THE CLINICAL EVALUATION OF THE LIKELIHOOD OF INAPPROPRIATE TERMINATION OF PSYCHOTHERAPY

by

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Abstract

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For the purposes of this study the literature about the dropout phenomenon was reviewed with a view toward identifying patient variables related to dropping out. A dropout was defined as anyone who unilaterally withdraws from psychotherapy, including rejectors. The brief vs. long term dichotomy was referenced as an orientation point for conceptualizing a bipolar incentive system for therapy; considerable support was found for separately considering those patients who seek relief from psychological or personality problems and those who are motivated by external, situational factors. We found a lack of complementarity in the literature between the services offered to clinic patients (long term insight oriented therapy) and the services which would have been useful to patients (brief, reality centered treatment). Dropout rates were substantially reduced in an environment which carefully screened patients. The early identification of potential dropouts and alternative treatment modality recommendations would help to lower dropout rates.

Among patient demographic variables, only socioeconomic status has been reported to be consistently related to every aspect of therapy,

including dropout rate. The literature also reveals some suggestive data relating dropout rates to the personality characteristics of: expression of and tolerance for anxiety, persistence, hopefulness, a low incidence of impulsivity and antisocial acting out, self doubts, suggestibility, flexibility, psychological mindedness, dependency, verbal fluency, defensiveness, and hostility. The variable of the patient's motivation as reported in the literature was vague, poorly defined, and had a history of non-replicatability. Patients' expectations, including those of "good patients," were usually not congruent with those of therapists, but were with the results in clinic settings: treatment sessions were few in number on the average. The diagnoses of depressive or anxiety reactions have been found to be related to staying in treatment. Presenting problems of psychological vs. somatic distress was related to remaining in therapy. Clinicians' ratings were about as accurate as sentence completion tests, Rorschach R, and Wechsler Bellevue IQ in discriminating remainers from dropouts.

There have been selection criteria operating in clinic settings which we found to be relevant: persons referred for psychotherapy were most like the referers and the therapists. Patients least in need were preferred, as were those who were considered easy to work with. Clinicians' detections of potential cues was seen as a viable method for building a scale to indicate a tendency to drop out. Three areas of input to the clinicians' judgment were considered in our study: what issues the patient addressed, the patient's behavior in the interview, and the clinician's global impression of the patient.

Based entirely on data available during the intake interview and

selecting subjects homogeneous in social class, we developed a checklist to identify dropouts. The first version of the checklist had 51 items; 24 related to patients' statements, 13 to interview behavior, 13 to global impression. Twenty-four items were scored D (associated with dropping out) and 27, L (associated with long term therapy). The occurrence of the items was studied in order to determine their value in predicting dropouts.

Intake interview reports from randomly selected sections of the closed case file were used as data for all three experiments. Cases reaching a clear criterion were used for evaluating reliability (Version I) and validity (Versions I, II, and III). Two judges were used to measure interjudge agreement, which ranged from 61% to 100% with an average of 85%. The total L and D scores showed that the D score and the discriminator score (D-L) differed suggestively between target groups. For each item an item-criterion correlation coefficient, $\underline{e}$, was calculated. The $\underline{e}$'s were used to rank the items by ability to discriminate.

Version II of the checklist strengthened the accuracy of the prediction by eliminating poor items and by expanding the format to a three point scale. Using 12 dropouts and 12 remainers in a method similar to that in Version I, we found the D and D-L scores discriminated between the target groups beyond the .01 level. A third version of the checklist was introduced to strengthen the scoring scale to four points, and to drop some items which could not discriminate in Version II. Version III was also cross validated. The method was again similar; 24 dropouts and 24 remainers were used, 12 each in each of two cross validation groups. Both D and D-L scores discriminated beyond the .02 level between target

groups. The average /e/ for all items on Version III differed beyond .05 from that obtained by Version I. An analysis of prediction was done from one cross validation group to the other. The accuracies measured exceeded 70%. We analyzed the contribution of each cue to the aggregate e and ranked the cues in order of importance.

The contributions to the measurement of reliability of judges' training, attitude in scoring, live vs. second source data, and quality of data are discussed. The uses described for the instrument include subject selection in research, clinical patient screening, and patient selection for training therapists. A detailed analysis of error sources and of cutoff selection is included. The evolution of the three versions is described, and suggestions offered to those interested in tailoring it to their particular needs. The paper closes with a discussion of the relative importance of the cues and the imputs to the judgment process.

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CHAPTER I

BACKGROUND AND HISTORY OF THE PROBLEM

Introduction

A persistent problem in the clinical practice of psychotherapy is the high incidence of premature termination. The incidence of this problem, ranging up to 70%, has been established (Garfield, 1971). In considering the allocation and utilization of limited resources, it urges us to evaluate the procedures used in arriving at a clinical decision to offer to or to withhold from a given applicant a particular mode of treatment, given the likelihood of the former's rejecting the latter. The present study sought to identify patient variables which were related to dropping out.

The literature is inconsistent regarding a putative statistical definition of dropout. Some authors have designated a specific number of interviews: two (Sue, McKinney, Allen, & Hall, 1974); three (White, Fichtenbaum, & Dollard, 1964); four (Frank, Gliedman, Imber, Nash, & Stone, 1957; Affleck & Mednick, 1959; Gliedman, Stone, Frank, Nash, & Imber, 1957); five (Hiler, 1959b); 13 (Taulbee, 1958). Sullivan, Miller, and Smelser (1958) chose to dichotomize about the median number of interviews without a substantial rationale. Lorr, Katz, and Rubinstein (1958) studied elapsed time. Hiler (1958, 1959a) distinguished two points in treatment: those who terminate before five interviews are considered dropouts; those who complete at least 20 or 25 are

considered remainers. It was sensibly suggested by Brandt (1965) that such numerical game playing be sidestepped in favor of a simple criterion such as ceased keeping appointments.

For our study a dropout was defined as a patient who, at any time, precipitously and unilaterally, withdraws from psychotherapy; or, as one who fails to accept psychotherapy when it has been offered. This category subsumes the terms rejectors or no-shows. What is viewed as crucial is the clinical decision to offer treatment and the decision not to persevere (Fiester, Mahrer, Giambra, & Ormiston, 1974). The latter decision may take place after zero psychotherapy sessions or at any point in treatment (Meltzoff & Kornreich, 1970).

A theoretical position which alleviated the sense of numbers selected arbitrarily or post hoc was suggested by Cartwright (1955). He postulated two distinct processes: brief and longer term psychotherapy. There is a failure zone in which long term patients act out their resistance to the anticipated emergence of threatening material by flight from treatment. He also postulated that there are two different types of presenting problems leading to the two kinds of treatment: situational problems lead to brief therapy; personality problems, to long term therapy. In a retrospective analysis in a group context, Grotjahn (1972) pointed out that those who entered treatment with situational problems were predictable dropouts.

Gliedman et al. (1957) found it useful to conceptualize a bipolar incentive system for treatment, separating those (1) seeking relief from psychological distress, improvement of interpersonal relationships, an increase in self awareness, and greater personal growth,

from those (2) whose entry into treatment reflects situational/environmental factors: family problems, problems with the law, and job related difficulties. Heilbrun (1974) postulated that one reason for early termination might be the effective early catharsis achieved by those capable of high rates of personal disclosure, thus arguing for a brief/long-term dichotomy as a function of patient style.

Dengrove and Kutash (1950) pointed out that therapy is vulnerable to external pressures on the patient to "do it on his own," to therapy as a corequisite to drug treatment, and to the loss of secondary gain, all extra-therapeutic factors among those influencing research results. McNair and Lorr's (1964) tripartite schema of therapeutic goals (viz., reconstructuve, stabilizing, supportive) can also be subsumed in a bipolar system: brief therapy for supportive interventions, long term for stability and reconstruction. Fiester et al. (1974) were especially impressed with the incidence of dropouts (34%) after only one or two contacts with community mental health facilities; they concluded that services are provided which are unusable by many clients (e.g., traditional long term dynamic therapy), and that services are required which are unavailable to many clients (e.g., briefer, reality oriented, problem centered treatment). It is likely that this lack of complementarity has confounded many studies of the dropout question.

In the above light we can understand that "contrary to the usual expectations concerning length of therapy, most clinic clients are done with it after only a few interviews" (Garfield, 1971, p. 275).

The scope of the dropout problem can be illustrated briefly by examining some published data reporting dropout rates in a variety of settings. Frank et al. (1957) reported a dropout rate of 31%; this

figure was reported to be low due to the elimination from analysis of patients with histories of antisocial acting out, character disorders, and alcoholism. Rosenthal and Frank (1958) found that 35% of those offered therapy refused it; of those who accepted therapy, 46% had dropped out by criterion. In 1961, Gallagher and Kanter noted that 70% of all accepted patients had dropped out by the ninth interview. It is not surprising to note that in a setting which adopted the conscious posture of a narrow band of patient acceptability, the dropout rate was lowered to 6% (Lief, Lief, Warren, & Heath, 1961). On the other hand, in a community mental health facility the selectivity is broadband and a dropout rate of 50% was reported (Sue, McKinney, Allen, & Hall, 1974); Kline and King (1973) found a dropout rate of 34% in a community mental health setting. Comparably, V.A. mental hygiene clinics, required by law to be broadband, had high dropout rates: 70% (Garfield & Kurz, 1952), 59% (Brown & Kosterlitz, 1964).

A desirable solution to the problem of high dropout rates would be the early identification of high risk patients followed by alternative recommendations such as supportive therapy, brief therapy, behavior therapy, crisis intervention, etc.

Patient Variables Relating to Dropping Out

There has been a number of attempts to posit, to isolate, and to correlate factors contributing to the persistent problem of high dropout rates. Variables studied have been subsumed under the major categories of patient factors, therapist factors, and patient-therapist matching (Luborsky, Auerbach, Chandler, Cohen, & Bachrach, 1971). Unfortunately, an exhaustive review of the literature revealed the lack

of consistency and replicatability of the research findings (Brandt, 1965). In the present study the focus was on patient variables.

Patient demographic variables

Among the demographic variables studied, age has not usually been seen as a significant element (Affleck & Garfield, 1961; Frank, Gliedman, Imbel, Nash, & Stone, 1957; Garfield & Affleck, 1959; Rosenthal & Frank, 1958; Sullivan et al., 1958). Fiester et al. (1974) have found no significant relationship between any demographic variables and dropping out in a community mental health setting. However, Katz and Solomon (1958), Heilbrun (1961), and Brown and Kosterlitz (1964) have found significant relationships between age and dropout tendency.

Educational level has similarly revealed a checkered pattern as a correlate of dropout rate. It was found to be unrelated by Affleck and Garfield (1961), Fiester et al. (1974), and Garfield and Affleck (1959). A non-significant but "suggestive" tendency for those with more education to accept and to remain in therapy was found by Brown and Kosterlitz (1964) and by Rosenthal and Frank (1958). But Frank et al. (1957), Heilbrun (1961), Katz and Solomon (1958), and Rubinstein and Lorr (1956) found that a higher educational level correlated significantly with remaining in treatment.

Sex of patient was shown not to be related to dropping out by Affleck and Garfield (1961), Garfield and Affleck (1959), Frank et al. (1957), and Katz and Solomon (1958). Brown and Kosterlitz (1964) and Rosenthal and Frank (1958) found that significantly more males stayed in therapy than did females. Heilbrun (1961) has found that females

tend to stay longer in counseling than males; he acknowledges and is further pursuing the confounding variable of therapist's sex.

Among the most consistent findings have been those relating the impact of social class on every aspect of therapy (Hollingshead & Redlich, 1958). Components of the social class of the patient are visible in referral source, treatment expectation (Aronson & Overall, 1966; Overall & Aronson, 1963), acceptance into treatment (Rosenthal & Frank, 1958), acceptance of treatment (Imber, Frank, Gliedman, Nash, & Stone, 1956; Imber, Nash, & Stone, 1955; Rosenthal & Frank, 1958), therapist assignment, and type of therapy received (Meltzoff & Kornreich, 1970). Among non-psychotic patients, lower social class patients drop out of therapy at a significantly higher rate compared with middle class patients (Imber et al., 1955; Rosenthal & Frank, 1958; Rubinstein & Lorr, 1956; Schaffer & Myers, 1954).

Personality of the patient

Research into patient personality characteristics related to dropouts has been only moderately successful in replicating findings; this is disappointing, for this area seems at first glance to be so potentially fruitful. The expression of and the tolerance for anxiety have been found by Frank et al. (1957), Katz and Solomon (1958), Lorr, Katz, and Rubinstein (1958); and Taulbee (1958) to be significantly and positively related to staying in therapy. Persistance (Frank et al., 1957; Katz & Rubinstein, 1958; Rubinstein & Lorr, 1956), hopefulness (Katz & Solomon, 1958), a low incidence of impulsivity and antisocial acting out (Hiler, 1959a; Lorr et al., 1958; Rubinstein & Lorr, 1956; Sullivan et al., 1958), suggestibility (Frank et al.,

1957; Imber et al., 1956; Strupp, 1974), flexibility and a compromising nature (Katz & Solomon, 1958; Lorr et al., 1958), psychological mindedness and an introspective attitude (Hiler, 1959b; Lorr et al., 1958; Taulbee, 1958), admitted self doubts and self dissatisfactions (Heilbrun, 1961; Lorr et al., 1958; Rubinstein & Lorr, 1956; Taulbee, 1958), dependency (Heilbrun, 1961; Lorr et al., 1958; Taulbee, 1958), and verbal fluency, both general and specific to personal, intimate subject matter (Affleck & Mednick, 1959; Auld & Myers, 1954; Frank et al., 1957; Heilbrun, 1961; Hiler, 1958, 1959a; Taulbee, 1958) all have been found to relate significantly to remaining in therapy. Attitudes of defensiveness (Garfield & Affleck, 1959; Strickland & Crowne, 1963) and of hostility (Kline & King, 1974; Rubinstein & Lorr, 1956) are significantly associated with dropping out, as is sensitivity to the "stigmatization" experienced as concomitant with needing psychological treatment (Dengrove & Kutash, 1950; Fischer & Turner, 1970). It should be pointed out that the methodology of the referenced studies is so variable as to cast considerable doubt on the accuracy of the findings, and more importantly, on the replications where effected. The foregoing should be considered to be highly suggestive of fertile areas for further inquiry, not as definitive.

