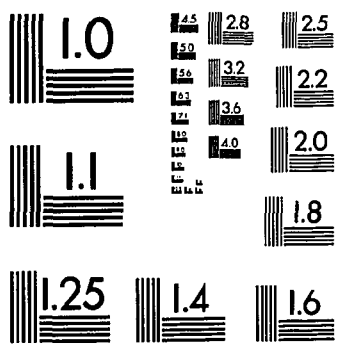


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**PATIENT AND THERAPIST VALUES RELATED TO DROPOUT**

*City University of New York*

**Ph.D. 1985**

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PATIENT AND THERAPIST VALUES RELATED TO DROPOUT

by

STEVEN KAUFMAN

A dissertation submitted to the Graduate Faculty in  
Psychology in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy, The City University  
of New York.

1985

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

PATIENT AND THERAPIST VALUES RELATED TO DROPOUT.

by

Steven Kaufman

Advisor: Professor Harold Wilensky, Ph.D.

Prior research has pointed to the relationship between client's dropping out of therapy and several variables. This study investigated the effects that status of patient and therapist values had on the process of dropping out.

It was hypothesized that long term commitment would be facilitated by the presence of certain personal values in patients and therapists. Secondly, other factors related to dropping out, such as, ethnicity, age, sex, educational level, marital status, religion and diagnosis, were explored.

Sixty nine patients applying for outpatient individual psychotherapy at two mental health outpatient clinics were included in the sample. After intake interview, and before the first therapy appointment, measures tapping patient personal values, self concepts, and symptoms, were administered to the patients. Therapist values, self concepts, and theoretical orientations were measured twice over a one year period.

Patient values, self concept and level of initial disturbance were measured by the Survey of Interpersonal Values (SIV), Survey of Personal Values (SPV), Symlog Value scale, The Semantic Differential (SD) and the Psychotherapy Problem Checklist (PPC). Therapists' (N=36) values, self concepts and theoretical orientation were measured by the Survey of Interpersonal Values (SIV), the Survey of Personal Values (SPV), the Symlog scale and the Therapist Orientation Questionnaire (TOQ).

Terminating patients (N=46) were distinguished from remainders (N=23) according to the number of sessions attended. Measures of difference were calculated within patient and therapist groups and for each patient and therapist dyad

The results supported the hypotheses that terminated relationships are characterized by certain patient values (patient dominance, goal orientation, achievement, and decisiveness), certain therapist values, (opposition to task oriented behavior) and the interaction between patient and therapist values. Therapist orientation did not change on the two TOQ administrations during the year.

The findings suggested that premature termination could be reduced by the therapist's active pursuit of an accurate and honest exploration of values with their patients, and/or by identifying patients and therapists in order to produce productive dyads. The SPV, SIV, Symlog and TOQ scales provided a basis for identifying high and low risk

therapy dyads.

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This work is dedicated to my wife, Barrie, for putting up with me; to my mother, Esther, for the same, to the memory of my father, Louis, and the future of my daughter, Rebecca.

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## CHAPTER 1 HISTORY

### Introduction

The dropout rate in individual psychotherapy at community mental health centers (CMHC's) is a problem that faces administrators and clinicians alike. It is costly in terms of time, money and staff morale. Valuable clinical time is exhausted when patients either drop out of treatment early into the psychotherapy relationship or fail to return for psychotherapeutic assignment after the completed period of intake assessment.

Overall estimates of the dropout rate at mental healthclinics range from twenty to eighty percent. Twenty to fifty percent of patients fail to return after the first visit; 31-56% attend less than four times (Overall & Aronson, 1963; Rosenthal & Frank, 1958,).

Studies find improvement to be related positively to continuation (Luborsky, Auerbach, Chandler, & Cohen, 1971). Although perhaps many dropouts would not improve in prolonged psychotherapy, and therefore may be exhibiting a self-selecting process in dropping out, it does appear that the longer the duration of therapy, the better the outcome.

Thus, the clinical importance of preventing premature termination is evident. Issues of cost effective provision of services, the mandate to provide services, staff morale and the need to establish viable working therapeutic

relationships, no matter what the therapeutic orientation of choice, are but some of the implications of the high dropout rate in these settings (Seeman, 1974).

Attempts to identify variables which could predict client attendance have used a wide range of instruments including measures of patient and therapist ideology (Carpenter & Range, 1980; Beutler, 1980), personality (Affleck & Mendick, 1959; Mendelson & Geller, 1967), therapist orientation and experience (Sundland & Barker, 1977) and patient demographic characteristics (Brandt, 1965; Garfield, 1971; Rosenthal & Frank, 1955). None of the instruments or variables has displayed a significant capacity to clearly select premature terminators.

The purpose of this study was to investigate patient and therapist variables and their relationship to premature termination. The variables included patient/therapist interaction in personality and values, patient and therapist personality and values examined independently, therapist theoretical orientation and patient demographic data, during the treatment process.

## Literature Review

### Premature Termination

#### Patient Variables Related to Premature Termination.

Studies of dropout in adult individual therapy at outpatient clinics have found several variables associated with duration of stay in adult outpatient psychotherapy.

Education level, annual income, motivation and referral source have been found to discriminate between acceptors and rejectors of treatment in some studies (Rosenthal & Frank, 1957) but not in others (Brandt, 1963). Differences might be accounted for by the difference in criterion: the latter study defined rejectors as patients who failed to accept treatment when available, whereas the former defined dropout as representing a cutoff time in which the patient had actually begun treatment and then quit.

Findings concerning the relationship of patient demographic characteristics, such as age and sex, to duration of treatment appear dependent on the type of treatment offered, referral source and patient socioeconomic status. Gottschalk (1967) found younger patients more likely to dropout in brief therapy, while longer term treatment facilities found particular age brackets (younger than thirty and older than forty) to be associated with an increase in the rate of dropout (Brown & Kosterlitz, 1964).

Female patients have been found more likely to dropout in several studies (Kosterlitz, 1964) but not in others (Rosenthal & Frank, 1958). Criterion issues and questions of field dependence appeared involved in the different results obtained in these studies.

The relationship between patient social class and duration has appeared dependent both on type of treatment (Hollingshead & Redlich, 1958) and interaction with value patterns (Pettit, Pettit & Welkowitz, 1974). Patient social

class, when treated with psychoanalytically oriented psychotherapy, has been predictive of dropout in 20 studies (Bakeland & Lundwall, 1975) but not predictive of dropout in non-psychoanalytic treatment settings (Hollingshead & Redlich, 1958, Lowinger & Dobie, 1968). In a study (Pettit & Welkowitz, 1967) investigating the relationship between values, social class and duration of therapy, lower class patients were found to be more authoritarian/submissive,<sup>1</sup> with a linear relationship indicating that the lower the social class and the higher (more authoritarian-submissive) the patient's score relative to his therapist's score (as measured by the SVIB and Ways To Live Scale), the longer the treatment duration. Therapist patient values discrepancy was noted as a significant factor in determining the duration of treatment.

Psychologically, the dropout has been characterized as less suggestible (Frank, 1957),<sup>2</sup> counterdependent (Heilbrun, 1961), overtly dependent (Heilbrun, 1961), high in self-disclosure (Heilbrun, 1973) and less psychologically minded (Katz & Solomon, 1958).

Heilbrun's (1973) examination of the role of dependency needs, in treatment duration, found that males high on counterdependency tended to terminate early, and that females high on overt dependency and self disclosure terminated early as well. Both variables appeared dependent on sex match and age of patient and therapist as well. Females were higher in termination rates with male therapists, while males termi-

nated more with therapists of similar age.

Diagnostic categories of low levels of anxiety and/or depression, paranoia, sociopathy and alcoholism, have been related to dropout in some studies (Frank, 1957; Hiler, 1958; Straker, 1967,) but shown to be unrelated in others (Rosenthal & Frank, 1958; Garfield & Affleck, 1959). Differences in results were attributed to the different measurements applied (clinical ratings vs. Rorschach), the different criteria used, and the finding that the relationship between anxiety, depression, and dropping out of treatment was too complex to analyze in the studies noted.

Seeman (1978) noted that terminators tended to drop out of therapy with the advent of transference elements similar to those prominent and difficult in their adolescence and previously avoided in their family. Kohut (1968) has discussed analysands who quit suddenly because of narcissistic insult. Cooperman (1970) saw the dropout's breaking off the treatment as a need to defeat the therapist.

Psychodynamic interpretations of the dropout phenomenon, although lending themselves to predictive verification, have typically involved small samples, subject variability, and post hoc subjective analyses of a largely speculative nature, without systematic controlled investigation. These studies have, however, observed a multidetermination of causes and shown the ability to suggest mechanisms to alert the therapist to the probability that treatment will be aborted (Levinson, et al, 1978).

In summary, the review of patient contributing factors to the dropout process reveals discrepancies in findings that outweigh consistencies. The findings have recommended the need to study the therapist patient relationship and to take account of the confounding influence of patient and therapist factors and the treatment situation. This study, while naturalistic in design, maintained a uniformity of therapeutic practitioners, a uniform set of criteria, a detailed demographic description and the use of an outpatient clinical sample, that is largely generalizable to the clinical population at large.

Therapist Variables Related to Premature Termination

Experience. More experienced therapists appear able to retain patients in treatment for a longer time, particularly patients of lower socioeconomic status. Baum et al (1967) and Sullivan (1958) investigated the dropout phenomenon in outpatient therapy with lower social class patients. They found more experienced therapists able to retain patients in therapy for a longer time. Lowinger & Dobie (1968), investigating the variable of therapist experience, found experienced therapists more likely to treat higher class, younger, white, female patients, whom they viewed as more communicative, and attractive; i.e., the YAVIS syndrome<sup>3</sup>(Schofield, 1964). The implication was that experienced therapists had better success rates due to an interaction between experience and the selective process of acquiring patients with such educational

and social class assets.

Sex Matching. Male therapists have been found more likely to lose less productive clients, while female therapists have been found to be able to keep unproductive clients, but lose highly productive ones (McNair, 1964). Sex matching has been significant in duration studies investigating patient-therapist cognitive similarity (Mendelson & Geller, 1967) and patient self-disclosure (Heilbrun, 1973). Heilbrun's (1973) study of patient counterdependence and self-disclosure and their relation to dropout, found the sex match of patient and therapist to be related to results with both variables. Terminators were higher self-disclosers to male therapists, whereas continuers were higher self-disclosers to females. Mendelson (etal, 1967) investigated therapist patient personality similarity and dropout and noted that sex matching of therapist and patient (same sex) reduced the dropout rate, but only for the freshman sample of the population studied.

Theoretical Orientation. While theoretical orientation has been considered an overrated variable in psychotherapy outcome research (Strupp, 1978), this criticism appears directed to the conceptual boundaries and official doctrines represented by the classical schools, such as the Freudian, Rogerian or Humanistic schools. The inclusive results of Heine's (1953) study of the relationship of therapist orientation to efficacy may have been related to the fact that comparison of therapists was made according to their official identification with schools of therapy, rather than actual measurement

of individual practice.

The use of available measures of therapeutic orientation (Sundland, 1962, 1977) to match patient and therapist on dimensions of personality and values has been useful and effective (Vardy, 1982; Dougherty, 1972; Beutler, 1983) and significant relationships have been found between novice psychotherapists' theoretical orientation and initial success in terms of early rapport with patients (Vardy & Kay, 1982). Specifically, equalitarian values (as measured by the Bales value scale) and expressive, experiential orientations and behavior were associated with therapist's initial rapport (Vardy, etal, 1982).

Dougherty (1972) utilized therapist orientation, as measured by the Therapist Orientation Questionnaire (Sundland & Barker, 1962)<sup>4</sup>, to predict outcome ratings with groups of patients homogeneous with respect to "personality"; and he used factor analytic techniques to develop a set of psychological variables measuring personality characteristics, needs, values and orientations to therapy. Therapist orientation was found most useful in predicting "negative matches", as applied to dyadic matching of relationships predicted to be optimally beneficial vs. those predicted to be "deterioration matches". These matches were based on a regression equation analysis of outcome in individual outpatient therapy, during the previous year at the same outpatient site.

An example of therapeutic orientation, as a variable affecting therapy duration, is the observation that psychoanalytically oriented treatment, when provided to lower class patients, has been found predictive of dropout. (Hollingshead & Redlich, 1958; Bakeland & Lundwall, 1975). This has suggested the importance of giving the lower class patient in psychotherapy both a form of treatment which agrees with his expectations (drugs, directiveness) and which also provides rapid symptomatic relief. This has been accentuated by Dodd's (1971) report of higher dropout in lower class patients not given medication.

Therapist Value Systems. Lerner (1972) explored the relationship of therapist qualities to duration and outcome of therapy with an outpatient population of lower class and severely impaired patients. She found that the therapist's commitment to democratic values was most strongly related to a longer duration and positive outcome and that duration and outcome were inversely related to therapist authoritarianism.

Carpenter & Range (1973) analyzed therapist's scores on Community Mental Health Ideology (CMHI) and Democratic Values (DV) scales, along with sex and professional affiliation, in order to predict the number of therapy visits of 166 predominantly middle class "neurotic" outpatients. They found that low-scoring CMHI therapists had significantly more therapy sessions than high-scoring CMHI therapists. The latter were thought to value briefer treatment approaches. Ther-

apist orientation and personal values, although not measured in relation to rate of dropout in these studies, were clearly related to duration of treatment.

Therapist Attitudes And Behavior. Yamamoto, James, Bloombaum, and Hattem (1967) found that in a clinic staffed by white practitioners, the attrition rate was higher for black clients than for white clients. A positive relationship was also found between therapists' rating on ethnocentricity and black attrition rates (Yamomoto, etal, 1967). Variables of therapist reaction toward clients, such as judgment with regard to therapeutic assets (Lowinger & Dobie, 1966), estimations of progress (Garfield & Affleck, 1959) and ratings of acceptability for treatment (Heine & Trosman, 1960), have also been associated with lack of continuation.

Heisler, etal (1982) found therapists' ratings of patient behavior to correlate significantly with length of stay in therapy. Therapists' ratings consisted of estimates of the number of sessions the patient would need and attend, the extent of their crisis, their use of defense mechanisms, their cooperativeness and assets. The possibility that therapist negative ratings created a self fulfilling prophecy in this study is plausible, since therapist ratings were gathered after the first interview.

Shapiro (1974) investigated the factors contributing to premature termination during family therapy and found that therapists' ratings of their own affective responses to continuers was consistently more positive than their respon-

ses to dropouts. No significant difference was found between continuers and terminators on ratings of psychopathology. Awareness, on the therapists' part, of their affective responses as providing cues of acceptance or rejection in their patients was stressed, in this study, particularly in the evaluation (or intake phase) of treatment.

Fiester (1977) investigated client perceptions of therapists with high dropout rates. He found no difference on therapist demographic variables, but emphasized the significance of specific therapy process factors, as measured by the Orlinsky & Howard (1966) Therapy Session Report in regard to the dropout phenomenon. Therapists characterized by their clients as anxious and aroused and ineffectual with confrontative clients produced higher rates of patient dropout.

Review of past studies in therapist variables finds them to have involved small samples (Garfield, 1971; Affleck & Muffly, 1963), a limited spectrum of therapist variables (Salzman, Shader, Scott & Binstock, 1970), and failure to consider the topic of cross-validation (Garfield & Affleck, 1961). The study of therapist variables, unrelated to patient variables, has been found lacking and the emphasis on the need to examine process dimensions has been stressed.

This study, while attending to the examination of patient and therapist variables in isolation, also examined initial interaction in variables in the patient/therapist dyad, across identical therapist and patient values and personality variables. The significance of therapy relationship

variables as the significant factor in comprehending the dropout phenomena was hypothesized. Community mental health outpatient facilities, which were staffed by experienced practitioners, were sampled, in order to increase the generalizability of the results to the outpatient population at large.

Therapist Patient Interaction Variables and Duration of Stay  
Therapist Patient Treatment Discrepancy. Discrepancy between patient and therapist treatment expectations and goals has been shown to increase dropout rate (Overall & Aronson, 1963; Heine & Trosman, 1960; Borghi, 1968; Sandler, 1975). Overall & Aronson (1963) found the interaction between patient expectations and perceptions of therapist behavior to be a significant predictor of early termination.

Sandler (1975) investigated the effects of patient therapist dissimilarity of role expectations in the dropping out process and found that terminated relationships manifested higher initial dissimilarity of role expectations than sustained relationships. This suggests that actively inducing accurate and congruent expectations in patients, or matching patients and therapists in order to produce dyads compatible in role expectations, might reduce dropout rate. This study was limited by its small sample size and by the fact that its therapist population consisted of students.

Patient and Therapist Personality Similarities. McLachlan (1972), studying patient and therapist similarity on dimensions of dependency and autonomy, suggested a positive rela

tionship between initial similarity and subsequent improvement. This study was limited to having been conducted in group therapy.

Studies of patient/therapist personality similarities in individual therapy, have employed a diversity of personality measures, cognitive measures and outcome criteria. Some studies have found a positive relationship between similarity and outcome (Carr, 1970; Mendelson, 1967), while others have found either a negative or nonsignificant one (Bare, 1967; Swensen, 1967; Wogan, 1970). These differences in results are explained in terms of the variety of personality dimensions measured and outcome criteria employed. These assessment instruments have included the Leary Interpersonal Matrix (Wogan, 1970) the MMPI (Carson & Heine, 1966), the MBTI (Mendelson & Geller, 1967), the Kelly Role Construct Repertory Test (Landfield & Nawas, 1971) and personality typologies developed from previous inventories (Beutler, 1982).

Mendelson & Geller (1967) found that patient dropout from psychotherapy was strongly associated with initial global client therapist personality similarity, as measured by the Myers Briggs Type Indicator (MBTI), a measure of cognitive style. Carson & Heine (1963) deriving an index of personality similarity for patient therapist pairs (from MMPI scores), found success to vary with similarity. The form of the relationship was curvilinear<sup>8</sup>. Attempts at replication (Carson & Llewleleyn, 1969; Lichtenstein, 1966) have

however, failed. Explanations for the inability to replicate the study have addressed the indexes of personality utilized.

The A/B therapist hypothesis<sup>9</sup> (Whitehorn & Betz, 1967; Razin, 1977), as a reported personality factor involved in therapy success, has yielded negative and inconsistent findings (Chartier, 1970, Razin, 1971). Recent investigations, comparing the relative effectiveness of the A/B dichotomy with other value and psychotherapy orientations, found the latter a more promising dimension of therapist attributes predictive of therapy success and duration (Vardy & Kay, 1982). The limitations of A/B studies (including their inpatient samples studied, the unreliability of patient diagnostic categories to which A and B therapists apply their skills, and other methodological considerations) have resulted in its loss of support in matching studies.

Patient Therapist Values Interaction Variables. Studies of the relationship between initial patient and therapist similarity in personal beliefs and values and subsequent treatment duration and outcome find the precise relationship between them inconclusive. Some studies show a relationship between the two and other studies do not show a relationship. Differences appear to be a result of the dimensions employed, the populations sampled and the criteria considered.

