RELATIONSHIP OF THE QUALITY OF THERAPISTS' JOINING TO CLIENTS' CONTINUANCE IN THERAPY

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CHAPTER I

INTRODUCTION

Background

Marriage and family therapists and researchers have long been calling for methods to assess, monitor, and evaluate therapeutic practice (Moon, Sells, & Smith, 1996; Andreozzi, 1985, Atkinson & Heath, 1987; Callam & Elliott, 1987; Gurman, 1987; Liddle, 1991; Reiss, 1988; Steier, 1985, 1988; Wassenaar, 1987; Wynne, 1988). In the past, Gurman (1987) and others (Andreozzi, 1985; Liddle, 1991; Pinsof, 1988; Steier, 1988; Wynne, 1988) recognized that research in this area is scant. Previously, evaluating therapeutic practice consisted of outcome research designs that compared the overall effectiveness of two or more different therapy models but failed to provide information on areas *within* the particular model that produced change (Gurman, 1987; Liddle, 1991). Gurman et al. (1986) suggests that more meaningful research might be produced if links are made between process (i.e., what happens in the therapy session) and outcome variables that are more closely coupled in time. For example, examining the tie between what happens in a specific therapy session and the assessment or outcomes of that session may provide insight into when change occurs in therapy (Gregory & Leslie, 1996). Jones and Zoppel (1982) postulate that greater knowledge of these smaller process-outcome links may culminate in greater understanding of longer term process-outcome links. This may be one reason recent research trends are examining more closely the factors that contribute to a successful therapeutic alliance.

There are several reasons why the study of clients who prematurely drop out of therapy is crucial. From the therapist's perspective, clients who prematurely terminate therapeutic services means a loss of resources, including time and revenue, and disrupted schedules (Bischoff & Sprenkle, 1993). More importantly from the client's perspective, research shows that contact between the two parties is likely to break off after the first

interview if a therapeutic alliance is not established (Simon, Stierlin, & Wynne, 1985; Phillips, 1987; Fiester, Mahrer, Giambra, & Ormiston, 1974). Clients who drop out after the first session lose a resource for helping them cope with their particular issues. This is particularly distressing when research shows that continuance in therapy is associated with improvement (Fraps, McReynolds, Beck & Heisler, 1982).

Notable theorists like Satir (Satir, Banen, Gerber, & Gomori, 1991) and Kottler (1993) believe that the basic ingredient of therapy is the relationship between the therapist and the client. Over the last two decades, the data show that therapeutic alliance is associated with outcome despite the therapy modality or approach used (Gurman, Kniskern, & Pinsof, 1986; Lambert, Shapiro, & Bergin, 1986; Pinsof & Catherall, 1986; Greenberg, Rice, & Elliot, 1993). These results have been consistent across different types of outcome measures and different sources of information (e.g. client, therapist, or clinical judge) (Gatson, 1990). Several review articles (Schaffer, 1982; Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, & Pilkonis, 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Pinsof & Catherall, 1986; Strupp & Hadley, 1979; & Orlinsky and Howard, 1986) have cited findings which confirmed the quality of therapeutic alliance as being associated with outcome. Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins, and Pilkonis (1996) supported these findings in the "largest study of the therapeutic alliance and outcome ever conducted" (p. 533), part of the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP). One of the more significant findings of the TDCRP study was that the strength of the relationship between alliance and outcome is an important factor regardless of the type of treatment provided, including the provision of clinical management only.

The connection between developing a working alliance and positive therapeutic outcomes has received renewed attention in discussions of family therapy (Barnard &

Kuel, 1995). The quality of the therapeutic relationship is becoming increasingly recognized as a predictor of psychotherapy outcome, as recent meta-analyses (Horvath & Symonds, 1991; Horvath & Greenberg, 1994) of studies have confirmed. Yet historically the particular characteristics of the interaction between client and therapist has been neglected (Parloff, 1956; Rogers, 1959; Strupp, Wallach, & Wogan, 1964; Swenson, 1967). In studying therapist and client characteristics, the focus has largely been on demographic variables, including race, gender, and experience of the therapist (Epperson, Bushway, & Warman, 1983; McKee & Smouse, 1983; Pekarik, 1985). The problem with the reliance on these types of variables is that the findings are inconsistently significant and have limited clinical value (Bischoff & Sprenkle, 1993; Brandt, 1965; Baekeland & Lundwall, 1975; Garfield, 1986).

Fiester (1977) found therapy process variables were of explanatory importance for client dropout. Studies relating process variables to premature termination are lacking and very few studies to date have identified within-session therapist and client behavior or their interaction that is related to premature termination (Bischoff & Sprenkle, 1993; Bray & Jouriles, 1995). Coady (1993) offered suggestions for regenerating emphasis on relationship factors in practice, research, and education. For researchers he suggested that the helping process be re-established as "empathic/collaborative, instead of technical/interventive" dimensions (p.124). Several theorists support this collaborative conceptualization (Inger & Inger, 1994; Baldwin & Satir, 1987; Fiester, 1977; Truax, 1963; Truax, Carkhuff, & Kodman, 1965; Truax & Mitchell, 1971). Bray and Jouriles (1995) support this position in that "therapists and clients who are viewed as responsive, cooperative, and collaborative tend to have more effective therapy sessions." In support, while studying strategic family therapies, Green and Herget (1991), Coleman (1987), Foreman and Marmar (1985), and Gurman et al.(1986) concluded that "a therapeutic stance lacking in warmth and active engagement contributes to poor outcomes" (p.173).

In addition, the importance of therapists' personal characteristics has a long history in psychotherapy in general (Rogers, 1957) and in family therapy in particular (Bowen, 1978; Guerin & Hubbard, 1987; Lawson & Sivo, 1998). In fact, in the first report of a research program designed to identify the most importance characteristics of the beginning marriage and family therapist, Figley and Nelson (1989) found that approximately half on the top 100 "generic skills" were more appropriately described as "personal traits." And only 5 of the top 25 items were clearly teachable behaviors; basic interviewing skills, establishing rapport, giving credit for positive changes, the ability to distinguish content from process, and setting reachable goals. Figley and Nelson (1989) argue, however, that even some of those behaviors may be considered "personal traits." Previous research suggests that client participation (Gomes-Schwartz, 1978; O'Malley, Suh, & Strupp, 1983), positive contributions (Horowitz, Marmar, & Weiss, 1984; Marziali, 1984), collaboration (Alexander & Luborsky, 1986) and depth of experiencing (Klein, Mathieu-Coughlan, & Kiesler, 1986) are consistent predictors of outcome. Taken together these findings suggest that relationship factors reflecting participants' active involvement during treatment are associated with successful outcome (Weissmark & Giacomo, 1995).

The aforementioned findings are clearly important for highlighting the association between various relationship factors and outcome. However, the data do not provide an exact account of participants' behaviors representative to relationship factors. The present study will utilize the empathic/collaborative conceptualization in emphasizing the importance for and operationalization of the relationship of therapist characteristics, as they relate to the establishment of an effective therapeutic alliance referred to as joining. Implications will be presented for how the characteristics relate to clients continuing or prematurely terminating the therapeutic relationship. In this study, the term "joining" refers to development of a specific type of working relationship between therapist and

family members. In this type of relationship, the therapist "joins" the family in order to facilitate changes in family structure (Simon, Stierlin, & Wynne, 1985).

Objectives

This study will stress the importance of knowing the identified therapist characteristics associated to clients' continuing in or early attrition from marital and family therapy. The information obtained from this study will offer researchers and clinicians information about and operationalization of critical process variables. The more information that is known about critical process variables, the more clinicians will be able to curb early attrition from therapy. A secondary objective is to underscore the importance of the relationship that is established between client and therapist. The following objectives will be addressed in this study:

1. To describe and measure the characteristics of a "well-joined" therapist.
2. To operationally define and measure the process variables of joining.
3. To identify the strength of the relationship between a "well-joined" therapist and therapeutic continuance past the second session.

CHAPTER II

LITERATURE REVIEW

Problem Statement

Although the quality of the therapeutic relationship is becoming increasingly recognized as a predictor of outcome, historically little research has been conducted on the quality of the interaction between client and therapist (Parloff, 1956; Rogers, 1959; Strupp, Wallach, & Wogan, 1964; Swenson, 1967). According to Poulin and Young (1997), one of the reasons for this lack of research is that the concept of the helping relationship has not been operationally defined. This study will offer and test an operational definition for joining. In addition, because the profession is currently emphasizing developing and testing models of intervention and measuring outcomes, the importance of the relationship has been neglected (Reid, 1994). Stiles and Snow (1984) have suggested that bridging the gap between process and outcome may be closed most effectively by examining session-level dynamics. Exploratory, discovery-oriented research studies are needed to understand what factors within a therapy session are associated with improvement or deterioration (Moon, Dillon, & Sprenkle, 1990; Pinsof, 1988; Wynne, 1988). A need exists to operationalize those factors which constitute a stable working relationship and to test the impact of those factors on positive therapeutic outcome. This study is especially important as Bischoff and Sprenkle (1993) have noted that very little research has been conducted on the first session of therapy specifically within the marriage and family therapy field.

Purpose

This study will examine how the quality of joining may be related to either continuance or premature termination of therapeutic services. Specific attention will be given to identifying therapist characteristics utilized in joining which are linked to either clients' continuing therapy or prematurely terminating. The basic assumption of this

research is that the quality of therapists' characteristics of joining directly corresponds to whether clients continue or prematurely terminate therapy. Therapists who demonstrate effective communication skills, respect, understanding and empathy, and competence are predicted to be better joined, maintain longer lasting therapeutic relationships, and be more effective with clients, than those who do not. The primary independent measure is the degree to which adequate joining has taken place in the first session. The primary dependent measures are the number of sessions attended by clients and the reason for termination.

The purpose of this study is to examine how the quality of joining may be related to client continuance of therapeutic services. The literature review will be composed of five areas: joining, including operationalization of the constructs of communication skills, respect, understanding and empathy, and competence, co-therapy, the definition of dropout, therapist demographic variables, and client demographic variables. The defining of these areas will provide insight into what joining is, how joining relates to therapeutic outcome, and which factors may influence the therapist's ability to join effectively with clients.

Joining

Though therapy models may differ in approach, most include the concept of therapists engaging in collaborative relationships with clients which include a therapeutic bond and shared opinions about the tasks and goals of treatment. Research on general psychotherapy outcomes consistently supports the position that the beneficial effects of therapy are more closely related to therapists' personal characteristics than to any specific intervention or approach (Crits-Christoph & Mintz, 1991; Lambert, 1989; Beutler, Machado, & Neufeldt, 1994). Carl Rogers (1951; 1957) offered the ideas of facilitative conditions of genuineness, congruence, unconditional positive regard, and empathy as necessary components of the counseling relationship.

Joining is a term that originated with structural family therapy in which the therapist accepts and often accommodates to clients in order to win their confidence and circumvent resistance (Nichols & Schwartz, 1995). Minuchin (1981) explains the therapist joins the family in a position of leadership, "... he will have to accommodate, seduce, submit, support, direct, suggest, and follow in order to lead... he has developed some skill in using himself as an instrument of transactional change" (p.29). According to Minuchin (1981), "joining is more an attitude than a technique, and it is the umbrella under which all therapeutic transactions occur. Joining is letting the family know that the therapist understands (p.31)." "...Joining is the glue that holds the therapeutic system together" (p.32). Joining begins with the therapist's first contact with clients, or as Brock and Barnard (1992) have noted, joining begins at the moment either the therapist or the client becomes psychologically aware of the other. This means that because the therapeutic system consists of mutual influence, the moment client and therapist acknowledge the relationship, influence is possible.

The concept of joining is vitally important because if a stable alliance between therapist and family is not achieved, interventions designed to change the structure of the family may remain unsuccessful, and contact between the two parties is likely to break off after the first interview (Simon, Stierlin, & Wynne, 1985; Fiester, Mahrer, Giambra, & Ormiston, 1974). Families have established homeostatic patterns, and will resist attempts at change unless efforts come from a position of acceptance and understanding. This is one reason why joining is so important. The therapist "joins" the system through demonstration of good communication skills, respect, understanding and empathy, and competence. The family will accept and admit the therapist into the family system when the therapist acknowledges and promotes the family's strengths, respects the family's existing hierarchies and value systems, supports family subsystems, and confirms each individual's feeling of self-worth (Simon, Stierlin, & Wynne, 1985). In order for the

therapist to join the client system, a delicate balance of flexibility and adaptability on the part of the therapist and the client must first be achieved.

Several theorists (Haley, 1976; Napier & Whitaker, 1978; Minuchin & Fishman, 1981; Brock & Bernard, 1992; de Shazer, 1988; Marziali, 1988; Tryon, 1990) have noted the importance of the initial phase of treatment as influencing successful therapeutic outcomes. Bischoff and Sprenkle (1993) found that therapists who rated high in joining skills have lower rates of client attrition. Alexander, Barton, Schiavo, and Parsons (1976) defined these joining skills as therapist directiveness and self-confidence, and these skills are interpreted as increased levels of therapist activity. Shields, Sprenkle, and Constantine (1991) found similar results in that when therapists engage in these skills in the initial interview, they are less likely to have clients who terminate therapeutic services prematurely. In addition to increased therapist activity, Alexander et al. (1976) found when they had therapy supervisors rate student therapists on relationship skills such as warmth, the higher students rated on relationship skills, the fewer clients dropped out. Similar results were found when Shields et al. (1991) measured therapists' "joining" skills during the initial interview. Numerous studies (Corey, Corey, & Callahan, 1988; Luborsky et al., 1986; Orlinsky & Howard, 1986; Strupp & Hadley, 1979) support the assumption that therapists' personal characteristics determine their ability to form helping alliances. Joining is defined in this study as a therapist who is accepting of and accommodating to families through demonstration of effective communication skills, respect, understanding and empathy, and competence.

Communication Skills. The demonstration of effective communication skills is the basis of therapy. Carkhuff, Piaget, and Pierce (1968) identify perceptual and communicative skills to be the basic ones for practicing therapists. Therefore, beginning therapists need to be trained in language skills (Glaser, 1980; Haber, 1990; Rambo, 1989; Small & Manthei, 1986; Winkle, Piercy, & Hovestadt, 1981). Marshall, Kurtz, and

Associates (1982) provided a comprehensive summary of interpersonal helping skills. Their findings included generic skills most frequently found in the professional literature, including empathy, questioning, and respect. Because people are unlikely to change or even reconsider their assumptions until they feel they've been heard and understood, therapists must be aware of the efficacy of their own communication skills. Therapists may demonstrate listening and empathic understanding to each client by making interpretations to clarify hidden and confusing aspects of experience (Nichols & Schwartz, 1995). Clinicians must first pay particular attention to both the general meaning and the specific application of words the client uses because some words and phrases can have entirely different meanings for different individuals (Latz, 1996). Troemel-Ploetz (1977) noted the therapist's awareness or lack of awareness of idiosyncratic application of words and phrases may be crucial to the outcome of a session. Brock and Barnard (1992) state that "nonverbal rules" include maintaining eye contact with the speaker, and using head nods which are visible to the speaker to communicate understanding. Both subskills communicate that the therapist is paying attention to what is being said so that the speaker feels tended to. Another subskill is tracking. In tracking, the therapist follows the content of the family's communications and behavior and encourages them to continue. The therapist tracks by asking clarifying questions, by making approving comments, or by amplifying a point which is punctuation (Minuchin, 1974).

The two primary types of communication skills commonly used in therapy are active listening skills and reflective listening skills. Both terms include allowing the speaker the opportunity to feel heard. Therapists can demonstrate active listening skills by nodding their head, making eye contact, and asking clarifying questions or making statements that shows the listener understands what the speaker is saying. The therapist can demonstrate reflective listening skills by repeating back to the client, in his own

words, what was heard in order to clarify any misunderstandings and to form a shared understanding of what is being said with the client. By demonstrating active and reflective listening skills, clients are most likely to feel heard. This information led to the hypothesis that therapists who demonstrate good communication skills as measured by clients' perceptions will have lower client dropout rates than those who do not. In addition to good communication skills, the therapist should demonstrate respect as well.

Respect. The word respect surfaces in literature across varying therapeutic models. Saltzman, Luetgert, Roth, Creaser, and Howard (1976) described therapist dimensions vital to forming a successful therapeutic relationship in their study which included the notion of respect. They defined respect as the client's conviction that no matter what he/she does, the therapist basically respects him/her as a human being. In addition, the concept of the therapeutic alliance was first discussed by Sterba in 1934. The therapeutic alliance is defined as the reality-based component of the patient-therapist relationship that supports and facilitates the therapeutic process (Chance, Ellis, & Glickauf-Hughes, 1995). Greenson (1967) continued this school of thought as he described the "relatively nonneurotic, rational relationship" between therapist and client. He contended that the relationship includes components of nonsexual, nonromantic, mild forms of love such as liking, trust, and *respect*. The therapist joins with the family by greeting each member by name which conveys respect. This information led to the formation of the hypothesis that therapists who demonstrate respect as measured by clients' perceptions will have lower client dropout rates than those who do not. In addition to feeling respected, clients will be more likely to remain in therapy if they feel they are being understood.

