted from one generation to the next" (Engel, Kollat, and Blackwell, 1986, p. 362). It includes personality types, summary constructs of religion, and learned patterns of behavior, feelings and reactions that are transmitted down through generations. It also includes material elements, the artifacts of a society. Culture is transmitted primarily by the family, while other strong influences include school and religion. Reference groups, friendship groups, social class, racial and ethnic groups all contribute to the mediation of culture.

Culture teaches a person how to respond to given situations, by providing solutions to recurring problems, which, if learned, become part of that person's response set. Of particular significance in the marketing field is the fact that cultural items learned early in life tend to resist change more than those learned later on (Engel, Kollat, and Blackwell, 1973). Culture refers to group habits, which are reinforced by social pressures exerted by people interacting with each other. Culture is also gratifying in that it serves to meet the current needs of a society. As those needs change, so does the culture evolve. As such, culture is adaptive.

Cultural values are "widely held beliefs or sentiments that some activities, relationships, feelings, or goals are important to the community's identity or well-being" (Loudon and Della Bitta, 1979, p. 125). American ideal cultural values include individualism, equality, activity, progress and achievement, efficiency and practicality, mastery of the environment, religion, humanitarianism, youth and romance, materialism and hedonism, and social interaction and conformity. Most authors note the changes occurring in the American value system, with consequent effects on marketing strategies. Significant among them are the increased emphasis on youthfulness, leisure, the "theology of pleasure", the increasing influence of children, and the changing role of women. Urbanization is also influencing the way people live, and an increasing sense of community is contributing to a greater focus on peace and the ecological survival of the planet.

Henry (1976), using this concept, found that cultural values were an underlying determinant in the study of ownership of general categories of automobiles.

Subcultures also exist within the larger culture. They include nationality groups, religious groups, racial groups, and groups based on geographic areas. Each brings with it core values and patterns which contribute additional influences to the decision-process. For example, subcultures play an important role in the definition of mental illness (Dohrenwend and Dohrenwend, 1969; Cole, Costanzo and Cox, 1980), which thereby influences problem recognition and information processing.

Another influence upon the decision-process is social class, which is defined as "relatively permanent and homogeneous divisions in a society into which individuals or families sharing similar values, life styles, interests and behaviors can be categorized" (Engel, Kollat, and Blackwell, 1973, p. 152). While there are no absolute boundaries between classes, there are distinct groupings wherein the majority of members tends to behave like each other. Social classes are hierarchical and are defined by such variables as power, privilege, prestige, influence, wealth and income, combined in some indefinable way. Social classes transmit culture, as it is filtered through the class value system.

Social class is determined by occupation, personal performance, personal interactions, possessions, value orientations, and class consciousness. Occupation is frequently considered to be the single best indicator of social class.

Research indicates that social class influences the psychological make-up of its members. Attitudes and values are transmitted differently among different social classes, including the concept of the ideal man or ideal woman. Personality, learning and intelligence, family structure, use of language, and religious affiliation are all strongly influenced by social class. Coleman (1983) presents an interesting discussion of the effects of social class on the use of income, rather than income as a determiner of social class. As in marketing, where members of one social class are frequently devising strategies for another social class, the mental health practitioner needs to be mindful of the social class impact on individual

psychological make-up, and the class-related value judgements inherent in treatment.

Reference groups are "interacting aggregations of people that influence an individual's self-conception, attitudes and behavior by acting as reference points for that individual" (Engel, Kollat, and Blackwell, 1973, p.161). There are small, face-to-face (primary) and organization (secondary) groups, formal and informal groups, membership groups, aspirational groups, dissociative groups, etc.

Reference groups perform several functions. They act as vehicles of socialization, influencing the awareness of, and preference for, alternative behaviors. As such, they influence attitudes and perceptions. Moschis (1976) found that informal groups exert considerable influence on purchasing behavior when there is high co-orientation among members, raising question about the credibility of "experts" in advertising.

Reference groups also perform a conformity enforcing function, maintaining adherence to group norms, which define how members should behave. The establishment and maintenance of an individual's self-concept is also influenced by such groups, in that it is closely linked to how an individual perceives him/herself to be evaluated by others. The reference group provides the standard by which a self-judgement is made.

Studies reflect the fact that the influence of reference groups varies in different situations, depending upon the product category involved (Bearden and Etzel, 1982), the characteristics of the group, the distance of the reference group (Cocanougher and Bruce, 1971), and the communication process (Engel, Kollat, and Blackwell, 1973). How conspicuous a product is

appears to be the most important variable in determining the degree of group influence (Bourne, 1957). Group cohesiveness is another factor, as well as the way in which information is communicated. People apparently do not like being "told" what to do.

Families are a special type of reference group. The nuclear family is a primary group which influences an individual's personality, attitudes, motives, concepts of daily life routine and interpersonal interactions. The family unit has an economic component, which may result in individual needs being subordinated to other family members needs or to the needs of the family as a whole due to financial constraints. The family performs a mediating function, filtering the norms of the larger social systems. The family has a life cycle, with different issues, needs, and financial resources available at different stages in the cycle. This has particular relevance in mental health, because the transition from one stage to the next is frequently stress producing. The role of each member in the family influences the decision process (Wind, 1976), and that influence may vary at each stage of the process.

Summary

This Chapter describes the development of the field of Consumer Behavior with its foundation in psychology, philosophy, sociology, and economics. Several decision-process models are described, and the Engel-Blackwell-Miniard model, the one used in this study is delineated in detail. The Decision-Process segment of this model, which includes Problem Recognition, Internal and External Search, Alternative Evaluation,

Purchase and Outcome, is the core of the model, and is the major focus of this study.

Using the EBM model as an organizing framework, this study explores the usefulness of a consumer behavior perspective in the understanding of the decision to use, or not to use, out-patient mental health services. While the identification of clients as consumers is not new, the study of their behavior as consumers has not yet been fully explored. Before the study is described, there will be a review the literature on the use of mental health services as it has been traditionally approached.

III. Literature Review

Introduction

This Chapter will review the literature in the social sciences covering the use, or non-use of mental health services in the last forty years. It will focus on the varied approaches which have been utilized in the attempt to understand who applies for help, how need is defined, and why people stay in psychologically-oriented treatment for vastly differing periods of time. The inconclusiveness of this material is indicative of the state of our understanding of how and why people decide to consult professionals for their mental health problems.

Before proceeding, it should be noted that the earlier studies were motivated by needs much different from those we are experiencing today. In the 1950s and 60s there were not enough treating professionals to meet the demands of people in need (Auld and Eron, 1953; Cole, Branch, and Allison, 1962; Borghi, 1968). The concern was therefore to find ways to predict which applicants for treatment would be most likely to follow through with the treatment process and benefit from it. High drop out rates raised questions about the most efficient use of these limited resources. An added concern was the fact that psychotherapy seemed to appeal to only a select group of people, with those from the lower classes frequently absenting themselves from even free clinics.

Questions were raised as to whether these people could be treated in an era "in which long-term psychotherapy was virtually the only outpatient psychiatric treatment that had any respectability in this country and was considered by many to be the very essence of American psychiatry" (Lazare, Eisenthal, and Wasserman, 1975, p. 558).

Changes in the variety of acceptable treatment modalities as well as advances in psychopharmacology broadened the range of help that could be offered to someone in need. The mental health movement mandated that everyone applying for help be treated, which changed the focus from selectivity to service provision. The 1970s were concerned with developing relevant services for the overabundance of unfulfilled demand, both in terms of numbers and "success" rates (Eisenthal and Lazare, 1976).

The 1980s have seen an upsurge of overt competition for a more selective patient/consumer, as an increasing supply of mental health service providers vie with one another, as well as with the self-help movement. The focus has now shifted from a concern for who can best use a limited resource to how to attract a more discriminating patient/consumer population-the selectivity is now going in the opposite direction. The concern now is on determining which services will attract the most people, with the patient/consumers playing a much greater role in the definition of problems and service development. While the primary goal remains the provision of treatment to the greatest number of people, in the

most effective and efficient manner, the secondary goal of survival adds a new sense of urgency to the process.

Articles on the use of mental health services have traditionally been grouped according to the primary variable or issue under consideration, e. g. studies of social class and treatment, age and treatment, race, help-seeking, etc. Studies have fallen into three broad, and often overlapping, categories: client characteristics, therapist characteristics, and process variables. In this review, the studies have been grouped differently. They have been loosely placed within the context of the Decision Process component of the EBM model. It is felt that many of these studies reflect one aspect of a process, and that they gain an added dimension using this perspective. Most of the variables studied can be found in the Variables Influencing the Decision Process section of the model. Articles will be arranged in chronological order within each section, to reflect any progression in the approach to understanding the drop-out phenomenon over time.

Problem Recognition

Defining Mental Illness

The definition of mental illness is the starting point in the process of the potential utilization of mental health services. Whether a person defines his/her problem or someone else's as one requiring professional help is determined by a variety of factors. Both the potential patient/consumer and the agency/professional

play a part in this definition. Some of the factors influencing this process have been explored in the following studies.

An experiment done by Lee and Temerlin (1970), to study the effect of interpersonal factors on diagnostic opinions, used a set interview, with the identifying data being changed to reflect different socioeconomic statuses. The group hearing the lower socioeconomic history diagnosed the patient as mentally ill with a fair prognosis, whereas a control group with no prior social history data diagnosed him as healthy with an excellent prognosis. Differences were not significant between the control group and the ones hearing the middle and upper class social histories.

As a second step, Lee and Temerlin asked residents to diagnose a case and rate the patient's socioeconomic status, while first being told how three other prominent clinicians had diagnosed the case. Socioeconomic status followed diagnosis, with the diagnosed psychotic patient rated as having a lower economic status than the neurotic patient, who was lower than the normal patient. They concluded that their study illustrated the biasing effect of sociological effectiveness, which they distinguish from social effectiveness, the latter being a better criteria of personal well-being.

Cole, Pennington and Buckley (1974) examined the effects of situational stress and sex roles on the attribution of psychopathology, using a story format with college students as subjects. They hypothesized that laymen consider person and

situation factors as well as the behavior itself when making judgements regarding mental illness. They found that the attribution of psychopathology was very much influenced by the situational factors surrounding the disordered behavior. They also found an interactive effect with the type of behavior and type of stress. Situational stress was found to have a significantly different effect on the attribution of disorder to males and females, with greater tolerance for deviance for women under some circumstances, without treatment being recommended. Females were not seen as being sicker than males, in contrast to other studies, but they were more favorably disposed to seeking help.

Two studies were done by Cole, Costanzo, and Cox, looking at mental illness as defined by "gatekeeper" professionals (1975), and by community subcultures (1980). In the first study they looked at how "gatekeepers", i.e. physicians, clergy, police, social workers, and public health nurses rated behavior in two communities in North Carolina. Such ratings would determine who was directed to mental health agencies. Their approach was based on Mechanic's conclusion that 'the basic decision about [presence of mental] illness is usually made by community members and not by [mental health] professional personnel' (p. 627).

Using items adapted from the M.M.P.I., they concluded that there were reliable differences among the professional groups in their sensitivity to deviance related to mental illness. Three

clusters-thought disorder, drug and alcohol abuse, and destructive tendencies- provided the working definition of extreme disorder for all subjects. While all the groups agreed as to the order of severity assigned to different problems, their responses to problems in the middle ranges differed. Therefore, response to problems in this range would be different, depending on the professional the troubled person contacted. The ease of access to a particular professional would then also influence the treatment recommended.

In their second study, they used a stratified sample of 469 laymen from two North Carolina communities. Variables were race, sex, and social class, each compared in relation to how they affected the mental illness rating on a 190-item MMPI-based questionnaire. At issue was whether different groups define illness differently, thereby helping to account for the different rates of usage of mental health services among these groups. They found no total score differences for race or social class. Women tended to find more signs of disorder than men across the total questionnaire.

It was in the item clusters that distinctions became highlighted. Upper and middle class laymen place greater value on proper cognitive functioning and behavioral self control. Middle class concerns are distinguished from upper class concerns by a greater moral tinge, such as with the concerns about alcohol or drug abuse. Lower class laymen are more concerned with issues of

social ease and personal self-esteem. In general, they characterize the concerns about mental illness as shifting from cognitive (upper class), to moral (middle class), to social (lower class) considerations.

The general ordering of severity of clusters was similar across the three groups, with Thought Disorder, Destructive Tendencies, and Drug and Alcohol Abuse being judged as severe by each. Differences are in degree of concern. Cole et al concluded that such distinctions provide an insight into differences in social values and social norms among the subcultures surveyed.

Significant racial differences in cluster scores were similar to the social class patterns. Whites were more concerned about thought disorders and substance abuse, whereas blacks were more concerned about social interactions. A distinction was drawn between internal and external control. The concerns of both the upper classes and whites are reflected in the traditional psychiatric view of mental illness. Cole et al suggest that mental health professionals take greater cognizance of the subcultural meaning of behavior and recognize the socially determined framework of social perception.

Peggy Thoits (1985) looked at labeling theory, expanding Thomas Scheff's concepts to account for voluntary treatment seeking for short episodes of psychological disturbance or distress. She conceptualizes disorder as "emotional deviance-the outcome of unsuccessful emotion management attempts" (p. 222).

Labeling theory posits that a person's self-identity comes from, and is sustained in, social relationships. Others need not be present, however, for a person to self-label his/her own behavior. The theory assumes that such a person is a well-socialized actor, that norms and their violation are known and labeled, and that the person is motivated to conform to social expectations, which brings rewards.

Thoits draws from Hochschild (1979) who introduced the concepts of feeling norms and expression norms, proposing that emotional behaviors are governed by sets of expectations or beliefs. Pugliesi (1981) extended this concept to suggest that violations of these norms may result in attributions of mental illness by others. Thoits contends that self-observed emotional deviance can lead to psychiatric treatment seeking. Such emotional deviance can come from norm-state discrepancy, which is defined as a discrepancy between their private experience of emotion and the states prescribed by the norm; inter-role conflicts, such as when feelings from one role spill over into another role situation; role strain; status inconsistency, wherein a person holds both a valued and a devalued identity; role transitions and identity transitions, which may have either normative emotion states or poorly defined rules of expression, both of which change over time as cultural transitions occur; and structural strains causing discrepancies between ideal behavior and real behavior.

Thoits defined an emotion as a configuration of four associated elements present in awareness: external situational cues, changes in physiological sensations, expressive gestures, and a cultural label. These elements are learned and reinforced in social interaction. Discrepancies in these elements can be transformed either cognitively, behaviorally or both. Failure in this "emotion management" can be caused by persistence or recurrence of discrepancy-producing situations such as is caused by stress, and lack of social support. Social support is defined as emotion management assistance, frequently from someone who has had similar experiences and feelings, and can therefore "normalize" the feelings.

Frequent failure to live up to one's emotional expectations can result in self-attributions of emotional disturbance. Social support can also increase the possibility of self-labeling, as it can be used to confirm one's tentative self-label, or give a label which requires help. Emotion management techniques can also backfire, as when their over use increases labeling by others. The use of drugs to initially manage depression or anxiety, for example, can eventually lead to a label of drug abuser. The eventual decision to seek professional help may help to restore the emotional equilibrium, in that the professional will provide effective social support, restoring consistency between feelings and situational norms. Feeling better means to feel normative again.

Attitudes Toward Seeking Help

Having defined something as a problem, there are various factors which influence a person's attitude toward seeking professional help.

Fischer and Cohen (1972) looked at the relation between help-seeking attitudes and the demographic variables of social class, education level, religion, and college major. They found that social class background had no connection to the subjects' help-seeking attitudes. There was, however, a positive association between education and attitude scores. For upper class subjects, attitudes were not affected by education, but for the middle and lower classes, attitudes were. Jewish subjects had more favorable attitudes than Protestants and Catholics, and social science majors, especially in psychology, had more positive attitudes toward help-seeking than those in other disciplines. Given that they did not find the expected relation between low social class and help-seeking attitudes, they speculate that a change in social climate and subsequent change in reference groups, may have a liberalizing effect on student attitudes.

Asser (1978) looked at the effects of social class on people's values and their help-seeking behavior. He focused on the values of autonomy and conformity. He hypothesized that those who value autonomy will employ a negotiating help-seeking style and that those who value conformity will employ a didactic or representational help-seeking style. In a negotiating style, the person retains primary responsibility for problem definition,

formulation, and solution. The didactic style is characterized by instruction, abdication, and representation. He used Bernstein and Melvin Kohn's theory to hypothesize that the higher one's social class, the higher is one's value on autonomy and the lower the value on conformity.

Asser conducted 42 intensive interviews, with equal representation of class, age and race. No significant differences were found on help-seeking styles or values by age or race. Also, no significant differences were found on values of autonomy or conformity for males or females, but they did differ significantly in their employment of negotiating or didactic modes. Males overwhelmingly employed a didactic style, while females were as likely to use either style. Regarding class differences, the middle class valued autonomy significantly more than the working or lower class. The differences in their help-seeking styles were not significant, although the working and lower classes employed didactic modes more often than negotiating modes. A follow-up survey of 1,052 respondents found a social class effect when the middle and working classes were combined and compared to the lower class.

Asser concluded that it might be useful for the helping agent to understand the patient's problem definition and help-seeking in terms of their help-seeking styles and the value and behavior orientations they represent.

The importance of social integration for the subjective well-being and predisposition toward professional counseling services of persons experiencing personal disruptions was explored by Linn and McGranahan (1980) in their survey of 1,423 northwest Wisconsin residents. They used measures of life satisfaction and happiness to assess subjective well-being. Social integration was measured at the level of the friendship system. 11% of the sample reported that they had thought about getting professional help in the past five years.

They found considerable support for the hypothesis that greater contact with close friends diminishes the effect of personal disruptions on individual well-being. Education was found to be a good predictor of whether a person would want to seek professional help, as were health problems and marital disruptions. There was some evidence that greater contact with close friends for persons with disruptions reduced their use of professional services.

Search

Non-Professional Resources

Community structure and informal help-seeking have been studied, in an attempt to understand what people do when they have a problem. From a decision-process perspective, these studies may reflect part of the Search process that ensues when someone has recognized a problem that needs to be addressed.

Raphael (1964) explored information diffusion in studying the geographic distribution of cases seen in a child guidance clinic. She found that they came more frequently from areas having a greater proportion of multiple dwelling units. She concluded that lay professionals such as teachers and social workers served as "definers" of mental illness, serving as mediators for the diffusion of the psychological and psychiatric interpretation of conduct, in areas with cultures incompatible with acceptance of this innovation.

Leutz (1976) identified informal caregivers in East Harlem, and provided them with information on formal service agencies. He observed that people in this community frequently go to local store merchants, spiritualists, and social club owners when they have a problem. He followed the example in North Dakota, where bartenders and student beauticians were given a training program in counseling and making referrals. He followed Katz and Lazarsfeld's (1955) "two-step flow of communication", wherein information from the outside world is obtained by local caregivers and then interpreted to others in the community. He concluded that one way to improve communication between potential clients and a formal agency is to utilize these informal resources, who used the information given to them in their contacts with community members.

Helpseeking: who seeks help, how the social network influences the type of help sought, and the outcomes of the helping

interactions, was reviewed in the literature by Gourash (1978). People who look for help are usually looking for comfort, reassurance, and advice. They tend to be young, white, educated, middle class and female. She notes that class related usage may be changing, and this may reflect greater success in linking the lower classes with services.

One of the major forms of assistance supplied by the social network was referral to human service agencies, with studies naming family , friends, or co-workers 75% of the time, as influential in their use of professional services. Social networks also buffer the experience of stress, provide instrumental and affective support, and transmit attitudes, values and norms about help-seeking. Gourash suggests that agencies could play an important role, and decrease the strain on scarce resources, by devoting some of their time to developing these social networks for community members.

A longitudinal survey of 1,106 urban adults aged 20 to 70 was conducted by B. Bradford Brown (1978) to investigate whether persons who sought help from informal and/or formal support systems for major troublesome life changes were distinguishable from those who handled problems without assistance in terms of demographic background, personal resources, social networks, or psychological barriers to help-seeking.

Two thirds of the 606 members of the sample experiencing troublesome life changes reported seeking assistance at least

once. Of those, 48% confined those contacts to informal helpers, 12% made formal contacts, and 40% did both. One third of the nonseekers were rated as self-reliant, feeling they could handle their problem alone, and the other two-thirds were rated as reluctant. Help-seeking declined with age, with a significant drop for women. Differences were also noted by race, which was also influenced by education. Less educated blacks sought help less often than whites. Overall, there were no differences by sex or marital status between the five sub-groups.

Help-seekers reported more troublesome life events than nonseekers, but this finding was confounded by the fact that the greater the number of problems one has, the more potential opportunities one has to seek help. The intensity of the role strain was greater for the help-seekers. The self-reliant nonseekers reported a higher percentage of troublesome events, but significantly less role strain than all the other groups.

The self-reliant group's personal resources were clearly superior to all the other groups. Informal resources were similar, except for intimacy, which was greater for help-seekers. While other studies have suggested that people turn to professional help when the informal resources are inadequate, this study did not find this to be so. Brown conjectured instead that people become reluctant to keep asking their family and friends for assistance.

Brown suggests that perhaps the knowledge that help is available reassures people in coping with their problems, without using that help.

Agency contact

Given the reportedly high drop-out rate of applicants for help (to be discussed in the Purchase section below), service providers have long been interested in finding ways to identify who will make the best use of the help offered. Some of these studies highlight the idea of coming into treatment as an "act", rather than as a process. They focus primarily on individual characteristics, such as personality attributes and social class, as the determinants of staying in therapy.

Rorschach tests have been used to try to predict who will stay in therapy (Kotkov and Meadow, 1953; Auld and Eron, 1953). After reporting on studies which got mixed results, Gibby, Stotsky, Hiler and Miller (1954) attempted to determine whether the Rorschach test could predict the duration of therapy for extreme groups.

They found that they could predict accurately 67% of the time those who stayed more than six months and those who terminated therapy, but were much more successful predicting terminators than remainers. They concurred with other studies in finding that the total number of responses to the Rorschach cards was consistently associated with continuance in therapy, but the cutting point remained a significant variable. They found no

correlation between responses and intelligence, as measured by the Wechsler. They did find a correlation between continuing in therapy and social class, with lower social class patients terminating more often. They concluded that patients who remained were more intelligent, more productive, had more middle class values, had greater psychological-mindedness, and were more motivated. They cautioned against using their formula with dissimilar settings, and also noted the need to take into account the affective type of therapist and the type of therapy, both of which can effect the predictive use of their formula.

A "sway" test, used to measure a person's susceptibility to hypnosis, was used by Imber, Frank, Gliedman, Nash, and Stone (1956) to determine the effect of suggestibility on the acceptance of psychotherapy. They then examined the relationship between suggestibility and social class. Their results indicated that most people who swayed stayed beyond a third interview, while non-swayers might or might not. They found that social class and suggestibility were independent variables, although they were both related to a person's acceptance of treatment. They note that prestige factors, such as the reputation of the service agency, contribute to the effect on the suggestible individual.

Lorr, Katz, and Rubinstein (1958) developed a battery of tests which they used to predict length of stay in psychotherapy. Their results showed trends in expected directions, identifying remainers for six months or longer as more anxious, more self-

dissatisfied, more willing to explore personal problems with others, more dependable, more controlled, more persistence in tasks, and less likely to have a history of antisocial acts than terminators. They also note (Katz, Lorr and Rubinstein, 1958) that those attributes associated with subsequent improvement may be very different from those that determine whether a patient will continue in treatment.

The Michigan Sentence Completion Test was used by Hiler (1959) to predict continuation in psychotherapy. He compared patients who terminated within five sessions with patients who remained in treatment for 20 or more sessions. He found five differences of significance: willingness to reveal self on test, feelings of inadequacy, desire for status, and objectivity were associated with remaining in therapy; evasiveness was associated with premature termination. The prediction formula developed discriminated between the two groups with 71% accuracy. The clinician, using intuitive or global judgement, achieved 68% accuracy. Hiler suggests that this test is a useful device for selecting patients for psychotherapy.

Using applicants at a child guidance clinic, Lake and Levinger (1960) developed an index, using the nature of the problem, goals in coming, co-operation with the worker, and agreement between client and worker to identify continuers and discontinuers. Those who received high scores on this index continued in treatment 79%

of the time. Those who received medium or low scores continued only 16% of the time.

In a separate study, Levinger (1960) described a patient's (P) continuance in treatment as a function of five variables: P's personal attributes, P's current environment, the helper's (H) personal attributes, H's current environment, and the characteristics of the P-H relationship. His review of the literature led him to conclude that continuers have greater discomfort, are more likely to see themselves as responsible for their problems, and have greater motivation to solve them. They also respond better to the helping person, and are more open. His review supported the observation that middle class patients are the most likely to continue in treatment. He noted that the influence of the environment had not been sufficiently explored to draw substantive conclusions. Another area for further exploration was the nature of the helper and the helping relationship.

In addition to supporting Lake and Levinger findings, Cole and Magnussen (1967) also found that symptoms dating more than six months prior to application were more frequently found among remainers than terminators.

Identifying early dropouts from psychotherapy was attempted by Cartwright, Lloyd and Wicklund (1980), using patients' self ratings on the Counseling Readiness Scale (CRS) of the Gough Adjective Check List and ratings by the intake worker. They pursued the material indicating that patients' initial motivation to

work on their problems and their ability to generate and share inner life material have been associated with early defection from the treatment process. Using a cutoff score on the CRS and two questions determined to be significant from the intake worker's evaluation, they predicted 62% of those who actually dropped out of treatment.

They then introduced a preparatory group, helping the potential dropouts to get in touch with their inner life material prior to starting treatment. They found that there was a significant difference in the dropout rate between those who had the preliminary training and a control group of potential dropouts with no training.

In a similar vein, France and Dugo (1985) found the mean attendance for the first 10 sessions significantly greater for 20 subjects who were given a one-session orientation program prior to starting group therapy.

In an effort to predict terminators and remainers, Borghi (1968) used the MMPI to identify defining characteristics. He found no significant differences between the two groups using this test. Conducting follow-up interviews with terminators led him to conclude that expectations were of greater significance in the success or failure of the treatment relationship, and suggested that the notion that personality attributes could identify terminators and remainers should be discarded.

The MMPI was again used, by Walters, Solomon and Walden (1982), to predict therapeutic persistence in groups of male and female outpatients. The results suggested that the MMPI was better at predicting male persisters than female persisters. Overall, they felt that the MMPI requires greater specificity of variable definition before it can be fully realized. Persistent males tended to be less defensive, more aesthetically oriented, more depressed, and more poorly adjusted psychologically relative to male outpatients who leave treatment early.

The relationship between excuses and dropout at a mental health center were studied by Bernal and Kreutzer (1976), focusing on their predictive value. They found that more dropouts than continuers tended to give one or more excuses at some point from the intake telephone call to the fifth clinic appointment. By the fifth appointment 53% of the subjects had dropped out, 82% of whom had been identified by their excuses. They noted that this approach also tended to misidentify some continuers.

Berrigan and Garfield (1981) studied the relationship of missed psychotherapy appointments to premature termination and social class. They defined dropping out as not having discussed leaving treatment with the therapist. They found that low socio-economic status was positively related to premature termination, with the percentage of dropouts ranging from none in the highest socio-economic class, to 27% of Class III, and 50% in Class V, in a linear relationship.

Socio-economic status was also related to missing one or more sessions. Clients who missed one or more sessions were significantly more likely to drop out of therapy, with 46.4% of the 28 clients who missed sessions terminating prematurely. Client cancellations were not significantly related to dropping out. They also found no relationship between client age, sex, or previous therapy and premature termination, or therapist-client sex pairing and dropping out of treatment.

They suggest that missing sessions may represent the first manifestation of the client's disillusionment with the psychotherapeutic process (p. 241). Since these missed sessions were not addressed in subsequent sessions, it was proposed that exploring the reasons for missing sessions might open the way for discussion of the client's dissatisfaction with the treatment process, with the potential for resolution of the problem.