The variety of attitudes and beliefs systems found to support initial therapist patient similarity have included reference to "social values" (Holzman, 1962), moral values (Rosenthal, 1955), personal constructs (Landfield, 1971; Land-

field & Nawas, 1964) and "terminal values" (Martini, 1978).

Some studies, which obtained a negative relationship between initial similarity of patient therapist belief systems and subsequent improvement, have examined a broad range of attitudes (Edwards & Edgerly, 1970; Pettit, Pettit, & Welkowitz, 1974; Welkowitz, Cohen, & Ortmeyer, 1967), and other studies used a narrow set of values to verify this negative relationship (Lesser, 1961; Kalafat, Boroto, & France, 1972).

It has been postulated that similarity in some values and attitudes, combined with dissimilarity on other dimensions, may produce a maximally compatible relationship. Beutler (1982) examined a range of patient's and therapist's values, including those toward religion, God, communism, premarital sex, and threat in the world and studied therapist/patient latitudes of acceptance and rejection. He found that selective rejection and acceptance of the therapist's values was conducive to improvement of the therapy relationship. Initial rejection of therapist's views of the world along with acceptance of their views about God and sexuality were demonstrated to be positively related with client improvement. The effect of such selective acceptance/rejection on the rate of dropout was found to be insignificant, but was not adequately evaluated. Latitudes of acceptance and rejection of values were compiled using a semantic differential sort of instruments with responses ranging from strongly agree to disagree.

Hence, compositions of patient and therapist mutual acceptance or rejection were not based on knowledge of the other participant's responses.

Rosenthal (1955), in the first systematic investigation of patient/therapist value similarity and outcome, found that 12 inpatients who were rated as having successful treatments, had become more like their therapists in attitudes concerning sex, aggression and discipline. Patients who were rated as having deteriorated during therapy were found to become less similar. Patient values (as measured by the Allport Vernon Lindsay Study of Values) did not show significant change, while patient values as measured by a Moral Values Q sort did show change. Changes in patient moral values centering on sex, aggression and authority were thought to occur because these issues would be involved in patient's conflicts.

Welkowitz, et al (1967) investigated patient therapist value similarity and therapist value homogeneity (as measured by loadings on the Ways To Live and Strong Vocational Interest Blank) and found similarity to be positively related to duration, and that therapists do not share a homogeneous value system. Parloff, et al (1960) found that therapists' values influenced the manner of their therapeutic intervention and selection of relevant material. These were then adopted by the patient. Parloff assessed values by having the therapist and patient rank for importance the various

issues that arose during the therapy sessions.

Holzman (1962) found that, among outpatients, the ability to carry out basic life functions, such as work, independence from parents and social ties, was enhanced when the therapist was of a similar socioeconomic background to the patients and had similar values.

Research investigating initial patient therapist religious similarity (Rosenbaum, 1956) found that very religious patients were less likely to benefit from therapy than those judged less religious. The rated lack of "improvement" among religious patients was hypothesized as related to the gross disparity between patient and therapist values. Therapist discordance with patient religious beliefs was considered to create less improvement with religious patients. The need for patient and therapist to share enough of their beliefs was hypothesized.

Nawas & Landfield (1963, 1964) suggested that a certain degree of similarity in self constructs between the patient and therapist (as measured by the Kelly Role Construct Repertory Test) was essential for duration and improvement in therapy. Cook (1966) studied the influence of value similarity on changes in client's self concept (as measured by the Semantic Differential) and found that medium patient therapist value similarity (as measured by the Study of Values) was associated with more positive change (as measured by the Semantic Differential). Either high or low similarity was associated with less positive change. Although

he did not study dropout rate, the assumption that counselor values had an impact on client changes, in very brief counseling, was supported.

Research ( Mendelsohn, 1966; Mendelson & Geller, 1963) has found evidence to indicate that greater client counselor initial similarity (as measured by the MBTI) resulted in failure to remain in therapy past the initial session. It was hypothesized that similarity led to the premature exploration of personal or conflictual material and excessive involvement in the personal interaction, thus creating patient ambivalence.

In a study (Lesser, 1961) which examined the relationship between client progress and client and counselor self concept similarity, similarity (as measured by the Butler Haigh Q-sort) was negatively related to duration and progress. Therapist' awareness of this similarity was, however, positively related. This suggested that the negative effects of similarity could be overcome by counselor awareness of them. Elucidation and recognition of the therapist's self concept was judged integral to the maintenance of the relationship.

Beutler (1974) investigated the use of attitude theory in predicting outcome in group therapy and found initial patient/ therapist value similarity related to patient rated improvement, but not predictive of dropout rate. The discrepant results may have reflected the type of therapy conducted and attitudes studied. Only attitudes of medium

centrality (as defined by Rokeach) were predictive of improvement and change. These were found to be of a philosophical and religious nature. Comparison of the predictive efficiency of concepts derived from the theories of social judgment (Hovland, 1961) and cognitive dissonance (Festinger, 1957), found that neither was able to predict outcome, when the studies involved values of "high" or "low" centrality rather than those of "medium centrality" <sup>10</sup> (Rokeach, 1968).

Review of the research thus considers a medium degree of patient therapist similarity in cognitive style and/or value systems to be conducive to a better outcome than either high or low patient therapist similarity (Meltzoff & Kornreich, 1970). Application of these findings in the study of psychotherapy outcome, to the problem of premature termination, has been lacking.

#### Values and Psychotherapy Outcome and Duration Research

Review of the writings of major authors in the field of values (Rokeach, 1973; Smith, 1969) points to the complexity of what is defined as values. The concept, however, has been shown to hold meaning for much of human behavior. Neurotic conflicts have been conceptualized as value dilemmas and/or conflicts throughout the clinical literature and across theoretical schools (Rogers, 1972; Feuer; 1955, Hartmann, 1960). Attitudes of a moral quality are significantly involved in people's emotional problems and the intensity of inner turmoil deriving from value and attitude dilemmas warrants further investigation on the part of therapy research-

chers into issues of personal values and basic beliefs.

As the personal characteristics of the therapist, his values, ideals, and attitudes, and their effect on the process of therapy come under increasing investigation, it is apparent that the therapists' own morals and values are revealed in the therapeutic relationship (Buhler, 1962; Bergin, 1980; London, 1964).

Successful therapists have long held the impressionistic belief that their patients' moral beliefs and attitudes come to resemble their own (Wolff, 1954). Glad (1959) has postulated that therapists from different schools differ in the values they provide their patients; their ideas about good adjustment appear as reflections of personal and professional value judgments, which are then transmitted to their patients in therapy.

The psychotherapy relationship has been described as being essentially similar to other relationships designed to produce attitude change (Frank, 1961; Goldstein, 1966; Pepinsky & Karst, 1964; Strong, 1968), specifically because of the tendency for patients to adopt the attitudes and values of their therapists (Rosenthal, 1955; Parloff, Goldstein & Iflund, 1960; Welkowitz, Cohen, & Ortmeyer, 1967). In extrapolations from attitude theory, the process of psychotherapy has viewed the therapist as analogous to the originator of persuasive communications; his patient as the recipient of such communications. The social psychology of interpersonal

persuasion has delineated numerous variables which seem to be related to the process of attitude change and adoption; and these parallel the psychotherapy process.

Recent attendance to the ethical and practical implications of a therapist's belief system finds that the concepts of interpersonal persuasion are being increasingly applied to the therapy relationship, with an increasing concern toward the ways in which a therapist's values and beliefs interface with the values and personal beliefs of his patients during this persuasion process (Bergin, 1980; Strupp, Hadley, Gomes-Schwartz, 1978).

Findings of changes in the self concepts and personal values systems of student therapists as a result of clinical training and practice (Kirchner, 1973; Vardy, 1972; Vardy & Kay, 1982; Plutchik, 1982; Perlman, 1974; Gordon & Mensch, 1962) draw attention to the need for training programs that will enable recognition of the psychotherapy experience as a means of promoting the change and growth of stable and/or unstable values in its future practitioners.

Attempts at the systematic comparison and application of attitude theories to the therapy relationship (Beutler, 1971) find dissonance theory (Festinger, 1957) and social judgment theory (Sherif & Hovland, 1961) to make essentially opposite predictions about the degree of similarity most conducive to both maintenance of the therapeutic relationship and positive attitude change. Whereas dissonance theory pre-

dicts the degree of recipient adoption of persuasive communication to vary as a function of increasing disparity, social judgment theory predicts a curvilinear relationship. While the results to date, have found initial patient therapist value dissimilarity to be predictive of higher patient/therapist values convergence and initial similarity to promote patient rated improvement, the effect of initial therapist/patient values similarity on patient dropout has been found to be nonsignificant. Attitudes of medium centrality, reflecting those of a philosophical and religious nature, have appeared to be most conducive to change and prediction of success in the psychotherapy outcome research. Results have failed to provide support for either theory, however, when using attitudes of other than medium centrality, as defined by Rokeach (Beutler, 1974).

Differences between the values of mental health professionals and their patient populations (Gordon, 1962; Bergin, 1980; Beutler, 1971), along with the relationships that exist between therapists' personal value orientations, professional beliefs and initial success scores in therapy (Vardy, etal 1982), underscore the need to attend to the study of the optimal compatibility of therapist's and patient's values.

The argument (Bergin, 1980) that treatment would be facilitated, if patients and therapists were selected in order to be similar in their views, while simplistic, raises

the importance of therapist and patient values evaluation and acknowledgement, so as to promote honesty in the relationship and subsequent lack of conflict in treatment plans and goal setting.

Initial status of patient and therapist values on dimensions not yet put to the rigors of systematic research, may promote duration of the therapeutic relationship. The similarities between the two participants might facilitate development of identification; the dissimilarities might provide the patient with a contrast object against which to assess his/her own conflicts, values and lifestyle.

The present study was directed to the complexity of the relationship between patients' and therapists' initial belief systems, identifying the dimensions relevant to duration and improvement in a discriminating way. Similarity has tended to be assessed as a global construct (ie, average similarity across a wide variety of beliefs or personality constructs). Efforts at specificity have found attitudes of medium centrality (Rokeach, 1973) more relevant to duration and improvement, which, in the light of previous research isolating religious and moral values, appear to support the notion of the further isolation of values of a philosophical and/or religious nature.

The specification of the relative patient therapist similarity conducive to duration and improvement, (and the specific attitudes examined ) could allow prediction, and the possibility of initial dyadic assignment (ie, matching of pa-

tients and therapists as to an optimal initial value dissimilarity).

The relationship of these specific value and professional orientations to therapeutic effectiveness in preventing premature termination has not been explored.

This study investigated the importance of patient and therapist personal as well as professional value orientations of psychotherapists as variables affecting their work in therapy. Are there differences between therapists with differing value and psychotherapy orientations in terms of their effectiveness in establishing lasting therapy relationships with their patients? And do differences in initial patient and/or therapist values and beliefs enable us to predict which patients will prematurely terminate the therapeutic relationship.

#### Hypotheses

This study examined the association of premature termination of the psychotherapeutic relationship with the following factors: 1) patient values 2) patient self concepts 3) therapist values/orientations and 4) relations between patients and therapists values. In particular, the study hypothesized that the following would relate to premature termination of psychotherapy.

a) differences in the value systems of patients defined as remainers from those defined as dropouts.

- b) differences in the self concept of remainder patients from dropout patients.
- c) differences in the value systems of therapists with higher and lower dropout rates.
- d) differences in the profiles of patient/therapist dyads.

The study examined the relationship between premature termination and patient and therapist values in the belief that long term commitment to therapy is facilitated when the values of the two parties are similar. The effect of other factors, on premature termination, including patient age, sex, marital status, ethnicity, religious preference, and diagnoses, were explored. The effects of therapist factors, such as age, experience and professional discipline, were also examined.

#### FOOTNOTES

<sup>1</sup> Authoritarian/submissive vs. independent was defined by factor analyses of the Strong Vocational Interest Blank and Morris Ways To Live Scale, to provide a Factor(2) reflecting a value for submission to and respect for authority, and preference for conformity to others; independence reflected an independent, unconventional stance.

<sup>2</sup> Frank (1961) has persuasively reviewed and emphasized the importance of suggestion in psychotherapy.

<sup>3</sup> Schofield's(1964) study involved the establishment , by questionnaire of therapist's descriptions of their ideal case, suggesting a systematic selection in the direction of patients who were young , attractive, verbal, intelligent, and successful, which he summarized as YAVIS.

<sup>4</sup> TheTherapistOrientationQuestionnaire (Sundland & Barker, 1962) is a 104 item multiple choice measure of therapist theoretical orientation, yielding eleven factors and three clusters, which range from analytic to cognitivistic to experiential.The version applied in this study is a revised version (Sundland, 1977).

<sup>6</sup>MMPI profiles referred to here, were given to patients and therapist in booklet form and similarity profiles computed by rank order correlation of two sets of T scores , yielding a measure of similarity of profile shape (Hathaway, 1959.)

<sup>7</sup> The Leary Interpersonal Matrix is a measure of interpersonal compatibility, providing measures of Love/Hate and Dominance/Submission (Dietzel, 1978).

<sup>8</sup> Curvilinear implies that as therapist patient personality dissimilarity increases through a range from maximum to minimum congruence, there will be a corresponding increase in therapeutic success up to a certain (unspecified) point, beyond which further increases in dissimilarity will be associated with decreasing success of the relationship.

<sup>9</sup> The A/B hypothesis (Whitehorn&Betz, 1954), originally noted the use of ten items of the Strong Vocational Interest Blank to separate therapists into "types" A and B. The former were found to be apparently more succesful with schizophrenic patients, the latter with psychoneurotic ines.

<sup>10</sup> Rokeach (1968) outlined three levels of value hierarchy; high, low , and medium centrality values. Low levels were considered most peripheral and most amenable to change, while high centrality values were most integral and most resistant to change.

## CHAPTER 2 METHODS

### Subjects

The study sample consisted of 69 patients, who applied for individual psychotherapy at the adult outpatient departments of a community mental health center (CMHC) and a public health hospital (PHH) during the period of October, 1983-October, 1984 and the staff of 36 psychotherapists at the two sites. Patients were offered long term psychodynamically oriented individual psychotherapy at both sites. Patients referred for group or marital therapy were not included in the sample. Fees at both clinics were based on an ability to pay scale.

Both the community mental health center and public hospital settings were located in the metropolitan Boston area. They provided comprehensive outpatient mental health services of a similar nature, including psychotherapy, testing and evaluation to residents of the city of Boston. The analysis of demographic characteristics of the patients found them to be characteristic of the area's population.

The mean age of the total patient group was 46.5 years (SD=16.7; range=18-80). The ethnic composition of the sample was 82.6% white and 17.4% non-white. The ethnic composition of the subject sample was representative of the area's generally white, Catholic, working class population. Of the total sample, 34.8% were male and 65.2% were female. (For a detailed description of patient educational level,

marital status and religious affiliation, see Table 1).

The therapist study sample consisted of the staff therapists at both clinic sites, who voluntarily agreed to participate in the study. The therapists were paid for their participation, at both points of test administration. Of the original 36 participating therapists, 34 remained in the study for its entire course. From the start, four therapists refused to participate or were unable to participate, due to illness, scheduling, or other situational factors. The 22 therapists at the PPH and the 14 therapists at the CMHC had a mean age of 36 years and a median of five years of experience (range of 1-10+ years) with degrees and licenses in clinical and counseling psychology and clinical social work. There were 14 males (38.9%) and 22 females (61.1%). (For a more detailed description of therapist marital status, professional affiliation, and ethnic composition, see Table 3).

Participating therapy staff tended to serve in the role of both intake interviewer and psychotherapist. The opportunity to investigate the relative contribution of therapist variables, in the roles of both therapist and/or intake interviewer, with regard to duration of treatment, was exploited in this study. Mean age for intake interviewer, as opposed to therapist, thus remained the same. Although six staff members were found to conduct the majority of intake interviews, 30 staff members were found to perform both duties in the course of the research period. The intake

TABLE 1

Demographic Characteristics (Age, Ethnicity, Sex, Marital Status, Religion, and educational level) of the study patient sample.

Variable

Age

N	69
Mean	46.5
SD	16.7
Range	18-80

Ethnicity

White	57 (82.6%)
Non White	12 (17.4%)

Sex

Male	24 (34.8%)
Female	45 (65.2%)

Religion

Catholic	36 (52.2%)
Jewish	6 (8.7%)
Protestant	8 (11.6%)
Other	4 (5.8%)
None	8 (11.6%)
Blank	7 (10.1%)

Marital Status

Single	24 (34.8%)
Married	19 (27.5%)
Divorced	16 (23.2%)
Widowed	10 (14.5%)

Educational Level

< High School	21 (30.4%)
High School	36 (52.2%)
College	8 (11.6%)
> College	4 (5.8%)

TABLE 2

Demographic Characteristics (Age, Ethnicity, Sex, Marital Status, Religion, education, and experience) of the therapist sample

Variable

Age

N	36
Mean	32.4
SD	4.6
Range	23-41

Ethnicity

White	36 (100.%)
Non White	0 (0 %)

Sex

Male	14 (38.9%)
Female	22 (61.1%)

Religion

Catholic	18 (50.0%)
Jewish	17 (47.2%)
Protestant	1 (2.8%)

Marital Status

Single	17 (47.2%)
Married	18 (50.0%)
Divorced	1 (2.8%)
Widowed	0 (0%)

Educational Level

B.A.	2 (5.6%)
M.A.	16 (44.4%)
MSW	7 (19.4%)
PH.D	10 (27.8%)
ED.D	1 (2.8%)

PROF YEARS

1.	1 (2.8%)	6.	6 (16.7%)
2.	2 (5.6%)	7.	7 (8.3%)
3.	4 (11.1%)	8.	3 (8.3%)
4.	2 (5.6%)	10.	6 (16.7%)
5.	9 (25%)		

interview was a scheduled formal procedure at both sites, conducted over one to two sessions. Following the intake interview, the procedure at both sites included an intake conference. Here, the intake interviewer would present the completed intake and receive formal consensus from the senior staff, as to the diagnosis and disposition of the case.

### Materials

The Survey of Interpersonal Values (SIV)(Gordon,1960) is a 30 item, 15 minute forced choice test designed to measure the relative importance which one ascribes to each of six factored interpersonal value dimensions. The Survey has adequate reliability for individual use ( $r=.86$ ). Factor analysis was employed in the original development of the scales. High school, college, industrial and other adult samples were used and norms were developed (Gordon, 1970).(See Appendix Q&R). The instrument consists of thirty sets of three statements or triads.(See Appendix H). For each triad, the respondent indicates one statement as representing what is most important and one statement as representing what is least important to himself.

The six values are defined as follows:

- 1)Support: Being treated with understanding, receiving encouragement from other people, being treated with kindness and consideration.
- 2)Conformity: Doing what is socially correct, following regulations closely, doing what is accepted and proper, being a

conformist.

3)Recognition: Being looked up to and admired, being considered important, attracting favorable notice , achieving recognition.

4)Independence: Having the right to do whatever one wants to do, being free to make one's own decisions, being able to do things in one's own way.

5)Benevolence: Doing things for other people, sharing with others, helping the unfortunate, being generous.

6)Leadership: Being in charge of other people, having authority over others, being in a position of leadership or power.

