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PATIENT AND THERAPIST VARIABLES IN SCHEDULING AND EARLY PSYCHOTHERAPY

BY

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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.

1977

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.

April 28, 1977
date

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Abstract

PATIENT AND THERPAIST FACTORS IN

SCHEDULING AND EARLY PSYCHOTHERAPY

by

George M. Smith

Adviser: Professor Harold Wilensky

This study examined variables involved in the time taken to schedule patients and early effects on psychotherapy. The setting for the study was a public mental health clinic where the allocation of limited professional time was an important factor. Data were collected from 102 consecutive adult applicants for treatment. There were 39 pretherapy dropouts. Examined first were patient and therapist factors involved in selective scheduling. Patient factors included severity of disturbance, age, income, education, occupation, marital status, and whether a call was made requesting scheduling. Therapist factors included experience, therapy style, and professional discipline. The second aspect of the study dealt with outcome measures and the effect of matching therapist preferences for patient characteristics on the outcome of early psychotherapy. Since both part and full time therapists were employed, the criterion measures for scheduling were delay time to first therapy appointment in terms of therapist working days, and total delay experienced by the patient. The criterion measures for outcome were the Strupp questionnaires, both

patient and therapist evaluations, and attendance (attendance vs. non-attendance). Two hypotheses with respect to scheduling were supported. The first was a relationship between a short delay period and pressure in the form of a phone call requesting scheduling. This was true for both delay in terms of therapist working days, and total delay. The second concerned professional discipline. A shorter delay period in terms of therapist working days was associated with being assigned to a psychiatrist. Two patient variables related to first appointment attained significance. Higher income, and more years of education were related to keeping a first appointment. The hypothesis predicting a more positive outcome when a therapist worked with a patient matching his preference received support from the therapist's viewpoint only. Since scheduling was independent of severity of disturbance and a premium was placed on patient initiative, the findings suggested that intake procedures be modified to give priority to severely disturbed patients.

ACKNOWLEDGEMENTS

I would like to thank the members of my committee, particularly Harold Wilensky, Ph.D., for his help with this paper.

I would also like to thank Joyce Hamilton, MSW, for help in collecting the data and Margaret R. Smith for help with the typing. The therapists who participated in this study also deserve thanks.

Finally, I would like to thank the members of my family, my wife Maryanne and sons Michael and Brian, who served as a continuing source of motivation.

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CHAPTER 1. HISTORY

The applicant seeking treatment in low cost, publicly supported clinics has found himself subject to a variety of chance factors which affect treatment in unknown ways. This study sought to examine variables involved in intake and their effect on scheduling and early treatment.

The waiting list has been viewed as an all to frequent phenomenon in mental health agencies and indicative of the gap between the number of applications for help and the professional time available (Pearlman, 1965). In such agencies the large number of applicants has demanded that decisions be made as to which applicants should be seen first, with consequent practical and ethical questions. A possible basis for such decisions, suggested by Schofield (1964), was predicated on characteristics of patients frequently unrelated to the seriousness of their problems. The assumption that patients with the greater urgency of need in terms of severity of maladjustment are seen on a priority basis may be unwarranted.

In addition to perceived severity of disturbance, other patient characteristics might enter into a decision to schedule a patient. For example, characteristics of the patient that render him an attractive or preferred candidate for psychotherapy might enter into such a decision. In Schofield's (1964) study, questionnaires were mailed to a sample of three groups of therapists: psychologists, social workers and psychiatrists. As part of the questionnaire, each of the therapists was asked to indicate the characteristics of his "ideal patient", the type of patient likely to

respond well to psychotherapy. Preferred patients presented what Schofield labled the "YAVIS syndrome" - patients who are youthful, attractive, verbal, intelligent and successful.

Personal observation suggested further patient characteristics which may be involved in scheduling. For example, a major variable may be the extent to which a patient demands service or creates pressure to be seen. He might do this by calling to request scheduling after applying, or by calling on emergency service. In addition, outside agencies or professionals might call on his behalf to request that he be seen.

On the other hand, it was felt that therapists might be reluctant to schedule patients whose clinic attendance was associated with court involvement. That is, patients on probation or parole for such offenses as assault, drug charges or sex offenses and whose clinic attendance was a condition of probation or parole. One assumption would be that these people applied under duress and found the process of therapy irrelevant.

Not only patient factors, but therapist factors as well may be related to scheduling. It was felt that the number of a therapist's pending cases and consequent ability to schedule new applicants may have been related to his characteristic method of working with patients. For example, a directive, advice-giving therapist might have spent less time with each patient, thus decreasing his time of delay for scheduling new applicants. In addition, an individual's therapy style and perhaps also his professional discipline might have resulted in a differential handling of cases. Similarly, a more experienced therapist within each of these categories might have apportioned his time in a

different way.

Consideration of the preceding patient and therapist characteristics raised the opportunity of examining the effects of meaningful selective matching of patient and therapist variables on outcome. Evidence cited below suggested that certain types of matches were associated with the variables related to a more favorable outcome. In any case, the format offered the opportunity of examining the question of whether therapists were successful regardless of the type of patient they dealt with or whether an appropriate match of patient and therapist characteristics was useful. Results in the latter direction might serve as a step toward realizing the position espoused by Rappaport to the effect that psychologists suit their therapy to the patient rather than the reverse.

In sum, this study dealt with problems of scheduling and outcome in an outpatient clinic where the presence of a waiting list demanded selective scheduling. A number of provocative questions raised by considering patient and therapist variables thought to be involved in these processes were addressed. The goal of the study was a practical one, concerned with the issues involved when allocation of limited professional time was an important factor.

Below is a list of variables considered in the study followed by a review of the relevant literature:

A. Patient Factors:

1. severity of disturbance
2. sex
3. age
4. education

5. social attainment

6. amount of pressure created by patient for scheduling

7. whether patient's attendance was a condition of probation

The variable of race was considered, but very few minority group members were seen at the Clinic where the study was carried out.

B. Therapist Factors:

1. experience

2. style

3. discipline

C. Factors related to outcome and attendance:

1. whether a therapist was assigned a patient matching his preference.

2. patient characteristics similar to the "YAVIS syndrome" (Schofield, 1972).

Patient Variables

Severity of Disturbance

The concept of severity of maladjustment is complex. The definition of maladjustment often included both the notions of subjective distress and objective signs (Buss, 1965); in practical terms, the criteria of discomfort and inefficiency in functioning. Similarly, in discussing the common denominators of psychotherapeutic change, Frank, Nash, Stone and Imber (1959) cited relief of symptoms (and presumably discomfort) and improved social effectiveness. Thus a comprehensive measure accounting for both the factors would be the most useful. In general, severity appeared to refer to the intensity or amount of maladjustive behavior.

In terms of the relationship between severity of disturbance and psychotherapeutic processes, subjective distress has often been

found to be associated with better motivation for therapy and more favorable expectations toward the process of therapy. Frank et al (1959) suggested that greater distress renders the patient less defensive and more willing to accept what is offered. Similarly, Gleidman, Stone, Frank and Imber (1957) regarded subjective distress as an incentive to restore a state of equilibrium through treatment. In her study of expectations, Borin (1974) found greater subjective distress associated with slightly more favorable expectations toward treatment.

Severity in the sense of presence of psychotic or borderline symptoms was often cited as being associated with less favorable outcome (Mahrer, 1970). Luborsky, Chander, Overbach, Cohen and Bachrach (1971) concluded that initially more disturbed patients do not improve as much as those initially less disturbed. Schizoid trends appeared to be especially negative prognostic indicators. Conversely, a high level of ego strength was correlated with positive change regardless of type of therapy (Kernberg, 1972; Voth and Orth, 1973). Truax and Carkhuff (1967) separated patient disturbance into the aspects of subjective distress and poor social functioning, hypothesizing that the former would be a positive prognostic sign, the latter a negative one. Tests of this hypothesis have resulted in equivocal findings (Prager and Garfield, 1972). Some of the discrepency may be accounted for by the tendency in many studies to use certain subscales of the MMPI such as Pa or Sc scales as indices of subjective distress, which may not be appropriate.