The role of patients' motivation

It is usually accepted as a given that a patient in psychotherapy must be motivated if any change is to occur in the course of treatment. Occasionally the motivations of the therapist may interfere; it is also widely accepted that therapists want patients most

like themselves in social class, educational level, goals, and expectancies of the treatment situation (Auld & Myers, 1954; Dengrove & Kutash, 1950; Hargreaves, 1974; Lief et al., 1961; Rosenthal & Frank, 1958). It would be foolhardy to believe that this is not communicated to patients (Shapiro, 1974). Rubinstein and Lorr (1958) stated that a crucial requirement for staying in therapy is a minimal level of active and goal directed persistent behavior aimed at culturally approved ends; motivation for treatment is further evidenced by heightened self-dissatisfaction and the ability to postpone gratification and to tolerate the inherent frustration. It seems appropriate to mention here the observatin of Sullivan et al. (1958) that those least able to cope with life's challenges stand least to gain from psychotherapy.

Hargreaves (1974) found that clients labeled as motivated were regarded as "good referrals" by therapists. The variables correlating significantly with high motivation (as rated) were shyness and being upset. Poor motivation was regarded by Dengrove and Kutash (1950) as a prime factor in dropping out. Rosenthal and Frank (1958) found that patients judged poorly motivated were less often referred for individual therapy; among those referred, however, they were judged as improved as those who had been rated as highly motivated before referral. Lief et al. (1961) judged motivation of applicants for psychoanalysis by rating expressed desire for it, behavior in overcoming obstacles to obtaining it, length of time willing to wait for it, behavior in intake interview, attitude shown to referral, and verbalization regarding psychotherapy. With unusually rigorous selection criteria, they were able to sustain a dropout rate of 6%.

It should be emphasized that Lief et al. (1961) selected patients whom they were motivated to treat for training purposes within a narrowly defined target population.

The issue is cloudy and poorly defined; moreover, there are conflicting data reported. McNair, Lorr, and Callahan (1963) found rated motivation related to length of stay in psychotherapy; however, Affleck and Garfield (1961) found "therapeutic assets" in general and motivation in particular not to be related to length of stay in treatment. Similarly, Garfield, Affleck, and Muffley (1963) were unable to show that therapists' rating of patient motivation was related to duration of treatment. It is apparent throughout the literature that ratings and judgements of motivation are idiosyncratic, unreliable, and vaguely phrased. Experiments are rarely replicated in a way which confidently relates newer findings to previous ones. Nevertheless, Strupp (1974) maintains that a patient should be motivated and be persuaded to accept the therapist's goals.

The importance of expectation

Patients' expectation from treatment can affect their commitment and are affected by the feedback received from the therapist, as outlined above. Heine and Trosman (1960) found that dropouts emphasized passive cooperation, medication, and diagnostic information, whereas the remainers showed active collaboration, advice seeking, and wished for help in changing behavior. In another study (Heine, 1962) dropouts were shown to be more likely to expect specific advice, and discriminated less often between psychotherapists and other health

professionals. Garfield and Wolpin (1963) reported interesting findings, unfortunately not replicated, showing that patients choosing psychotherapy, acknowledging emotional factors as crucial, and expecting to gain from increased self understanding (i.e., "good patients") nevertheless anticipated improvement by the fifth session (73%) and expected treatment to be ten or fewer sessions (70%). This is a clear failure of congruence of expectancies between patients and therapists (cf., Heine & Trosman, 1960, discussed above). It appears that a complementarity of expectancies may be influential in establishing and maintaining a therapeutic alliance.

To assess the foregoing assumption, Hoehm-Saric, Frank, Imber, Nash, Stone, and Battle (1964) attempted an experimental induction of an appropriate patient role; the manipulation showed some positive effect upon attendance in therapy. Wilkins (1973) is critical of the method of the evaluation of the importance of client expectancies, arguing for more rating by clients and fewer reports of ratings by therapists. Wilkins also points out that the experimental induction was not conducted in a double blind manner; i.e., the therapists knew of the expectancy condition. The prevailing attitude seems to be that if the expectancies of the therapist and of the patient are incongruent, then a new set of expectancies is to be induced in the patient. Yet the expectancies shown by patients is often congruent with what eventually occurs in clinic settings: treatment sessions are few in number, on the average (cf., Garfield, 1971, Tables 8.1, 8.2, pp. 274-275).

Psychiatric history and pathology

Psychopathology and psychiatric history have been investigated with a view toward relating them to course of and dropout from psychotherapy. Psychiatric diagnosis has generally been found to be unrelated to staying in treatment (Gallagher & Kanter, 1961; Garfield & Affleck, 1959; Katz & Solomon, 1958; Rosenthal & Frank, 1958). However, Frank et al. (1957) found that those patients diagnosed as having anxiety or depressive reactions were more likely to stay longer in psychotherapy than patients with other diagnoses. Presenting problems seem to be significantly related to staying in psychotherapy: dropouts are more likely to complain about somatic problems, remainers about psychological distress (Hiler, 1959a). Dropouts are more likely to complain about trouble with the law and antisocial acting out (Lorr et al., 1958).

Inquiry into results of psychological tests has yielded variable results. The findings of Sullivan et al. (1958) and those of Taulbee (1958) were divergent regarding the correlation of personality traits inferred from the derivative MMPI scales and dropping out. The Rorschach has yielded several combined functions; none is more powerful than number of responses (Meltzoff & Kornreich, 1970) which is significantly related to IQ and to social class and educational achievement (Auld & Eron, 1953). Hiler (1959b) used a sentence completion test; 15 of the 100 items discriminated the dropouts from the remainers. The accuracy of the discrimination was 71%, compared with 68% for Rorschach R, 65% for WB IQ, and 68% for a global rating by a clinician.

Patient Selection for Psychotherapy

Our focus will be on the selection process operating over the field of patient variables. The body of research reviewed revealed equivocal findings and imprecise methods regarding client variables in relatin to the phenomenon of dropouts from therapy in a clinic setting.

Selection procedures in widespread use

Insofar as increasing social class, education, and IQ are probably related positively to remaining in treatment, the dropout problem may to a considerable degree reflect the discrepancy between the services available to and needed by the clinic population (Fiester et al., 1974).

Among the patients who come to clinics, selection procedures exist in that some are not offered psychotherapy. In a study by Garfield and Kurz (1952), 43% of the applicants were accepted for therapy; 32% were seen for evaluation only; 14%, therapy not indicated; 6%, hospitalized, 5%, ineligible. Rosenthal and Frank (1958) reported their classic finding that psychiatrists tend to refer for psychotherapy persons who are most like themselves; they referred significantly more whites than blacks, more of those with higher social standing and educational achievement, and more of those applicants who were younger, judged more motivated and less sick. Frank et al. (1957) in their study showed a clear bias against selecting antisocial character disorders, alcoholics, overt psychotics, and mental defectives. Brown and Kosterlitz (1964) found significant relationships between male social class, female marital status, somatic complaints, and female multiple complainants with acceptance for outpatient treatment; age,

male marital status, female social class, and other diagnostic patterns were not related. In a community mental health center, Lubin, Hornstra, Lewis, and Bechtel (1973) found that social class, education, occupation of head of household, age, race, referral source, psychiatric history, diagnosis, and interpersonal problems presented were all significantly related to treatment modality offered (inpatient referral, medication clinic, group therapy, individual therapy). Thus, whereas the data attempting to relate patient characteristics and the tendency to drop out are tentative and suggestive, the reports of client selection criteria have been fairly consistent since Myer and Schaffer (1954) reported a significant relationship between social class of patient and acceptance for therapy.

Clinical judgments about patients

It is the clinician's process of judging the likelihood of a patient's remaining in therapy that we wish to study further here. Garfield and Affleck's (1959) study of therapists' ratings of patients revealed that there is wide agreement among clinicians regarding judgment of prognosis, personal feeling about the patients, interest in working with the patients, and patients' assets for psychotherapy. Only prognosis was found to be significantly related to length of stay in treatment in this study. Parenthetically, there was a desire to work with those patients rated easiest to work with and least in need of help (cf., Sullivan et al., 1958).

Brandt's (1965) review described several studies in which the accuracy of dropout prediction by clinical judgment was similar to prediction by actuarial methods. Little appears in the literature

describing the actions occurring in this judgment process. Bieri et al. (1966) used a primarily psychophysical model embellished by information theory in an attempt to understand the discrimination of behavioral information in clinical and social settings. The research they reported dealt almost exclusively with discrete stimuli, e.g., sounds, lights, movements. While they made a commendable effort to organize and to systematize thinking about interpersonal perception, their atomistic approach afforded but slight penetration into the issue of clinical vs. actuarial prediction as exemplified by the dilemma of Meehl's (1954) fence sitting posture. Meehl's salient point was that the clinician's forte, compared with that of the calculator, is the generation of hypotheses based on skilled observation and on experience. The position taken here, similar to Meehl's, is that certain cues or cue combinations are involved in general hypothesis generation by the clinician about a specific patient. In particular, a clinician may generate hypotheses similar to: "this patient has many assets for psychotherapy" or "this patient will probably be overwhelmed by a male therapist" or "this patient won't be able to tolerate the anxiety inherent in psychotherapy and will probably drop out."

In the above brief review of the literature about dropouts, only one parameter was well established and widely recognized as correlated with the phenomenon of dropping out of psychotherapy: decreasing social class. Other patient demographics were inconsistently related, if at all, to dropping out. To the extent that this variable could be held constant (e.g., by studying a population which is relatively homogeneous in social class), we have focused on the clinical judgment made at the

time of the initial interview.

The clinical prediction of dropping out

The failure of any of the esoteric combinatorial functions of the Rorschach and MMPI to improve significantly on the global clinical impression as a predictor of therapy dropouts (Hiler, 1959a) suggests that the clinician's judgment process is indeed a fruitful area for investigation. Clinicians have been found to concur in their use of terms employed to describe internsity and abnormality of personality characteristics (Buss & Gerjuoy, 1957).

The goal of the present study was the compilation of a simple, brief checklist to enable the interviewer to detect cues indicative of a tendency to drop out vs. the probability of remaining in treatment. In compiling and working with such a checklist we have replicated some of the research cited.

Three areas of input to the judgment process were investigated to discern if any cues were reliably associated with the tendency to drop out. First consider what the patient said; i.e., what issues and topics he selected for presentation or produced in response to questioning. These potential cues were in the form of a verbalized self report and the clinician attended to what was said and to what was omitted but presumed present (Dollard & Miller, 1959, p. 255). The former are available as factual stimuli; the latter may be used in developing a speculative dynamic formulation about the patient.

The clinician listened not only to what was said, but to how it was said; the clinician attended to the manner in which data were presented (Fromm-Reichmann, 1950). The clinician is an observer of the

process of interaction (Sullivan, 1953). Houck and Hansen (1972) described in minute detail the clinician's behavioral assessment by observation of the patient's dress, grooming, carriage, facial expression, mannerisms, mood, emotional tone, and verbal style. Patient attitudes and behaviors can reveal serious defensiveness: insolence, unpleasantness, attempts to control the interview, and a pseudo self-reliant air. This second source of information, direct observation of the behavior of the patient, is accessible in a factual manner as was the first: the patient was aloof; or: the patient was not anxious. Like the first source, the second may also contribute to the development of a dynamic formulation about the patient (Fromm-Reichmann, 1950; Sullivan, 1953).

In summary, two sources of cues for the generation of clinical hypotheses from the initial interview are: the content of the patient's verbal productions and the patient's behavior. Occurrences of particular topics or behaviors can be counted, and a theory of this patient's personality can be generated to explain how he has come to the present state, to estimate the prognosis, and to make a therapeutic recommendation. Inferences regarding the nature and scope of the patient's ego defenses, regarding the patient's personal style, and regarding his assets for therapy can also be made. This speculative, global, intuitive impression of the patient constitutes the third of our presently considered areas of input to the clinical judgment process.

Specific aims of the present study

The following cluster of variables has been selected from the literature as having potential for discriminating between dropouts

and remainers:

A. The personality characteristics of: (1) the tolerance for and expression of anxiety, (2) defensiveness, (3) flexibility and compromising nature, (4) hopefulness, (5) hostility, (6) impulsivity and the tendency to act out, (7) persistance, (8) psychological mindedness and introspectiveness, (9) self doubts and dissatisfactions, (10) suggestibility and dependency, (11) general and personal verbal fluency

B. The diagnoses of: (1) anxiety reaction, (2) depressive reaction

C. The presenting problem polarity of (1) personal problems, (2) situational difficulties.

In summary, the present study developed a checklist based on the above variables, and judged as described earlier. It was rated solely on the basis of the initial interview contact in a college psychological clinic. The subjects, a total of 98, were homogeneous in age, class, and level of psychological dysfunction. The items on the checklist were tested for reliability and for correlation with the tendency to drop out of treatment. The objective was a scale which identified potential dropouts. Where potential dropouts are offered a long term therapy, we hypothesized that they will drop out more often than those patients identified as remainers.

In the course of the development of the checklist we tested the hypotheses that the variables can reliably be detected during the initial interview, and that the incidence of items on the checklist relates to the tendency for a patient to drop out of therapy.

CHAPTER II

PILOT STUDY

Introduction

Version I of the checklist is presented in detail, with theoretical and empirical support for each item, in Appendix 7. The pilot phase of the three phase study determined interjudge reliability, frequency of item occurrence, and an index of association of each item with the tendency to drop out.

The checklist (Table 1) consists of 51 items: the 24 in group I reflect statements made by the patient spontaneously or in response to questioning; the 13 in group II are behavioral observations made by the interviewer during the interview, similar in some items to a mental status report; the remaining 13 items, comprising group III, are inferential, impressionistic, global formulations and ideas about the patient. Each item is keyed with a capital letter D or L, indicating that the item was theoretically associated with dropping out from (D) or with long term commitment to (L) psychotherapy. There are 10 D's and 15 L's in group I, and 7 D's and 6 L's each in groups II and III, for a total of 24 D's and 27 L's. The aim is to study the occurrence of items keyed D and items keyed L, and to study their value, if any, in predicting who stays and who drops out, and thereby to learn which cues provide the clinician with his intuitive hypotheses in making these judgments.