The Survey of Personal Values (SPV) (Gordon, 1967) is a companion instrument to the SIV. Factor analysis was employed to develop its scales; and the forced choice format was also employed in the administration of the SPV (Gordon, 1967).

The SPV measures the relative importance ascribed to factored personal values involving the manner of coping with the problems of everyday living. Its six subscales are defined as follows: (See Appendix I).

1)Practical Mindedness: To always get one's money's worth, to take good care of one's property, to get full use out of one's possessions, to do things that will pay off, to be very careful with one's money.

2)Achievement: To work on difficult problems, to have a challenging job to tackle, to strive to accomplish something

significant, to set the highest standards of accomplishment for oneself, to do an outstanding job in anything one tries.

3)Variety: To do things that are new and different, to have a variety of experiences, to be able to travel a great deal, to go to strange or unusual places, to experience an element of danger.

4)Decisiveness: To have strong and firm convictions, to make decisions quickly, to always come directly to the point, to make one's position on matters very clear, to come to a decision and stick to it.

5)Orderliness: To have well organized work habits, to keep things in their proper place, to be a very orderly person, to follow systematic approach in doing things, to do things according to a schedule.

6)Goal Orientation: To have a definite goal toward which to work, to stick to a problem until it is solved, to know precisely where one is headed.

After an extensive review of the literature relating to values, seven dimensions were identified for inclusion in the SPV. Seven hypothesized factors emerged, six of which were used. Kuder Richardson reliabilities were sufficiently high as to permit interpretation of SIV and SPV scores for individual use. Statistically, data on the SIV and SIV indicate reliabilities estimated by Kuder Richardson to have a mean of .81 and test retest correlations of .76, reflecting relatively good reliability (Mental Measurements

Yearbook, 8th ed.). Reports of correlations between the SIV and many other widely used tests demonstrate good convergent validity. Normative data, with means and standard deviations, are presented for specialized groups. (See Appendix A-D).

Correlations between values as measured by the SPV and the SIV indicate that the scales are independent of one another. The SIV and SPV have been successfully utilized in the context of research projects investigating the values of medical school students at different levels of training (Gordon & Mensch, 1962) and the values and value changes during and after graduate study in psychology (Kirchner, 1974).

Studies concerned with patients in therapy have found outpatients to score significantly higher than the normal population on Support, Recognition, and Independence, and lower than the normal population on Conformity and Benevolence (Rozecki, 1969). (See Appendix A).

Therapist Orientation Questionnaire(1977)

A revised version of the Therapist Orientation Questionnaire (TOQ) (Sundland & Barker, 1962) was used (Sundland, 1972) to examine some of the recent issues and techniques in psychotherapy. Two factor analytic studies yielded similar ten factor solutions; and one further factor which contained only new items relating to body awareness, Gestalt therapy, and release of emotions was also identified. A second order factor analysis yielded three clusters, which were labeled:

Experiential, Analytic and Cognitivistic. Using this factor analysis as a guide, the TOQ was shortened (Sundland, 1972). One hundred and four (104) items were answered on a 5 point rating scale, ranging from strongly agree to strongly disagree. (See Appendix M).

#### Symlog

The Symlog Value statement rating form is a 26 item, multiple choice measurement instrument of values. It provides scores on three major dimensions of individual and organizational values. It is capable of showing whether an individual perceives himself as valuing dominant or submissive behavior, friendly or unfriendly behavior, and whether they tend to value acceptance or opposition to the task orientation of established authority. (See Appendix J).

The empirical and theoretical work upon which this scale is based is reported in R.F. Bales, *Personality and Interpersonal Behavior*, and Bales, Cohen, & Williamson, *Symlog*, 1979.

#### Semantic Differential (Self concept)

The Semantic Differential (SD)(Osgood & Tannenbaum, 1952) is a valid and reliable measure of constructs. The form used in this study consists of 30 bipolar adjectives expressed on a 7 point scale (eg. strong-weak). Positive responses are scored as 5, 6, or 7, negative as 1, 2, or 3, and neutral as 4. This scoring system, used successfully in a number of predictive studies (Morrison, 1977, 1980; Morrison, Coccozza & Vanderwyst, 1978; Morrison & Teta, 1977, 1980), produces a total

score (range 30-210) that reflects overall positive or negative constructs of a person(eg, self, mother, father). (See Appendix K).

#### Psychotherapy Problem Checklist

The Psychotherapy Problem Checklist (PPC)(Morrison & Cometa, 1980), is a reliable ( $r=.81$ ) and valid (Morrison, 1977) self report measure of client problem resolution. The checklist consists of 21 items of symptoms, that are mostly indicative of excessive anxiety. The PPC is scored by assigning a score of 1 for each problem designated by the client (range:0-21). (See Appendix L).

#### Criterion Measures

Premature termination was defined as having occurred either when the patient failed to keep a scheduled first appointment for therapy after completion of intake interview or when the patient unilaterally decided to leave before completion of intake or when the patient unilaterally left therapy against the advice of the therapist prior to six therapy sessions. Since this directly measures the patient's exposure to treatment, the number of actual therapy appointments completed was found preferable to the patient's length of time in treatment as a measure of dropout (Bakeland & Lundwall, 1975).

Sixtysix % of the 69 patients who began therapy, terminated within the five sessions. The mean number of sessions held was 6.7, while the median was 3.37 sessions.

TABLE 3

Patient Frequency Distribution of sessions(n=69).

No. of sessions	Abs. Freq.	Pct.	Cum Pct.
1	3	4.3	4.3
2	21	30.4	34.8
3	12	17.4	52.2
4	4	5.8	58.0
5	6	8.7	66.7
6	2	2.9	69.6
7	1	1.4	71.0
8	2	2.9	73.9
10	5	7.2	81.2
12	3	4.3	85.5
14	1	1.4	87.0
15	2	2.9	89.9
20	7	10.1	100.0

Mean = 6.26

Median = 3.37

SD = 5.85

(For a detailed frequency distribution of sessions attended, see Table 3).

### Criterion Groups

Lack of patient continuation at both the points of intake interview and therapy, provided two indices for judgment of premature termination. Utilizing these criteria, therapy relationships, therapists, and patients were categorized as follows:

- 1) prematurely terminated relationships included all patient therapist relationships that met for less than six sessions.
- 2) Non prematurely terminated relationships included all patient therapist relationships that met for six or more sessions.

### Procedure

Upon application to either clinic, prospective patients completed the clinic's standard intake interview. Upon completion of the intake interview, the interviewer (if a research participant) would read the standardized announcement form (see Appendix N) to the patient, informing them of the voluntary study that was being conducted at the clinic. Prospective subjects would then be committed to receiving a telephone call from the principal investigator, requesting their participation in the study. The intake conference committee, which consisted of senior staff (psychiatrists and psychologists), reserved the right to remove a patient from further participation upon review of their intake form.

Patients diagnosed as actively suicidal, or suffering from alcohol or drug intoxication were considered unsuitable for the study. This allowed for clinical judgment of a patient's suitability for the study to remain under the control of the staffs from the respective sites. Upon successful completion of intake, approval for suitability and assignment for individual psychotherapy by intake conference, subjects were contacted by the investigator. If they agreed to participate, they were asked to complete, prior to the first psychotherapy session, the Survey of Interpersonal (SIV) and Personal (SPV) Values, Symlog, Semantic Differential (SD), and Psychotherapy Problem Checklist (PPC), in order to gauge patient's personal and interpersonal values, self concept and level of initial disturbance. Administration of the testing materials took approximately thirty minutes. (See Appendix H-M for all scales).

The procedure for administration of test materials to staff therapists and intake interviewers was as follows. At a general meeting, staff were informed by the principal investigator, about the general nature of the study, its approval by the institutional review board, its voluntary status, and the time that would be required on their part for participation (approximately one hour for each of two occasions). Therapy staff were kept blind to the study's exact nature, being informed only of its general purpose as research investigating the psychotherapy process.

After recruitment of staff, participating staff were administered the Surveys of Interpersonal and Personal Values (SIV, SPV), Symlog scale (S), Semantic Differential (SD), and Therapist Orientation Questionnaire (TOQ). At the completion of the first test administration, staff were given instructions regarding the reading of the post intake research announcement form to patients (Appendix N) and they were given a set of standardized instructions for responding to client inquiries. Over the course of the study, staff were regularly reminded of the study's ongoing status, and of the need for subjects, by memos from the principal investigator.

One year later, the staff again completed the identical test battery and were informed of the final date for collection of patient data by the investigator. All procedures were monitored and supervised by the research committees of the respective outpatient departments at the two sites. On site supervisors at both sites included licensed psychologists.

At the conclusion of the year allotted for data collection, predictive and demographic data were gathered retrospectively by the principal investigator through review of clinical files at both sites. All available case records for patients requesting treatment during the calendar year of the study were reviewed. Thus there was access to descriptive data regarding the total population of the two clinics over the course of the year. One primary reason for collect-

ing these data was to ensure the representativeness of the sample of patients who participated in the study. These data were also used to determine the dropout rate that each therapist established over the course of the year. Data gathered included patient age, sex, marital status, educational level, race, religion, name of intake interviewer and therapist assigned, and the number of sessions held with each therapist (See Tables 4 & 5). All patient data were coded to insure confidentiality.

This data collection insured availability of the total caseload of both sites requesting individual psychotherapy and provided demographic and diagnostic data for purposes of validity and reliability in generalizing from the results of the study.

Data as to the number of patients lost during the orientation period to the study were available, upon retrospective analysis of the site's total caseload of patients during the research period. (See Table 5). The actual number of patients that were engaged in the intake interview process with participating therapy staff was 254 (See Table 5). Staff's lack of cooperation in the collection of such data, on an ongoing basis, allowed for only the post hoc gathering of this information by the principal investigator. The question of whether this lack of cooperation had an effect on the representativeness of the sample obtained, was determined through comparison of the tested and untested samples overall

TABLE 4

Total Patient Frequency Distribution of sessions  
(n= 254).

No. of sessions	Ab. Freq.	Pct.	Cum Pct.
1	30	12	12
2	55	22	33
3	27	11	44
4	8	3	47
5	11	4	52
6	11	4	56
7	4	2	57
8	8	3	61
9	4	2	62
10	9	4	66
11	1	0	66
12	67	26	93
15	2	1	94
16	1	0	94
20	7	3	97
25	1	0	98
30	6	2	100

Mean = 7.22

Median = 5.13

SD = 6.26

TABLE 5

Demographic Characteristics (Age, Ethnicity, Sex, Marital Status, Religion, and educational level) of all patients seen at the CMHC & PHH during the calendar year of study.

Variable

Age

N	254
Mean	40.9
D	16.8
Range	18-92

Ethnicity

White	236 (93.%)
Non White	12 (7.%)

Sex

Male	84 (33.1%)
Female	170 (66.9%)

Religion

Catholic	183 (72.%)
Jewish	23 (9.1%)
Protestant	24 (9.4%)
Other	9 (3.5%)

Marital Status

Single	89 (35.0%)
Married	66 (26.0%)
Divorced	62 (24.2%)
Widowed	35 (13.8%)

Educational Level

< High School	81 (31.9%)
High School	142 (55.9%)
College	28 (11.0%)
> College	3 (2.4%)

characteristics. (See Tables 1 & 2). Uniformity of the two samples allowed for a generalizability from the sample obtained. Data obtained from the intake questionnaire was attached to other pertinent clinic intake data. This resulted in its eventual placement in the patient's clinical chart. It was often found blank. This was assumed to mean noncompliance on the part of participating staff, in informing the patients of the study's existence.

#### Data Analysis

The independent variables consisted of the dropout vs. remainder status of the respective patient and therapist groups, and/or dyads. The thirty one scored factors, clusters, and individual scale scores for all value, self concept, level of disturbance and theoretical orientation scales served as dependent variables, to be associated with dropout status, either for the patient, the therapist, or the patient therapist interaction. Mean difference scores were computed for each patient and therapist group (dropout vs. remain) to test the hypotheses that involved patient and therapist differences in values and orientation. Multiple regression scores were used to test the hypotheses that involved the interaction of the patient's and the therapist's value systems. The multiple regression scores were derived for each of the sixty nine dyadic relationships.

The hypotheses that were investigated were as follows:

1A. It was hypothesized that differences would be found in

the values of dropout and remainder patients, such that remainder patients would value support, conformity, benevolence and leadership (as measured by the SIV scale) and a positive identification with outside authority (as measured by the Symlog dominance scale), more than dropout patients. These values would tend to promote maintenance of the relationship.

B. It was hypothesized that dropout patients would value the need for achievement, goal orientation, decisiveness, recognition and practical mindedness (as measured by the SIV and SPV) and task orientation (as measured by the Symlog) more than remainder patients. Higher scores on these values would tend to represent potential sources of frustration for the patient, in the beginning stages of therapy, leading to disappointment in the therapeutic process.

C. It was hypothesized that differences would not be found in the two groups on the values of variety and independence and on the dimensions of friendly vs. unfriendly behavior.

2. It was hypothesized that differences would be found in the level of self concept of dropout and remainder patients (as measured by their Semantic Differential scores), such that dropout patients would be found to have initially lower levels of self concept than remainder patients. The healthier patient (higher self concept) would tend to make better use of the available treatment facilities offered.

3. It was hypothesized that differences would not be found in

the level of initial disturbance of dropout and remainder patients, as measured by their PPC scores (a measurement of overall diagnostic symptomatology). The contradictory evidence in the research literature concerning level of initial diagnostic category and dropout rate would result in a lack of differences in initial diagnostic category and dropout rate in this study.

4A. It was hypothesized that differences would be found in the personal values and theoretical orientation of therapists with high and low dropout rates. Therapists with lower dropout rates would tend to value achievement, decisiveness, goal orientation, benevolence and leadership (as measured by the SIV and SPV), dominant and task oriented behavior (as measured by the Symlog), and personal involvement and a results based therapeutic approach (as measured by the TOQ) more than the therapists with the higher dropout rates.

B. It was hypothesized that therapists with high dropout rates would be found to value submissive and unfriendly behavior towards others and an opposition to task orientation and outside authority (as measured by the Symlog scale) more than therapists with lower dropout rates.

C. In accordance with the previous research, it was hypothesized that the values of variety, conformity, independence, support, recognition and the theoretical orientation factors and clusters reflecting specific technical interventions associated with a particular school of thought would not be

significant predictors of either high or low dropout rate in the therapist sample.

This hypothesis examined the relative importance of technical vs. personal "nonspecific " qualities of the therapist with regard to their dropout rate and the therapist's attention or lack of attention to issues of authority and the need for a task oriented approach in the early stages of the therapeutic engagement process.

5.It was hypothesized that additional differences would be found in the personal values and self concept of dropout and remainder patients and high and low dropout therapists when the interaction of individual patient-therapist dyads was analyzed. This hypothesis was examined to investigate further the application of an interactive, dyadic approach to the study of the dropout phenomena.

6.It was hypothesized that differences would not be found in the therapists' values, self concept and theoretical orientation in the course of two administrations, given one year apart. Although student therapists have shown significant decreases in the value of benevolence and conformity and increases in the value of support, recognition, independence and self concept over time, practicing therapists have not demonstrated such changes in these values.

7.It was hypothesized that differences in patient and therapist demographic data and patient diagnoses would not be found in comparing the various dropout and remainder groups.

It was expected that the contradictory findings in the previous research regarding demographic data would be manifested by findings of a lack of significant differences between groups in this study.

### CHAPTER 3 RESULTS

All of the patient subjects completed the full battery of questionnaires. Thirty four of the thirty six participating therapists were able to complete the battery on both occasions; the remaining two were only able to complete the initial battery.

In order to test the hypotheses,  $t$  tests for differences between the means of dropout (N=46) and remainder (N=23) groups were calculated. (The means, SDs,  $t$  and  $p$  levels on personal and interpersonal values, level of self concept and initial disturbance are presented in Table 6). For a more precise weighting of the variables, a multiple regression technique was used, based on the total number of therapy dyads (N=69).

Where a specific direction was hypothesized, a significance level greater than the .05 level and less than .10 was accepted as indicating support for the hypotheses.

#### Patient Variables Related to Dropout

Hypothesis 1. Differences in the hypothesized direction were found between the dropout and the remainder patients' personal values of dominance ( $p < .01$ ) and friendliness towards outside authority ( $p < .05$ ).

No differences were found for the variables of support, conformity, benevolence or leadership.

B. Differences in the hypothesized direction were found

between the dropout and remainder patients in the values of decisiveness ( $p < .05$ ) and achievement ( $p < .01$ ). No differences were found in the values of goal orientation, recognition, practical mindedness and task orientation.

C. In addition, no differences were found, as hypothesized, on the variables of variety, independence and the dimensions of friendly vs. unfriendly behavior.

The hypothesis that there would be differences in the values of dropout and remainers was partially supported.

Attempts were then made to distinguish the pretherapy dropouts who had failed to return after intake (pretherapy dropouts;  $N=11$ ), from those whom had dropped out during therapy (therapy dropouts;  $N=35$ ). The differences noted were for pretherapy dropouts to value support more strongly than therapy dropouts ( $p < .01$ ) and to value orderliness less than therapy dropout patients. ( $p < .05$ ).

#### Difference in Self Concepts

2. Dropouts were found to demonstrate a lower self concept score than remainers. ( $p < .05$ ). (See Table 6). The hypothesis that lower self concept would be related to dropout was supported.

#### Patient Dropout Rate and Initial Level of Disturbance

3. Consistent with the hypothesis, the results demonstrated no significant difference between dropout and remainder groups in level of initial disturbance.

#### Patient Dropout Rate and Demographic Variables.

TABLE 6

Means , SDs , t value, and p level for dropout(n=46) and remainder(n=23) patients on assessment tests.

Variable	Dropout		Remainer		t val	p Level
	Mean	SD	Mean	SD		
SIV 1 SUPPORT	18.95	4.5	20.21	4.1	-1.12	0.268
SIV 2 CONFORMITY	12.86	6.2	10.69	7.3	1.29	0.203
SIV 3 RECOGNITION	11.17	4.6	12.95	3.7	-1.60	0.115
SIV 4 INDEPENDENCE	18.69	7.4	17.17	7.0	0.82	0.416
SIV 5 BENEVOLENCE	18.00	6.4	17.00	5.0	0.65	0.516
SIV 6 LEADERSHIP	10.28	5.6	11.86	7.5	-0.98	0.331
SPV 1 PRACTICAL	13.00	4.9	14.47	5.2	-1.15	0.254
SPV 2 ACHIEVEMENT	17.84	4.9	15.43	4.3	2.00	0.049
SPV 3 VARIETY	9.93	6.3	11.82	6.8	-1.14	0.260
SPV 4 DECISIVENESS	17.28	5.1	14.82	5.2	1.87	0.066
SPV 5 ORDERLINESS	13.95	6.3	15.78	4.4	-1.24	0.221
SPV 6 GOAL ORIENTED	17.91	4.8	17.60	4.9	0.24	0.808
SYMLOG 1 DOMINANT	7.69	3.1	10.34	3.2	-3.26	0.002
SYMLOG 2 SUBMISSIVE	11.00	3.0	12.08	2.4	-1.48	0.143
SYMLOG 3 FRIENDLY	8.86	3.0	10.30	2.5	-1.95	0.055
SYMLOG 4 UNFRIENDLY	7.10	3.1	8.04	3.0	-1.17	0.245
SYMLOG 5 ACCEPTING	8.84	3.2	9.86	2.6	1.33	0.189
SYMLOG 6 OPPOSING	9.67	3.3	9.91	2.7	-0.30	0.768
SEMANTIC DIFF	126.80	18.7	136.39	20.5	-1.94	0.057
SYMPTOM CHECKLIST	8.21	3.8	8.08	4.3	0.13	0.899

Comparisons were then made between the two patient groups in order to test the contribution of any patient demographic variables to the rate of dropout. Neither age, sex, educational level, ethnicity, religious preference, marital status, nor diagnostic category were found to differentiate the dropouts from the remainers. (See Tables 7-14).