The relationship between severity of disturbance and scheduling has not been fully addressed in the literature.

The YAVIS Syndrome

Schofield's (1964) study involved a questionnaire sent to a sample of therapists, which provided information on their personal characteristics and background, a description of their typical cases and a description of their "ideal" case in terms of a number of indices. Complete returns were obtained from 88 clinical psychologists, 149 social workers and 140 psychiatrists, working in a variety of settings. The following table (Table 1) illustrates the results for their ideal patients for psychotherapy.

Table 1

The YAVIS Syndrome

	Social Workers	Psychologists	Psychiatrists
Sex	female	female	female
Age	20 - 40	20 - 40	20 - 40
Marital Status	married	married or single	married
Education	high school plus	some college or degree	some college or degree
Occupation	no clear preference	professional - managerial	professional - managerial

Schofield, 1964; page 129

Considering the data by inspection revealed few instances of marked incompatability between the therapist's typical and ideal cases. Psychologists demonstrated only a minor incompatability, perhaps because many in the sample were in private practice. Although not providing a complete test, Schofield's study suggested that there was a systematic selection in the direction of patients who were young, attractive, verbal, intelligent and successful, which he summarized

by the acronym YAVIS.

Social Attainment and Education

These variables overlap components of the YAVIS syndrome. In addition to the suggestive evidence from Schofield, there was a good deal of confirming evidence that patients with higher education and greater social attainment have been seen as more successful in psychotherapy. Luborsky et al (1971) in a review of 166 psychotherapy studies indicated that educational assets appeared as a strong correlate of positive change. The literature on social class position which often included education, income and occupation, and remaining in psychotherapy provided another line of support. Representative studies include those of Frank, Gleidman, Imber, Nash and Stone (1957), Rosenthal and Frank (1958),and those in Bakeland and Lundwall's (1974) review. All provided support for the tendency of patients with more education and greater social attainment to complete a therapeutic program.

Status with Regard to the Court System

There was a good deal of evidence to suggest that candidates for psychotherapy referred through the court system might be viewed as less attractive applicants. A frequent observation in psychotherapy outcome studies (e.g., Maher's 1971 review), was that sociopathically impulsive patients do poorly in psychotherapy, perhaps because they were more concrete and action oriented and behave capriciously. Such persons were likely to have legal trouble with authority and come to therapy under court auspices, perhaps temporarily submitting to treatment to appear favorably in the court's view (Bakeland and Lundwall, 1974). What proportion of people referred by probation who can be

described as sociopathically impulsive is not clear. In any case, when an individual is pressured to attend a clinic, less favorable expectations about psychotherapy may be likely. They may attend and participate in passive fashion or terminate early. Heine and Trosman (1969) found that patients in their study anticipating a passive role terminated early. Marcus (1968) commented on the positive effects of a belief in the value of psychotherapy. Thus, it is likely that therapy attendance associated with probation or parole may be seen by therapists as a poor prognostic indicator.

Experience as a Psychotherapist

A therapist's experience has frequently been demonstrated to be related to therapy process and outcome. Fiedler (1950) found that more experienced therapists achieved an "ideal relationship" with their patients more frequently than less experienced therapists of the same school or approach to psychotherapy (e.g., Rogerian or psychoanalytic). Strupp (1955) concluded that more experienced therapists from differing schools of thought demonstrated more diversity of technique. Luborsky et al (1971) in their review, found that therapist correlates of positive change included experience level of the therapist. In the literature on premature termination, Baum, Felzer, D'Zmura and Shumaker (1966) demonstrated that therapists with more experience have fewer patients who drop out.

Thus, more experienced therapists were seen as behaving differently in therapy, and presumably would do so with respect to scheduling as well. In addition, they were seen as achieving more positive results, probably because they should be more highly skilled. Highly skilled therapists have been shown to succeed regardless of

type of therapy (Kernberg et al, 1972; Voth and Orth, 1973).

Therapy Style

Therapy styles in the sense of type of therapy (e.g. psychotherapy versus behavior therapy) have been routinely differentiated. A representative example is DiLoretto's 1971 study. However, Bergin and Suinn in their 1975 review article concluded that evidence for the differential effects of form of therapy has declined and was not well established. Strupp (1971), Verzins (1968) and Rickers - Ovsiankina et al (1971) detailed variations in therapist's expectations of client role behavior. Specific techniques and methods varied in effectiveness as well. For example, Ricks (1974) studied the methods of two therapists with disturbed adolescent boys. There were striking differences in their therapeutic styles and long term outcomes with the more disturbed boys. The less successful therapist's patients deteriorated. The Truax and Charkuff variables of empathy, warmth and positive regard may also be indices of successful components of therapeutic style. Bergin and Suinn (1975) commented that although these variables are clearly not as powerful as once thought, their presence is ubiquitous.

In sum, therapeutic styles in the sense of form of therapy, expectations of client behavior and specific techniques have been demonstrated to vary and in general to be differentially associated with positive results.

Professional Discipline

Despite difference in training experiences, the issue of professional discipline, as well as theoretical persuasion, was often thought to be of less importance then skill or experience in therapist's

performance (Fiedler, 1950; Strupp, 1955). Similarly, Schofield (1972) found therapists expressed preferences for patients to show only minor variations across discipline on the indices he studied. However, there were persisting notions within the professions with respect to differing character style, and by implication therapy variations across the three professional disciplines: social workers, psychiatrists and psychologists. Henry, Simms and Spray (1973) detailed such opinions in a study of nearly 4,000 practicing therapists in New York, Chicago and Los Angeles. Therefore, the variable of professional discipline was included in the present study.

Patient and Therapist Match

The usefulness of patient and therapist matching received support from studies on expectations in therapy. Congruent or similar expectations were often cited as facilitating a positive therapy outcome. Lennard and Bernstein (1960) found less "strain" and dissatisfaction with similar expectations. The study also suggested the notion that the role of patient was learned and that the therapist can increase efficiency by teaching or socializing his patients. Clems and D'Andrea (1965) measuring the effects of initial interview on patient anxiety with premature termination as the criterion, concluded that congruence of role expectations was associated with remaining in therapy. Appel (1960) concluded that more successful patients change in order to become more congruent with the therapist's "ideal" patient. Questioning the assumption that only patients vary in expectations, Sandler (1974) measured both patient and therapist's expectations with scales derived from Rickers - Ovsiankina (1971). Using premature termination as a criterion, the study supported the notion of patient

and therapist matching with respect to expectations. Similarly, Luborsky et al (1971) cited similarity of patient and therapist as one of the correlates of positive change in psychotherapy.

However, Wilkins (1973) in a review of the literature, criticized expectancy as a poorly defined construct and questioned its influence on outcome. Furthermore, there was evidence to support the position that certain therapists were successful regardless of the type of patient they dealt with. For example, in a study at the Menninger Clinic summarized by Kernberg (1973) it was found that highly skilled therapists were successful regardless of the type of therapy they employed, whereas less skilled therapists did better with "expressive therapy". Expressive therapy was defined as a type of therapy which focused on the here and now of the transference and on structuring of patients' lives outside of treatment. Ricks (1974) studied the adult status of disturbed adolescent males seen by two therapists at a child guidance clinic. There were no differences in the long term outcome with the less disturbed boys. However, there were striking differences in the results with the more disturbed patients. In his discussion, Ricks retained the label "Supershrink" given the more successful therapist by one of the boys. Thus, the issue of the usefulness of patient and therapist matching as a general issue has remained unsettled.

HYPOTHESES

Patient Factors

Based on the literature and personal observation, the following patient factors were predicted to be associated with early scheduling:

(1) more severely disturbed patients

(2) female patients

(3) younger patients

(4) patients with more education

(5) patients with greater social attainment in terms of occupation

(6) patients whose income was higher

(7) patients who created pressure to be seen

(8) patients whose attendance was not associated with the court

(9) married patients

Therapist Factors

Questions were raised with respect to the following therapist factors and early scheduling:

(10) amount of experience

(11) directive therapy style was predicted to be associated with early scheduling

(12) professional discipline

Hypotheses with regard to outcome and attendance:

(13) A more positive outcome was predicted when a therapist worked with a patient matching his preference.