TABLE 1

SCORING SHEET OR "CHECKLIST"

I. Topics occurring in interview

1 D Drugs/alcoholism

2 D Conduct/legal problems

3 D Promiscuity

4 D Physical abuse

5 D Divorce

6 D Varying nurturant figures

7 D Frequent/dramatic moving

8 D Frequent job/goal changes

9 L Quarrels, arguments

10 L Unusual traumata

11 L Tantrums

12 D Suddenly leaving home

13 L Adaptability, humor

14 L Anxiety

15 L Doubt, insecure, inferior

16 L Remorse, depression

17 L Feeling different

18 L Depersonalization

19 D Defiant independent acts

20 L Seeks approval/fears disapproval

21 L Seeks dependency

22 L Insulting behaviors

23 L Resentment

24 L Loneliness; lacks friends

25 L Inner anger and hostility

TABLE 1--Continued

II. Behavior during interview			III. Overall impression of patient		
1	L	Verbally fluent	1	D	Narcissistic
2	D	Flighty	2	L	Hysterical
3	L	Logical, orderly	3	D	Paranoid
4	D	Guarded/suspicious/evasive	4	L	Unassertive/Passive aggressive
5	L	Passive	5	D	Hostile
6	D	Hostile	6	D	Controlling/manipulative
7	L	Depressed	7	L	Childlike, immature
8	D	Cold, distant	8	L	Conventional
9	L	Warm, humorous	9	D	Uses avoidance/escape
10	D	Facade of confidence	10	L	Intellectualizes
11	D	Controlling	11	L	Psychologically minded
12	L	Feeling oriented	12	D	Don Juan
13	D	Asks for direct advice	13	D	Situational problem reaction

Method

Subjects

A section of the past files was randomly selected; this section contained 41 adult cases. Fifteen children and/or families were eliminated as outside the bounds of our interest. The intake interview reports were separated from the 41 adult cases folders and keyed for later reassociation. Then the case histories were examined and divided into three batches: first, criterion long term remainers (LT); there were 14 patients who showed a commitment to become and to stay involved in treatment by attending sessions regularly until a therapist-agreed-to termination. Second, criterion dropouts (DO); there were 12 patients who terminated unilaterally, without having become involved in the treatment offered. Third, no criterion cases, among which were poorly kept records (N = 6), cases with novice therapists' serious blunders in establishing a therapeutic alliance (N = 5), and cases which were not accepted and/or referred out (N = 4).

Reliability and validity were studied using the 26 cases falling into the two criterion batches. The patients were all undergraduates with an average age of 22.7 years. The dropouts included five males and seven females; they had a range of from zero to six sessions of therapy, with a modal number of sessions equal to one. The remainers included nine males and five females; they had a range of 22 to 107 sessions, with a median of 45.

Procedure

Using the 15 interview reports corresponding to the cases which failed to reach a criterion (batch three, above), the author trained an

undergraduate senior majoring in psychology to rate intake interview reports. The trainee was familiarized with the items and instructed to check them if they were reported by the patient (Group I items), observed by the interviewer (Group II items), or inferred either by the interviewer in the formulation and diagnostic impression, or by the trainee in reading the reports (Group III items). After the ninth report, it was considered that the trainee was sufficiently familiar with the checklist and the procedure to qualify as a judge for the purposes of reliability evaluation. The author was a second judge.

Each of the 26 criterion cases was rated once by each judge, producing 52 records. For each record, the number of occurrences of items keyed D and of items keyed L was determined, yielding sum scores of D's and L's, symbolized here as D and L, respectively. This was preparatory to evaluating total score reliability and predictive validity (below).

Reliability was also studied on an item by item basis. For each of the 51 items on each record (N = 26), it was noted whether the judges had agreed or disagreed in checking the item as present or in not checking the item as absent. When both judges checked the item or neither checked it an agreement was scored; when only one judge checked an item, a disagreement was noted.

Results

Reliability

The interjudge agreement for all 51 items ranged from 61% to 100%; modal agreement was 88%, median, 86%, mean 85%. Thus the frequency distribution of percentage agreement extends from 61% to 100%, skewed

to the left, with a peak at 88%.

Predictive validity

Predictor variables

A summary of obtained L and D scores, including a discriminator score, D-L (Anastasi, 1968), is presented in Table 2. These results implied that the D score or the discriminator score, D-L, might be useful as predictors in that they yielded at least a suggestive if not significant mean difference between the target groups.

Target variables

Since the goal of the present study was to compile a checklist to discriminate between the tendency to drop out and the probability of remaining in treatment, the latter was selected as a target variable. The probability of a long term therapy, symbolized by Plt, is related to the tendency to drop out by 1-Plt.

Now Plt for a closed case is a jump continuous variable. As it is a probability, it may take on any value in the closed interval (0,1). Because the cases are closed, the results are known and dichotomous values may be assigned. Thus, Plt is assigned a value of 1 for remainers or a value of 0 for dropouts.

The correlation coefficients were computed for each of the two predictor variable candidates, D and D-L, with Plt as the target variable. The correlation between Plt and D was -.372 (p = .073). The correlations are suggestive but not significant.

Item analysis

Correlation coefficients between each of the 51 items on the

TABLE 2

MEANS, STANDARD DEVIATIONS, *t*'s, AND PROBABILITIES OF *t*'s OBTAINED FOR THE SCORES D,L, AND D-L, FOR BOTH REMAINERS AND DROPOUTS

		D	L	D-L
Remainers (N = 14)	Mean	2.43	7.57	-5.14
	SD	1.65	1.83	2.69
Dropouts (N = 12)	Mean	3.83	7.08	-3.25
	SD	1.99	2.61	2.71
t		1.89	0.54	1.71
p		.072	NS	0.10

checklist and the criterion, the tendency to remain in psychotherapy, were calculated. We call these item-criterion correlation coefficients estimators, and symbolize them by e. The e's estimate the degree of association between each item and the likelihood of remaining in therapy, a negative value being associated with dropping out, a positive value with remaining in therapy. The obtained values of e and the frequency of occurrence (f) of each item in the sample are presented in Table 3. The overall mean /e/ was .143; SD, .103. The mean f was 19.7%; SD, 16.2%.

TABLE 3

ESTIMATORS (e) AND FREQUENCIES (f) FOR VERSION I

I. Topics occurring in interview	e	f (%)
1 D Drugs/alxoholism	+.173*	15.4
2 D Conduct/legal problems	-.374*	11.5
3 D Promiscuity	-.022	7.7
4 D Physical abuse	+.090	11.5
5 D Divorce	+.135	32.1
6 D Varying nurturant figures	+.256*	7.7
7 D Frequent/dramatic moving	-.371*	30.8
8 D Frequent job/goal changes	-.238*	15.4
9 L Quarrels, arguments	-.132	34.6
10 L Unusual traumata	+.039	26.9
11 L Tantrums	+.181*	3.8
12 D Suddenly leaving home	-.022	7.7
13 L Adpatability, humor	0.0	0.0
14 L Anxiety	-.024	65.5
15 L Doubt, insecure, inferior	0.0	50.0
16 L Remorse, depression	+.288*	65.5
17 L Feeling different	+.059	19.2
18 L Depersonalization	-.238*	15.4
19 D Defiant independent acts	-.022	7.7
20 L Seeks approval/fears disapproval	+.079	46.2
21 L Seeks dependency	-.070	46.2
22 L Insulting behaviors	+.173*	15.4
23 L Resentment	-.132	34.6

TABLE 3--Continued

I. Topics occurring in interview	e	f (%)
24 L Loneliness; lacks friends	+.138	57.7
25 L Inner anger and hostility	+.173	15.4
II. Behavior during interview		
1 L Verbally fluent	+.271*	30.8
2 D Flighty	+.181*	3.8
3 L Logical, orderly	+.090	11.5
4 D Guarded/suspicious/evasive	+.059	19.2
5 L Passive	-.300*	7.7
6 D Hostile	-.142	11.5
7 L Depressed	-.130	19.2
8 D Cold, distant	-.300*	7.7
9 L Warm, humorous	+.090	11.5
10 D Facade of confidence	-.205*	3.8
11 D Controlling	+.090	11.5
12 L Feeling oriented	+.181*	3.8
13 D Asks for direct advice	-.205*	3.8
III. Overall impression of patient		
1 D Narcissistic	-.374*	11.5
2 L Hysterical	-.128	26.9
3 D Paranoid	+.110	30.8
4 L Unassertive/Passive aggressive	+.070	53.8
5 D Hostile	-.300*	7.7
6 D Controlling/manipulative	-.041	32.1
7 L Childlike, immature	-.050	30.8

TABLE 3--Continued

III. Overall impression of patient	e	f (%)
8 L Conventional	-.022	7.7
9 D Uses avoidance/esca;e	-.217*	23.1
10 L Intellectualizes	-.041	23.1
11 L Psychologically minded	+.090	11.5
12 D Don Juan	-.142	11.5
13 D Situational problem reaction	-.022	7.7

* Indicates item with /e/ $\geq$ overall mean /e/

CHAPTER III

VERSION II OF THE CHECKLIST

Rationale for Modifications

In view of the results obtained in the pilot study, viz., the relatively low average /e/<(.143), the large number of items where /e/ .143 (30 out of 51), and the improved rater reliability possible with a shorter scale, weak items were eliminated. The goal was to strengthen accuracy of prediction and to eliminate items which were not discriminating between dropouts and remainers. The criteria adopted for Version II were: (1) a maximum of 30 items; (2) retention of only those items from Version I where /e/ > .143, with specialized exceptions (stated below), (3) an apparent three level scoring system to help in scoring an item when it seems less than fully indicated.

The 20 items satisfying the criterion of /e/ >.143 are indicated by an asterisk (*) in Table 3. Among these we decided to drop I-11, Tantrums in childhood, because of low incidence. A second group of items was expanded to separate the patient's experience from those of his family. Item I-1, Using hard drugs; abusing drugs; alcoholism, was opposed in presumed vs. observed direction of association. We decided to expand this item into two, separating the patient as addict from his family members as addicted, for the purpose of inquiry. Although associated in the expected direction, item I-8, Frequent and/or poorly planned changes in jobs and/or goals, was also expanded into two items

for purposes of inquiry in order to separate the patient's personal experiences from those of his family of origin. Item I-5, Divorce: breakup of serious affair, fell just below criterion: *e* = +.135; however, the sign is opposed to that predicted. For this reason, and because of the increasing incidence of divorce, we decided to include this item in the second version, again expanded to two items separating personal from familial experiences; N = 23.

Other illustrations of items falling just below criterion but in directions opposed to those predicted were: I-9, Quarrels, arguments; I-23, Resentment; II-7, Depressed mood; and III-3, Paranoid. From this group we decided to retain only the last because it enjoys the widest theoretical support and empirical agreement by an order of magnitude; N = 24. Items I-22 and 25, Insulting behavior: hypercritical outbursts, and Refers to "inner anger and hostility," were collapsed into a single item since they are similar in theoretical justification and were found to be scored together; N = 23.

Becuase of the theoretical and practical importance of the situational vs. personal problem dichotomy, we decided to retain III-13, Situational problem reaction: patient experiencing a well defined, limited, circumscribed situational difficulty, despite its low *e* of -.022. Moreover, due to resonance with the practical and theoretical issues of situational vs. personal problems and of anxiety tolerance, III-13 was expanded to a second item: Unable to tolerate anxiety: "emergency," panicky, for inclusion in group III; N = 25.

Table 4 shows the second version of the checklist. Note that each item is more fully explicated and that a single page format,

TABLE 4

VERSION II OF THE CHECKLIST

Intake Interview Checklist

Case #_____ Age _____

Sex _____ Race _____

Occup _____

Instructions: Please circle one of the three letters in the left margin for each item. Circle the N if the item is not indicated or not mentioned. Circle the P if the item is partially or slightly indicated. Circle the Y if the item is strongly or definitely indicated. Please use the space at the bottom and back of the sheet for any additional comments, notes or observations you feel relevant. Thank you.

I. Topics mentioned by patient during interview

N P Y 1 Using hard drugs; abusing drugs; alcoholism (self)

N P Y 2 Using hard drugs; abusing drugs; alcoholism (family)

N P Y 3 Conduct problems: difficulties with authorities (school, law, etc.)

N P Y 4 Divorce; break-up of serious affair (self)

N P Y 5 Divorce (family)

N P Y 6 Varying nurturant figures; shuttled from pillar to post in childhood

N P Y 7 Frequent or highly significant residence changes; cultural transplants

N P Y 8 Frequent, poorly planned changes in goals, jobs (self)

N P Y 9 Frequent, poorly planned changes in goals, jobs (family)

N P Y 10 Remorse, depression, guilt, shame, worthlessness, suicidal ideas

N P Y 11 Experiences depersonalization; feels strange, outside of self

N P Y 12 Insulting; hypercritical outbursts; inner anger and hostility

II. Behavior and attitudes during interview

N P Y 1 Verbally fluent: spoke easily, readily, spontaneously; no difficulties with words as medium

N P Y 2 Flighty: flitted from topic to topic

N P Y 3 Passive: needs to be guided and prompted

N P Y 4 Cold, distant: formal, stilted, stiff manner; blandness, apathy

N P Y 5 Operated via a facade of self confidence while distress is evident; macho act; rigid posturing

N P Y 6 Oriented to feelings; openly describes feelings; shows affect

N P Y 7 Asks explicitly to be given direct advice

III. Overall impression of patient

N P Y 1 Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive

N P Y 2 Paranoid: externalizes; projects; is guarded, suspicious

N P Y 3 Hostile aggressive: actively, obviously hostile and aggressive

N P Y 4 Uses avoidance, escape: quits, runs away; cops out of difficulty

N P Y 5 Situational problem reaction: well defined, limited, circumscribed situational difficulty

N P Y 6 Unable to tolerate anxiety; "emergency," panicky

albeit of legal length, was maintained. The dropout key, D or L, was omitted to help eliminate the contamination by the interviewers' personal predictions regarding the likelihood of a patient's dropping out. The tripartite score, Y P N, was intended first to insure that each item would be considered, even if rejected as irrelevant to the patient under consideration (i.e., scored as N). It was possible to omit items altogether and to fail to check items considered relevant when using Version I. Secondly, the score can provide an apparent method whereby the rater could hedge in his judgment and qualify his rating of the item, P and Y both being indicators of the presence of the implied cues for our purposes.

Method

Subjects

A group of cases was randomly selected from the file of closed cases. The intake interview reports were separated from the records, an associative identification being recorded on the intake to enable its reassociation with the record, the intake reports were read, rated, then reassociated with the file. Records were selected for the above outlined procedure provided they were not records of children or families in treatment, not so poorly kept that a determination of the kind of termination was impossible, nor ambiguous in type of termination. We began our search at a random point in the files, and continued until we had 12 criterion remainers and 12 criterion dropouts.

Among the dropouts the mean age was 22.8 years; there were six males and six females. The remainers had a mean age of 23.3 years;

there were seven males and five females. Mean number of sessions was 4.25 for dropouts, 38.9 for remainers; SD = 6.25 and 21.7, respectively.

Procedure

The interjudge reliability for the items had been determined in the first study. However, an additional measure of realiability as obtained with a group of nine judges rating a single videotaped interview. Rating using the instrument occurred after viewing the interview.