The prediction of dropout rate from patient variables alone was further analyzed with multiple regression techniques, for a more refined weighting of the variables.

Differences were found between the remaining and the dropout patient on dominance ( $p < .01$ ), achievement ( $p < .01$ ) and self concept ( $p < .05$ ). Patients who remained in therapy had higher dominance scores ( $p < .01$ ) and higher self concept scores ( $p < .05$ ) than patients who dropped out of therapy.

Patients who dropped out of therapy had higher achievement scores ( $p < .01$ ) than patients who remained in therapy. (See Table 15 for  $r^2$ , beta weights and  $F$  scores). An examination of the histogram produced a prediction rate of 69%.

#### Therapist Variables

##### Change in Therapist Values and Orientations During Therapy.

The change in the set of personal and interpersonal values, self concept and theoretical orientation held by the therapists was measured by the mean differences in the two administrations of the Surveys of Interpersonal and Personal Values, Symlog scales, Semantic Differential, and Therapist Orientation Questionnaire. The first administration assessed

TABLE 7

Patient Dropout Status Frequency Distribution by Site

Site	Count	Dropout	Remain	Row Total
PPH	1.	36	16	52(75.4%)
CMHC	2.	10	7	17(24.6%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)

Pearson's  $r = 0.09696$        $\underline{P} = 0.2140$

TABLE 8

Patient Frequency Distribution of sex by dropout status.

Sex	Count	Dropout	Remain	Row Total
Male	1.	16	8	24(34.8%)
Female	2.	30	15	45(65.2%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)

Pearson's  $r = 0.0$        $\underline{P} = 0.5000$

TABLE 9

Patient Frequency Distribution of ethnicity by dropout status.

Ethnic	Count	Dropout	Remain	Row Total
White	1.	40	17	57(82.6%)
Black	2.	5	6	11(15.9%)
Other	3.	1	0	1(1.4%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)

Pearson's  $r = 0.12014$        $\underline{P} = 0.1627$

TABLE 10

Patient Frequency Distribution of religion by dropout status.

Religion	Count	Dropout	Remain	Row Total
Jewish	1.	4	2	6(8.7%)
Catholic	2.	24	12	36(52.2%)
Protestant	3.	4	4	8(11.6%)
Other	4.	3	1	4(5.8%)
None	5.	7	1	8(11.6%)
Blank	6.	4	3	7(10.1%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)

Pearson's  $r = 0.03383$        $\underline{P} = 0.3913$

TABLE 11

Patient Frequency Distribution of marital status by dropout status.

Marstat	Count	Dropout	Remain	Row Total
Married	1.	12	7	19(27.5%)
Single	2.	17	7	24(34.8%)
Divorced	3.	12	4	16(23.2%)
Widowed	4.	5	5	10(14.5%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)

Pearson's  $r = 0.04046$        $\underline{P} = 0.3707$

TABLE 12

Patient Frequency Distribution of education by dropout status.

Education	Count	Dropout	Remain	Row Total
< H.S.	1.	12	9	21(30.4%)
H.S. Grad	2.	26	10	36(52.2%)
College	3.	5	3	8(11.6%)
M.A.	4.	3	1	4( 5.6%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)

Pearson's  $r = -0.08919$        $\underline{P} = 0.2331$

TABLE 13

Patient Frequency distribution of Axis 1 diagnosis by dropout status.

Axis 1	Count	Dropout	Remain	Row Total
None	1.	12	5	17(24.6%)
Anxiety	2.	7	2	9(13.0%)
Adjust.	3.	13	7	20(29.0%)
Panic	4.	1	0	1(1.4%)
Schizoph	5.	2	0	2(2.9%)
Somatic	6.	1	0	1(1.4%)
Bipolar	7.	1	0	1(1.4%)
Psychosis	8.	1	0	1(1.4%)
Depression	9.	7	9	16(23.2%)
Dementia	10.	1	0	1(1.4%)
Column Total		46(66.7%)	23(33.3%)	69(100.0%)
Pearson's r =	0.15217	<u>P</u> = 0.1060		

TABLE 14

Patient Frequency of DSM 3 Axis 2 diagnosis by dropout status

Axis 2	Count	Dropout	Remain	Row Total
None	1.	29	15	44 (63.8%)
Borderline	2.	4	2	6 (8.7%)
Dependent	3.	4	4	8 (11.6%)
Antisocial	4.	1	0	1 (1.4%)
Narcissist	5.	2	1	3 (4.3%)
Schizoid	6.	3	1	4 (5.8%)
Miscell	7.	3	0	3 (4.3%)
Column Total		46 (66.7%)	23 (33.3%)	69 (100.0%)

Pearson's  $r = 0.10296$       $\underline{P} = 0.1999$

TABLE 15

Multiple Regression Using Patient Variables to Predict Outcome

Summary Table

Variable	Multiple R	R sq.	Beta	F
SYMLOG1 DOMINANT	.37024	.13708	.38406	12.614
SPV2 ACHIEVEMENT	.45591	.20785	-.25195	5.897
SEMANTIC DIFFERENTIAL	.49900	.24900	-.20345	3.561
(CONSTANT)	0.6599134			

Total F = 6.76743

Note: The F statistic tests the contribution of each predictor after the others have been entered into the equation.

therapist personal values, self concepts and theoretical orientation prior to the initiation of the study, while the second set of administrations was obtained after the therapists had completed an additional year of conducting psychotherapy. Thirty four therapists had completed both administrations and could be included in the analysis (N=34). (See Table 16).

Differences were found to exist between the therapists' pre and post scores.(See Table 17). The differences were an increase in the therapists' valuing of independence ( $p<.01$ ), recognition ( $p<.08$ ) and lack of countertransference issues ( $p<.01$ ), and decrease in their valuing of benevolence ( $p<.01$ ), submissiveness ( $p<.10$ ) and self concept ( $p<.10$ ). The variables were not correlated. We chose to use the average scores of the therapists' two administrations for the remaining analyses, and allowed the inclusion of the analyses of the two therapists who had been unable to complete the second administration.

The hypothesis that continuing practice of psychotherapy would not be associated with a change in the personal values, self concept and/or theoretical orientation of the practicing psychotherapists was not fully confirmed. The finding of a decrease in the valuing of benevolence was consistent with the previous literature on changes in the personal value systems of mental health professionals over time (Kirchner,

1974; Mensch, 1962).

#### Therapist Dropout Rate and Personal Values

The classification of therapists as having either a high or low dropout rate was obtained by the development of a frequency distribution of each therapist's dropout rate. This distribution was based on their caseload at the research site, for the entire year. Only therapists (N=21) with at least three cases were considered for this classification. (See Table 16).

The therapists were then divided into two subgroups of high (50% or more) and low (less than 50%) dropout rate.

The comparisons of therapists with high rate of dropout (N=12) and the therapists with a low rate of dropout (N=9) are presented in Table 18.

Differences were found, as hypothesized, on the valuing of independence ( $p < .01$ ) unfriendly behavior ( $p < .07$ ) and use of cognitive approaches ( $p < .06$ ) such that therapists whose patients were remainers had higher scores than the therapists whose patients were dropouts. Differences were not found, as hypothesized on the valuing of submissive behavior, achievement, decisiveness, goal orientation, benevolence and leadership.

Hypothesis four was not fully confirmed as the high and low dropout rate therapists had only moderate differences in their systems of values and theoretical orientation.

TABLE 16

Therapist Total Dropout Rate Frequency Distribution  
(n=21) based on three or more cases.

Dropout Rate(%)	Freq(abs.)	Pct.	Pct.(Cum.)
0	3	14.3	14.3
10	1	4.8	19.0
25	2	9.5	28.6
29	1	4.8	33.3
33	1	4.8	38.1
40	1	4.8	42.9
50	4	19.0	61.9
60	1	4.8	66.7
63	1	4.8	71.4
67	3	14.3	85.7
75	1	4.8	90.5
100	2	9.5	100.0
Total	21	100.0	100.0
Mean = 45.68	Median = 49.68	Mode = 50.00	

Table 17

Means , SDs, t and p level for pre and post therapist variables (n=34).

Variable	Mean	SD	Mean	SD	t	p level
SIV 1	21.47	4.2	21.47	4.4	0.0	1.000
SIV 2	4.64	3.2	5.35	2.7	-1.41	0.169
SIV 3	13.38	3.6	14.35	4.2	-1.82	0.078
SIV 4	19.67	5.4	19.17	5.3	0.65	0.520
SIV 5	15.61	4.5	13.82	5.1	3.08	0.004
SIV 6	15.00	5.1	15.91	6.4	-1.37	0.179
SPV 1	11.50	5.2	11.14	5.9	0.47	0.640
SPV 2	20.97	4.8	20.73	4.6	0.39	0.699
SPV 3	13.58	6.8	13.79	8.0	-0.31	0.760
SPV 4	16.08	4.5	16.50	4.6	-.75	0.456
SPV 5	11.82	4.4	11.97	4.2	-.21	0.832
SPV 6	15.97	4.5	15.85	5.3	0.16	0.875
SYMLOG 1	10.11	2.6	10.11	2.7	0.0	1.000
SYMLOG 2	13.73	2.2	13.05	2.8	1.73	0.093
SYMLOG 3	10.58	2.5	10.32	2.6	.49	0.627
SYMLOG 4	6.97	2.9	7.41	3.2	-.77	0.444
SYMLOG 5	10.58	2.2	10.76	2.1	-.51	0.614
SYMLOG 6	9.58	2.2	9.97	2.8	-.99	0.330
SEMANTIC DIFF	144.70	15.18	141.88	13.55	1.78	0.085
SUND 1	22.44	3.7	21.94	3.7	1.15	0.257
SUND 2	46.38	5.4	46.61	4.9	-.29	0.771

TABLE 17 (cont)

SUND 3	15.61	1.6	15.20	2.0	1.14	0.262
SUND 4	26.55	2.4	26.47	3.0	0.18	0.862
SUND 5	15.50	2.6	16.14	2.2	-1.68	0.102
SUND 6	27.38	3.1	28.00	2.9	-1.27	0.241
SUND 7	11.44	1.6	11.83	1.1	-.66	0.517
SUND 8	14.82	2.2	16.14	2.2	-2.87	0.007
SUND 9	16.29	2.7	16.47	3.2	-.44	0.665
SUND 10	6.50	1.4	6.76	1.5	-.99	0.331
SUND 11	28.05	3.7	28.23	3.6	-.33	0.745

TABLE 18

Means , SDs , t and p level for therapists with high(n=12), and low(n=9) dropout rates on assessment tests.

Variable	LOW Mean	D.O. SD	HIGH Mean	D.O. SD	T	p level
SIV 1 SUPPORT	21.22	5.0	21.83	4.0	-0.31	0.762
SIV 2 CONFORMITY	3.88	2.4	4.75	2.6	-0.76	0.456
SIV 3 RECOGNITION	13.77	2.9	15.58	2.7	-1.45	0.162
SIV 4 INDEPENDENCE	22.55	3.6	16.66	4.4	3.26	0.004
SIV 5 BENEVOLENCE	15.00	4.4	15.25	3.7	-0.14	0.890
SIV 6 LEADERSHIP	14.77	5.1	17.58	5.5	-1.18	0.251
SPV1 PRACTICAL	10.88	5.7	11.83	4.5	-.42	0.678
SPV2 ACHIEVEMENT	19.88	5.8	21.08	2.9	-.62	0.544
SPV3 VARIETY	17.00	8.4	15.00	7.1	0.59	0.563
SPV4 DECISIVENESS	17.44	5.1	15.66	3.7	0.93	0.367
SPV5 ORDERLINESS	10.11	5.1	13.08	4.2	-1.45	0.162
SPV6 GOAL ORIENTED	15.77	3.9	15.08	4.9	0.34	0.735
SYMLOG1 DOMINANT	10.88	2.4	9.91	1.7	1.06	0.301
SYMLOG2 SUBMISSIVE	13.66	3.3	14.00	2.2	-0.27	0.788
SYMLOG3 FRIENDLY	10.77	2.6	10.50	1.5	0.30	0.766
SYMLOG4 UNFRIENDLY	8.44	2.0	6.33	2.7	1.95	0.066
SYMLOG5 ACCEPTING	11.77	2.1	11.00	1.8	0.91	0.375
SYMLOG6 OPPOSING	10.33	2.0	10.33	2.7	0.0	1.00
SEMANTIC DIFF	141.22	7.44	143.58	16.00	-0.41	0.688
SUND 1	21.77	3.2	23.08	3.5	-.87	0.396
SUND 2	49.00	3.3	46.58	4.5	1.33	0.188
SUND 3	15.66	.8	15.33	1.7	0.53	0.602

TABLE 18 (cont)

SUND 4	26.66	2.2	26.91	2.2	-0.25	0.804
SUND 5	16.33	1.6	16.83	1.8	-0.65	0.523
SUND 6	27.77	1.7	28.00	3.7	-.16	0.871
SUND 7	11.44	1.6	11.83	1.1	-0.66	0.517
SUND 8	15.66	1.4	16.00	2.0	-.43	0.675
SUND 9	17.22	1.9	16.58	2.7	.60	0.555
SUND 10	7.33	1.0	6.25	1.3	2.01	0.058
SUND 11	28.55	3.9	27.41	3.3	0.72	0.483

Multiple regression techniques were then calculated, in order to provide a more refined analysis of differences between therapists whose patients were remainers and the therapists whose patients were dropouts, based on the total of studied therapy dyads (N=69). (See Table 19).

Differences were found between the therapists whose patients remained and the therapists' whose patients dropped out on therapists' lack of task orientation, (as measured by the Symlog values scale), ( $p < .01$ ). Therapists whose patients were Dropouts had higher scores on lack of task orientation than therapists whose patients were Remainers. Differences were found between the therapists' whose patients were Remainers and the therapists' whose patients were Dropouts on their use of cognitive behaviors, (as measured by the Therapist Orientation Questionnaire) ( $p < .01$ ) and on their marital status ( $p < .05$ ). Therapists whose patients were remainers had higher scores on the use of cognitive behaviors than therapists whose patients were Dropouts and the former group of therapists more often had a single marital status. (See Table 19 for  $r^2$ , beta weights,  $F$  score). An examination of the histogram produced a prediction rate of 71%.

#### Therapist and Patient Personal and Interpersonal Values.

The joint analysis of patient and therapist values was investigated through the use of multiple regression techniques and was based on the total number (N=69) of therapeutic dyads.

TABLE 19

Multiple Regression Using Therapist Variables to Predict Outcome for their patients.

Variable	Multiple R	R sq.	Beta	F
SYMLOG6 OPPOSING THERAPIST	.28069	.08392	-.38467	10.802
SUND 10 COGNITIVE THERAPIST	.38680	.14961	.31731	7.604
MARITAL STATUS	.44820	.20089	.24433	4.170
(CONSTANT)	1.266636			
TOTAL F =	5.44672			

Note: The F statistic tests the contribution of each predictor after the others have been entered into the equation.

Differences were found between the Remaining group and the Dropout group on patient dominance ( $p < .01$ ) and patient support ( $p < .05$ ). Patients who remained in therapy had higher scores on dominance and support than patients who dropped out of therapy.

Differences were found between the Remaining group and the Dropout group on patient achievement ( $p < .01$ ) and goal orientation, ( $p < .05$ ). Patients who dropped out of therapy had higher scores on achievement and goal orientation than patients who remained in therapy.

Differences were found between the Remaining group and the Dropout group on the degree to which the therapist was non-task oriented. (as measured by the Symlog values scale) ( $p < .01$ ). Therapists whose patients were dropouts had higher non task oriented scores than therapists whose patients were remainers.

Differences were found between the Remaining group and the Dropout group on therapist personal caring (as measured by the Therapist Orientation Questionnaire) ( $p < .05$ ). Therapists whose patients were remainers had higher scores on personal caring than therapists whose patients were dropouts. (See Table 20 for beta weights,  $F$  score). The examination of the histograms produced a prediction rate of 73%.

Hypothesis five was supported as the joint analysis of the patient's and the therapist' value systems produced discriminating variables in the prediction of dropout rate in the

TABLE 20

Multiple Regression Using Patient and Therapist Variables  
Conjointly to Predict Outcome

Variable	Multiple R	R sq.	Beta	F
SYMLOG11 DOMINANT,PATIENT	.37024	.13708	.32926	10.664
SPV2 ACHIEVEMENT, PATIENT	.45591	.20785	-.35309	11.225
SYMLOG 6 OPPOSING,THERAPIST	.50828	.25835	-.39549	12.857
SPV6 GOAL ORIENTATION, PATIENT	.54980	.30228	-.30907	7.531
SUND 6 CARING THERAPIST	.59409	.35294	.27115	6.908
SIV11 SUPPORT, PATIENT (CONSTANT) 1.651222	.62908	.39574	.21447	4.391

Total F = 6.76743

Note: The F statistic tests the contribution of each predictor after the others have been entered into the equation.

therapy relationship.

### Summary of Results

The hypotheses that sought to investigate the relationship between therapist patient values on the dimension of similarity/dissimilarity were unable to be investigated due to therapist sample size.

The hypothesis that there would be differences in the values of dropout and remainers was partially supported in that prematurely terminated patients (dropouts) demonstrated some personal and interpersonal values that were different in direction from the values of patients who remained in therapy. The hypothesis that lower self concept would be related to dropout was supported as differences were found in the hypothesized direction between the self concept of patients who remained and the patients who dropped out.

The hypothesis that there would be no difference between dropout and remainder groups in level of initial disturbance was supported in that patients who dropped out were found to be no different from patients who remained in level of initial disturbance.

The hypothesis that differences would be found in the personal values and theoretical orientation of therapists with high and low dropout rates was partially supported in that personal values did distinguish between those therapists whose patients were remainers and those therapists whose patients were dropouts. The therapists whose patients were remainers

were found to value independence and the use of cognitive behaviors more than the therapists whose patients were dropouts. The differences were considered minimal in relation to the number of therapist variables (N=30) contrasted. The hypothesis that additional differences would be found in the personal values and self concept of dropout and remainder patients and high and low dropout therapists in the analysis of the interaction of individual patient-therapist dyads was supported as differences were found in the conjoint analysis of patient and therapist values in dyads that were characterized as remainers vs those defined as dropouts. The hypothesis that differences would not be found in the therapists' values, self concept and theoretical orientation in the course of two administrations, given one year apart was partially supported as only a few significant changes were found in the therapist's personal values, theoretical orientation and self constructs over a one year period. The valuing of benevolence was found to decrease. Additional analyses found patient demographic variables to show no significant differences in distinguishing the patient who dropped out from the patient who remained.