Understanding and Empathy. For use in this study, when a therapist conveys understanding, every member of the client system will perceive the therapist understands what each is saying and is feeling. Creaser et al. (1976) found that understanding, or the

client's feeling that the therapist understands him/her is a vital component to a successful therapeutic relationship. Moon et al. (1996) found similar findings in their study. They cited important practitioner qualities in developing the therapeutic relationship including the therapist listens, is sincere, and understands. In addition, they defined understanding as clients believing their therapists understand their feelings or problems. Clients stated that these qualities allowed them to feel more at ease or comfortable about the counseling process. This information led to the formation of hypothesis that therapists who demonstrate understanding as measured by clients' perceptions will have lower client dropout rates than those who do not. Another important characteristic research has supported as being associated with successful formation of the therapeutic relationship is that the therapist is able to demonstrate empathy. Humanistic therapists such as Rogers, (1951; 1957; 1975) and Patterson (1984) equated the therapeutic relationship with certain therapist-offered conditions, including empathic understanding, which were seen as necessary for successful treatment outcomes. Strupp and Hadley (1979) deduced that positive client changes were attributable to a "benign helping relationship" based on therapists' ability to communicate empathy and concern to the client. Moon et al (1996) supported the notion of empathy and defined empathy as the therapist being caring and sensitive. In fact, clients who drop out of treatment often describe their experience as lacking mutuality and collaboration and therapists have not adequately expressed warmth, acceptance, respect and caring (Levine & Herron, 1990). Caring may be demonstrated by responsive nonverbal behaviors, interpretive statements, few therapist disclosures, actions that demonstrate a concern for confidentiality, and consistent interest (Odell & Quinn, 1998). Heppner and Dixon (1981) have noted that many of these behaviors affect the therapeutic process in a positive manner and thus the formation of the hypothesis that therapists who demonstrate empathy as measured by clients' perceptions will have lower client dropout rates than those who do not. In addition to feeling understood and cared

for, if clients perceive their therapist is demonstrating competence, clients will more likely stay in therapy.

Competence. Tomm and Wright (1979) list conveying professional competence as an important task in establishing positive relationships with clients. The American Psychological Association (APA) Ethical Standards (1990) cite therapist competence as an essential aspect of therapists' responsibility to clients. Shaw and Dobson (1988) broadly define competence as the therapist's ability to promote positive client change. Saltzman et. al (1976) list security as the client's confidence that his/her therapist is both competent and committed to be of help to him/her as long as help is needed, as being an important component to the therapeutic relationship. Brock and Barnard (1992) state one way to demonstrate competence early in treatment is by clarifying the problem. In doing so, the family may begin to understand what has been contributing to the problems they experience. The process of clarifying the problem provides the client with a sense of the therapist's competence and capacity for appropriately managing their destructive process. Competence may also be viewed as an "executive skill" which is broken down into several categories. Among them include adjusting communication to cognitive level of clients, adopting the same expressive words/phrases that family members use, conveying the capacity to tolerate a wide range of affect by allowing expression of intense emotional turmoil, respecting family loyalties while explaining importance of open inquiry as crucial, respecting appropriate interpersonal boundaries by exploring particular issues within appropriate subsystems, and interrupting excessive or inappropriate disclosure and temporarily supporting the family's usual coping/defense mechanisms. Strupp (1992) found that the therapist who lets therapy flounder without clear goals tends to experience clients who prematurely discontinue therapeutic services. This information led to the formation of hypothesis that therapists who demonstrate competence as measured by clients' perceptions will have lower client dropout rates than those who do not. In

addition to clients' perceptions of therapist competence, joining opportunities through utilization of co-therapy teams family therapy has been found.

Co-Therapy

Co-therapy is the use of two therapists meeting with a couple, family, or group (Hendrix, Fournier, & Briggs, 1998). Support for this approach has largely come from group therapists (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 199; Benjamin & Benjamin, 1994), sex therapists (Masters & Johnson, 1970; LoPiccolo, Heiman, Hogan, & Roberts, 1985), and family therapists (Napier & Whitaker, 1978; Hannum, 1980; Selvini & Palazzoli, 1991). There are four reasons De Luca et al. (1996) present as a rationale for co-therapy, including increased resources for treatment options, sharing of responsibilities, the opportunity to model appropriate behaviors, and the opportunity for co-therapists to provide clients with a greater sense of stability and cohesion in the treatment process. Co-therapy can also provide clients opportunities to observe therapists participating in a healthy relationship, which will aid clients in trusting the therapeutic relationship (Napier & Whitaker, 1978). In addition, the concept of co-therapy is in keeping with the notion of wholeness which is described in the framework session of this paper in further detail. Several theorists support this notion in their belief that two heads are better than one (Selvini & Palazzoli, 1991; Bateson, 1979). Even with this support in mind, the literature has neglected to study the relationship between co-therapy and client dropout rates. The current study will attempt to fill this gap in research as an extension and operationalization of the aforementioned support which led to the formation of hypothesis that co-therapy teams are less likely than individual therapists to experience client premature termination rates than those who do not.

Definition of Dropout

Empirical literature on premature termination in the field of marital and family therapy is lacking (Bischoff & Sprenkle, 1993). In fact, Garfield (1986) identified only

one study in his review, Shapiro (1974), that related to "family therapy" dropout. Part of the problem of generating empirical literature in the family therapy field is that researchers have been unable to agree on an operational definition of therapy dropout (Bischoff & Sprenkle, 1993; Brandt, 1965; Garfield, 1986, 1989; Pekarik, 1985). The difficulty in determining an acceptable operational definition for therapy dropout is that findings could vary according to differences in the definitions themselves (Pekarik, 1985). Existing literature proposes three approaches to defining dropout. The most common definition is to classify clients by duration of treatment. The number of sessions, or the duration of treatment, has been correlated with successful outcome in therapy (Luborsky, Auerback, Chandler, Cohen, & Bachrach, 1971; Anderson, Atilano, Bergen, Russell, & Jurich, 1985; Ware, 1978; Berger, 1983; Greenfield, 1983; Gaston & Sabourin, 1992). Hampson and Beavers (1996) found that families who attended four or more sessions attained a 93.8 percent "improvement" rate based on therapist ratings of goals met in therapy. In addition, client premature termination is commonly defined as clients who discontinue therapeutic services against the therapist's wishes after the first or second session (Davis & Dhillon, 1989; Epperson, Bushway, & Warman, 1983; Hoffman, 1985; Slipp, Ellis, & Kressel, 1974; Luborsky et al., 1971). Taken together, these findings suggest continuance in therapy is linked not only with the opportunity for clients to make change but for clients to maintain changes over a period of time as well. Another way to define dropout is by clients who drop out of therapy against the judgment of the therapist *anytime* after the third session (Brandt, 1965; Sledge, Moras, Hartley, & Levine, 1990; Bischoff & Sprenkle, 1993). This definition differs from the previous in that emphasis is placed on whether the therapist concurred with the client about the termination. And finally, whether or not treatment goals have been accomplished at termination of therapy is a way of defining dropout (Anderson et. al, 1985; McAdoo &

Roeske, 1973). The literature supports goal attainment as being positively correlated with positive therapeutic outcomes (Gelso & Carter, 1994).

The present study will combine these criteria to define dropouts as clients who dropout of therapy against the therapist's wishes before the third session. Continuers will be defined as clients who continue therapy beyond the third session.

Therapist Variables

When studying dropout, there are two major categories of variables to consider: therapist and client variables (Bischoff & Sprenkle, 1993). Because the main purpose of this study is to examine and test therapist behaviors that may contribute to pre-termination or continuance in therapy, therapist demographic variables are considered first. To understand client characteristics that may be associated with dropout is important so that clinicians will be able to monitor their interventions and joining styles to accommodate varying populations. To date, there are three therapist demographic variables that have generated significant results regarding dropout in marital and family therapy literature. These variables include: gender and race of therapist, and therapist experience (Bischoff & Sprenkle, 1993).

Therapist Gender and Race. In 1970, the first attempt to look at the impact of race and gender on family services was undertaken as part of a larger survey or utilization of Family Service Agencies (Beck & Jones, 1973). Though dated, this study is remarkable because this is one of the only major empirical studies in the family therapy field which considered both race and gender (Gregory & Leslie, 1996). The literature that has been conducted on race and gender is largely theoretical with clinical case applications (Boyd-Franklin, 1989; Goodrich, Rampage, Ellman, & Halstead, 1988). Results generated in the literature regarding ethnicity are mixed and complex. Beck and Jones (1973) found that when white therapists were assigned to black clients, there were higher rates of premature termination than if the clients were assigned to black counselors. No

significant results were found for white clients seeing black therapists. Yet Viale-Val et al. (1984) in their study did not find race to be significant. These mixed results are reflective of the inconsistency of findings regarding therapist demographic variables. Because of this divergence in findings, no hypothesis for the demographic variable of race has been generated.

In the last decade, however, at least theoretically, the roles of race and gender have been included in the study of family therapy (McGoldrick, Pearce, & Giordano, 1982; Walter, Carter, Papp, & Silverstein, 1989; Gregory & Leslie, 1996). Jones (1992), Jones, Krupnick, and Kerig (1987) and Sue (1988) have all paid a great deal of attention to the interaction of therapist and client race and gender as critical variables affecting the course of individual therapy as well (Gregory & Leslie, 1996). Beck and Jones (1973) found that dropout rates decreased when primary clients were matched according to sex of therapist. In addition, Viale-Val, Rosenthal, Curtiss, and Marohn (1984) found in their study of a child guidance clinic sample, that when adolescent clients were matched with the same-sex therapist, dropout rates were lower. This information led to the hypothesis that clients who are matched with therapists of the same gender are more likely to continue therapy than those who are not.

Mas, Alexander, and Barton (1985) and Newberry, Alexander, and Turner (1991) have examined the impact of gender on therapists', adolescents', mothers', and fathers', behavior in the initial session of family therapy. They found that fathers responded more positively than mothers to structuring behavior by the therapists, and female therapists were more likely than male therapists to respond to family members' supportive behaviors with structuring interventions. This finding suggests that gender does operate in the response patterns of both therapists and clients. In addition, more supportive responses were given to a female therapist who engaged in supportive behavior. This finding demonstrated that family members responded in different ways to the same

behavior by male and female therapists. In their study, Shields and McDaniel (1992) examined process differences in the initial family therapy session as a function of therapist gender. Similar to Alexander and colleagues (1976), they found families made more structuring and directive statements with male therapists, and more internal family disagreement was observed with female therapists. Male therapists were also found to make more statements during therapy than female therapists. Allgood and Crane (1991), and Epperson, Bushway, and Warman (1983) found that male therapists who conducted the first interview were more likely to experience clients who dropped out after that session than were female therapists.

With the exception of these few studies, however, there is a lack of empirical attention to the impact of both race and gender in family therapy (Gregory & Leslie, 1996). In their 1986 review of marital and family therapy research, Gurman, Kniskern, and Pinsof don't mention any empirical studies of the effects of race and gender in family therapy. This study will attempt to fill this void in research by describing the impact of gender on the therapeutic relationship.

Therapist Experience. Therapist experience is another demographic variable to be considered. Although therapist experience has been found to be moderately associated with client satisfaction (Scher, 1975; Slater, Linn, & Harris, 1981), weakly correlated (UMHPEC, 1981), or not related at all (Frank, Salzman, & Fergus, 1977). Sager, Masters, Ronall and Normand, (1968) found that the rate of clients dropping out decreased as therapists gained experience in family therapy. Slipp and Kressel (1978) found inexperienced therapists were associated with all of their family therapy dropouts. To demonstrate the significance of therapist experience even further, Berg and Rosenblum (1977), Epperson, Bushway, and Warman (1983), Pekarik (1985), and McKee and Smouse (1983) found the number of therapy experiences therapists had were significantly and positively correlated to the percentage of families who successfully

engaged, or joined with the therapist(s) in family therapy. The literature reflecting the correlation of therapist experience to dropout led to the formation of hypothesis that the more experience the therapist has in terms of amount of time the therapist has practiced, the less likely the client is to dropout of therapy.

Client Variables

Socioeconomic Status. In addressing premature termination, the predominant research in marital and family therapy pertains to client demographic variables. The client's socioeconomic status (SES), and drug and alcohol abuse have both been associated with premature termination. Even though some studies have not found an association between SES and premature termination (Slipp et al., 1974; Gaines & Stedman, 1981), Hunt (1962) found clients lowest in the lowest socioeconomic bracket tended to terminate contact with therapists early in treatment. Other studies have also supported such results (Kazdin, 1990; Fiester & Rudestam, 1975; Lake & Levinger, 1960; Pekarik & Stephenson, 1988; Slipp, Ellis, & Kressel, 1974; Viale-Val, et al. 1984; Luborsky et al., 1971). This information led to the formation of hypothesis that the lower the client's economic status, the more likely the client is to dropout of therapy.

Drug and Alcohol Abuse. Another demographic variable that has been most consistently linked to client dropout is alcohol and drug abuse (Baekeland & Lundwall, 1975). They found drug and alcohol use is related negatively to the number of session clients attended. Friedman, Tomko, and Utada, (1991) supported this finding in their research. This information led to the hypothesis that the greater the alcohol use, the more likely the client is to dropout of therapy.

Presenting Problem. Research has been conducted on how the type, severity, and client perceptions of the presenting problem influences therapeutic outcome. One of the variables found to predict marital therapy outcome most consistently is the level of initial distress (Johnson & Talitman, 1997). Jacobson, Follette, and Pagel (1986) and Whisman

and Jacobson (1990) found that when severely distressed couples were considered separately from the mildly and moderately distressed, severely distressed couples were less likely to be classified as recovered at follow-up. Other research findings have also found that severely distressed couples are less likely to be satisfied at the end of therapy (Baucom & Hoffman, 1986; Snyder, Mangrum, & Wills, 1993). These findings are important as client satisfaction is critical to therapeutic continuance. Studies also show that the more severe or chronic the presenting problem is, the less likely the client is to pre-terminate therapeutic services (Kazdin, Mazurick, & Bass, 1993; Gaines & Stedman, 1981; Hoffman, 1985; Roeske, 1973) which led to the formation of hypothesis that the greater the severity of the presenting problem, the less likely clients are to drop out of therapy. Gaines and Stedman (1981) reported that length of presenting problem was correlated with clients continuing therapy which led to the hypothesis that the greater the duration of the presenting problem, the less likely clients are to drop out of therapy. They found clients who experienced and reported problem duration of longer than six months tended to stay in therapy.

Little research has been conducted on the client's attitude toward the likelihood of the presenting problem to change, and how this attitude is linked to outcome in therapy. Balked and Lundwall (1975), while studying pre-termination of therapeutic services, found that the client's negative attitude toward the therapy process and the ability of therapy to reduce symptoms can increase likelihood of dropping out. Goldstein and Shipman (1961) stated that greater the expectation of symptom reduction in the beginning of therapy was positively related to later symptom reduction in treatment. These findings indicate that a positive client attitude toward change is positively associated with continuance in therapy. This information lead to the hypothesis that the less likely the client feels the problem is to change, the more likely the client will preterminate therapeutic services.

Presenting problems have been found to be correlated with client satisfaction. In 1979, Larson and colleagues found that clients seeking therapy for anxiety, thought disturbance, and relationship problems were more likely to be satisfied than were those treated for depression or job-related difficulties. University students who were counseled for depression and anxiety were less likely to indicate satisfaction with treatment than were those seeking to improve self-confidence and self-esteem (Greenfield, 1983). In support, McAdoo & Roeske (1973) found that people who do drop out of therapy prematurely tend to have less severe, more transitory problems.

Conceptual Framework

In studying the relationship between the therapist's quality of joining and clients continuing or prematurely terminating therapeutic services, the two most appropriate theories to use are Family Systems Theory and Social Exchange Theory. The experiment is conducted through an umbrella framework known as process research. Therefore, process research will be explained first, followed by the descriptions and utility of Family Systems Theory and Social Exchange Theory.

Process Research. Process research is an effective tool for conceptualizing the study of therapist-client interaction. Greenberg and Pinsof (1986) present a definition of process research which incorporates a variety of new ideas about process research that have been emerging over the last ten to fifteen years. They define process research as the study of the interaction between patient and therapist systems in order to elucidate the mechanisms and processes of change. Process research covers all of the behaviors and experiences of these systems, within and outside the treatment sessions, which pertain to the process of change. Linking process to outcome makes process research the study of the process of therapy. Process research is important because without the knowledge gained from this research, what actually occurs in therapy and the processes associated with success or failure of treatment, remains a mystery. Process research can provide

clinicians with information that can have an impact on their own behavior. For example, to know that the process of joining a particular type of family system by being active and directive results in a better therapeutic alliance than joining a similar family system by being more reflective and passive, is directly meaningful to therapists. Process research seeks to link process and outcome. This study, therefore, is guided overall by a process research framework.

Family Systems Theory. Family Systems Theory is a special application of General Systems Theory. In the 1950's, researchers were seeking ways to unify the social sciences into one category, General Systems Theory. The attempt failed but some researchers chose to conceptualize families through General Systems Theory. Before systems theory, the family tended to be seen mostly as a collection of individuals who operated independently of one another. Family interactions were viewed in mechanistic terms of "cause and effect." Freudian psychoanalysis or psychodynamic psychology grew out of causal explanations for human behavior. Gregory Bateson (1956) offered an alternative to the cause and effect conceptualization of behavior. He introduced cybernetics, which is the study of control processes in systems, and contended that family systems theory is a way of viewing families where members are interrelated with one another and operate as a system. Patterns of interaction within the system provide opportunities for members to influence one other (von Bertalanffy, 1975).