Validity was determined by having the author rate the 24 criterion cases, calculate the L and D scores for each, and relate them to the probability of dropping out.

Results

Reliability

The additional measure of reliability obtained showed that among nine judges mean agreement over all items was 84.2%. The frequency distribution of percentage agreement ranged from 50% to 100%. The mode occurred at 100%, the distribution being skewed to the left.

Predictive validity

A summary of obtained D, L, and D-L scores is presented in Table 5. Using Version II of the checklist, clear support is found for the assertions that both the mean D score and the mean D-L derivative score differ between remainers and dropouts.

Correlation coefficients were calculated for Plt and both D and D-L. The correlation between Plt and D was -.598 (p = .0026). The correlation between Plt and D-L was 0.587 (p = .0026). The correlations show significant relationships between Plt and both D and D-L.

TABLE 5

MEANS, STANDARD DEVIATIONS, *t*'s, AND PROBABILITIES OF *t*'s OBTAINED WITH VERSION II FOR THE SCORES D, L, AND D-L, FOR BOTH REMAINERS AND DROPOUTS

		D	L	D-L
Remainers (N = 12)	Mean	2.333	1.667	0.667
	SD	1.919	0.778	1.922
Dropouts (N = 12)	Mean	5.000	1.500	3.500
	SD	1.813	1.169	2.152
t		3.349	0.394	2.260
p		0.003	NS	0.004

The values of *e* and *f* for each item were calculated. Table 6 shows *e*, *f*, and the scoring key for the items. For Version II, mean /*e*/ was .166; SD, .145. This value did not differ significantly from that obtained in Version I. The mean *f* was 19.0%; SD, 13.7%.

TABLE 6

CODING OF ITEMS, e VALUES, AND % OCCURRENCE; VERSION II

Key	e	f(%)		
I. Topics mentioned by patient during interview				
D	-.362	13	1	Using hard drugs; abusing drugs; alcoholism (self)
D	-.185	25	2	Using hard drugs; abusing drugs; alcoholism (family)
D	-.121	13	3	Conduct problems: difficulties with authorities (school, law, etc.)
D	0.163	42	4	Divorce; break-up of serious affair (self)
D	0	25	5	Divorce (family)
D	+.087	29	6	Varying nurturant figures; shuttled from pillar to post in childhood
D	-.160	50	7	Frequent or highly significant residence changes; cultural transplants
D	-.369	25	8	Frequent, poorly planned changes in goals, jobs (self)
D	-.098	21	9	Frequent, poorly planned changes in goals, jobs (family)
L	+.079	54	10	Remorse, depression, guilt, shame, worthlessness, suicidal ideas
L	-.214	17	11	Experiences depersonalization; feels strange, outside of self
L	0	8	12	Insulting; hypercritical outbursts; inner anger and hostility
II. Behavior and attitudes during interview				
L	0	50	1	Verbally fluent: spoke easily, readily, spontaneously; no difficulties with words as medium
D	0	8	2	Flighty: flitted from topic to topic
L	0	8	3	Passive: needs to be guided and prompted
D	-.214	17	4	Cold, distant: formal, stilted, stiff manner; blandness, apathy

Key	e	f(%)		
D	0	8	5	Operated via a facade of self confidence while distress is evident; macho act; rigid posturing
L	-.296	21	6	Oriented to feelings: openly describes feelings; shows affect
D	-.362	13	7	Asks explicitly to be given direct advice

III. Overall impression of patient

D	-.362	13	1	Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive
D	-.121	13	2	Paranoid: externalizes; projects; is guarded, suspicious
D	-.289	8	3	Hostile aggressive: actively, obviously hostile and aggressive
D	-.369	25	4	Uses avoidance, escape: quits, runs away; cops out of difficulty
D	-.361	21	5	Situational problem reaction: well defined, limited, circumscribed situational difficulty
D	0	0	6	Unable to tolerate anxiety: "emergency," panicky

CHAPTER IV

THE THIRD VERSION OF THE CHECKLIST

Rationale for Version III

In addition to the need for cross validation of the scale presented as Version II, some additional modifications were indicated. Several items were dropped due to lack of discriminating ability, and the scoring system was changed to a four point scale from a three point scale.

Among the items dropped from Version II because of a lack of ability to differentiate between remainers and dropouts were: I-5, Divorce (family), I-12 Insulting: hypercritical outbursts; inner angers and hostility, II-1 Verbally fluent, II-2 Flighty, II-3 Passive, and II-5 Operated via a facade of self confidence.

Item I-6, Varying nurturant figures: shuttled from pillar to post in childhood, was found in Version I and in Version II to have a predictive sense opposed to that expected was dropped; this phenomenon is elaborated upon in the discussion of the results, below. Item I-11, Experiences depersonalization, also opposed in the expected sense of association in Versions I and II was dropped as a scorable item; it was retained for purposes of inquiry.

Version III of the checklist has an apparent 4 point scoring system; interviewers were asked to select from among the following choices of degrees of relevance of each item to the patient in question: N = Not at all indicated; W = Weakly indicated; M = moderately

indicated; S = Strongly indicated. This modification further clarified the center or "hedged judgment" position from Version II, and allowed us to evaluate the meaning of the interior pair more clearly; viz.: we scored again on the basis of a binary quantity (i.e., absent or present), and we grouped N and W responses a meaning item absent, M and S as present. This clarified somewhat the ambiguity of the score of P (partially indicated) in Version II, and forced the user to make a choice while he might gratify his need to hedge his judgment.

Table 7 presents Version III of the checklist. There are 18 items: nine in group I, three in group II, and six in group III. Of these, one is not for scoring (I-9); two are scored "L" (I-º and II-2); the remaining 15 are scored "D."

Method

Subjects

A section of the clinic files was randomly selected; files of children or of families in treatment were bypassed. For each of the remaining records in the section it was determined whether the patient could be considered clearly and unambiguously to be a dropout or a remainer. If it could not be determined, the record was bypassed for purposes of the study. If it could, the intake interview reports were separated from the files, keyed by file number for reassociation, stacked, read, and rated using the checklist. The reports and their respective files were then reassociated, and the rated checklist annotated to indicate whether the case was a dropout or a remainer, and the number of sessions kept. Demographic data were also noted at this time.

TABLE 7

VERSION III OF THE CHECKLIST

Case # _____ Age _____

Ethnic _____ Sex _____

Occup _____

Instructions: Please circle one of the four letters in the left margin for each item. Circle the N if the item is not at all indicated or mentioned. Circle the W if the item is weakly indicated. Circle the M if the item is moderately indicated. Circle the S if the item is definitely or strongly indicated. Please use the space at the bottom or on the back for any additional comments. Thank you.

I. Topics mentioned by patient during interview

N W M S 1 Using hard drugs; abusing drugs; alcoholism (self)

N W M S 2 Using hard drugs; abusing drugs; alsoholism (family)

N W M S 3 Conduct problems: difficulties with authorities (school, law, etc.)

N W M S 4 Divorce; break-up of serious affair

N W M S 5 Frequent or highly significant residence changes; cultural transplants

N W M S 6 Frequent, poorly planned changes in goals, jobs (self)

N S M S 7 Frequent, poorly planned changes in goals, jobs (family)

N W M S 8 Remorse, depression, guilt, shame, worthlessness, suicidal ideas

N W M S 9 Experiences depersonalization; feels strange, outside of self

II. Behavior and attitudes during interview

N W M S 1 Cold, distant: formal, stilted, stiff manner; blandness, apathy

N W M S 2 Oriented to feelings; openly describes feelings; shows affect

N W M S 3 Asks explicitly to be given direct advice

TABLE 7--Continued

III. Overall impression of patient

N	W	M	S	1	Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive
N	W	M	S	2	Paranoid: externalizes; projects; is guarded, suspicious
N	W	M	S	3	Hostile aggressive: actively obviously hostile and aggressive
N	W	M	S	4	Uses avoidance, escape: quits, runs away; cops out of dicciculty
N	W	M	S	5	Situational problem reaction: well defined, limited, circumscribed situational difficulty
N	W	M	S	6	Unable to tolerate anxiety; "emergency,: panicky

The subjects included 24 remainers and 24 dropouts. Among the remainers there were 12 males and 12 females; their average age was 24.7 years; their mean number of sessions was 37.9 with SD of 11.9. The dropouts included 10 males and 14 females; average age, 23.9 years; mean number of sessions, 5.1, SD of 5.3.

Procedure

Reliability was again evaluated as a subscale of both prior versions. Additionally, a group of eight judges rated a single interview, presented on videotape to a seminar in interviewing; the judges consisted of the graduate students in the seminar and the professor conducting.

Validity was studied by having the author rate the randomly selected clinic file intakes, and associate the scores with the likelihood of remaining in therapy.

The 24 remainers and 24 dropouts were divided into four subgroups for the purpose of cross validation. Thus the data from 12 remainers (group one LT's) and 12 terminators (group one DO's) were analyzed separately from those of the other 12 remainers (group two LT's) and the other 12 terminators (group two DO's). The purpose of this analysis was to develop from the one group of remainers and terminators a measure for "predicting" the results in the second group, and vice versa.

Results

Reliability

The additional measure of reliability (interjudge agreement)

obtained showed that among eight judges the mean agreement over all items was 83.9%. The frequency distribution of percentage agreement ranged from 60% to 100%. The modal agreement was 80%.

Predictive validity

A summary of obtained D, L, and D-L scores is presented in Table 8. It can be clearly seen that the mean D and the mean D-L scores differ significantly between remainers and terminators in the "prediction" group and in the "cross validation" group (groups one and two, respectively).

Correlation coefficients linking Plt with both D and D-L for each of the two groups and for the combined data were calculated. For group one, the correlation between Plt and D-L was -.630 (p = .0012). The Correlation between Plt and D was -.664 (p = .006). For group two, the correlation between Plt and D-L was -.555 (p = .005). The correlation between Plt and D for group two was -.498 (p = .012). For the combined groups, the correlation between Plt and D-L was -.629 ($p < .001$). The correlation between Plt and D for the combined data was -.591 ($p < .001$).

The e values for each item were calculated. Table 9 shows these values, the frequency of occurrence (f) and scoring key for each item. The presented data reflect combined groups. For Version III of the checklist mean /e/ was .207, with a standard deviation of .122; this represents a significant increase over the level attained in Version I (t = 2.083, df = 66, p = .04). The mean frequency of occurrence remained constant at 21.6%, with a standard deviation of 15.7%.

TABLE 8

MEANS, STANDARD DEVIATIONS, *t*'s, AND PROBABILITY OF *t*'s OBTAINED FOR THE SCORES D, L, AND D-L, FOR GROUPS ONE AND TWO AND FOR BOTH GROUPS COMBINED, FOR BOTH REMAINERS AND DROPOUTS, ON VERSION III

	Group one (N = 24)			(Group two (N = 24)			Both groups (N = 48)		
	D	L	D-L	D	L	D-L	D	L	D-L
Remainers									
Mean	1.58	.917	.667	2.17	0.75	1.42	1.88	.833	1.04
SD	1.44	.793	1.15	1.27	.866	.996	1.36	.835	1.12
Dropouts									
Mean	4.33	.583	3.75	3.75	.583	3.17	4.04	.583	3.45
SD	1.78	.669	2.01	1.60	.669	1.53	1.68	.669	1.77
t	3.98	1.07	4.42	2.57	.507	3.18	3.31	.775	3.82
p	.001	NS	.001	.017	NS	.004	.002	NS	.001

TABLE 9

SCORING KEY, e VALUES, AND FREQUENCY OF OCCURRENCE (f), FOR VERSION III

Key	e	f(%)		
I. Topics mentioned by patient in interview				
D	-.308	21.7	1	Abusing drugs; alcoholism (self)
D	-.225	17.4	2	Abusing drugs; alcoholism (family)
D	-.206	10.9	3	Conduct problems: difficulties with authorities (school, law, etc.)
D	-.216	41.3	4	Divorce; break-up of serious affair
D	-.085	47.8	5	Frequent or significant residence changes; cultural transplants
D	-.227	32.6	6	Frequent, unplanned changes in goals, jobs (self)
D	-.162	19.6	7	Frequent, unplanned changes in goals, jobs (family)
L	+.171	47.8	8	Remorse, depression, guilt, worthlessness, etc.
L	-.098	20.8	9	Experiences depersonalization
II. Behavior and attitudes in interview				
D	-.296	15.2	1	Cold; formal; bland, apathetic; stiff
L	+.097	26.1	2	Oriented to feelings; shows affect
D	-.206	10.9	3	Asks explicitly to be given direct advice
III. Global impression of patient				
D	-.162	19.6	1	Narcissistic: conceited; prancing; seductive
D	-.509	15.2	2	Paranoid: externalizes, projects; suspicious

TABLE 9--Continued

Key	e	f(%)		
D	-.257	6.5	3	Hostile aggressive: actively, obviously hostile
D	-.269	19.6	4	Uses avoidance, escape: quits, runs away
D	-.177	15.2	5	Situational problem reaction
D	+.145	2.2	6	"Emergency," unable to tolerate anxiety

Prediction

Based on the D-L score, selecting a cutoff at the mean, the results obtained from Group One were used to "predict" the remainers and dropouts in Group Two; then vice-versa. The mean D-L score in Group One was 2.21. We predicted that Group Two subjects with D-L greater than two would be dropouts, and that Group Two subjects with D-L $\leq$ two would be remainers. We correctly predicted 11 of the 12 remainers (remainer accuracy, 91.7%) and 8 of the 12 dropouts (dropout accuracy, 66.7%) for an overall accuracy of 79.2%.

The mean D-L score in Group Two was 2.29. Thus, the prediction rule applied to Group One was identical to that applied to Group Two: predict dropout if D-L $>$ 2, remainer if D-L $\leq$ 2. We correctly predicted 11 of the 12 remainers (remainer accuracy, 91.7%) and 9 of the 12 dropouts (dropout accuracy, 75%) for an overall accuracy of 83.3%.

Combining both groups we found the probability of a false dropout prediction (defined as 1 - remainer accuracy; also, Type I error) to be .083. The probability of a false remainer prediction (1 - dropout accuracy; Type II error) was .292. The overall accuracy of the prediction using D-L as predictor was 81.25%.

Based on the D score, and selecting a cutoff at the mean, the results in Group One were used to predict the remainers and dropouts in Group Two and vice versa. Now the mean D score was 2.96 in each of the two groups, so a cutoff was selected accordingly: we predicted that subjects with D $\leq$ 2 would be remainers, and that subjects with D $\geq$ 3 would be dropouts. In Group One we correctly predicted 75% of the remainers and 83.3% of the dropouts for an overall accuracy of 70.8%.