## Chapter 4 Discussion

### Implications of the study

The particular clinical population studied represented the typical community mental health center and an apparently average crosssection of subscribers to mental health treatment facilities. Previous studies have noted that such clinical populations have tended to respond to more concrete, directive approaches (Dodd, 1971).

A description of the patient and therapist values and self concepts , at the beginning of therapy was found to indicate that both particular patient values and particular therapist values were associated with the potential degree of difficulty in maintaining a continuing therapeutic relationship in the population studied. Patients who were found to value achievement, goal orientation, and decisiveness were found at risk to drop out of treatment (5 or less sessions) when compared to Remainer patients who were found to value dominance and support. Therapists who were found to value opposition to task orientation were found to lose patients. Therapists who valued the use of a more personal approach and a more concrete and results oriented approach were found to maintain more therapy dyads.

Although the primary focus of the study was on the patient-therapist dyad, and on the identification of variables that could be related to premature termination, the patients' and therapists' individual contributions to the dropout process

were examined first. The separate therapist and patient analyses were followed by a joint consideration of the patient and therapist interaction, in a regression analysis.

#### Patient Values and Dropout

The findings portrayed the dropout as an impatient patient; the more a patient valued the qualities of achievement goal orientation and decisiveness, the higher their risk to drop out of treatment. The qualities inherent in these value loadings (i.e. the striving to set the highest standard of accomplishment, to do an outstanding job, to make quick decisions, to make one's position on matters very clear) provided a sense of a potential for early frustration. In the initial stages of the psychotherapeutic relationship, the therapist is often oriented to a posture of not making immediate decisions, not setting standards and not seeking outstanding accomplishments. Lack of clarity and lack of precise direction are acknowledged. This may simply have been too disconcerting an experience for these patients, resulting in their leaving the field.

The finding of three patient values associated with remaining in therapy (i.e, dominance, support and friendliness toward authority) suggested a patient's movement in social space towards status or power. This included a tendency to identify the self with powerful persons or images such as a powerful and/or idealized parental or authority figure. (i.e. the therapist). In this sort of patient, there is the

potential for an overidealized positive transference, resulting in a longer duration of stay for the patient. The data of this study indicate that this sort of configuration characterized the patients who were able to remain in therapy. The high value they accorded to personal support, stressed the patient's desire to be treated with understanding and encouragement and kindness and consideration from others. The patient's identification with an overidealized authority image, appeared to result in their remaining in treatment; the sense of frustration in the patient profiled as valuing clarity, quick decisions and a feeling of certainty in their lives, resulted in their dropping out of the relationship.

#### Patient Self Concept and Dropout Rate

The data indicated that the healthier the individual patient prior to the beginning of treatment (as characterized by higher level of self concept that was measured by the semantic differential), the longer was their duration of stay. This lends further support to prior research which has noted that the already healthy patient tends to get healthier and also tends to make better use of the treatment facilities (Garfield, 1971). In addition, the notion of a "yavis" syndrome, (Schofield, 1974), where the healthier patient is regarded as more attractive to their respective therapist, was also supported.

#### Therapist Values and Dropout

A strong relationship was found between

the therapist's valuing of non-task oriented behaviors, in opposition to the task demands of authority (which appeared to express the feeling of let's back off the demands) and a high rate of dropout for that therapist. The "high risk" therapist appeared to value emotionally expressive and intuitive responses, a break from presently established routine demands, and a feeling that growth and development require time, play and patience. These values were certainly in opposition to the patient traits described for patients at risk of dropout. The potential for conflict between such differently valuing individuals, in a task oriented relationship, was evident. The therapist, a nonconformist, reflective individual, approached the issue of growth and movement from his unique perspective and time frame and was in conflict with the goal oriented patient, who was found prone to quick frustration, if answers were not at hand.

The therapist variables found to be associated with maintenance of the psychotherapy relationship, appeared to point to both a valuing of personal involvement and caring, and a cognitive, task oriented, concrete approach to their role as psychotherapist.

A question this study raised, in consideration of the high risk factors found in the therapist's contribution to the dyadic success rate, involved the issues of role clarification and orientation for the therapist. Theoretical orientation (as defined by the three cluster scores of the

Therapist Orientation Questionnaire) did not appear to be involved in the determination of a therapist's success rate at keeping patients in treatment. On the other hand, factors which emphasized the personal involvement and concrete goal oriented aspects of the therapy process, were found to contribute significantly to maintenance of the therapeutic relationship. These findings were consistent with research that has investigated the contribution of "nonspecific variables" to therapy process and outcome (Kasdin, 1978; Frank, 1980; Strupp, 1979). The present study has hypothesized nontechnical factors to account for the majority of treatment successes. The scales used were recently revised to account for the most recent trends and changes in theoretical orientation, and they provided an exhaustive set of factors accounting for the contribution of the major schools of clinical training and thought. The theoretical orientation factors that were found to be most indicative of therapist success in sustaining the relationship, all appeared to represent the more personal , nontechnical aspects of the therapist's style, substantiating the belief in the importance of the personal qualities of the practitioner over their particular technical interventions (Strupp, 1979; Garfield, 1971; Beutler, 1980; Luborsky, 1984).

Data collected through the Symlog scale (a study of interpersonal values) found the therapist's lack of task orientation to be the most significant therapist variable

associated with a tendency to lose patients. This finding substantiated the hypotheses of this study and the findings of Fiester (1977) and others (Beutler, 1982) that the search for therapist differences is best pursued through the use of relationship oriented questionnaires that are interpersonal in nature. The combination of intra and interpersonal factors in both therapists and patients that indicate high risk of termination prior to the beginning of the therapy relationship, speak to the multidimensional nature of this complex dyadic relationship.

Disruptive effects of therapist personal values.

While much of the previous research in premature termination has been concerned with the patient's "high risk" characteristics, the potentially disruptive effects of the therapist's values must be considered, in light of the results found. It appears necessary for the therapist to adjust his values and theoretical orientation so as to meet his client on common ground; to serve mutuality. The belief that therapists should acknowledge and be prepared to alter their personal value framework and/or their theoretical orientation seemed justified if the goal is to avoid early termination.

Previous findings that social class covaried with duration of therapy have found lower class patients to value a medical model, authority and advice giving. Experience with traditional psychotherapy which demanded a verbal give and take, introspection and talking about feelings,

clearly created dissatisfaction and flight from the field in this homogeneous lower working class population.

Therapists have values and preferences for the ways of practice that they find gratifying. If the therapist's values, self concepts and/or theoretical orientation lead him to be uneasy with particular patients and cause him difficulty in empathizing with them and their subcultural values, standards and way of life, then the recognition of the problem can provide a starting ground for rapproachment.

Psychotherapy has been described as a process occurring within the context of three value systems: those of the therapist, the patient and the community at large (Strupp, Hadley & Schwartz, 1977). The complex relationship between these three value systems operating simultaneously has been an object of focus in the literature in pursuit of a better understanding of the potential for therapist, patient and community congruence and/or incongruence in goals and expectations. (Rogers, 1972; Bergin, 1980; Strupp, etal, 1977).

#### Change in Therapist Values and Orientation

As hypothesized, therapist personal values and theoretical orientation showed only minor changes during the conduct of professional practice.

The thirty categories of personal values and theoretical orientation initially held by therapists, did undergo some changes during the one year period, including the devaluing of benevolence and increase in personal security with coun-

tertransference issues. These findings were consistent with the previous research (Kirchner, 1972; Mensch, 1962; Strupp, 1978) which has found that both clinical psychology and medical students tend to devalue benevolence (as measured by the Surveys of Interpersonal and Personal Values) as time in clinical training continued and that experience results in continued self confidence and lowering of a defensive stance in practicing psychotherapists. Although the changes were few, in the statistical sense, the consistencies in the changes that were found are worthy of further investigation.

#### Patient Therapist Interaction of Personal Values

The interaction of the patient's and therapist's values was found to be related to the premature termination of the psychotherapy relationship.

This was supported by multiple regression analyses.

In the population studied, the data of both therapists and patients yielded variables that could determine the high risk potential for patients and therapists to effect premature termination. When both therapist and patient variables were considered together, (in the matching of the sixty nine individual dyads), they contributed significantly toward identification of discriminating factors that would predict risk for premature termination of the psychotherapy dyad. It may be possible to categorize, at the point of intake interview, both a therapist's risk level to lose patients and a patient's potential high or low risk to drop out of the

relationship.

The therapist's high risk factors, in interaction with the patient's status, was characterized by a lack of concern for task orientation (as defined by the Bales Symlogscale). The high risk therapist was portrayed as concerned with a more creative, freewheeling approach to the therapy process, at the expense of attention to the achievement of immediate specific results - a flight into process. Specifically, it appeared to operate alongside an opposition to task orientation as required by outside authority; a devaluing of the time concept, a feeling of a let's take our time and see what happens approach. This process oriented approach appeared to exacerbate an already frustrating experience for the high risk patient. The latter was found to value such traits as achievement and goal orientation, which (as measured by the SPV&SIV) portrayed such patients as desiring a results oriented experience. They preferred to be provided with a feeling of clear movement towards a goal, if not results themselves and with a sense that there was movement toward getting the task accomplished. These simultaneous therapist and patient high risk factors clearly provided a conflict, in which the therapist valuing of a time out from results approach did not respond to the patient's need for such results. The probability that such needs manifested a high level of patient anxiety and led to patient's difficulty with a feeling-oriented, process-oriented experience such as individual

psychotherapy, should be explored.

Closer examination of the patient therapist interaction factors associated with remaining in therapy indicated that the patient also valued support and continued to value dominance. The latter value (as elaborated by Bales) appeared to manifest itself interpersonally with a strong identification with idealized authority figures, a hothouse for a positive transference experience. The picture was of a patient whose need for such identification would almost always result in their maintenance of the relationship. This latter value was the most powerful patient factor, both within patients as a group and in relationship to the intercorrelation of all therapist factors, when predicting their length of stay in the therapy relationship.

Patient positive endorsement of support, characterized by a valuing of the receiving of kindness and consideration from others, appears manifestly logical.

Despite the fact that specific therapist orientation clusters were not found to be significant in the prediction of their dropout risk, two orientation factors were found to predict a tendency to remain.

The Sundland factor of therapy as a learning process (see Appendix F; Factor 6) depicted a loading on cognitive, concrete factors, which in conjunction with a high loading on personal involvement and caring (see Appendix F), may have made the difference in the crucial early period of engagement

in the therapy process. The finding that nontechnical factors, those not identified with particular schools of therapeutic orientation or practice, appeared to be most predictive of therapist success, substantiated recent emphasis on the study of the personal qualities of the therapist, often referred to as the nonspecific factors of the therapist's contribution (Frank, 1971; Strupp, 1980; Garfield, 1972). Factor loadings on caring and personal involvement (Factor 6) tended to support the Rogerian client-centered "necessary and sufficient condition" of warmth (Rogers, 1955; Butler & Haigh, 1968; Truax, 1972). The loadings on conceptual learning supported recent findings of the success in the use of a more cognitive approach in the treatment of outpatient problems. The relationship between a more concrete, behaviorally oriented approach, and maintenance of the therapeutic dyad could be interpreted as providing the patient with a more immediate sense of accomplishment and consequent lessening of frustration.

Beutler's (1978) observation, that certain combinations of patient and therapist values interaction are most compatible with successful outcome in a psychotherapy dyad, helped our understanding of continuation in psychotherapy. Continuation in therapy required a mixture of high levels in some values and low levels in others (Beutler, 1980). The prediction that dissimilarity of personal values, unless reconciled, would lead to termination of the

relationship, was untestable; but we did find premature termination of therapy to result from a failure to recognize a potential conflict in the values held by the participants in the dyad. Festinger's (1957) theory of cognitive dissonance and Hovland's social judgment theory both shed light on this process. When dissonance is present, in addition to trying to reduce it, the person will actively avoid the situation that would probably further increase the dissonance (Festinger, 1957). Although the results could not clearly define a "good" vs. a "bad" therapeutic match, the findings did provide characteristics of "good" and "bad" therapists and patients. These lend support to previous findings (Dougherty, 1972) and could be the source of future investigations into the feasibility of matching traits, in addition to the individual traits found in this study.

#### Demographic Variables and Dropout Rate

The finding in this study that patient demographic variables did not correlate with duration of therapy is consistent with previous findings. The lack of correlation, compared with other studies, is understandable. The only demographic variables that approached significance in the prediction of patients' risk to dropout, were therapist variables. Although not an object of focus in this study, the findings that 80% of patients were found to have obtained a high school education or less, seems important in future observation of therapist patient relationship compatibility. The homogeneity of the

population sampled should also be recognized as inherently limiting the study's ability to observe the effect of demographic differences on the criteria.

#### Other Patient Variables

The absence of significant findings on several variables that have been demonstrated as significant for differentiating terminators from remainers in other studies is relatively unremarkable. Contradictory findings on such variables abound in the literature. In his review, Brandt (1965) indicates that only sex, age and marital status consistently failed to distinguish remainers from dropouts. Findings regarding the effects of all other variables are consistent only in their inconsistency, and so the contribution of these variables to early termination may be ruled out for some types of patient populations but not for others.

#### The Intake Interview and Dropout

Additional analyses were performed to examine the relative contribution of the intake interview procedure to the dropout process. Initially, investigations were conducted to search for differences between those patients who "dropped out" during the initial intake interview stage (pretherapy dropout) and those who dropped out during the therapy proper (therapy dropout).

The pretherapy dropout was found to value support more than the therapy dropout and to value orderliness less than the therapy dropout. These differences appear to point to the patient's possible lack of organization in presenting their

problems and needs, coupled with a strong need for support and contact in the initial stages.

Additionally, analyses were performed to examine the importance of the period of transfer from intake to therapy. Chi square analyses found that the dropout rates of therapists became significantly lower when the therapist, while in the role of intake interviewer, proceeded to continue seeing the patient as his or her psychotherapist. (See Table 21). This finding, in need of further investigation, acknowledged the need for clinicians to recognize and attend to the critical importance of the early stages of patient institutional contact. Possible areas for future exploration might include an examination of what the patient experiences and/or how he/she interprets the meaning of this transfer period. In light of this study's findings, one interpretation would hypothesize a further exacerbation of an apparently low patient tolerance for frustration, when an intake was non-directive, i.e., feeling that nothing has been accomplished and that I have to start over again.

#### Implications for clinic practice

Patient length of stay was characterized by high rates of dropout and low mean length of stay in the sample tested and in the total population attending the clinic.

All of the following findings speak to the nature of the clinical settings studied: a dropout rate of two thirds (66.7%) in the sample studied; an overall yearly dropout rate

TABLE 21

Chi Square and p level for therapist dropout rate for intake and therapy only vs. intake and therapy together.

Total Therapist Group		Total Therapist Group	
Intake	Intake&Therapy	Therapy	Intake&Therapy
95	87	58	87
116	32	42	32
55%	26.9%	42%	26.9%
Chi Square= 23.14 p<.001)		Chi Square = 4.89 p<.05)	

Intake(N= 21)      Therapy =(N=100)      Intake &Therapy(N=119)

of 55%; a mean length of stay for all tested patients of 6.26 sessions and a mean length of stay for the entire year's caseload of 7.22 sessions. Whether aware of it or not, the clinics participated in the provision of relatively short term therapy.

The establishment of a patient's dropout status was accomplished by a thorough examination of the records using the criterion that a dropout was defined as a patient who left the treatment setting without the provider's agreement. Treatment, then, was clearly not satisfactorily completed or pursued. The settings were specifically designed to provide long term treatment and so short-term, time limited goals probably were not set.

A summary of values compatibility in therapy

It has been proposed that, in therapy, values relate to each other within a framework. According to this framework, the typical adult outpatient enters therapy valuing support and other qualities that accentuate the need for direction and results. In the sample, those patients valuing of achievement, goal directedness and decisiveness were found to be associated with patient dropout from therapy.

The therapists, in addition, seemed to provide alternative profiles in terms of values and theoretical orientation, that could be interpreted as either supportive or frustrating of the patient's values.

Overall, these findings offer some insight into and confirmation of what the previous research has found concerning the beliefs and values that patients hold; about what transpires over time in the values systems of therapists during the conduct of their professional life; and about the effect that these respective values systems have on the process and outcome of the psychotherapeutic dyad. It is recommended that researchers seriously consider the continuation of the study of therapist and patient values in further attempts to evaluate the efficacy of psychotherapy.

#### Recommendations

It seems crucial to focus on and clarify the degree of congruence that exists between therapist and patient values early in treatment. The use of an abbreviated form of these protocols, in order to "flag" particular loadings and/or disparities in values or expectations, could minimize the potential for putting the patient at a high risk for dropout.

Considering that the interaction of patient values with those of therapists was found to both impede and facilitate duration of different relationships, such recommendations appear justified in order to maintain patients in therapy. It is necessary to innovate or devise approaches to reduce frustration in those patients with a need for quick results and a feeling of certainty and accomplishment. This is

particularly so in cases where these needs may already be known to exist, as in the case of lower class patients (Baum, 1966; Welkowitz, Cohen & Ortmeyer, 1967). Previous studies have focused on providing the patient with a role induction type experience. These studies have been designed with the hopeful aim of clarifying the often frustrating nature of the upcoming therapy relationship, and the designs have been found to be successful in bringing into line the expectations of the patient and the therapist (Hoehn-Saric, 1965). Such studies of patient and therapist role expectation have found that a disparity between patient and therapist does exist. This study has provided some clarification on specific areas of such disparity.

Subsequent studies could focus on the process within sessions through which patient/therapist differences and similarities in specific values can make or break the therapy relationship. Unanswered important questions include understanding the process through which values change in therapy and the factors that operate in facilitating or impeding such change. The difficulty involved in obtaining repeated testing of outpatients in a typical clinical setting should, however, be known to future researchers. It appears crucial that therapists and intake interviewers make every effort to elicit and clarify those values that are potentially discrepant during the initial phase of therapy.

Both parties should have a clear understanding

of their own values and roles in therapy and they should understand the values and premises of the other person that is affecting them. This intervention can greatly reduce the disruptive force of incompatible values. In the assignment of patients to therapists, future research could examine prospective matching of the patient and therapist according to their individual sets of values. This could facilitate compatibility even further. This would enhance efforts toward selecting the therapist most suited for each patient. Use of the Surveys of both Interpersonal(SIV) and Personal (SPV) Values as instruments for quickly assessing values seems promising.

This is one of the few studies that has dealt with the characteristics of therapists which may be partly responsible for patients' decision to discontinue therapy (Hiler, 1958; Fiester, 1977). Future studies could further examine the contribution that therapist values have made to premature termination.