(14) A positive relationship was predicted between patient variables similar to the "YAVIS" factors and attending a first appointment, specifically age, sex, education, income and occupational level. Higher education, income and occupational level were expected to result in attending.

CHAPTER 2. METHOD

Setting for the Study

The setting for the study was a multi-disciplinary agency, the only mental health clinic in a county with a population estimated at 250,000. Applicant's eligibility for clinic services was based upon residency in the county.

The clinic was supported by state and local funds as well as fees and clinic fund raising programs. A staff of twelve full-time and part-time professionals, and varying numbers of pre and para-professionals, and volunteers (see Table 2) served in excess of 1000 individuals and families annually in treatment services.

Table 2

Staff

Professional (Full Time)		
Psychologist (adminstr. Director)	1	(3/5 clinic, 2/5 admin.)
Psychologist	2	
Social Workers	3	
Professional (Part Time)		
Psychiatrists	3	
Psychologists	3	
Total	12	

Most applicants to the clinic were self-referred or referred by schools, physicians, other social services agencies and the court system (including the probation department). The clinic had an open intake

policy, accepting for services all eligible applicants, referring to other agencies only those who were clearly better served elsewhere.

In addition to the outpatient service, the Clinic provided consultation and education services to various community agencies (Police, juvenile shelter, day care centers, etc.) and maintained a 24 hour emergency service.

The application process at the Clinic was relatively simple and was usually accomplished over the phone. The applicant had to give only identifying and demographic data, and a brief statement of the problem. The information on which therapists judged severity of disturbance consisted in the patient's statement of the problem on applying and the further details he provided on a subsequent background information form. Much of the data relevant to the questions raised were collected routinely. For example, calls regarding scheduling, whether attendance was associated with the court and so forth.

There was little pressure to see people quickly by the clinic administration. Therapists decided their own scheduling priorities as well as the duration of therapy with their patients. An assignment committee composed of a psychologist, a psychiatrist and a social worker assigned cases to therapists on a rotating basis proportionate to the amount of time they worked.

Subjects

Data were collected from 102 consecutive adult applicants, age 18 or over. Children, adolescents and marital cases were excluded from the sample. In general, marital cases were defined as those cases in which patients requested marital counseling on applying. In a few cases,

applicants were excluded because in the judgement of the interviewer, they would be offered marital counseling, although they had not requested it initially. Patients who were offered primarily medication therapy and/or group therapy were also excluded. These were often transfers from an ongoing post-hospital medication clinic. The demographic characteristics of the subjects are described in Table 3.

Occupational level was scaled following Hollingshead's system (1958), with the subject being assigned to one of seven occupational classes with number one being the highest (professional). Most frequently, the subject's occupation was used for this purpose. If, however, the applicant was a housewife, her husband's occupation was scaled. In the case of the few students, father's occupation was scaled. The mean for the group was 4.6 (See Table 3). This reflected occupations such as owners of little businesses, clerical and sales workers and technicians.

The modal yearly income was four thousand dollars, indicating the number of applicants receiving welfare, unemployment or retirement benefits. Eighteen applicants fell in these categories.

Table 3

Characteristics (age, sex, education, income, occupational level and marital status) of the subjects.

N = 102 (30 Male; 72 Female/ 48 married; 54 non-married)

Variable	Mean	SD	Range
Age	31	12	18-63
Education (Years)	12.3	2.3	2-18
Income Yearly	7781	4475	2500-25,000
Occupational Level	4.6	1.51	1-7

The therapists were eleven professional staff members of the Mental Health Clinic, including 5 psychologists, 3 social workers and 3 psychiatrists, working full and part-time. There were 9 male therapists and two female therapists.

Procedure

The sequence of the study involved conducting a structured interview with patients prior to assignment to therapists, in order to assess the severity of their problems. The structured and scaled interview to assess maladjustment (Gurland, Yorkston, Stone, Frank & Fleiss, 1972) was used for this purpose (See Appendix A for sample page). The SSIAM measures a number of different aspects of maladjustment providing results in the form of a rating. Each rating scale varies from a reasonable level of adjustment to the most severe degree of maladjustment found in out-patient psychotherapy practice. The interview included 45 questions about an individual's adjustment to work, social life, family, marriage and sex. In each of these five areas, the interviewer rated deviant behavior, friction with others, and subjective distress, thus providing a comprehensive measure of severity of maladjustment. A further 15 items covered environment distress, prognostic information and aspects of positive mental health.

If any of the scales of the SSIAM were not applicable with a particular patient, the total score was prorated. This occurred frequently when a patient was single, in which case the marital questions did not ordinarily apply. The mean score for the sample was 179 with a standard deviation of 74 and ranged from 28 to 356.

Since approximately thirty of the SSIAM interviews were conducted by an assistant, it was felt necessary to demonstrate reliability between the two interviewers. This procedure served also as a check to insure that one or the other was not a "unique" interviewer. Published reliability data on the SSIAM (Gurland et al, 1972) described joint ratings by three psychiatrists on fifteen patients. The magnitudes of coefficients of reliability for the six factors indicated that the raters agreed in their rank orderings of the patients. In addition, the differences in mean ratings made on patients grouped according to their interviewer were by and large not significant.

In the present study, joint interviews were conducted with twenty patients. These patients were not included in the major analysis. Scores for the reliability sample ranged from 82 to 323. There were twelve females and eight males who ranged in age from 19 to 42. Six were married, the remainder were not. The scaled occupation score was 5, reflecting a slightly higher occupational level than the overall sample. The inter-rater correlation coefficient was .98 indicating a high level of agreement between the two raters.

Only 7 patients in the current sample were court referred and all were males. Because of the small number, this variable was eliminated from the analysis. These applicants were included in the sample for analysis on the other variables. A follow-up was done on these court referred applicants. Two entered prison shortly after beginning therapy and two were pre-therapy dropouts. One was seen in ongoing therapy, and in two cases, a mutual decision was made between the applicant and his therapist not to begin therapy.

In order to determine the degree of pressure associated with a call, three categories were recorded: 1. The absence of a call.

2. A call where a written message was left. 3. A call where the applicant spoke with a professional. There were 31 message calls and 15 patients called and spoke with a professional.

Demographic information was available in patient's records or obtained at the time of the SSIAM interview.

The Therapist's Pretherapy Expectancy Inventory (Sandler, 1974) was used to gauge therapist's style. The questions on the inventory were meant to elicit role expectations from the therapist's perspective. The scale was derived by Sandler from the patient's Psychotherapy Expectancy Inventory developed by Rickers-Ovsiankina (1971). It consisted of 24 items answered on a 7 point rating scale and summarized by the following four factors:

1. Approval - obtaining the therapist's support and guidance.
2. Advice - the expectation that the therapist provides support and guidance.
3. Audience - seeking - the patient's engaging in verbal initiative during therapy.
4. Relationship - seeking - the expectation of emotional give and take in the context of an egalitarian relationship with the therapist.

Thus, therapists responded concerning therapist and patient role expectations from their perspective as therapists. The advice scale from this inventory was used to measure directive therapy style in the present study. (A copy of the Therapist's Pretherapy Expectancy Inventory is included in Appendix B).

Therapist preference for patient characteristics were gauged by presenting therapists with a selection of characteristics with respect to age, sex, occupational level, marital status and years of education and simply asking therapists to indicate a preference in a forced choice fashion. With respect to occupational level, therapists selected from the job description presented by Hollingshead (1958). Their preference was assigned a score based on scale category which varied from one to seven.

Therapist characteristics with respect to experience and style are described in Table 4.

Table 4

Therapist Characteristics

Variable	Mean	SD	Range
Experience	8.8	9.2	2-35
Directive Style	23.29	5.1	14-34

The three psychiatrists had the most experience, the three social workers the least, and the psychologists generally fell in the mid range.

Therapist preferences for patient characteristics are detailed in Table 5 below.