In Group Two we correctly predicted 83.3% of the remainers and 91.7% of the dropouts for an overall accuracy of 87.5%.

Combining both groups we found the probability of a false dropout prediction to be .208 and the probability of a false remainer prediction to be .125. The overall accuracy of the prediction using D was 79.2%. Using D as a predictor for these samples yielded a decrease in the probability of false remainer errors of 57.2% compared with that obtained using D-L. The cost for this change was a 150% increase in false dropout errors.

Relative evaluation of contributing cues

The 10 remaining characteristics presumed to be involved in predicting dropouts vs. remainers were evaluated by a proportional assessment of e, the item-criterion correlation coefficient, for each item. As an example of the process, consider item I-3, Conduct problems. Locate the corresponding item in Version I (using Appendix I). The required item is I-2. Next locate this item in Table 11 in Appendix 7. The related cues are coded A1b, A5, A6, and C2. Find these cues in Table 10 in Appendix 7, noting that our item, I-2 in Version I, is listed for all the cues. The four cues presumed to be inferred by the Conduct problems item are: poorly tolerated anxiety, hostility, impulsiveness, and situational problems. Next find the e value for this item in Table 9; it is -.206. This value is to be apportioned among the four cues, adding -.0515 to each cue. This process is repeated for each item, forming sums for each of the 10 cues.

The absolute values of the resulting sums were then ranked in order to assess the hierarchy of importance of the cues. The resulting

list was: 1) Impulsivity and the tendency to act out (A6); 2) Situational problems (C2); 3) Defensiveness (A2); 4) Poorly tolerated anxiety (A1[b]); 5) Inconsistency, erratic behaviors (A7[b]); 6) Hostility (A5); 7) Diagnosis of depressive reaction (B2); 8) Self doubts and dissatisfactions (A9); 9) Verbal fluency (A11); 10) Personal problems (C1).

It should be recognized that as a result of refining the instrument several cues were dropped. See discussion below.

Contributions of patient report, behavioral observation, and global impression items to the judgment process

In order relatively to assess the contribution of each of the three groups of input to the clinical judgment process, /e/ values associated with the items in each group were averaged. We then calculated the percentage of overall /e/ apportioned to each group. Group I, patient report, had a mean /e/ of .200, with 49% of overall /e/. Group II, behavioral observation, had a mean /e/ of .200, with 18.4% of overall /e/. In Group III, global impression, the mean /e/ was .178, with 32.7% of overall /e/. Chi-squared analysis comparing obtained percentages with percentages predicted under the assumption that the overall mean /e/ were equally apportioned among the items in all three groups showed no significant deviation between the assumed and observed distributions: $\chi^2 = .303$, $df = 2$, $p = .862$. In fact, an analysis of the variance showed $F = .034 < 1$; i.e., there was more variation among the items within each of the three groups than there was between the three groups.

CHAPTER V

DISCUSSION

The Results Obtained with Version III

Reliability

The overall reliability of the instrument was adequate. Considering the fact that the raters in the group of eight who judged a videotaped interview had scant training--they had just been introduced to the instrument--we could expect even higher higher agreement with experienced raters. The higher reliability obtained with Version I, despite its length, was due to the considerably better trained judges.

We also discovered during a discussion after rating had occurred that three of the eight judges recognized their having "forgotten" or "neglected" some relevant items. One of these judges is an interviewer with considerable experience and expertise. These incidents underscore the necessity for a careful, attentive attitude during rating.

Rating from a live intake entails the processing of more data than is available to judges who are rating intake interview reports. In the live situation, the data acquisition must occur in real time in the presence of what could be a glut of information; nevertheless there is more data available. Lapses in attention in the live situation mean lost data; when rating from a document, looking back is possible.

The reliability study for Version I and the predictive validity studies for Versions I, II, and III were all conducted using data from

secondary sources. The scores obrained for each subject were taken entirely from the intake interview reports. These reports were of variable quality; sometimes relevant aspects of patient history were omitted; occasionally important questions were not asked. The raters often wished that they could conduct the interviews themselves. Despite these difficulties, the results were impressive.

Prediction with the instrument

Based on the results presented above, the instrument is useful in predicting dropouts from psychotherapy. The instrument has potential use as a research tool, as a clinical screening device, and as an adjunct to training. As a research tool the checklist has applications in studying dropout correlates in varying patient populations, and in selecting patients as subjects and controls for experimental modalities of treating dropouts. In a clinic the instrument could be used to identify potential dropouts, separating them from remainers for administrative and therapeutic efficiency. Queues could be shortened by having two or more "tracks." In training, the instrument would be useful for selecting patients for various kinds of treatment to be taught and administered; this would promote better patient-therapy matches and more efficient training.

Using the instrument

There is a choice to be made both in selecting a criterion score (D or D-L), and in choosing a cutoff point (between 0 and 1, between 1 and 2, . . . between 4 and 5). For our patient population we found that D-L was the most useful score and 2.5 the most useful cutoff

point. Ignoring the contribution of the L items and thereby relying on D alone for prediction results in a marked decrease in sensitivity to remainers; i.e., an increase in Type I errors, false positive prediction of dropout, at all considered cutoff levels. Utilizing the L scores to reduce the impact of the D total yields a predictor which is considerably more sensitive to remainers while only slightly increasing the likelihood of false detection of a remainer (i.e., of making a Type II error).

For both D and D-L, as the value selected for cutoff increases from 0.5 to 4.5, the probability of a false dropout error decreases while the probability of a false reaminer error increases. The overall accuracy follows an inverted U curve, peaking at a cutoff of 2.5, a point at which both false detection errors are fairly low. Using 2.5 as cutoff and D-L as predictor, our cross validation samples showed that the probability of a false dropout was .0833 or 1 out of 12, that the likelihood of a false remainer was .2917 or 7 out of 24, and that the overall accuracy was 81.25%. This is a substantial increase in accuracy over Hiler's (1959b) findings of 71% for the sentence completion test, 68% for Rorschach number of responses, 65% for the Wechsler--Bellevue IQ, and 68% for clinicians' global impressions.

Inextricably interwoven with improved techniques are attendant policy changes. The criteria selected above for discriminating between remainers and dropouts using the instrument makes it 3.5 times more likely that a dropout might slip through the net than that a remainer would be incorrectly labeled. This is fortuitous; however, it underscores the necessity of making policy both cognizant of the special

problems inherent in treating dropouts, and sufficiently flexible to allow for changes in therapeutic approach when the latter are strongly indicated.

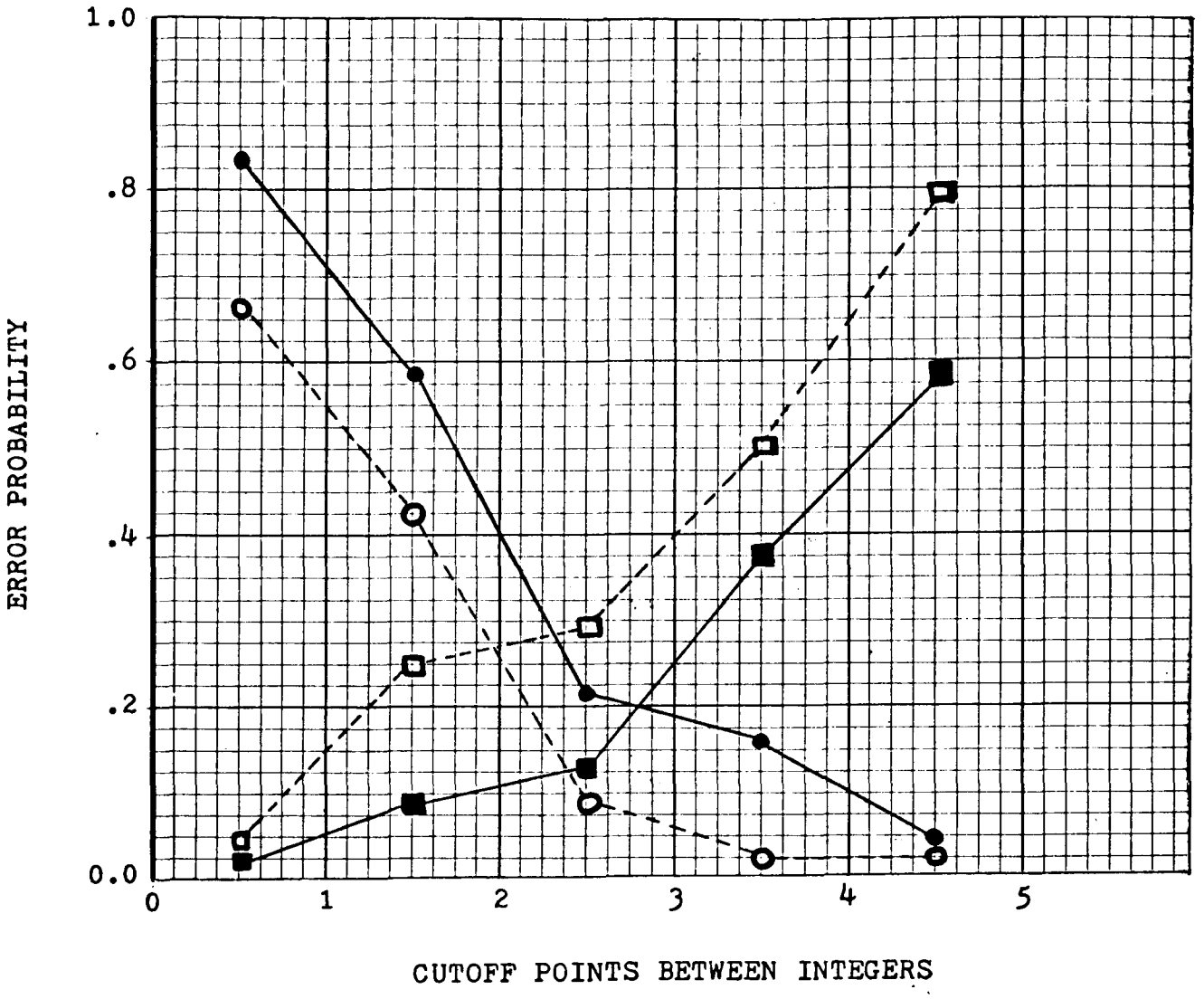
Similarly, the instrument is flexible and can be adapted to a variety of clinical needs. In a situation where it is of stringnet importance for training purposes to exclude dropouts, false remainer errors must be minimized. This can be realized by decreasing the cutoff point, e.g., from 2.5 to 1.5, using D along and ignoring L. This results in an accuracy of 66.7%, with a probability of a false dropout error of .4167, and a probability of a false remainer error of only .0833. On the other hand, where an experimental modality for treating dropouts may be under investigation, the instrument could be used as a screening device to select dropouts. For this purpose the cutoff criteria could be tuned as follows: raise the threshhold to 3.5 and use D-L as predictor, resulting in an accuracy of 75%, a false dropout error probability $< .02$, and a false remainer error probability of 0.5. See Figure 1 for a presentation of the variation of false dropout and false remainer errors in our sample as functions of predictor variable and of cutoff point.

Modifications to the Instrument

The evoluation of Version III

From a 51 item questionnaire (Version I) we have evolved a 17 item instrument. In the course of the modifications, two items have been expanded (Version I: I-1 and I-8 to Version III: I-1,2 and I-6,7), one item has been added (Version II and Version III: III-6), and 37 have been dropped (see below).

Figure 1. Probabilities of False Remainer and False Dropout Errors as functions of Predictor Variable choice and Cutoff Point.



In going from the first to the second version, three items had been expanded in order to separate the patient's experience from those of his family members. In Version I, Drug abuse (I-1) was found reversed in direction of association; in Version II (I-1,2) and Version III (I-1,2) this item pair was found to be associated in the expected manner. The result in Version I was probably an anomaly of the sample, not a function of the self or the family; these items could be condensed again. No advantage was realized in expanding item I-8 on Version I, Frequent job/goal changes, to items I-8,9 (Version II) or I-6,7 (Version III). These items could also be condensed, both aspects contributing to the total D score.

We did obtain clarification by expanding Version I item I-5, Divorce, into Version II items I-4,5. We found that the unanticipated sign of the e result in Version I was again likely a sampling error; in Version II the e of the item referring to the patient's experience was of the expected sign and had a moderate amplitude. The e of the family members item had a zero association despite a higher than average frequency. Therefore, in Version III we retained the item (I-4) exactly as it had appeared in Version I; its e had the expected sign, and its amplitude and frequency were above average.

Item III-6 in Versions II and III had been added to assess the predictive potential of a type of patient only recently noted in quantity at the clinic: the panicky, "emergency" intake patient. The results of our study are ambiguous on this point: on the basis of the relationship to situational problems and to the extent to which

the patients are understood to be escaping intolerable anxiety, this item could be associated with dropouts. However, we must consider that the syndrome of an anxiety reaction may be present, implying a remainer (Frank et al., 1958). Our findings show a below average e with a sign associated with remainers. Yet the low incidence (0 in Version II, 2.2% in Version III) mitigates against accepting this verdict as final. This is a conceptually sound item which we could not exploit due to sampling characteristics.

Among the 37 items dropped, seven potential cues have been struck from consideration in the present form: flexibility, hopefulness, persistance, introspectiveness, diagnosis of anxiety reaction, the expression of and tolerance for anxiety, and suggestibility and dependency.

The items to be dropped were usually selected by statistical procedures; in two cases this was not so. Varying nurturant figures: shuttled from pillar to post in childhood was found both in Versions I and II to yield a result opposite to that predicted. The expectation had been that this item would reflect a failure to form lasting personal ties (Rubinstein & Lorr, 1956); hence a lack of persistance, under-developed superego, and erratic behaviors follow (Fenichel, 1945). Instead of the expected acting out tendency, this factor in certain constellations may be acting to reinforce the therapeutic alliance in the hope of working through the need for a constant, consistent object (Waelder, 1960).

Similarly, Experiences depersonalization; feels strange, outside of self was found in working with Versions I and II to have a higher than average estimator opposed in sign to that expected. Frequently

a symptom of serious disturbance, we predicted that this topic would be associated with remaining (Frank et al., 1957; Hiler, 1959a; Katz & Solomon, 1958). It may that this experience, common but transient in normals (Buss, 1961), is part of a pattern of a withdrawn personality resisting changes (Fromm-Reichmann, 1950). Or, an extremely short cathartic therapy entered into after a frightening experience like drug induced depersonalization may be quickly terminated once the cathartic aim has been achieved (cf., Heilbrun, 1974); this speculation is consistent with the moderate and homogeneous levels of dysfunction encountered in the patients sampled. It was decided to retain this item in Version III for purposes of inquiry only, not scoring. The resulting e and f showed a persistent negative sign, albeit lower in magnitude, and an equally persistent average frequency; this lends support to the alternative hypotheses.