Interaction between client and therapist in a therapy session may be viewed as an interacting system where influence is possible. Utilizing a systemic framework for examining therapist characteristics as they relate to continuing or prematurely terminating from therapy is crucial for several reasons. First, as applied to this study, systems theory examines the relationship, or interaction, between client and therapist. This may be referred to as the notion of wholeness, in which the whole is greater than the sum of its parts. Wholeness implies cohesion. Characteristics of wholeness surface from studying

emergent properties which only arise through interaction (Whitchurch & Constantine, 1993, p. 329). Information from this study will identify the emergent properties crucial to understanding early client attrition from therapy.

Second, the notion of *boundaries* is important to understand when utilizing a systemic framework for examining therapist characteristics as they relate to continuing or prematurely terminating from therapy. Family therapists often consider the processes of boundary distinction between individuals, family subsystems, and the family and the external environment to be of primary importance. Boundaries allow for the differentiation and development of structure. Structure is defined as the totality of the relationships between the elements of a dynamic system (Simon, Stierlin, & Wynne, 1985). Minuchin (1974) claims boundaries of a system or a subsystem are determined by "the rules defining who participates [in the family or subsystem] and how" (p.53). The act of identifying several components as a system is equivalent to drawing a boundary between who is included within the system and who is not part of the system (Spencer & Brown, 1972).

Boundaries are often characterized by their relative amount of permeability, or the degree to which they allow or prevent the flow of matter, energy, or information into and out of the system (Whitchurch & Constantine, 1993, p. 333). Boundaries are an indication of the extent to which systems are or can become open and the crossing of boundaries changes closed systems into open ones. In other words, crossing of boundaries transforms stable structures which is termed "morphostasis," into flexible structures which is termed "morphogenesis" (Simon, Stierlin, & Wynne, 1985). Saltzman et al. (1976) alluded to the concept of boundaries in their discussion of *openness*. They defined openness as the client's ability to express thoughts and feelings openly during the session and the client's conviction that the therapist in turn reacts

openly to their thoughts and feelings. In addition, openness refers to the extent to which the therapist feels he/she is able to express the things he/she wishes to communicate.

Simon, Stierlin, and Wynne (1985) state that boundaries between the family and the external environment are determined by the difference in the interactional behavior that family members exhibit toward other family members and toward nonfamily members. Psychological distance is regulated between client and therapist by boundaries. The ebb and flow of information that is generated and received between client and therapist is dependent upon the flexibility and adaptability of both systems. The family's willingness to extend their boundaries to include the therapist may be dependent upon how well the therapist demonstrates effective communication skills, respect, understanding and empathy, and competence.

Third, when utilizing a systemic framework for examining therapist joining characteristics, *morphostasis* is another concept to consider. Systems routinely make self-correcting adjustments and are one of the self-regulating mechanisms which promotes morphostasis, or the status quo. A system responds to any source of disturbance by acting to reduce the deviation from the prior state of morphostasis (Whitchurch & Constantine, 1993, p. 335). There are certain systems that can compensate for certain changes in the environment while maintaining relative stability in their own structures (Ashby, 1952). That is, when any deviation from the state of morphostasis occurs, the system responds by enacting negative feedback to bring the system back to the previous morphostatic state (Whitchurch & Constantine, 1993, p. 335). An example of morphostasis is when clients naturally attempt to remain stable and revert to a familiar way of doing things even when the condition of relationships may become uncomfortable. The essential mechanisms that enable the system to do this are *negative feedback loops*. *Negative feedback* can be defined as self-corrective processes whereby feedback counteracts deviation that goes beyond certain limits (Simon, Stierlin,

& Wynne, 1985). This type of loop is also referred to as a deviation-dampening loop. An example of negative feedback is if a child's disruptive behavior is ignored, the behavior might extinguish over time because the behavior is not rewarded. In contrast, positive feedback is information generated within the system that when acted upon has the effect of changing the system's structure. Such loops are sometimes called deviation-amplifying loops because they result in more variation in system behavior (Constantine, 1986). For example, if a child's behavior is rewarded with a smile or any other valued response, the result is an increase in the probability of that behavior being repeated and intensified. The interaction between client and therapist may be understood through the notion of *feedback* as well. Feedback is information which is contained within the client-therapist system and is transmitted or circulated within the system. In therapy, however, therapists often recognize a need exists to modify the system. When utilizing the concept of *positive feedback*, the therapist provides information and if the client system is open and flexible enough, the system will accept the feedback and modify systemic structures. In this study, the expectation is that clients are more likely to accept positive feedback when the therapist demonstrates respect, competence, effective communication, and understanding and empathy. The therapeutic process may be viewed as a complex set of interconnected positive and negative feedback loops that combine to provide both stability (clients continuing in therapy) or change (clients prematurely terminating therapy).

Fourth, circular causality is the idea that events are related through a series of interacting loops or repeating cycles (Nichols & Schwartz, 1995). In therapy, this means that the client and therapist are both responsible for what happens. This concept has important implications for studying premature termination. For example, when goals for therapy have been identified and are acceptable to therapist and client, premature terminations have been found to decrease (Gelso & Carter, 1994).

Social Exchange Theory. Social exchange emerged as a major framework in sociology and social psychology in the late 1950's and early 1960's, but the methodological application in the study of family-related phenomena occurred somewhat later (McDonald, 1981). In the late 1960's, early 1970's, Edwards (1969), and Broderick (1971) highlighted the central role that exchange theory had played in the existing research and the potential it offered for further theoretical development in the field of family studies. By the end of the 1970's, exchange theory had become one of the most universally used theoretical frameworks in family research (Sabatelli & Shehan, 1993). In the early 1980's, McDonald (1981) concluded that the exchange framework had been most effectively used to explain processes of relationship formation and mate selection.

The social exchange framework focuses on how relationships are developed and experienced, on the patterns and dynamics that emerge within ongoing relationships, and on the factors mediating the stability of relationships (Sabatelli & Shehan, 1993). In addition, the framework is concerned with the exchange relationship and the factors that mediate the formation, maintenance, breakdown, and dynamics that characterize the relationship. The basic assumption of this theory suggest that humans are rational beings who make decisions based on their experiences and expectations in order to receive the most rewards and fewest costs. All behavior is costly in terms of energy and time. Therefore, people choose relationships they perceive will produce the greatest profit. This is true in therapy, as well. Clients will often decide whether or not to continue with the therapist in the first session which is why joining early in treatment is so critical for therapists.

The major concepts in exchange theory can be broken down into four general categories: the characteristics that each partner brings to the exchange relationship, the norms and rules that regulate exchange relationships, the emergent characteristics of the exchange relationship that influence the decisions about whether to remain in or leave the

relationship, and the concepts addressing relationship dynamics (Sabatelli & Shehan, 1993, p. 397). When utilizing a social exchange framework for examining therapist joining characteristics, these concepts are important to consider.

Included in this category of the characteristics that each partner brings to the exchange relationship are resources, views about what constitutes rewards and costs, expectations for relationships, perceptions of alternatives, and exchange orientations (Sabatelli & Shehan, 1993, p. 397). Exchange theories use the concepts of rewards and costs borrowed from behavioral psychology, and resources which was borrowed from economics when discussing the foundation of the interpersonal exchange (Sabatelli & Shehan, 1993, p. 397). In 1959, Thibaut and Kelley developed the concept of comparison level (CL). They developed CL to explain the role of previous experiences and expectations in clients' evaluation of the quality of exchange outcomes. The CL is a standard by which people evaluate the costs and rewards of a given relationship in terms of what they feel is deserved and/or realistically obtainable (Sabatelli & Shehan, 1993, p. 398). In therapy, clients bring with them their resources which make up their own perspective. Clients will quickly determine if the rewards outweigh the costs for being in therapy. This is why joining with clients early in treatment is so critical and it is crucial for therapists to maximize opportunities for clients to continue therapy. Maximizing rewards must first begin with identifying therapists' joining characteristics.

Because high levels of rewards alone, do not determine the likelihood that a relationship will continue. Thibaut and Kelley (1959) also developed the concept of comparison level for alternatives (CLalt) which is defined as the lowest level of outcome a person will accept from a relationship in light of available alternatives. This concept is of critical importance in therapy because the concept helps explain clients' decision to remain in or leave a relationship (Albrecht & Heaton, 1991; Sabatelli & Shehan, 1993, p. 400). Clients will not only determine if the rewards outweigh the costs for remaining in

therapy, but will also decide if other alternatives for getting help appear more attractive. The CLalt is determined by the perceived quality of the best currently available alternative to the present relationship. The second category includes norms and rules, such as norms of fairness that regulate exchange relationships. Each exchange relationship has a unique set of norms and rules that guide the relationship. Society partly determines what behavior is acceptable and appropriate in relationships. Because relationships are embedded in a context, norms are prescribed culturally through roles. These roles are internalized and expressed which are referred to as cognitive expressions (McDonald, 1981.) The level of gratification within the relationship is derived from the evaluation of the outcomes available in the relationship. Outcomes are equal to the rewards obtained minus the costs incurred while engaged in the exchange relationship. Rules in the relationship take into account experiences and expectations of both parties (Nye, 1979; Sabatelli, 1984; 1988; Sabatelli & Pearce, 1986; Thibaut & Kelley, 1959). Norms of fairness is also referred to as the norms of distributive justice which states that rewards should be proportional to costs and profits should be proportional to investments (Homans, 1961).

The third category includes the emergent characteristics of the exchange relationship that influence the decisions about whether to remain in or leave the relationship, such as each actor's subjective satisfaction with the outcome of the relationship, perceptions of fairness and reciprocity, trust of the partner, and commitment to the relationship. This category is of particular importance to the therapist, because clients who perceive each of these as positive will probably rate a higher comparison level, and thus remain in treatment. Clients who feel they can trust their therapist and believe the therapist is committed to the relationship are more likely to remain in the therapeutic relationship, as trust is a typical positive feeling associated with the therapeutic alliance (Chance et al., 1995).

The final category includes concepts addressing relationship dynamics, such as decision making, power, and control. Exchange theorists address the bases of power by focusing on the constructs of resources and dependence (Sabatelli & Shehan, 1993, p. 406). The unit of analysis is the dyad, not the individual. Relationships are characterized by attempts to balance dependence and power (Emerson, 1972a,b). If clients do not perceive the therapist as having adequately demonstrated respect, understanding, and competence, then clients may be more likely to resist therapists' efforts to facilitate change. In fact, if a therapist is not adequately joined and they employ confrontational techniques, their actions may be met with a power struggle. Or worse, clients may dropout of therapy.

In sum, social exchanges are regulated by norms of reciprocity. Interactions, expectations for rewards, and costs guide people's behavior. In therapy, clients may decide to continue or terminate therapy based upon perceived costs and benefits of maintaining the therapeutic relationship. Again, that is why the therapist who demonstrates respect, understanding, and competence is likely to experience fewer premature terminations than those who do not.

Hypotheses

Hypothesis I: Threrapists who are well-joined with clients early in therapy will have lower drop-out rates than therapists who are less well-joined.

HI.I: Therapists who demonstrate good communication skills as measured by clients' perceptions will have lower client dropout rates than those who do not.

HI.2: Therapists who demonstrate respect as measured by clients' perceptions will have lower client dropout rates than those who do not.

HI.3: Therapists who demonstrate understanding as measured by clients' perceptions will have lower client dropout rates than those who do not.

HI.4: Therapists who demonstrate competence as measured by clients' perceptions will have lower client dropout rates than those who do not.

HI.5: Therapists who demonstrate empathy as measured by clients' perceptions will have lower client dropout rates than those who do not.

Hypothesis II: Co-therapy teams are more likely to be joined with clients and less likely than individual therapists to experience client premature termination.

Hypothesis III: The therapist demographic variables that will be related to the client's choice to continue or preterminate therapeutic services are gender and therapist experience.

H3.I: Clients who are matched with therapists of the same gender are more likely to continue therapy.

H3.2: The more experience the therapist has, the less likely the client is to drop out of therapy.

Hypothesis IV. Client's socioeconomic status (SES) and alcohol consumption will be the only two client demographic variables examined as they related to dropout in therapy.

H4.I: The lower the client's economic status, the more likely the client is to dropout of therapy.

H4.2: The greater the alcohol use, the more likely the client is to dropout of therapy.

Hypothesis V: The presenting problem is correlated with clients' continuance in therapy.

H5.I: The greater the severity of presenting problem, the less likely clients are to drop out of therapy.

H5.2: The greater the duration of the presenting problem, the less likely clients are to drop out of therapy.

H5.3: The degree to whether clients believe how likely the problem is to change directly corresponds to whether clients continue in or prematurely terminate therapy.

CHAPTER III

METHOD

Rationale

The purpose of this descriptive study is to examine the characteristics of a well-joined therapist and how the quality of joining may be related to client continuance of therapeutic services. Discovery-oriented research uncovers relationships between variables and accounts for within-group variance. In addition, discovery-oriented research involves identifying linkages between process and outcome variables. The findings of this study are important not only to clinicians providing quality therapeutic services, but also to researchers in furthering their endeavor of studying the variables of process research as they relate to therapeutic outcome. The method section will explain how experimental data will be gathered to assess the hypotheses derived from the literature review. The study population will be described, followed by an outline of measurement and data collection procedures.

Study Population

The target population will be all clients receiving marital and family therapy services and all therapists and interns providing marital and family therapy during the time of the study. This study involves data gathered during a three month period at a university-based marriage and family therapy training clinic. The sampling unit of analysis will be the individual client, the therapist, and the therapeutic system. The sample will be representative of the target population since the procedures for first sessions are essentially the same. The limitation of this study is the relatively small sample size which will limit the generalizability of results. In addition, the study used a non probability sample because participants were not randomly drawn; therefore, the chances for any particular client to be included in the sample were not equal.

Measurement

Three general areas are assessed: client perceptions of the therapist's quality of joining, trained observers' perceptions of the therapist's quality of joining with the therapeutic system, and the therapist's perception of how well he or she is joined with the therapeutic system. The primary independent measure is the degree to which adequate joining has taken place in the first session. The primary dependent measures are the number of sessions attended by clients and the reason for termination. The instruments used include a joining questionnaire designed by the researcher, and forms used as part of the facility's standard intake procedure including the intake form, background form and counseling agreement.

Joining Assessment. Research has shown that clients' and therapists' reports of their session-by-session reactions were strongly related to outcome (Alexander & Holtzworth-Munroe, 1994). To assess joining, including the extent to which the therapist demonstrates effective communication skills, respect, understanding and empathy, and competence, each therapist, client, and observer will be asked to make a series of ratings on a Likert-type response scale. The scale ranges from 1-Strongly Agree, 2-Agree, 3-Neither Agree nor Disagree, 4-Disagree, to 5-Strongly Disagree. The authors chose the Likert-type scale to sensitively and accurately gauge the course of treatment. The scale will attempt to accurately measure the evaluative perceptions of participants and will group together into three underlying attitude dimensions: (1) the individual's evaluation of the joining characteristics; (2) the individual's perception of the potency or power of the therapist; and (3) the client's perception of the activity of the therapist. The questionnaire will read: Using the following scale, please answer the following questions: The questionnaire will consist of twenty three questions assessing therapist characteristics of communication skills, respect, understanding and empathy, and competence. For the purpose of generating multi-measure, multi-perspective results,

three parallel versions of the joining assessment were developed by the researchers, a version for each group of clients, therapists, and observers. The face validity of the measurement is gained by the collaboration of marital and family therapy researchers. The reliability will be generated from this study. The questionnaires are included in Appendix B.

The joining assessment is comprised of four subscales. These subscales include communication, respect, understanding and empathy, and competence. Items included in the communication subscale are: question #1: The therapist(s) listened to the client, question #2, The therapist(s) understood the client, question #3: The therapist(s) helped the client to clarify the client's problem, question #4: The therapist maintained good eye contact with the client, question #7: The therapist(s) understood what the client(s) said, question #9: the therapist(s) understood the client's problem, question #16: The therapist(s) kept the conversation going, and question # 18: The therapist(s) helped the client(s) to feel comfortable.

Items included in the respect subscale were question # 5: The therapist(s) respects the client(s), question #6: The therapist(s) greeted each person in the client's family, and question #23: The client(s) trust the client's relationship with the client's therapist(s).

The subscales of understanding and empathy were combined and included question #8: The therapist(s) understood how the client(s) felt, question #14: The therapist(s) was easy to talk to, and question #20: The therapist(s) gave the client(s) hope that progress could be made.

The competence subscale was comprised of question #10: The client appeared to have confidence that the therapist(s) could help, question #11: The therapist(s) is committed to helping the client(s), question #12: The therapist(s) helped the client understand the client's problem, question #13: The therapist(s) was calm when things were intense, question #15: The therapist(s) respects the client's relationships with

family members, question #17: The therapist(s) kept the session focused, question #19: The therapist(s) helped the client(s) to establish clear goals, question #21: The therapist(s) gave the client(s) a reason to come back, and question #22: The therapists presented a variety of treatment options.