#### Limitations of the study and recommendations for future research

##### Naturalistic vs. Manipulative studies

This study followed the naturalistic research model. Many variables could be investigated simultaneously in a comprehensive fashion. Statements about causality or directionality could not, however, be made. The finding of an association between therapist/patient values and premature termination of

the dyad does not mean that the former produced the latter. Although the theory upon which this study was based did imply causality, this was not directly tested. The study attempted to test a prediction that followed from and indirectly supported the theoretical formulation. To establish the cause and effect relationship of values interaction to dropping out would require the control of values interaction by preselection. Each therapist could be assigned patients who are profiled in terms of particular high and low risk attributes. The SIV, SPV, Symlog and SD could be used to assess the relationship and provide the basis for assignment of patients such that each therapist has both high and low risk patients. Identifying the mixture of high and low risk values as variables related to premature termination is the first step in this direction. In spite of the study's relatively small sample size, support for hypotheses of interaction suggest that it may prove to be a practical and theoretically valuable variable for future research. Manipulative studies on premature termination have utilized a preparatory interview or induced expectancies as the independent variable (Hoehn-Saric, 1965; Frank, 1964; Sloane & Cristol, 1970).

These types of studies have presented a methodological problem. The inducement of the desired values change would need to be determined and verified. The values surveys could be used as an independent measure to determine whether change in particular high risk values occurred as a result of an

induction procedure. This would involve the administration of the scale before and after the intake interview to patient groups receiving and not receiving an induction.

#### Generalizability of Results

One of the major difficulties in evaluating psychotherapy research involves the definition of the criterion measure. The criterion for dropping out has varied among studies and this has made generalization difficult. Some of the inconsistency among studies of terminators and remainers could be the result of the variation in cut off points for defining these groups.

The range (1-10+yrs.) of the therapist's experience limited generalizations, as did their theoretical orientation. Whether similar findings can be demonstrated within other systems of psychotherapy remains to be investigated.

Furthermore, the patient population at the two psychotherapy centers may differ from the population at other public clinics. The median number of treatment sessions was less than at other clinics (Garfield, 1971; Koss, 1980) and the number of terminators was relatively large compared to what is found at other clinics. The results of the present study must be considered in this light. Generalizations about the results are restricted by the criterion, the clinical setting, and the patient and therapist sample that was utilized.

#### Problems in Data Collection

Gathering data on the terminators who were available was difficult, especially once a patient left treatment.

While in treatment, a patient may have had enough incentive to complete the requested forms. Once terminated, particularly if dissatisfied, he was difficult to recruit. Since the clinical sites maintained comprehensive clinical records, post hoc data were available on a wide range of demographic and diagnostic areas.

In evaluating change in any variable during psychotherapy, the absence of a control group leaves questions unanswered. Patients were found to have certain characteristics, but this does not rule out the possibility that the results were the effect of setting. Previous studies have provided data on distinct patient differences (Rozecki, 1972).

#### Staff Participation in the Research

Substantial reluctance to participate in this research was evidenced on several staff levels. Therapists were cooperative about completing research materials, but they were forgetful about informing patients of the existence of the study; this was a necessary condition for the study's completion. The principal investigator was continually providing written and personal reminders to the staff to read the necessary forms to patients. From the beginning, the therapists viewed the research as an invasion of privacy. Executive and administrative staff expressed worry about how the study might interfere with the therapy. Several voiced the apprehension that the initial questionnaire would stimulate untimely issues in therapy about values. Perhaps the behavior

of the staff toward the research was another manifestation of the opposition to task oriented behavior that was found in the data.

The issue of the extent to which the process of measurement of the variables under study (the Heisenberg phenomenon) is as difficult in dealing with people as with physical particles. The effect seemed to be greater on the therapists than on the patients.

Four therapists refused to cooperate from the beginning; two withdrew their participation during the course of the study. It appeared that therapists, more than the patients, experienced the research to be intrusive. Patients, for the most part, seemed to enjoy the chance to participate in something "scientific". The resistance to the research by the therapists was surprising since both sites serve as teaching facilities and have university affiliations known for their research contributions. The professional training of most staff comes from institutes that support the conduct of research. Neither site, however, had an active research project in progress in their psychology departments at the time of the study.

The effect of the study itself in precipitating early termination of therapy was determined from a comparison of the study's data with the dropout percentages of the patients who were not exposed to the study's existence. The study had no such influence (see Tables 1 & 2).

Relatively well experienced therapists were used in this research, contrary to the overwhelming use of inexperienced student therapists in the vast majority of psychotherapy outcome studies (Smith, 1978). In addition, the clinical sites used were community public mental health facilities, as opposed to the often used university based clinics. These factors made for greater generalizability of the study's results to the general population.

#### Conclusions

The finding that dropouts could be differentiated from remainers on certain variables supported the concept that terminators could be potentially identified in terms of independent predictor variables. Identification of the patient's and therapist's values could be useful information for either selecting the therapist best suited for each patient or informing the therapist about the magnitude of the potential conflict between himself and his patient. The scales used were rather simple, stable instruments that could be administered quickly. They could be useful for future therapy research.

If a suitable match of patient and therapist could not be effected, one could suggest that the therapist might actively structure the relationship in the direction of greater mutuality by acknowledging and focusing in on their discrepancies. While the matching and manipulating of patient and therapist's values may depart from usual clinical practice,

it appears to be potentially helpful.

Continued investigations of the interaction between therapist and patient on relevant variables may help to clarify the forces that lead to stable therapy relationships. Although the problem of continuation in therapy may be secondary to the matter of therapeutic effectiveness, staying in therapy is a necessary, although not sufficient condition for a patient to improve from therapy. Finally, further increased emphasis on process oriented studies is advised with a focus on the goal of better understanding the nature of therapy and its participants.

An aim of this study was to stress the apparent need to implement greater efforts toward reducing dissonance within the dyad so that treatment can continue. Studies aimed at identifying which patients will remain and which will discontinue may be abused if the goal is only to select good patients for therapy. This would only reduce further the number of people offered therapy. The ethical implication implied in the ability to identify a set of potential high and low risk factors in both patients and therapists becomes one for mental health practitioners and administrators to ponder. The question of whether one should consider changing the nature of the provided services in order to better suit the apparent values of the client vs. the possibility of further educating , or , in some other way, modifying or changing the

attitudes or expectancies of the client in order to better suit the current plan for allocation of resources, will be with us for time to come.

APPENDIX A

Means, SDs, and mean difference scores for Survey of Interpersonal Values scales of psychiatric outpatient and nonpatient samples

Variable	Male OPT		Male NONPT		Mean Difference
	Mean	SD	Mean	SD	
Support	17.9	4.9	15.0	5.7	2.9**
Conformity	8.8	5.5	14.8	6.5	-6.0**
Recognition	13.9	4.1	11.2	5.2	2.7**
Independence	20.3	4.5	16.9	7.4	3.4**
Benevolence	13.2	6.5	15.8	5.8	-2.6**
Leadership	16.5	7.8	16.1	7.7	0.4
N	61		213		
Variable	Female OPT		Female NONOPT		Mean Difference
	Mean	SD	Mean	SD	
Support	20.1	5.0	18.2	4.9	1.9*
Conformity	12.9	6.5	18.0	5.8	-5.1**
Recognition	13.0	4.7	9.9	4.2	3.1**
Independence	18.1	6.6	15.7	5.9	2.4**
Benevolence	16.8	6.7	20.4	4.8	-3.6**
Leadership	8.9	6.4	7.9	5.2	1.0
N	60		212		

\* denotes p<.05) level

\*\* denotes p<.01) level

Note: reprinted from Mensch(1960).

APPENDIX B

Means, and SDs for Survey of Interpersonal Values for male psychiatric residents.\*

Scale	Residents	
	Mean	SD
Support	14.7	5.9
Conformity	7.3	5.3
Recognition	13.3	4.1
Independence	22.6	7.2
Benevolence	12.2	4.6
Leadership	19.9	5.4
N	10	

\* reprinted from Mensch(1970).

Means and Standard Deviations for clinical psychologists(A=academic & P=practitioner).\*

Variable	Psych(A)		Psych(P)	
	Mean	SD	Mean	SD
Support	16.0	6.3	17.1	5.2
Conformity	4.2	3.0	8.80	5.1
Recognition	15.2	4.3	11.5	4.4
Independence	18.8	8.8	20.9	7.9
Benevolence	17.5	5.6	17.0	5.6
Leadership	18.6	4.4	14.7	6.9
N	8		9	

\* reprinted from Gila Kornfield Jacobs(1971).

APPENDIX C

Means and standard deviations for Survey of Interpersonal Values scales for female social workers, practitioners\*

Scale	Social Workers	
	Mean	SD
Support	20.5	3.2
Conformity	9.3	4.8
Recognition	10.8	3.8
Independence	21.0	5.7
Benevolence	18.8	3.6
Leadership	9.0.	3.7
N	9	

\* reprinted from Kornfield-Jacobs(1971).

APPENDIX D

Means and standard deviations for Survey of Interpersonal Value scales for adult males(n=213) and females.\*

Scale	Adult males		Adult Females	
	Mean	SD	Mean	SD
Support	15.0	5.7	18.2	4.9
Conformity	14.8	6.5	18.0	5.8
Recognition	11.2	5.2	9.9	4.2
Independence	16.9	7.4	15.7	5.9
Benevolence	15.8	5.8	20.4	4.8
Leadership	16.1	7.7	7.9	5.2

\* reprinted from Gordon(1970).

APPENDIX E

Therapist Orientation Questionnaire Cluster Scores for all therapists.

Therapist ID No.	Experiential	Analytic	Cognitive/Behavioral
1	1.58	-0.61	-0.89
2	0.48	-0.84	0.57
3	-1.38	-1.17	0.24
4	2.21	1.60	1.03
5	0.47	-1.31	1.03
6	1.18	-0.70	-0.53
7	0.37	0.88	-0.32
8	0.87	0.19	-1.23
9	0.47	0.89	0.40
10	-1.34	2.43	1.18
11	0.87	-0.24	0.94
12	-1.05	-0.54	1.39
13	-1.07	-1.28	-0.16
14	-1.38	2.05	-3.12
15	1.43	-0.33	0.09
16	0.81	-1.27	-0.74
17	-0.30	-0.69	-0.21
18	0.69	-0.25	-1.02
19	0.76	-0.02	-1.45

APPENDIX E (cont).

20	-0.86	-0.68	-0.56
21	1.16	0.55	-1.09
22	-0.00	-1.13	0.37
23	-1.34	0.49	0.53
24	-0.57	1.06	0.34
25	0.18	0.13	-0.99
26	-0.24	-1.32	0.09
27	-0.03	.98	-0.98
28	-.51	0.23	0.94
29	-0.81	-1.02	0.57
30	-0.12	1.09	1.38
31	-0.56	-0.07	0.33
32	-1.94	-0.96	-1.4
33	-0.95	0.00	0.39
34	-0.32	1.44	0.85
35	-0.01	0.20	0.18
36	1.28	0.24	1.51

## APPENDIX F

## Therapist Orientation Factor Descriptions

Brief Descriptions of the Factors

Factor	<u>Label (high score)</u>
1	Use of expressive techniques In working with dreams, effective therapists have their patients role-play the characters and other elements of their dreams. (710) <sup>a</sup>
2	Psychoanalytically - oriented. For a patient to improve his current way of life, he must come to understand his early childhood relationships. (701)
3	Social adjustment Having a patient move in the direction of the goals of society is <u>not</u> an important therapeutic aim. (793)
4	Interruptive / active I interrupt a patient while he is talking. (704)
5	Importance of feeling awareness The patient's coming to accept and experience his feelings is <u>not</u> the primary gain he derives from therapy. (780)
6	Involvement and caring. A good therapist acts personally and emotionally involved and concerned with his patient. (691)
7	No innate drive toward health People do not have any inherent "drive towards health". (884)
8	Lack of countertransference. At times, I feel contempt for a patient.
9	Personality and artistry. Patients get better more because their therapists are kinds of persons they wish than because of professional training. (750)
10	Verbal / Conceptual process. In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist. (784)
11	Acceptance of physical contact / massages etc. It is sometimes all right for a patient and therapist to embrace. (725)

<sup>a</sup>value of the factor loading

FACTORS - THERAPIST ORIENTATION QUESTIONNAIRE - 1972 FORM

FACTOR 1

Body, Guided Daydream, Gestalt Therapy, Release of Emotions

- (2) A good therapist will help his patients become aware of their bodily movements and postures, and help them explore their possible meanings. (New) (655)
- (10) Good psychotherapists encourage their patients to use meditation techniques. (New) (483)
- (12) It is very beneficial to use the "guided-daydream" technique. (New) (648)
- (23) Rather than talk about another person, good therapists have their patients talk to an empty chair as if the person were sitting there. (New) (699)
- (60) Release of pent-up bodily energies is important as part of psychotherapy. (New) (668)
- (74) In working with dreams, effective therapists have their patients role-play the characters and other elements of their dreams. (New) (710)
- (83) Body movements and posture tell us a lot about the patient's psychopathology. (New) (519)
- (26) It is a useful therapeutic technique for the patients to shout, or beat pillows to express blocked feelings. (New) (686)

FACTOR 2

Need to Know about Childhood, Conceptualize Case, Psychoanalytic  
Analyze Transference, Intensive Therapy

- (-7) It is unnecessary for a patient to learn how early childhood experiences have left their mark on him. (68-5) (665)
- (-14) People can be understood without recourse to the concept "unconscious determinants of behavior". (20-5) (667)
- (-19) Desensitization and re-conditioning are effective psychotherapeutic techniques. (416)
- (21) It is very important for a therapist to conceptualize, think through how a patient is relating to him. (55-3) (351)
- (30) With most patients I do analytic dream interpretation. (3-5) (675)
- (37) I instruct most patients to free associate. (33-5) (629)
- (-45) For effective therapy, it is only necessary to concentrate on the here-and-now experiencing of the patient. (New) (560)
- (61) For a patient to improve his current way of life, he must come to understand his early childhood relationships. (37-5) (701)
- (68) It is important to analyze the transference reactions of the patient. (62-5) (624)
- (-80) For a patient to improve his current way of life, he does not necessarily have to come to understand his early childhood relationships. (106-5) (624)
- (93) To make sense of a patient's behavior, one must assume motives of which he is unaware. (114-5) (581)
- (100) I prefer to conduct intensive rather than goal-limited therapy. (New) (469)
- (-53) It is possible to make sense of a patient's behavior without assuming motives of which he is unaware. (49-5) (543)
- (-11) Primary emphasis should be placed on the patients' manifest behavior. (New) (529)
- (-4) Understanding why one does things is not the major factor in correcting one's behavior. (82-4) (483)

FACTOR 3

Treatment Plan Important, Need to Adjust to Society

- (8) A mature, healthy person will necessarily move in the direction of society's goals. (18-1) (585)
- (-35) A successful adjustment to the social environment is not important goal of therapy. (67-1) (748)
- (-69) A treatment plan is not important for successful therapy. (2-3) (567)
- (73) It is important for a patient to be helped to make a social adjustment. (70-1) (706)
- (-94) Having a patient move in the direction of the goals of society is not an important therapeutic aim. (111-1) (793)

FACTOR 4

Confront, Use Knowledge, Interrupt, Be Active

- (-8) A therapist should never interrupt a patient while he is talking. (113-10) (544)
- (-20) I would not interrupt a patient during a therapy session as I might if we were merely having a social conversation. (22-10) (591)
- (41) I am a fairly active, talkative therapist, compared to most therapists. (10-10) (632)
- (52) The patient should be directly confronted with evidence of his irrational thoughts and behavior. (New) (452)
- (57) I interrupt a patient while he is talking. (83-10) (704)
- (-71) I am a fairly passive, silent therapist, compared to most therapists. (30-10) (615)
- (85) It is quite acceptable to interrupt a patient while talking. (52-10) (656)
- (103) Good therapists do a lot of talking during the therapeutic hour. (83-10) (609)

FACTOR 5

Important to Become More Aware of Feelings.

- (-16) The patient's coming to experience his feelings more fully is not the most important therapeutic result. (42-2) (760)
- (46) The most important results of therapy are the new feelings and emotions that the patient comes to experience. (94-2) (722)
- (51) The most beneficial outcome of therapy is the patient's becoming more open to his feelings. (23-2) (767)
- (-64) An affective change in the patient is not the major gain from therapy. (75-2) (630)
- (-78) The patient's coming to accept and experience his feelings is not the primary gain he derives from therapy. (115-2) (780)

FACTOR 6

Personal Involvement, Care.

- (9) A good therapist expresses to his patients a sense of personal involvement and concern. (45-6) (646)
- (17) It is important that a therapist show caring and concern for his patients. (New) (521)
- (-27) It is preferable for the therapist to feel impersonal in the therapy relationship. (59-6) (628)
- (95) A good therapist acts personally and emotionally involved and concerned with his patient. (122-6) (691)
- (-36) The therapist should not act as though he were personally or emotionally involved with the patient. (72-6) (657)
- (-43) Whatever the intensity or nature of the patient's emotional expression, the therapist is most effective when he feels detached, objective, and impersonal. (84-6) (631)
- (76) It is important for the therapist to feel a deep personal and emotional involvement with his patient. (110-6) (663)
- (-94) It is irrelevant whether a therapist "cares" for the people who come to him for help. (New) (494)

FACTOR 7

No Innate Drive Toward Health

- (-42) Inherent in human beings is a natural propensity toward health, physical, mental and emotional. (27-9) (863)
- (62) People do not have any inherent "drive towards health". (58-9) (884)
- (89) There is not an innate tendency in human beings toward emotional health. (118-9) (884)
- (-97) In all human beings there is a sort of "life force", a striving for perfection. (98-9) (692)

FACTOR 8

Lack of Countertransference Feelings - Secure Therapists

- (15) A patient can be very critical of me or very appreciative of me without any resulting change in my feeling toward him. (61-7) (607)
- (-34) Even a good therapist may find it difficult to cope with a patient's hostility. (New) (511)
- (-63) My own attitudes toward some of the things my patients say or do stop me from really understanding them. (13-7) (630)
- (-82) At times, I feel contempt for a patient. (78-7) (648)
- (-98) A therapist should realize that his efforts may prove harmful to patients. (New) (406)
- (96) I am very secure and comfortable in my relationships with my patients. (127-7) (452)

**FACTOR 9**

**Therapist's Personality Crucial, Therapy More an Art**

- (1) The therapist's personality is more important to the outcome of therapy than his professional training. (90-3) (737)
- (39) Patients get better more because their therapists are the kinds of persons they are, than because of their therapist professional training. (50-3) (750)
- (78) The more effective therapists do things during the therapy hour for which they have no reasoned basis, merely a feeling that it is right. (14-3) (642)
- (86) In effective therapy, the patient learns mostly through the affective and un verbalized relationship between himself and the therapist. (109-4) (604)
- (87) Psychotherapy is much more an art than a science. (New) (665)

**FACTOR 10**

**Learning Process is Verbal and Conceptual**

- (47) In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist. (70-4) (786)
- (66) The crucial learning process in therapy is a verbal and conceptual process. (88-4) (774)
- (104) The most important results of therapy are the new ideas and new ways of thinking about himself that the patient achieves. (121-4) (631)

**FACTOR 11**

**Against Marathons, Sensitivity, Etc; Against Physical Contact. (Formal)**

- (-3) It is sometimes all right to visit a patient socially in his home. (36-8) (674)
- (28) It is never all right for a therapist to have physical contact with patients (except perhaps for occasional handshakes.) (66-8) (663)
- (39) Hopefully the current fad of sensitivity training will soon disappoint. (New) (587)
- (50) It is never all right to accept a friend or a relative for therapy. (124-8) (566)
- (-67) It is sometimes all right to take a walk with the patient during the therapy hour. (71-8) (593)
- (-70) Marathon psychotherapy groups are useful in helping a patient progress in treatment. (New) (684)
- (-77) Encounter groups are a useful addition to the approaches to mental health. (New) (671)
- (90) It is never all right to offer a patient a ride, or ask him for one. (81-8) (587)
- (-101) It is sometimes all right for a patient and therapist to embrace. (112-8) (725)

CLUSTER 1<sup>a</sup>

Loading	Factor No.	Item Content
(.55)	1	Awareness of body, guided daydreams, Gestalt Therapy, released emotions.
(.51)	5	Awareness of feelings.
(-.69)	7	Innate drive toward health.
(.41)	6	Personally involved, caring and concern.
(.39)	9	Therapist's personality crucial, therapy more an art than a science.
(-.37)	11	Approval of physical contact with clients, marathons, sensitivity training.
(.16)	2	Know childhood, conceptualize case, psychoanalytic.