Table 5

Therapist Preferences

Variable	Number of Choices
Age	
18-30	6
30-40	5
Sex	
Male	0
Female	11
Marital Status	
Married	7
Non-Married	4
Edueation	
High School	1
Some College or Degree	7
Advanced Degree	3
Occupational Level	
I	1
II	3
III	3
IV	2
V	1
VI	1
VII	0

The therapists by and large indicated preferences for YAVIS Characteristics. The average score of 3.1 on the occupational scale corresponded to a category of administrators of large concerns, owners of small independent businesses and semi-professionals.

Criterion Measures

The major criterion measure for scheduling was patient's waiting time expressed in terms of therapist working days. That is, weekends, holidays or days on which the therapists were out of the clinic or not scheduling patients, were excluded. Cases were assigned on a rotating basis, proportionate to the amount of time a therapist worked. Since therapist's working schedules varied, it was necessary to calculate the length of time a patient had to wait with respect to the schedule of the therapist to whom he was assigned.

The actual total of calendar delay was also recorded. This represented the delay period actually experienced by the patient.

The outcome measures were Strupp's (1971) questionnaires for both patient and therapist. The questionnaires measured satisfaction in therapy. The items of the questionnaires were found by Strupp to be correlated with criteria of change in psychotherapy including ratings of therapist's final case summaries of overall success and sympton improvement. The items presented some technical problems in that several of the questions were provided with seven point scales, while the majority were rated on five point scales. Strupp has published no weighting system, so that the scores on the individual items were simply added to produce an overall score. (See Appendices C and D).

The design included a measure of attendance. No-shows, that is patients who fail to begin therapy, were recorded.

To insure feasibility of data collection, an upper limit of 12 sessions was set for completing the outcome questionnaires. This limit was meant to bracket the concept of "early therapy" (Cartwright, 1955; Meltzoff and Kornreich, 1970).

The following table (Table 6) defines the main variables in the study with respect to scheduling and how they were measured.

Table 6

Variables Related to Scheduling

Variable	Measure
Patient Factors:	
Severity of disturbance	Score of the SSIAM (Gurland et al, 1972)
Age	Number of years
Sex	Male or female (female patients considered as preferred)
Education	Number of years of education
Occupation	Occupation scaled according to Hollingshead's system
Income	Yearly expressed in dollars
Pressure	A call by the patient requesting scheduling or a call made on his behalf (all calls are recorded in the patient's file)
Court Involvement	Clinic attendance associated with the Court
Therapist Factors:	
Directive Therapist Style	Score on the Therapist Pretherapy Expectancy Inventory (Sandler, 1974) for the advice scale.
Therapist Experience	Number of years in mental health setting working full time.
Professional Discipline	Contrasts with respect to professional discipline.

Table 6 (Contd.)

Variables Related to Scheduling

Variable	Measure
Criterion:	
Date of first interview with therapist	1. Clinic working days for his therapist. 2. The total or actual number of days of waiting time.

With regard to post therapy measures, two questions were addressed. First, is the result more favorable if a therapist works with his ideal patient than with a patient where patient characteristics and therapist preferences are not similar?

The second question addressed was the relationship between the YAVIS factors and therapy attendance.

These variables were examined in relation to keeping a first therapy appointment.

In addition, a telephone survey was conducted to determine why the 39 no shows failed to keep their first appointment. This consisted of telephoning these applicants and recording the reasons they offered for not attending. The number of pretherapy dropouts was consistent with a study done in the same setting (Schild, 1976).

CHAPTER 3. RESULTS

Delay

Since both part and full time therapists were employed, the criterion measures for scheduling were delay time to first therapy appointment in terms of therapist working days, and total delay experienced by the patient. The delay time even in terms of therapist working days averaged 24.21 days (range: 1-72 days; standard deviation: 17.90 days). More importantly, the median of the distribution of the actual number of days patients were delayed was 50 days, or a little over a month and a half. Most striking in terms of differences in the applicants' experience of delay, was the range in actual delay from one day to 210 days. Thus, a person might have been seen almost immediately, or in some extreme cases, waited as long as seven months. Twenty-four applicants waited three months or longer.

An intercorrelation matrix was the principal method of analysis for the study. The significant intercorrelations are presented in Table 7.

Scheduling

Pressure. Of the twelve hypotheses examined concerning patient and therapist factors involved in scheduling two were supported. The first dealt with amount of pressure. This hypothesis predicted a relationship between a short delay period and pressure in the form of a phone call requesting scheduling. Therapists decided their own priorities in scheduling and frequently received phone calls from the patient or another agency requesting early scheduling. These types of calls were found to be related to a short delay period. Biserial

Table 7

Significant Intercorrelations Among Variables (Decimals Omitted)

VARIABLE	N	KEPT	SSIAM	AGE	INCOME	MALE SEX	EDUCATION	MARRIED	CALLS	OCCUPATION	THER. EXPERIENCE	THER. STYLE	DELAY (WORKING DAYS)	TOTAL DELAY	OCCUP. MATCH	EDUC. MATCH	SEX MATCH	AGE MATCH	MARITAL MATCH	TOTAL MATCH	PATIENT QUEST.	THERAPIST QUEST.
KEPT	102																					
SSIAM	102																					
AGE	102																					
INCOME	102	25																				
MALE SEX	102				20																	
EDUCATION	102	26																				
MARRIED	102			42	43																	
CALLS	102																					
OCCUPATION	102				28		52															
THER. EXPERIENCE	102	31		42																		
THER. STYLE	102																					
DELAY - (WORKING DAYS)	102	-26							-45													
TOTAL DELAY	102	-31							-32				48									
OCCUP. MATCH	102			25						-31	45											
EDUC. MATCH	102						60			-38	-29											
SEX MATCH	102																					
AGE MATCH	102			-52							-20	-34										
MARITAL MATCH	102			24				36					21	23								
TOTAL MATCH	102					-62	26	20				-20	-23		68	59	67	52				
PATIENT QUEST.	28		-37			-31	-41						-33	-31					-37			
THERAPIST QUEST.	40					35	31								52	69	-34		28	30	-33	

For N = 102: r = 20, $p < .05$; r = 25, $p \leq .01$
For N = 28: r = 36, $p < .05$; r = 46, $p < .01$
For N = 40: r = 30, $p < .05$; r = 40, $p < .01$

correlations between the presence of a call vs. the absence of a call, and working time delay (r = -.45), and between calls and actual delay experienced by the patient as well (r = -.32) were evident. The Pearson correlations between the amount of pressure on a three point scale and delay time were also calculated, yielding a correlation of -.44 between pressure and working delay, and a correlation of -.25 between pressure and total delay. This indicated that calling to request an appointment resulted in a short delay, and an even shorter delay when a patient was able to speak with the professional. The average total wait for a patient who called and spoke with the professional was 17.3 days. The wait when a call was made and a message was left averaged 48.2 days, or about a month and a half. When no call was made, the total average wait was 76.14 days, or over two months. Each increment in pressure reduced the wait experienced by the patient by about one month.

Professional Discipline. The second hypothesis receiving support concerned the relationship between professional discipline and delay period expressed in working days. Psychiatrists tended to see patients sooner. This was true both when psychiatrists were contrasted with psychologists (chi square = 11.59; $p < .001$), and when psychiatrists were contrasted with social workers (chi square = 4.63; $p < .05$). Social workers and psychologists did not differ on this variable. The average working time delay for psychologists was 28 days, that for social workers was 24 days, while the average working day delay for psychiatrists was 16 days. There was no relationship between professional discipline and total or actual delay experienced by the patient. All psychiatrists worked part time so that actual delay was similar for both psychiatrists and non-psychiatrists.

Two relatively low unhypothesized relationships between patient and therapist match score and delay were found which were contrary to the expected direction. Total match score was related to delay in terms of therapist working days ($r = .23$) with the marital match individually significant with both measures of delay (.21 and .23 respectively).

Keeping a First Appointment

Higher income ($r = .25$) and more years of education ($r = .26$) were related to keeping a first appointment. Thus, two components of the YAVIS syndrome dealing with socioeconomic status were associated with keeping a first therapy appointment.