Since clinic procedures sometimes utilize co-therapy teams space is provided on client and observer versions of the joining assessment for rating each therapist independently. These questions remained on the subscales even though co-therapy teams were not used in this study.

Intake Form. The intake form is filled out by a therapist from the information gathered at the time of the request for service (Appendix C). Hypothesis number two states that clients with a lower socioeconomic status are more likely to dropout of therapy. The support of this hypothesis will be based upon the answer from a question on the intake form that reads: Yearly income before taxes. The fee for service is determined by a sliding fee scale dependent upon the gross income of clients and how many people are dependent upon that income. Clients may negotiate fees for services further during the first session, if they cannot afford the sliding fee scale rate.

Background Form. Before their first session, clients complete a background questionnaire including information about client's age, health problems, alcohol use, reason for seeking services, presenting problem, attitudes of change, seriousness of problems and previous and current therapeutic services in which the client may be engaged. The perception of problem data (Appendix C) was measured by two four-point Likert-type scales. The range of severity and likelihood of problem to change was from not at all serious/likely to very serious/likely. Clients complete the questionnaire before the beginning of the first session. There are currently no previously reported measures of reliability of the form. The background form's face validity of the instrument was established by the collaboration of three licensed marital family therapists and approved

supervisors with both clinical and academic expertise in the family therapy field. The form was also approved by the professional agency which grants accredited status.

There are several questions regarding client demographic variables on the background questionnaire. Hypothesis number two states that the greater the alcohol use, the more likely the client is to dropout of therapy. The question regarding alcohol use on the background form reads, "Do you drink alcohol? If yes, How much?" If clients drink, they are to mark 1 for yes and 2 for no. Then the actual consumption is measured when the client marks 1 for On occasion, 2 for 1-3 times weekly, 3 for 4-6 times weekly, 4 for 7+ times weekly, or 5 for multiple times daily.

Counseling Agreement. In order to inform clients of research in progress, as well as to assure clients their confidentiality will be maintained, at the beginning of each first therapy session, all clients sign a counseling agreement which specifically states, "I (we) acknowledge the importance of research in increasing the effectiveness of therapy and in training high quality therapists. I (we) do consent to any research that may be completed through the clinic on my (our) case. We understand that names are never used in research and that the Center for Family Services guarantees the confidentiality of our records."

FACES III. As stated earlier, one of the variables found to predict marital therapy outcome most consistently is the level of initial distress (Johnson & Talitman, 1997). The Family Adaptability and Cohesion Scale III (FACES III) by Olson, Portner, and LaVee (1985) is used to assess couple level of functioning according to level of cohesion and flexibility at intake. This measure has a systemic focus and the information produced will be an individual's assessment of the interaction of a couple/family. Based on the Circumplex Model of Marital and Family Systems, (Olson, 1991), FACES III uses a five-point Likert-type scale ranging from (1) almost never to (5) very often. According to Olson et al. (1985), FACES III has good face and content validity and adequate internal consistency reliability for cohesion, flexibility, and total score. An example of a

flexibility item is "Different persons act as leaders in our family." An example of a cohesion item is "We like to do things with each other." Clients complete FACES III prior to their first session.

Communication and Satisfaction. Like FACES III, the subscales of the ENRICH inventory represent process, as communication and satisfaction, cohesion and adaptability are dynamic processes which are continually changing. In order to examine how the level of functioning at intake is related to clients' prematurely terminating or continuing therapeutic services, communication and satisfaction scales based on the ENRICH inventory will be used. According to Olson (1991), the extent to which individuals and families are satisfied with their current level of cohesion and adaptability provides meaningful measurement of the family system's functioning. The Couple Relationship and Family relationship satisfaction scales are used to determine individual's perceptions and attitudes of satisfaction toward family and partner relationships (Olson, Fournier, & Druckman, 1987). Though similar, the family and couple satisfaction scales are not identical. For example, and item from the Couple Relationship satisfaction scale states, "We ask each other for help," whereas the Family Relationship satisfaction scale states, "Family members ask each other for help." Individuals, in addition to families, complete the Family Relationship satisfaction scales. These measures are used prior to the first session to assess personal characteristics of family members and the degree of happiness or contentment one feels when considering those characteristics or their relationship with family members or partners. Participants who score high are usually well satisfied whereas low-scoring participants are generally not. On both the Family and Couple Relationship satisfaction scales, participants mark their answers from a five-point Likert-type scale ranging from 1 (almost never) to 5 (almost always).

Communication facilitates change in cohesion and flexibility. Olson et al. (1987) measured communication according to the "individual's feeling, beliefs, and attitudes

about the communication in his or her relationship" (p.69). The Couple Communication Skills Scale (CCSS) by Olson, Fournier, and Druckman (1987), and the Family Communication and Satisfaction scales were used to assess the third dimension of the Circumplex Model of marital and family systems (Olson, 1991). The Family Communication and Satisfaction scale used for families and individuals, is similar to the CCSS, which is based on two subscales from ENRICH. For example, an item from the CCSS states, "It is very easy for me to express all my true feelings to my partner," whereas an item from the Family Communication and Satisfaction scale states, "We express our true feelings to each other." Both the CCSS and Family Communication and Satisfaction scales consist of two twenty-item scales addressing clients' perceptions of communication and satisfaction with their families and/or partner. Like the satisfaction scales, participants mark their answers from a five-point Likert-type scale ranging from 1 (almost never) to 5 (very often). The dimensions are plotted on scales ranging to extremes. High scores represent more optimal levels of perceived communication and satisfaction than low scores (Olson, Fournier, & Druckman, 1987). The scales are administered after clients arrived but before their first appointment takes place. Participants are allowed as much time as needed to complete the forms individually. The CCSS contains items that are reversed scored so when calculated, high scores represent more optimal levels of perceived satisfaction and communication (Olson, Fournier, & Druckman, 1983). Both scales also contain high Cronbach's alpha reliability scores respectively, r=.73, .81 (Fournier, Olson, & Druckman, 1983).

Procedure

Data will be gathered from the initial phone call, the first session, the second session, and whether or not clients return for a third session. The intake form, background form, FACES III Inventory, two subscales of the Enrich Inventory, and counseling agreement will be administered by the client's therapist before the initial

session. Clients are asked to arrive fifteen minutes early for their scheduled appointment in order to allow time to complete paperwork. Clients complete the background form in the waiting room without the therapist present unless special assistance is requested. The therapist watches from behind a one-way mirror in case a question should arise.

All therapists and observers were brought together for a training session on how to collect the data by the researchers. Examples of the instruments and procedural information sheets were distributed. Each item was discussed and participants had the opportunity to ask questions. The training session lasted one hour.

Upon completion of the first and second sessions, each therapist who conducted the session and two trained observers will rate the therapist's ability to join with the therapeutic system. Observers will be selected based upon availability and number of times they already observed in order to give each observer as many times to observe as possible. Therapists will not be allowed to see the observers' ratings in order to keep therapists from modifying their joining behaviors to improve their therapeutic relationship. Upon completion of session two, client(s) who are twelve years or older will rate his or her perception of the therapist's ability to join with them. Clients will be will be made aware their confidentiality will be protected and informed that their therapist(s) will not see their ratings. The data will be entered and stored at the location of the training clinic. In addition, names will not be used on any of the instruments. Clinic procedure includes assigning all therapists their own ID#. Each therapist and observer will be asked to mark their assigned ID#'s in the upper right-hand corner of the joining questionnaire, which will generate the information needed for analyzing the gender portion of the study.

Research Design

Because random assignment is not feasible for this study, and in order to discover the association between the quality of joining and clients' continuing or preterminating

therapeutic services, the research design consists of a quasi-experimental, sequential, cross-sectional design with all participants attending at least two sessions. Therapists will not be informed of the results from the joining questionnaire and therefore will not be aware of which areas in joining need improvement. The confidential results from the questionnaires will help control for confounding variables, or the manipulation of the independent measure. Due to the inability of previous research to empirically define dropout, the current study will attempt to simplify the question by using two classifications of dropout. Dropouts will be defined as clients who dropout of therapy against the therapist's wishes before the third session. Continuers will be defined as clients who continue therapy beyond the third session. The data will be collected in a university based MFT training clinic. This research is descriptive as the major purpose of the study is to examine how the quality of joining may be related to client continuance of therapeutic services. In reference to the analysis of client and therapist characteristics, the unit of analysis will be the individual. The unit of analysis of the client type (individual, couple, or family) will be the client system. Data will be gathered upon completion of the first and second sessions, and whether or not the client returned for a third session. This type of data collection constitutes a cross-sectional design.

CHAPTER IV

RESULTS

The current study yielded a sample of eight cases in which clients, therapists, and observers rated a therapy session at least once by completing joining questionnaires. Overall, clients rated therapists highest, followed by observers, and then therapists rated themselves lowest. Empirical findings from the study can be found in Table 1. There were three points of data collection. The first two data collections took place after the first and second session by collection of the joining questionnaires. For the third data collection, researchers checked files to determine whether clients returned for a third session. Multiple participants provided for the multi-level and multi-perspective nature of this research.

Insert Table 1 Here

Clients

Of the thirteen clients who participated in this study, two were husbands/fathers, six were wives/mothers, two were daughters, one was a son, and two were an unmarried couple. There were nine (69.2%) female clients, and four (30.8%) male clients. Caucasian participants comprised 72.7% of the sample, 18.2% were African American, and 9.1% were Native American. Seventy-three percent of participants held a high school diploma or bachelor degree. Mean client education in years yielded 12.73, or most clients having finished high school and some college. Some clients reported using alcohol "on occasion." The question on which clients rate the severity of the problem ranges from 1 (not at all serious) - 4 (very serious). The percent of the clients who described their presenting problem as being very and moderately serious was 38.5%. The

percentage of clients who deemed the presenting problem as being "not at all serious," or as "slightly serious" was 23.1%. The mean for severity of the problem was 3.0 (moderately serious). The question of how likely the clients believed the problem would change ranged from 1 (not at all likely) - 4 (very likely). The mean for how likely clients believed the problem would change was 2.75. The mean of duration of problems was 4 months, with a range of 68 months, or almost six years. The median income was $19,640.00 with a standard deviation of $11,000.00. Seventy-nine percent of clients (n=11) did return for session three, while 21% (n=3) did not.

Therapists and Observers

Of the four therapists who participated in the study, one was male, and three were females. The male was a third year student and the females were second year students. Of the five observers, four were female, one was male. Three were first year students and one was a second year student, and the other was a third year student. Results for therapists and observers' ratings at time 1 can be found in Table 2.

Insert Table 2 Here

Reliability

Reliability is the extent to which a measure contains random error components. An instrument that is "consistent" or "dependable" is determined to be reliable (Miller, 1986). In order for research results to be meaningful, reliable measurement is imperative. Based on the premise that random measurement errors vary not only over time but also from one question or test item to another within the same measure (Judd, Smith, & Kidder, 1991), the internal consistency reliability of the joining scales was tested using Cronbach's alpha. Cronbach's (1951) alpha is a measure of internal consistency reliability. Reliability coefficients are often expressed as correlation coefficients which is

a statistical index of the strength of relationship between two variables (Judd, Smith, & Kidder, 1991). Reliability coefficients yield scores ranging from 0, or complete unreliability, to 1.0, or perfect reliability, with higher scores designating greater internal consistency reliability. The joining scales were tested for internal consistency reliability using Cronbach's alpha which yielded a full-scale alpha of .94, based on independent ratings. Carmine's and Seller (1979), state, "As a general rule, we believe that reliabilities should not be below .80 for widely used scales." Because the alpha for the full-scale joining instrument (.94) far exceeds Carmine's and Zellar's (1979) cutoff of .80 for "widely used scales" the instrument might be described as having remarkable internal consistency. Because deletion of any item would not enlarge the overall alpha, corrected item-total correlations indicate that all items should be retained. Reliabilities for the current study are contained in Table 3.

Insert Table 3 Here

Validity

If an instrument measures that which is intended, then validity has been achieved. Contrasted with reliability, validity describes the appropriateness of the use to which the instrument is put, whereas reliability, or the lack thereof, is a characteristic of the measurement itself (Miller, 1986). Therefore, the possibility exists that a measure may be reliable and not valid for the use in the immediate research problem. Face validity is evaluated by a group of experts to determine whether the measuring technique measures what its name suggests. The questions in the joining instrument were developed by the researcher and three clinical faculty members. The faculty members assessed the instrument for face validity.

Hypothesis Testing

All hypotheses were tested using analysis of variance, or ANOVA, with the exceptions of hypotheses two and three. These hypotheses were not tested due to lack of data to test hypothesis 2 (no co-therapy teams were included in the sample) and lack of adequate variation in gender and experience of therapists to test hypothesis 3. These two hypotheses will be discussed in further detail below. Responses for the joining scale ranged as follows: 1 (Strongly Agree) - 5 (Strongly Disagree). Joining in this study was defined as a therapist who is accepting of and accommodating to families through demonstration of effective communication skills, respect, understanding and empathy, and competence. Time 1 refers to data collected after session 1, whereas Time 2 refers to data collected after the second session. Time 1 Full Sample refers to results for therapists and observers, whereas Time 2 Full Sample is representative of results for all respondents who participated in the study, including clients, therapists, and observers. The following sections will state the results of the ANOVA tests for Hypothesis I and attributable subscales utilizing several different groups, including Time 1 Full Sample (results of session 1 for therapists and observers) and Time 2 Full Sample (results of session 2 for clients, therapists, and observers). However, the breakdown by participant will be listed only in Time 2 Full Sample since Time 2 Full Sample is representative of all respondents. In addition, the results for all hypotheses, including hypotheses 2, 3, 4, and 5, will be given in Time 2 Full Sample. For further detail, see Table 4.

Insert Table 4 Here

Hypothesis 1.0

Hypothesis 1.0 predicted that a therapist who is overall able to accept and to accommodate to families will less likely experience clients who drop out of therapy prematurely than therapists who do not join as effectively. This hypothesis was tested using two groups, including Time 1 Full Sample (therapists and observers) and Time 2 Full Sample (clients, therapists, and observers).

Time 1 Full Sample. Analysis of the results for therapists and observers who rated therapists after the first session proved not to be significant. The means for this hypothesis were 1.98 for continuers and 1.86 for dropouts meaning there was no significant difference between how therapists rated themselves and how observers rated therapists on overall joining in the first session $F(1, 82) = .92$, $p = .340$.

Time 2 Full Sample. Results were significant for clients, therapists, and observers combined who rated therapists' overall joining performance after the second session. However, though the full scale analysis proved significant, the results were not proved in the direction to support the hypothesis. Those who continued in therapy had a mean of 1.95, where those who dropped out had a mean of 1.48. This indicates that those who continued rated therapists lower on joining than those who dropped out, $F(1, 80) = 9.98$, $p < 01$.

Time 2 Clients. For clients who completed the joining questionnaire after the second session, results for therapists' ability to join overall did not support this hypothesis. The results were significant but not in the predicted direction. The item means for continuers was 1.94 and for dropouts was 1.12, indicating continuers rated therapists lower on overall joining than did dropouts $F(1, 16) = 6.86$, $p < .05$.

Time 2 Therapists. Results for therapists who rated themselves on overall joining at the close of the second session showed that there was no significant difference between how therapists rated themselves for clients who continued in therapy versus those who

dropped out $F(1, 20) = 2.09$, $p = .164$. The item means for continuers was 2.07 and for dropouts was 1.67.

Time 2 Observers. Observers' ratings for therapists after the second session did not support the hypothesis of the ability of therapists to overall join effectively. The item means for continuers was 1.89 and for dropouts was 1.50. This indicates there was no significant difference between how observers rated therapists' overall ability to join with continuers and dropouts $F(1, 40) = 3.29$, $p = .077$.

Hypothesis 1.1

Hypothesis 1.1 stated that therapists who demonstrate good communication skills as measured by clients' perceptions will have lower client dropout rates than those who do not. Questions included in the communication subscale were 1, 2, 3, 4, 7, 9, 16, and 18. This hypothesis was tested using groups of Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. Full scale analysis after the first session for the communication subscale was not significant. The means for the communication subscale were 1.84 for those who continued and 1.73 for those who did not. No significant difference existed between how therapists and observers rated therapists' ability to join through effective communication skills with continuers and dropouts. There was no significant difference between how the two groups rated therapists on the subscale of communication $F(1, 82) = .71$, $p = .401$.

Time 2 Full Sample. The communication subscale hypothesis was not supported by overall analysis of all respondents at Time 2. ANOVA indicates analysis of the communication subscale was significant but not in the predicted direction to support the hypothesis. The mean for continuers was 1.84, and the mean for dropouts was 1.36. Clients who dropped out rated therapists higher on communication skills than those who continued in therapy $F(1, 80) = 10.92$, $p < .001$.

Time 2 Clients. Results for client ratings on the communication subscale after the second session were significant but not in the predicted direction. Item means for the subscale of communication were 1.83 for dropouts and 1.67 for continuers. Clients who continued therapy beyond 3 sessions rated therapists lower on the communication subscale than did dropouts $F(1, 16) = 6.30$, $p<.05$.

Time 2 Therapists. Results of the communication subscale for therapists' self-ratings after the second session were not significant. The item means for the subscale of communication was 1.92 for dropouts and 1.55 for continuers. This means there was no significant difference between how therapists rated themselves for both continuers and dropouts on the communication subscale $F(1, 20) = 2.89$, $p = .105$.