This seems similar to the old (Sundland & Barker, 1962) general factor pole of EXPERIENTIAL, the feelers, touchers, let it all hang out with a small loading of psychoanalytic interests. A feeler but acknowledging psychoanalytic concepts and techniques. Bioenergetic types should typify the extreme of this mode.

## CLUSTER 2

(.64)	11	Disapproves of physical contact with client, marathons, sensitivity training.
(.58)	2	Know childhood, conceptualize case, psychoanalytic.
(-.44)	4	Non-interruptive, passive, non-confrontative.
(-.24)	6	Impersonal, emotionall uninvolved.
(-.22)	1	Unbeliever in body awareness, guided daydreams, Gestalt Therapy, emotional release.

This is the other pole of the 1962 General Factor. The formal, passive, psychoanalytic approach. It seems surprising that it is orthogonal to Cluster 1.

## CLUSTER 3

(-.52)	9	Professional training important, psychotherapy <u>NOT</u> more of an art than a service.
(.41)	10	Learning through verbal and conceptual interchange.
(.40)	8	Have a lack of countertransference feelings.
(=.38)	6	Impersonal, emotionally uninvolved.
(.26)	11	Disapproval of physical contact, marathons and sensitivity training.
(-.25)	1	Unbeliever in body awareness, guided daydreams, Gestalt Therapy, emotional release.
(-.24)	3	A social adjustment is important.

This seems to be the behavior therapists, the cognitivist, the adjuster to society. Therapy is a rational process to help the client make his way in the world.

<sup>a</sup> Factors with minus loadings have been reworded to adjust for this.

## DIRECTIONS

In this booklet are statements representing things that people consider to be important to their way of life. These statements are grouped into sets of three. This is what you are asked to do:

Examine each set. Within each set, find the one statement of the three which represents what you consider to be most important to you. Blacken the space beside that statement in the column headed M (for most).

Next, examine the remaining two statements in the set. Decide which one of these statements represents what you consider to be least important to you. Blacken the space beside that statement in the column headed L (for least).

For every set you will mark one statement as representing what is most important to you, one statement as representing what is least important to you, and you will leave one statement unmarked.

*Example*

	M	L
To have a hot meal at noon.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>
To get a good night's sleep.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>
To get plenty of fresh air.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Suppose that you have examined the three statements in the example, and although all three of the statements may represent things that are important to you, you feel that "To get plenty of fresh air" is the most important to you. You would blacken the space in the column headed M (for most) beside the statement. Notice that this has been done in the example.

You would then examine the remaining two statements to decide which of these represents something that is least important to you. Suppose that "To have a hot meal at noon" is the least important to you. You would blacken the space in the column headed L (for least) next to this statement. Notice that this has been done in the example.

You would leave the remaining statement unmarked.

In some cases it may be difficult to decide which statement to mark. Make the best decision that you can. This is not a test; there are no right or wrong answers. Be sure to mark only one M (most) choice and only one L (least) choice in a set. Do not skip any sets. Answer every set. Turn this booklet over and begin.

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To be in a position of not having to follow orders.....	M	L
To follow rules and regulations closely .....	==	==
To have people notice what I do .....	==	==
To hold an important job or office .....	M	L
To treat everyone with extreme kindness .....	==	==
To do what is accepted and proper .....	==	==
To have people think of me as being important.....	M	L
To have complete personal freedom .....	==	==
To know that people are on my side .....	==	==
To follow social standards of conduct.....	M	L
To have people interested in my well being.....	==	==
To take the lead in making group decisions .....	==	==
To be able to do pretty much as I please.....	M	L
To be in charge of some important project .....	==	==
To work for the good of other people .....	==	==
To associate with people who are well known.....	M	L
To attend strictly to the business at hand.....	==	==
To have a great deal of influence .....	==	==
To be known by name to a great many people.....	M	L
To do things for other people .....	==	==
To work on my own without direction.....	==	==
To follow a strict code of conduct.....	M	L
To be in a position of authority.....	==	==
To have people around who will encourage me.....	==	==
To be friends with the friendless.....	M	L
To have people do good turns for me.....	==	==
To be known by people who are important .....	==	==
To be the one who is in charge .....	M	L
To conform strictly to the rules.....	==	==
To have others show me that they like me .....	==	==
To be able to live my life exactly as I wish.....	M	L
To do my duty.....	==	==
To have others treat me with understanding.....	==	==
To be the leader of the group I'm in .....	M	L
To have people admire what I do .....	==	==
To be independent in my work .....	==	==
To have people act considerately toward me .....	M	L
To have other people work under my direction.....	==	==
To spend my time doing things for others.....	==	==
To be able to lead my own life .....	M	L
To contribute a great deal to charity .....	==	==
To have people make favorable remarks about me .....	==	==

To be relatively unbound by social conventions.....	===	===	===	===
To work for the good of society.....	===	===	===	===
	M	L	M	L
To have the affection of other people.....	===	===	===	===
To do things in the approved manner.....	===	===	===	===
To go around doing favors for other people.....	===	===	===	===
	M	L	M	L
To be allowed to do whatever I want to do.....	===	===	===	===
To be regarded as the leader.....	===	===	===	===
To do what is socially correct.....	===	===	===	===
	M	L	M	L
To have others approve of what I do.....	===	===	===	===
To make decisions for the group.....	===	===	===	===
To share my belongings with other people.....	===	===	===	===
	M	L	M	L
To be free to come and go as I want to.....	===	===	===	===
To help the poor and needy.....	===	===	===	===
To show respect to my superiors.....	===	===	===	===
	M	L	M	L
To be given compliments by other people.....	===	===	===	===
To be in a very responsible position.....	===	===	===	===
To do what is considered conventional.....	===	===	===	===
	M	L	M	L
To be in charge of a group of people.....	===	===	===	===
To make all of my own decisions.....	===	===	===	===
To receive encouragement from others.....	===	===	===	===
	M	L	M	L
To be looked up to by other people.....	===	===	===	===
To be quick in accepting others as friends.....	===	===	===	===
To direct others in their work.....	===	===	===	===
	M	L	M	L
To be generous toward other people.....	===	===	===	===
To be my own boss.....	===	===	===	===
To have understanding friends.....	===	===	===	===
	M	L	M	L
To be selected for a leadership position.....	===	===	===	===
To be treated as a person of some importance.....	===	===	===	===
To have things pretty much my own way.....	===	===	===	===
	M	L	M	L
To have other people interested in me.....	===	===	===	===
To have proper and correct social manners.....	===	===	===	===
To be sympathetic with those who are in trouble.....	===	===	===	===
	M	L	M	L
To be very popular with other people.....	===	===	===	===
To be free from having to obey rules.....	===	===	===	===
To be in a position to tell others what to do.....	===	===	===	===
	M	L	M	L
To always do what is morally right.....	===	===	===	===
To go out of my way to help others.....	===	===	===	===
To have people willing to offer me a helping hand.....	===	===	===	===
	M	L	M	L
To have people admire me.....	===	===	===	===
To always do the approved thing.....	===	===	===	===
To be able to leave things lying around if I wish.....	===	===	===	===

To work on something difficult.....	M	I
To have well-defined goals or objectives.....		
To keep my things neat and orderly.....		
To be practical and efficient.....	M	I
To seek amusement or entertainment.....		
To continually improve my abilities.....		
To know exactly what I am trying to accomplish.....	M	I
To look at things from a practical point of view.....		
To take direct action toward solving a problem.....		
To do new and different things.....	M	I
To do things in an outstanding fashion.....		
To have a very definite objective to aim for.....		
To keep my goals clearly in mind.....	M	I
To schedule my time in advance.....		
To act with firm conviction.....		
To come to decisions without delay.....	M	I
To get full use out of what I own.....		
To direct my efforts toward clear-cut objectives.....		
To attain the highest standard in my work.....	M	I
To have a well-organized life.....		
To be able to travel a great deal.....		
To take proper care of my things.....	M	I
To settle a problem quickly.....		
To be systematic in the things I do.....		
To have new or unusual experiences.....	M	I
To get full value for what I spend.....		
To have well-organized work habits.....		
To do things I never did before.....	M	I
To do more than is generally expected of me.....		
To know exactly what I am aiming for.....		
To hold firmly to my beliefs.....	M	I
To have a variety of experiences.....		
To finish something once started.....		
To shop carefully for the things I buy.....	M	I
To come to a definite decision on matters.....		
To keep things in their proper place.....		
To be methodical in my work.....	M	I
To experience an element of danger.....		
To struggle with a complex problem.....		
To have a challenging job to tackle.....	M	I
To visit new and different places.....		
To have a definite goal toward which to work.....		
To take good care of my property.....	M	I
To stick firmly to my own opinions or beliefs.....		
To plan my work out in advance.....		

To have an objective in mind and work toward it.....	M	L	M	L
To do things that are highly profitable.....				
To accomplish something important.....				
To try out different things.....	M	L	M	L
To do things in an organized manner.....				
To do an outstanding job in anything I try.....				
To lead a well-ordered life.....	M	L	M	L
To be very careful with my possessions.....				
To always come directly to the point.....				
To go to strange or unusual places.....	M	L	M	L
To be systematic in my work.....				
To stick with a problem until it is solved.....				
To set the highest standard of accomplishment for myself	M	L	M	L
To have very specific aims or objectives.....				
To do things that are new and different.....				
To keep my things in good condition.....	M	L	M	L
To devote all my energy toward accomplishing a goal.....				
To make my position on matters very clear.....				
To take frequent trips.....	M	L	M	L
To do things according to a schedule.....				
To make decisions quickly.....				
To be very careful with my money.....	M	L	M	L
To be able to overcome any obstacle.....				
To do things that are dangerous or exciting.....				
To have strong and firm convictions.....	M	L	M	L
To have well-defined purposes.....				
To always keep myself neat and clean.....				
To do things that will pay off.....	M	L	M	L
To be a very orderly person.....				
To take a definite stand on issues.....				
To experience the unusual.....	M	L	M	L
To always get my money's worth.....				
To work on a difficult problem.....				
To have an important job to tackle.....	M	L	M	L
To approach a problem directly.....				
To do things in a methodical manner.....				
To know precisely where I am headed.....	M	L	M	L
To strive to accomplish something significant.....				
To do things in a practical and efficient manner.....				
To follow a systematic approach in doing things.....	M	L	M	L
To come to a decision and stick to it.....				
To take very good care of what I own.....				
To seek adventure.....	M	L	M	L
To have a definite course of action in mind.....				
To be able to do things in a superior manner.....				

# SYMLOG

Your Name \_\_\_\_\_ Group \_\_\_\_\_

Name of person described \_\_\_\_\_ Circle the best choice for each item:

	(0)	(1)	(2)
U . . . material success and power . . . . .	not often . . . . .	sometimes . . . . .	often
UP . . . popularity and social success . . . . .	not often . . . . .	sometimes . . . . .	often
UPF . . . social solidarity and progress . . . . .	not often . . . . .	sometimes . . . . .	often
UF . . . efficiency, strong effective management . . . . .	not often . . . . .	sometimes . . . . .	often
UNF . . . a powerful authority, law and order . . . . .	not often . . . . .	sometimes . . . . .	often
UN . . . tough-minded assertiveness . . . . .	not often . . . . .	sometimes . . . . .	often
UNB . . . rugged individualism, self-gratification . . . . .	not often . . . . .	sometimes . . . . .	often
UB . . . having a good time, self-expression . . . . .	not often . . . . .	sometimes . . . . .	often
UPB . . . making others feel happy . . . . .	not often . . . . .	sometimes . . . . .	often
P . . . equalitarianism, democratic participation . . . . .	not often . . . . .	sometimes . . . . .	often
PF . . . altruism, idealism, cooperation . . . . .	not often . . . . .	sometimes . . . . .	often
F . . . established social beliefs and values . . . . .	not often . . . . .	sometimes . . . . .	often
VF . . . value-determined restraint of desires . . . . .	not often . . . . .	sometimes . . . . .	often
V . . . individual dissent, self-sufficiency . . . . .	not often . . . . .	sometimes . . . . .	often
NB . . . social nonconformity . . . . .	not often . . . . .	sometimes . . . . .	often
B . . . unconventional beliefs and values . . . . .	not often . . . . .	sometimes . . . . .	often
PB . . . friendship, liberalism, sharing . . . . .	not often . . . . .	sometimes . . . . .	often
DP . . . trust in the goodness of others . . . . .	not often . . . . .	sometimes . . . . .	often
DPF . . . love, faithfulness, loyalty . . . . .	not often . . . . .	sometimes . . . . .	often
DF . . . hard work, self-knowledge, subjectivity . . . . .	not often . . . . .	sometimes . . . . .	often
DNF . . . suffering . . . . .	not often . . . . .	sometimes . . . . .	often
DN . . . rejection of popularity . . . . .	not often . . . . .	sometimes . . . . .	often
DNB . . . admission of failure, withdrawal . . . . .	not often . . . . .	sometimes . . . . .	often
	noncooperation with authority . . . . .	sometimes . . . . .	often
	quiet contentment, taking it easy . . . . .	sometimes . . . . .	often
	giving up all selfish desires . . . . .	sometimes . . . . .	often

I believe that \_\_\_\_\_ can be described as follows:

intimate \_\_\_\_\_ remote  
 light \_\_\_\_\_ heavy  
 foolish \_\_\_\_\_ wise  
 intelligent \_\_\_\_\_ ignorant  
 strange \_\_\_\_\_ familiar  
 active \_\_\_\_\_ passive  
 sincere \_\_\_\_\_ insincere  
 predictable \_\_\_\_\_ unpredictable  
 weak \_\_\_\_\_ strong  
 slow \_\_\_\_\_ fast  
 understandable \_\_\_\_\_ mysterious  
 rugged \_\_\_\_\_ delicate  
 warm \_\_\_\_\_ cold  
 clean \_\_\_\_\_ dirty  
 safe \_\_\_\_\_ dangerous  
 relaxed \_\_\_\_\_ tense  
 valuable \_\_\_\_\_ worthless  
 sick \_\_\_\_\_ healthy  
 good \_\_\_\_\_ bad  
 sociable \_\_\_\_\_ unsociable  
 nice \_\_\_\_\_ awful  
 brave \_\_\_\_\_ cowardly  
 constrained \_\_\_\_\_ free

aggressive \_\_\_\_\_ defensive  
hard \_\_\_\_\_ soft  
involved \_\_\_\_\_ uninvolved

Circle yes or no in answering all of the following questions. Please answer question honestly.

1. Do you frequently have headaches?  
Yes No
2. Does your stomach often feel like it is tied up in knots?  
Yes No
3. Does your chest often feel tight and constricted?  
Yes No
4. Are you easily depressed?  
Yes No
5. Do you feel anxious a great deal of the time?  
Yes No
6. Do you often have problems getting to sleep?  
Yes No
7. Do you frequently toss and turn at night?  
Yes No
8. Do you usually wake up feeling rested?  
Yes No
9. Do you often wake up early and are not able to get back to sleep?  
Yes No
10. Are you a heavy smoker? (More than one pack a day)  
Yes No
11. Do you often drink alcohol to excess?  
Yes No
12. Do you always try to keep busy with something?  
Yes No
13. Do you ever seriously consider suicide?  
Yes No

14. Do you bite your fingernails?  
Yes No
15. Do you easily lose your temper?  
Yes No
16. Do you take tranquilizers and pills to "calm your nerves"?  
Yes No
17. Do you often use any drugs (marijuana, heroin, LSD, etc.)?  
Yes No
18. Do you consider your life happy?  
Yes No
19. Do you think about the past much?  
Yes No
20. Do you worry about the future a great deal?  
Yes No
21. In your estimation, do you have any serious sexual problems?  
Yes No

APPENDIX M

Therapist Orientation Questionnaire

Indicate your AGREEMENT or DISAGREEMENT  
with the following statements.