Professional discipline was also related to keeping a first appointment. Being assigned to a psychiatrist was associated with keeping a first appointment when contrasted with psychologists (chi square = 9.38; $p < .01$), and with social workers (chi square = 6.01; $p < .05$). Social workers and psychologists did not differ on this variable.

There were other post hoc relationships. Keeping a first appointment was related to being assigned to a therapist with more experience ($r = .31$). Patients presumably would not be aware of how much experience their therapist had. Recalling that psychiatrists had a higher average experience level, and that being assigned to a psychiatrist was associated with keeping a first appointment, probably accounts for the result with respect to experience. The average years of experience for psychiatrists was 20.3, and that for psychologists was 9, and that for social workers was 4.

Finally, there was a relationship between delay in terms of therapist working time ($r = -.26$) and total delay experienced by the

patient (r = -.31) as well, and keeping first appointments. Thus, as an after the fact observation, a long waiting time was associated with failing to keep first appointments. It may be assumed that the crises which caused these people to initate the application may have passed.

Outcome

Since there were 63 patients who attended at least a first interview, the return on the Strupp Therapist Questionnaire (N = 40) and Patient Questionnaire (N = 28) was not complete. This occurred despite the attempts to insure completion of the questionnaires. At the outset of the study all the therapists agreed to cooperate with completing the questionnaires. The problem then reduced to one of reminding them and bringing the questionnaires to their attention at the proper time. This was done by a note to the therapist and by having the secretaries keep track of the number of sessions and checking to see that the patient followed through. Those patients who discontinued were contacted by phone after the questionnaire was mailed with a stamped return envelope, and urged to return the questionnaire.

The average score for the patient questionnaire of 101 fell somewhat above the total midpoint score for the items on the questionnaire of 86, indicating that patients in general, felt positively about their therapy experience. The reverse was true for the therapist questionnaire. The average score of 62 was below the total midpoint score of the items on the scale of 75. The correlation between the two was -.33.

This discrepancy between the outcome of therapy from the patient's and the therapist's point of view is a frequent finding, consistent with the literature on the multidimensional nature of outcome (Borin, 1976).

Therapist Questionnaire. The hypothesis indicating a more positive outcome when a therapist worked with a patient matching his preference received support from the therapist's viewpoint only. The correlation between the overall match and the therapist questionnaire was .30. The correlation between the patient questionnaire and the overall match was not significant.

In terms of the individual variables comprising the match, three of the variables contributed significantly in the predicted direction. These were marital match ($r = .28$), occupation match ($r = .52$) and educational match ($r = .69$). Age match was not significant. Sex match was significant, but opposite from the predicted direction, with males perceived as doing better than females ($r = .34$).

Patient Questionnaire. Post hoc analysis of the patient questionnaire revealed a correlation between patient education and satisfaction in therapy ($r = -.41$) in contrast to the results of the therapist questionnaire. The results for male sex ($r = -.31$) and marital match ($r = -.37$) and the patient questionnaire contrasted with the results of the therapist questionnaire.

Severity of disturbance (score on the SSIAM) was related to satisfaction on the patient questionnaire ($r = -.37$) as well. Evidently patients who were more severely disturbed initially did not feel they improved. Finally, a long delay period, both in terms of therapist working days ($r = -.33$; $p < .10$) and total delay ($r = -.31$; $p < .10$) was related to satisfaction on the patient questionnaire. If patients were delayed they were less satisfied, perhaps because they began therapy with a negative set.

CHAPTER 4. DISCUSSION

Scheduling

A therapist's decision as to whether to schedule a patient early was based in part on whether the patient called to request an appointment. The observation of no relationship between calling to request an appointment and severity of disturbance as determined by an independent judge indicated a poorly functioning system in this respect. Scheduling was independent of severity of disturbance and a premium was placed on patient initiative. The information on which the therapist judged severity of disturbance consisted in the patient's statement of the problem on application and the further details he provided on a subsequent background information form. This once again stressed the patient's initiative in conveying the extent of his problem and suggested the need for further study and possible change in the intake procedure. Alternatively, some therapists felt, as two in this sample stated, that severity should not be the sole criterion for setting priorities. They stated that they may have little to offer extremely disturbed patients in terms of hope for success, and that they should concentrate on those they might help.

In informal discussions, therapists complained that patients' descriptions of problems on applications were frequently too generalized. In this sample, although some patients mentioned suicidal thoughts at the time of application, none indicated suicidal intent. Suicidal ideation was not always perceived as sufficient to warrant an automatic priority in the context of the patient's complaints.

It was clear from discussions with the individual therapists that scheduling in response to phone calls was a conscious process.

With respect to calls from agencies (family planning or welfare, for example), therapists stated that they often scheduled patients whose need for a priority appointment might be questionable in order to insure a continuing climate of cooperation with the particular agency. Pressure also operated in a negative manner. In one instance, a local politician called a therapist to request an appointment for an applicant who was a personal acquaintance. The applicant's degree of disturbance was mild. This blatant form of pressure was resisted by the therapist who intentionally set an initial appointment approximating his average delay. The outcome in this instance was considered good by both patient and therapist, perhaps because as Borin (1976) pointed out the referral source was positive. In terms of personal calls received from applicants, therapists described a difficulty in not following up on a person they had learned somewhat more about during a telephone contact.

Considering an extreme case, the applicant who experienced the longest wait in this study (seven months) began therapy, but was perceived as doing poorly by his therapist (the patient did not return his questionnaire). The patient's degree of disturbance was in the mild to moderate range. The long delay in this case appeared to have been due to chance factors.

Some anecdotal material regarding patients' response to delays was collected in conversations with the therapists. Most therapists felt that the degree of objection expressed to delays in scheduling was not strong. Perhaps by the time these people were seen, whatever had been bothering them had been resolved. Of course, the most vocal applicants had already created pressure to be seen and were

scheduled and would have no complaint about delay. Several therapists mentioned that their highly educated patients expressed less dissatisfaction with delays. One such patient for example mentioned anticipating a six month wait and seemed pleased to have waited about two months.

Professional discipline was also related to delay with patients assigned to psychiatrists experiencing shorter delay periods in terms of therapist working days. The relationship did not hold with total or actual delay. Because all the psychiatrists worked part time, actual delay was similar for both psychiatrists and non-psychiatrists. Since a proportion of the psychiatrists' case load consisted of people they were treating with medication, they tended to see these people for briefer appointments and to schedule more appointments. Psychiatrists thus experienced a greater turnover rate and could see new patients sooner.

It is perhaps surprising to find even a low relationship between extent of match and a long delay time. Patients who met the preferred characteristics waited longer, suggesting that therapists did not play favorites in regard to early appointments.

The results were in contrast to what Schofield's (1964) hypothesis implied. The fact that many of the therapists in Schofield's study were in private practice may account for the difference. A therapist in private practice might be in a better position to select patients matching his preferences.

The relationship between subjective distress and pressure was examined in post hoc fashion on the assumption that more upset

and distress would result in more calls. No relationship was found between the subjective distress subscale on the SSIAM and pressure. The people who called were evidently not more subjectively upset or distressed than those who did not call.

To sum up the findings regarding a therapist's scheduling priorities, creating pressure to be seen by calling to request an appointment resulted in a shorter delay. A second finding was that psychiatrists saw patients sooner than non-psychiatrists. Being seen earlier was related to greater satisfaction with outcome on the patient questionnaire.

Keeping a First Appointment

The relationship between education and income, and keeping a first appointment was quite consistent with the literature (Bakeland and Lundwall, 1974). They reported that people with higher education and income were generally better informed about treatment procedures, accepted delays, and tended to keep first therapy appointments. The results pointed out that efforts to reduce the pretherapy dropout rate should be concentrated among those with lower education and income.