Fraps, McReynolds, Beck, and Heisler (1982) used pre-and post-intake questionnaires to predict client attrition from psychotherapy. They focused on past behavior, situational factors in their lives that might influence attendance, and self-predictions concerning continuance. They found that situational and behavioral variables are associated with psychotherapy attendance, although this approach had only modest predictive power.

Kelner (1982) used Jochim's PT Scale to predict premature termination from outpatient psychotherapy. He summarizes that the MMPI, the Myers-Briggs Type Indicator, the Michigan State

Sentence Completion Test, the Rorschach, social class, education level, and ethnicity have all been unsuccessful predictors of premature termination. Kelner was not able to discriminate between remainers and terminators with the predicted accuracy using the PT Scale. He suggests, based on his other research, that the interaction between patient and therapist interpersonal needs may provide better understanding of remaining or terminating treatment.

Heilbrun did a series of studies covering a 20 year period focused on predicting early termination from counseling. He found sex differences in client variables such as manifest personality traits, self-acceptance, problem-solving, effects of pretherapy briefing, and preference for interviewer style. A few of these studies will be summarized here.

Using college students, he found that the client who conforms most closely to the expected cultural stereotype of femininity or masculinity tends to terminate early (1961a, b). At the same time, he found that the female client who stays in treatment tends to be more masculine, and the male client more feminine, as rated on the Gough Adjective Check List.

Another study, of counseling readiness (1962), found that premature termination was primarily determined by a lesser need for psychological assistance, and an avoidance of feelings ranging from mild embarrassment to humiliation stemming from the perceived inferior role status of the client. He recommended

actions to increase the status of the client's role, and to acknowledge the client's feelings about his perceived inferior status role.

Heilbrun (and Sullivan) developed a Counseling Readiness Scale (CRS), to be used as an economic and objective psychometric procedure for predicting premature termination of psychotherapy, which he then tested on varied populations. It successfully predicted the longevity of longer-term psychotherapy with non-college adults (1966), and in a brief-contact campus clinic (1978). He later attempted to improve on this Scale (1974), and was able to better discriminate between clients predicted to drop out who actually dropped out, and clients predicted to drop out who actually stayed. He was unable to improve on the differentiation of client predicted to stay who actually stayed, and clients predicted to stay who actually left.

Females and self-disclosure were the focus of another study (1973), based on role-expectancy theory. Using college students, he found that female terminators were higher self-disclosers to males, whereas female remainers were higher self-disclosers to females. He conjectured that the terminators received the cathartic benefits of revealment, and that the passive style of male therapists may have enabled them to fully express themselves. An assessment of interviewer style (1974) supported these findings, with greater satisfaction with nondirective interviewing reported by females more likely to defect. This

variable influenced the effectiveness of the predictive ability of the CRS, in that the CRS was unable to predict termination when the client saw a more directive interviewer. Heilbrun followed this with a study of tolerance for ambiguity in female clients, which fit with his catharsis model (1982). He concluded that tolerance for ambiguity in female clients was associated with earlier departure from counseling and with less improvement. Females with a lower tolerance for ambiguity tended to continue.

Heilbrun also looked at client cognition, to see if it would help to predict client behavior (1982). He examined social insight and psychological defensiveness, and found a three-way interaction with these two variables and sex. Continuation in counseling would be predicted for highly defended but less insightful males and for highly defended but more insightful females. He also found that improvement does depend on duration of counseling, even in a brief-treatment agency, and that the CRS scores are relevant to actual improvement.

Alternative Evaluation. Purchase

There have been numerous studies of "drop-outs" from the pre-therapy-therapy process. The assumption is that an appointment constitutes a commitment to purchase treatment, and that the patient/consumer has failed to uphold his/her end of the bargain. One of the difficulties with treatment is that there is no well-defined point when a person can be considered to have truly purchased the service, despite the possible monetary

payment. A person may come "to" treatment, but it is well known that this does not necessarily mean that s/he is "in" treatment. Having a "person" does not guarantee that one has a "patient". A working alliance between patient and therapist is probably the best criteria for a purchase having been made, but this factor does not show up in drop-out studies, nor is it easy to operationalize. Therefore, using the Decision Process model here, results in some haziness between Search, Purchase, and Outcome. It is also felt, however, that this haziness is what complicates the "drop out" studies reviewed in this section.

Purchase includes how and where one buys a product or service, and is a function of buying intentions and situational influences. Alternative Evaluation is the process by which consumers evaluate alternatives to make a choice. It is felt that, in the case of mental health and psychotherapy, alternative evaluation is more often an integral part of the purchase process itself. A consumer seldom returns a refrigerator, having shopped around before the final decision to purchase a particular model and brand was made. In the case of human services, the initial "purchase" may just be part of evaluating alternatives, and may not reflect a final decision at all. Therefore, articles relating to these two sections of the model have been reviewed together. It is felt that the alternative evaluation component is an underlying factor in many of the other studies as well.

Alternative Evaluation

The following studies have been placed in this section because they reflect some of the dynamics operating in the initial stages of the negotiation to purchase a service.

The process of applicancy, which in mental health is part of evaluating alternatives, was explored by Levinson, Merrifield, and Berg (1967). They defined applicancy as a transaction between an applicant and one or more agents, wherein the transaction itself, the characteristics of the agency, the characteristics of the applicant, and the life situation must all be taken into account. Their question was: on what basis does the selection of patients for a limited number of openings for treatment take place?

Three models of applicancy were studied. The diagnostic model defines the primary purpose of applicancy as diagnosing the nature of the applicant's illness, and on this basis planning an appropriate treatment. The professional is in total control of this approach. This model assumes that everyone who is diagnosed as sick will receive treatment. However, there was no relationship between diagnosis and treatment received, although applicants with less severe diagnosis were more likely to receive treatment.

The suitability model defines the purpose of applicancy as determining which applicants are best qualified for the position of psychotherapy patient at the clinic. The emphasis is on meeting the needs of the clinic, if there is a conflict between clinic needs and applicant needs. Suitability was determined by motivation, psychological mindedness, potential for growth and contribution to

society, a favorable response in the initial interview, and personal appeal, evoking a favorable response in the staff. Suitability and diagnosis were unrelated. Previous hospitalization tended to be associated with low suitability, as was the greater the degree of current impairment.

The help-seeking model addresses the fact that both of the other models ignore the applicant's capacity for affecting the course of applicancy, neglecting the transactional character of the encounter, as well as the fact that any encounter can be a psychotherapeutic intervention. This model focuses on what the applicant wants from and does with the clinic. The decision to continue or terminate the applicancy process is seen as an active, decisive response. The experience of the applicancy process may lead to a re-definition of the problem, or in the evaluation of the clinic as a treatment source. The agency's role is to understand the problem in the applicant's terms. This model was not seen as exerting major influence on clinic policies or staff behavior. A realistic view of clinic procedures and offerings, a psychological self-oriented view of one's troubles, a personal involvement in treatment, and high self-initiative in seeking help are positively related to receiving psychotherapy, with self-initiative being the strongest predictor of outcome.

Levinson et al suggest the development of a new, more comprehensive, theoretical framework for applicancy, that of negotiated consensus. In this model the applicant comes to the

clinic looking for help for his/her problem. The agent negotiates with him/her regarding the nature and sources of the problem, the kind of service that might be helpful, and what the clinic can provide and what the alternatives may be. The participants in this exchange attempt jointly to arrive at a consensus in their understanding of the problems and in their decision about what is to be done. This model seeks to foster activities and skills in both the applicant and the agent. These include: "clarifying the nature and sources of the problems; searching for relevant available help; exchanging information; acknowledging the limits of our therapeutic capacities and the pain that such recognition may occasion; developing genuine mutual interests; and being allied with, but not overwhelmed by, a large organization." This process is felt to provide the best possibility of an applicant's entry into treatment.

Using this approach, Lazare, Cohen, Jacobsen, Williams, Mignone and Zisook (1972), Lazare, Eisenthal and Wasserman (1975), and Lazare, Eisenthal, Wasserman, and Harford (1975), focused on the patient as customer, identifying 15 categories of patient requests, which they defined as representing the patient's hopes or desires. They distinguished these from the patient's expectations, which they suggest represent the anticipation of roles, techniques, duration of treatment, and outcome (Goldstein, 1962). They observed that, in initial interviews, "the complaint is

invariably elicited, the goal is usually elicited, and the request is often not elicited" (Lazare, Eisenthal and Wasserman, 1975, p. 554).

The 15 categories of requests identified from the analysis of several hundred interviews were: administrative requests, advice, clarification, community triage, confession, control, limit setting, medical, psychological expertise, psychotherapy, social intervention, reality contact, succorance, ventilation, and nothing. They suggested that viewing the patient from this perspective makes "treatment" more attractive to a greater variety of people, in that it is more responsive.

They concluded that "customer" is a useful metaphor to describe a relationship in which the patient has the right to ask for what he wants, to negotiate, and to take his business elsewhere if he so desires, while the clinician has the obligation to listen, negotiate, and offer treatment that meets his professional standards. [This] "customer" relationship is in the interest of both parties (Lazare, Eisenthal, and Wasserman, 1975, p. 558).

Eisenthal and Lazare (1976) used Levinson et al's model of negotiated consensus in the development of their "customer approach" to dealing with patients in a walk-in clinic in a large, urban general hospital. They started with the premise that most patients who come to the clinic have an idea of how they would like the clinic to help them. They felt that it is the clinician's task to elicit the patient-customer's request, gather other relevant

data, and then enter into a negotiation with the patient over the request and the overall treatment plan. The negotiation provides material on goals, expectations and motivation not always focused on in the initial interview. With a better understanding of the request comes a greater ability to work toward a treatment plan. Eisenthal and Lazare also proposed that this process provides a look at the patient's preferred working style in a helping relationship. They concluded that, as a result of this approach, both parties feel more knowledgeable, more confident in the treatment plan, better respected and more satisfied.

The purpose of their study was to investigate the effects of the customer approach on the patient according to the patient's own perspective. They noted that there are few outcome studies of the initial interview itself. They found that being satisfied with the interview is more directly connected with being treated as a customer than in finding symptom relief or in getting the plan they originally wanted. They suggested that patients are prepared for productive negotiation, and that they value the active, helping, and collaborative features of this approach. The fact that 81% of the patients were in Classes III-V supports the observation that patients in the lower social classes prefer a more dynamic interaction. They concluded that the customer approach focuses on treatment planning and not treatment itself, and thereby suggest that the tasks of the initial interview which lead to satisfaction need to be distinguished from those of ongoing therapy.

Lazare, Eisenthal and Frank (1976), reporting on this "customer approach to patienthood" in a hospital walk-in clinic, looked at acceptance or nonacceptance, with the patient's requests being the starting point for treatment planning. The initial interview is seen as a process of negotiation. 51% of the applicants were accepted, 10% were told to return as needed, 32% were referred elsewhere, and 7% were told that no treatment was needed.

They found no effect by age, sex, education, occupation, social class, referral source, target complaint, or diagnostic impression on acceptance or nonacceptance. Only clinic status and treatment history were significant. They did, however, find effects on the dispositions made within the outpatient facilities. Patients referred to the psychiatric clinic, as opposed to the social service department, special programs or the walk-in clinic itself, were significantly younger, better educated, higher in social class, more likely to have been diagnosed as having a transient situational reaction, and newer to the hospital. They also tended to be male and to have a household higher in occupational status. Social service referrals were predominantly female.

Their acceptance of 61% of their applicants, as opposed to other rates of acceptance in traditional outpatient psychiatric clinics (e. g. Levinson's finding of 38% acceptance), led them to conclude that such services can be structured to make care

available to patients irrespective of their social characteristics and diagnoses.

Beliefs, attitudes

Other authors approached the patient-screener interaction with a focus on expectations, which are comparable to the beliefs and attitudes components of the model. Their conclusions were somewhat at variance with the "customer approach" theorists.

Heine and Trosman (1960) focused on expectations and their influence on whether a patient continues in treatment. They suggested that mutuality of expectation between patient and therapist was a significant variable. They found that most patients conceive of treatment from a "guidance-cooperation model", while therapists approach it from a "mutual participation" model. Although the latter approach may lead to greater autonomy and independence in the long run, the authors suggest that greater attention to the patient's expectations in the initial stages of treatment might lead to greater sticking power.

Overall and Aronson (1963), looking at expectations and the lower classes, did a six-month survey of new patients, 57% of whom dropped out after the first interview. They cited Hollingshead and Redlich, who found that almost all Class V neurotics drop out of treatment, in part because they expect the doctor to assume an authoritarian stance and tell them what to do, and magically make them better. Following this concept, Overall and Aronson hypothesized that the greater the discrepancy between

the patient's expectations and their perceptions of the treatment, the greater the likelihood that the patient will drop out.

They studied 40 patients in Classes IV and V who came to an outpatient psychiatric clinic. The patients filled out a questionnaire before their first interview covering their expectations regarding the level of the therapist's activity, his/her focus on medical issues, his/her degree of support, the degree of activity of the patient, and the degree to which the therapist focuses on psychiatric material. The questionnaire was again completed at the conclusion of the interview plus three questions covering whether the patient found it to be a positive experience. The therapist also filled out a questionnaire. Their sample showed that the discrepancy scores were significantly greater for the No Return population. They concluded that lower-class patients predominantly expect a medical-psychiatric interview with the therapist generally assuming an active but permissive role. They suggested that the dropout rate might be reduced by re-educating the lower class applicant as to both their role and the therapist's role in the treatment.

Flester and Rudestam (1975) looked at the early dropout process using a multivariate analysis. They looked at the joint interaction of patient demographics and pretherapy expectations, therapist demographics, and the patient's perspective of the therapy process for two groups of patients. The patient samples were similar as to age, sex, and social standing. They concluded

1) many patients get what they wanted in one or two sessions and
2) therapist treatment approaches may influence the drop-out rate, particularly among the lower class patients and those who report themselves as seriously disturbed. Those who come looking for guidance and help in dealing with "today's" problems may be turned off by a more traditional, psychodynamically oriented approach. They also suggest that external events may play a part in termination decisions.

Horenstein and Houston (1976) investigated the relationship between the expectancy-reality discrepancy and premature termination. Significant inverted-U relationships were found between expectancy confirmation scores and dropout groups, revealing that those who dropped out after the initial contact exhibited the least expectancy confirmation. Those who dropped out after the second contact exhibited the greatest expectancy confirmation, while those who remained in treatment exhibited an intermediate degree of expectancy confirmation (p. 376). Differences between their findings and those of others were attributed to social class, with lower class subjects having a linear relationship between expectancy confirmation and dropping out.

Intentions

As every initial contact does not result in a "patient", attempts have been made to see what people did, who did not

follow through with their application for treatment at a particular clinic.

Brandt (1964) contacted 155 former applicants from three clinics who had withdrawn their requests prior to being seen. He found that 63 of the 100 subjects reached had entered psychotherapy elsewhere. He called them pseudo-rejectors, and questioned the attempts to find a test to determine who will stay in treatment, as he found two distinct groups, those who go elsewhere and those who change their minds about treatment.

Riess and Brandt (1965) studied 500 consecutive applicants for therapy at the Postgraduate Center for Psychotherapy in N.Y.C. 26.6% of the applicants never showed up for their intake appointment and 11% had intakes, but withdrew before treatment. Almost one-third of those contacted on follow-up reported that they had gone elsewhere for treatment, indicating that they had not rejected therapy, only a particular clinic. Of the 25 patients who terminated treatment before the seventh session, 92% indicated that they did not seek treatment elsewhere, reflecting a difference between the two groups. They suggested that frequency of sessions needs to be looked at, in order to better understand the dropout process. They found that patients who attend more sessions per week have a lower dropout rate. They also suggested that cut-off points seem to be somewhat arbitrary, and that the more significant differences between groups begin to emerge using time frames, e.g. before six weeks and after twenty-five weeks.

Noonan (1973) studied people who made appointments for first interviews, but never showed up. Comparing them to a demographically similar group, he found that the dropouts gave vaguer descriptions of their presenting problems, and that 70% of his 64 dropouts reported an improvement of their emotional status. 39% of the dropouts could give no specific reason why they failed their appointments, and 35% reported improvement in their condition, with neither group contacting any other treatment source.

Individual characteristics and social influences

The person, and his/her environment, must also be considered as factors influencing the decision process. Individual characteristics include motives, values, life-style, and personality. Social influences include culture, reference groups, and family. Most of these variables have been studied, in an attempt to understand their influence on terminating or remaining in therapy.

Albronda, Dean, and Starkweather (1964) focused primarily on social class comparing three groups of patients over a five year period: those who continued, those who declined interviews, and those who dropped out. No differences in their social class distribution were found, although they did seem different in the stability of their social adjustment. They did not select out any patients based on models of treatability, e. g. demonstrating sufficient motivation, intelligence, or past adaptation. 74% of

their 384 patients were in the two lower classes, using the Hollingshead scale. They concluded that "neither 'psychological mindedness' nor readiness for self-examination is significantly related to economic circumstances or education" and that both can be taught and learned.

15% of their applicants did not show up for their screening interview. They had a higher rate of divorce or separation, were less affluent, and had more often been referred for psychological help after having sought treatment for somatic complaints. 20% of their patients dropped out. They were older and more stable in their general life situation than the other two groups. They observed that the point of measurement was significant, in that early in treatment the upper class cases had fewer drop-outs and were considered more improved, but over time these differences leveled off. They concluded that the longer a patient remained in treatment, regardless of social class, the greater the probability that he/she would be helped.

Brandt reviewed the literature on dropouts as of 1965, to see what variables had been consistently found to be significantly related to treatment persistence. Comparison of these studies was complicated by the fact that "dropout" was not clearly defined, e. g. did the patient stop coming or were they terminated by the therapist? Looking at 25 studies in the literature, he found that pre-therapy dropout varied from 3% to 35%. 50% of the patients in therapy dropped out between the third and forty-fourth session.

Because the methods of reporting, and the circumstances of each clinic were so varied, comparisons could not be made between these studies.

Of 29 variables investigated, only sex, age, and marital status consistently did not differentiate between dropouts and remainers. The only variable which consistently differentiated between these two groups was "personality characteristics", which were not consistently defined or measured from one study to the next. One study by Weinberger and Gay (1949) seemed to show that intake process is related to dropout, in that, by changing their intake procedure, they decreased their dropout rate from as high as 76.5% to 39.6%. (Peterson, 1982, reported that preappointment reminder calls decreased the no-show rate for first appointments from 25% to 10-15%).

Brandt also looked at pre-therapy dropout studies, but found the literature lacking, in that it is almost impossible to follow up on these people.

Brandt included one of his own studies, wherein he found that post-intake dropouts presented their problems as lying in the environment rather than in themselves, and used fewer words and verbs when writing about their problem, as compared to those who continued on in treatment. He also found that those who continued had slightly more education and fewer had previous therapy than the dropout group, which contradicted findings by Rosenthal and Frank (1958). He concluded that "perhaps the distinction between

rejectors, early terminators, and those who remain in treatment until some desired changes have occurred, is an artifact: persons who have applied for psychotherapy are at various stages of a complex decision-making process" (p. 10). He advocated replicating studies, in order to provide variable consistency.

Demographics were the focus of Flester, Mahrer, Giambra and Ormiston (1974). They found that dropouts from a community mental health clinic were demographically similar to those who remained in treatment. They discovered a population of persons who "have minimal experience with community mental health facilities, who try out one agency, recoil from its services after one or two contacts, and avoid further mental health facilities" (p. 178). They add support to Mahrer's proposal of a group of people looking for what typical mental health facilities do not provide (1972), who do not want what these facilities do offer (1970a), or who only need one or two sessions of clinic contact (1970b). They suggest that demographics are not the critical factors, and that the need is to identify those factors that determine whether or not a person will drop out, in order to broaden the base of client utilization. Implied is that current services are structured to serve only a small population segment.

Carpenter, Morrow, Del Gaudio, and Ritzler (1981) found that psychiatric screening applicants who kept their initial appointment (759) differed from those who did not (347) in age, previous psychiatric treatment, source of referral, chief

complaint, and number of days they waited for an appointment. They speculate that patients' absences may be the result of a complex interaction of demographic, clinical, and "treatment system" variables. Being referred by a significant other resulted in a better attendance record than those being self-referred, referred by a psychiatric emergency room, or referred through a crisis telephone source. This supported the findings of Adler et al (1963), who found that referral by a family physician, family, or friend resulted in a significantly higher attendance rate. Giving evasive and vague reasons for wanting to seek treatment was found to be significantly related to failure to keep an appointment, which agreed with Noonan (1973). A follow-up of those who did not keep their appointment found that about half of them had sought treatment, either at the same facility or elsewhere.

Client factors related to premature termination were investigated by Hoffman (1985). Three variables were found to be significantly related to premature termination: diagnosis, presenting problem and previous psychiatric experience. Clients with a diagnosis of psychotic were less likely to be terminators. Clients with a presenting problem of thought disorder were more likely to remain, while clients with presenting problems in the area of interpersonal relationships were more likely to terminate. Clients with previous psychiatric contact were more likely to remain. Hoffman suggests that more community education might

make potential clients more comfortable in making a decision about using counseling services.

Greenspan and Kulish (1985) found that premature terminators were found to differ significantly as to age, race, referral source, employment, type of payment, presenting complaint, and diagnosis, but not as to sex, residence or marital status. Looking at the therapists involved, they found that Ph.D.s had lower rates of premature termination than M.D.s or M.S.W.s, as did those who had had personal therapy. They found no difference with relation to therapists' defense style and personal life stresses, age, sex, or years of experience. Premature terminators were more often black, not middle-aged, referred by a professional from within the clinic, had their treatment paid for by insurance, were employed by an automobile company, entered treatment with initial complaints of family or marital discord, and were given the diagnosis of depressive reaction. They were more likely to perceive their problems as situational and/or external to themselves, and generalized the primary patient factor as relating to motivation. They concluded that therapists and patients each make different contributions to premature termination, and that focusing on the effect of different matchings of patients and therapists might be worthwhile.

Outcome: Satisfaction, Dissatisfaction?

There have been few studies done of the actual outcome of treatment, from either the therapist's or the patient's perspective.

Focus has instead most often been directed to who stays in treatment, and who leaves. Outcome, therefore, refers to whether or not a person becomes a patient. Situational factors may play a significant role in whether someone stays in therapy or not, and the parameters of the therapy itself become one of the factors to be considered.

Outcome

Many studies have been done on the rates and reasons for applicants dropping out of treatment. "Drop out" has not always been consistently defined, but in general it refers to someone leaving a relationship with an agency without mutual agreement. In the Garfield and Kurz (1952) report, 43% attended four sessions or less, and 67% attended nine or less. Myers and Schaefer (1954) found 54% of their 114 patients stayed less than ten weeks. Kurland (1956) stated that 29% of his applicants did not start the first session. Nash (1957) indicated that, of 48 patients, 20, or 42% attended four or less sessions. Rosenthal and Frank (1958) reported that 35% of their sample did not accept treatment when it became available. Gallagher and Kanter (1961) reported similar findings, with 26% of their 299 patients not attending one appointment after screening, 30% not attending more than 2 or 3 sessions, and only 16% attending more than 21 appointments. A large-scale study by the National Center for Health Statistics (1966) reported that for 979,000 Americans who consulted a psychiatrist during the twelve month period from July, 1963 to

June 1964, the average number of visits was 4.7 (Greenspan and Kulish, 1985, p. 75).

Gundlach and Geller (1958) question whether the termination problem really reflects the kinds of problems the staff is interested in, or skilled at handling. They note that their clinic focused on particular types of clients, and had a 6% rate of termination after 1-5 sessions, dramatically lower than other reported rates. Their focus was conducive to patients whose problems inclined them to remain in treatment for extended periods of time.

One of the problems inherent in comparing these findings is made clear by the report by Lief, Lief, Warren, and Heath (1961). Their drop-out rate was 6% for 5 or less sessions, with 87% having 10 or more sessions. At their clinic every intake was conferenced by the same person. They also saw patients 2-3 times per week, with some being seen 1 or 4 times a week. Frequency, as well as modality, become potentially influential variables when looking at percentages. They question whether a patient coming once a week for 10 weeks can be compared to a patient who came 4 times a week for two and a half weeks.

Situational influences

Dengrove and Kutash (1950) explored some of the reasons for termination of treatment of VA patients in New Jersey. They identified factors attributable to the patient: poor motivation, dissuasion by others, not being able to "take" treatment, inadequate

personality, antagonism to doctors and/or VA personnel, not paying from their own pocket, and mechanical reasons, such as moving or time conflicts; factors attributable to the therapist: countertransference, poor technique, and personality conflicts; and factors attributable to management: errors in therapeutic technique, passing through too many hands, lack of therapeutic means, missed appointments by therapist, short duration of interviews, physical set-up of clinic, lack of trust, and psychotherapy being oversold. They conclude that the solution to many of these interacting factors are self-evident, particularly those having to do with the therapist and the organizational structure.

In addition to confirming other studies regarding the higher drop-out rate for the lower classes, Cole, Branch, and Allison (1962) identified several factors which they felt discriminated against the lower class applicant. The waiting list, which works against the need for immediate gratification associated with the lower class, the distance from the clinic and potential loss of time from work, the need for child care, and the threat posed by the clinic to the lower class male, along with general hostility to agencies, all contribute to the lower rate of continuance for this group of applicants.

They also cite personality characteristics which are indicative of the "good" patient, noting that many of these reflect middle class values. They suggest that more attention might be

paid to matching patients to therapists with compatible values, and note that the tendency to assign lower class patients to social workers might reflect a "tacit recognition that these people are more able to participate with these patients" (p. 1011).

Hunt (1960), Hornstra, Lubin, Lewis, and Willis (1972), and Kaufman (1985) also speak to this issue of patient-professional values and fit. Evers (1985), by contrast, found that client-therapist fit did not predict dropouts, but that client satisfaction with the therapist was a useful predictor of dropouts.

Therapist contribution to the drop-out process with lower socioeconomic patients was studied by Baum, Felzer, D'Zmura and Shumaker (1966). Their experienced therapists had a dropout rate of 16% before the sixth session, whereas their inexperienced therapists had a dropout rate of 46%. They noted that the more experienced therapists were able to approach the patient on a relationship level and in a flexible manner, according to the needs of the situation, whereas the less experienced therapists were more rigid and less aware of the therapeutic interactions in the interviews.

They also found that inappropriate referrals, lack of support of the referral source during the critical early phase of treatment, unrealistic expectations on the part of the patient, overwhelming reality problems, lower intelligence and capacity to fantasize, resignation to the problem, social stigma, crisis orientation, and

expectation of rejection were other factors contributing to the dropout process.

Negative second-order effects of treatment identified were by Graziano and Fink (1973). They included the negative impact of labeling someone as mentally ill, both in terms of society's response and in terms of the labeled person's self image. People may become secretive in order to avoid social stigma, or may incur negative feedback from family members. Financial responsibility, potentially results in the need to curtail other expenditures, depletion of savings, and debt. They speculate that it may not be that the first-order effects of treatment are so bad, but rather that the negative second-order effects of being in treatment reduce their effectiveness. They recommend greater attention to these negative effects in the planning and implementation of treatment.

The effect of modality assignment on treatment acceptance was investigated by Hargreaves, Showstack, Flohr, Brady, and Harris (1974). They looked at assignment to individual therapy, group therapy, or an interim brief treatment group. They found that individual therapy led the other two modalities in show rate, and in ratings of therapy helpfulness. Poorly motivated clients were less likely to accept group therapy. They caution, however, that they examined initial acceptance only, and not what happened a few sessions later, noting that some clients who were initially unhappy

about their group assignment, later reported it to have been helpful.

Lothstein (1978) looked at group therapy dropouts, reporting a 29% rate in her two-year study. She found that the therapists disliked the patients who dropped out, and that many of these patients were seen as hostile toward the therapists. She suggests that the dropout phenomenon may serve a positive clinical function for increasing the integrity of the group while increasing group cohesion. She found that after the 12th session, the group stabilized and dropouts were no longer an issue.