Time 2 Observers. The communication subscale hypothesis was not supported by analysis of observers' responses at the end of session 2. While there were significant differences between continuers and dropouts, the differences were not in the predicted direction to support the hypothesis. The item means for the subscale of communication were 1.80 for dropouts and 1.29 for continuers. Little difference between how observers rated therapists' ability to demonstrate effective communication skills with both continuers and dropouts rated therapists $F(1, 40) = 4.23$, $p<.05$.

Hypothesis 1.2

Hypothesis 1.2 was the next hypothesis measured. This hypothesis stated that therapists who demonstrate respect as measured by clients' perceptions will have lower client dropout rates than those who do not. Included in this hypothesis were questions 5, 6, and 23. This hypothesis was tested using respondent groups of Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. Results for therapists and observers' ratings after the first session did not prove to be significant. The mean for continuers on the respect subscale was 1.95, and for dropouts was 1.80. This means there was no significant difference

between how therapists and observers rated therapists' ability to demonstrate respect to continuers and dropouts $F(1, 82) = .17$, $p = .202$.

Time 2 Full Sample. This hypothesis was not supported through analysis of overall data from all respondents at Time 2. The mean for the respect subscale for continuers was 1.85, and for dropouts was 1.57. This means there was no significant difference between how continuers and dropouts rated therapists on the respect subscale $F(1, 79) = 3.26$, $p = .081$.

Time 2 Clients. The respect subscale hypothesis was not supported by clients who responded at the end of the second session. The item means for continuers on the respect subscale was 1.80 and 1.33 for dropouts. This means there was no significant difference between how continuers and dropouts rated therapists on the subscale of respect

$F(1, 15) = 1.14$, $p = .303$.

Time 2 Therapists. The respect subscale hypothesis was not supported by analysis of data from therapists responding at the end of the second session. The item means for continuers on the respect subscale was 1.92 and 1.60 for dropouts. This means no significant difference existed between how therapists rated themselves with continuers and dropouts on the subscale of respect $F(1, 20) = 1.50$, $p = .235$.

Time 2 Observers. The results of observers responding at the end of the second session did not prove significant. The item means for continuers on the respect subscale was 1.83 and 1.61 for dropouts. This means there was no significant difference between how observers rated therapists on their ability to effectively demonstrate respect to continuers or dropouts $F(1, 40) = .95$, $p = .335$.

Hypothesis 1.3

Hypothesis 1.3 stated that therapists who demonstrate understanding as measured by clients' perceptions will have lower client dropout rates than those who do not. This

hypothesis and Hypothesis 1.5, empathy, were seen as such similar constructs they were combined. Therefore, these hypotheses combined were tested using respondent groups for Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample. Questions included in the understanding subscale were 8, 14, and 20.

Time 1 Full Sample. Results for therapists and observers at the end of session 1 did not prove significant. The means for the understanding subscale were 1.90 for continuers and 1.83 for dropouts. This means there was no significant difference between how therapists and observers rated therapists on the understanding subscale $F(1, 82) = .26$, $p = .615$.

Time 2 Full Sample. Results from full scale analysis after the second session on the understanding subscale proved significant but not in the predicted direction to support the hypothesis. The mean for the understanding subscale for continuers was 2.00 and 1.51 for the dropouts. This indicates that therapists rated lower on the understanding subscale when their clients continued $F(1, 79) = 5.81$, $p < .05$.

Time 2 Clients. The understanding subscale hypothesis was not supported by data from clients responding at the end of the second session. The item means for the understanding subscale was 1.98 for continuers and 1.67 for dropouts. This indicates no significant difference existed between how continuers and dropouts rated therapists on the understanding subscale $F(1, 15) = 2.55$, $p = .131$.

Time 2 Therapists. After the second session, results from therapists' ratings of themselves on the understanding subscale did not prove to be significant. The item means for the understanding subscale was 2.25 for continuers and 1.67 for dropouts, indicating no significant difference existed between how therapists rated themselves for both continuers and dropouts on the understanding subscale $F(1, 20) = 2.25$, $p = .149$.

Time 2 Observers. This hypothesis was not supported by data from observers responding at Time 2. The item means for the understanding subscale was 1.89 for

continuers and 1.50 for dropouts. This indicates there was no significant difference between how observers rated therapists with clients who continued and clients who dropped out on the understanding subscale $F(1, 40) = 2.13$, $p = .152$.

Hypothesis 1.4

Hypothesis 1.4 stated that therapists who demonstrate competence as measured by clients' perceptions will have lower client dropout rates than those who do not. This hypothesis was tested using respondent groups from Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample. The competence subscale included questions 10, 11, 12, 13. 15, 17, 19, 21, and 22.

Time 1 Full Sample. The competence subscale hypothesis was not supported by results of data analysis for therapists and observers after the first session. The mean therapist rating on the competence subscale was 2.19 for clients who continued and 2.08 for clients who dropped out. This means there was no significant difference between ratings on the subscale of competence $F(1, 82) = .75$, $p = .390$ for clients who continued or dropped out.

Time 2 Full Sample. The results from analysis of data from all respondents at Time 2 were significant but not in the predicted direction to support the hypothesis. The means for the competence subscale were 2.13 for continuers and 1.64 for dropouts, indicating that dropouts rated therapists better on the competence subscale than continuers $F(1, 80) = 8.23$, $p < .01$.

Time 2 Clients. Clients' results on the competence subscale after the second session proved significant but not in the expected direction. The item means for continuers on the competence subscale was 2.10 and 1.11 for dropouts. This means that continuers rated their therapists lower on the competence subscale than did dropouts $F(1, 16) = 7.27$, $p < .05$).

Time 2 Therapists. Therapists' results after the second session did not prove significant on the competence subscale. The item means on the competence subscale was 2.23 where clients continued and 1.87 where clients dropped out. No significant difference existed from therapist' self ratings on the competence subscale for continuers or dropouts $F(1, 20) = 1.13$, $p = .300$.

Time 2 Observers. Analysis of data from observers' ratings after the second session did not prove significant. The item means on the competence subscale were 2.10 where clients continued and 1.72 for dropouts $F(1, 40) = 2.57$, $p = .117$.

Hypothesis 1.5

Hypothesis 1.5 stated that therapists who demonstrate empathy as measured by clients' perceptions will have lower client dropout rates than those who do not. As stated earlier, this hypothesis and Hypothesis 1.3, or understanding, were seen as such similar constructs, they were combined. The analysis for this hypothesis was included in the section of Hypothesis 1.3 (understanding).

Hypothesis 2.0

Hypothesis two stated that co-therapy teams are less likely than individual therapists to experience client premature termination. This hypothesis was not tested because no co-therapy teams were used in this study.

Hypothesis 3.0

This hypothesis stated that the therapist demographic variables related to the client's choice to continue or preterminate therapeutic services included gender and therapist experience. This hypothesis was not tested because there was not enough variation for therapist gender or experience.

Hypothesis 4.0

Hypothesis 4.0 stated that Client's socioeconomic status (SES) and alcohol consumption will be the only two client demographic variables considered in this study to be associated with dropout in therapy. These hypotheses were tested using ANOVA.

Hypothesis 4.1.

This hypothesis stated the lower the client's economic status, the more likely the client is to dropout of therapy. Support was found for this hypothesis but the results were not significant $F(1, 14) = .665$, $p = .428$. The mean for continuers' income in thousands was 44.15, and for dropouts the mean for income in thousands was 24.

Hypothesis 4.2.

This hypothesis stated the greater the alcohol consumption the more likely the client is to drop out of therapy. Support was found for this hypothesis but the results were not significant $F(1, 15) = .856$, $p = .370$. The results for the mean for the use of alcohol and drug use was 1.07 for continuers, and the mean for alcohol and drug use for dropouts was 1.33, see Table 5.

Insert Table 5 Here

Hypothesis 5.0

Hypothesis 5.0 stated that the presenting problem is correlated with clients' continuance in therapy. This hypothesis was tested using ANOVA.

Hypothesis 5.1.

This hypothesis stated that the greater the severity of presenting problem, the less likely clients are to drop out of therapy. Support was found for this hypothesis but the results were not significant $F(1, 16) = .042$, $p = .841$. The means for continuers for

severity of the problem was 3.20, or moderately serious, and 3.33 for dropouts which is closer to very serious.

Hypothesis 5.2.

This hypothesis stated that the greater the duration of the presenting problem, the less likely clients are to drop out of therapy. Support was found for this hypothesis but the results were not significant $F(1, 16) = .153$, $p = .701$. The mean for duration of problem in months for continuers was 15, and the mean for dropouts' duration of problem in months was 3, see Table 6

Insert Table 6 Here

Hypothesis 5.3.

This hypothesis stated that the less likely the client feels the problem is to change, the more likely the client will preterminate therapeutic services. Support was found for this hypothesis but not in the predicted direction $F(1, 15) = 1.59$, $p = .226$.

CHAPTER V

DISCUSSION

The primary purpose of the current study was to determine how the quality of joining may be related to client continuance of therapeutic services. The specific research question tested was whether the quality of joining directly corresponds to clients' choosing to continue or prematurely terminate therapy. In addition, this study attempted to underscore the importance of the relationship that is established between client and therapist. By describing and measuring the characteristics of a "well-joined" therapist, by operationally defining and measuring the process variables of joining, and by identifying the strength of the relationship between a "well-joined" therapist, marriage and family therapists and researchers will be better able to assess, monitor, and evaluate therapeutic practice, particularly in the area of joining. Clinicians will also be better able to curb early attrition from therapy. The current chapter will consider and suggest interpretations of the significant and non-significant results that were found. Limitations and suggestions for helping professionals and researchers are offered.

Results for each hypothesis tested will be given followed by the breakdown of each participant's ratings. Time 1 Full Sample is only representative of therapists and observers' responses in contrast to Time 2 Full Sample which is representative of all participant responses which include clients, therapists, and observers. Therefore the breakdown by participant will be given only in Time 2 Full Sample.

Hypothesis 1.0.

This hypothesis predicted that the better the therapist is joined, the less likely the client is to drop out of therapy. Hypothesis 1.0 was tested using several different groups, including Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. This hypothesis was not supported and analysis was not significant. The means for this hypothesis were 1.98 for continuers and 1.86 for dropouts meaning there was little difference between how therapists and observers rated therapists on overall joining, yet dropouts may have been slightly more satisfied with delivery of services than continuers. On the joining scale, Agree is denoted by the value 2, "Agree." Even though the hypothesis was not supported, both therapists and observers marked their answers between "Strongly Agree" and "Agree" on the joining scale. The means for this question fell toward the positive end of the joining scale. This information implies raters agreed that therapists were able to join effectively with their clients more than they were not able to join. One might conclude that both therapists and observers agree that good joining does exist.

Time 2 Clients. At the end of the second session, clients' responses of how well the therapists joined overall fell toward the positive end of the joining scale. Though this hypothesis was not supported, the results were significant. The item means for continuers was 1.94 and for dropouts was 1.12, indicating continuers rated therapists lower on overall joining than did dropouts. One reason as to why continuers rated therapists lower than dropouts was that dropouts may have known they were not coming back for a third session and thus marked ratings higher to "save face." On the joining scale, the means for Time 2 Clients fall between "Strongly Agree," and "Agree," which is toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to join with their clients.

Time 2 Therapists. Therapists' ratings of themselves at the end of the second session on overall joining did not prove significant. Hypothesis 1.0 predicted that the better the therapist is joined, the less likely the client is to drop out of therapy. This hypothesis was not supported as there was no significant difference between therapists' ratings for continuers and dropouts. The item means for continuers was 2.07 and for

dropouts was 1.67. Therapists' means fell between "Agree" and "Neither Agree nor Disagree," for continuers and therapists' means for dropouts' fell between "Strongly Agree" and "Agree." Though not significant, therapists rated themselves lower with clients who continued than with those who dropped out. A possible explanation for this is that therapists may have had time between the first and second session to ponder their performance over time. Situational factors may have also come into play- clients or therapists may have had a bad day. Although this hypothesis was not supported, respondents' answers did fall on the positive end of the joining scale, which means they believed therapists were able to join with their clients.

Time 2 Observers. The item means of observers' ratings for continuers was 1.89 and for dropouts was 1.50 on the therapists' ability to join overall after the second session. This means there was little difference between how observers rated therapists with clients who continued and clients who dropped out. Observers, however, did rate therapists slightly lower with clients who continued than with those who dropped out. In therapy, typically by the 2nd session, therapists aid clients in clarifying their problem and setting goals. These tasks may include therapists' reframing the problem or possibly even challenging the clients' view of the problem. If therapists do not conduct this session in a focused manner, or "miss" what clients are telling them, observers may rate therapists lower with clients who are present at this stage of therapy. In addition, there may have been greater expectations for joining by observers for therapists' starting the goal-setting stage. On the joining scale, therapists and observers' means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. As their ratings imply, respondents agreed therapists were overall able to join with their clients.

Time 2 Full Sample. Full scale analysis proved significant for clients, therapists, and observers ratings of therapists but not in the predicted direction to support the

hypothesis. Those who continued in therapy had a mean of 1.95, where those who dropped out had a mean of 1.48. This means that for clients who continued, clients therapists, and observers rated therapists lower on joining than those who dropped out. On the joining scale, these means fall between "Strongly Agree," and "Agree." Again, an observation worth noting was that even though the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to join with their clients.

Hypothesis 1.1

Hypothesis 1.1 stated that therapists who demonstrate good communication skills as measured by clients' perceptions will have lower client dropout rates than those who do not. Hypothesis 1.1 was tested using several different groups, including Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. This hypothesis was not supported as no significant difference existed between how therapists and observers rated therapists' on communication skills with continuers or dropouts. The means for the communication subscale were 1.84 for those who continued and 1.73 for those who did not. This means that though there was little difference between how therapists and observers rated therapists on the subscale of communication, therapists and observers rated therapists slightly lower for clients who continued than for those who did not. One reason therapists and observers may have rated therapists lower with those who continued may have been that overall, therapists rated themselves the lowest on all items, i.e., were most critical of their own performance, followed by observers. Therapists must demonstrate effective communication skills in order to help the clients clarify hidden and confusing aspects of experience (Nichols & Schwartz, 1995). In addition, therapists must be aware of the general meaning and the specific application of words the client uses because some words and phrases could have entirely different meanings for different individuals (Latz,

1996). Both groups may have been looking specifically for therapist's ability to demonstrate active or reflective listening, and depending upon the personal style of the therapist, these particular behaviors may not have occurred frequently enough to satisfy raters. For example, if a therapist spoke more than listened, there may not have been as many opportunities for therapists to demonstrate their ability to reflect back to the client what the clients were saying. On the joining scale, the therapists' and observers' means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express effective communication skills.

Time 2 Clients. Results for clients' ratings on the communication subscale after the second session were significant but not in the direction to support the hypothesis. The item means for the subscale of communication was 1.83 for dropouts and 1.67 for continuers. Clients who continued rated therapists lower on communication than did dropouts. This may be due to clients having already seen their therapist twice, as opposed to clients who dropped out and saw their therapist only once, which provided them with more information on the ability of their therapists to demonstrate their communication skills. The more information that was given, the greater the chance that clients saw something about their therapist's ability to demonstrate effective communication skills that they didn't like. However, on the joining scale, these means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express effective communication skills.

Time 2 Therapists. Therapists' ratings on the communication subscale after the second session did not support the hypothesis. The item means for the subscale of communication was 1.92 for dropouts and 1.55 for continuers. Therapists consistently

rated themselves lower than clients or observers on the joining scale. For example, Time 2 Therapists' means were 1.92 and 1.55, whereas Time 2 Clients means were 1.83 and 1.67. Although there was not a huge difference between how therapists rated their communication skills with continuers or dropouts, enough of a difference existed that is worth noting. Therapists' means fall between "Strongly Agree," and "Agree." Ratings for this question fell toward the positive end of the joining scale, which implies that raters agreed therapists were overall able to express effective communication skills.

Time 2 Observers. The communication subscale hypothesis was not supported by observers' ratings after the second session. While there were significant differences between how observers rated therapists with clients who continued and with clients who dropped out, the differences were not in the predicted direction to support the hypothesis. The item means for the subscale of communication was 1.80 for dropouts and 1.29 for continuers. This means there was little difference between how continuers and dropouts rated therapists on overall joining. On the joining scale, these means fall between "Strongly Agree," and "Agree." Again, the results show that observers rated therapists lower with clients who continued than with clients who dropped out. A possible explanation for this may have been that observers' expectations were higher for the second session because again, the second session is when therapists are working to clarify the client's problem and set goals. Effective communication skills are of particular importance at the second stage, because goals are what will guide the rest of the interaction between client and therapist throughout treatment. Tracking allows the therapist to follow the content of the client's communications and behavior. The therapist can only demonstrate this understanding of their clients by communicating that understanding. This ability to demonstrate effective communication skills may be crucial to the outcome of a session. Although the hypothesis was not supported, the means for

this question fell toward the positive end of the joining scale. As their ratings imply, respondents agreed therapists were overall able to express effective communication skills.