Suggestions for further revisions

In an environment similar to that from which the subjects used in the cross validation study were drawn, the instrument could be used successfully as is. It might be further streamlined by recombining the drug abuse items (I-1 and 2) and the frequent, unplanned goal changes items (I-6 and 7), and by eliminating the depersonalization (I-9) and emergency/panic (III-6) items. This sketched refinement makes the instrument easier to use (only 14 items) without rendering it useless.

Since the prediction studies quoted above used scores obtained from a single rater, the author, there may be a skewed impression in the results due to rater style. In a clinic setting where the checklist

were being used as a screening device by a staff of interviewers, recalibration of cutoff points might be required.

In view of the narrow patient population, college undergraduates, and of the fact that most of the intake interviewers and therapists were novices, the results of our development from Version I to Version III might be too restrictive from another perspective, e.g., a Community Mental Hygiene Clinic. In an environment with a staff of highly skilled interviewers and therapists and with a broad range of patients, the process of evolution as done in our study, based on Version I as starting point, is a useful guideline. This allows the development of a situationally tailored instrument. The item-criterion correlation coefficient, e, serves as the prime index of quality for decisions about item retention; the frequency of occurrence, f, is a secondary index.

The Status of Fundamental Assumptions in the Last Version

Cues: the bases for clinical inference

As a result of the modifications dictated by the goal of an instrument with predictive validity, some fundamental cues in the construction of the checklist as it initially took shape were discarded; others were strengthened. Among the cues which we were unable to detect such that they might contribute to a useful predictive score were the following: the diagnosis of anxiety reaction; the personality traits of flexibility, hopefulness, persistence, introspectiveness, suggestibility and dependency, and anxiety tolerance.

The cues which we were able to detect and to use in making

predictions about the tendency to drop out vs. the tendency to remain in treatment were, in order of relative predictive value: (1) Impulsivity and the tendency to act out, (2) Situational problems, (3) Defensiveness, (4) Anxiety intolerance, (5) Inconsistency, erraticism, (6) Hostility, (7) Diagnosis of depressive reaction, (8) Self doubts and dissatisfactions, (9) Verbal fluency, (10) Personal problems.

Impulsivity and the tendency to act out is the cue which enjoys the most widespread support as a correlate of psychotherapy dropouts (Frank et al., 1957; Hiler, 1959a,b; Katz & Solomon, 1958; Kline & King, 1973; Lorr et al., 1958; Rubinstein & Lorr, 1956). Our finding this trait to be first confirms the previous findings and the ease with which it is detected, occurring dramatically as aggressive outbursts, difficulty with authorities, restlessness, impatience, and irresponsibility.

Situational problems were also easily detected and properly associated with the tendency to drop out. They, too, are fairly obvious; the sense of the locus of the difficulty is experienced as outside of the patient (Frank et al., 1957; Hiler, 1959a; Katz & Solomon, 1958).

Defensiveness was easily detected, primarily by the behavior during the interview: coldness, excessive distance or formality, blandness, or apathy. Here, too, we have a striking characteristic easily observed (Fromm-Reichmann, 1950). The global indication of a paranoid character structure added only slightly to the detection of defensiveness in our sample.

Anxiety intolerance was detected by a variety of signs indicating

an inclination to avoid anxiety: drug abuse, running away from problems, hostility, narcissism, conduct problems. There were numerous patients who could tolerate anxiety or revealed some symptoms of anxiety reaction; however, these cues could not discriminate between dropouts and remainers on our instrument. On Version I there were seven items keyed to anxiety tolerance/anxiety reaction, with 12 items keyed to anxiety intolerance. Version II had only one keyed to anxiety tolerance; seven were keyed to anxiety intolerance. By Version III, the last remaining item keyed to tolerance had been discredited, while six items remained keyed to intolerance of anxiety.

Inconsistency, erraticism as a cue was successfully inferred by mention of divorce, and frequent, dramatic residence and/or goal changes. However, its opposite, persistence, could not be detected and linked to a firm valence; those items intended to tap this trait, logical order, intellectual and introspective styles were equivocal in their association with dropouts. Note that the trait of introspectiveness is also related to these items, failures in discriminating between terminators and remainers.

Items relating to suggestibility and dependency, although high in frequency, were ambiguous in association. Signs of flexibility and of hopefulness were rare and ambiguous in their manner of association with target criteria. It is appropriate to note that in the population from which our samples were drawn the traits of anxiety tolerance, flexibility, hopefulness, persistence, introspectiveness, and dependency are fairly widespread: a college campus, with its emphasis on achievement, intelligence, delayed gratification, a "liberal education,"

and youth. It is therefore not surprising to find that these traits occur equally among dropouts as among remainers.

The five remaining cues were easily detected and were moderately useful in predicting the tendencies in the expected directions. Hostility was indicated by global impression and by a history of conduct disorders. Depressive reaction was indicated by depressive ideation and affect, as were Self doubts and dissatisfactions and Personal problems, the opposite of Situational difficulties. Verbal fluency was indicated by a willingness to talk about affect laden, feeling oriented data.

Input to the judgment process

It was found that the items in each of the three groups (Group I, patient report; Group II, behavioral observation; Group III, global impression) were approximately equal in contribution to overall prediction. No single group contained items which were more powerful predictors than other groups. The strength of the prediction of each group varied as a function of the number of items in each group, not as an inherent function of the group per se. Thus Group I, patient report, accounted for 49% of the total /e/ in our sample primarily because 8 of the 17, or 47.1%, of the items are in Group I. Extrapolating from this conclusion we may assert that in our sample global impression was 1.78 times as fecund as behavioral observation as a source of cues for clinical judgment. Similarly, patient report was 2.66 times as fertile as behavioral observation.

Conclusion

Our study showed that is possible to develop a simple, easy to

use checklist, relying solely on data obtained during an initial interview, which is capable of providing a consistent index of the likelihood of the patient's being a remainer or a dropout. In order to do so we have ignored some of the traditional variables in the dropout equation: patient motivation, patient expectation, and therapist variables; we have attempted to control for socioeconomic variables by restricting our devleopmental work on our instrument to a population which is homogeneous in socioeconomic status. If desired, the checklist could be recalibrated in a setting which includes patients with a broader range of socioeconomic backgrounds. This could serve to adapt the instrument to a new environment and to test the imapct of socioeconomic status on the instrument's present form.

APPENDIX 1

PART I OF SCORING GUIDE

Guide to Scoring Intake Interviews. 1.

Issues and topics mentioned by patient during intake, regarding self and/or family of origin

1 D Using hard drugs; abusing drugs; alcoholism

2 D Conduct problems; difficulties with the law or other authorities

3 D Promiscuity; sexual acting out

4 D Physical abuse; violence

5 D Divorce; break-up of serious affair

6 D Varying nurturant figures; shuttled from pillar to post in childhood

7 D Frequent or highly significant residence changes; cultural transplants

8 D Frequent and/or poorly planned changes in jobs and/or goals

9 L Quarrels, arguments as an important complaint

10 L Unusual traumata: early death of parent, concentration camp history, etc.

11 L Tantrums in childhood

12 D Suddenly, impulsively, unplanned leaving home

13 L Refers to own adaptability, resourcefulness, flexibility, compromising nature, sense of humor

14 L Suffers anxiety attacks; feels anxious

15 L Self doubts and/or dissatisfactions; feels insecure and/or inferior; uncertainty; lack of confidence; feels stupid, ugly, etc.

16 L Feels remorseful, depressed, guilty, ashamed, worthless; suicidal ideas

17 L Feels different; outsider

18 L Experiences depersonalization; feels strange, outside of self

19 D Refers to inappropriate, defiant, self-defeating acts of pseudo-independence

20 L Seeks and/or needs approval; fears and/or avoids disapproval

21 L Needs and/or seeks and/or wishes to depend on someone

22 L Insulting behavior; hypercritical outbursts

23 L Resentment; jealousy

24 L Loneliness; lack of friends

25 L Refers to "inner anger and hostility"

APPENDIX 2

PART II OF SCORING GUIDE

Guide to Scoring Intake Interviews. 2.

Behavior and attitudes evident during the interview

1 L Verbally fluent: spoke easily, readily, spontaneously; showed little difficulty with words as medium

2 D Flighty: flitted from topic to topic

3 L Logical, orderly presentation of data; controlled attitude to data

4 D Guarded, cautious in revealing personal data; suspicious and questioning of motives of interview, interviewer, confidentiality; gives evasive answers to personal questions

5 L Passive: needs to be guided and prompted

6 D Hostile: expresses anger toward interview, interviewer, Center, etc.

7 L Depressed: sad, tearful, blocked

8 D Cold, distant: formal, stilted, stiff manner; blandness

9 L Warm, humorous: genuinely warm, friendly, likeable, open, affable; relaxedly confident; able to laugh at self; showed sense of humor

10 D Operated via a facade of self confidence, while distress evident; macho act; rigid posturing

11 D Controlling: deals with self selected issues; wrests control of interview, doesn't respond to specific questions directly

12 L Oriented to feelings; openly describes feelings; shows some affect

13 D Asks explicitly to be given direct advice

APPENDIX 3

PART III OF SCORING GUIDE

Guide to Scoring Intake Interviews. 3.

Overall impression of patient

1 D Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive

2 L Hysterical: dramatic; labile; free expression of affect; flirtatious, "la belle indifference"

3 D Paranoid: externalizes; projects; is guarded, suspicious

4 L Not assertive: picked on; taken advantage of; used; fails to stand up for self; scapegoated; Passive aggressive: subtly, indirectly, inactively aggressive

5 D Hostile aggressive: actively, obviously hostile and aggressive

6 D Controlling and/or manipulative: tries to control others; wishes to change others; seeks power over others

7 L Childlike and/or immature: naive; not planning ahead; goals without means-end cognizance; age inappropriate behavior

8 L Conventional: prefers conformity to autonomy

9 D Uses avoidance and/or escape: quits; runs away; leaves difficulties

10 L Intellectualizes: rationalizes; seeks explanations

11 L Psychologically minded: reflective; introspective; seeks explanations within self

12 D Don Juan, Casanova: seeks love and attention; insatiable need for sexual conquest

13 D Situational problem reaction: patient experiencing a well defined, limited circumscribed, situational difficulty

APPENDIX 4

SCORING SHEET OR "CHECKLIST"

Topics occurring in interview

1 D Drugs/alcoholism

2 D Conduct/legal problems

3 D Promiscuity

4 D Physical abuse

5 D Divorce

6 D Varying nurturant figures

7 D Frequent/dramatic moving

8 D Frequent job/goal changes

9 L Quarrels, arguments

10 L Unusual traumata

11 L Tantrums

12 D Suddenly leaving home

13 L Adaptability, humor

14 L Anxiety

15 L Doubt, insecure, inferior

16 L Remorse, depression

17 L Feeling different

18 L Depersonalization

19 D Defiant independent acts

20 L Seeks approval/fears disapproval

21 L Seeks dependency

22 L Insulting behaviors

23 L Resentment

24 L Loneliness; lacks friends

25 L Inner anger and hostility

(continued)

Behavior during interview

1 L Verbally fluent

2 D Flighty

3 L Logical, orderly

4 D Guarded/suspicious/evasive

5 L Passive

6 D Hostile

7 L Depressed

8 D Cold, distant

9 L Warm, humorous

10 D Facade of confidence

11 D Controlling

12 L Feeling oriented

13 D Asks for direct advice

Overall impression of patient

1 D Narcissistic

2 L Hysterical

3 D Paranoid

4 L Unassertive/Passive aggressive

5 D Hostile

6 D Controlling/manipulative

7 L Childlike, immature

8 L Conventional

9 D Uses avoidance/escape

10 L Intellectualizes

11 L Psychologically minded

12 D Don Juan

13 D Situational problem reaction

APPENDIX 5

VERSION II OF THE CHECKLIST

Intake Interview Checklist

Case #_____ Age _____

Sex _____ Race _____

Occup _____

Instructions: Please circle one of the three letters in the left margin for each item. Circle the N if the item is not indicated or not mentioned. Circle the P if the item is partially or slightly indicated. Circle the Y if the item is strongly or definitely indicated. Please use the space at the bottom and back of the sheet for any additional comments, notes or observations you feel relevant. Thank you.

I. Topics mentioned by patient during interview

N P Y 1 Using hard drugs; abusing drugs; alcoholism (self)

N P Y 2 Using hard drugs; abusing drugs; alcoholism (family)

N P Y 3 Conduct problems: difficulties with authorities (school, law, etc.)

N P Y 4 Divorce -- break-up of serious affair (self)

N P Y 5 Divorce (family)

N P Y 6 Varying nurturant figures; shuttled from pillar to post in childhood

N P Y 7 Frequent or highly significant residence changes; cultural transplants

N P Y 8 Frequent, poorly planned changes in goals, jobs (self)

N P Y 9 Frequent, poorly planned changes in goals, jobs (family)

N P Y 10 Remorse, depression, guilt, shame, worthlessness, suicidal ideas

N P Y 11 Experiences depersonalization; feels strange, outside of self

(continued)

N P Y 12 Insulting; hypercritical outbursts; inner anger and hostility

II. Behavior and attitudes during interview

N P Y 1 Verbally fluent: spoke easily, readily, spontaneously; no difficulties with words as medium

N P Y 2 Flighty: flitted from topic to topic

N P Y 3 Passive: needs to be guided and prompted

N P Y 4 Cold, distant: formal, stilted, stiff manner; blandness, apathy

N P Y 5 Operated via a facade of self confidence while distress is evident; macho act; rigid posturing

N P Y 6 Oriented to feelings; openly describes feelings; shows affect

N P Y 7 Asks explicitly to be given direct advice

III. Overall impression of patient

N P Y 1 Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive

N P Y 2 Paranoid: externalizes; projects; is guarded, suspicious

N P Y 3 Hostile aggressive: actively, obviously hostile and aggressive

N P Y 4 Uses avoidance, escape: quits, runs away; cops out of difficulty

N P Y 5 Situational problem reaction: well defined, limited, circumscribed situational difficulty

N P Y 6 Unable to tolerate anxiety; "emergency," panicky

APPENDIX 6

VERSION III OF THE CHECKLIST

Intake Interview Checklist

Case #_____ Age _____

Ethnic _____ Sex _____

Occup _____

Instructions: Please circle one of the four letters in the left margin for each item. Circle the N if the item is not at all indicated or mentioned. Circle the W if the item is weakly indicated. Circle the M if the item is moderately indicated. Circle the S if the item is definitely or strongly indicated. Please use the space at the bottom or on the back for any additional comments. Thank you.