Betz and Shullman (1979) examined the relationship of client sex, intake counselor sex and experience level, and the sex of the treating counselor to the percentage of clients returning for counseling following an intake interview. 24% of the 141 subjects interviewed failed to return following intake. They found that subjects were significantly less likely to return when initially interviewed by male counselors, and were also significantly less likely to return when interviewed by male counselors and then assigned to male counselors for therapy. No significant relationship was found between counselor experience and return rate.

Krauskopf, Baumgardner, and Mandracchia (1981) attempted to replicate Betz and Shullman's findings. They did not find significant sex differences, and expressed more concern as to why

counselor experience does not seem to make a difference, and why so many clients fail to return to further treatment.

Another replication, by Epperson (1981), found that male counselors had higher return rates than female counselors. They used a different criteria for dropout, noting that clients who fail to return for their first appointment, do often come to their second or third. They suggest that individual characteristics other than gender per se might be more useful in understanding the patient-therapist interaction and outcome.

Folkins, Hersch and Dahlen (1980) studied waiting time and no-show rate of clients in a community mental health center. A highly significant relationship between waiting time and appointment keeping behavior was found. For those who kept their appointments, the number of treatment contacts after three months was not significantly different related to waiting time. The writers suggest that those who wait longer may resolve their crises on their own. They also note that if follow through is quick, the image of accessibility and thus effectiveness of the center would be enhanced.

Acosta (1980) looked at the reasons for termination of Mexican American, Black American and Anglo-American patients, noting that minority patients are still more likely to terminate therapy prematurely. The three groups were not significantly different in the reasons given for leaving therapy, citing negative attitudes towards therapists and perceiving therapy as no benefit

as the major reasons. Environmental constraints was also given by a considerable number of subjects. Anglo-Americans were most likely to get therapy someplace else, and all three groups thought therapy might be useful for someone else, if not for themselves.

Reder and Tyson (1980) reviewed the literature on dropouts from brief and long-term individual psychoanalytically oriented psychotherapy and psychoanalysis. Using unilateral patient termination as a criteria for dropping out, they found the rate decreased from long-term psychotherapy, to brief psychotherapy, to psychoanalysis. The analysis of the literature was hampered by a lack of definition of the type of treatment employed. They suggested that the high rate of attrition from long-term psychotherapy is because these patients might have more appropriately been assigned to brief psychotherapy. No consistent findings were noted relating to frequency of sessions. They also suggested that selection criteria may account for the different rates of premature termination at different clinics, with this selection process being poorly reported in the literature.

They also refer to the setting of treatment, citing ongoing theory regarding payment. They suggest that the issue is no longer who pays for the treatment as much as what the meaning is to the individual patient. Whether the setting carries a stigma associated with mental illness may also be a factor. They conclude that "premature" dropout from psychotherapy may really reflect symptomatic improvement or maximum gain for that patient, and

that, as Hollender suggested (1964), some patients have started treatment, but they have not really "entered" it. The first ten to twenty sessions may, in fact, be a trial period.

Who pays for the treatment and the impact on its duration was studied by Carpenter and Range (1983). Their sample was divided into Medicaid, insurance, insurance plus self-payment, and scaled self-payment only. They found that scaled self-payment patients had significantly more sessions than those whose fee was paid by Medicaid. However, analysis by education and sex, which were highly correlated with payment source, accounted for most of the difference in treatment duration. Medicaid patients had lower education levels and were primarily female. They suggest that the findings indicate the need to investigate psychotherapy process and outcome on multivariate rather than univariate levels.

In another study (1982), they investigated the relationship between duration of outpatient psychotherapy and therapists' professional affiliation, sex, democratic values, and community mental health ideology. They concluded that these therapist variables alone account for very little of the variation in the outcome of psychotherapy.

Rodolfa, Rapaport, and Lee (1983) investigated the influence of sex and experience level of intake and assigned counselor, sex of client, and administrative variables on premature termination. Their results indicated that length of initial interview, days from intake to assignment, and level of assigned counselor were the only

significant factors related to premature termination. Shorter intake interviews, shorter time from intake to assignment, and more experienced counselors were associated with client return following intake. They state that the factors accounting for premature termination are not accounted for in this setting by gender variables.

Kolb, Beutler, Davis, Crago and Shanfield (1985) assessed the relationship between pretherapy patients and process variables and change. They found that process variables rather than preexisting patient traits were the best predictors of outcome. In relation to premature termination, they found that preexisting patient variables were significant only on patient locus of control scores. Premature terminators had higher scores on levels of expected internal control in interpersonal relationships. Kolb (1981) also found that internals were more likely to drop out than externals, and that those who remained perceived a better quality of therapeutic relationship, and became more involved in the treatment.

Several process variables distinguished remainers from terminators. Premature terminators rated their therapists as having fewer facilitative relationship skills and were rated by their therapists as having been both less involved in therapy and as having received less directive support than those who remained in therapy (p. 707). It was also noted that there was little relationship between remaining in treatment and either

symptomatic or global improvement. Kolb et al cite Garfield's (1978) suggestion that patients drop out for many reasons, only one of which is that the relationship is not benefiting them.

Satisfaction, Dissatisfaction: Success or Failure?

Garfield (1963) studied 24 terminators, 12 of whom left treatment prior to the seventh session. Six of the early terminators gave external factors as reasons for terminating, while three felt that the therapy was not helping. He notes that both groups reported getting along well, with the early terminators giving more favorable reports. May (1984) suggests that terminators (less than 6 sessions) may be unspoken successes, in that early terminators experienced positive change. Moras (1985), on the other hand, found that subjects who attended less than 5 sessions were treatment failures.

Bent, Putnam, Kiesler and Nowicki (1976) explored correlates of successful and unsuccessful psychotherapy. They pursued Strupp, Fox, and Lessler's (1969) finding that a positive attitude toward the therapist proved to be closely related to success in therapy. They found that those patients who were very satisfied with therapy, as opposed to those who were not very satisfied, described their therapists as warmer, more likeable, more active, and more involved. They also saw a generalized and noticeable effect on their behavior.

Silverman and Beech (1979) followed up on 47 dropouts who had attended only one session at a community mental health clinic.

70% were satisfied with the services they received. 79% reported that their presenting problem had been solved, including some clients who were not satisfied with the services they received. Those reporting problem solution noted that other, non-treatment sources had also been of help, such as friends and family. 74% had expectations of receiving personal interest from their therapists, 69% insight, and 55% advice. Satisfaction was significantly related to confirmation of expectations. More women than men reported being helped by the clinic. Emergency room referrals reported receiving more help than those clients with a formal appointment. They conclude that crisis intervention was an appropriate treatment for these dropouts, who are not necessarily treatment failures, or dropouts, at all.

Lippman (1983) states that the arbitrary cutoff between terminators and remainers is not valid. He found that terminators felt good, but not as good as remainers.

Pekarik examined the belief that clients who drop out are treatment failures. He followed up on 46 dropouts 3 months after they terminated treatment (1983a). He found that 39% quit due to "no need for services", 35% due to "environmental constraints", and 26% due to "dislike of services." All of the clients had filled out a Brief Symptom Inventory at the time of application, and this was again administered at follow-up. The "no need for services" group and the "environmental constraints" group had significant decreases in BSI scores, whereas the "dislike of services" group

showed no significant change. He suggests that dropouts are not a homogeneous group, and do improve despite leaving treatment.

In a second study of 89 dropouts (1983b), he found that one-session dropouts had an extremely poor follow-up adjustment, while those with three or more visits had quite good adjustment. He suggests that symptom reduction should be looked at in reference to treatment impact, rather than just therapist-judged appropriateness of termination.

Pekarik and Finney-Owen (1987) looked at therapists' attitudes and beliefs regarding dropouts. They found that therapists preferred a treatment duration longer than that expected by clients (11-21 versus less than 10 visits), and overestimated actual treatment length by 2.5-3.0 to 1.0. They underestimated actual dropout rates for their clients and for their clinic (estimated 30.3-31.3% versus actual 57.0-64.1%), and cited dislike of therapy or the therapist less often than clients as reasons for premature termination (11% versus 26%). Pekarik and Finney-Owens suggest that these discrepancies may account for the lack of attention given by psychotherapists to the dropout problem.

To conclude this section, the study by Baekeland and Lundwall (1975) provides an overview of the state of our knowledge regarding drop-outs, using traditional orientations. Baekeland and Lundwall did a critical review of the dropout literature on six treatment groups (medical, psychiatric, drug, e. g.) covering a

twenty year period. Only the outpatient psychiatric findings are summarized here. They addressed the findings that between 20-57% of all patients failed to return after the first visit. They noted the significance of understanding these patients better, in that they are the typical patient. Definitions have confounded comparisons of studies, in that dropout was not always clearly defined, and readmissions were often treated as being the same as new admissions. Patient selection criteria were often omitted, as well as the effects of waiting lists and attrition therefrom. Patient demographics also potentially influenced results, as well as an institutions's staffing, admission procedures, and treatment methods. Differential case assignment could have been be a factor, with a high probability that case assignment was biased. They suggested that between-treatment or between-therapist differences in patient characteristics should be a routine part of data analysis. They cautioned that a certain number of significant differences can be obtained by chance. Labeling a dropout as an automatic treatment failure was challenged because of the assumptions that such a patient is forever lost to treatment, that improvement is directly proportional to number of sessions, and that spontaneous improvement does not take place (p. 743). Studies have found that between 21-46% of patients who do not attend the first session end up in treatment elsewhere within the next year.

Grouping studies together by variables, Baekeland and Lundwall found few consistent findings. They did find that 13 variables or clusters of variables turned up consistently: age, sex, socioeconomic status, social isolation and affiliation, social stability, symptom levels and symptom relief, aggressive and passive-aggressive behavior, sociopathic features, motivation, psychological mindedness, behavioral and/or perceptual dependence, therapist attitudes and behavior, and family pathology, attitudes and behavior. Of 20 studies of temporal variables (how long a patient is in treatment), 10 found positive relationships between temporal variables and outcome, and 10 did not. Age was related to dropping out in 3 studies, but not in 1 other. Female patients were more likely to drop out in 4 studies. Socioeconomic status was predictive of dropping out in 16 out of 18 studies in clinics where psychoanalytically oriented psychotherapy was emphasized. No relationship was found in settings where this treatment was not used. Psychiatric diagnosis was found to be significant in 5 studies, but not in the other 4 looking at this variable.

The dropout has been described as poorly motivated, less inadequate and inferior, less likely to have had previous treatment, less likely to be self-referred, less psychologically minded, and more likely to come with a chief complaint of an isolated somatic symptom. S/he is more defensive, less objective about him/herself, has limited verbal productivity, censors emotions,

and is disinclined to express ideas dealing with human activity. The dropout is less suggestible, conforms more to cultural stereotypes of masculinity and femininity, and has a high need for approval.

Other variables studied included extra-patient variables, including the personality of the therapist, delays in case assignment, therapists' attitudes toward their patients, therapists' expectations of patient improvement, interruption of the therapeutic relationship, and responding to patient expectations of treatment. Another approach addressed the dependent and independent needs and styles of both patient and therapist, and the match between male and female patients and therapists. The therapist most likely to lose his/her patient is less experienced, more ethnocentric, dislikes his/her patients or finds them boring, and does not give lower SES patients medication (p. 759).

They recommended that waiting lists should be eliminated and immediate admission be offered, satisfying the patients' dependency needs by offering as wide a range of ancillary services as possible, and offering a wide range of treatment modalities and applying to the patient the one most suited to him/her, rather than the one easiest or most readily available.

As has been shown, many variables have been studied in the attempt to understand the complicated process that is involved in a person deciding whether s/he has a problem, and if so, what to do

about it. What has not been focused on is the process itself, what influences how the consumer/patient moves from problem recognition to problem resolution, and the various steps along the way. Such knowledge may provide the "glue" that binds some of the variables covered in the above studies together, and makes them more usable when developing and marketing services.

The next Chapter provides a description of this study, which followed a consumer behavior perspective, using the EBM Decision Process Model of Consumer Behavior as its framework.

IV. The Project Setting, Design and Methodology

Overview

In this Chapter, the departmental framework within which the project was implemented will be described, the applicancy process from the hospital's perspective will be detailed, the design of the project will be outlined, the methodology of its implementation will be delineated, and the plan for data analysis will be set forth. The sample will be described demographically, and will be compared to the population using the AOPD from November 1987 thru October 1988.

The Adult Outpatient Department (AOPD)

The population used in this project comes from the Hauberk AOPD. Approximately 300 patient visits are recorded each week, or slightly over 17,000 a year (for the past three years). Social Workers are the only full time treating staff, and their caseloads include 20 individual cases (including marital or family cases) and three groups, with a maximum of eight members per group. Most individual cases are seen once a week, although Residents see some cases in twice a week therapy. Patients requiring medication are usually seen for such monthly, by a Resident or Staff Psychiatrist, unless need dictates more frequent visits. These visits are in addition to their regularly scheduled treatment.

The AOPD is open officially Monday from 9 AM to 9 PM, and Tuesday through Friday from 9 AM to 5 PM. Workers who find it convenient to work

late on a different night may do so, which adds greater flexibility to patient scheduling. With all new employees being required to work two late nights, further options have been added. Evening hours were originally reserved for group therapy and family or marital cases. With the increase in evening time, some individual sessions are now also available.

Payment is on a sliding fee scale, based on gross income. Any insurance coverage is assigned to the AOPD, to cover the difference between the full fee for treatment (currently \$75 per individual visit) and the patient's pro-rated fee. The AOPD also accepts Medicaid and Medicare. The AOPD would like to attract more patients with insurance coverage, in order to increase their total revenue.

There is an extensive MIS program, which collects such data as age, sex, marital status, education, household composition, source of referral, previous treatment, diagnosis, and type and length of treatment of all applicants. Aside from reports generated for accountability purposes, there has been very little use made of this information in relation to identifying the current AOPD population or developing strategies for attracting those patients who meet the needs of the clinic.

The Applicancy Process

All calls related to the AOPD are handled by one worker in the Central Intake department, which handles applicants for every program at Hauberk. Originally, any Central Intake worker might handle calls for the AOPD, but it was decided that having a specific worker consistently handle these calls would create a greater investment and interest in this service, as

well as provide a more knowledgeable worker to whom callers would speak about this specific service.

The Central Intake worker for the AOPD received 728 calls in the months from November, 1987 to April 1988, the time frame used here. There was an average of 122 calls a month regarding outpatient services, with variations ranging from a low of 65 calls to a high of 155 calls per month. 458 calls were from women and 180 calls were from men. 61 of these women and 19 of these men were calling for someone else. Ninety calls were from referring professionals, for a total of 728 calls. Some of these callers potentially require immediate intervention, and are referred to the Walk-In Clinic, where they can be seen for evaluation the same day. Others are calling for information, for other people, or for private referrals. Those who are interested in applying for treatment in the AOPD are scheduled for a screening appointment, which may be available in a few days, or a few weeks. Professionals call either in reference to someone in particular, or to get information about our programs for future reference. If they want to refer someone to the OPD, the person being referred must call Central Intake before they will be given an appointment for a screening. Calls from professionals were not included in this project. Table 1 provides a breakdown of the disposition of the calls, which are divided into those who called for themselves (S), and those who called for someone else (O). Those who called for someone else are grouped according to the sex of the caller, not the sex of the person for whom they were calling.

TABLE 1
DISPOSITION OF CALLS TO CENTRAL INTAKE

Disposition	Called for self		Called for other		Totals	
	Female	Male	Female	Male	T-#	%-T
Information	102 (26%)	19 (12%)	13 (21%)	5 (26%)	139	22%
Referral	75 (19%)	27 (17%)	12 (20%)	7 (37%)	121	19%
Walk-In Clinic	45 (11%)	24 (15%)	20 (33%)	3 (16%)	92	14%
Screening	116 (29%)	56 (35%)	6 (10%)	0	178	28%
Left Message	35 (9%)	21 (13%)	3 (5%)	4 (21%)	63	10%
Denied Calling	0	2 (1%)	1 (2%)	0	3	0.4%
Not reached	21 (5%)	11 (7%)	6 (10%)	0	38	6%
Direct Re-open	3 (.8%)	1 (.6%)	0	0	4	0.6%
Subtotals: Self-397		161	Other-61	19	Total: 638	

Of the 638 calls received in the six month period being used, 178 directly resulted in screening appointments being scheduled. Another 21 were referred for screenings when they went to the Walk-In Clinic, for a total of 199 (31%) screening appointments. Table 2 shows the outcome of these screening appointments.

TABLE 2
SCREENING APPOINTMENT OUTCOME

Outcome	F	%	M	%	Total	%	% Calls
No Show	12	9	2	3	14	7	2%
Subject Cancelled	26	19	5	8	31	16	5%
Clinic cancelled	5	4	1	2	6	3	0.9%
Screened only	22	16	18	30	40	20	6%
Not accepted	1	0.7	0	0	1	0.5	0.2%
Referred	4	3	5	8	9	5	1%
Started Treatment	21	15	10	17	31	16	5%
Five sessions or more	46	33	19	32	65	33	10%
Screened before	2	1	0	0	2	1	0.3%
Subtotals:	F=139		M=60		Total:199		30.4%

As can be seen from Table 2, almost three quarters (146) of these appointments are kept. 66% of those screened (96) begin treatment in the AOPD; 67% of those who begin treatment stay for 6 sessions or more. From a different perspective, of the 638 eligible calls to Central Intake, 96 callers (15%) will come into treatment, and 65 callers (10%) will still be involved with the AOPD after 5 sessions.

One question which this raises is what happened to everybody else who called Central Intake? Why do some people start and stop, and why do some people continue? This project attempts to understand the process involved in the decisions about treatment made by some of these people.

The Project Design

The Sample

The Central Intake worker handling calls for the AOPD keeps a record of every call she receives, with the date of the call, the age of the caller, the presenting problem, and the disposition of the call. The sample used for this project was drawn from her record of calls, beginning with November 1987, through April 1988. Of the 728 calls received, 449 were determined to be eligible for this study. To be eligible, a caller had to be calling about outpatient services for him/herself, because the questionnaire relates to making decisions about one's own problems. Excluded from consideration were people who were calling for someone else (82), people who were in treatment elsewhere (29), people calling about a particular study being conducted by our Research department (11), people requiring hospitalization or medication only (13), all professional calls (90), people who were deemed inappropriate either by the Central

Intake worker or this writer because they were too fragile or too paranoid (17), people who were not really calling for Outpatient services (9), and people who did not fit the criteria for miscellaneous reasons, e.g it was not clear if they were calling for the AOPD or another clinic, they could not be reached by phone, or they had been verbally abusive to the Central Intake worker (28). These excluded calls totaled 279.

The eligible sample included 320 females (71%) and 129 males (29%).

The Method of Data Collection

An exploratory questionnaire was designed to elicit information regarding the process callers went through in the decision whether or not to use the services of the AOPD. Whether they chose to continue with the AOPD or not, the questionnaire attempts to follow the process involved in their decisions as to what to do about the problem for which they originally called. (See Appendix A for a sample of the questionnaire.) The questionnaire was based on the EBM model of the decision process used in consumer behavior research.

Data collection began between three and six months after the initial call to Central Intake.

Two approaches were used to collect the data. Callers who were not currently in treatment in the AOPD were contacted by phone to see if they would be willing to participate in the study. This approach was used for several reasons. One reason was that the questionnaires were to be mailed, and the caller's address was not known. Secondly, it was felt that the questionnaire should not be sent to anyone without their prior approval, because of the confidential nature of their contact with the

hospital in the first place. (Some people do not like to be contacted at home at any time.) The third reason was to hopefully cut down on the usually high rate of non-responses to mail surveys because of the high cost of mailing the questionnaire, which included a stamped return envelope. (For a sample of the script read to each person called, requesting their participation, see Appendix A.) Everyone who agreed to participate was sent a questionnaire and asked to respond as soon as possible.

Contact with the people currently in treatment began with the therapist being contacted in writing to see if s/he had any objections to his/her patient being approached for this study. (See Appendix A for a copy of this letter.) If approval was given, the patient was approached. This was originally done by leaving a letter at the reception desk where the patient checks in before his/her appointment, asking him/her to respond as to his/her willingness to participate. At first it was thought that this writer would conduct the interviews in person. However, responses to this approach were extremely low. It was suggested that patients might be more willing to participate if they could take the questionnaire home and answer it at their convenience. The procedure was revised by giving the questionnaire to the treating therapist to give to the patient, who could then return it to the therapist, or leave it at the reception desk, from where it would be forwarded to the writer. (See Appendix A for samples of the cover letter sent to the callers with the questionnaire when they agreed to participate, and the letters given to the

patients 1) asking for their participation and 2) covering the questionnaire given to them.)

Approximately 511 calls were made to the eligible sample. Each person was called from one to three times, on different days, and at different times of the day. 162 people were not contacted. Time constraints prevented continued attempts to reach them. An additional 49 people had changed their phone numbers, had given the wrong number, changed jobs, or moved, and therefore could not be reached. 190 people were reached. 153 (81%) agreed to participate and were sent questionnaires. 37 refused. 48 callers were in treatment in the AOPD at the time of the study. 4 therapists did not feel that their patient should participate. 3 patients directly refused to participate. 41 patients were given questionnaires.

In summary, of the 449 people in the eligible sample, 194 (43.2%) received questionnaires. A total of 69 questionnaires were returned, for a return rate of 35.6%. 49 of these returns were from the mailed questionnaires and 20 were from those given to current patients from the eligible sample. 54 (78%) of the returned questionnaires were complete enough to be included in this study. Consequently, the data is drawn from 27.8% of the sample receiving questionnaires, or 12% of the eligible sample.

A second, accidental sample was drawn from those patients currently in treatment in the AOPD, who were not part of the original eligible sample. The six Social Workers in the AOPD were asked to introduce the study to all of their patients and ask them to participate. Any patient who

agreed was given a questionnaire. Despite instructions to the contrary, there was a great deal of selectivity in this process, except by this writer, who was one of the Social Workers. Workers made their own assessment as to who might be willing to fill out the questionnaire, based on who they thought would be interested, or who they thought would make a good subject for the project.

From a total caseload of approximately 210 cases, 82 questionnaires were distributed. 31 were returned, of which 26 were usable. In percentages, this means that 39% of the AOPD patient population received questionnaires, and 38% of those patients returned them. The 26 usable questionnaires therefore represent 12% of the eligible AOPD population.

Combining the two samples, there were 276 questionnaires distributed to an eligible sample of 659 people, for a distribution rate of 42%. 100 questionnaires were returned, for a return rate of 36%. 80 questionnaires were usable, representing 12% of the eligible population.

Demographics

Demographic information obtained from the questionnaires will be reported in the following section. When available, it will be compared with demographic information on the AOPD population, showing that the two groups are comparable. The In and Out groups will also be compared to one another, showing that they are also demographically similar. Data on the part of the In group drawn from the population that called Central Intake, and that part of the In group that came from the AOPD's working caseload will be shown, to reflect their similarity, and the basis for combining them into one In group for the purpose of analysis.

Age

The distributions of the AOPD population and the sample by age were not significantly different, as can be seen in Table 3.

TABLE 3
AGE DISTRIBUTION BY SEX

Age	AOPD				Sample			
	F	M	T	%	F	M	T	%
15-19	7	8	15	2.52	0	0	0	0
20-24	37	18	55	9.25	6	2	8	10.12
25-34	103	52	155	26.09	11	8	19	24.05
35-44	71	55	126	21.21	11	5	16	20.25
45-54	55	27	82	13.80	9	1	10	12.65
55-64	48	25	73	12.28	8	3	11	13.92
65-74	47	22	69	11.61	11	4	15	18.98
75+	12	7	19	3.19	0	0	0	0
Totals:	380	214	594		56	23	79	

There were no significant differences between the In and Out groups in age distribution. The mean age of the sample was 45.06 years. The mean age of the Out group was 43.36 years, and the mean age of the In group was 46.12 years. The mean ages for the two segments of the In group were 45.13 and 46.48 years respectively.

Neither were there significant differences in age when sex or education were considered.

Sex

The sex distributions in each of the groupings are similar to one another. The AOPD population had 214 men (36%) and 380 women (64%). The project sample is composed of 23 men (29%) and 57 women (71%).

The In group had 18 men (31%) and 39 women (67%), and the Out group had 5 men (23%) and 17 women (77%). The two In group segments had 11 men (34%) and 21 women (66%) and 7 men (28%) and 18 women (72%) respectively.

Education

The educational distribution of the AOPD and sample groups, which were not significantly different, is shown in Table 4.

TABLE 4
EDUCATION LEVEL

Education	AOPD		Sample		In		Out	
	P	%	P	%	P	%	P	%
Some grade	6	1	0	0	0	0	0	0
Completed grade	11	2	0	0	0	0	0	0
Some high	70	12	6	7.5	4	7	2	9
Completed high	173	29	19	24	15	26	4	18
Some college	154	26	27	34	17	29	10	45.5
Completed college	94	16	25	31	20	34.5	5	23
Graduate school	53	9	3	4	2	3	1	4.5
Voc/Bus/Tech	11	2	0	0	0	0	0	0
Unknown	22	4	0	0	0	0	0	0
Totals:	594		80		58		22	

As can be seen, the sample population has a slightly higher overall level of education. Divided into two groups of High school or less, and Some college or more, the AOPD divides into 260 (44%) and 312 (53%) patients respectively, and the sample divides into 25 (31%) and 55 (69%) subjects respectively.

There were no significant differences between the In and Out groups, nor between the two In groups. 27% of the Out group and 33% of the In group had a High School education or less, and 73% of the Out group and 67% of the In group had Some college education or more. The two In groups divided as follows: 44% and 19% High School or less, and 56% and 81% Some college or more.

Income

Information on income for the AOPD population is not available. 59 of the 80 subjects in the sample provided income information on themselves and their spouses. Of those who answered, the sample subjects had a mean income of \$19,746 and a median income of \$20,000, with a low of no income and a high of over \$100,000. 16 of the 22 subjects in the Out group responded, reporting a mean income of \$13,412, and a median income of \$14,000. 43 of the 58 subjects in the In group responded, reporting a mean income of \$22,309, and a median income of \$20,000. The two In groups reported a mean income of \$28,174 and \$15,210, and a median income of \$30,000 and \$22,000.

These facts are confounded by the fact that spouses also work, thereby effecting the overall income level in a family. The mean income of the 6 spouses reporting in the Out group was \$27,000 and the median

Income was \$29,500. The 21 reported spouses in the In group had a mean income of \$40,619 and a median income of \$25,000. The two In groups reported mean income for their spouses of \$41,692 and \$38,875, and median incomes of \$24,000 and \$27,500. Adding the incomes together, the sample households had a mean income of \$36,864 and a median income of \$25,000. The Out group households had a mean income of \$24,563 and a median income of \$20,000. The In group households had a mean income of \$41,442 and a median income of \$28,000.

Religion

Table 5 shows the distribution by religion for the groupings. The overall distributions were not significantly different for the three groupings.

TABLE 5
RELIGIOUS AFFILIATION

Religion	AOPD		Sample		In		Out		In-1		In-2	
	#	%	#	%	#	%	#	%	#	%	#	%
Protestant	52	9	5	6	2	4	3	14	2	6	0	0
Catholic	223	38	25	32	20	36	5	24	12	39	8	32
Jewish	227	37	37	48	27	48	10	48	14	45	13	52
Other	27	6	1	1	1	2	0	0	0	0	1	4
None			9	12	6	11	3	14	3	10	3	12
Totals:	529		77		56		21		31		25	

Race

There were no significant differences between the AOPD and the sample populations by race. The AOPD had 527 Whites (89%), 37 Blacks

(6%), 1 Indian (.2%), 7 Spanish (1%), and 6 Orientals (1%). The sample had 68 Whites (85%), 5 Blacks (6%), and 3 Spanish (4%). The In and Out groups and the two In groups had similar distributions.

Marital status

There were no significant differences between the samples when marital status was considered. 41% of the AOPD sample was married, and 36% had never been married. 44 subjects (55%) in the sample were married. 20 (25%) had never been married, and the rest were either separated, divorced, or widowed. 9 subjects (41%) in the Out group and 35 subjects (60%) in the In group were married. The Out group had 7 subjects (32%) and the In group had 13 subjects (22%) who were never married. The two In groups had 59% and 61.5% of their subjects who were married, and 25% and 19% who were never married.