Time 2 Full Sample. ANOVA indicates results for the communication subscale for clients, therapists, and observers, who completed the joining questionnaires after the second session, were significant but not in the predicted direction to support the hypothesis. On the communication subscale, the mean for continuers was 1.84, and the mean for dropouts was 1.36. This means clients who dropped out rated therapists higher on communication skills than those who continued in therapy. Because communication skills have been identified as basic skills for practicing therapists, (Carkhuff, Piaget, & Pierce, 1968), the ability to demonstrate effective skills is crucial to the success of therapy. On the joining scale, these means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express effective communication skills.

Hypothesis 1.2

Hypothesis 1.2 stated that therapists who demonstrate respect as measured by clients' perceptions will have lower client dropout rates than those who do not. Hypothesis 1.2 was tested using several different groups, including Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. Therapists' and observers' means for therapists' ability to join with continuers on the respect subscale was 1.95, and for dropouts was 1.80. This means there was little difference between how continuers and dropouts rated therapists on the respect subscale. A possible reason that therapist's and observers rated therapists lower with those who continued may have been that in the first session, therapists did not greet each member of the family by name, for example, which conveys respect. On the joining scale, these means fell toward the positive end of the joining scale, between

"Strongly Agree," and "Agree." As their ratings imply, respondents agreed therapists were overall able to express respect for their clients.

Time 2 Clients. Clients' ratings after the second session did not support the subscale hypothesis of respect. The item means for continuers on the respect subscale was 1.80 and 1.33 for dropouts. A possible explanation may have been that clients did not feel that during the goal-setting stage that their therapists did not respect their position on the problem, especially at a time of reframing the client's problem. Though there was little difference between how continuers and dropouts rated therapists on the subscale of respect, on the joining scale, these means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. As their ratings imply, respondents agreed therapists were overall able to express respect for their clients.

Time 2 Therapists. Results for therapists' ratings after the second session on the respect subscale were not significant. This hypothesis was not supported. The item means for continuers on the respect subscale was 1.92 and 1.60 for dropouts. In the second session, therapists may have learned more about the client's problem, and may have felt they did not outwardly provide respectful behavior to their clients and clients' family members. Little difference existed between how continuers and dropouts rated therapists on the subscale of respect and these means fall between "Strongly Agree," and "Agree" on the joining questionnaire. Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. As their ratings imply, respondents agreed therapists were overall able to express respect for their clients.

Time 2 Observers. The item means for observers' ratings on the respect subscale of therapists with clients who continued was 1.83 and 1.61 for dropouts. On the joining scale, these means fall between "Strongly Agree," and "Agree" which is the positive end of the joining scale. Again, observers rated therapists' ability to convey respect higher

with continuers than with dropouts. A possible explanation for this may be that to some, challenging the clients' view, if not executed in a skillful way with a clear vision, may have seemed picky or even disrespectful to clients at times. Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express they respected their clients.

Time 2 Full Sample. Full scale analysis was not supportive of the respect subscale hypothesis. The mean for the respect subscale for continuers was 1.85, and for dropouts was 1.57. This means there was little difference between how continuers and dropouts rated therapists on the respect subscale. When discussing the therapeutic relationship, respect is a concept surfaces throughout the literature as to a vital component of the successful relationship between client and therapist. On the joining scale, these means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to show they respected their clients.

Hypothesis 1.3

Hypothesis 1.3 stated that therapists who demonstrate understanding/empathy as measured by clients' perceptions will have lower client dropout rates than those who do not. Hypothesis 1.3 was tested using several different groups, including Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. Therapists and observers' ratings on understanding/empathy subscale of the joining questionnaire at the end of session one did not produce significant results. This hypothesis was not supported as no significant difference existed between ratings of continuers and dropouts. The means for the understanding subscale were 1.90 for continuers and 1.83 for dropouts. This means there was little difference between how

the two groups rated therapists on the understanding subscale. For clients to feel their therapists understands them is important to establishing a successful therapeutic relationship (Moon et al., 1996). Therapists must be able to demonstrate they understand their clients, their client's problem, and how their clients felt by demonstrating therapist-offered conditions, including empathic understanding. In this way, clients can feel their therapist is caring and sensitive to their needs. The reason therapists and observers rated therapists lower with clients who continued as opposed to clients who dropped out is that raters may not have seen therapists conduct interpretive statements or responsive nonverbal behaviors in this first session. Odell and Quinn (1998) have found that these types of behaviors affect the therapeutic process in a positive way. A lack of these behaviors may be viewed as the inability to demonstrate adequate understanding/empathy. On the joining scale, these means fall between "Strongly Agree," and "Agree." Although the hypothesis was not supported, the means for this question fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express they understood their clients.

Time 2 Clients. Results for clients' ratings on the understanding/empathy subscale after the second session did not support this hypothesis. The item means for the understanding subscale was 1.98 for continuers and 1.67 for dropouts. On the joining scale, these means fall between "Strongly Agree," and "Agree." Again, clients who dropped out rated their therapists' performance on understanding/empathy higher than with clients who continued. One reason for this discrepancy in ratings may have been that clients who continued may have not interpreted their therapists as caring about them. In addition, clients who dropped out may have marked their answers quickly or in a positive manner to "save face," a product of the influence of social desirability. Although the hypothesis was not supported, the means for this question fell toward the positive end

of the joining scale which implies that clients agreed therapists were overall able to express they understood them.

Time 2 Therapists. The item means for therapists' ratings on the understanding/empathy subscale was 2.25 for continuers and 1.67 for dropouts. This is one of the first samples of measurement in which continuers' and dropouts' means fell in two different categories. Therapists' means for clients who continued fell between "Agree," and "Neither Agree nor Disagree," therapists' means for clients who dropped out fell between "Strongly Agree" and "Agree." These results again demonstrate how therapists rated themselves more critically on the joining scale than observers or clients. Evidently, therapists did not feel they joined very well with clients on the understanding/empathy subscale after the second session. Even though this hypothesis was not supported, respondents' answers fell toward the positive end of the joining scale.

Time 2 Observers. Observers' item means for the understanding/empathy subscale was 1.89 for continuers and 1.50 for dropouts. On the joining scale, these means fall between "Strongly Agree," and "Agree." Observers may not have felt that therapists adequately displayed the ability to demonstrate responsive nonverbal behaviors, such as nodding of the head, in order to demonstrate understanding. Observers' mean fell toward the positive end of the joining scale which implies that raters agreed therapists were overall able to express they understood their clients.

Time 2 Full Sample. The full scale analysis of understanding/empathy subscale proved significant but not in the predicted direction to support the hypothesis. The mean for the understanding subscale for continuers was 2.00 and 1.51 for the dropouts. This means that continuers rated therapists lower on the understanding subscale than dropouts. Continuers' means fell directly on "Agree," and dropouts' means fell between "Strongly Agree" and "Agree." This sample of responses is the second circumstance of raters' answers falling into two different response categories. Dropouts may have marked

therapists higher in the area of understanding/empathy than continuers but the demonstration of those skills may have not been as important to dropouts, as say, competence. Or, continuers may have rated their therapists lower because they may have viewed their therapists as having skills in other areas which were more important to them than having a therapist who understood them. Although this hypothesis was not supported, respondents' answers fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express they understood their clients.

Hypothesis 1.4

Hypothesis 1.4 stated that therapists who demonstrate competence as measured by clients' perceptions will have lower client dropout rates than those who do not. Hypothesis 1.4 was tested using several different groups, including Time 1 Full Sample, Time 2 Clients, Time 2 Therapists, Time 2 Observers, and Time 2 Full Sample.

Time 1 Full Sample. The results of therapists' and observers' ratings were not significant for the competence subscale. The mean for therapists' and observers' with clients who continued was 2.19 and for clients who dropped out was 2.08. Because competence is the ability to promote positive change (Shaw & Dobson, 1988), therapists must actively engage in the process of clarifying the problem from the beginning of therapy (Brock & Barnard, 1992). Therapists and observers may not have seen the therapist making the clarifying statements needed to adequately demonstrate competence early in the first session. Although on the joining scale these means fall between "Agree," and "Neither Agree nor Disagree," respondents' ratings were closer to "Agree" than to "Neither Agree nor Disagree."

Time 2 Clients. Clients' ratings after the second session proved significant for the competence subscale hypothesis, but not in the expected direction. The item means for continuers on the competence subscale was 2.10 and 1.11 for dropouts. This means that

continuers rated therapists lower on the competence subscale than did dropouts. On the joining scale, the means for continuers fall between "Agree," and "Neither Agree nor Disagree," and the means for dropouts fall between "Strongly Agree" and "Agree," which is third time respondent's ratings fell into two different response categories. One of the reasons for this is that clients may have not felt their therapists were "on the same level" as they were. Clients may have not felt the therapist stayed in control if the session became intense. And another reason is that if clients did not perceive their therapists as having the ability to keep the session focused with a clear end in sight, they may have not viewed their therapist as being as competent. In addition, dropouts may not have had as much of an opportunity to view their therapists as executing these types of behaviors, especially if they did not return for a second or third session. Therefore, if the behaviors were not present, then they were not rated.

Time 2 Therapists. The competence subscale hypothesis was not supported by therapists who rated themselves after the second session. The item means for continuers on the competence subscale was 2.23 and 1.87 for dropouts. Continuers rated therapists lower on the competence subscale than did dropouts. Therapists' means for clients who continued fell between "Agree," and "Neither Agree nor Disagree," and therapists' means for clients who dropped out fell between "Strongly Agree" and "Agree." This is the fourth time ratings fell into two different response categories. Although this hypothesis was not supported, respondents' answers fell toward the positive end of the joining scale.

Time 2 Observers. Observers' item means for clients who continued on the competence subscale was 2.10 and 1.72 for clients who dropped out. This means that continuers rated therapists lower on the competence subscale than did dropouts. Continuers' means fell between "Agree," and "Neither Agree nor Disagree," and dropouts' means fell between "Strongly Agree" and "Agree." A possible reason for this is that observers may not have witnessed what they determined to be a clear direction for

therapy. If therapists seemed to let therapy "flounder" (Strupp, 1992), observers may not have viewed therapists as competent. Although this hypothesis was not supported, respondents' answers fell toward the positive end of the joining scale. This information implies that raters agreed therapists were overall able to express their competence.

Time 2 Full Sample. Full scale analysis for clients, therapists, and observers on the competence subscale proved significant but not in the predicted direction to support the hypothesis. The means for the competence subscale were 2.13 for continuers and 1.64 for dropouts. Continuers' means fell between "Agree," and "Neither Agree nor Disagree," and dropouts' means fell between "Strongly Agree" and "Agree." There are several possibilities for why clients who continued rated therapists lower than those who dropped out. Respondents may not have observed therapists as calm when things were intense, kept the session focused, or helped clients to clarify their problem adequately enough to determine appropriate therapeutic goals. Although this hypothesis was not supported, respondents' answers fell toward the positive end of the joining scale. These ratings imply that respondents agreed therapists were overall able to express their competence.

Hypothesis 1.5

Hypothesis 1.5 stated that therapists who demonstrate empathy as measured by clients' perceptions will have lower client dropout rates than those who do not. As stated earlier, empathy was combined with understanding due to a lack of variation between the concepts of understanding and empathy. Results for this subscale hypothesis can be found in the previous understanding/empathy section.

Hypothesis 2

Hypothesis two stated that co-therapy teams are less likely than individual therapists to experience client premature termination. This hypothesis was not tested because no co-therapy teams were used in this study.

Hypothesis 3

This hypothesis suggested that the therapist demographic variables related to the client's choice to continue or pre-terminated therapeutic services included gender and therapist experience. This hypothesis was not tested because there was not enough variation for therapist gender or experience.

Hypothesis 4.1

Hypothesis 4.1 stated that the lower the client's socioeconomic status (SES), the more likely the client is to drop out of therapy. Hypothesis 4.1 was supported but the results were not significant. The mean for continuers' income in thousands was 44.15, and for dropouts the mean for income in thousands was 24.

Hypothesis 4.2.

Hypothesis 4.2 stated the greater the alcohol consumption the more likely the client is to drop out of therapy. Support was found for this hypothesis but the results were not significant. The results for the mean for the use of alcohol and drug use was 1.07 for continuers, and the mean for alcohol and drug use for dropouts was 1.33.

Hypothesis 5.1

Hypothesis 5.1 stated that the greater the severity of presenting problem, the less likely clients are to drop out of therapy. This scale ranged from 1-"Not At All Serious," 2-"Slightly Serious," 3-"Moderately Serious," 4-"Very Serious." The results for this hypothesis approached but did not support the predicted direction. The means for continuers for severity of the problem was 3.20, or moderately serious, and 3.33 for dropouts which is closer to very serious. Because the sample was so small, more meaningful results may have been found in a study conducted with a larger sample size.

Hypothesis 5.2

Hypothesis 5.2 stated that the greater the duration of the presenting problem, the less likely clients are to drop out of therapy. Support was found for this hypothesis but

the results were not significant. The mean for duration of problem in months for continuers was 15, and the mean for dropouts' duration of problem in months was 3. Again, if the sample had been larger, For further explanation, see Table 5.

Hypothesis 5.3

Hypothesis 5.3 stated that the less likely the client feels the problem is to change, the more likely the client will preterminate therapeutic services. Support was found for this hypothesis but not in the predicted direction $F(1, 15)=1.59$, $p=.226$.

Limitations and Implications

In this section, interpretation of the meaning and possible explanation of non-significant results is discussed. Some potentially beneficial implications for future research are suggested by the limitations of the current study.

Sample Size. One of the possible reasons the data showed that the three respondent groups (client, therapist, and observer) consistently rated joining with continuers lower than joining with dropouts could be due to the small sample size. Because there were so few dropouts, the sample did not contain enough participants to adequately portray a wide range of variance. The results may have been different from the current study had there been a larger sample with which to compare results. In the future, to have a larger sample with more dropouts would provide much of the missing information to develop a more informed study. Due to the small sample size and lack of variation between dropouts and continuers, caution needs to be taken when generalizing the findings of the current study.

Inflation of Scores. The data showed that a consistent inflation of scores existed in the findings. With regard to the joining scale, the whole range (from strongly agree to strongly disagree) was never used. Therefore, the sample did not contain a lot of variance. Furthermore, clients consistently rated therapists the highest, followed by observers, and therapists proved to consistently rate themselves the lowest. Possible

explanations for the inflation of scores include inexperienced therapists, social desirability, or insufficient training. With regard to experience level, three of the five observers were first year students who had not yet begun conducting therapy sessions and thus could have been less familiar with the ratings than the experienced students. Another possible explanation for inflation of scores is social desirability. Anastasi (1976) notes that self-report inventories usually contain one answer that is recognizable as socially more desirable or acceptable than the others. For this reason, respondents may be motivated to "fake good," or choose answers that create a favorable impression. A. L. Edwards (1957) was the first to research the social desirability variable and conceptualized the notion as a tendency for a rater to "put up a good front," of which the respondent is usually unaware. This tendency may imply lack of insight into one's own characteristics, self-deception, or an unwillingness to face one's own limitations. Crowne and Marlow (1964) and Frederiksen (1965) have stated that the strength of the social desirability response set is related to the individual's more general need for self-protection, avoidance of criticism, social conformity, and social approval. Although participants were told their answers would be held in the strictest confidence by the experimenters, social desirability may still have influenced therapists' ratings. Furthermore, the instruction for this experiment could present another reason for raters' inflation of scores. Training was conducted by the experimenter with all participating therapists present, in a one-hour, explanation-question- answer forum. Handouts were given explaining the process of the research. Included in the handouts were a description of which questionnaires were to be distributed to whom, and an outline of the roles defining the responsibilities of the clients, therapists, distributors, and observers.

One suggestion for further research to help prevent inflation of scores would be to include several items on the joining questionnaires that would need to be reverse scored,

By reverse scoring items, raters would be required to slow their response rate to carefully consider their answers. Reversed scored items could prevent habitual responses.

In addition, researchers may want to consider using videotaped training which would demonstrate the full use of the joining scale. All participating therapists and observers would be required to watch several vignettes exhibiting adequate and inadequate joining behaviors. Discussion and debate of the videotaped vignettes would follow in order to allow different perspectives regarding joining to surface. Through this process, a more shared perspective of joining behaviors could occur.

Interrater Reliability. During the study, questions were raised regarding whether or not certain behavior form the joining items actually took place in the therapy session. For example, one observer stated that "things were never intense in the therapy session" (see question 13). However, the researcher predicated that question on the assumption that by the sensitive nature of the therapy relationship, a certain amount of intensity is always present. In this example, the observer stated they did not know which answer to choose so number 3 (neither agree nor disagree) was chosen. The researcher, however, would have marked number 2 (agree). In another example, an observer did not know which answer to pick for question 21 because the observer stated there was no visible action taken by the therapist in order to give the client a reason to come back. Again, number 3 (neither agree nor disagree) was chosen by default. On this question, however, the researcher would have chosen answer number 5 (strongly disagree). Again, a taped demonstration of example behaviors representative of the full range of the joining scale would possible have lead to greater interrater reliability. However, due to lack of variance in therapists gender and experience, greater interrater reliability for this study may not have been plausible.

One implication from this study could be the use of the instrument in training first year clinical students. The professor could use the joining assessment to identify and

discuss joining behaviors with the class. Upon generating a meta-level understanding of the concept of joining, students could then role play effective and ineffective joining behaviors in a mock therapuetic session. Students could then discuss what was seen and how the demonstrations coincide or conflict with their own individual definitions of joining. By comparing and contrasting students' definitions of joining different perspectives may emerge by which students may refine their ability to identify joining behaviors.