I. Topics mentioned by patient during interview

N W M S 1 Using hard drugs; abusing drugs; alcoholism (self)

N W M S 2 Using hard drugs; abusing drugs; alcoholism (family)

N W M S 3 Conduct problems: difficulties with authorities (school, law, etc.)

N W M S 4 Divorce -- break-up of serious affair

N W M S 5 Frequent or highly significant residence changes; cultural transplants

N W M S 6 Frequent, poorly planned changes in goals, jobs (self)

N W M S 7 Frequent, poorly planned changes in goals, jobs (family)

N W M S 8 Remorse, depression, guilt, shame, worthlessness, suicidal ideas

N W M S 9 Experiences depersonalization; feels strange, outside of self

(continued)

II. Behavior and attitudes during interview

N W M S 1 Cold, distant: formal, stilted, stiff manner blandness, apathy

N W M S 2 Oriented to feelings; openly describes feelings; shows affect

N W M S 3 Asks explicitly to be given direct advice

III. Overall impression of patient

N W M S 1 Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive

N W M S 2 Paranoid: externalizes; projects; is guarded, suspicious

N W M S 3 Hostile aggressive: actively obviously hostile and aggressive

N W M S 4 Uses avoidance, escape: quits, runs away; cops out of difficulty

N W M S 5 Situational problem reaction: well defined, limited, circumscribed situational difficulty

N W M S 6 Unable to tolerate anxiety; "emergency," panicky

APPENDIX 7

CUES IN ASSESSING THE LIKELIHOOD OF A PATIENT'S DROPPING OUT

The literature cited above implies that some patient personality traits, diagnoses, and presenting problems may be useful in assessing the likelihood of a patient's prematurely terminating psychotherapy.

A. The personality characteristics under consideration are:
   1. anxiety: the tolerance for, and the expression of
   2. defensiveness
   3. flexibility; a compromising nature
   4. hopefulness
   5. hostility
   6. impulsivity and the tendency to act out
   7. persistence
   8. psychological mindedness and introspectiveness
   9. self doubts and dissatisfactions
   10. suggestibility and dependency
   11. verbal fluency: general and personal.

B. The diagnoses considered are:
   1. anxiety reaction
   2. depressive reaction

C. The presenting problem polarities are:
   1. personal problems
   2. situational difficulties.

Each cue is considered, as reported and cited in the literature, to relate to dropping out from or to relate to a long term commitment to psychotherapy. Cues associated with dropping out are coded "D," those associated with long term therapy, "L." Each cue, sign, and citation will be presented with the method or methods used by the researchers to assess the presence of the given cue. The manner in which the cue may be inferred from statements made by the patient, from the patient's behavior in the interview, and from a global clinical impression of the patient will be described.

The checklist has been compiled in such a way as to separate the three areas of information input involving three degrees of objectivity: (I) Issues and topics mentioned by patient during intake interview; (II) Behavior and attitudes observed during the interview; and (III) Overall impression of patient. The degrees of objectivity range from explicit statements made by the patient, through observed behavior, to subjective impression by the interviewer.

The Guide to Scoring Intake Interviews is presented in Appendixes 1, 2, and 3; the checklist for scoring the interviews is presented in Appendix 4. They are subdivided into the levels of inference described above.

The rationale, type of data, and documentation for the relationship between dropping out and the specific personality characteristics, diagnoses, and types of presenting problems are presented below. For each cue the checklist items are identified according to level of inference (I, II, or III) and item number within the section.

A. Personality Characteristics

1. Anxiety.

Frank et al. (1957): diagnosis of anxiety reaction; Taylor Manifest Anxiety Scale

Hiler (1958): Wechsler-Bellevue Test

Hiler (1959a): presenting complaint

Lorr, Katz, and Rubinstein (1958): short form of Taylor scale; interviewer rating

Taulbee (1958): MMPI and Rorschach

(a): the presence of and tolerance for anxiety: L

The verbalized report of anxiety is an acceptable indicator in the interview (see item I-14, Appendix 1). The complaint of quarrels and arguments as a significantly felt problem (I-9) suggests the presence of a strongly experienced interpersonal anxiety as irritability (Buss, 1966, pp. 51, 65). Verbal fluency in the interview (II-1), orderly speech (II-3), an intellectual approach (III-10), and introspectiveness (III-11) are indicators of a tolerance for the anxiety inherent in the situation (Fromm-Reichmann, 1950).

(b): poor tolerance for anxiety: D

Drug abuse and alcoholosm (I-1), conduct problems (I-2), promiscuity (I-3), flighty speech (II-2), anger at interview(er) (II-6), attempts to control the interview (II-11), and the personal styles of narcissism (III-1), paranoia (III-3), aggressive hostility (III-5), manipulativeness (III-6), avoidance (III-9), and Casanovism (III-12) each indicate an inability to tolerate anxiety and a strong bent towards inappropriate attempts to avoid it (Buss, 1966, pp. 119, 437,

442ff.; Erikson, 1950, pp. 61, 409ff.; Fromm-Reichmann, 1950, pp. 45-68, 121ff., 121f.; Kline & King, 1973; Sullivan, 1953, p. 273).

2. Defensiveness: D

Hiler (1959b): Sentence completion test

Lorr, Katz, & Rubinstein (1958): unpublished behavior disturbance scale; interviewer rating

Rubinstein & Lorr (1956): psychopathic personality inventory

Strickland & Crowne (1963): therapists' ratings

Taulbee (1958): MMPI and Rorschach.

Defensiveness is considered to be reported by the patient in mentioning inappropriate, defiant behavior (I-19; Lorr et al., 1963; Rubinstein & Lorr, 1956). Suspiciousness and guardedness during the interview (II-4), as well as hostility (II-6), excessive distance and formality (II-8), and attempts to wrest control of the procedure (II-11) are taken as indicators of defensiveness (Fromm-Reichmann, 1950; Waelder, 1960; Lorr et al., 1963; Strupp, 1973). Similarly a paranoid style (III-3) or a dominating power seeking character (III-6) are understood as defensive postures (Shapiro, 1965).

3. Flexibility; a compromising nature: L

Katz & Solomon (1958): therapists' rating

Lorr, Katz, & Rubinstein (1958): unpublished behavior disturbance scale; interviewer rating

Rubinstein & Lorr (1956): F scale.

A reference to the qualities of adaptability, resourcefulness, flexibility, a compromising nature, humorousness (I-13) as perceived to be part of the self may be taken as an indicator, as may be behaviors

revealing these attributes during the interview (II-9; Fromm-Reichmann, 1950). The compliant or passive-aggressive personality (III-4) and the conventional character (III-8) also reveal a compromising nature, albeit to neurotic excess (Shapiro, 1956).

4. Hopefulness: L

Frank et al. (1957): social history

Katz & Solomon (1958): patient attitudes rated by therapists

This quality is indicated by optimistic, relatively confident verbalization (I-13), and mood (II-9).

5. Hostility: D

Kline & King (1973): social history

Lorr, Katz, & Rubinstein (1958): unpublished behavior disturbance scale; interviewer rating

Rubinstein & Lorr (1956): psychopathic personality inventory.

This trait may be inferred by referral to conduct problems (I-2) and violent behavior (I-4), by evidence of overt hostility during the interview (II-6), and by the clinical impression of a hostile, aggressive personality.

6. Impulsivity and the tendency to act out: D

Frank et al. (1957): screening interview

Hiler (1959a): presenting problems

Hiler (1959b): sentence completion test

Katz & Solomon (1958): presenting problems

Kline & King (1973): social history

Lorr, Katz, & Rubinstein (1958): unpublished behavior disturbance scale; interviewer rating

Rubinstein & Lorr (1956): psychopathic personality inventory

Sullivan et al. (1958): MMPI Scales.

This is the most often mentioned and most widely agreed upon personality trait correlating with the tendency to drop out of psychotherapy. It is appropriate to emphasize here that Hiler (1959a) mentions acting out and assaultiveness as presenting problems indicative of this trait; furthermore that the psychopathic personality inventory used by Rubinstein and Lorr (1956), correlated with dropout likelihood, stresses topics such as lack of impulse control, aggressive acting out, frequent trouble with authorities, a lack of ethical standards, and poor goal persistence.

It seems clear that alcohol or drug abuse (I-1), conduct problems (I-2), promiscuity (I-3), physical abuse (I-4), frequent or sudden changes in goals (I-8), sudden changes in living (I-12), or defiant acts (I-19), as related by the patient can infer this trait. Evasiveness (II-4), posturing or showing a bland facade (II-10) are frequently behavioral indicators of this characteristic (Hiler, 1959b; Strickland & Crowne, 1963). From a global perspective, the narcissistic (III-1), paranoid (III-3), hostile (III-5), megalomanic (III-6), avoidant (III-9), and Casanova (III-12) characters all satisfy the outline of an impulsive, restless, impatient, anxiety intolerant, externalizing individual unlikely to look within the self for the cause of and for the relief from suffering.

7. (a) Persistence: L

Frank et al. (1957): perseverance in attempting to get treatment

Lorr, Katz, & Rubinstein (1958): interviewer rating

Rubinstein & Lorr (1956): psychopathic personality inventory

Taulbee (1958): MMPI and Rorschach.

This trait may be inferred from the patient's manner of organizing and presenting data (II-3), and from the personal styles of intellectualism and psychological mindedness (III-10,11).

(b) Inconsistency; erratic behaviors: D

The lack of persistence may be deduced from a history of nomadism, restlessness, lack of real personal ties (see especially Rubinstein & Lorr, 1956; I-3,5,6,7,8,12,19), as well as from a flighty, flip attitude in the interview (II-2).

8. Introspectiveness: L

Hiler (1958): Wechsler-Bellevue Scale

Hiler (1959b): Sentence completion test

Lorr, Katz, & Rubinstein (1958): unpublished behavior disturbance scale; interviewer rating

Taulbee (1958): MMPI & Rorschach

We intuit the quality of introspectiveness in the intellectual (III-10) and in the psychologically minded (III-11).

9. Dissatisfactions and doubts about the self: L

Frank et al. (1957): Patient's history

Hiler (1959b): Sentence completion test

Lorr et al. (1958): Interviewer rating

Taulbee (1958): MMPI and Rorschach

Any mention of dissatisfaction or doubt is sufficient to adduce the patient as having these attitudes and/or feelings about himself (I-15,16,17), including worthlessness and feeling "outside." The patient considered to be unassertive or passive-aggressive (III-4) may also be considered to be dissatisfied and doubt ridden (Sullivan, 1953, p. 351).

10. Suggestibility and dependence: L

Frank et al. (1957): sway test

Heilbrun (1961): diagnostic impression

Hiler (1959b): sentence completion test

Lorr, Katz, & Rubinstein (1958): unpublished behavior distrubance scale; interviewer rating

Strickland & Crowne (1963): therapists' ratings

Taulbee (1958): MMPI and Rorschach.

The patients who state their needs for approval and dependence (I-20,21), the patients who need to be "spoon fed" during the interview (II-5), as well as the patients who are unassertive or passive-aggressive (III-4), immature (III-7), or conventional (III-8) are suggestible and dependent (Strupp, 1973).

11. Verbal fluency: L

Frank et al. (1957): patient history and style of interview response

Katz & Solomon (1958): style of presentation of patients' problems

Lorr, Katz, & Rubinstein (1958): interviewer rating

Strickland & Crowne (1963): therapists' ratings.

This trait is present where aggressiveness and irritability assume verbal forms (I-9), where the patient is at ease with words in the interview (II-1), where the patient describes feelings openly, and where the hysterical style may be inferred (III-2).

B. Diagnoses

1. Anxiety reaction: L

(Please refer to Section A(1), personality characteristics: anxiety, above.)

2. Depressive reaction: L

Frank et al. (1957): diagnosis

Heilbrun (1961): diagnosis.

Unusual traumata in the patient's history (I-10) as well as explicitly verbalized depressive ideation (I-15,16) are indicative of depression. During the interview passivity (II-5), depressed mood (II-7), or the display of morose affect (II-12) reveal depressive symptomatology.

C. Presenting problems

1. Personal problems: L

(See next section.)

2. Situational problems: D

Frank et al. (1957): screening interview

Hiler (1959a): presenting complaint

Katz & Solomon (1958): presenting problems.

Patients' emphasis on psychological problems or their awareness of feelings, attitudes, or beliefs experienced as ego alien (I-11,14,

15,16,17,18,20,21,22,23,24,25) as opposed to issues like drug dependency, external authority conflicts, divorce (I-1 thru 5), wherein the difficulty is experienced as outside the self or in faits accomplis, help to resolve this bipolar dimension. The patient who asks explicitly for advice (II-13) may conceive of his difficulties as external to the self, as does the patient who clearly leaves the clinical impression of a situational reaction (III-13). (For I-11 see especially Sullivan, 1953, pp. 211ff.)

Table 10 is a summary of potential cues and the checklist items presumed to relate to the cues. For each checklist item and its associated tendency sign (D or L), the rationale for the relevance to the cue or cues to which the item is assumed to relate is provided below.

Section I. Issues and topics mentioned by patient during intake, regarding self or family of origin

1. Using hard drugs; abusing drugs; alcoholism: D

This topic is presumed to relate to the inability to tolerate frustration and anxiety, to impulsivity, to a tendency to act out, or to a presenting complaint conceptualized as situational (i.e., external to the self) by the patient. Jellinek (1952) notes that the distinction between social drinking and alcoholism first becomes apparent when heavy drinking is used to avoid problems and to support waning confidence. The syndrome of addiction is consonant with impulsivity and acting out in that control is given up, trouble with authorities is likely, and goal orientation becomes thwarted. To the extent that the abuse of drugs is seen by the patient as caused by the external environment and is not felt as a personal response, the attitude of a situational complaint obtains.