Place and type of residence

61% of the sample lives in the county in which the hospital is located and 28% lives in the neighboring county, which is very close to the hospital. 52% of the sample lives in houses, 18 % live in co-ops, and 30% live in apartments. 48% of the subjects own their dwelling and 52% are renting.

The Method of Data Analysis

The data analysis will be divided into sections based on the EBM Decision Process model, reflecting the Problem Recognition, Search, Alternative Evaluation, Purchase, and Outcome components of the model. Chi-Square analysis will be done on the responses to each question, to

determine if there is a significant difference between the responses of those who continued in treatment for 6 or more sessions, at Hauberk or elsewhere (In), and those who had no treatment, screenings only, or dropped out of treatment after 5 or less sessions (Out). The data will also be analyzed in the same manner by Age (divided into two groups of 49 or under and 50 or over), Sex (male and female), and Education (divided into two groups of High School education or less and Some college education or more). The responses will be reported both in actual number of responses and in percentages. Only those results deemed theoretically interesting or statistically significant will be reported.

For purposes of analysis, the In group that came from the callers to Central Intake (the first sampling), and the In group that came from the working AOPD population (the second sampling) were combined into one In group. This was due to the small number in the second sampling, which, if evaluated separately, would have resulted in groupings too small for meaningful analysis. The decision to combine these groups was based on the fact that they were not significantly different demographically. These data will be shown in the next section.

Subjects who "decided to live with the problem" at one of the decision points in the model will be grouped together for the analysis of their responses following that decision. This is due to the small number of subjects at each decision point, ranging from 1 to 6, and totalling 22. This sub-sample is ultimately comprised of the subjects in the Out group.

Each section will contain the results of the questions from the questionnaire which relate to the decision process issue of that section,

and the questions therefore will not be reported in the order in which they were asked. Reference will be made to the dropout and consumer behavior literature relevant to each section.

Summary

728 calls were received by the Hauberk Central Intake worker in the six month period being used, of which 449 were determined to be eligible for this study. 194 questionnaires were sent out, of which 69 were returned, and 54 were complete enough to be included in this study. The data is therefore drawn from 12% of the eligible sample. A second sampling, of patients currently in treatment in the AOPD, resulted in 26 additional questionnaires, representing 12% of the eligible AOPD population.

The study sample was compared to the AOPD population, and it was found that the two groups are similar, with regard to age, sex, education, religion, and marital status. There were also no significant differences found between the In and Out groups, and the two In groups in relation to these variables. The In group was found to have a higher family income than the out group, but this was not a significant difference.

The question to be answered relates to the fact that of the 638 calls from potential patients received by Central Intake, only 65 callers (10%) are still involved in the AOPD after 5 sessions. The following chapter reports the data obtained from a questionnaire using a consumer behavior decision process perspective. The study is an attempt to understand how such callers decide what to do about their problems, and whether this

approach helps to understand what happened to the other 90% of the callers.

V. Survey Results

Overview

This Chapter will report the data analysis based upon the 80 questionnaires being used in this study. The data will initially be reported in aggregate. Results will then be reported for the two comparison groups: 1) subjects who had no treatment, screenings only, or dropped out of treatment after 5 or less sessions (Out); and 2) subjects who were in treatment for 6 or more sessions, at Hauberk or elsewhere, or who were in treatment at the time they completed the questionnaire (In). Data obtained when the variables age, sex, and education were held constant will be reported when statistically significant or theoretically interesting. This Chapter will make use of the EBM decision process model as an organizing framework. It will, therefore, be divided into three sections: Problem Recognition; Search; and Purchase, Outcome, Satisfaction, Dissatisfaction. This analysis is intended to determine whether patterns in the data are better understood when they are placed within this theoretical framework.

Problem Recognition

The Problem

Problem recognition, as stated earlier, occurs when an individual perceives a difference between an ideal and an actual state, but it does not always lead to problem-oriented activity. It can, for example, be internally recognized, from information or experience, or can be activated by social or situational influences.

In this section, the results indicate that the subjects had numerous problems, that they had them for some time, and that, frequently, they had sought treatment in the past. Subjects told other people about their problems, who were not significantly influenced by this information. A variety of changes took place in subject's lives around the time they applied for help, which may have impacted on their perception of their problems.

Eighteen problems, divided into five categories (Personal, Marital, Family, Social, Life-Stage), were presented to the subjects, who were asked to identify the problem(s) that led them to call Hauberk. Subjects checked an average of 5.45 problems each, with a high of 12 problems and a low of 1 problem. The In group checked 5.5 problems and the Out group checked 5.3 problems. Depression (77.5%), Anxiety (75%), and Low Self-esteem (56.3%) were the most commonly checked problems for the sample.

There were no significant differences between the In and Out groups in the number of individual problems identified, nor in the broader categories.

Age

There were 45 subjects age 49 or younger and 34 subjects 50 or older in the sample. Those subjects 49 or younger had a mean number of 5.02 problems, while those 50 or older had a mean number of 5.97 problems.

There were no significant differences between the two age groups in the categories Personal problems, Marital problems, Family problems, or Social problems. There was a significant difference between the groups in the category Life-Stage problems, with more people in the older group having problems in this category (Chi-Square=12.59462, D.F.=1, p=.0004). 40% of the 49 or younger group had Life-Stage problems, whereas 82% of

the 50 or older group had such problems. Dividing this category into its component problems, significantly more subjects in the older group had problems with Job loss/retirement (Chi-Square=12.60994, D.F.=1, $p=.0004$), and with Health problems (Chi-Square=5.46534, D.F.=1, $p=.0194$), both not surprising findings. 29% of the older group had Job loss/retirement problems, whereas none of the younger group did. 50% of the older group had health problems, while only 22% of the younger group reported problems in this area.

Within the Family problems category, there was a difference between the two age groups in relation to Getting along with children, with significantly more subjects in the older group having problems in this area (Chi-Square=12.97327, D.F.=1, $p=.0003$). 9% of the younger group and 47% of the older group had problems with their children. There were no significant differences between the two groups in relation to the other problems.

Sex

There were 23 men and 57 women in the sample. The men had a mean number of 5.56 problems, and the women had a mean number of 5.40 problems.

There was no significant difference between the sexes in overall Personal problems, Marital problems, Family problems, or Social problems. A significantly greater number of women than men had Life-Stage problems (Chi-Square=4.05402, D.F.=1, $p=.0441$). 39% of the men had Life-Stage problems, whereas 67% of the women did.

When the problems were itemized, there were no significant differences between the sexes, except for Alcohol abuse, which

significantly more men had (21.7%) than women (0) (Chi-Square=9.76761, D.F.=1, $p=.0018$).

The percentage of each group having the individual problems was interesting, and while not significant, was not always as might have been expected. A greater percentage of men reported having anxiety, depression, and low self-esteem, problems which are more commonly associated with women. Table 6 shows the problem distribution percentages.

TABLE 6
PROBLEM DISTRIBUTION BY SEX

Problem	Male (n=23)	Female (n=57)
Anxiety	21 (91%)	39 (68%)
Depression	19 (83%)	43 (75%)
Phobias	6 (26%)	20 (35%)
Low self-esteem	16 (79%)	29 (46%)
Eating disorder	2 (9%)	12 (21%)
Communication	12 (52%)	22 (39%)
Sexual problems	10 (43%)	17 (30%)
Physical violence	0	5 (9%)
Conflicts w/children	3 (13%)	17 (30%)
Conflicts w/parents	6 (26%)	13 (23%)
Getting along w/others	11 (48%)	15 (26%)
Alcohol usage	5 (21%)	0
Drug abuse	3 (13%)	2 (4%)
Job loss/retirement	3 (13%)	7 (12%)
Divorce	1 (4%)	6 (11%)
Death	2 (9%)	17 (30%)
Health	5 (22%)	23 (40%)
Aging	1 (4%)	3 (5%)

Education

There were 25 subjects in the sample with a High School education or less, and 55 with Some college education or more. The less educated subjects had a mean number of 4.56 problems and the more educated subjects had a mean number of 5.85 problems. While there were no significant differences between these two groups in either the broad categories or the individual problems, it was interesting to note that the more educated group reported a larger percentage having each problem for a majority of the problems listed.

It was not possible to compare these data with results reported in the literature because of the nature of the reporting. The literature on dropouts frequently refers to presenting problems and to diagnosis. Subjects in this study were not asked about the problem they reported to the screening professional, and the information given on the questionnaire does not allow for diagnostic impressions.

Length of Problem

Having identified numerous problems, the question arises as to how long these problems have existed, and whether anything had been done about them in the past. Cole and Magnusson (1967) found that there was a difference between remainers and terminators in therapy related to how long they had had their symptoms. They found that having symptoms for more than six months was more frequently found among remainers than terminators. This study found no overall differences between the In and Out groups in relation to problem duration.

Subjects in the sample had problems lasting for vastly different periods of time. 36 subjects (45%) had some problems lasting A year or less, while some problems lasted from Over one to five years for 48 Subjects (60%), from Over five to ten years for 23 subjects (29%), and Over ten years for 43 subjects (54%). From another perspective, the shortest time subjects had any of their problems was A year or less for 36 subjects (45%), from Over one to two years for 15 subjects (19%), Over two to three years for 9 subjects (11%), Over three to five years for 6 subjects (7.5%), Over five to ten years for 5 subjects (6%), and More than 10 years for 7 subjects (9%). The average length of time for the three most troublesome problems identified by each subject was between 2-3 years.

Duration of the problem was not significantly different between the In and Out groups when these more definitive time frames were used. However, when the time frames were condensed to A year or less and More than a year, there was a significant difference between the two groups in relation to Communication problems (Chi-Square=9.66114, D.F.=3, $p=.0217$). Of those who had this problem ($n=34$), significantly more subjects in the In group (92%, $n=25$) had been experiencing Communication problems longer than a year than in the Out group (56%, $n=9$). 33% of the Out group had this problem for A year or less, whereas none of the In group did.

There was also a nearly significant difference related to the Death of an important person. Of those who had this problem ($n=19$), significantly more subjects in the In group (82%, $n=11$) had this problem for a longer time than in the Out group (37.5%, $n=8$) (Chi-Square=7.66913, D.F.=3, $p=.0534$).

50% of those in the the Out group with this problem had been coping with it for A year or less, whereas only 9% of the In group had.

Age

There was a significant difference between the 45 subjects in the 49 or younger, and the 34 subjects in the 50 or older groups in the length of time they had been having Conflicts with their children (Chi-Square= 16.41742, D.F.=3, $p=.0009$), in problems with Retirement/job loss (Chi-Square= 15.15345, D.F.=3, $p=.0017$), and in problems with Health (Chi-Square= 10.02686, D.F.=3, $p=.0183$). 32% of the older group and 4% of the younger group had conflicts with their children for More than a year, and only 3% and 4% respectively had them for A year or less. None of the subjects in the younger group reported problems with Retirement/job loss, whereas 18% of the older group had them for More than a year, and 9% had them for A year or less. 35% of the older group and 18% of the younger group reported Health problems lasting More than a year. 3% and 4% respectively reported them existing for A year or less. When only those subjects who reported specific problems were analyzed, the above differences were not significant.

Sex

Analysis was done to see if the sex of the subject influenced how long they had their problems. There were no significant differences between the 23 males and 57 females in the length of time that they had their problems. Only men reported alcohol abuse, which lasted for More than a year for 13%

and A year or less for 4%. Only women reported physical violence, which 2% experienced for A year or less and 7% experienced for More than a year.

Education

There were no significant differences between the two education groups in the length of time they had their problems. When only those subjects who reported specific problems were analyzed, there were significant differences between the group with a High School education or less and the group with Some college education or more related to Anxiety and Communication problems. Of the 20 subjects in the less educated group who reported Anxiety, 35% had it for A year or less and 55% had it for More than a year. Of the 39 subjects in the more educated group, 20.5% had Anxiety for A year or less and 79% had it for More than a year (Chi-Square=6.10495, D.F.=2, $p=.0472$). Communication problems were reported by 8 subjects in the less educated group, 25% of whom had it for less than a year, and 62.5% for more than a year. 24 subjects in the more educated group reported Communication problems, with 4% having it for A year or less and 96% having it for More than a year (Chi-Square=6.53968, D.F.=2, $p=.0380$). Overall, the more educated group had more problems lasting for a longer period of time than the less educated group.

Past Problem Solving Efforts

The fact that subjects identified problems as having lasted for so long does not necessarily mean that they recognized them as problems in the past. Had there been problem recognition that led to any treatment in the past? The results indicate that 69% of the sample had been in treatment

before, 7.5% had considered it but not gone, and 22.5% had not considered it before. Those who had considered it but not gone cited procrastination, skepticism, financial issues, and improvement as reasons for not pursuing treatment previously.

Of those who had been in treatment before (n=55), 75% were in treatment again, and 25% were not. Of those who had not been in treatment before (n=24), 67% came into treatment this time, and 33% did not.

The shortest time any subject had a problem, whether they were in treatment before, and whether they were in treatment now is shown in Table 7.

TABLE 7
PROBLEM LENGTH AND TREATMENT HISTORY

<u>Problem length</u>	<u>Previous Tx</u>	<u>Current Tx</u>
Over 10 yrs. (n=6)	6 (100%)	5 (83%)
Over 5-10 yrs. (n=5)	5 (100%)	5 (100%)
Over 3-5 yrs. (n=6)	4 (67%)	4 (67%)
Over 2-3 yrs. (n=9)	5 (56%)	8 (89%)
Over 1-2 yrs. (n=15)	11 (73%)	10 (67%)
Up to 1 yr. (n=36)	22 (61%)	24 (67%)
Unknown (n=3)	2 (67%)	2 (67%)
Totals: n=80	55	58

From a different perspective, 9% of those with prior treatment received it more than 30 years ago, 11% more than 20 years ago, 24% more than 10 years ago, and 60% within the past ten years.

There were no significant differences between any of the comparison the groups in relation to prior treatment. 30 of the 45 subjects (67%) in the

younger group and 24 of the 34 (71%) in the older group had been in therapy before. 18 of the 23 men (78%) and 37 of the 57 women (65%) had been in therapy before. 17 of the 25 subjects with a high school education or less (68%) and 38 of the 55 subjects (69%) with some college education or more had been in therapy before.

Brandt (1965) found that fewer remainers had had prior therapy. Hoffman (1985), on the other hand, found a positive relationship between previous treatment and remaining. No differences were found in this study between the In and Out groups, which supports the findings of Berrigan and Garfield (1981).

Only 18% of the 55 subjects who had been in treatment before had been at Hauberk Hospital previously. 25% had seen private therapists, and 27% had been treated at a clinic, agency or hospital. 4% reported being in treatment at several places. Of the 41 subjects in the In group who had been in therapy before, 9 had been in therapy at Hauberk (22%). Only 1 of the 14 subjects in the Out group who had been in therapy before received it at Hauberk (7%).

Situational Variables

Situational variables can also be a factor, either creating problems or influencing their impact and the response to them. Life changes: births, marriages, separation or divorce, illness or death, people moving, and retirement, and financial changes: decreased income, increased expenses, and increased income were considered in relation to their impact on the decision process. 55 subjects (69%) reported changes in either their life situation or their financial circumstances. 38 (66%) of those in treatment

and 17 (77%) of those not in treatment reported changes. Of the 16 subjects who had not been in treatment before, but were in treatment now, 10 (63%) reported changes. 12 (86%) of the subjects who had been in treatment before, but were not now, reported changes.

The changes reported were distributed as shown in Table 8.

TABLE 8

SITUATIONAL CHANGES FOR IN AND OUT GROUPS

<u>Changes (n=55)</u>	<u>In (n=38)</u>	<u>Out (n=17)</u>
<u>Family:</u>		
Births	5 (13%)	0
Marriages	3 (8%)	2 (12%)
Separation, Divorce	1 (3%)	0
Illness, Death	8 (21%)	4 (24%)
People moving	8 (21%)	2 (12%)
Retirement	0	0
Combination	3 (8%)	1 (6%)
Other	0	1 (6%)
Totals:	28 (74%)	10 (59%)
<u>Financial:</u>		
Decreased income	12 (32%)	5 (29%)
Increased expenses	10 (26%)	5 (29%)
Increased income	2 (5%)	1 (6%)
Totals:	24 (63%)	11 (65%)

Was there an association between a subject's most recent problem, changes in their environment, and coming into treatment? There were no significant differences between the In and Out groups in relation to these

variables. The distribution of changes in relation to problem length for the sample is shown in Table 9.

TABLE 9
MOST RECENT PROBLEM AND ENVIRONMENTAL CHANGES

<u>Length of most recent problem</u>	<u>Life change</u>	<u>Financial change</u>
Up to 1 yr. (n=36)	50%	50%
Over 1-2 yrs. (n=15)	33%	33%
Over 2-3 yrs. (n=9)	56%	67%
Over 3-5 yrs. (n=6)	33%	50%
Over 5-10 yrs. (n=5)	60%	0%
Over 10 yrs. (n=6)	67%	33%
Length unknown (n=3)	33%	33%

Age

Age was not a significant factor in the reporting of recent family changes or income changes. Seventeen of the 45 subjects (38%) in the 49 or younger group reported recent changes in their family, and 20 (44%) reported recent income changes. Twenty of the 34 subjects (59%) in the 50 or older group reported recent family changes, and 15 (44%) reported recent income changes.

Sex

Eight of the 23 men (35%) and 30 of the 57 women (53%) reported recent changes in their family. There was a significantly greater percentage of change in women's than men's families (Chi-Square=6.80098, D.F.=2, $p=.0334$). There were no significant differences in income changes

between the two groups. Ten men (43.5%) and 25 women (44%) reported recent income changes.

Education

There were no significant differences between those subjects with a High School education or less and those with Some college education or more with regard to either recent changes in their families or in their income. Eight of the 25 subjects (32%) in the less educated group reported recent family changes, and 14 (56%) reported recent income changes. 30 of the 55 subjects (54.5%) in the more educated group reported recent family changes, and 21 (38%) reported recent income changes.

Influence of Other People

Problems are often defined by other people, or are given definition by the process of sharing them with others. Subjects were asked to identify who knows they have a problem, how they know, and whether knowing about the problem has influenced how they feel about the subject. The immediate family knew about the problem for 97% of those in the In group, with 88% of the subjects (51) having told them directly. This compared with the immediate family knowing for 55% of those in the Out group, with 50% of the subjects (11) having told them directly. This difference was significant ($\chi^2=22.49503$, D.F.=4, $p=.0002$). 50% of those in the In group told their relatives, 60% told their friends, and few people told their co-workers, neighbors or other professionals. 32% of those not in treatment (Out) told their relatives and 45% told their friends. These differences were not significant. Linn and McGranahan (1980) suggested that greater contact with close friends might decrease the use of

professional services. However, this study found no significant difference between users and non-users based on contact with friends, and in fact, found a trend in the opposite direction.

From a different perspective, Brown (1978) conjectured that people turn to help because they are reluctant to keep asking their family and friends for help. The results of this study may lend some support to that idea, in that there was a significant difference between the In and Out groups in relation to the importance of the opinions of others. However, another possible interpretation is that people who share more with others may also be more comfortable sharing with a professional. Both groups felt that knowing about their problems did not significantly influence how other people felt about them. 55% of the In group felt it had no influence, and 21% felt it had a negative influence. The Out group results were 27% and 5% respectively. However, significantly more subjects in the In group reported that the opinions of their immediate family ($\text{Chi-Square}=26.53881$, $\text{D.F.}=2$, $p=.0000$) and their relatives ($\text{Chi-Square}=6.37707$, $\text{D.F.}=2$, $p=.0412$) were important to them than did the Out group. 90% of the In group felt the opinions of their immediate family were important, 43% felt the opinions of their relatives were important, and 52% felt the opinions of their friends were important. The results for the Out group were 36% for immediate family, 14% for relatives, and 41% for friends. It should be noted that the response rate for the Out group was less than 50% for this question, raising question as to whether the differences between the two groups would remain if more subjects in the Out group had responded.

Age

Age did not have a significant effect on who subjects told about their problems. About 85% of both groups told immediate family, and more subjects in the younger group told their friends and relatives. Age also did not make a significant difference in the influence this knowledge had on other people, with both groups reporting that it did not have much influence. The importance of peoples' opinions was not significantly different based on the age of the subject. Except for professionals, peoples' opinions were always more important than not for both groups.

Sex

Significantly more of the 57 women (71.9%) than the 23 men (39.1%) told their friends they were having problems ($\text{Chi-Square}=6.18764$, $\text{D.F.}=1$, $p=.0129$). There were no significant differences between them related to who else they told. A majority of both groups felt that knowing about their problems did not influence how people felt about them. There was a significant difference between men and women in relation to the opinions of relatives ($\text{Chi-Square}=7.22386$, $\text{D.F.}=2$, $p=.0270$), with more women (42.1%) than men (17.4%) giving importance to their opinions.

Personal Feelings

The decision to take action may also be influenced by how one feels about oneself, knowing that a problem exists. 17% of the In group felt that having a problem did not influence how they felt about themselves, while 60% felt that it influenced them negatively. 41% of the Out group reported their problem as having no influence on how they felt about themselves,

whereas 50% reported a negative influence. Those citing negative changes noted, for example, decreased self-esteem (24% for the In group and 23% for the Out group), and an increase in negative affects (45% for the In group and 32% for the Out group). These results were not significant.

Age, sex, education

Neither age, sex, nor education made a significant difference in whether their problems changed how subjects felt about themselves. 73.5% of the 45 subjects 49 or younger, and 67% of the 34 subjects 50 or older reported that their problems had changed how they felt about themselves. 74% of the 23 men and 70% of the 57 women said their problems changed how they felt about themselves. 85% of the 25 subjects with a High school education or less reported that having problems influenced how they felt about themselves. 64% of the 55 subjects with Some college education or more reported that their problems had influenced how they felt about themselves.

Search, Alternative Evaluation

Search Activities

Subjects were often involved in a variety of activities aimed at coping with their problem(s) before they called Hauberk. These activities included talking to friends, relatives, and professionals, and engaging in diversionary activities and self-help groups. The sample of 80 people engaged in a total of 232 activities, with an average of 2.9 activities per subject. The In group averaged 3.2 activities per subject and the Out group averaged 2.5 activities per subject, with a low of no activities, and a high for both groups of 6 activities. Initially, subjects in both groups most often did

nothing about their problem (In-26%; Out-18%), followed by speaking to their family (In-21%; Out-18%). Table 10 lists the activities engaged in by the In and Out groups.

TABLE 10
SEARCH EFFORTS OF IN AND OUT GROUPS

<u>Done about problem</u>	<u>In</u>	<u>Out</u>
Nothing	21 (36%)	8 (36%)
Talked to family	37 (64%)	9 (41%)
Talked to relatives	20 (34%)	7 (32%)
Talked to friends	24 (41%)	9 (41%)
Talked to religious leader	7 (12%)	2 (9%)
Talked to medical doctor	25 (43%)	6 (27%)
Talked to former therapist	7 (12%)	3 (14%)
Talked to other professional	26 (45%)	7 (32%)
Diversionary activity	7 (12%)	3 (14%)
Self-help	7 (12%)	1 (5%)
Other	2 (3%)	0
Total activities:	183	55

Age

The 45 subjects in the sample who were 49 or younger engaged in an average of 3.06 activities to cope with their problems. The 34 subjects who were 50 or older took a mean of 2.88 actions. There was a significant difference between the younger and older groups in the percentage of subjects who talked to their immediate family about their problem. 73.5% of the older group spoke to their immediate family, while only 47% of the younger group did the same (Chi-Square=4.69442, D.F.=1, $p=.0303$). Overall, a greater percentage of subjects in the younger group engaged in each of seven of the other nine activities, or did nothing.

Sex

The mean number of things done to cope with their problems by the men in the sample was 2.82. The mean number for the women in the sample was 3.03. A significantly greater percentage of the 23 men (61%) than of the 57 women (26%) initially did nothing about their problem (Chi-Square=7.03751, D.F.=1, $p=.0080$). A significantly larger percentage of women (49%) than men (22%) talked to friends (Chi-Square=4.00366, D.F.=1, $p=.0454$).

Education

Those in the sample with a High School education or less did a mean of 2.92 things, while those with Some college education or more did 3.00 things. There were no significant differences in the kinds of activities subjects engaged in to deal with their problems based on education level.

Kinds of Help Received

Subjects received a variety of kinds of help from the activities they engaged in, including: support/reassurance (33%), specific recommendations/advice (25%), evaluation/diagnosis/treatment (16%), problem-solving (3%), improved feelings about oneself (0.9%), and other (5%). They got no help 17% of the time, two-thirds of this coming from doing nothing about the problem.

The types of help the In group got most often from each activity were: support/reassurance from their friends (79%), relatives (70%), and family (59%), both support and advice from their religious leader (43%), advice from their former therapist (71%), specific recommendations/advice from their medical doctor (48%), evaluation/diagnosis/treatment from other

professionals (62%), other help from diversionary activities (86%), and evaluation and problem-solving from self-help groups (29%).

The Out group got support/reassurance from their family (56%) and friends (44%), no help from their relatives (43%), both support and problem-solving from their religious leader (50%), advice from their medical doctor (50%), support and advice from their former therapist (33%), evaluation/diagnosis/treatment from other professionals (57%), improved feelings about themselves and other help from diversionary activities (33%), and improved feelings from self-help groups (100%).

The overall difference between the kinds of help received from relatives for the two groups was significant with a greater percentage of the subjects in the In group (70%) than in the Out group (29%) receiving support/reassurance ($\text{Chi-Square}=10.83699$, $\text{D.F.}=2$, $p=.0044$). The difference for friends was also significant, with 79% of the In group and 44% of the Out group receiving support/reassurance from friends ($\text{Chi-Square}=9.13820$, $\text{D.F.}=3$, $p=.0275$).

Gourash (1978) suggests that people who look for help are looking for comfort, reassurance, and advice, and this appears to be what this sample got most often, and found most helpful. Subjects in the In group who talked to relatives and friends found it helpful 75% of the time, religious leaders 71% of the time, family 70% of the time, medical doctors 60% of the time, former therapists 57% of the time, and other professionals 50% of the time. Self-help groups were helpful 86% of the time and engaging in diversionary activities was helpful 57% of the time.

For the Out group, the percentage of help was 100% for religious leaders and self-help groups, 67% for medical doctors, 56% for friends, 44% for family, 43% for other professionals, 33% for former therapists, 33% for diversionary activity, and 14% for relatives.

A significantly greater percentage of those in the In group (79%) than in the Out group (14%) who talked to relatives found it helpful (Chi-Square=13.95248, D.F.=3, $p=.0030$). Help received from immediate family was helpful to a significantly greater percentage of subjects in the In group (70%) than in the Out group (44%) who spoke to them (Chi-Square=6.30331, D.F.=2, $p=.0428$).

Age, Sex

The age of the subject did not make a significant difference in what they found helpful in attempting to cope with their problems. Well over half of both the older and younger groups found talking to family, relatives, friends, religious leaders, and medical doctors, diversionary activities and self-help helpful.

There were no significant differences between men and women as to how helpful they found the things they did to cope with their problems. More than half of both sexes found talking to their immediate family and relatives helpful. A majority of the women found talking to friends, religious leaders, and medical doctors, diversionary activities, and self-help helpful. A majority of the men found talking to their former therapist helpful.

Education

Education level did not make a significant difference in what actions subjects found helpful in trying to cope with their problems. A majority of subjects in both education groups found talking to immediate family, relatives, friends, religious leaders, and medical doctors, and self-help helpful.

The Call to Hauberk

Having searched in other areas for help, the question was asked as to why the subjects finally decided to call Hauberk Hospital. More than one answer was given by 8 subjects in the Out group and by 25 subjects in the In group. The reasons given for finally calling Hauberk are listed in Table 11 along with the distribution of the responses.