As mentioned previously, being assigned to a psychiatrist was associated with a better rate of keeping a first appointment. It was not clear whether applicants in this study were aware of the professional discipline of their therapist prior to scheduling. They would have known whether their prospective therapist would be addressed as doctor, indicating either a psychiatrist or psychologist. Therapistsconfirmed that their patients were aware of this distinction prior to scheduling. Whether patients were aware of the discipline of their respective therapists before scheduling was unclear. All applicants received a

follow-up letter from the clinic which listed the professional staff by discipline, so that they may have determined the discipline of their therapist if they were attentive to this. If applicants were unaware of their therapist's discipline, then the important variable in keeping a first appointment may simply be the length of delay. Length of delay was also related to keeping a first therapy appointment.

The psychiatrists' patients were also older. The assignment procedure was not entirely random. Applicants were screened by an assignment committee composed of a social worker, psychologist and psychiatrist. In discussing this finding with the assignment committee, they indicated a tendency to assign older patients to psychiatrists, since these older people were more likely to have concurrent medical problems.

Interestingly, calling to request an appointment was not associated with a more favorable rate of keeping a first appointment. In discussions with therapists, an applicant's failing to attend after calling for an appointment was seen as a particularly frustrating event. There were 46 patients who called in this study and of these 14 were pretherapy dropouts. This represented a dropout rate of 30% among callers, compared to the overall dropout rate of 38%, so that there was little practical difference between the two rates.

The post hoc observation of a relationship between a long delay and failing to keep was understandable but raised questions as to what became of those applicants who failed to keep their first appointment.

In an attempt to answer these questions, a telephone survey was conducted to determine why these 39 patients failed to attend. Each patient was called on at least three occasions at varying times of the day. Twenty patients were reached directly and the relatives of three others were contacted. The reasons and frequencies are reported in Table 8, along with the number of patients in each category who called to request scheduling.

Table 8

Telephone Survey: Reasons for No Shows Offered by Applicants

Reason for Not Attending	Number of Patients Called in No Show Survey	Pressure (Number of Patients Who Called to Request Scheduling)
Requested Rescheduling (Offered excuse for not attending)	2	0
Sought other help	6	2
No longer interested or feeling better	8	1
Practical problems (e.g., transportation, working hours)	4	3
Temporarily away, (e.g., at school) spoke with relative	3	1
Moved, number disconnected no phone	9	3
Phoned but no answer	7	4

The types of other help sought included family physicians, private mental health practitioners, in-patient psychiatric hospitalization

in one case and attendance at an out-of-county mental health clinic. Two people requested new appointments. The largest number of failures comprised those who felt they no longer needed help (eight) and who apparently had either experienced spontaneous recovery or were simply resistant to attending. Although the ease of the application process in this setting was intended to encourage patients to use the agency it may also have resulted in some applications where motivation was minimal. The application process was designed to eliminate barriers to seeking help but it may have this negative aspect.

A study similar to the above was conducted by Noonan (1973) with 64 adult pretherapy dropouts at a university clinic. Noonan made several recommendations such as providing the applicant with some orientation with regard to clinic procedure and philosophy at the time of the initial call. (Schild (1976) did mail a brochure including this information to applicants prior to scheduling. However, this procedure made no difference with respect to pretherapy dropouts.

Noonan also suggested contacting the applicant by phone on the day prior to his first scheduled appointment to confirm it. Lifschitz and Watkins (1973) did telephone fourteen first appointments. Of those called, ten kept the first appointment, one did not, one cancelled, and two were cancelled by the clinic. Comparing the data to ordinary no show rates by inspection indicated that the procedure was helpful in improving first appointment attendance, and in wasting less of the therapist's time with only one of 14 as a no show (7%).

If a patient is anxious as to what to expect, a telephone contact might serve to allay fears and to reassure him. Calling to remind the client of an appointment seems to hold promise. It may be considered as a type of

pressure in reverse, it shows interest in the applicant when his wait is long, and from a practical point of view, it can determine if the state of his problem has changed so that he no longer is interested in therapy.

In this study, telephone contacts would have revealed those no longer interested, those who were temporarily away, those who had moved and so on, before scheduling an appointment that ended in a waste of therapists' time. Arrangements may have been made with those with practical problems that would have allowed them to attend. Also the 14 no shows who were presumably given priority appointments based on their pressure represented a considerable loss of time along with considerable feelings of resentment.

To sum up, telephone contacts have been used to advantage in improving first appointment attendance. Although its effectiveness should be determined in different settings, the procedure can be easily initiated.

Outcome

Despite efforts to insure completion of the outcome questionnaires, the return was not complete. Although none of the patients overtly refused to return their questionnaires, 35 were simply not returned. The questionnaires that were completed were done at the proper time, or very close to it. That is, at the end of twelve sessions or at the end of the therapeutic contact. This was particularly true of the therapist questionnaires.

Of the therapist questionnaires not completed 18 were omitted on quite reasonable grounds. These were cases where patients were seen for too brief a period and the therapist felt he did not have the evidence to complete the questionnaire. After the study was in progress, one of the therapists refused to complete the questionnaires, offering no explanation. This eliminated five therapist evaluations. Perhaps

the observation by Weiss (1973) that clinicians at all levels resent filling out records, viewing them as an accountability system checking up on them, applied in this case. An attempt was made in the present study to clarify the purpose for which the research was being conducted. There was an occasional comment as to time pressures from the therapists but, aside from the one instance, no direct opposition to the questionnaires. In fact, cooperation from the therapists in this study was considered as very good.

Therapist Questionnaire

As stated previously, there was a significant positive relationship between the extent of the overall match (patient characteristics and therapist preferences), and score on the therapist questionnaire. Marital match, occupation match and education match contributed to the relationship in the predicted direction. The therapists generally preferred highly educated patients so that patient education and educational match were in effect the same variable. There was some variation in therapist preferences for patient occupation and marital status.

The results are qualified by the absence of a relationship between sex match and the therapist questionnaire. In fact the results are in the opposite direction for this sample, with males perceived as doing better, even though therapists initially expressed a preference for females. Sex differences in outcome were not frequently observed (Bergin and Suinn, 1975). With respect to their initial preference for females, therapists reasoned that females would be more

willing to discuss feelings and distress, in accord with cultural expectations. They stated that their initial expectation was that some males perceived attendance at a mental health clinic as a sign of weakness and therefore would begin therapy with a more negative set. They suspected that males might often be in greater distress but not have admitted it. An indirect measure of distress might have revealed this. Since therapists felt more positively about outcome with males, the sample they evaluated must not have fit this preconception.

An alternative explanation might be suggested by Beck in terms of this concept of learned helplessness. Female patients might be more dependent and less likely to take action leading to change than male patients would be. This could account for the therapists' more favorable impression of outcome with their male patients.

The average score on the therapist scale was somewhat below the midpoint score for the scale. A frequent observation in the literature (e.g., Cartwright, 1955) was a positive relationship between number of sessions attended and outcome score. This was true in the present sample for the therapist questionnaire only. The correlation between the therapist questionnaire and number of sessions attended was very strong ($r = .71$; p .001). There was no relationship between

the patient evaluation of outcome and number of sessions attended. It is seen as important to understand what occurs during early psychotherapy since the average number of sessions attended in the mental health clinic in which the study was conducted, as in those in the state in which the clinic was located, was between six and eight sessions. The average number of sessions attended within the limits of the present study was seven (no shows excluded). Observations made here are meant to apply to this stage of therapy, or extent of therapy as the case may be.

In contrast to the results of Mintz (1972) there was no evidence to suggest that the therapist's feelings about outcome were conditioned by the initial severity of the patient's problems. The relationship between score on the SSIAM and the therapist outcome measure was not significant. There was however, a relationship between the patient questionnaire and score on the SSIAM, in accord with Mintz' findings.

Results of the correlations between the subjective distress subscale of the SSIAM and the outcome questionnaires paralleled those above. There was no relationship between subjective distress and the therapist questionnaire, and the correlation between subjective distress and the patient questionnaire was -.36.

To sum up, it appeared that the therapists were reluctant to attribute much positive change to patients they had seen for brief

periods (12 sessions and under). When they did feel positively, their observations were related to factors similar to the YAVIS factors (patient occupation and education) and perhaps by such overlapping variables in combination (overall match, composed of marital, occupational and educational match). Sex match was significant but opposite from the predicted direction. Men were rated as more improved, even though the therapists' preferences were for women patients.