TABLE 10

CUES AND THEIR ASSOCIATED CHECKLIST ITEMS

Cues	Checklist items		
Number and name of cue	Section I	Section II	Section III
A. Personality traits			
1(a). Anxiety: expressed, well tolerated: L	9,14	1,3	10,11
1(b). Anxiety: poorly tolerated: D	1,2,2	2,6,11	1,3,5,6,9,12
2. Defensiveness: D	19	4,6,8,10,11	3,6
3. Flexibility: L	13	9	4,8
4. Hopefulness: L	13	9	
5. Hostility: D	2,4	6	5
6. Impulsive; acts out: D	1,2,3,4,8,12,19	4,10	1,3,5,6,9,12
7(a). Persistence: L		3	10,11
7(b). Inconsistent, erratic: D	3,5,6,7,8,12,19	2	
8. Introspective: L			10,11

TABLE 10--Continued

Cues	Checklist items		
Number and name of cue	Section I	Section II	Section III
9. Doubts, dissatisfactions: L	15,16,17		4
10. Suggestible, dependent: L	20,21	5	4,7,8
11. Verbal fluency: L	9	1,12	2
B. Diagnoses			
1. Anxiety reaction: L	14		
2. Depressive reaction: L	10,15,16	5,7,12	
C. Presenting problems			
1. Personal: L	11,14-18,20-25		
2. Situational: D	1-5	13	13

2. Conduct problems; difficulties with the law or other authorities: D

Conduct problem and psychopathy in particular show an absence of anxiety (Buss, 1966, p. 436). Hostility is revealed by aggressive acting out or assaultiveness. Impulsivity and acting out patterns are revealed in the egocentric, consequence denying history, and the lack of standards of behavior. The external problem issue is frequently present with persons in difficulties with authorities; often an attempt to mollify authority, to reduce punishment, or to plead extenuating circumstances in involved (Rubinstein & Lorr, 1956; Hiler, 1959a).

3. Promiscuity; sexual acting out: D

This topic shares justification with items 1 and 2 above with regard to avoiding anxiety, acting out, and external problems. Additionally, the cue of inconsistency and erraticism is present in the evident lack of real personal ties implicit in promiscuity (Rubinstein & Lorr, 1956).

4. Physical abuse; violence: D

This particularly brutal type of acting out reflects hostile aggressivity, and is likely to result in a patient's being compelled to enter therapy under protest (see especially Hiler, 1958, 1959b).

5. Divorce; break-up of a serious affair: D

Divorce may bring the patient into therapy as a reaction to the external problem, i.e., on the rebound. It may also reflect a lack of persistence, being part of a history of restlessness, nomadism, and a lack of enduring personal attachments (Rubinstein & Lorr, 1956).

6. Varying nurturant figures: shuttled from pillar to post in childhood: D

This issue in the history can result in a lack of persistence through a failure to form lasting personal ties (Rubinstein & Lorr, 1956). See also item 7, next.

7. Frequent or highly significant residence changes; cultural transplants: D

Fenichel (1945) states that a loveless environment, inconsistent environmental influences, and frequent changes of milieu hamper the development of the superego. As a result persistence in the face of adversity is also underdeveloped; the seeds of erratic behavior are sown.

8. Frequent and/or poorly planned changes in jobs and/or goals: D

These are direct behavioral indicators of impulsivity, poor goal orientation, and restlessness. In conjunction with #7 above, the picture of the psychopath who assumes different identities may be emerging (Frankenstein, 1959).

9. Quarrels, arguments as an important complaint: L

The interpersonal anxiety, expressed as irritability is present; also the hostility, as in pickiness, is reported but contained: n.b., the verbal component of the hostility or aggressiveness or irritability is preeminent here. The verbal mode of expression in the presence of the hostile, aggressive impulses suggests a substantial ease with words as medium; this augurs well for psychotherapy, as does the control implicit in not having acted out the impulses (Hiler, 1958; see also sections A1[a] and A11).

10. Unusual traumata: early death of parent, concentration camp history, etc.: L

Reaction to loss, whether immediate or delayed until triggered by a subsequent, compounding loss, as well as high levels of guilt and anxiety (which are present in some patients with bizarre circumstances in histories) all suggest depressive symptomatology (see Buss, 1966, pp. 180ff.).

11. Tantrums in childhood: L

The felt component, anger, of this rage behavior is often learned as a technique for expressing resentment and interpersonal anxiety, typical personal, intrapsychic, non-situational problems (see Sullivan, 1953, 211-213).

12. Suddenly, impulsively leaving home: D

The impulsivity is apparent, as is the erratic quality of this act, having as an important component the quality of being unplanned.

13. Refers to own adaptability, resourcefulness, flexibility, compromising nature, sense of humor: L

The patient who makes such a reference while remaining believable may be taken at his word; he will also be expressing an optimism and a conviction that he can "make it," can do it. This is parenthetically the type of patient who satisfies the contrapositive of the dictum of Sullivan et al. (1958), that those least able to cope with life's challenges stand the least to gain from therapy. Here, those best able to cope stand to gain the most.

14. Suffers anxiety attacks; feels anxious: L

The report of the symptoms of an anxiety reaction or the report of the experience of anxiety is sufficient to conclude the factors of (1) the expression of and tolerance for anxiety, and (2) personal problems as opposed to situational complaints. (See section A1[a], above.)

15. Self doubts and/or dissatisfactions; feels insecure and/or inferior; uncertainty; lack of confidence; feels stupid, ugly, etc.: L

The inclusion of any verbalization relating to this topic satisfies the criterion of admitting doubts and dissatisfactions about the self. Depression may also be indicated. (See section A9, above.)

16. Feels remorseful, depressed, guilty, ashamed, worthless, etc.; has suicidal ideas: L

Here the level of self esteem is lower than that indicated by the previous item, #15, where doubts and dissatsifactions were admitted; now depressive symptoms are more apparent and a depressive reaction may be present. (See A9, B2, above.)

17. Feels different; outsider: L

18. Experiences depersonalization; feels strange, outside of self: L

22. Insulting behavior; hypercritical outbursts: L

23. Resentment; jealousy: L

24. Loneliness; lack of friends: L

25. Refers to "inner anger and hostility": L

This group of complaints, items 17, 18, 22 thru 25, all share the factor of usually being viewed as personal problems, not as external ones. Typically they are stated as follows: "I feel different from everybody else." "I feel funny sometimes." "I can't keep any friends."

"I am always hypercritical." "I feel angry down inside.", etc. (See C1, C2, above.)

19. Refers to inappropriate, defiant, self defeating acts of pseudo independence: D

The acting out involved in the pseudo independent act and in inappropriate, defiant behaviors suggests strong impulses and weak controls. (See Buss & Gerjuoy, 1957.)

20. Seeks and/or needs approval; fears and/or avoids disapproval: L

21. Needs and/or seeks and/or wishes to depend on someone: L

In the opinion of several writers (refer to section A10, above) the wish for dependency or approval is crucial to therapy. These issues are frequently verbalized directly as in: "I want my father to like what I do." "I worry about what my friends will say about my being in therapy." "I want someone to lean on."

Section II: Behavior and attitudes evident during interview

1. Verbally fluent: spoke easily, readily, spontaneously; showed little difficulty with words as medium: L

This item is intended to pick up verbal facility and comfort with the moderate level of anxiety inherent in the situation. Refer to A1(a) and A11 above.

2. Flighty: flitted from topic to topic: D

This item is intended to reflect behaviors indicative of escaping anxiety by manic defenses, and of an erratic inconsistent personal style. See A1(b) and A7(b) above.

3. Logical, orderly presentation of data; controlled attitude toward data: L

This is the opposite of the item directly preceding (II-2). Refer to A1(a) and A7(a) above.

4. Guarded, cautious in revealing personal data; suspicious and questioning of motives of interview, interviewer, confidentiality; gives tio evasive answers to personal questions: D

General defensive behavior and attitude are the key words in this item; refer to A2 above. Some tendency to act out may also be implied by evasiveness; see A6 above.

5. Passive: needs to be guided and prompted: L

Depressive inertia and the trait of suggestibility are the rationales for remarking this behavior; see B2 and A10 above.

6. Hostile: expresses anger toward interview, interviewer, Center, etc.: D

Defensiveness, overt hostility, and poor tolerance for anxiety are indicated by this attitude; see A2, A5, A1(b) above.

7. Depressed: sad, tearful, blocked: L

Direct behavioral indications of depression; see B2 above.

8. Cold, distant; formal, stilted, stiff manner; blandness: D

10. Operated via a facade of self confidence while distress evident; macho act; rigid posturing: D

Two additional items intended to note defensive attitudes; refer to A2 above.

9. Warm, humorous: genuinely warm, friendly, likeable, open, affable; relaxedly confident; able to laugh at self; showed sense of humor: L

The behavioral counterpart of item 13 in Group I above; see A3,

A4 above.

11. Controlling: deals only with self selected issues: wrests control of interview; doesn't respond to specific questions directly: D

The behaviors suggest defensiveness; the manner suggests poorly tolerated anxiety. See A2 and A1(b) above.

12. Oriented to feelings; openly describes feelings; shows some affect: L

Verbal fluency in personal areas is important here (see A11). Depending on the affect shown, depression may be indicated (see B2).

13. Asks explicitly to be given direct advice: D

This request usually betokens a conception of the problem as external; see C2 above.

Section III: Overall impression of patient.

1. Narcissistic: self absorbed; conceited; seeks center stage; macho; prancing peacock; seductive: D

The key words mentioned in the guide for the narcissistic character are not exhaustive but suggestive. The narcissistic person is most likely to act out impulsively with few restraints, and is least tolerant of anxiety. Refer to A6, A1(b) above; see also Shapiro (1965).

2. Hysterical: dramatic; labile; free expression of affect; flirtatious; "la belle indifference": L

The hysterical style is consistent with verbal fluency. Although often shallow rather than insightful, the glib easy flow of words or affect provides data for psychotherapy; see A11 above.

3. Paranoid: externalizes; projects; is guarded, suspicious: D

The paranoid character structure (Shapiro, 1965) usually contains

three elements of interest to us here: (1) highly articulated defensiveness, (2) restlessly externalizing and occasional assaultive acting out, and (3) anxiety intolerance. Refer to A2, A6, and A1(b) above.

4. Not assertive: picked on; taken advantage of; used; fails to stand up for self; scapegoated. Passive aggressive: subtly, indirectly, inactively aggressive: L

The unassertive and passive aggressive characters are often flexible and compliant (A3), doubting of themselves (A9), and highly amenable to suggestion (A10) (Horney, 1945; Sullivan, 1953).

5. Hostile aggressive: actively, obviously hostile and aggressive: D

This character directly reveals the trait of hostility (A5), assaultive acting out (A6), and poor anxiety tolerance (A1[b]).

6. Controlling and/or manipulative: tries to control others; wishes to change others; seeks power over others: D

The character who habitually seeks dominion over others shows a highly defensive personality (Horney, 1945, 63-72; see A2 above), and hints at megalomanic acting out (Sullivan, 1953, 351ff.; refer to A6 above).

7. Childlike and/or immature: naive; not planning ahead; goals without means-end cognizance; age inappropriate behavior: L

The immature character is usually suggestible and dependent. Refer to A10 above.

8. Conventional: prefers conformity to autonomy: L

This character structure is adaptive and suggestible. See A3 and A10 above.

9. Uses avoidance and/or escape: quits; runs away; leaves difficulties: D

The quitter is the avoider of anxiety par excellence; refer to A1(b). He is likely to act out his need to avoid anxiety (see A6 above) by dropping out of therapy, for example.

10. Intellectualizes: rationalizes; seeks explanations: L

11. Psychologically minded: reflective; introspective; seeks explanations within self: L

The rationalizer and the reflective character share a tolerance for anxiety (see A1[a] above) in their ability to analyze and to reflect; they are persistent (see A7), usually being able to maintain goal orientation; finally they are introspective, willing to explore their inner worlds (see A8).

12. Don Juan, Casanova: seeks love and attention; insatiable need for sexual conquest: D

This character compulsively acts out; refer to A6 above.

13. Situational problem reaction: patient experiencing a well defined, limited, circumscribed, situational difficulty: D

The clinician's observation and conclusion that the problem is situational places the focus on external rather than personal issues. Compare C1 and C2, above.

Table 11 summarizes the checklist items, in the short format useful for scoring an intake, and gives the related variables for each item. The referenced variables are alluded to encoded into a paragraph heading (e.g., A6, standing for impulsivity and the tendency to act out.)

TABLE 11

CHECKLIST ITEMS AND THEIR ASSOCIATED CUE CODES

I. Topics occurring in interview	Associated cue codes
1 D Drugs/alcoholism	A1b, A6, C2
2 D Conduct/legal problems	A1b, A5, A6, C2
3 D Promiscuity	A1b, A6, A7b, C2
4 D Physical abuse	A5, A6, C2
5 D Divorce	A7b, C2
6 D Varying nurturant figures	A7b
7 D Frequent/dramatic moving	A7b
8 D Frequent job/goal changes	A6, A7b
9 L Quarrels, arguments	A1, A11
10 L Unusual traumata	B2
11 L Tantrums	C1
12 D Suddenly leaving home	A6, A7b
13 L Adaptability, humor	A3, A4
14 L Anxiety	A1, C1
15 L Doubt, insecure, inferior	A9, B2, C1
16 L Remorse, depression	A9, B2, C1
17 L Feeling different	A9, C1
18 L Depersonalization	C1
19 D Defiant independent acts	A2, A6, A7b
20 L Seeks approval/fears disapproval	A10, C1
21 L Seeks dependency	A10, C1
22 L Insulting behaviors	C1

TABLE 11--Continued

(I. Topics occurring in interview)	Associated cue codes
23 L Resentment	C1
24 L Loneliness; lacks friends	C1
25 L Inner anger and hostility	C1
II. Behavior during interview	
1 L Verbally fluent	A1, A11
2 D Flighty	A1b, A7b
3 L Logical, orderly	A1, A7a
4 D Guarded/suspicious/evasive	A2, A6
5 L Passive	A10, B2
6 D Hostile	A1b, A2, A5
7 L Depressed	B2
8 D Cold, distant	A2
9 L Warm, humorous	A3, A4
10 D Facade of confidence	A2, A6
11 D Controlling	A1b, A2
12 L Feeling oriented	A11, B2
13 D Asks for direct advice	C2
III. Overall impression of patient	
1 D Narcissistic	A1b, A6
2 L Hysterical	A11
3 D Paranoid	A1b, A2, A6
4 L Unassertive/Passive aggressive	A3, A9, A10
5 D Hostile	A1b, A5, A6

TABLE 11--Continued

(III. Overall impression of patient)			(Associated cue codes)
6	D	Controlling/manipulative	A1b, A2, A6
7	L	Childlike, immature	A10
8	L	Conventional	A3, A10
9	D	Uses avoidance/escape	A1b, A6
10	L	Intellectualizes	A1, A7, A8
11	L	Psychologically minded	A1, A7, a8
12	D	Don Juan	A1b, A6
13	D	Situational problem reaction	C2

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