TABLE 11

REASONS FOR CALLING HAUBERK

<u>Reasons for calling Hauberk</u>	<u>Sample</u>	<u>In</u>	<u>Out</u>
Problem was getting worse	48 (60%)	37 (64%)	11 (50%)
Told to by relative	7 (9%)	7 (12%)	0
Told to by professional	12 (15%)	9 (16%)	3 (14%)
Told to by friend	6 (7.5%)	4 (7%)	2 (9%)
Wanted things to be better	44 (55%)	29 (58%)	15 (68%)
Other	5 (6%)	5 (9%)	0

All of the multiple answers included "problem was getting worse" and/or "wanted things to be better" as part of the response. 35% of the In group and 23% of the Out group were told to seek help by someone else. Thoits (1985) postulates that people self-label their own behavior as

emotionally disturbed, and are motivated to seek help in order to feel normative again. The findings of this study appear to support this idea, in that the majority of subjects were responding to some affective self-assessment, as opposed to an externally imposed directive. She further states that people label themselves as emotionally deviant as the outcome of unsuccessful emotion management attempts. The fact that subjects try several other avenues before they finally call a mental health agency suggests that they are searching for alternative solutions, and thereby, labels, for themselves.

People also get stimulated by other people they know who have been in therapy, and may remember this as an alternative method of problem solving. 57 subjects in the sample (71%) knew someone who had been in therapy, and 19 subjects (24%) did not. 72% of the In group and 64% of the Out group knew one or more people who had been in therapy. 36% of both groups remembered these people saying something positive about their therapy experience. Negative feedback was remembered by 3% of the In group and 5% of the Out group, and 7% of the In group remembered mixed feedback. These results were not significant.

Age, sex, and education

55.5% of the 45 subjects in the 49 or younger group, and 59% of the 34 subjects in the 50 or older group knew someone who had been in therapy. 56.5% of the 23 men and 58% of the 57 women knew someone who had been in therapy. 56% of the 25 subjects with a High School education or less and 58% of the 55 subjects with Some college education or more knew someone who had been in therapy. None of these results were significant.

A question was asked regarding how subjects heard about Hauberk. Of the total sample, 8 (10%) heard about it from the media, 9 (11%) heard about it from various sources, e.g. phone book, being an employee, etc., 11 (14%) were previous patients, 14 (17.5%) heard about it from relatives, 16 (20%) heard about it from friends/neighbors, and 20 (25%) heard about it from a professional. 30 subjects (37.5%) had heard about Hauberk from non-professional people in their lives. These findings and those related to why subjects finally called Hauberk do not support Gourash's findings (1978), that the social network is the referral source 75% of the time. Nor do they support the informal consensus at Hauberk that the majority of referrals come from friends and relatives.

People may decide to do something, but they don't always act on their decisions immediately. There was a significant difference between the two groups in regard to postponing calling Hauberk, with fewer subjects in the In group postponing the call ($\text{Chi-Square}=15.95019$, $\text{D.F.}=3$, $p=.0012$). 40 subjects in the In group (69%) and 9 subjects in the Out group (41%) did not postpone calling. 3 subjects in the In group (5%), and 9 subjects in the Out group (41%) postponed calling.

Calling a clinic does not automatically mean that the caller is interested in coming into treatment. One subject (1%) wanted information only. 23 subjects (29%) wanted information and if it sounded O.K., wanted to make an appointment. Over half of the subjects (47 or 59%) definitely wanted to make an appointment. 5 subjects (6%) still weren't sure what they wanted to do. There was a significant difference between the In group and the Out group in relation to what they wanted when they called, with a

greater percentage of the In group wanting to make an appointment (Chi-Square=12.07822, D.F.=4, $p=.0168$). The In group fell into the following categories: 16 (28%) wanted information and might make an appointment, 37 (64%) definitely wanted to make an appointment, and 1 (2%) still wasn't sure. The Out group responded as follows: 1 (5%) wanted information only, 7 (32%) wanted information and might make an appointment, 10 (45%) definitely wanted to make an appointment, and 4 (18%) still weren't sure.

Evaluative Criteria

People who call a clinic have various concerns about the specifics of that particular agency. For the sample in general, the order of concerns was: the kind of help offered (77.5%), cost (71%), the quality of the staff (66%), what would happen if they didn't go for help (57.5%), time (52.5%), convenience of location (46%), what would happen if they did go for help (42.5%), and what others would think (19%). The concerns of the In group, in order of importance, were: the kind of help offered (79%), the quality of the staff (76%), cost (72%), what would happen if they didn't go for help (64%), time (59%), convenience of location (48%), what would happen if they did go for help (47%), and what other people would think (17%). The concerns of the Out group, in order of importance, were: the kind of help offered (73%), cost (68%), convenience of location (41%), quality of staff (41%), what would happen if they didn't go for help (41%), time (36%), what would happen if they did go for help (32%), and what other people would think (23%).

There was a significant difference between the two groups in their concerns about the quality of the staff (Chi-Square= 8.80792, D.F.=2, $p=.0122$), and what others would think if the subject went for help (Chi-

Square=9.67226, D.F.=3, $p=.0216$). The quality of the staff was a major concern for 44 subjects in the In group (76%) and for 9 subjects in the Out group (41%). 5 subjects in the Out group (23%) and 10 subjects in the In group (17%) were concerned about what other people would think if they went for help. 5 subjects in the Out group (23%) and 33 subjects in the In group (57%) were not concerned.

There was also a near-significant difference in relation to the time help was available (Chi-Square=5.90290, D.F.=2, $p=.0523$). Time was a major concern for 34 subjects in the In group (59%) and 8 subjects in the Out group (36%).

Age

There was a significant difference between the 45 subjects in the 49 or younger group, and the 34 subjects in the 50 or older group in their concerns about the time help was available (Chi-Square=8.06567, D.F.=2, $p=.0177$) and in their concerns about the quality of the staff (Chi-Square=10.02163, D.F.=2, $p=.0067$). There were more subjects in the younger group who were concerned about both time (64% versus 35%) and staff quality (80% versus 47%). Overall, the younger group reported more concerns than the older group.

Information Obtained

Having the concerns they have, do callers get the information they want in relation to these concerns? Six concrete information areas were presented to the sample, to see what information they obtain in the initial call. The results are shown in Table 12.

TABLE 12

INFORMATION OBTAINED IN INITIAL CALL TO HAUBERK

Information about	Sample	In	Out
Fees	52 (65%)	44 (76%)	8 (36%)
Hours	52 (65%)	30 (52%)	12 (55%)
Type of treatment	47 (59%)	36 (62%)	11 (50%)
Staff credentials	23 (29%)	19 (33%)	4 (18%)
Waiting list	29 (36%)	21 (36%)	6 (27%)
Location	48 (60%)	36 (62%)	12 (55%)

There was a significant difference between the In and Out groups in relation to getting fee information, with a significantly greater percentage of the In group getting this information (Chi-Square=10.75319, D.F.=1, $p=.0010$).

The concerns of the subjects were compared to the information they got when they called Hauberk. Both groups cited the kind of help available as their first concern, but only 59% of the sample got this information. The In group listed staff credentials second, but only 33% of them got this information. For the Out group cost was second, with 36% getting this information. Cost was third for the In group, but 76% got this information. The Out group cited location as third, and 55% got this information. In general, concerns and information solicited did not necessarily coincide. However, there was no significant difference between concerns about the parameters of treatment, and whether the subjects got information related to these concerns. Overall, the In group solicited 3.2 pieces of information and the Out group solicited 2.4 pieces of information.

Having gotten this information, the question then arises as to whether subjects were satisfied with the information they received. The sample receiving information reported the following level of satisfaction with that information: location (87.5%), fees and hours (83%), waiting list (79%), and type of treatment (74%). There was an error in the reporting of satisfaction with the quality of the staff, in that more subjects reported being satisfied with the information than got that information (130%). There were no significant differences between concerns and satisfaction with the information received about those concerns.

There is a group of subjects who called other clinics/therapists after they called Hauberk. There was also no significant difference for them between their concerns and the information they received, and the information they received and their satisfaction with it.

Table 13 shows the distribution by In or Out group and satisfaction, based on those in each group who got the information.

TABLE 13		
SUBJECTS SATISFIED WITH INFORMATION RECEIVED		
<u>Information about</u>	<u>Satisfied</u>	
	<u>In</u>	<u>Out</u>
Fees	38 (86%)	5 (62.5%)
Hours	33 (82.5%)	10 (83%)
Type of treatment	29 (81%)	6 (55%)
Staff credentials	26 (137%)	4 (100%)
Waiting list	21 (91%)	2 (33%)
Location	33 (92%)	9 (75%)

There was a significant difference between the two groups in relation to satisfaction with fee information (Chi-Square= 7.69275, D.F.=1, p=.0055) and waiting list information (Chi-Square=4.25078, D.F.=1, p=.0392). In relation to both variables, a significantly greater percentage of the In group was satisfied with the information they received.

Having tried other things, called Hauberk and gotten information, the sample then made the decisions shown in Table 14.

TABLE 14
DECISION MADE FOLLOWING INITIAL CALL TO HAUBERK

<u>Decision</u>	<u>Sample</u>	<u>In</u>	<u>Out</u>
Made screening appointment	63 (79%)	52 (90%)	11 (50%)
Called another clinic	9 (11%)	6 (10%)	3 (14%)
Talked to other people	1 (1%)	0	2 (9%)
Tried something else	2 (2.5%)	0	2 (9%)
Decided to live with problem	5 (6%)	0	4 (18%)

Alternative Evaluation

Figure 2 traces the decisions that subjects made at various stages of the decision process. There were six major decision points identified: getting information, calling another clinic, making a screening appointment, having a screening, having an appointment to begin treatment, and starting treatment. At each point, subjects could make one or more of the five decisions listed in Table 14.

Subjects who "decided to live with the problem" at one of the decision points were grouped together for analysis, because of their small number at each separate point. The number who made this decision at each point were:

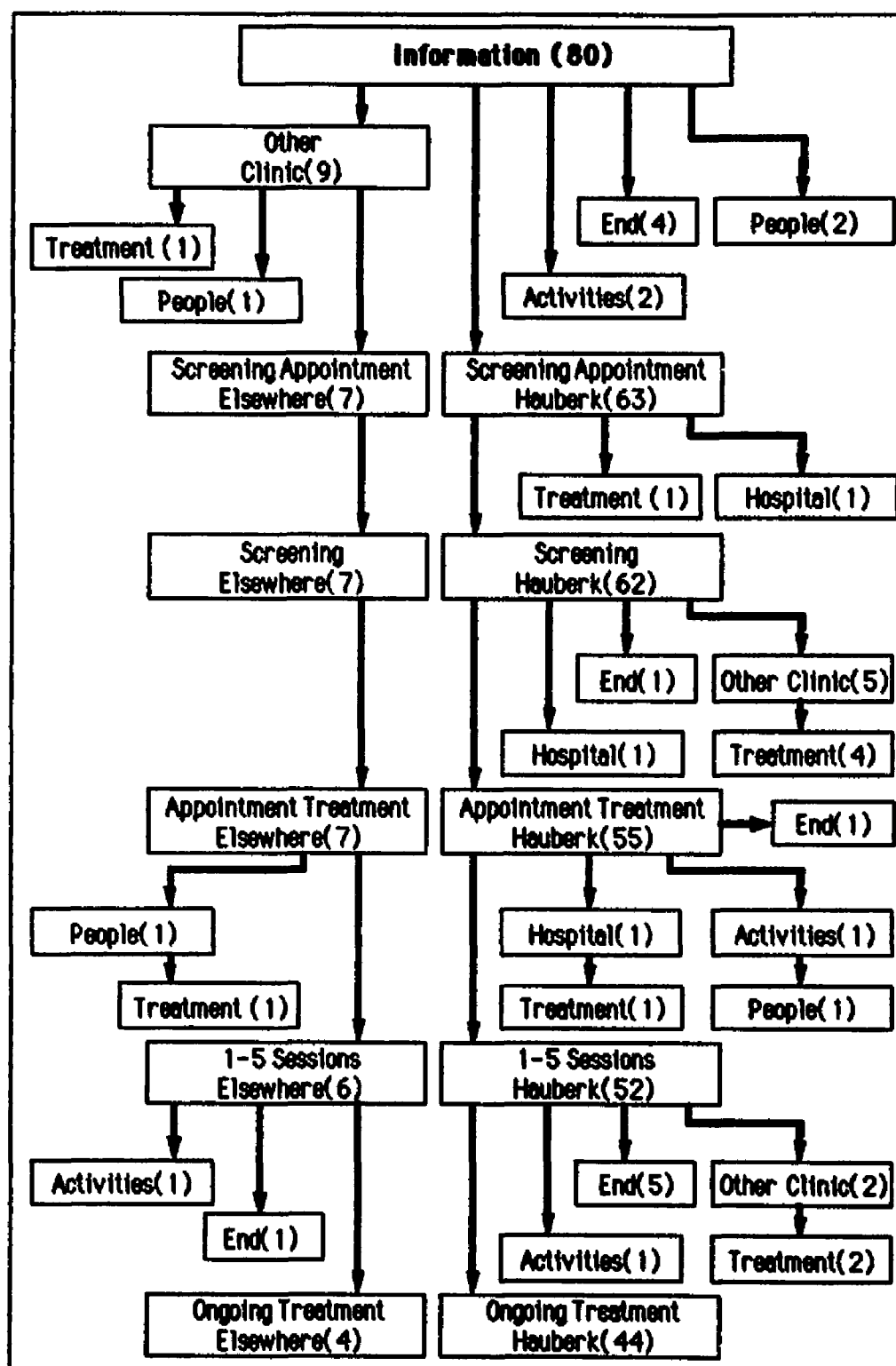


Figure 2. Decisions made by Subjects (number in parentheses) at Different Stages of the Decision Process.

getting information, n=4; calling another clinic, n=1; making a screening appointment, n=0; having a screening, n=1; having an appointment to begin treatment, n=2; and starting treatment, n=6. Additional decision points included talking to other people, n=4, and trying something other than therapy, n=4. These subjects comprise that portion of the sample in the Out group.

The EBM model lists Variables Influencing the Decision Process as one component. The question was whether something had happened in the lives of these subjects that influenced them in making this decision. They were asked whether their life situation had changed, the problem had changed, their thinking about the problem had changed, if someone had influenced them in their decision, and for those who started therapy, if feelings about the therapy had influenced their decision. They were also asked if the problem had changed since they decided to live with it, if they were thinking about doing anything about it in the future, what would influence that decision, how satisfied they were with the decision they made, and if they think that there was anything that might have caused them to make a different decision.

Flester and Rudestam (1975) suggest that external events may play a part in termination. In this study, 15 subjects (68%) reported no changes in their life situation. 5 subjects (27%) did report changes, 3 reporting an improvement, and 2 reporting a worsening of their life situation.

There was no change in the problem reported by 14 subjects (64%). Of the 4 subjects (18%) who reported changes in the problem, 1 reported

getting a new perspective, 2 reported the problem improving, and 1 reported the problem getting worse.

Changes in their thinking about the problem were reported by 10 subjects (45%). 4 cited a decision to adjust, 1 reported being more accepting of the problem, 4 reported having a better perspective, and 1 reported some other change in their thinking. 9 subjects (41%) reported no change in their thinking.

The influence of other people was also explored. 15 subjects (68%) said they were not influenced by anyone, and 3 (14%) said they were. Those subjects who were influenced cited therapists and self-help groups as influencing them.

Those subjects who had started therapy (n=6) cited therapy issues (50%) and pessimism regarding the treatment process (17%) as contributing factors in their decision to quit. Overall and Aronson (1963) and Flester and Rudestam (1975) examine expectations patients have about treatment as contributing to the dropout process. Borghi (1968) also cites expectations as being significant in the success or failure of a treatment relationship. Silverman and Beech (1979) found satisfaction with agency contact, even for those who dropped out, to be related to confirmation of expectations. Although the number is small here, the results appear to support the idea that patients are not getting what they thought they would.

What happened to the problem once the subjects decided not to do anything about it? 5 subjects noted no change in the problem (23%), 12 reported a positive change (55%), 3 reported a negative change (14%), and 1 reported a change of an unspecified nature (5%). Noonan's finding of a 70%

improvement rate in the problems of dropouts (1973) is greater than the one found here. However, over half of the dropout subjects reporting an improvement in their problem supports Noonan's finding that dropouts improve without treatment. Pekarik (1983a) also found that dropouts were not treatment failures, and Thoits (1985) suggested that a screening or a few sessions may help to normalize feelings again. Brown (1978) speculates that the knowledge that help is available may be helpful in and of itself.

The subjects were asked if they were thinking about doing anything about their problem in the future. 3 subjects said no (14%), 9 subjects said they were unsure (41%), 2 subjects said they would if necessary (9%), 3 subjects said their decision would be relationship-related (14%), 2 subjects were getting help through self-help groups (9%), and 1 subject said yes (5%). Asked if therapy was something they might consider for the future, 1 subject said no (5%), 1 said s/he was unsure, 1 was pessimistic about therapy, and 3 said they had a history of therapy helping before and might therefore consider it again (14%).

Deciding to do something about their problem in the future would be influenced by how bad things got for 9 subjects (41%), by finances and fees for 1 subject (5%), by life circumstances for 3 subjects (14%), and by treatment parameters for 3 subjects (14%). One subject was unsure what might be influential.

Was there something that might have caused them to make a different decision? 10 subjects said no (45%). 6 subjects cited different treatment parameters (27%), and 3 subjects cited different life circumstances (14%).

Subjects in the In group cited financial issues (2%), success of other efforts (10%), different treatment parameters (2%), and different life circumstances (9%), as factors potentially causing them to make a different decision. 32 subjects (55%) said nothing would have caused them to make a different decision.

Overall, how satisfied were the subjects with the decision they made about what to do about their problem? In the Out group, 13 subjects (59%) were satisfied with their decision, with the majority being very satisfied. 7 subjects were not satisfied with their decision (32%). This compares with 45 subjects in the In group being satisfied with their decision (78%), and 2 subjects not being satisfied with their decision (3%).

Time

Time is always a factor in any decision process. Cole, Branch and Allison (1962) suggested that time, and the need to wait, may discriminate against the lower class client, thereby contributing to their greater dropout rate. A significant difference was found by Rodolfa, Rapaport and Lee (1983) between remainers and terminators in relation to the length of time from intake to assignment. Folkins, Hersch and Dahlen (1980) proposed that problems may resolve themselves if clients have to wait too long for treatment. In this study, time did not appear to play a significant part in the decision process. Subjects in this study were asked how long they waited from the time they called until they had their screening appointment, and how long they waited from the time of their screening until they were called to set up their first therapy appointment. Subjects in the In group who responded (n=49) waited an average of 2.9 weeks for a

screening appointment, with the majority waiting between 1 and 2 weeks, and one subject waiting as long as 20 weeks. Subjects in the Out group who responded (n=12) waited an average of 1.6 weeks. Only one subject, in the In group, did not keep her screening appointment, because she was hospitalized before her screening. There differences were not significant.

The In group averaged 2.8 weeks between the time of their screening and the call to set up their first therapy appointment, with the majority waiting between 1 and 2 weeks, and the longest wait being 24 weeks. The Out group waited an average of 3.1 weeks, with the majority waiting between 1 and 3 weeks, and the longest wait being 6 weeks. 3 subjects (5%) felt better by the time they were called for an appointment, but made one anyway. One subject was hospitalized before her first outpatient appointment, one became physically ill, and one became pregnant.

Did subjects think twice about coming for their screening appointment? 87% of the 69 subjects who had screenings did not think about cancelling their appointment. 10 of the 13 subjects in the Out group (77%), and 50 of the 56 subjects in the In group (89%) who were screened, did not think twice. Ambivalence about getting help accounted for the second thoughts in the Out group. Three subjects in the In group (5%) were ambivalent, and another three had feelings about the treatment process that caused them to think twice. Need was the primary factor causing doubters to keep their appointments anyway (67%). These differences were not significant.

The Screening

Subjects were asked how they felt about the screening interview. 81% or 56 subjects in the sample of 69 had positive feelings about the screening interview, and 9 subjects (13%) had negative feelings about it. 1 subject (1.4%) had mixed feelings about it. There were no significant differences between the In and Out groups in their feelings about the interview. Taken separately, the two groups had similar percentages. Of the 10 subjects who had mixed or negative feelings about the screening interview, only one did not pursue treatment any further. Two others went elsewhere, and began treatment there.

Age, sex, education

80% of the 35 subjects in the 49 or younger group who were screened, and 90% of the 30 subjects in the 50 or older group who were screened had positive feelings about the screening. 95% of the 19 men, and 81% of the 47 women who were screened reported that it was what they expected and/or they felt good about it. 14 of the 19 subjects (74%) with a High School education or less, and 42 of the 47 subjects (89%) with Some college education or more responded favorably to the screening.

All applicants to the AOPD are asked to take a computer test at the time of their screening, which tests for organicity. 75% of the 36 subjects who answered had no concerns about the test, and understood what the test was for. 25% had concerns, and did not understand the purpose of the test. Of this 25%, only one did not continue in the AOPD. Differences between the In and Out groups were not significant.

The screening doctor felt that the AOPD could be helpful to 97% of the 69 subjects screened. One subject was hospitalized, and one was referred

privately. 55% of those screened were offered individual therapy, and 25% were offered group therapy. Medication was recommended for 20 of the subjects screened (29%). There were no significant differences between the In and Out groups in the type of treatment recommended by the screening doctor, nor in the prescription of medication.

Hargreaves et al (1974) found a relationship between modality assignment and acceptance of treatment, with individual therapy having the most favorable initial response. This study did not find a similar relationship. 51 subjects (74%) felt that the kind of help offered was the kind they were looking for, and 13 (19%) did not. 5 subjects (7%) were unsure. Differences between the In and Out groups were not significant. Of the 18 who were either dissatisfied or unsure, 3 (17%) were dissatisfied with the hospital or the process, 11 (61%) were dissatisfied with the recommendation, and 2 (11%) were made uncomfortable by the stimulation of negative affects. Only two subjects (11%) communicated their decision not to proceed further to the screener.

Did subjects get what they were expecting following the screening? 35 subjects (51%) were offered individual therapy, and 21 subjects (31%) were offered group therapy. 55 subjects (81%) were comfortable with the set fee and the time of their therapy, and 52 subjects (76%) were comfortable with the assigned treatment modality. 8 subjects (12%) were uncomfortable with each of these treatment parameters. There were no significant differences between the In and Out groups.

Outcome: Satisfaction, Dissatisfaction

Treatment

60 of the 69 subjects screened (87%) kept their first treatment appointment. 5 subjects (8%) thought about not keeping their first appointment. 4 of these subjects were fearful or apprehensive about the treatment process, and 1 had concerns about being in a group with strangers. A sense of need prompted them to keep their appointment anyway.

8 subjects in the Out group attended up to 5 sessions. This is 36% of the total Out group, and 62% of that group that was screened. The In group subjects had been in treatment from one session to several years.

6 subjects (75%) in the Out group who left therapy discussed their decision with their therapist prior to leaving, while 2 (25%) did not. Of the 6 who discussed their decision, the therapists for 4 of them agreed with their decision, while 2 did not. 3 subjects said the opinion of their therapist did not influence their decision, while 1 said that it did.

Subjects were asked if they were satisfied with the therapy they were getting. Results from this study support the conclusions of Bent et al (1976), who found a positive relationship between positive feelings about the therapist, improvement in behavior and satisfaction with therapy. In this study, 48 of the 58 subjects in therapy said they were happy with their therapy (83%), and 10 said no (17%). Of the 48 subjects who were satisfied, 13 said it was helping or that they were feeling better (27%), 12 said they liked the treatment process (25%), 11 had positive feelings about their therapist (23%), 4 anticipated help in the future (8%), and 8 gave nonspecific reasons (17%). Of the 10 subjects who were dissatisfied with

their therapy, 5 noted having to change therapists, and 5 questioned its helpfulness.

Asked what the major reason was for staying in therapy, 19 (33%) said it was helping, 34 (59%) anticipated future resolution of other goals, 6 (10%) liked the therapy process, and 2 (3%) gave miscellaneous reasons. Subjects gave more than one answer to this question.

Graziano and Fink (1973) cite the impact of negative second-order effects on staying in treatment. Subjects in this study did not report significant second-order consequences of treatment. 10% reported changes in their work schedule and finances, 9% reported changes in their daily scheduling, and 3% reported nonspecific changes.

Significant others can also provide second-order effects, as people other than the subject in therapy can be affected by the therapeutic process. Subjects were asked if anyone else had been directly affected by their being in treatment. 36 of the 58 subjects in therapy said their immediate family had not been affected by their being in therapy (62%), while 18 said their family had been positively affected (31%). 54 said their therapy did not affect their relatives (93%), 53 said it did not affect their friends (91%), and 100% said it did not affect their neighbors, co-workers, or other professionals. 3% noted a positive effect on relatives, and 7% noted a positive effect on friends. 2% said it had a negative effect on relatives and friends.

Age, Sex, Education

There were no significant differences related to each of these variables and whether other people were affected by subjects being in therapy. Of the 32 subjects in the younger group, there were 9 (28%) whose therapy affected their immediate family, and 3 subjects (9%) whose therapy affected their relatives and friends. 52% of the 25 subjects in the older group had immediate family, 4% had relatives, and 8% had friends who were affected.

37.5% of the 18 men and 39% of the 40 women reported that their therapy affected their immediate family. 6% of the men said it affected their relatives and friends. 7.5% of the women said it affected their relatives, and 10% said it affected their friends.

The 39 subjects (44%) with more education had a greater percentage whose immediate family were affected than the 19 subjects (26%) with less education. 10% of the subjects with more education had relatives who were affected. Friends were affected of 8% of the more educated group and 10.5% of the less educated group.

Influence of Others

Did the subjects tell people that they were in therapy? 44 subjects (76%) told their immediate family, 31 (53%) told their relatives, 32 (55%) told their friends, and 5 (9%) told their co-workers and neighbors.

Did this knowledge have an influence on how these other people feel about the subject? 32 subjects (55%) said this knowledge did not influence their immediate family, 8 (14%) said it influenced them positively, and 3 (3%) said it had a negative influence. 24 subjects (41%) said this information did not influence their relatives, 2 (3%) said it had a positive

influence, and 4 (7%) said it had a negative influence. Friends of 25 subjects (43%) were not influenced by this information, friends of 4 subjects (7%) were positively influenced, and friends of 2 subjects (3%) were negatively influenced. 4 subjects (7%) said it had no influence, and 1 subject (2%) said it had a negative influence on the feelings of their co-workers.

Age, Sex, Education

Being in therapy did not have any significant influence on how anyone in the subjects' lives felt about them, when correlated with age, sex, or education. 24% or less of each of the groups felt that the opinions of others were affected by the knowledge that the subject was in therapy.

The opinions of their family were important to 59% of the subjects, opinions of relatives to 38%, of friends to 40%, and co-workers and neighbors to 5% of the subjects. There were no significant differences between any of the groups related to the importance of the opinions of others.

What about how the subjects felt about themselves, as a result of being in therapy? 14% said it had not changed how they felt about themselves. 34% reported feeling better about themselves and 16% said they felt an increased sense of control over their lives. 7% gave miscellaneous changes, and 9% said therapy had changed how they felt about themselves, but were nonspecific.

Of the 48 subjects who responded to the question (out of 58), 96% said they were satisfied with the decision they made to come into treatment. 4% reported not being very satisfied.

Subjects Not in Treatment

The answers to those questions answered by subjects who did something other than stay in therapy in the AOPD will be summarized briefly, because the number of subjects in each decision category is very small. For example, 16 subjects called another clinic/therapist at some point after they called Hauberk, and 14 of them pursued treatment elsewhere and are therefore included in the previously reported results on screenings, therapy, etc. The one remaining subject decided to talk to other people, and the other decided to live with the problem.

5 subjects reported deciding to talk to other people after calling Hauberk, 4 of whom decided to live with their problem after that, without pursuing any further help. The fifth subject eventually went into treatment.