Patient Questionnaire

A dramatic observation with respect to the outcome data was the difference between the patients' and therapists' evaluation of outcome. The patients as a group felt more positively about their experience than did the therapists. As mentioned earlier, this phenomenon of difference in patient and therapist view of outcome is frequently observed in a similar direction, but appears as particularly pronounced in this study.

Since subjective experience is a fact, and overt behavior was unknown, one cannot say that either the patients' or therapists' point of view about outcome was more valid. Informal talks with these therapists revealed that four of them held a model of psychotherapy based on personality change and insight over a long term contact and that their criteria for progress was more stringent. Patients with similar viewpoints were more likely to be found among the more highly educated in a university clinic setting or a

psychoanalytically oriented private practice. Patients in this public mental health setting were more concerned with weathering a crisis and in symptomatic relief. In terms of their judgments about outcome, therapists may simply have learned from their life long experience to be cautious about subjective reports not supported by external evidence.

Since the hypothesis regarding match and the patient questionnaire was not supported, the results discussed consist in post hoc observations, and need to be viewed with appropriate caution.

The three patient variables of patient education, male sex (patient variables) and marital match were correlated negatively, with the patient questionnaire and, from this point of view, presented almost a mirror image of the statistically significant variables with the therapist questionnaire. As above, sex differences, or differences in marital status, were not frequently observed in outcome research. The result regarding education was contrary to most findings. It was difficult to discern any common features among the pairs of patient and therapist questionnaires where there was disagreement. However, examining the individual pairs of patient and therapist questionnaires where agreement existed (seven pairs) by inspection revealed that patient education for this group was higher than the average for the entire group. The group's education was beyond high school. Thus, patients with certain

characteristics might be seen as sharing the therapist's point of view with respect to outcome. This appeared to be the case for education. Perhaps patients with more education shared the therapist's model of therapy or skepticism regarding a brief contact. With less educated patients, an acquiesence set may have played a role in that they may have been reluctant to criticize the expert.

There was a disagreement between patient and therapist in the majority of cases. The therapist felt somewaht less satisfied about the outcome. Previous research has suggested that there was likely to be a change in terms of more commonality in point of view about therapy between patient and therapist, if the patient continued to attend (Sandler, 1974).

As mentioned above, severity of disturbance was associated with a low score on the patient questionnaire and specified that for this group of patients the contact was unsatisfactory.

The negative correlation between the patient questionnaire and the two measures of delay, if this result is replicated, is potentially important in that it highlights so clearly the need for timely intervention.

Crisis intervention theory has suggested that intervening quickly results in a better therapy outcome by providing an opportunity for a patient to learn problem solving techniques. Such an opportunity for patients in crisis was lost if the patient experienced a long delay.

CHAPTER 5. CONCLUSION

The presence of a waiting list in an outpatient clinic demands efficient use of professional time and means that decisions as to priorities must be made. The goal of this study was to improve service in such settings by examining patient and therapist variables involved in scheduling and early effects on therapy. The results revealed that pressure in the form of a phone call requesting scheduling can be an important factor determining priority scheduling. Calling to request an appointment resulted in a short delay, and an even shorter delay when a patient was able to speak with the professional. A phone call where a message was left reduced the wait experienced by the patient by about one month. When the patient was able to speak with the professional, the wait was reduced by almost two months. The system appeared to operate on the basis of the familiar adage "the squeaking wheel gets greased". Since severity of disturbance was not a factor in scheduling and a premium was placed on patient initiative, the findings suggested the need for a change in intake procedures to give priority to severely disturbed patients.

A price was paid when patients were delayed both in terms of first appointment attendance and outcome. Patients who were delayed were less likely to attend a first therapy appointment. The deleterious effect of a long delay on outcome was observed in post hoc fashion with regard to the patient questionnaire. Patients who were delayed were less satisfied, perhaps because they began therapy with a negative set. Furthermore, crisis intervention theory has suggested that immediate contact provides an opportunity for a person

in crisis to learn problem solving techniques. Such an opportunity has been lost with the patients in crisis who experience a long delay.

Reducing no shows in the context of limited time is an obvious step to attempt. This study demonstrated that patients with lower education and income should be a target population for such efforts. Efforts might be directed at conveying greater information and toward telephone contacts as suggested by the literature. Telephone contacts have been used to advantage in improving first appointment attendance and its effectiveness should be evaluated in different settings.

To sum up further early effects on therapy in this study, a dramatic observation was the difference between the patients' and therapists' evaluations of outcome. The patients felt more positively than the therapists. It appeared that therapists were reluctant to attribute much change to patients they had seen for brief periods. The hypothesis predicting a more positive relationship when a therapist worked with his "ideal" patient (i.e., a patient matching his preferences) received support from the therapist's viewpoint only. When therapists did feel positively their observations were related to certain YAVIS factors (education and occupation) and perhaps such factors in combination. The results with respect to therapists' preference were not uniform. Sex match was significant, but contrary to the predicted direction. Therapists perceived males as doing better even though their initial preference was for female patients.

APPENDIX

APPENDIX A

Structured and Scaled Interview to Assess Maladjustment (SSIAM) Sample Page.

1.	Field	WORK	
2.	Introduction	Q: I'd like to talk now about your work and how you get along in your job. My first question is about the number of jobs you've had recently.	
3.	Type of item	deviant behavior	deviant behavior
4.	Item heading	W1 UNSTABLE	*W2 INEFFICIENT
5.	Question	Q: Do you have difficulty in holding down a job (or maintaining a course of study)?	Q: How well do you do your work?
6.	Guides	1) For students 'terminating a job' means failing or breaking off a course of study. 2) Housewives: N.A.	1) 'Usual job': that which pt. is best trained to do. 2) 'Job' includes current courses of study. 3) Inefficiency: include unproductive effort (e.g. obsessional rechecking); inadequate productivity or earnings due to time off work; failing courses.

			4) Judge efficiency against standard required by job not pt's. own standards.
7.	Ordered for paired comparisons	Higher first	Lower first
8.	Rating scale	-Has terminated 6 jobs in last 4 months of working.	-Unable to work at all or grossly inefficient even in job easier (in effort or time) than 'usual job'.
	Rating mark	-Has terminated 4 jobs in last 4 months of working.	-Efficiency adequate only for job easier than 'usual job'.
		-Has terminated 2 jobs in last 4 months of working.	-Definitely inefficient but adequate for holding 'usual job'.
	Second lowest anchoring description	-Has terminated 1 job in last 4 months of working.	-Manages 'usual job' satisfactorily but only when work going smoothly.
		-Has not terminated any jobs in last 4 months of working.	-Managing 'usual job well under all circumstances.
9.	Not known	-Not known	-Not known
10.	Not applicalbe	-Not applicable	-Not applicable
11.	Scope of each item	scope	scope
		The number of jobs terminated in the last 4 months (or for students, the courses failed or broken off).	The job he is best trained to do, the job he is actually doing, the standard of work required, and his efficiency at the current job.

APPENDIX B

Psychotherapy Expectancy Interview - Revised

DURING YOUR NEXT HOUR OF PSYCHOTHERAPY ---

1. How strongly do you expect to be reassuring?
2. How strongly do you expect your patient to say whatever comes into his mind?
3. How strongly do you expect your patient to act as freely as he would with his best friend?
4. How strongly do you expect your patient to feel "free" and "open"?
5. How strongly do you expect your patient to watch your behavior for "helpful hints" as to the desirable behavior during the hour?
6. How strongly do you expect your patient to feel like opening up without any help from you?
7. How strongly do you expect to be gentle in phrasing your opinions about an important topic?
8. How strongly do you expect your patient to behave in a spontaneous manner?
9. How strongly do you expect your patient to be concerned with the impression he makes on you?
10. How strongly do you expect your patient to make efforts to please you?
11. How strongly do you expect your patient to be comfortable in expressing his feelings to you?
12. How strongly do you expect your patient to feel as though he were "in charge" of the hour?
13. How strongly do you expect to give definite advice to your patient?
14. How strongly do you expect to discover what's responsible for your patient's current problems?
15. How strongly do you expect to suggest what your patient should do about his problem?