CIRCLE one of the following:

- 5 Strongly agree 5
- 4 Agree 4
- 3 Undecided 3
- 2 Disagree 2
- 1 Strongly disagree 1

1. The therapist's personality is more important to the outcome of therapy than his professional training. 5 4 3 2
2. A good therapist will help his patients become aware of their bodily movements and postures, and help them explore their possible meanings. 5 4 3 2
3. It is sometimes all right to visit a patient socially in his home. 5 4 3 2
4. Understanding why one does things is not the major factor in correcting one's behavior. 5 4 3 2
5. Effective therapists vary their technique from patient to patient. 5 4 3 2
6. A therapist should never interrupt a patient while he is talking. 5 4 3 2
7. It is unnecessary for a patient to learn how early childhood experiences have left their mark on him. 5 4 3 2
8. A mature, mentally healthy person will necessarily move in the direction of society's goals. 5 4 3 2
9. A good therapist expresses to his patients a sense of personal involvement and concern. 5 4 3 2
10. Good psychotherapists encourage their patients to use meditative techniques. 5 4 3 2
11. Primary emphasis should be placed on the patient's manifest behavior. 5 4 3 2
12. It is very beneficial to use the "guided-daydream" technique. 5 4 3 2
13. Psychotherapists should join organized groups and attempt to influence state and federal legislation pertinent to psychotherapy. 5 4 3 2
14. People can be understood without recourse to the concept "unconscious determinants of behavior". 5 4 3 2
15. A patient can be very critical of me or very appreciative of me without any resulting change in my feeling toward him. 5 4 3 2
16. The patient's coming to experience his feelings more fully is not the most important therapeutic result. 5 4 3 2
17. It is important that a therapist show caring and concern for his patients. 5 4 3 2
18. Ideally, psychotherapy would be available free-of-charge for all who wanted it, just like public education. 5 4 3 2

Indicate your AGREEMENT or DISAGREEMENT  
with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 19. Desensitization and re-conditioning are effective psychotherapeutic techniques.  | 5 | 4 | 3 | 2 | 1 |
| 20. I would <u>not</u> interrupt a patient during a therapy session as I might if we were having merely a social conversation.                   | 5 | 4 | 3 | 2 | 1 |
| 21. It is very important for a therapist to conceptualize, think through, how a patient is relating to him.                                      | 5 | 4 | 3 | 2 | 1 |
| 22. A therapist should have empathic understanding of his patients.  | 5 | 4 | 3 | 2 | 1 |
| 23. Rather than talk <u>about</u> another person, good therapists have their patients talk to an empty chair as if the person was sitting there. | 5 | 4 | 3 | 2 | 1 |
| 24. The most beneficial outcome of therapy is for the patient to know the reasons for his behavior.  | 5 | 4 | 3 | 2 | 1 |
| 25. The social class of a patient should not affect the psychotherapy he receives.   | 5 | 4 | 3 | 2 | 1 |
| 26. It is a useful therapeutic technique for patients to shout, or beat pillows to express blocked feelings.                                     | 5 | 4 | 3 | 2 | 1 |
| 27. It is preferable for the therapist to feel impersonal in the therapy relationship.   | 5 | 4 | 3 | 2 | 1 |
| 28. It is never all right for a therapist to have physical contact with patients (except perhaps for occasional handshakes).                     | 5 | 4 | 3 | 2 | 1 |
| 29. No matter how emotionally mature and sensitive a person is, he cannot be a good therapist without training in psychopathology.               | 5 | 4 | 3 | 2 | 1 |
| 30. With most patients I do analytic dream interpretation.   | 5 | 4 | 3 | 2 | 1 |
| 31. Most therapists are more effective with some patients than with others.  | 5 | 4 | 3 | 2 | 1 |
| 32. It is important for the therapist to confront the patient with his (the therapist's) feelings and thoughts.                                  | 5 | 4 | 3 | 2 | 1 |
| 33. Good therapists keep all aspects of their private life out of the therapy session.   | 5 | 4 | 3 | 2 | 1 |
| 34. Even a good therapist may find it difficult to cope with a patient's hostility.  | 5 | 4 | 3 | 2 | 1 |
| 35. A successful adjustment to the social environment is <u>not</u> an important goal of therapy.  | 5 | 4 | 3 | 2 | 1 |
| 36. The therapist should not act as though he were personally or emotionally involved with the patient.  | 5 | 4 | 3 | 2 | 1 |

Indicate your **AGREEMENT** or **DISAGREEMENT**  
with the following statements.

**CIRCLE** one of the following:

- |   |                   |   |
|---|-------------------|---|
| 5 | Strongly agree    | 5 |
| 4 | Agree             | 4 |
| 3 | Undecided         | 3 |
| 2 | Disagree          | 2 |
| 1 | Strongly disagree | 1 |

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 37. I instruct most patients to free associate.  | 5 | 4 | 3 | 2 | 1 |
| 38. It is desirable for the therapist to reinforce the patient's expressions of positive feelings about himself.   | 5 | 4 | 3 | 2 | 1 |
| 39. Hopefully the current fad of sensitivity training will soon disappear.   | 5 | 4 | 3 | 2 | 1 |
| 40. A good therapist constantly and deliberately uses his thorough knowledge of psychopathology and his training in psychotherapeutic techniques.              | 5 | 4 | 3 | 2 | 1 |
| 41. I am a fairly active, talkative therapist, compared to most therapists.  | 5 | 4 | 3 | 2 | 1 |
| 42. Inherent in human beings is a natural propensity toward health, physical, mental, and emotional.   | 5 | 4 | 3 | 2 | 1 |
| 43. Whatever the intensity or nature of the patient's emotional expression, the therapist is most effective when he feels detached, objective, and impersonal. | 5 | 4 | 3 | 2 | 1 |
| 44. State licensing or certification of psychotherapists is necessary to protect the public.   | 5 | 4 | 3 | 2 | 1 |
| 45. For effective therapy, it is only necessary to concentrate on the here-and-now experiencing of the patient.  | 5 | 4 | 3 | 2 | 1 |
| 46. The most important results of therapy are the new feelings and emotions that the patient comes to experience.  | 5 | 4 | 3 | 2 | 1 |
| 47. In effective therapy, the patient learns mostly through the verbal and conceptual interchange between himself and the therapist.                           | 5 | 4 | 3 | 2 | 1 |
| 48. It is <u>unwise</u> for a therapist's remarks and reactions to a patient to be unplanned, spontaneous, not thought-through.                                | 5 | 4 | 3 | 2 | 1 |
| 49. Psychotherapy should be conducted by or supervised by a psychiatrist.  | 5 | 4 | 3 | 2 | 1 |
| 50. It is never all right to accept a friend or relative for psychotherapy.  | 5 | 4 | 3 | 2 | 1 |
| 51. The most beneficial outcome of therapy is the patient's becoming more open to his feelings.  | 5 | 4 | 3 | 2 | 1 |
| 52. The patient should be directly confronted with evidence of his irrational thoughts and behavior.   | 5 | 4 | 3 | 2 | 1 |
| 53. It is possible to make sense of a patient's behavior without assuming motives of which he is unaware.  | 5 | 4 | 3 | 2 | 1 |
| 54. A good therapist is able to get the feeling and meaning of his patient's communication.  | 5 | 4 | 3 | 2 | 1 |

Indicate your AGREEMENT or DISAGREEMENT  
with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 55. Deliberately expressing approval of desirable patient behavior is <u>not</u> a good therapeutic policy.                                       | 5 | 4 | 3 | 2 | 1 |
| 56. A warm, giving attitude is the most important characteristic of a good therapist.   | 5 | 4 | 3 | 2 | 1 |
| 57. I interrupt a patient while he is talking.  | 5 | 4 | 3 | 2 | 1 |
| 58. A good therapist treats the patient as an equal.  | 5 | 4 | 3 | 2 | 1 |
| 59. Patients get better more because their therapists are the kinds of persons they are, than because of their therapist's professional training. | 5 | 4 | 3 | 2 | 1 |
| 60. Release of pent-up bodily energies is important as part of psychotherapy.   | 5 | 4 | 3 | 2 | 1 |
| 61. For a patient to improve his current way of life, he must come to understand his early childhood relationships.                               | 5 | 4 | 3 | 2 | 1 |
| 62. People do <u>not</u> have any inherent "drive toward health".   | 5 | 4 | 3 | 2 | 1 |
| 63. My own attitudes toward some of the things my patients say or do stop me from really understanding them.                                      | 5 | 4 | 3 | 2 | 1 |
| 64. An affective change in the patient is <u>not</u> the major gain from therapy.   | 5 | 4 | 3 | 2 | 1 |
| 65. A good therapist will almost never let silences build up during the therapy hour.   | 5 | 4 | 3 | 2 | 1 |
| 66. The crucial learning process in therapy is a verbal and conceptual process.   | 5 | 4 | 3 | 2 | 1 |
| 67. It is sometimes all right to take a walk with a patient during the therapy hour.  | 5 | 4 | 3 | 2 | 1 |
| 68. It is important to analyze the transference reactions of the patient.   | 5 | 4 | 3 | 2 | 1 |
| 69. A treatment plan is <u>not</u> important for successful therapy.  | 5 | 4 | 3 | 2 | 1 |
| 70. Marathon psychotherapy groups are useful in helping a patient progress in treatment.  | 5 | 4 | 3 | 2 | 1 |
| 71. I am a fairly passive, silent therapist, compared to most therapists.   | 5 | 4 | 3 | 2 | 1 |
| 72. The patient's coming to accept and experience his feelings is <u>not</u> the primary gain he derives from therapy.                            | 5 | 4 | 3 | 2 | 1 |
| 73. It is important for a patient to be helped to make a social adjustment.   | 5 | 4 | 3 | 2 | 1 |

Indicate your AGREEMENT or DISAGREEMENT  
with the following statements.

CIRCLE one of the following:

5	Strongly agree	5
4	Agree	4
3	Undecided	3
2	Disagree	2
1	Strongly disagree	1

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 74. In working with dreams, effective therapists have their patients role-play the characters and other elements of their dreams.                  | 5 | 4 | 3 | 2 | 1 |
| 75. It is important that the therapist model self-disclosing behavior by talking about his own thoughts and feelings.                              | 5 | 4 | 3 | 2 | 1 |
| 76. It is important for the therapist to feel a deep personal and emotional involvement with his patients.   | 5 | 4 | 3 | 2 | 1 |
| 77. Encounter groups are a useful addition to the approaches to mental health.   | 5 | 4 | 3 | 2 | 1 |
| 78. The more effective therapists do things during the therapy hour for which they have no reasoned basis, merely a feeling that it is right.      | 5 | 4 | 3 | 2 | 1 |
| 79. It is desirable for therapists to encourage experimental behavior on the part of patients in their attempts to overcome their problems.        | 5 | 4 | 3 | 2 | 1 |
| 80. For a patient to improve his current way of life, he does <u>not</u> necessarily have to come to understand his early childhood relationships. | 5 | 4 | 3 | 2 | 1 |
| 81. It is important for the therapist to clearly structure the therapeutic relationship.   | 5 | 4 | 3 | 2 | 1 |
| 82. At times, I feel contempt for a patient.   | 5 | 4 | 3 | 2 | 1 |
| 83. Body movements and postures tell us a lot about the patient's psychopathology.   | 5 | 4 | 3 | 2 | 1 |
| 84. It is irrelevant whether a therapist "cares" for the people who come to him for help.  | 5 | 4 | 3 | 2 | 1 |
| 85. It is quite acceptable to interrupt a patient while he is talking.   | 5 | 4 | 3 | 2 | 1 |
| 86. In effective therapy, the patient learns mostly through the affective and un verbalized relationship between himself and the therapist.        | 5 | 4 | 3 | 2 | 1 |
| 87. Psychotherapy is much more an art than a science.  | 5 | 4 | 3 | 2 | 1 |
| 88. The patient should be given useful information to help him achieve his life goals.   | 5 | 4 | 3 | 2 | 1 |
| 89. There is not an innate tendency in human beings toward emotional health.   | 5 | 4 | 3 | 2 | 1 |
| 90. It is never all right to offer the patient a ride, or ask him for one.   | 5 | 4 | 3 | 2 | 1 |
| 91. Effective therapists almost always know what they are doing, and why, and where they are heading.  | 5 | 4 | 3 | 2 | 1 |
| 92. An effective therapist adheres closely to one major school of thought  | 5 | 4 | 3 | 2 | 1 |

Indicate your AGREEMENT or DISAGREEMENT  
with the following statements.

CIRCLE one of the following:

- |   |                   |   |
|---|-------------------|---|
| 5 | Strongly agree    | 5 |
| 4 | Agree             | 4 |
| 3 | Undecided         | 3 |
| 2 | Disagree          | 2 |
| 1 | Strongly disagree | 1 |

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 93. To make sense of a patient's behavior, one must assume motives of which he is unaware.                                    | 5 | 4 | 3 | 2 | 1 |
| 94. Having the patient move in the direction of the goals of society is <u>not</u> an important therapeutic aim.              | 5 | 4 | 3 | 2 | 1 |
| 95. A good therapist acts personally and emotionally involved and concerned with his patient.                                 | 5 | 4 | 3 | 2 | 1 |
| 96. I am very secure and comfortable in my relationships with my patients.  | 5 | 4 | 3 | 2 | 1 |
| 97. In all human beings there is a sort of "life force", a striving for perfection.   | 5 | 4 | 3 | 2 | 1 |
| 98. A therapist should realize that his efforts may prove harmful to patients.  | 5 | 4 | 3 | 2 | 1 |
| 99. A good therapist must guide the patient towards taking responsibility for his own behavior and life situation.            | 5 | 4 | 3 | 2 | 1 |
| 100. I prefer to conduct intensive rather than goal-limited therapy.  | 5 | 4 | 3 | 2 | 1 |
| 101. It is sometimes all right for a patient and a therapist to embrace.  | 5 | 4 | 3 | 2 | 1 |
| 102. A good therapist occasionally makes a patient angry.   | 5 | 4 | 3 | 2 | 1 |
| 103. Good therapists do a lot of talking during the therapeutic hour.   | 5 | 4 | 3 | 2 | 1 |
| 104. The most important results of therapy are the new idea and new ways of thinking about himself that the patient achieves. | 5 | 4 | 3 | 2 | 1 |

CLIENT RESEARCH ANNOUNCEMENT FORM

There is a study going on in which a researcher is trying to learn about the values and preferences people have, and how they relate to the benefits they gain in psychotherapy.

The person running this study is Steven Kaufman, a doctoral candidate, and he would like to call you to invite your participation in the study.

May he give you a brief call to discuss this with you? The study is voluntary, confidential, and will take only 30 minutes of your time. It will not, of course, influence your treatment here.

## VALUES AND PREFERENCES IN PSYCHOTHERAPY

Steven Kaufman

Department of Clinical Psychology, CUNY Graduate Center

I understand that this study involves the evaluation of the changes in values and preferences in the psychotherapeutic relationship. I understand that I will be asked to complete a brief series of forms (evaluating values and preferences) on two occasions, each series taking approximately 30 minutes.

The first series will be administered immediately upon my consent, thus my presence will be required for only one other assessment period. The second administration will be requested eight weeks from this date.

I understand that these tests consist of paper and pencil multiple choice questionnaires.

I understand that all my responses will be held in the strictest confidence, and will not be available to the staff of \_\_\_\_\_ . Further, I understand that my responses will be identified by an identification number and not my name.

I understand that I may refuse to participate in this study. I also understand that if, for any reason I wish to discontinue my participation in this study at any time, I will be free to do so without in any way influencing my course of treatment.

I have read this consent form, and I have discussed with \_\_\_\_\_ the procedures described above. I have been given the opportunity to ask questions which have been answered to my satisfaction. If I have any further questions, I can contact Steven Kaufman, the principal of this study

I hereby consent to \_\_\_\_\_ procedures set forth above. I have been given the opportunity to receive a copy of this consent form.

I understand that the only personal information made available to Mr. Kaufman will be my age, sex, and diagnosis.

I understand that upon the completion of the study, I will be contacted by Mr. Kaufman who will make the results of my participation available to me at that time.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Witness

APPENDIX P

Intake Conference Review Form

Client's Name:

Client's Age:

Client's Sex:

M            F

Intake Person  
Approves for study

Yes          No

If Yes, has sheet  
been read.

Yes          No

If Yes,

Client tel. # \_\_\_\_\_

Client Address \_\_\_\_\_

INTAKE CONFERENCE DATA:

Do Intake Conference  
Chairperson & Intake  
Person Concur

Yes          No

DSM III

Raw Score	COLLEGE NORMS - FEMALE				
	P	A	V	B	C
32					99
31					98
30					97
29					96
28					95
27					92
26					89
25					85
24					81
23					76
22					70
21					64
20					57
19					51
18					44
17					38
16					32
15					26
14					20
13					15
12					11
11					8
10					6
9					4
8					3
7					2
6					1
5					
4					
3					
2					
1					
0					

Raw Score	COLLEGE NORMS - MALE				
	P	A	V	B	C
32					99
31					98
30					97
29					96
28					95
27					92
26					89
25					85
24					81
23					76
22					70
21					64
20					57
19					51
18					44
17					38
16					32
15					26
14					20
13					15
12					11
11					8
10					6
9					4
8					3
7					2
6					1
5					
4					
3					
2					
1					
0					

\* reprinted from Gordon (1970).

APPENDIX R

Survey of Personal Values: H.School Norms

Raw Score	P	A	V	B	O	G	Raw Score
32							32
31			99				31
30			98				30
29			95				29
28			91				28
27		99	88			99	27
26		98	84			98	26
25	99	97	81			96	25
24	97	96	77			92	24
23	95	94	73			87	23
22	92	92	69			81	22
21	89	89	65			75	21
20	85	85	61			69	20
19	80	80	57			64	19
18	74	74	53			59	18
17	68	67	49			53	17
16	61	58	44			47	16
15	54	49	40			41	15
14	48	40	36			35	14
13	41	32	33			29	13
12	34	25	29			23	12
11	28	18	25			18	11
10	21	12	21			13	10
9	16	7	19			7	9
8	11	4	16			5	8
7	7	2	10			3	7
6	4	1	11			2	6
5	3		9			1	5
4	2		7				4
3	1		4				3
2			3				2
1			1				1
0							0

Raw Score	P	A	V	B	O	G	Raw Score
32							32
31			99				31
30			96				30
29			93				29
28			90				28
27		99	86			99	27
26		98	83			96	26
25	99	97	80			91	25
24	95	90	77			87	24
23	93	87	73			82	23
22	90	83	75			77	22
21	87	78	72			71	21
20	83	72	70			64	20
19	76	65	67			58	19
18	72	58	64			52	18
17	66	50	60			47	17
16	59	42	54			42	16
15	52	35	52			36	15
14	45	28	48			31	14
13	38	21	44			26	13
12	31	15	40			21	12
11	24	11	36			16	11
10	18	6	32			12	10
9	13	5	28			9	9
8	10	3	24			6	8
7	7	2	20			4	7
6	5	1	17			2	6
5	3		16			1	5
4	2		9				4
3	1		6				3
2			4				2
1			2				1
0			1				0

\* reprinted from Gordon(1970)

APPENDIX S

Means, and standard deviations for patients (n=69) on assessment tests.

Variable	Mean	Std Dev.
SIV1	19.37	4.42
SIV2	12.14	6.65
SIV3	11.76	4.42
SIV4	18.18	7.26
SIV5	17.66	5.97
SIV6	10.81	6.33
SPV1	13.49	5.04
SPV2	17.04	4.82
SPV3	10.56	6.53
SPV4	16.46	5.23
SPV5	14.56	5.80
SPV6	17.81	4.85
SYMLOG1	8.57	3.40
SYMLOG2	11.36	2.89
SYMLOG3	9.34	2.93
SYMLOG4	7.42	3.12
SYMLOG5	9.18	3.03
SYMLOG6	9.75	3.14
SDTOTAL	130.00	19.73
SYMPTOMS	8.17	3.96

APPENDIX T

Means and standard deviations for therapists(n=36) on assessment tests.

Variable	Mean	Std Dev.
SIV1	21.38	4.19
SIV2	5.08	2.70
SIV3	13.97	3.66
SIV4	19.75	5.02
SIV5	15.05	4.47
SIV6	16.22	5.67
SPV1	11.58	5.27
SPV2	21.00	4.35
SPV3	14.47	7.34
SPV4	16.44	4.27
SPV5	11.80	4.06
SPV6	16.19	4.59
SYMLOG1	10.16	2.23
SYMLOG2	13.50	2.47
SYMLOG3	10.50	2.10
SYMLOG4	7.25	2.70
SYMLOG5	10.86	2.00
SYMLOG6	9.97	2.27
SDTOTAL	142.52	13.87
SUND 1	22.61	3.46

APPENDIX T(cont)

SUND 2	46.58	4.68
SUND 3	15.52	1.59
SUND 4	26.75	2.28
SUND 5	16.27	2.19
SUND 6	28.00	2.71
SUND 7	11.83	1.53
SUND 8	15.61	1.82
SUND 9	16.75	2.71
SUND 10	6.86	1.22
SUND 11	28.03	3.45

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