5 subjects eventually decided to try one or more things other than therapy to cope with their problem. These activities included self-help groups (2), religion (2), exercise (1), volunteer work (1), positive actions (4), and reading (1). 4 subjects went no further, while 1 decided to talk to other people.

Summary

This chapter reports the data analysis obtained from the answers given by 80 subjects to 124 questions, with over 950 possible responses. Chi-square analysis was done, with the responses reported in aggregate, and then divided into four comparison groups: those subjects in or out of treatment, those subjects who were 49 or younger and 50 or older, those subjects who were male or female, and those subjects who had a High School education or less and Some college or more.

There were 32 significant differences found on individual variables: 15 between the In and Out subjects, 10 between the Age groups, 7 between the Sexes, and 2 between the Education groups. The In group had a significantly greater number of subjects who had had Communication problems for a longer time (more than a year) than the Out group. Significantly more subjects in the In group than the Out group told their family members about their problems, and felt that the opinions of their families and relatives were important. Support and reassurance was received from friends and relatives by significantly more subjects in the In group. The help received from family and relatives was experienced as helpful by significantly more of the In group than the Out group subjects. Significantly fewer of the In group postponed calling Hauberk, and significantly more of them definitely wanted to make an appointment when they called. The In group had significantly more subjects who were concerned about the quality of the staff, the fee, and who were not concerned about what others would think. Significantly more of this group was satisfied with the information they received when they called regarding fee and the waiting list.

The Age group 50 or older had significantly more members who had Life Stage problems in general, and problems with Job loss/retirement and Health when this category was broken down into individual components. Significantly more of this group also had Conflicts with their children. These three individual problems had existed longer for a significantly greater number of subjects in this age group. A significantly greater number of subjects in the older group spoke to their families about their problems. When they called Hauberk for information, significantly more of

the subjects in the 49 or younger group were concerned about the time that help was available, and the quality of the staff.

Significantly more women had Life Stage problems, and significantly more men had alcohol abuse problems. Changes in their families were reported by significantly more women. Family members were told about their problems by significantly more women. The opinions of relatives were important to significantly more women. Significantly more men initially did nothing about their problem, and significantly more women spoke to their friends about their problem.

There was a significant difference between the time that the More and Less educated groups experienced Anxiety. The Less educated group had this problem for A year or less, whereas the More educated group had it for More than a year. The More educated group also had significantly more subjects who had been having Communication problems longer than the Less educated group.

Overall, the sample had an average of 5.45 problems. 54% had had problems for more than 10 years, and 45% had had problems for less than 1 year. 69% had been in treatment before, 18% of those at Hauberk. 69% reported changes in either their life situation or their financial situation within the past year. The sample engaged in an average of 2.9 activities in an attempt to cope with their problems before they called Hauberk. The help that they got most often from these activities was support and reassurance. Everyone who called was motivated in part by how they were feeling. 70% of the sample knew someone who had been in treatment.

The sample was primarily concerned about the kind of help that was available, the cost, and the quality of the staff, when considering treatment. They got an average of 3.1 pieces of information, and after getting this information, 79% made a screening appointment. The sample waited a minimum of 1.6 weeks for their screening appointment, and another 2.8 weeks minimum before they were called for their first therapy appointment. 79% of the sample had positive feelings about the screening, 97% were accepted for treatment, and 74% agreed with the screening doctor's recommendation. 87% of those screened kept their first appointment, and 83% of the 48 subjects who stayed in treatment were happy with it. Overall, 76% of the sample was happy with the decision they made about what to do about their problem.

It was found that there were few significant differences between the four comparison groups, especially in view of how many possibilities for differences existed in the questionnaire. What is important to know then, may have more to do with what these subjects have in common, rather than just what their differences are. The search process that these subjects engaged in has been delineated by their responses to the questionnaire, which followed the EBM framework. Does having a better understanding of this process by using this framework have implications for program development and delivery, and consequent marketing strategies? The next chapter will address these issues.

VI. Discussion

Overview

This Chapter will discuss whether the EBM decision process model has been found to have utility in furthering our understanding of patient decisions to purchase outpatient mental health services. It will discuss the findings of the study using this methodology, as well as the implications of these findings for future research. Limitations of the study will be addressed, which potentially impact on the overall generalizability of the results. The chapter concludes with a discussion of the organizational implications of this approach, in relation to program development and marketing strategies.

Consumer behavior is a field with which social work professionals should be quite comfortable. Both involve methodologies which focus on the person in his/her environment, seeking to understand and address the multiple variables which impact on the individual internally as well as externally. Consumer behavior also provides a framework and a language by which social work administrators and direct service workers can communicate more effectively with today's business-oriented health and mental health care administrators.

Marketing, which uses information drawn from consumer behavior, also helps to provide a conceptual bridge between frequently adversarial and conflicting theoretical perspectives. So, for example, while Kotler (1982) notes the need for carefully formulated programs with specific objectives,

with the emphasis being on measuring and satisfying consumer needs, he also focuses on the exchange of values between two parties. This focus on exchange allows for consideration of both exchanges between client and institution, and exchanges between social work and its host setting. By being more user oriented (Genkins, 1985), social work can potentially accomplish its goals more effectively with this dual focus.

Integration of the findings

The fact that the articles and studies on treatment usage and nonusage fit fairly easily into the decision process model components suggests that they reflect part of a process, and that they gain in utility when seen from this broader perspective. Of particular significance is the Search component of the model, which is felt to be particularly useful when addressing the "dropout" phenomenon. Consumers/patients have not dropped out of anything; they just haven't necessarily found what they want to purchase. For those who could be considered to have made a purchase, it might be the difference between buying a single candy bar to quench a momentary hunger, and buying a bag of candy bars to satisfy an ongoing sweet tooth. Some consumers/patients may benefit from a single session, whereas others may need ongoing treatment in order to feel satisfied.

Problem recognition

Consumer behavior theory states that problem recognition occurs when a person perceives a difference between an ideal and an actual state, but does not always lead to action. Social and situational influences, among others, contribute to problem recognition. This is consistent with the "dropout" literature, which addresses the contingent nature of problem

definition and recognition. Lee and Temerlin (1970) focus on socioeconomic factors; Cole, Pennington and Buckley (1974) look at sex roles; Cole, Costanzo, and Cox (1975, 1980) professional definitions and class definitions. Each study finds differential problem recognition, based on the variable being considered. Thoits (1979) relates to the "ideal versus actual state" in her discussion of the need to feel normative again.

In this study, the conceptual model identifies similar elements. Subjects identified an average of 5.45 problems, lasting from one-three months to more than 10 years, with 69% of the sample having sought professional help in the past. Problem recognition seemingly varied over time, and was undoubtedly influenced by numerous other factors. 66% of those in treatment and 77% of those not in treatment reported life changes or financial changes in the past year. Significantly more women than men reported changes in their family.

Social influences were also identified. Significantly more subjects in the In group told their immediate family about their problem, and more subjects in the In group than the Out group told their relatives and friends. The In group was also significantly more concerned about the opinions of their immediate family and relatives. Significantly more women told their friends, and felt that the opinions of their relatives were important.

Search and alternative evaluation

It is the search and alternative evaluation concepts which add the most to the understanding of the decision process regarding the use of outpatient mental health services, in that they reframe the process of "remaining" or "terminating." Search involves the gathering of information focused on need

satisfaction and problem resolution, and can be internal and/or external. Alternative evaluation is the process by which consumers evaluate alternatives to make a choice. Included are evaluative criteria, influenced by personality, stored information, and social influences; beliefs, attitudes and intention. Beliefs include an image of the product or service under consideration. Attitude reflects the readiness to respond and intention is the immediate determinant of actual purchase.

Raphael (1964), Leutz (1976), and Gourash (1978) found that people turn to the informal network for help, and are usually looking for comfort, reassurance and advice. This may also be what they are looking for when they come to a mental health clinic, and some of those who do not continue may have gotten that for which they came (Flester and Rudestam, 1975).

The findings that lower class patients terminate more often (Gibby et al, 1954; Imber et al, 1956; Overall and Aronson, 1963; Flester and Rudestam, 1975; Horenstein and Houston, 1976; Berrigan and Garfield, 1981) may have to do with expectations of the treatment relationship, and a conflict between what the therapist wants to give and what the patient wants. Alternatively, they may be more easily satisfied. Or, social conditions may impinge more upon their compliance. Studies done to try to predict who would stay and who might terminate therapy identify certain personality characteristics which distinguish remainers from terminators. It is proposed that these characteristics also reflect the patient's beliefs regarding what treatment is about, and what will be helpful.

Greater psychological-mindedness (Gibbey et al, 1954), being willing to explore problems with others (Lorr et al, 1958), greater willingness to

reveal self on a test (Hiler, 1959); cooperation with the worker and agreement on the nature of the problem and treatment goals (Lake and Levinger, 1960); the willingness to reveal (Heilbrun, 1973); these all suggest that the patient understood what treatment was about, and was doing, as well as getting, what was expected.

Cartwright et al (1980) found that terminators did not share inner life material as much as remainers. They instituted a preparatory group to teach patients how to do this, resulting in a lower rate of termination. France and Dugo (1985) conducted a one-session orientation to therapy, with the same results. These results suggest that the consumer/patient's beliefs and attitudes were not originally in keeping with the process of traditional treatment. Hoffman (1985) recommends community education to help people comfortably make a decision about using counseling services. Borghi (1968) suggests that expectations are of greater significance than personality characteristics (Heine and Trosman, 1960; Flester et al, 1974). Defining the problem in terms of expectations allows for the possibility of resolving it, either through education or program expansion or restructuring. Attributing it to personality alone leaves little room for change.

A person must be motivated to approach a mental health facility for help. This motivation is related to how bad they feel. Those who remained in treatment were found to suffer role strain (Brown, 1978), be dissatisfied with themselves (Gibby et al, 1954; Lorr et al, 1958), feel more inadequate (Hiler, 1959), experience greater discomfort (Lake and Levinger, 1960), and

greater need (Heilbrun, 1962). 57.5% of the sample felt more negatively toward themselves because of their problem definitions.

This study lends clarity to the search process engaged in by potential patients. Subjects engaged in an average of 2.9 activities, with some subjects doing nothing else to seek help before they called Central Intake, and others making use of as many as six other sources of help prior to calling the hospital. In the order of greatest frequency, these subjects talked to immediate family, talked to friends and other professionals, spoke to their medical doctor, talked to relatives, talked to their former therapist, tried diversionary activities, talked to religious leaders, and tried self-help groups. They found support and reassurance most helpful. Overall, the In group got more help than the Out group, suggesting that the In group may be clearer about their needs, or more ready to receive help.

Calling Hauberk came after these other activities, and can be seen as another step in the process of trying to find a solution to the caller's problem. The fact that 60% of the subjects reported that their problem was getting worse suggests that their other efforts had not produced the desired results. 55% were motivated by the desire for things to be better, and 31.5% had been told to seek help by others.

Internal search is also a factor here. 71% of the sample knew someone who had been in therapy before, and 36% remembered hearing positive things about that experience. 69% had been in treatment before themselves.

59% of the sample definitely wanted to make an appointment for a screening when they called Hauberk. There was a significant difference between the In and Out groups, again suggesting that the Out group was less

clear regarding their goals and intentions. All of the 37 subjects in the In group who definitely wanted to make an appointment did so, as did 10 of the 16 who said they would if the information received was satisfactory. The other 6 went into treatment elsewhere. 7 of the 10 subjects in the Out group who definitely wanted to make an appointment did so, as did 4 of the 7 who said they might. The 1 subject in the In group who was unsure, made an appointment, whereas all 4 of the subjects who were unsure in the Out group did not. These results suggest that the In and Out groups were at different stages of a process of decision making.

When subjects call Central Intake, they have certain evaluative criteria which they bring to the decision process. Seeing this call more in those terms might influence the way in which information is communicated. The fact that the In group was significantly more concerned about the quality of the staff, and that significantly more of them got information about the fee again suggests that they were getting down to the specifics of their decision. Overall, the In group got more information than the Out group, and was more satisfied with that information.

There was little support for the connotation that external variables influenced the decision not to pursue treatment. 68% of the Out group reported no changes in their life situation, and 64% reported no change in the problem.

Purchase, Outcome

Purchase includes where to buy something and is a function of buying intentions and situational influences. Outcome involves the postpurchase evaluation of the choice made. The "dropout" literature reports differences

in the dropout rate from between 6% to 67% depending on the number of sessions used as a measurement. However, intentions cannot be measured by a person's response to one clinic. Brandt (1964) found that 63% of the "rejectors" he contacted had gone elsewhere in one study, and 33% in another (Riess and Brandt, 1965). 70% of Noonan's subjects (1973) felt better without treatment. Brandt (1965), citing Kadushin, suggests that the distinction between rejectors, early terminators and remainers is merely an artifact. As noted earlier, he contends that people are in various stages of a complex decision-making process.

Situational factors are often cited as issues in dropping out. Dengrove and Kutash (1950), Cole et al (1962), Baum et al (1966), Garziano and Fink (1973), Hargreaves et al (1974) and Folkins et al (1980) focus on everything from administrative procedures and waiting time, to therapist personality and modality assignment to explain why some patients continue and some terminate.

In this study, a few situational factors were found to have influenced dropping out. 67% of those who started treatment in the Out group (n=6) had problems with the treatment process and confidence in its utility, but this represents only 30% of the Out group as a whole. 10 subjects in the Out group stated that nothing would have caused them to make a different decision. The sample had to make few adjustments to being in therapy, and the majority did not feel that significant people in their lives had been affected by their decision.

Satisfaction cannot necessarily be measured by clinic attendance. For example, Silverman and Beech (1979), Lippman (1983), and Pekarik (1983a)

found improvement and satisfaction with services received, even though patients had attended as few as one session.

In this study, 55% of the Out group reported an improvement in their problem without ongoing treatment. 59% were satisfied with the decision they made regarding their problem. 45% did report a change in their thinking, with positive results. This may reflect the possibility that even brief contact with a treating facility, or the act of seeking help can be beneficial, as well as the possibility that just knowing that help is available is helpful (Brown, 1978). By contrast, 78% of the In group was satisfied with their decision.

The Utility of the Decision Process Model for Outpatient Mental Health

The decision process model broadens the clinical perspective in relation to the decision to purchase outpatient mental health services by providing a before and after to the actual clinic contact. It often supports the findings of other, traditional studies, but provides a different framework, with different implications. Focusing on what people have done to cope with their problems in the past provides an idea of what they find helpful, and what they are looking for what they didn't get. It also suggests the possible need to broaden the range of services offered to a prospective patient. The fact that some "dropouts" feel better after a few sessions suggests that they may have gotten what they needed. Greater attention to the way patients use services might result in more brief contact therapy or "crisis intervention."

The model also suggests that people are not static, to be defined and understood in a single moment. However, personality characteristics,

focused on in conventional studies, are treated as static. Rather than explain why some people stay in therapy and others leave, they may instead explain why particular people react to a particular form of treatment in particular ways.

The premise of the decision process model is starting from where the consumer says s/he is at, as opposed to where someone else says s/he is at. Only a few of the studies on dropouts have attempted to ask the "dropouts" themselves what motivated their decisions, or have explored what happened before, as well as after, they contacted a particular mental health facility. This approach puts the contact in a different perspective. It is not an isolated, single-step event. Rather, it is part of a process, of which the actual contact is only one stage. As with therapy itself, this decision process has a beginning, middle, and end.

Professionals tend to assume that the decision to come into therapy as the solution for one's problems has been made once the "patient" reaches the office. Even the concept of "contracting" often starts with the premise that the "patient" has decided to be one, and now simply has to negotiate respective roles and tasks. It would appear that, for some people, "contracting" should at first focus on whether ongoing, traditional therapy is understood and what is really desired. From a consumer perspective, this should be the primary function of the screening. Instead, the screening is usually merely diagnostic.

At Hauberk, the whole registration and recording process presumes a "patient" role incumbency from the first in-person contact, which is usually the screening. It doesn't allow for a trial period, or "test drive." The

elaborate documentation process contributes to the professional's sense of finality regarding the presumed decision. A treatment plan note, required after the patient has attended four sessions, presumes the patient will attend that long. In 1987, 52.5% of the patients who terminated treatment attended four sessions or less. In 1988 the number was 45%.

Only people who have been former patients can return for up to three sessions without becoming "patients" again. They come to either cope with a crisis situation, have a "refresher course", or discuss whether returning to treatment is the appropriate decision for them to make at that time. For them, there is no immediate resumption of "patienthood". Attention to evaluating treatment as one alternative solution of several to a problem thus has implications for the way the initial in-person contact with an agency is handled. Could something have been done differently that would have enabled those who started and left treatment to get more help from it?

The concept of search has even greater significance for the other 88% of those people in the eligible sample who called Central Intake, but never came in. What were they looking for? What did they want? What did they decide to do, and how did they go about making that decision? If many of these people decided to pursue treatment elsewhere, as did 15 subjects (19%) in this study, it is important to know why. If they decided not to go into treatment, their reasons for making this decision are also important. Perhaps some remain unclear as to how therapy helps. Perhaps some are still unclear as to what they need.

How important is the call to Central Intake, and what weight does it play in the decision process? Is there significant information that should

be volunteered or stressed at the time of the call? Would sending out an informative brochure to callers help? What information should be in the brochure and how should it be presented? Marketing theory stresses the strategic placement of information, designed to reach a carefully delineated population of potential consumers. Where should information be placed to reach "desirable patients"? What information is significant in the decision process? In this study, subjects were most concerned about the kind of help offered, the cost of treatment, and the quality of the staff, but they didn't always get that information. Would that have made a difference?

The degree of search, as well as the sources of information and the importance of each, are significant facts to know in understanding the decision process, as well as in planning a marketing strategy. People usually have an idea of what to look for when buying a car or tooth paste, and marketing analysts know how people go about making these purchase decisions. However, people may not always know what evaluative criteria to use when considering the purchase of mental health services. It has become commonplace in the field today to advise people to "shop around" for a therapist. However, the advice seldom tells them what they should be looking for and how they should make their judgements.

Nonetheless, in this study, subjects listed an average of 4.5 concerns, or criteria. It is not known how these criteria are weighted in the final decision. It might also be important to know if additional criteria should be introduced, which consumers might not know are significant when applying for treatment. For example, the availability of onsite laboratories for medication monitoring might be important to those prospective patients in

need of medication. Some of the current radio advertising for services provided by major city hospitals include evaluative criteria as their framework, mentioning specialization, board certification, location and language, among others.

The decision process model can potentially provide valuable information to those who wish to better understand a consumer's entry into treatment. It again raises questions about the appropriateness of the term "dropout." Such patients may have been "dropped from" agency census figures, but they have not necessarily dropped out of a process. 45% of the subjects in this study went on to other problem-solving activities. To give these patients such a terminal title suggests that we have nothing to learn from them, that we are finished with them. Those who continue in treatment and those who move on have much to teach us about what is useful and what is not, both in the presentation and the delivery of services.

Limitations of the Study

The study has several limitations, which should be considered when reviewing its findings. The sample is drawn from only 12% of the eligible population, from both the callers to Central Intake and the current AOPD population. In addition, a very small number of "dropouts" responded, especially given the fact that approximately 93% of the eligible callers do not come into treatment in the AOPD, or stay for more than five sessions. The results of the questionnaire should therefore be interpreted in terms of the potential utility of the model, rather than as generalizable findings in and of themselves.

The questionnaire is initially imposing, with its 123 multi-part questions plus demographics. While the sample responding is comparable to the AOPD population in relation to education, the overwhelming majority of both populations have at least a high school education. The study findings may therefore reflect the same bias of which traditional therapy has been accused, namely, under-representing the perspectives of the less educated person. Either these people are not calling the AOPD to begin with, or they were intimidated by such a seemingly complex, "intellectual" task of the research method. Nonresponders in my own caseload tended to be people who had more difficulty revealing themselves to others. This may be an issue with any survey, and may also have relevance to the low "dropout" return rate.

From a technical perspective, the questionnaire directions may have been confusing to some people, particularly with reference to moving back and forth from one section to another. On occasion, it was obvious that subjects should have gone to another section but chose instead to fit their answers into the wrong place. Some of the questionnaires that were not complete enough to be used seemed to suggest that the subject had given up along the way, or had used a shotgun approach, answering a question here and another there.

It was also discovered well into the sampling process that the structure of the questionnaire didn't allow for subjects who had more than one screening. This may have resulted in the loss of subjects who fell into this category and got frustrated. (The effort to which one subject obviously

went to circumvent this fault suggests that such a subject had to be very determined to complete the questionnaire.)

It is suggested that a simpler instrument, perhaps focusing on only one aspect of the decision process may result in better response rates and richer results. Subjects might be less intimidated by such a long instrument, and would also find it easier to successfully complete. In the interest of exploring the usefulness of the approach overall, the answers to specific questions might not have been obtained. For example, it is not clearly determined why people decided to come to Hauberk, as opposed to someplace else. Timing should also be considered, in relation to when it is most advantageous to sample callers.

Organizational Implications

Hauberk is presently in a period of transition, following the appointment of the new Chairman of the Department of Psychiatry. The AOPD is also in transition, being merged with another department into one Ambulatory Care Center (ACC). This appears to be an opportune time to delineate an identity, an image, and to determine how to best market that image to the consuming public. Integral to that process is understanding what consumers want and how they go about finding it.

Garton (1978), DiGiulio (1984), and Sargent (1984), among others, stress the need for defining an "image" when developing a marketing strategy. Name recognition may be an issue with Hauberk. When people were called to participate in this study, they did not always recognize Hauberk's name. However, they did recognize the name of the Medical

Center. At issue is whether Hauberk will benefit more from a separate identity, or from being seen as synonymous with the larger institution.

The presumed future direction of Hauberk, with its focus on research and neuropsychiatry, will require extensive internal as well as external marketing. The concept "research" continues to conjure up images in clinicians of unserved patients who do not fit into research protocols, and images in the community of smoking test tubes and dangerous drugs. This is even farther away from the concept of help than traditional therapy has already appeared to some people. How this new orientation will effect the AOPD and its role in the ACC remains unclear.

The decision process model suggests several actions to take. Exit interviews, not foreign to social work, should be held routinely with every patient who moves on from Hauberk. This retrospective questioning will provide information regarding the patient's satisfaction with the services received, their assessment of their own improvement, as well as their future plans. Information obtained will potentially have implications for service delivery, as well as influence our understanding of the treatment process.

A second direction involves a better understanding of the search process engaged in by potential patients in the quest for problem resolution. This study indicates that such a search does take place. It is important to know what attracted people to Hauberk, and how they decided to use this clinic. Any future changes in program direction must take cognizance of existing assets and processes, and learn how to integrate them into future planning. This exploration could be done at the time of application. In the

form of a short questionnaire, it could be another of the numerous forms filled out at that time, or taken home and returned at the time of the screening.

Engel, Blackwell, and Miniard (1986) state that knowing how to advertise lies in knowing the direction and sequence of the search process used by most potential buyers (p. 74). Using the decision process approach, this study found that, in order of frequency, subjects talked to their families, friends and professionals, medical doctors, and relatives. Further research might focus on narrowing down the sequence of information obtained, thereby suggesting how this flow of information might be influenced. Should Hauberk continue to only relate to the professional community, they will be overlooking an important source of information dissemination. What follows from this information is a marketing strategy which targets this information acquisition process.

Conclusion

We have ample information regarding who uses mental health services. We know the problems from which they suffer. However, we do not know how often people who inquire about such services actually receive them, and how many are satisfied with the help received. Moreover, we do not always know why people move on from the mental health system, or what factors contribute to their entering it. Consumer behavior theory provides a different perspective from which to expand our understanding of this process. It opens up a new avenue of research, which holds potential benefits for both those in need of services and those who wish to provide them.

This study found few significant differences between the four groups used for purposes of comparison. Instead, the commonalities suggest that there is a shared process engaged in by people looking for solutions to their problems. The In and Out groups, for example, may have been at different stages of this process when they contacted Hauberk, and may also have had different treatment needs. The EBM decision process model appears to hold promise in furthering our understanding of this decision to use outpatient mental health services. Greater refinement in the delineation of this process, with its consumer orientation, has significant implications for screening procedures, treatment options, and marketing strategies.

APPENDIX A
STUDY PROTOCOL

The Initial Phone Call

Hello. My name is Edna Johnson and I am calling from the Medical Center. I am contacting everyone who has called Hauberk in the past six months or so, to see if they would be willing to participate in a survey we are doing about decision-making.

I would like to know if you would be willing to let me send you a questionnaire, which asks questions about how people decide what to do about problems that concern them. All you have to do is answer the questions and return the questionnaire in the pre-addressed, stamped envelop. All of your answers are anonymous and confidential.

Do you think you would be willing to participate?

(If yes) Could you please tell me where I would send it?

I will be sending this out in the next day or two. When you get it, if you would fill it out and return it as soon as possible, that would be very helpful.

Thank you very much.

APPENDIX A
STUDY PROTOCOL

Hello.

I am asking everyone who has recently begun treatment in the Hauberk Outpatient Department if they would be willing to participate in a survey about decision-making. We are interested in understanding the way people make decisions about what to do about their problems. I am trying to gather information about what goes into a person's decision to contact a mental health clinic, and how s/he decides whether or not to become involved in outpatient psychotherapy.

Participation will involve answering questions on a questionnaire. Your answers will be kept strictly confidential and will be anonymous. We are interested in general patterns of decision-making, and will therefore be combining your answers with those of other people who have contacted Hauberk recently.

If you would be willing to participate, you can

_____Take the questionnaire home with you, fill it out, and bring it with you to your next session.

_____Be interviewed before or after your therapy session, and I will complete the questionnaire with you. Please indicate what day and time would be convenient for you._____

_____Be interviewed over the phone, and I will complete the questionnaire with you. Please indicate when would be a good time for me to call you._____

Please check which way of participating would be the most convenient for you.

_____If you do not wish to participate, please check here.

Thank you for your consideration of this request, and I look forward to your participation.

Sincerely,

APPENDIX A
STUDY PROTOCOL

Hello.

You were given a letter some time ago asking if you would be willing to participate in a survey about decision-making.

It was recently brought to my attention that some people might find it more convenient to take the survey home, fill it out, and return it when they come for their next session.

If you are one of those people, you will find the survey and a cover letter in the enclosed envelop. I hope you will agree to participate and return the survey next week.

If you do not wish to participate, simply return the survey by giving it to the receptionist or to your therapist.

Thank you for your consideration of this request.

Yours truly,

APPENDIX A
STUDY PROTOCOL

Hello.

Thank you for agreeing to participate in this survey about decision-making.

Please start with Question #1 and follow the directions as you go along. This questionnaire is printed on both sides of the page, so just follow the question numbers. The questionnaire is divided into sections. The directions will tell you which section to go to next. Not everyone will answer the questions in every section, only those sections that apply to you.

Everyone will answer the questions on the back page.

Please do not hesitate to include any additional information that you think will help us understand what contributed to you making the decisions you made. You can write anywhere on the questionnaire if you want to add something, or on the back of this page if you need more room.

All of your answers will remain confidential and anonymous. Your answers will be combined with others, to see what patterns emerge about decision-making about problems.

To begin, think about what was going on when you decided to call Hauberk. The questionnaire starts around that time.

Completing this questionnaire will probably take about 15 minutes. Please turn to the next page and begin.

After you complete this survey you can leave it with the receptionist, or give it to your therapist, who will forward it to me.

If you have any questions, please feel free to call me at 693-8232, between 9-5 weekdays.

Yours truly,

APPENDIX A
STUDY PROTOCOL

Hello.

Thank you for agreeing to participate in this survey about decision-making.

Please start with Question #1 and follow the directions as you go along. This questionnaire is printed on both sides of the page, so just follow the question numbers. The questionnaire is divided into sections. The directions will tell you which section to go to next. Not everyone will answer the questions in every section, only those sections that apply to you.

Everyone will answer the questions on the back page.

Please do not hesitate to include any additional information that you think will help us understand what contributed to you making the decisions you made. You can write anywhere on the questionnaire if you want to add something, or on the back of this page if you need more room.

All of your answers will remain confidential and anonymous. Your answers will be combined with others, to see what patterns emerge about decision-making about problems.