APPENDIX B (Continued)

DURING YOUR NEXT HOUR OF PSYCHOTHERAPY

16. How strongly do you expect your patient to be the one who begins the talking?

17. How strongly do you expect to clearly announce your value judgments about your patient's behavior?

18. How strongly do you expect your patient to be concerned with how he appears to you?

19. How strongly do you expect your patient to "carry the ball" conversationally?

20. How strongly do you expect your patient to discuss whatever comes to mind without "pulling punches"?

21. How strongly do you expect your patient to seek "answers" from you?

22. How strongly do you expect your patient to initiate the conversation?

23. How strongly do you expect your patient to lead the way in bringing up topics to talk about?

24. How strongly do you expect to pick ideas apart and criticize them?

APPENDIX C

STRUPP THERAPIST QUESTIONNAIRE

Please rate each of the following items, comparing the patient with other patients whom you see in psychotherapy.

	(1) very little	(2) some	(3) Mod-erately	(4) Fairly great	(5) very great
1. Defensive-ness	_____	_____	_____	_____	_____
2. Anxiety	_____	_____	_____	_____	_____
3. Ego strength	_____	_____	_____	_____	_____
4. Degree of disturbance	_____	_____	_____	_____	_____
5. Capacity for insight	_____	_____	_____	_____	_____
6. Over-all adjustment	_____	_____	_____	_____	_____
7. Personal liking for patient	_____	_____	_____	_____	_____
8. Motivation for therapy	_____	_____	_____	_____	_____
9. Improvement expected (prognosis)	_____	_____	_____	_____	_____
10. Degree to which coun-tertransfer-ence was a problem in therapy	_____	_____	_____	_____	_____

APPENDIX C (continued)

		(1) very little	(2) some	(3) mod-erately	(4) fairly great	(5) very great
11.	Degree to which you usually enjoy working with this kind of patient in psychotherapy	____	____	____	____	____
12.	Degree of symptomatic improvement	____	____	____	____	____
13.	Degree of change in basic personality structure	____	____	____	____	____
14.	Degree to which you felt warm-toward the patient	____	____	____	____	____
15.	How much of an "emotional investment" did you have in this patient	____	____	____	____	____
16.	Degree to which you think the patient felt warmly toward you	____	____	____	____	____
17.	Over-all success of therapy	____	____	____	____	____

18. How would you characterize your working relationship with this patient?

Extremely poor	Fairly poor	Neither good nor poor	Fairly good	Extremely good

APPENDIX C (continued

19. How satisfied do you think the patient was with the results of his therapy?

Extremely dissatisfied	Fairly dissatisfied	Neither satisfied not dissatisfied	Fairly satisfied	Extremely satisfied

20. How would you characterize the form of psychotherapy you conducted with this patient?

Largely supportive								Intensive analytical

21. Do you recall any strikingly pelasant experiences that you had during the therapy sessions with this patient? Yes_____ No_____ If yes, please circle the number that best indicates the degree of pleasantness.

1 2 3 4 5 6 7 8 9
Mildly pleasant Extremely pleasant

22. Do you recall any strikingly unpleasant experiences you had with this patient? Yes_____ No_____. If yes, please circle the number that best indicates the degree of unpleasantness.

1 2 3 4 5 6 7 8 9
Mildly unpleasant Extremely unpleasant

23. Over-all, how would you characterize your experiences with this patient?

1 2 3 4 5 6 7 8 9
Unpleasant pleasant

Additional comments (please use reverse side, if necessary):

APPENDIX D

STRUPP PATIENT QUESTIONNAIRE

The questions that follow deal with your feelings about therapy and your therapist. These questions assume that your therapy is completed. If, in fact, you are not yet finished with therapy, answer according to how you feel now.

Circle the appropriate answer

1. How much in need of further therapy do you feel now?

(5)	(4)	(3)	(2)	(1)
a great deal	a fair amount	could use more	considerable need	very great need

2. How much have you benefited from your therapy?

(5)	(4)	(3)	(2)	(1)
a great deal	a fair amount	to some extent	very little	not at all

3. Everything considered, how satisfied are you with the results of your psychotherapy experience?

_____1. Extremely dissatisfied
_____2. Moderately dissatisfied
_____3. Fairly dissatisfied
_____4. Fairly satisfied
_____5. Moderately satisfied
_____6. Highly satisfied
_____7. Extremely satisfied

4. What impression do you have of your therapist's level of experience?

_____1. Extremely inexperienced
_____2. Rather inexperienced
_____3. Somewhat inexperienced
_____4. Fairly experienced
_____5. Highly experienced
_____6. Exceptionally experienced

Please indicate to what extent each of the following statements describes your therapy experience. Disregard that at one point or another in therapy you may have felt differently. Use the following code and circle your answer.

5 4 3 2 1 5. I feel the therapist was rather active most of the time.

5 4 3 2 1 6. I am convinced that the therapist respected me as a person.

APPENDIX D (continued)

5 4 3 2 1 7. I feel the therapist was genuinely interested in helping me.

5 4 3 2 1 8. I often felt I was "just another patient" (Note: reverse coding)

5 4 3 2 1 9. The therapist is always keenly attentive to what I had to say.

5 4 3 2 1 10. The therapist tended to be rather stiff and formal. (Note: reverse coding)

5 4 3 2 1 11. The therapist's manner was quite natural and unstudied.

5 4 3 2 1 12. I feel that he often didn't understand my feelings. (Note: reverse coding)

5 4 3 2 1 13. His general attitude was rather cold and distant. (Note: reverse coding)

5 4 3 2 1 14. I was never sure whether the therapist thought I was a worthwhile person.

5 4 3 2 1 15. I has a feeling of absolute trust in the therapist's integrity as a person.

5 4 3 2 1 16. I felt there usually was a good deal of warmth in the way he talked to me.

5 4 3 2 1 17. The tone of his statements tended to be rather cold. (Note: reverse coding)

5 4 3 2 1 18. I usually felt I was fully accepted by the therapist.

5 4 3 2 1 19. I never had the slightest doubt about the therapist's interest in helping me.

5 4 3 2 1 20. The therapist's manner of speaking seemed rather formal. (Note: reverse coding)

5 4 3 2 1 21. My therapist stressed intellectual understanding as much as emotional experiencing.

APPENDIX D (continued)

22. How severely disturbed did you consider yourself at the beginning of your therapy?

5.	4.	3.	2.	1.
Extremely disturbed	very much disturbed	Moderately disturbed	somewhat disturbed	very slightly disturbed

23. How much anxiety did you feel at the time you started therapy?

5.	4.	3.	2.	1.
a tremendous amount	a great deal	a fair amount	very little	none at all

24. How much do you feel you have changed as a result of psychotherapy?

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

25. How much of this change do you feel has been apparent to others?
(a) People closest to you (husband, wife, etc.)

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

(b) Close friends

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

(c) Co-workers, acquaintances, etc.

5.	4.	3.	2.	1.
a great deal	a fair amount	somewhat	very little	not at all

26. On the whole how well do you feel you are getting along now?

_____7. Extremely well
_____6. Very well
_____5. Fairly well
_____4. Neither well nor poorly
_____3. Fairly poorly
_____2. Very poorly
_____1. Extremely poorly

APPENDIX D (continued)

27. How adequately do you feel you are dealing with any present problems?

5.	4.	3.	2.	1.
Very adequately	fairly adequately	neither adequately nor inadequately	somewhat inadequately	very inadequately

28. To what extent have your complaints or symptoms that brought you to therapy changed as a result of treatment?

_____6. Completely disappeared
_____5. Very greatly improved
_____4. Considerably improved
_____3. Somewhat improved
_____2. Not at all improved
_____1. Got worse

29. How soon after entering therapy did you feel any marked change?

_____ months and/or _____ hours of therapy (approximately)

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