Suggestions for Future Research

This section will discuss suggestions for future research based upon the findings and implications of the present study. By offering ideas for conducting further research, researchers and clinicians may be able to re-produce the study in a beneficial way to yield more meaningful results.

Sample Size. This study would probably obtain more variation and significant results if the sample was larger. Because of the small sample size, the full range was not utilized enough to produce ample variation. Researchers may wish to consider collecting data for a longer period of time to obtain more clients so that more opportunity would be generated for clients utilizing the full range of the joining scale. The results may produce more variation and thus more meaningful implications for clinicians and researchers.

Generalizability. In addition to including both more continuers and dropouts, researchers may wish to consider conducting this experiment in a variety of clinical populations. Community mental health centers or specialized agencies, such as a local domestic violence center for example, may offer a more randomized example of participants. In addition, using varied collection sites may yield information about the type of joining behaviors needed to join with different client population types. With the information produced from a variety of sources, researchers may be able to tease out response patterns. This may give information about how to redesign the instrument to

curb test fatigue or learned responses. With information gained from a variety of sample populations, a larger ability to generalize test results may exist.

Instrument Design and Training. Clinicians and researchers may wish to consider redesigning the instrument. For example, including items in a manner which requires reverse scoring may produce more meaningful results due to the inhibition of learned responses and test fatigue. Also, shortening the instrument in some way would also help raters to give more thought to each item.

Lengthening the training session for therapists and observers may be something for future researchers to consider. The joining scale was designed as an attempt to accurately measure the evaluative perceptions of participants and group those perceptions together into three underlying attitude dimensions: (1) the individual's evaluation of the joining characteristics; (2) the individual's perception of the potency or power of the therapist; and (3) the client's perception of the activity of the therapist. Particular attention may be given to participants' underlying attitudes and assumptions of each item by administering an open-ended questionnaire asking therapists and observers to describe their knowledge and experience of each dimension. By discussing each item on the instrument in greater detail, a more shared understanding of what constitutes certain joining behaviors in therapy sessions may develop. In addition, researchers may wish to consider showing participants a tape of vignettes representative of the full range of joining behaviors. For example, the tape could show two simulated therapy sessions in which the therapist first demonstrates the session floundering without clear goals or focus. The next vignette could show how a therapist might keep control over the structure of the therapy session while also staying focused on the client's goals. Several two-part vignettes could be shown over different items found on the joining scale. If time allows, researchers could then ask for impromptu demonstrations over any items left on the instrument which may be in question, showing adequate joining behaviors.

Discussion could follow after each demonstration until all items in question have been reviewed. This thorough approach would allow participants to share their concerns and different perceptions of adequate joining and also allow for debate until a shared vision of what constitutes adequate joining has surfaced.

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APPENDIX A

TABLES

Table 1

Empirical Findings

Name Of Scale	Items	Range of Scale		X	SD	Reliability	Clients		Therapists		Observer	
		Theoretical/Actual					X	SD	X	SD	X	SD
Full Scale	All-(Times 1 & 2)	2-115	23-76	43.69	12.15	.94	41.39	13.20	47.74	13.20	42.04	11.58
Communication	1,2,3,4,7,9,16,18	8-40	8-28	14.22	4.33	.88	13.72	3.80	5.6	12.12	13.60	4.51
Respect	5,6,23	3-15	2-9	4.92	1.41	.53	4.78	1.90	5.22	1.43	4.79	1.29
Understanding	8,14,20	3-15	2-11	5.66	1.93	.68	5.44	2.23	6.5	1.96	5.28	1.74
Understanding	8,14,20	3-15	2-11	5.66	1.93	.68	5.44	2.23	6.5	1.96	5.28	4.98

Table 2

Therapists and Observers' Ratings at Time 1.

	RATER			
	Therapist		Observer	
Question #	Cont.	D/O	Cont.	D/O
1	2.00*	1.45*	1.35	1.32
2	1.94	1.64	1.65	1.59
3	2.71	2.27	2.09	2.41
4	1.59	1.45	1.32	1.27
5	1.53	1.45	1.24	1.27
6	1.53	1.27	1.59	1.27
7	2.00	1.73	1.59	1.73
8	2.00	2.18	1.82	1.91
9	2.41	1.91	1.97	2.23
10	2.71	2.36	2.12	2.18
11	1.82**	1.36**	1.32	1.32
12	2.76	2.18	2.32	2.41
13	2.35	2.18	1.85	1.68
14	2.00	2.00	1.26	1.41
15	1.76	1.82	1.32	1.32
16	2.59*	1.73*	1.44	1.64
17	2.94**	1.82**	1.65	1.73
18	2.59**	1.82**	1.76	1.64
19	3.18	2.55	2.94	3.32
20	2.94**	1.91**	1.97	1.86
21	2.35	1.91	1.74	1.86
22	3.18*	2.36*	2.82	3.00
23	2.47	2.18	2.29	2.14

*p < .001, **p < .01, ***p < .05

Table 3

Values of Cronbach alpha of the FTSC

Items	Alpha	M	D
The therapist(s):	(if deleted)		
...listened to the client.	.95	1.53	.64
...understood the client.	.95	1.79	.69
...helped the client to clarify the client's problem.	.95	2.27	.92
...maintained good eye contact with the client(s).	.95	1.37	.53
...respected the client(s).	.95	1.39	.55
...greeted each person in the client's family.	.95	1.34	.55
...understood what the client(s) said.	.95	1.79	.74
...understood how the client(s) felt.	.95	1.97	.81
...understood the client's problem.	.95	2.15	.87
The client had confidence the therapist(s) could help.	.95	2.23	.89
The therapist(s):is committed to helping the client(s).	.95	1.44	.55
...helped the client understand the client's problem.	.95	2.28	.93
...was calm when things were intense.	.95	2.02	.85
...was easy to talk to.	.95	1.58	.64
...respected relationships with family members.	.95	1.53	.60
...kept the conversation going.	.95	1.69	.79
...kept the session focused.	.95	1.86	.94
...helped the client(s) to feel comfortable.	.95	1.78	.67
...helped the client(s) to establish clear goals.	.95	2.79	1.11
...gave the client(s) hope that progress could be made.	.95	2.10	.98
...gave the client(s) a reason to come back.	.94	1.96	.95
...presented a variety of treatment options.	.95	2.80	1.12
The client(s) trusted their relationship	.95	2.14	.81
TOTAL SCALE	.94		

Table 4

Client, Therapist, and Observers' Ratings at Time 2

	RATER							
	Full Sample		Client		Therapist		Observer	
Q#	Cont.	D/O	Cont.	D/O	Cont.	D/O	Cont.	D/O
1	1.62*	1.14*	1.20	1.00	1.82*	1.20*	1.69	1.17
2	1.91*	1.43*	1.67	1.33	2.06	1.80	1.94*	1.17*
3	2.32**	1.57**	2.67**	1.33**	2.06	1.80	2.31*	1.50*
4	1.34	1.14	1.40	1.00	1.47	1.00	1.25	1.33
5	1.41	1.36	1.53	1.67	1.53	1.20	1.31	1.33
6	1.28	1.15	1.27	1.00	1.41	1.20	1.22	1.17
7	1.84*	1.36*	1.73	1.33	1.82	1.60	1.89*	1.17*
8	2.13**	1.43**	2.13	1.33	2.12	1.60	2.14	1.33
9	2.10	1.71	2.07	1.33	2.06	2.00	2.14	1.67
10	2.24**	1.50**	2.00	1.00	2.53	1.80	2.19	1.50
11	1.47	1.14	2.13*	1.00*	1.29	1.20	1.28	1.17
12	2.29*	1.64*	2.33	1.33	2.35	1.80	2.25	1.67
13	2.28	2.21	2.00	1.00	2.76	2.40	2.17	2.67
14	1.72	1.38	1.80	1.00	2.06	1.60	1.53	1.33
15	1.54	1.43	1.93	1.00	1.71	1.80	1.31	1.33
16	1.72**	1.21**	2.07*	1.00*	1.94**	1.40**	1.47	1.17
17	1.78	1.50	1.73	1.00	1.88	2.00	1.75	1.33
18	1.84**	1.29**	1.80	1.00	2.12	1.60	1.72	1.17
19	2.62**	1.79**	2.07	1.00	2.41	1.80	2.94	2.17
20	2.15	1.64	2.00	1.00	2.59	1.80	2.00	1.83
21	2.10*	1.43*	2.13	1.33	2.29	1.60	2.00	1.33
22	2.85*	2.14*	2.60*	1.33*	2.82	2.40	2.97	2.33
23	2.25**	1.50**	2.27	1.00	2.53	1.60	2.11	1.67
H:I(Full Scale)	1.95**	1.48**	1.94*	1.12*	2.07	1.66	1.89	1.50

*p < .001, **p < .01, ***p < .05

Table 5

H:4: Mean Alcohol Use for Continuers vs. Dropouts

	Continuers	Dropouts
Income (in thousands)	44.15	24.00
Alcohol/Drug Use	1.07	1.33

Table 6

H:5: Mean Duration of Problem of Continuers vs. Dropouts

	Continuers	Dropouts
Severity of Problem	3.20	3.33
Duration (in months)	53.33	42.00

APPENDIX B

JOINING ASSESSMENT

FOR OFFICE USE ONLY
ID #_____
FAMILY MEMBER____

JOINING ASSESSMENT (CLIENT)

Using the following scale, please answer the following questions:

Strongly Agree	Agree	Neither agree nor disagree	Disagree	StronglyDisagree
1	2	3	4	5

Therapist I:	Therapist II: *(If applicable)*
_____	_____1. My therapist(s) listened to me.
_____	_____2. My therapist(s) understood me.
_____	_____3. My therapist(s) helped me to clarify my problem.
_____	_____4. My therapist(s) maintained good eye contact with me.
_____	_____5. My therapist(s) respects me.
_____	_____6. My therapist(s) greeted each person in my family.
_____	_____7. My therapist(s) understood what I said.
_____	_____8. My therapist(s) understood how I felt.
_____	_____9. My therapist(s) understood my problem.
_____	_____10. I have confidence my therapist(s) can help me.
_____	_____11. My therapist(s) is committed to helping me.
_____	_____12. My therapist(s) helped me understand my problem.
_____	_____13. My therapist(s) was calm when things were intense.
_____	_____14. My therapist(s) is easy to talk to.
_____	_____15. My therapist(s) respects my relationships with family members.
_____	_____16. My therapist(s) kept the conversation going.
_____	_____17. My therapist(s) kept the session focused.
_____	_____18. My therapist(s) helped me to feel comfortable.
_____	_____19. My therapist(s) helped me to establish clear goals.
_____	_____20. My therapist(s) gave me hope that progress could be made.
_____	_____21. My therapist(s) gave me a reason to come back.
_____	_____22. My therapists presented a variety of treatment options.
_____	_____23. I trust my relationship with my therapists.
	Answer only if there is a co-therapy team:
_____	_____24. My therapists worked together as a team.
_____	_____25. I believe "two heads [therapists] are better than one."

FOR OFFICE USE ONLY
ID #_____
FAMILY MEMBER____
THERAPIST ID #_____

JOINING ASSESSMENT (THERAPIST)

Using the following scale, please answer the following questions:

Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
1	2	3	4	5

_____1. I listened to my client.

_____2. I understood my client.

_____3. I helped the client to clarify my client's problem.

_____4. I maintained good eye contact with my client.

_____5. I respected my client.

_____6. I greeted each person in my client's family.

_____7. I understood what my client said.

_____8. I understood how my client felt.

_____9. I understood my client's problem.

_____10. My client was confident I can help.

_____11. I was committed to helping my client.

_____12. I helped my client understand the problem.

_____13. I was calm when things were intense.

_____14. I was easy to talk to.

_____15. I respected my client's relationships with family members.

_____16. I kept the conversation going.

_____17. I kept the session focused.

_____18. I helped my client to feel comfortable.

_____19. I helped my client to establish clear goals.

_____20. I gave my client hope that progress could be made.

_____21. I gave my client a reason to come back.

_____22. I presented a variety of treatment options.

_____23. Our client(s) trusted the relationship they have with us.

Answer only if you were part of a co-therapy team:

_____24. We worked together as a team.

_____25. Our client(s) believed "two heads [therapists] are better than one."

FOR OFFICE USE ONLY
ID #_____
FAMILY MEMBER____
OBSERVER ID #_____

JOINING ASSESSMENT (OBSERVER)

Using the following scale, please answer the following questions:

Strongly Agree	Agree	Neither agree nor disagree	DisagreeStrongly	Disagree
1	2	3	4	5

Therapist I:	Therapist II: *(If applicable)*
_____	_____1. The therapist(s) listened to the client.
_____	_____2. The therapist(s) understood the client.
_____	_____3. The therapist(s) helped the client to clarify the client's problem.
_____	_____4. The therapist(s) maintained good eye contact with the client(s).
_____	_____5. The therapist(s) respects the client(s).
_____	_____6. The therapist(s) greeted each person in the client's family.
_____	_____7. The therapist(s) understood what the client(s) said.
_____	_____8. The therapist(s) understood how the client(s) felt.
_____	_____9. The therapist(s) understood the client's problem.
_____	_____10. The client appeared to have confidence that the therapist(s) could help.
_____	_____11. The therapist(s) is committed to helping the client(s).
_____	_____12. The therapist(s) helped the client understand the client's problem.
_____	_____13. The therapist(s) was calm when things were intense.
_____	_____14. The therapist(s) was easy to talk to.
_____	_____15. The therapist(s) respects the client's relationships with family members.
_____	_____16. The therapist(s) kept the conversation going.
_____	_____17. The therapist(s) kept the session focused.
_____	_____18. The therapist(s) helped the client(s) to feel comfortable.
_____	_____19. The therapist(s) helped the client(s) to establish clear goals.
_____	_____20. The therapist(s) gave the client(s) hope that progress could be made.
_____	_____21. The therapist(s) gave the client(s) a reason to come back.
_____	_____22. The therapists presented a variety of treatment options.
_____	_____23. The client(s) trust the client's relationship with the client's therapists
	Answer only if you're observing a co-therapy team:
_____	_____24. The therapists worked together as a team.
_____	_____25. The client(s) believe "two heads [therapists] are better than one."

APPENDIX C

INTAKE FORM

Intake Person: _____
Packet sent on: _____

TELEPHONE INTAKE

Date: _____

Time: _____

Name: _____

Address: _____

_____

Telephone number: _____ Best Time to be contacted within 24 hours: _____

Who made the call? _____

Presenting Problem?

Who is in the family? (2-3 generation genogram)

Who else is involved in the problem?

How long has it been a problem? _____

Is there any alcohol or drug use? _____ If yes, who and how much?

Who will be able to attend sessions?

Times/days available for sessions?

Is anyone in the family on any kind of medication? If yes, who and what?

Is anyone in the family receiving mental health services anywhere else? If yes, who, where, and for what?

How did you hear about us? Who referred you?

___ Telephone Book

___ Referred by _____

___ Received services before

___ Other (Explain below)

Any financial considerations?

___ No

___ Yes. If yes, explain below

Yearly income before taxes_____

Fee _____

Therapist(s) assigned _____

Date _____

Case #_____

APPENDIX D

BACKGROUND FORM

FOR OFFICE USE ONLY
ID # _____
FAMILY MEMBER _____
TODAY'S DATE _____

Center For Family Services
104 Human Environmental Sciences West
Stillwater, Oklahoma 74078

BACKGROUND FORM

(This information is part of your *confidential* file and will be available to CFS staff for reference/research purposes)

NAME_____ AGE (YEARS) _____ GENDER MALE FEMALE (Circle One)

ADDRESS_____ ETHNICITY_____

HOME TELEPHONE_____ WORK TELEPHONE_____

SOCIAL SECURITY NUMBER_____ RELIGIOUS PREFERENCE_____

PRIMARY OCCUPATION_____ HIGHEST LEVEL OF EDUCATION COMPLETED_____

ARE YOU MARRIED: YES NO (Circle One) IF YES, HOW LONG _____ TIMES MARRIED BEFORE? 0 1 2 3 4 5 (Circle One)

ARE YOU A MILITARY VETERAN? YES NO (Circle One) YEARS OF SERVICE_____TO_____

FOR IMMEDIATE FAMILY MEMBERS (SPOUSE, CHILDREN, AND STEP-CHILDREN). PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP TO YOU, AND CURRENT RESIDENCE (SAME AS YOU OR DIFFERENT).

NAME	GENDER	AGE	RELATIONSHIP TO YOU	RESIDENCE (Circle One)	(CITY/STATE IF DIFFERENT)
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____
_____	M F	____	_____	SAME DIFFERENT	_____

Notes:

Office Use

01=Husband/Father 02=Wife/Mother 03=Son1 04=Daughter1 05=Step Father 06=Step Mother
08=Fiance-Female 09=Fiance-Male 13=Son2 23=Son3 33=Son4 14=Daughter2 24=Daughter3 34=Daughter4
98=Individual Female 99=Individual Male 71=Step-Son1 72=Step-Son2 73=Step-Son3 74=Step-Daugh1 75=Step-Daugh2

FOR RELATIVES FROM THE FAMILY IN WHICH YOU GREW UP, PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP, CURRENT RESIDENCE, AND MARITAL STATUS OF ALL WHO ARE STILL LIVING (PARENTS, BROTHERS, SISTERS, STEP-BROTHERS, AND STEP-SISTERS).