To begin, think about what was going on when you decided to call Hauberk. The questionnaire starts around that time.

Completing this questionnaire will probably take about 15 minutes. Please turn to the next page and begin.

After you complete this survey, please return it in the stamped, pre-addressed envelop. Returning the survey within the next two weeks will be a great help.

If you have any questions, please feel free to call me at 693-8232, between 9-5 weekdays.

Yours truly,

Survey Questionnaire

- ☐ Retirement
☐ Divorce
☐ Death of important person
☐ Health
☐ Other:

- [illegible]

- ___ No one knows
- ___ Immediate family (spouse; partner; children; parents). Specify
- ___ Relatives (parents; siblings; aunts; uncles; cousins). Specify
- ___ Friends
- ___ Co-workers
- ___ Neighbors

4. If someone knows, how do they know?

- ☐ Subject told them. Indicate who:
- ☐ They told subject. Indicate who:
- ☐ Other people told them. Indicate who:
- ☐ Subject just thinks they know. Indicate who:
- ☐ Other:

5. If someone knows, do you think this has influenced how they feel about you?

Who? Yes (How?) No

_____	_____	_____
_____	_____	_____
_____	_____	_____

6. How important to you are these people's opinion of you? Please put #1 if very important, #2 if somewhat important, #3 if not very important, and #4 if not at all important next to each person selected.

7. Has having this problem changed how you feel about yourself?

☐ No ☐ Yes In what way?

8. What had you done about the problem up until you called Heuberk? Please number your choices in the order that you did them.

- ☐ Did nothing and hoped it would go away
 - ☐ Talked to a member of my immediate family (spouse/partner; child). Specify:
 - ☐ Talked to relatives (siblings; parents; aunts, uncles, cousins). Specify:
 - ☐ Talked to a friend
 - ☐ Talked to my religious leader
 - ☐ Talked to my medical doctor
 - ☐ Contacted my former therapist
 - ☐ Spoke to other professional/
- Please specify:
- ☐ Got involved in some diversionary activity.
 - ☐ Please specify:
 - ☐ Called Heuberk right away
 - ☐ Other. Please specify:

9. What kind of help did you get from each of the choices you indicated? Help might include moral support and encouragement; lectures on self-reliance and tolerance; therapy recommendation; other recommendation (please specify); medication; other (please specify).

10. Please indicate how helpful each of the things you did were in trying to deal with your problem, using #1 for very helpful, #2 for somewhat helpful, #3 for not very helpful, and #4 for not at all helpful. Place your answers on the short lines next to your choices.

11. What made you finally decide to call Hauberk?

- ☐ Problem was only getting worse
☐ I was told to. By whom: _____
☐ I wanted things to be better
☐ Other. Please specify: _____

12. Had you ever considered therapy before?

- ☐ Yes When? _____
☐ No

If yes, and you did not go into therapy at that time, what was the main reason you made that decision?

13. Have you ever been in therapy before?

- ☐ No ☐ Yes
 If yes, When? _____
 Where? _____
 How Long? _____

14. Has anyone you know ever been in therapy?

- ☐ No ☐ Yes
 If yes, Who? _____
 When? _____
 Where? _____

Do you remember them saying anything about their experience? If so, what?

15. How did you hear about Hauberk?

- ☐ Previous treatment at Hauberk.
 When? _____
☐ From friends, neighbors, relatives.
 Please specify: _____
☐ From a professional. Please specify: _____
☐ From newspapers, T.V., pamphlets.
 Please specify: _____
☐ Other. Please specify: _____

16. Please indicate how much of a concern any of the following items were in your decision to call Hauberk, using #1 if it was a major concern, #2 if it was of some concern, #3 if it wasn't of much concern, and #4 if it was of no concern.

- ☐ What therapy would cost
☐ How convenient the hospital was to get to
☐ What kind of help Hauberk offered
☐ What time help was available
☐ The quality of the staff
☐ What would happen if I didn't go for help. Please specify: _____
☐ What would happen if I did go for help. Please specify: _____
☐ What other people would think if I went for help. Please specify who: _____
☐ Other. Please specify: _____

17. Once you had decided to call Hauberk, did anything happen that caused you to postpone calling? Please specify: _____

18. When you called, did you

- ☐ Want information only
☐ Wanted information, and if it sounded O.K., wanted to make an appointment
☐ Definitely wanted to make an appointment
☐ Still wasn't sure what I wanted
☐ Other. Please specify: _____

19. When you called, did you find out about the following facts? How did you feel about these facts?

	Got information		Satisfied	
	Yes	No	Yes	No
Fees	_____	_____	_____	_____
Hours	_____	_____	_____	_____
Type treatment	_____	_____	_____	_____
Staff credential	_____	_____	_____	_____
Waiting list	_____	_____	_____	_____
Location	_____	_____	_____	_____
Other.Specify:	_____	_____	_____	_____

20. What did you do next?

a. ☐ Made an appointment for a screening.
Please go to Question #27.

b. ☐ Called another clinic, private therapist.
Please go to Question #90.

c. ☐ Talked to other people about the problem. Please go to Question # 103.

d. ☐ Decided to try something other than therapy. Please go to Question # 114

e. ☐ Decided to live with the problem.
Please continue with next Question.

21. What happened that made you decide to live with the problem? I am interested in understanding how you decided to live with it, what you thought about in coming to that decision.

a. Did your life situation change? How:

b. Did the problem change? How:

c. Did your thinking about the problem change? How?

d. Did someone influence you in your decision? Who:

22. Has the problem changed since you decided to live with it?

☐ Better ☐ Worse ☐ Unchanged
Please explain:

23. Are you thinking about doing anything about it in the future?

☐ Yes ☐ No Please explain:

24. What do you think will influence whether you do anything in the future?
Please explain:

25. Overall, how satisfied are you with the decision you made about what to do about your problem?

☐ Very satisfied

☐ Fairly satisfied

☐ Satisfied

☐ Not very satisfied

☐ Very unsatisfied

Please explain:

26. Is there anything in particular that might have caused you to make a different decision?

☐ Yes ☐ No Please explain:

PLEASE TURN TO LAST PAGE AND ANSWER QUESTIONS THERE

For subjects who made a screening appointment:

27. How long was the time between when you called, and when your appointment was scheduled?

28. Did you keep the appointment?

☐ No ☐ Yes (If yes, please go to question 36.)

29. What happened that made you decide not to keep the appointment? I am interested in understanding how you decided not to keep the appointment, what you thought about in coming to that decision.

a. Did your life situation change? How:

b. Did the problem change? How:

c. Did your thinking about the problem change? How?

d. Did someone influence you in your decision? Who:

30. Has the problem changed since you decided not to keep the appointment?

☐ Better ☐ Worse ☐ Unchanged
Please elaborate:

31. What have you done about the problem since you decided not to keep the appointment?

___ Called another clinic. Please go to Question # 90.

___ Talked to other people. Please go to Question # 103.

___ Decided to try something other than therapy. Please go to Question # 114.

___ Nothing. Please continue with next Question.

32. Are you thinking about doing anything about it in the future? Please specify:

33. What do you think will influence whether you do anything in the future? Please specify:

34. Overall, how satisfied are you with the decision you made about what to do about your problem?

___ Very satisfied

___ Fairly satisfied

___ Satisfied

___ Not very satisfied

___ Very unsatisfied

Please elaborate:

35. Is there anything in particular that might have caused you to make a different decision?

___ Yes ___ No

Please elaborate:

PLEASE TURN TO LAST PAGE AND ANSWER QUESTIONS THERE

For subjects who kept their screening appointment:

36. Did you think about not keeping your appointment? ___ Yes ___ No

If yes, what kinds of things did you think about?

What made you decide to keep the appointment anyway?

37. How did you feel about the screening interview?

___ It was what I expected

___ It wasn't what I expected.

Please explain:

___ It made me very uncomfortable.

Please explain:

___ I felt good about it.

Please explain:

___ Other:

38. Did you have any concerns about the computer test?

___ No ___ Yes. Please explain:

Did you understand what the test was for?

___ Yes ___ No

39. Did the screening Doctor feel that the clinic could be of help to you?

___ Yes ___ No

If no, what was recommended?

40. If yes, what type of treatment did the Doctor say s/he was recommending?

___ Individual, 1x/week

___ Individual, 2x/week

___ Group therapy

___ Marital therapy

___ Family therapy

___ Other:

41. Was medication recommended?

___ Yes ___ No

42. As a result of the screening, did you feel that this was the kind of help you were looking for?

___ No ___ Yes (If yes, Please go to question 54.)

43. What made you feel that this was not the kind of help you were looking for? Please explain:

If you decided to continue anyway, please go to Question 54.

If you decided not to continue, please go to the next Question (#44).

44. Did anything happen prior to the screening that influenced your decision? I am interested in understanding how you decided that this was not the help you wanted, what you thought about in coming to that decision.

a. Did your life situation change? How:

b. Did the problem change? How:

c. Did your thinking about the problem change? How?

d. Did someone influence you in your decision? Who:

45. Did you tell anyone at the hospital at that time that you did not wish to use its services?

___ Yes. Who?

___ No. Why?

46. If no, did someone call you to set up an appointment for therapy?

___ Yes ___ No

47. What did you tell them at that time?

48. Has the problem changed since you came for the screening?

___ Better ___ Worse

___ Unchanged

Please elaborate:

49. What have you done about the problem since you decided not to come to Heuberk for therapy?

___ Called another clinic. Please go to Question #90.

___ Talked to other people. Please go to Question #103.

___ Decided to try something other than therapy. Please go to Question #114.

___ Nothing. Please continue with next question.

50. Are you thinking about doing anything about it in the future? Please elaborate:

51. What do you think will influence whether you do anything in the future? Please specify:

52. Overall, how satisfied are you with the decision you made about what to do about your problem?

___ Very satisfied

___ Fairly satisfied

___ Satisfied

___ Not very satisfied

___ Very unsatisfied

Please elaborate:

53. Is there anything in particular that might have caused you to make a different decision?

___ Yes ___ No

Please elaborate:

PLEASE TURN TO LAST PAGE AND ANSWER QUESTIONS THERE

For subjects who made appointment for therapy

54. How long after the screening did someone call you to set up an appointment to begin therapy?

55. Had anything changed between the time of the screening and the phone call to start therapy?

___ No ___ Yes. Please specify:

56. What kind of therapy were you offered?

57. Were you comfortable with each of the following?

Fee ___ Yes ___ No

Therapy modality ___ Yes ___ No

Time ___ Yes ___ No

58. Did anything change between the time of the phone call and the time of your appointment?

☐ No ☐ Yes. Please specify:

59. Did you keep your appointment?

☐ No ☐ Yes (If yes, please go to question 67.)

60. What happened that made you decide not to keep the appointment? I am interested in understanding how you decided not to keep the appointment, what you thought about in coming to that decision.

a. Did the problem change?

b. Did your thinking about the problem change? How:

c. Did someone influence you in your decision? Who:

d. Did your life situation change? How:

61. Has the problem changed since you decided not to keep the appointment?

☐ Better ☐ Worse

☐ Unchanged

Please explain:

62. What have you done about the problem since you decided not to keep the appointment?

☐ Called another clinic. Please go to Question #90.

☐ Talked to other people. Please go to Question #103.

☐ Decided to try something other than therapy. Please go to Question #114.

☐ Nothing. Please continue with next question.

63. Are you thinking about doing anything about it in the future? Please specify:

64. What do you think will influence whether you do anything in the future? Please specify:

65. Overall, how satisfied are you with the decision you made about what to do about your problem?

☐ Very satisfied

☐ Fairly satisfied

☐ Satisfied

☐ Not very satisfied

☐ Very unsatisfied

Please elaborate:

66. Is there anything in particular that might have caused you to make a different decision?

☐ Yes ☐ No

Please elaborate:

PLEASE TURN TO LAST PAGE AND ANSWER QUESTIONS THERE

For subjects who came for from
1 to 5 sessions

67. Did you think about not keeping your first appointment?

☐ Yes ☐ No

If yes, what kinds of things did you think about?

What made you decide to keep the appointment anyway?

68. How many therapy sessions have you attended? _____ (If you are still in therapy, please go to Question 79.)

69. What made you decide to stop coming for therapy? I am interested in understanding how you decided to stop coming for therapy, what you thought about in coming to that decision.

Did the problem change? How:

Did your thinking about the problem change? How:

Did your life situation change? How:

Did someone influence your decision? Who?

Did you have feelings about the therapy itself that influenced your decision

Other:

70. Did you discuss your decision with your therapist?

☐ Yes ☐ No. Why not?

71. If yes, did your therapist agree with your decision?

☐ Yes ☐ No. Why not?

72. If no, did his/her opinion influence you in any way?

☐ No ☐ Yes. Please explain:

73. Has the problem changed since you stopped therapy?

☐ Better ☐ Worse ☐ Unchanged
Please elaborate:

74. What have you done about the problem since you stopped therapy?

☐ Called another clinic. Please go to Question #90.

☐ Talked to other people. Please go to Question #103.

☐ Decided to try something other than therapy. Please go to Question #114.

☐ Nothing. Please continue with next question.

75. Are you thinking about doing anything about it in the future? Please specify:

Is therapy one of the things you might consider?

☐ Yes. Why:

☐ No. Why:

76. What do you think will influence whether you do anything about it in the future? Please specify:

77. Overall, how satisfied are you with the decision you made about what to do about your problem?

☐ Very satisfied

☐ Fairly satisfied

☐ Satisfied

☐ Not very satisfied

☐ Very unsatisfied

Please explain:

78. Is there anything in particular that might have caused you to make a different decision? ☐ Yes ☐ No
Please explain:

PLEASE TURN TO LAST PAGE AND ANSWER QUESTIONS THERE

For subjects who are currently in therapy

79. Are you satisfied with the therapy you are getting? (Both answers may be checked.) ☐ Yes ☐ No

If yes, what is it that you are satisfied with?

If no, what is it that you are dissatisfied with?

80. What would you say is the major reason that you are continuing in therapy? (If more than one reason, please list them in order of importance.)

81. Are there any concrete changes or adjustments that you have had to make as a result of being in therapy? This could include, but not be limited to, financial, scheduling, or work changes. Please list the changes in order of their importance:

82. Have any other people been directly effected by you being in therapy?

___Yes. Who?

How?

___No.

83. People have many different feelings about therapy. Does anyone know that you are in therapy? If yes, please indicate who.

___ No one knows

___ Immediate family (spouse; partner; children; parents). Specify:

___ Relatives (parents; siblings; aunts; uncles; cousins). Specify:

___ Friends

___ Co-workers

___ Neighbors

84. If someone knows, how do they know?

___ Subject told them.

Indicate who:

___ Other people told them.

Indicate who:

___ Subject just thinks they know.

Indicate who:

___ Other:

85. If someone knows, do you think this has influenced they feel about you now?

Who? Yes (How?) No

86. How important to you are the opinions of these people? Please put #1 if very important, #2 if not somewhat important, #3 if not very important, or #4 if not at all important next to each person selected.

87. Has being in therapy changed how you feel about yourself?

___No ___Yes. Please explain:

88. Overall, how satisfied are you with the decision you made about what to do about your problem?

___ Very satisfied

___ Fairly satisfied

___ Satisfied

___ Not very satisfied

___ Very unsatisfied

Please explain:

89. Is there anything in particular that might have caused you to make a different decision?

___ Yes ___ No

Please explain:

PLEASE TURN TO LAST PAGE AND ANSWER QUESTIONS THERE

For subjects who called another clinic/therapist:

90. How did you hear about

_____?

___ Previous treatment at

When? _____

___ From friends, neighbors, relatives.

Please specify:

___ From a professional.

Please specify:

___ From newspapers, T.V., pamphlets.

Please specify:

___ Other. Please specify:

91. How many clinics/therapists did you call besides Hauberk? _____

How long would you say this process took? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BASED ON THE LAST CLINIC/THERAPIST YOU CALLED

92. Please indicate how much of a concern any of the following items were in your decision to call this clinic/therapist, using #1 if it was a major concern, #2 if it was of some concern, #3 if it wasn't of much concern, or #4 if it was of no concern.

- ___ What therapy would cost
- ___ How convenient it was to get to
- ___ What kind of help was being offered
- ___ What time help was available
- ___ The quality of the staff
- ___ What would happen if I didn't go for help. Please specify: _____
- ___ What would happen if I did go for help. Please specify: _____
- ___ What other people would think if I went for help. Please specify who: _____
- ___ Other. Please specify: _____

93. Once you had decided to call, did anything happen that caused you to postpone calling? Please specify: _____

94. When you called, did you

- ___ Want information only
- ___ Wanted information, and if it sounded O.K., wanted to make an appointment
- ___ Definitely wanted to make an appointment
- ___ Still wasn't sure what I wanted
- ___ Other. Please specify: _____

95. When you called, did you find out about the following facts? How did you feel about these facts?

	Got information		Satisfied	
	Yes	No	Yes	No
Fees	___	___	___	___
Hours	___	___	___	___
Type of treatment	___	___	___	___
Staff credentials	___	___	___	___
Waiting list	___	___	___	___
Location	___	___	___	___
Other. Please specify: _____	___	___	___	___

96. What did you do next?

- a. ___ Made an appointment for a screening. Please go to Question #27.
- b. ___ Talked to other people about the problem. Please go to Question #103.
- c. ___ Decided to try something other than therapy. Please go to Question #114.
- e. ___ Decided to live with the problem. Please continue with the next Question.

97. What was the major reason why you made that decision?

98. During this time period, were there any changes?

- a. Did your life situation change? How: _____
- b. Did the problem change? How: _____
- c. Did your thinking about the problem change? How: _____
- d. Did someone influence you in your decision? Who: _____

99. Are you thinking about doing anything about your problem in the future? Please specify: _____

100. What do you think will influence whether you do anything about your problem the future? Please specify: _____

101. Overall, how satisfied are you with the decision you made about what to do about your problem?

- ___ Very satisfied
- ___ Fairly satisfied
- ___ Satisfied
- ___ Not very satisfied
- ___ Very unsatisfied

Please explain: _____

102. Is there anything in particular that might have caused you to make a different decision?

- ___ Yes ___ No
- Please explain: _____

NOW PLEASE TURN TO THE LAST PAGE
AND ANSWER THE QUESTIONS THERE.

For subjects who talked to other
people:

103. Who did you talk to?

___ Talked to a member of my
immediate family (spouse/partner;
child). Specify:

___ Talked to relatives (siblings;
parents; aunts, uncles, cousins).

Specify:

___ Talked to a friend

___ Talked to my religious leader

___ Talked to my medical doctor

___ Contacted my former therapist

___ Spoke to other professional/clinic.

Please specify:

___ Other. Please specify:

104. If you talked to more than one person,
please put a number next to each person
in the order that you spoke to them, with
#1 for the first person, etc.

105. What kind of help did you get from
each of the choices you indicated?
Help might include moral support and
encouragement, lectures on self-reliance
and tolerance, therapy recommendation,
other recommendation (please specify),
medication, other (please specify).

106. Please indicate how helpful each of
the people you spoke to were in
trying to deal with your problem, using
#1 for very helpful, #2 for somewhat
helpful, #3 for not very helpful, or
#4 for not at all helpful. Place your
answer on the short line next to your
choices.

107. How much time overall did you spend
talking to other people?

108. What did you decide to do next?

a. ___ Called another clinic/therapist.

Please go to Question #90.

b. ___ Decided to try something other
than therapy. Please go to Question #114.

c. ___ Decided to live with the problem.

Please continue with the next Question.

109. Were there any changes during this
time period? I am interested in
understanding how you decided to
live with your problem, what you
thought about in coming to that decision.

a. Did your life situation change? How:

b. Did the problem change? How:

c. Did your thinking about the problem
change? How?

d. Did someone influence you in your
decision? Who?

Has the problem changed since you
decided to live with it?

___ Better ___ Worse ___ Unchanged

Please explain:

110. Are you thinking about doing anything
about your problem in the future?
Please explain:

111. What do you think will influence
whether you do anything in the future?
Please explain:

112. Overall, how satisfied are you with the
decision you made about what to do
about your problem?

___ Very satisfied

___ Fairly satisfied

___ Satisfied

___ Not very satisfied

___ Very unsatisfied

Please explain:

113. Is there anything in particular that might have caused you to make a different decision?

___ Yes ___ No

Please explain:

NOW PLEASE GO TO THE LAST PAGE
AND ANSWER THE QUESTIONS THERE

**For subjects who decided to try
something other than therapy**

114. What else have you tried, in an attempt to cope with your problem? Please list the things that you did in the order that you did them:

1. _____
2. _____
3. _____
4. _____

115. Please indicate how helpful each of the things you did were in trying to deal with your problem, using #1 for very helpful, #2 for somewhat helpful, #3 for not very helpful, or #4 for not at all helpful.

116. In what way were each of them helpful or not helpful?

1. _____
2. _____
3. _____
4. _____

117. How long did you try each of the things you mentioned?

1. _____
2. _____
3. _____
4. _____

118. What did you decide to do next, to deal with your problem?

a. ___ Called another clinic/therapist.

Please go to Question #90.

b. ___ Talked to other people about the problem. Please go to Question #104.

c. ___ Decided to live with the problem.

Please continue with the next Question.

119. Were there any changes during this time period? I am interested in understanding how you decided to live with your problem, what you thought about in coming to that decision.

a. Did your life situation change? How:

b. Did the problem change? How:

c. Did your thinking about the problem change? How?

d. Did someone influence you in your decision? Who:

Has the problem changed since you decided to live with it?

___ Better ___ Worse ___ Unchanged

Please explain:

120. Are you thinking about doing anything about the problem in the future?

Please explain:

121. What do you think will influence whether you do anything in the future?

Please explain:

122. Overall, how satisfied are you with the decision you made about what to do about your problem?

___ Very satisfied

___ Fairly satisfied

___ Satisfied

___ Not very satisfied

___ Very unsatisfied

Please explain:

123. Is there anything in particular that might have caused you to make a different decision?

___ Yes ___ No

Please explain:

NOW PLEASE GO TO THE NEXT PAGE
AND ANSWER THE QUESTIONS THERE

Now, I'd like to ask you some questions about yourself. This information will be combined with information from other people interviewed, to see if particular groups of people make decisions in the same way. For example, if women make decisions the same way men do, or if people between the ages of 35-45 make decisions differently than people between the ages of 46-55, etc.

Sex: ☐ Male ☐ Female

Age: _____

Marital status: ☐ Married
☐ Separated

☐ Divorced ☐ Widowed

☐ Never Married ☐ Living with

Children(*): ☐ If have, how many at home

☐ Any other relatives living in household?

☐ If yes, who?

Have there been any recent changes in your family, e.g. births, marriages, deaths, people moving in or out of household, etc.? Please specify:

Highest education completed:

Self _____ Spouse _____

Occupation: Self _____

Spouse _____

Do either of you work more than one job?

Self: ☐ Yes ☐ No

Spouse: ☐ Yes ☐ No

What is your yearly income? _____

Your spouse's yearly income? _____

Have there been any recent changes in your financial situation, e.g. income changes, exceptional expenses, etc.? Please specify:

What town or area do you live in?

Do you live in a ☐ house ☐ apartment
☐ co-op

Do you ☐ own ☐ rent

Do you drive?

Were you raised in a particular religion?
☐ No ☐ Yes. Please specify:

Do you practice a particular religion now?
☐ No ☐ Yes. Please specify:

What is your ethnic background?

Do you identify with the culture and traditions of this background? ☐ Yes ☐ No

Is there a particular philosophy of life, or rules to live by, that was passed along to you by your family? ☐ No ☐ Yes.
Please explain.

Have you had any life experiences which influence how you feel about seeking help? ☐ No ☐ Yes.
Please explain:

How do you spend your non-working hours?

Thank you for your time and effort.

BIBLIOGRAPHY

- Acosta, Frank X. 1980. Self-Described Reasons for Premature Termination of Psychotherapy by Mexican American, Black American, and Anglo-American Patients. Psychological Reports, Vol. 47: 435-443.
- Adler, L. M., Goin, M., and Yamamoto, J. 1963. Failed Psychiatric Clinic Appointments--Relationship to Social Class. California Medicine, Vol. 99: 388-392.
- Ahtola, Olli T. 1975. The Vector Model of Preferences: An Alternative to the Fishbein Model. Journal of Marketing Research, Vol. XII: 52-59.
- Albronda, H.; Dean, R.; and Starkweather, J. 1964. Social Class and Psychotherapy. Archives of General Psychiatry, Vol. 10: 276-283.
- Allport, Gordon. 1935. Attitudes. In Handbook of Social Psychology. C. Murchison, ed. Worcester, Massachusetts: Clark University: 798-884.
- Anderson, R. E. 1973. Consumer Dissatisfaction: The Effect of Disconfirmed Expectancy on Perceived Product Performance. Journal of Marketing Research, Vol. 10 : 38-44.
- Asser, Elliot S. 1978. Social Class and Help-Seeking Behavior. American Journal of Community Psychology, Vol. 6, No. 5: 465-475.
- Auld, F., and Eron, L. D. 1953. The Use of Rorschach Scores to Predict Whether Patients Will Continue Psychotherapy. Journal of Consulting Psychology, Vol. 17: 104-109.
- Baekland, Frederick, and Lundwall, Lawrence. 1975. Dropping Out of Treatment: A Critical Review. Psychological Bulletin, Vol. 82, No. 5: 738-783.
- Baum, Eugene O., Felzer, Stanton B., D'Zmura, Thomas L., and Schumaker, Elaine. 1966. Psychotherapy Drop-Outs and the Lower SES Patients. American Journal of Orthopsychiatry, Vol. 36: 629-635.

- Bearden, William O., and Etzel, Michael J. 1982. Reference Group Influence on Product and Brand Purchase Decisions. Journal of Consumer Research, Vol. 9:183-194.
- Beckwith, Neil E., and Lehmann, Donald R. 1976. Halo Effects in Multi-Attribute Attitude Models: An Appraisal of Some Unresolved Issues. Journal of Marketing Research, Vol. XIII: 418-421.
- Belk, Russell W. 1974. An Exploratory Assessment of Situational Effects in Buyer Behavior. Journal of Market Research, Vol. 11: 156-163.
- Bent, Russell J., Putnam, David G., Kiesler, Donald J., and Nowicki, Stephen, Jr. 1976. Correlates of Successful and Unsuccessful Psychotherapy. Journal of Consulting and Clinical Psychology, Vol. 44, No. 1:149.
- Bernal, Martha E. and Kreutzer, Susan L. 1976. Relationship Between Excuses and Dropout at a Mental Health Center. Journal of Consulting and Clinical Psychology, Vol. 44, No. 3: 494.
- Berrigan, Lee P. and Garfield, Sol L. 1981. Relationship of Missed Psychotherapy Appointments to Premature Termination and Social Class. British Journal of Clinical Psychology, Vol. 20: 239-242.
- Betz, Nancy E., and Shullman, Sandra L. 1979. Factors Related to Client Return Rate Following Intake. Journal of Counseling Psychology, Vol. 26, No. 6: 542-545.
- Block, Carl E., and Roering, Kenneth J. 1979. Essentials of Consumer Behavior, 2nd ed. Hinsdale, Illinois: The Dryden Press.
- Borghi, J. 1968. Premature Termination of Psychotherapy and Patient-Therapist Expectations. American Journal of Psychotherapy, Vol. 22: 460-473.
- Bourne, Francis S. 1957. Group Influence in Marketing. In Day, R. L., ed. 1964. Marketing Models. Scranton, Pennsylvania: International Text Book Co.
- Brandt, L. W. 1964. Rejection of Psychotherapy? The Discovery of Unexpected Numbers of Pseudorejectors. Archives of General Psychiatry, Vol. 10: 310-313.

- _____. 1965. Studies of Dropout Patients in Psychotherapy: A Review of the Findings. Psychotherapy: Theory, Research and Practice, Vol. 2, No. 1: 6-12.
- Brown, B. Bradford. 1978. Social and Psychological Correlates of Help-Seeking Behavior Among Urban Adults. American Journal of Community Psychology, Vol. 6, No. 5: 425-439.
- Carpenter, Paul J., Morrow, Gary R., Del Gaudio, Andrew C., and Ritzler, Barry A. 1981. Who Keeps the First Outpatient Appointment? American Journal of Psychiatry, Vol. 138, No. 1: 102-105.
- _____, and Range, Lillian M. 1982. Predicting Psychotherapy Duration from Therapists' Sex, Professional Affiliation, Democratic Values, and Community Mental Health Ideology. Journal of Clinical Psychology, Vol. 38, No. 1: 90-91.
- _____. 1983. The Effects of Patients' Fee Payment Source on the Duration of Outpatient Psychotherapy. Journal of Clinical Psychology, Vol. 39, No. 2: 304-306.
- Cartwright, Rosalind, Lloyd, Stephen, and Wicklund, Jane. 1980. Identifying Early Dropouts from Psychotherapy. Psychotherapy: Theory, Research, and Practice, Vol. 17, No. 3: 263-267.
- Cocanogher, A. Benton, and Bruce, Grady D. 1971. Socially Distant Reference Groups and Consumer Aspirations. Journal of Marketing Research, Vol. 8: 379-381.
- Cohen, J. B. 1967. An Interpersonal Orientation to the Study of Consumer Behavior. Journal of Marketing Research, Vol. 4: 270-278.
- _____, and Goldberg, M. E. 1970. The Dissonance Model in Post-Decision Product Evaluation. Journal of Marketing Research, 7: 315-321.
- Cole, John D., Costanzo, Philip R., and Cox, Gary B. 1980. Behavioral Determinants of Mental Illness Concerns: A Comparison of Community Subcultures. American Journal of Community Psychology, Vol. 8, No. 5: 537-555.

- _____. 1975. Behavioral Determinants of Mental Illness Concerns: A Comparison of 'Gatekeeper' Professions. Journal of Consulting and Clinical Psychology. Vol. 43, No. 5: 626-636.
- Cole, John D., Pennington, Bruce F., and Buckley, Hendey H. 1974. Effects of Situational Stress and Sex Roles on the Attribution of Psychological Disorder. Journal of Consulting and Clinical Psychology. Vol. 42, No. 4: 559-568.
- Cole, James, and Magnussen, Max G. 1967. Family Situation Factors Related to Remainers and Terminators of Treatment. Psychotherapy: Theory, Research and Practice. Vol. 4, No. 3: 107-109.
- Cole, Nyla J., Branch, C. Hardin, and Allison, Roger B. 1962. Some Relationship Between Social Class and the Practice of Dynamic Psychotherapy. American Journal of Psychiatry. Vol. 118: 1004-1012.
- Coleman, Richard P. 1983. The Continuing Significance of Social Class to Marketing. Journal of Consumer Research. Vol. 10, No. 3: 265-280.
- Consumers More Opinionated about Services. May 5, 1986. Hospitals, p. 112.
- Cooper, P. D., ed. 1979. Health Care Marketing. Germantown, Md.: Aspen Systems Corp.
- _____, and Maxwell, Richard B. III. 1979. Marketing: Entry Points and Pitfalls. Hospital and Health Services Administration. Vol. 24: 34-53.
- Dengrove, E., and Kutash, S. 1950. Why Patients Discontinue Treatment in a Mental Hygiene Clinic. American Journal of Psychotherapy. Vol. 4: 457-472.
- Di Giulio, Joan Ferry. 1984. Marketing Social Services. Social Casework: 227-234.
- Dichter, Ernest. 1960. The Strategy of Desire. New York; Doubleday and Co.

- Dohrenwend, B. P., and Dohrenwend, B. S. 1969. Social Status and Psychological Disorder. New York: Wiley.
- Donabedian, Avedis. 1973. Aspects of Medical Care Administration: Specifying Requirements for Health Care. Cambridge: Harvard University Press.
- Donnelly, J. H., and Ivancevich, J. M. 1970. Post-Purchase Reinforcement and Back-Out Behavior. Journal of Marketing Research, Vol. 7: 399-400.
- Duesenberry, J. S. 1949. Income, Saving, and the Theory of Consumer Behavior. Cambridge, Massachusetts: Harvard.
- Elsenthal, S., and Lazare A. 1976. Evaluation of the Initial Interview in a Walk-In Clinic: The Patient's Perspective on a "Customer Approach". Journal of Nervous and Mental Diseases, Vol. 162: 169-175.
- Engel, J. F., Blackwell, R. D., and Miniard, P. 1986. Consumer Behavior, 5th ed. New York: The Dryden Press.
- Engel, J. F., Kollat, O. T., and Blackwell, R. D. 1973. Consumer Behavior, 2nd ed. New York: Holt.
- Epperson, Douglas L. 1981. Counselor Gender and Early Premature Terminations from Counseling: A Replication and Extension. Journal of Counseling Psychology, Vol. 28: 349-356.
- Evers, Pascale V. 1985. Effects of Satisfaction and Dropout of Confirmation/Disconfirmation of Clients' Preferences for Therapeutic Style, Level of Disturbance, and Level of Distress. Ph.D. dissertation, University of Maryland. Dissertation Abstracts International, 46, 2803B.
- Festinger, Leon. 1957. A Theory of Cognitive Dissonance. Stanford, California: Stanford University Press
- Flester, A. R., Mahrer, A. R., Giambra, L. M., and Ormiston, D. W. 1974. Shaping a Clinic Population: The Dropout Problem Reconsidered. Community Mental Health Journal, Vol. 10, No. 2: 173-179.

- Fiester, A., and Rudestam, K. 1975. A Multivariate Analysis of the Early Drop-Out Process. Journal of Consulting and Clinical Psychology, Vol. 43, No. 4: 528-535.
- Fischer, E. H. and Cohen, S. L. 1972. Demographic Correlates of Attitude Toward Seeking Professional Psychological Help. Journal of Consulting and Clinical Psychology, Vol. 39: 70-74.
- Fishbein, Martin. 1968. An Investigation of the Relationships Between Beliefs About an Object and the Attitude Toward That Object. Human Relations, Vol. 16: 233-240.
- _____, ed. 1967. Readings in Attitude Theory and Measurement, New York: John Wiley and Sons, Inc.
- _____, and Ajzen, Icek. 1975. Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research, Reading, Mass.: Addison-Wesley.
- Folkins, Carlyle, Hersch, Paul, and Dahlen, Dennis. 1980. Waiting Time and No-Show Rate in a Community Mental Health Center. American Journal of Community Psychology, Vol. 8, No. 1: 121-123.
- France, Doris G. and Dugo, James M. 1985. Pretherapy Orientation as Preparation for Open Psychotherapy Groups. Psychotherapy, Vol. 22, No. 2: 256-261.
- Frank, J. D., Gliedman, L. H., Imber, S., Nash, E. H., and Stone, A. R. 1957. Why Patients Leave Psychotherapy. Archives of Neurology and Psychiatry, Vol. 77: 283-299.
- Fraps, Carolyn L., McReynolds, William T., Beck, Niels C., and Heisler, Gerald H. 1982. Predicting Client Attrition from Psychotherapy Through Behavioral Assessment Procedures and a Critical Response Approach. Journal of Clinical Psychology, Vol. 38, No. 4: 759-764.
- Friedman, Milton. 1957. A Theory of the Consumption Function, Princeton, N. J.: Princeton.
- Gallagher, E. B. and Kanter, S. S. 1961. The Duration of Outpatient Psychotherapy. Psychiatric Quarterly Supplement, Vol. 35: 312-331.

- Garfield, S. L. 1963. A Note on Patient's Reasons for Leaving Psychotherapy. Psychological Reports, Vol. 13: 38.
- _____. 1978. Research on Client Variables in Psychotherapy. In S. L. Garfield and A. E. Bergin, eds. Handbook of Psychotherapy and Behavior Change, 2nd ed. New York: John Wiley.
- _____, and Kurz, M. 1952. Evaluation of Treatment and Related Procedures in 1,216 Cases Referred to a Mental Hygiene Clinic. Psychiatric Quarterly, Vol. 26: 414-424.
- Garton, Tim. 1978. Marketing Health Care: It's Untapped Potential. Hospital Progress, Vol. 59, No. 46: 46-50.
- Genkins, Mary. 1985. Strategic Planning for Social Work Marketing. Administration in Social Work, Vol. 9, No. 1: 35-46.
- Gibby, Robert G., Stotsky, Bernard A., Hiler, E. Wesley, and Miller, Daniel R. 1954. Rorschach Criteria for Predicting Duration of Therapy. Journal of Consulting Psychology, Vol. 18, No. 3: 185-191.
- Goldstein, A. 1962. Therapist-Patient Expectancies in Psychotherapy. New York: Pergamon Press.
- Gourash, Nancy. 1978. Help-Seeking: A Review of the Literature. American Journal of Community Psychology, Vol. 6, No. 5: 413-423.
- Graziano, A. M., and Fink, R. S. 1973. Second-Order Effects in Mental Health Treatment. Journal of Consulting and Clinical Psychology, Vol. 40, No.5: 356-364.
- Greenspan, Marie, and Kulish, Nancy Mann. 1985. Factors in Premature Termination in Long-Term Psychotherapy. Psychotherapy, Vol. 22, No. 1: 75-82.
- Gundlach, R. H., and Geller, M. 1958. The Problem of Early Termination: Is It Really the Terminee? Journal of Consulting Psychology, Vol. 22: 410.

- Hardy, James M. 1986. Integrating Marketing and Corporate Planning in Human Service Organizations. Journal of Marketing for Mental Health, Vol. 1, No. 1: 21-33.
- Hargreaves, W. A., Showstack, J., Flohr, R., Brady, C., and Harris, S. 1974. Treatment Acceptance Following Intake Assignment to Individual Therapy, Group Therapy, or Contact Therapy. Archives of General Psychiatry, Vol. 31: 343-349.
- Heilbrun, Alfred B., Jr. 1961a. Client Personality Patterns, Counselor Dominance, and Duration of Counseling. Psychological Reports, Vol. 9: 15-25.
- _____. 1961b. Male and Female Personality Correlates of Early Termination in Counseling. Journal of Counseling Psychology, Vol. 8, No. 1: 31-35.
- _____. 1962. Psychological Factors Related to Counseling Readiness and Implications for Counselor Behavior. Journal of Counseling Psychology, Vol. 9, No. 4: 353-358.
- _____. 1966. On Predicting Defection from Psychotherapy. Psychological Reports, Vol 19: 61-62.
- _____. 1973. History of Self-Disclosure in Females and Early Defection From Psychotherapy. Journal of Counseling Psychology, Vol. 20, No. 3: 250-257.
- _____. 1974. Improved Detection of the Early Defecting Counseling Client. Journal of Consulting and Clinical Psychology, Vol. 42, No. 5: 633-638.
- _____. 1974. Interviewer Style, Client Satisfaction, and Premature Termination Following the Initial Counseling Contact. Journal of Counseling Psychology, Vol. 21, No. 5: 346-350.
- _____. 1978. Prediction of Continuing Client Contact in a Brief-Treatment Campus Mental Health Agency. Psychological Reports, Vol. 42: 481-482.

- _____. 1982. Cognitive Factors in Early Counseling Termination: Social Insight and Level of Defensiveness. Journal of Counseling Psychology, Vol. 29, No. 1: 29-38.
- _____. 1982. Tolerance for Ambiguity in Female Clients: A Further Test of the Catharsis Model for Predicting Early Counseling Dropout. Journal of Counseling Psychology, Vol. 29, No. 6: 567-571.
- Heine, R. W., and Trosman, H. 1960. Initial Expectations of the Doctor-Patient Interaction as a factor in Continuance in Psychotherapy. Psychiatry, Vol. 23: 275-278.
- Henry, Walter A. 1976. Cultural Values Do Correlate with Consumer Behavior. Journal of Marketing Research, Vol. XIII: 121-127.
- Hiler, E. W. 1959. The Sentence Completion Test as a Predictor of Continuation in Psychotherapy. Journal of Consulting Psychology, Vol. 23: 544-549.
- Hochschild, Arlie R. 1979. Emotion Work, Feeling Rules, and Social Structure. American Journal of Sociology, Vol. 85: 551-575.
- Hoffman, Joseph J. 1985. Client Factors Related to Premature Termination of Psychotherapy. Psychotherapy: Theory, Research and Practice, Vol. 22, No. 1: 83-85.
- Hollender, M. H. 1964. Selection of Patients for Definitive Forms of Psychotherapy. Archives of General Psychiatry, Vol. 10, No. 4: 361-369.
- Horenstein, David, and Houston, B. Kent. 1976. The Expectancy-Reality Discrepancy and Premature Termination from Psychotherapy. Journal of Clinical Psychology, Vol. 32, No. 2: 373-378.
- Hornstra, R. K., Lubin, B., Lewis, R. V., and Willis, B. S. 1972. Worlds Apart: Patients and Professionals. Archives of General Psychiatry, Vol. 27: 553-581.
- Hospitals Call a Marketing Time Out. June 5, 1986. Hospitals: 50.

- Hospitals Tap Business Sector for Marketers. February 20, 1986.
Hospitals: 64.
- Howard, John A. 1963. Marketing: Executive and Buyer Behavior. New York: Columbia University Press.
- _____, and Sheth, Jagdish N. 1969. The Theory of Buyer Behavior. New York: Wiley.
- Hunt, R. C. 1960. Social Class and Mental Illness: Some Implications for Clinical Theory and Practice. American Journal of Psychiatry. Vol. 116: 1065-1069.
- Imber, S. D., Nash, E. H. Jr., and Stone, A. R. 1955. Social Class and Duration of Psychotherapy. Journal of Clinical Psychology. Vol. 11: 281-284.
- Jaccard, James, Brinberg, David, and Ackerman, Lee J. 1986. Assessing Attribute Importance: A Comparison of Six Methods. Journal of Consumer Research. Vol. 12, No. 4: 463-468.
- Jacoby, Jacob, Szybillo, George J., and Berning, Carol Kohn. 1976. Time and Consumer Behavior: An Interdisciplinary Overview. Journal of Consumer Research. Vol. 2: 320-339.
- Johansson, Johny K., MacLachlan, Douglas L., and Yalch, Richard F. 1976. Halo Effects in Multiattribute Attitude Models: Some Unresolved Issues. Journal of Marketing Research. Vol. XIII: 414-417.
- Kadushin, Charles. 1969. Individual Decisions to Undertake Psychotherapy. Administrative Science Quarterly. Vol. 3: 379-411.
- Kassarjian, H. H. 1971. Personality and Consumer Behavior. Journal of Marketing Research. Vol. 8: 409-418.
- Katona, George. 1960. Psychological Economics. New York: Elsevier Scientific Publishing Company, Inc..
- Katz, E. and Lazarsfeld, P. 1955. Personal Influence. New York: Free Press.

- Katz, M., Lorr, M., and Rubinstein, E. 1958. Remainer Patient Attributes and Their Relation to Subsequent Improvement in Psychotherapy. Journal of Consulting Psychology, Vol. 22: 411-413.
- Kaufman, Steven E. 1985. Patient and Therapist Values Related to Dropout. Ph.D. dissertation, City University of New York. Dissertation Abstracts International, 46, 4000B.
- Kelner, Frederick A. 1982. An Evaluation of Jochim's PT Scale in the Prediction of Premature Termination from Outpatient Psychotherapy. Journal of Clinical Psychology, Vol. 38, No. 1: 106-108.
- Kimmel, Wayne A. 1977. Needs Assessment: A Critical Perspective. Office of Program Systems, Office of the Assistant Secretary for Planning and Education, Department of Health, Education and Welfare.
- Kinnear, Thomas C. and Taylor, James R. 1976. Psychographics: Some Additional Findings. Journal of Marketing Research, Vol. XIII:423-425.
- Kolb, Daniel, Beutler, Larry E., Davis, Carl S., Crago, Marjorie, and Shanfield, Stephen B. 1985. Patient and Therapy Process Variables Relating to Dropout and Change in Psychotherapy, Psychotherapy, Vol. 22, No. 4: 702-710.
- Kotkov, B., and Meadow, A. 1953. Research Criteria for Predicting Continuing in Individual Psychotherapy. Journal of Consulting Psychology, Vol. 17:16-20.
- Kotler, Philip. 1972. A Generic Concept of Marketing. Journal of Marketing, Vol. 36: 46-54.
- _____. 1982. Marketing for Nonprofit Organizations, 2nd ed. New Jersey: Prentice-Hall.
- _____, and Levy, Sidney J. 1969. Broadening the Concept of Marketing. Journal of Marketing, Vol. 33: 10-15.

- Krauskopf, C. J., Baumgardner, Ann, and Mandracchia, Steve. 1981. Return Rate Following Intake Revisited. Journal of Counseling Psychology, Vol. 28: 519-521.
- Kurland, S. H. 1956. Length of Treatment in a Mental Hygiene Clinic. Psychiatric Quarterly Supplement, Vol. 30: 83-90.
- Lake, Martha, and Levinger, George. 1960. Continuance Beyond Application Interviews at a Child Guidance Clinic. Social Casework, Vol. 41: 303-309.
- Lazare, Aaron, Eisenthal, Sherman, and Frank, Arlene. 1976. Disposition Decisions in a Walk-In Clinic: Social and Psychiatric Variables. American Journal of Orthopsychiatry, Vol. 46, No. 3: 503-509.
- _____, Eisenthal, Sherman, and Wasserman, L. 1975. The Customer Approach to Patienthood: Attending to Patient Requests in a Walk-In Clinic. Archives of General Psychiatry, Vol. 32: 553-558.
- _____, Eisenthal, Sherman, Wasserman, Linda, and Harford, Thomas C. 1975. Patient Requests in a Walk-In Clinic. Comprehensive Psychiatry, Vol. 16: 467-477.
- _____, Cohen, Frances, Jacobson, Alan M., Williams, Melvin W., Mignone, Robert J., and Zisook, Sidney. 1972. The Walk-In Patient as a "Customer": A Key Dimension in Evaluation and Treatment. American Journal of Orthopsychiatry, Vol. 42: 872-883.
- Lee, Stephen D., and Temerlin, Maurice K. 1970. Social Class, Diagnosis, and Prognosis for Psychotherapy. Psychotherapy: Theory, Research and Practice, Vol. 7: 181-185.
- Leutz, W. N. 1976. The Informal Community Caregiver: A Link Between the Health Care System and Local Residents. American Journal of Orthopsychiatry, Vol. 46: 678-688.
- Levinger, G. 1960. Continuance in Casework and Other Helping Relationships. Social Work, Vol. 5: 40-51.
- Levinson, D., Merrifield, J., and Berg, K. 1967. Becoming a Patient. Archives of General Psychiatry, Vol. 17: 385-406.

- Liberman, R. 1965. Personal Influence in the Use of Mental Health Resources. Human Organization 24 (1965): 231-235.
- Lief, H. I., Lief, V. F., Warren, C. O., and Heath, R. G. 1961. Low Dropout Rate in a Psychiatric Clinic. Archives of General Psychiatry, Vol. 5: 200-211.
- Linn, J. Gary and McGranahan, David A. 1980. Personal Disruptions, Social Integration, Subjective Well-Being, and Predisposition Toward the Use of Counseling Services. American Journal of Community Psychology, Vol. 8, No. 1: 87-100.
- Lippman, Bernard Benjamin. 1983. Premature Termination of Psychotherapy: The Patient's Perspective. Ph.D. dissertation, The Fielding Institute. Dissertation Abstracts International, 45, 677B.
- Locander, William B. and Hermann, Peter W. "The Effects of Self-Confidence and Anxiety on Information Seeking in Consumer Risk Reduction. Journal of Marketing Research, Vol. 16: 268-274.
- Lorr, M., Katz, M. M., and Rubinstein, E. A. 1958. The Prediction of Length of Stay in Psychotherapy. Journal of Consulting Psychology, Vol. 22 : 321-327.
- Lothstein, Leslie M. 1978. The Group Psychotherapy Dropout Phenomenon Revisited. American Journal of Psychiatry, Vol. 135, No. 12: 1492-1495.
- Loudon, David L. and Della Bitta, Albert J. 1979, 1984. Consumer Behavior: Concepts and Applications, 1st and 2nd editions, New York: McGraw Hill, Inc.
- MacStravic, Robin E. 1977. Marketing Health Care, Germantown, Maryland: Aspen Systems Corp.
- Mahrer, A. R. 1970. Some Known Effects of Psychotherapy and a Reinterpretation. Psychotherapy: Theory, Research, and Practice, Vol. 7: 186-191.

- _____. 1970. Motivational Theory: Foundations of Personality Classification. In A. R. Mahrer, ed. New Approaches to Personality Classification. New York: Columbia University Press.
- _____. 1972. The Human Relations Center: Community Mental Health from a Motivational Perspective. Corrective Psychiatry and Journal of Social Therapy, Vol. 18, No. 2: 39-45.
- Marketing Budgets on the Rise. March 5, 1986. Hospitals: 68.
- Mechanic, D. 1962. Some Factors in Identifying and Defining Mental Illness. Mental Hygiene, Vol. 46: 66-74.
- Moschis, Goerge P. 1976. Social Comparison and Informal Group Influence. Journal of Marketing Research, Vol. XIII: 237-244.
- Myers, J. and Schaefer, Leslie. 1954. Social Stratification and Psychiatric Practice: A Study of an Outpatient Clinic. American Sociological Review, Vol. 19, No. 3: 307-310.
- Nash, E. H., Frank, J. D., Gliedman, L. H., Imber, S. D., and Stone, A. R. 1957. Some Factors Related to Patients Remaining in Group Psychotherapy. International Journal of Group Psychotherapy, Vol. 7: 264-274.
- Nicosia, Francesco M. 1966. Consumer Decision Processes. Englewood Cliffs, N. J. : Prentice-Hall.
- Noonan, J. Robert. 1973. A Follow-up of Pretherapy Dropouts. Journal of Community Psychology, Vol. 1: 43-44.
- Overall, B. and Aronson, H. 1963. Expectations of Psychotherapy in Patients of Lower Socio-Economic Class. American Journal of Orthopsychiatry, Vol. 33: 421-430.
- Packard, Vance. 1957. The Hidden Persuaders. New York; McKay.
- Park, C. Whan. 1976. The Effect of Individual and Situation-Related Factors on Consumer Selection of Judgemental Models. Journal of Marketing Research, Vol. XIII: 144-151.

- Payne, John W. 1982. Contingent Decision Behavior. Psychological Bulletin, Vol. 92: 382-402.
- Pekarik, Gene. 1983a. Follow-Up Adjustment of Outpatient Dropouts. American Journal of Orthopsychiatry, Vol. 53, No. 3: 501-511.
- _____. 1983b. Improvement in Clients Who Have Given Different Reasons for Dropping Out of Treatment. Journal of Clinical Psychology, Vol. 39, No. 6: 909-913.
- _____, and Phinney-Owen, Karen. 1987. Outpatient Clinic Therapist Attitudes and Beliefs Relevant to Client Dropout. Community Mental Health Journal, Vol. 23, No. 2: 120-129.
- Peter, J. Paul and Tarpey, Lawrence X. Sr. 1975. A Comparative Analysis of Three Consumer Decision Strategies. Journal of Consumer Research, Vol. 2, No. 1: 29-36.
- Peterson, Jane W. Preappointment Reminder Calls to Decrease No-Show Rates. 1982. Hospital and Community Psychiatry, Vol. 33, No. 4: 311.
- Pugliese, Karen. 1981. The Role of Emotional Behavior in the Labelling of Mental Illness. MA thesis, Department of Sociology, Washington State University.
- Punj, Girish N. and Staelin, Richard. 1983. A Model of Consumer Information Search Behavior for New Automobiles. Journal of Consumer Research, Vol. 9: 366-380.
- Punj, Girish N., and Stewart, David W. 1983. An Interaction Framework of Consumer Decision-Making. Journal of Consumer Research, Vol. 10, No. 2: 181-196.
- Raphael, E. E. 1964. Community Structure and Acceptance of Psychiatric Aid. American Journal of Sociology, Vol. 69: 340-358.
- Rasmussen Brings Sales to Catholic Multi. September 5, 1986. Hospitals: 65.

- Reder, Peter, and Tyson, Robert L. 1980. Patient Dropout from Individual Psychotherapy. Bulletin of the Menninger Clinic, Vol. 44, No. 3: 229-252.
- Riess, B. F., and Brandt, L. W. 1965. What Happens to Applicants for Psychotherapy? Community Mental Health Journal, Vol. 1, No. 2: 175-180.
- Rodolfa, Emil R., Rapaport, Ross, and Lee, Virginia E. 1983. Variables Related to Premature Terminations in a University Counseling Service. Journal of Counseling Psychology, Vol. 30, No. 1: 87-90.
- Rokeach, Milton. 1960. The Nature of Human Values. New York: Basic Books, Inc.
- Rosenberg, Larry J. 1977. Marketing. Englewood Cliffs, N. J. : Prentice-Hall, Inc.
- Rosenthal, D. and Frank, J. 1958. The Fate of Psychiatric Clinic Outpatients Assigned to Psychotherapy. Journal of Nervous and Mental Disorders, Vol. 127: 330-343.
- Ryan, Michael J. 1982. Behavioral Intention Formation: The Interdependency of Attitudinal and Social Influence Variables. Journal of Consumer Research, Vol. 9: 263-278.
- Sargent, Susan C. 1984. Marketing Psychiatric Services. Psychiatric Annals, Vol. 14, No. 5: 375-384.
- Schaninger, Charles M. , and Sciglimpaglia, Donald. 1981. The Influence of Cognitive Personality Traits and Demographics on Consumer Information Acquisition. Journal of Consumer Research, Vol. 8: 208-216.
- Scheff, T. J. 1966. Users and Non-users of a Student Psychiatric Clinic. Journal of Health and Social Behavior, Vol. 7: 114-121.
- Silverman, Wade H., and Beech, Robert P. 1979. Are Dropouts, Dropouts? Journal of Community Psychology, Vol. 7: 236-242.

- Sirgy, M. Joseph. 1982. Self-Concept in Consumer Behavior: A Critical Review. Journal of Consumer Research, Vol. 9: 287-300.
- Strupp, H. H., Fox, R. E., and Lessler, K. 1969. Patients View Their Psychotherapy. Baltimore: Johns Hopkins University Press.
- Thoits, Peggy A. 1985. Self-labeling Processes in Mental Illness: The Role of Emotional Deviance. American Journal of Sociology, Vol. 91, No. 2: 221-249.
- Walters, Glenn D., Solomon, Gary S., and Walden, Vicki R. 1982. Use of the MMPI in Predicting Psychotherapeutic Persistence in Group of Male and Female Outpatients. Journal of Clinical Psychology, Vol. 38, No. 1: 80-83.
- Weinberger, J. L., and Gay, E. 1949. Utilization of Psychiatrist and Social Worker as an Intake Team. American Journal of Psychiatry, Vol. 106: 384-388.
- Wells, William D. 1975. Psychographics: A Critical Review. Journal of Marketing Research, Vol. XIII: 196-213.
- Wentz, Walter B. 1979. Marketing. St. Paul, Minnesota: West Publishing Co.
- _____, and Eyrich, Gerald I. 1970. Marketing: Theory and Application. New York: Harcourt, Brace and World, Inc.
- Westing, J. H. and Albaum, Gerald, eds. 1964. Modern Marketing Thought. New York: The Macmillan Company.
- Wind, Yoram. 1976. Preference of Relevant Others and Individual Choice Models. Journal of Consumer Research, Vol. 3: 50-57.
- Winston, William J. 1986. Basic Marketing Principles for Mental Health Professionals. Journal of Marketing for Mental Health, Vol. 1, No. 1: 9-20.
- Woods, Walter A. 1981. Consumer Behavior: Adapting and Experiencing. New York: North Holland.

Wright, Peter. 1975. Consumer Choice Strategies: Simplifying versus Optimizing. Journal of Marketing Research, Vol. XII: 60-67.

_____, and Weitz, Barton. 1977. Time Horizon Effects on Product Evaluation Strategies. Journal of Marketing Research, Vol. XIV: 429-443.