NAME	GENDER	AGE	RELATIONSHIP TO YOU	RESIDENCE (CITY/STATE)	MARITAL STATUS

IF ANY MEMBER(S) OF YOUR FAMILY (SPOUSE, CHILDREN, PARENTS, BROTHERS, SISTERS, IS/ARE DECEASED, PLEASE LIST BELOW:

NAME	RELATIONSHIP	AGE AT DEATH	DATE AT DEATH	CAUSE OF DEATH

FAMILY PHYSICIAN: NAME _____

ADDRESS _____

_____

CIRCLE YOUR PRESENT STATE OF HEALTH:

EXCELLENT **GOOD** **FAIR** **POOR**

PLEASE CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING DURING THE PAST SIX MONTHS:

___SEVERE HEADACHES
___SEVERE BACKACHES
___STOMACH PROBLEMS
___EATING PROBLEMS
___SEIZURES
___UNEXPLAINED WORRY OR FEARFULLNESS
___FREQUENT TIREDNESS
___FREQUENT TROUBLE SLEEPING
___DIZZINESS OR FAINTING
___LARGE WEIGHT LOSS OR GAIN
___ASTHMA OR OTHER RESPIRATORY PROBLEMS
___OTHER PROBLEMS (PLEASE SPECIFY)
_____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EXPERIENCED ANY OF THE BEFORE MENTIONED SYSMPTOMS IN THE LAST SIX MONTHS?_____ IF YES, PLEASE EXPLAIN.

HAVE YOU EVER HAD A SERIOUS MEDICAL ILLNESS?_____IF YES, PLEASE EXPLAIN.

HAVE ANY OF YOUR CHILDREN OR SPOUSE EVER HAD A SERIOUS MEDICAL ILLNESS?_____
IF YES, PLEASE EXPLAIN.

LIST ALL MEDICATIONS AND/OR DRUGS TAKEN WITHIN THE LAST 6 MONTHS, BOTH PRESCRIPTION AND NON PRESCRIPTION:

NAME OF MEDICATION/DRUG	REASON TAKEN	CHECK IF TAKING NOW

DO YOU SMOKE?_____IF YES, HOW MUCH?

DO YOU THINK YOU SMOKE TOO MUCH?

DO YOU DRINK?_____IF YES, HOW MUCH?

DO YOU THINK YOU DRINK TOO MUCH?

DO YOU THINK ANOTHER FAMILY MEMBER SMOKES OR DRINKS TOO MUCH?_____IF YES, PLEASE EXPLAIN.

HAVE YOU EVER ATTEMPTED SUICIDE?_____ IF YES, GIVE DATE(S) AND DETAILS.

HAS ANYONE IN YOUR FAMILY EVER ATTEMPTED SUICIDE?_____ IF YES, GIVE NAME(S), RELATIONSHIP TO YOU, AND DETAILS.

ARE YOU CURRENTLY RECEIVING SERVICES FROM ANOTHER THERAPIST/COUNSELOR?_____
IF YES, WHO AND FOR WHAT?

HAVE YOU EVER BEEN TREATED BY ANOTHER THERAPIST/COUNSELOR?__IF YES, WHEN, WHERE, AND FOR WHAT?

FROM THE FOLLOWING LIST, PLEASE CHECK THE REASONS HAT YOU ARE SEEKING SERVICE AT THIS TIME.

__PERSONAL ENRICHMENT	__SINGLE PARENTING
__RELATIONSHIP ENRICHMENT	__PARENTING-TWO PARENT FAMILY
__MARITAL ENRICHMENT	__STEP-PARENTING
__FAMILY ENRICHMENT	__CHILD BEHAVIOR PROBLEMS
__MARITAL CONFLICT	__ADOLESCENT BEHAVIOR PROBLEM
__FAMILY CONFLICT	__ALCOHOL ABUSE-CHILD/ADOLESCENT
__SEXUAL PROBLEMS	__DRUG ABUSE-CHILD/ADOLESCENT
__PHYSICAL ABUSE	__ALCOHOL ABUSE-ADULT
__SEXUAL ABUSE	__DRUG ABUSE-ADULT
__DIVORCE ADJUSTMENT	__FAMILY STRESS
__ADJUSTMENT TO LOSS	__OTHER (Specify)_____

PLEASE DESCRIBE IN YOUR OWN WORDS THE MAJOR REASON FOR SEEKING OUR SERVICES AT THIS TIME.

HOW SERIOUS WOULD YOU SAY THIS PROBLEM IS RIGHT NOW? (CIRCLE ONE)

NOT AT ALL SERIOUS	SLIGHTLY SERIOUS	MODERATELY SERIOUS	VERY SERIOUS

HOW LIKELY DO YOU THINK THE PROBLEM IS TO CHANGE? (CIRCLE ONE)

NOT AT ALL LIKELY	SLIGHTLY LIKELY	MODERATELY LIKELY	VERY LIKELY

WHAT DO YOU HOPE TO GAIN FROM OUR SERVICES?

WHO REFERRED YOU TO OUR SERVICES? IF SELF-REFERRED, HOW DID YOU FIND OUT ABOUT OUR SERVICES?

APPENDIX E

FACES III

COMMUNICATION AND SATSIFACTION

FAMILY COMMUNICATION & SATISFACTION

ID# ____ FM# ____
Times Taken ____
Family Form = 2

Center For Family Services - Oklahoma State University

INSTRUCTIONS:

Communication and satisfaction are important aspects of family relationships. Please review the statements below and respond according to how you see **YOUR COMMUNICATION AND SATISFACTION** as it is NOW.

Put an X in one box					
Almost Never 1	Occasionally 2	Sometimes 3	Often 4	Very Often 5	
☐	☐	☐	☐	☐	1. We are satisfied with how family members communicate with each other.
☐	☐	☐	☐	☐	2. Family members are good listeners.
☐	☐	☐	☐	☐	3. Family members express affection to each other.
☐	☐	☐	☐	☐	4. Family members avoid talking about important issues.
☐	☐	☐	☐	☐	5. When angry, family members say things that would be better left unsaid.
☐	☐	☐	☐	☐	6. Family members discuss their beliefs and ideas with each other.
☐	☐	☐	☐	☐	7. When we ask questions of each other, we get honest answers.
☐	☐	☐	☐	☐	8. Family members try to understand each other's feelings.
☐	☐	☐	☐	☐	9. We can calmly discuss problems with each other.
☐	☐	☐	☐	☐	10. We express our true feelings to each other.
☐	☐	☐	☐	☐	11. How often are you satisfied with the degree of closeness between members of your family.
☐	☐	☐	☐	☐	12. How often are you satisfied with your family's ability to cope with stress.
☐	☐	☐	☐	☐	13. How often are you satisfied with your family's ability to be flexible.
☐	☐	☐	☐	☐	14. How often are you satisfied with your family's ability to share positive experiences.
☐	☐	☐	☐	☐	15. How often are you satisfied with the amount of arguing that occurs between family members.
☐	☐	☐	☐	☐	16. How often are you satisfied with your family's ability to resolve conflicts.
☐	☐	☐	☐	☐	17. How often are you satisfied with the amount of time you spend together as a family.
☐	☐	☐	☐	☐	18. How often are you satisfied with the way problems are discussed in your family.
☐	☐	☐	☐	☐	19. How often are you satisfied with the fairness of criticism in your family.
☐	☐	☐	☐	☐	20. How often are you satisfied with your family's concern for each other.

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Date: ____ mm-dd-yy

Session # ____

1	2	3	4	5
Almost Never	Occasionally	Sometimes	Often	Very Often

FAMILY RELATIONSHIPS

ID# _____ FM#___
Times Taken ____
Family Form = 2

Center For Family Services - Oklahoma State University

INSTRUCTIONS:
Family relationships are varied and differ greatly from family to family. Please review the statements below and respond according to HOW YOU WOULD DESCRIBE YOUR FAMILY AS IT IS NOW.

Put an X in one box						
Almost Never 1	Once In A While 2	Sometimes 3	Frequently 4	Almost Always 5		
1 Almost Never	2 Once In A While	3 Sometimes	4 Frequently	5 Almost Always		
☐	☐	☐	☐	☐	1. Family members ask each other for help.	
☐	☐	☐	☐	☐	2. In solving problems, the children's suggestions are followed.	
☐	☐	☐	☐	☐	3. We approve of each other's friends.	
☐	☐	☐	☐	☐	4. Children have a say in their discipline.	
☐	☐	☐	☐	☐	5. We like to do things with just our immediate family.	
☐	☐	☐	☐	☐	6. Different persons act as leaders in our family.	
☐	☐	☐	☐	☐	7. Family members feel closer to other family members than to people outside the family.	
☐	☐	☐	☐	☐	8. Our family changes its way of handling tasks.	
☐	☐	☐	☐	☐	9. Family members like to spend free time with each other.	
☐	☐	☐	☐	☐	10. Parent(s) and children discuss punishment together.	
☐	☐	☐	☐	☐	11. Family members feel very close to each other.	
☐	☐	☐	☐	☐	12. The children make the decisions in our family.	
☐	☐	☐	☐	☐	13. When our family gets together for activities, everybody is present.	
☐	☐	☐	☐	☐	14. Rules change in our family.	
☐	☐	☐	☐	☐	15. We can easily think of things to do as a family.	
☐	☐	☐	☐	☐	16. We shift household responsibilities from person to person.	
☐	☐	☐	☐	☐	17. Family members consult other family members on their decisions.	
☐	☐	☐	☐	☐	18. It is hard to identify the leader(s) in our family.	
☐	☐	☐	☐	☐	19. Family togetherness is very important.	
☐	☐	☐	☐	☐	20. It is hard to tell who does which household chores.	

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University of Minnesota, St. Paul, MN 55108

Date: _____ mm-dd-yy
Session #___

COUPLE COMMUNICATION & SATISFACTION

ID#____ FM#____
Times Taken ____
Couple Form = 1

Center For Family Services - Oklahoma State University

INSTRUCTIONS:
Communication and satisfaction are important aspects of relationships. Please review the statements below and respond according to how you see **YOUR COMMUNICATION AND SATISFACTION** as it is **NOW.**

Put an X in one box

Strongly Agree 1	Agree 2	Undecided 3	Disagree 4	Strongly Disagree 5	
					1. It is very easy for me to express all my true feelings to my partner.
					2. When we are having a problem, my partner often gives me the silent treatment.
					3. My partner sometimes makes comments which put me down.
					4. I am sometimes afraid to ask my partner for what I want.
					5. I wish my partner was more willing to share his/her feelings with me.
					6. Sometimes I have trouble believing everything my partner tells me.
					7. Sometimes my partner does not understand how I feel.
					8. I am very satisfied with how my partner and I talk with each other.
					9. I do not always share negative feelings I have about my partner because I fear he/she will get angry.
					10. My partner is always a good listener.
					11. I am not pleased with the personality characteristics and personal habits of my partner.
					12. I am very happy with how we handle role responsibilities in our marriage.
					13. I am not happy about our communication and feel my partner does not understand me.
					14. I am very happy about how we make decisions and resolve conflicts.
					15. I am unhappy about our financial position and the way we make financial decisions.
					16. I am very happy with how we manage our leisure activities and the time we spend together.
					17. I am very pleased about how we express affection and relate sexually.
					18. I am not satisfied with the way we each handle our responsibilities as parents.
					19. I am dissatisfied about our relationship with my parents, in-laws and/or friends.
					20. I feel very good about how we each practice our religious beliefs and values.

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Date: _____ mm-dd-yy

Session #____

COUPLE RELATIONSHIP

ID# _____ FM# ____
Times Taken _____
Couple Form = 1

Center For Family Services - Oklahoma State University

INSTRUCTIONS:
Couple relationships differ greatly from each other. Please review the statements below and respond according to **HOW YOU WOULD DESCRIBE YOUR COUPLE RELATIONSHIP AS IT IS NOW.**

Put an X in one box										
Almost Never 1	Once In A While 2	Sometimes 3	Frequently 4	Almost Always 5	1 Almost Never	2 Once In A While	3 Sometimes	4 Frequently	5 Almost Always
☐	☐	☐	☐	☐	1. We ask each other for help.				
☐	☐	☐	☐	☐	2. When problems arise, we compromise.				
☐	☐	☐	☐	☐	3. We approve of each other's friends.				
☐	☐	☐	☐	☐	4. We are flexible in how we handle our differences.				
☐	☐	☐	☐	☐	5. We like to do things with each other.				
☐	☐	☐	☐	☐	6. Different persons act as leaders in our marriage.				
☐	☐	☐	☐	☐	7. We feel closer to each than to people outside our marriage.				
☐	☐	☐	☐	☐	8. We change our way of handling tasks.				
☐	☐	☐	☐	☐	9. We like to spend free time with each other.				
☐	☐	☐	☐	☐	10. We try new ways of dealing with problems.				
☐	☐	☐	☐	☐	11. We feel very close to each other.				
☐	☐	☐	☐	☐	12. We jointly make the decisions in our marriage.				
☐	☐	☐	☐	☐	13. We share hobbies and interests together.				
☐	☐	☐	☐	☐	14. Rules change in our marriage.				
☐	☐	☐	☐	☐	15. We can easily think of things to do together as a couple.				
☐	☐	☐	☐	☐	16. We shift household responsibilities from person to person.				
☐	☐	☐	☐	☐	17. We consult each other on our decisions.				
☐	☐	☐	☐	☐	18. It is hard to identify who the leader is in our marriage.				
☐	☐	☐	☐	☐	19. Togetherness is a top priority.				
☐	☐	☐	☐	☐	20. It is hard to tell who does which household chores.				

Available From: Family Social Science, 290 McNeal Hall, University of Minnesota, St. Paul, MN 55108

Date: _____ mm-dd-yy

Session# ___

APPENDIX F

COUNSELING AGREEMENT

CENTER FOR FAMILY SERVICES
102 Human Environmental Sciences West
Stillwater, Oklahoma 74078
(405) 744-5058

Counseling Agreement

The Oklahoma State University Center for Family Services is dedicated to the treatment of families and the the training of skilled family therapists. In an effort to offer clients the best therapy possible, the Center's family-oriented approach includes observation by fellow therapists-in-training, video-taping and diagnostic evaluation, if deemed appropriate.

I (We), the undersigned, do consent to the observation and video-taping of my (our) therapy sessions. I (We) understand that I (we) may request the tape turned off or erased at any time either during my (our) session(s) or any time thereafter. I (We) understand that any video-tapes will be used to assist the therapist(s) in working with me (us) to improve the quality of therapy that I (we) receive. I (We) understand that I (we) will not be video-taped without our verbal consent, at the time of taping, and that all video-tapes of sessions are erased immediately following viewing by my (our) therapists. I (we) acknowledge the importance of research in increasing the effectiveness of therapy and in training high quality therapists. I (we) do consent to any research that may be completed through the clinic on my (our) case. We understand that names are never used in research and that the Center for Family Services guarantees the confidentiality of our records.

Since OSU is an educational institution, I (we) recognize that any counseling, testing, taping, or diagnostic work will be seen by the clinical supervisor and may be used by the supervisor for training purposes. No information about me (us) may be given to any person outside the Center without my (our) written consent or a court subpoena. However, if I (we) am (are) dangerous to myself or others, I (we) am (are) aware that mental health professionals have the responsibility to report information to appropriate persons with or without my (our) permission.

I (We) agree to notify the Center for Family Services at least 24 hours in advance should I (we) need to cancel an appointment. If not, a fee for services will still be charged. Payment for services is due when services are rendered. I (We) understand this fee to be $_____ per session. When I (we) decide to discontinue therapy, I (we) agree to discuss this with the therapist(s) at a regular therapy session, not by phone.

I (We) understand that should I (we) attend a therapy session impaired by alcohol or drug use that the session will be terminated and another session scheduled for a future time. This event will be treated as a missed session and charged at full fee.

I (We) am (are) aware that the Oklahoma State University Center for Family Services is not an emergency service, and, that in an emergencey situation if I (we) cannot reach my (our) therapist, I (we) have been advised to contact my (our) local community mental health center or another crisis counseling center.

My (our) rights and responsibilities as client(s) of the Center for Family Services and the procedures and treatment modalities used have been explained to me (us) and I (we) understand and agree to them.

_____	_____
(Name)	(Name)
_____	_____
(Name)	(Name)
_____	_____
(Witness)	(Date)

APPENDIX G

INSTITUTIONAL REVIEW BOARD APPROVAL

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 02-12-99 **IRB #: HE-99-055**

Proposal Title: RELATIONSHIP OF THE QUALITY OF THERAPIST'S JOINING TO CLIENTS' CONTINUANCE IN THERAPY

Principal Investigator(s): Charles Hendrix, Trey Trotter

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

Signature: Carol Olson Date: February 12, 1999

Carol Olson, Director of University Research Compliance
cc: Trey Trotter

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Trey Lynn Trotter

Candidate for the Degree of

Master of Science

Thesis: RELATIONSHIP OF THE QUALITY OF THERAPISTS' JOINING TO CLIENTS' CONTINUANCE IN THERAPY

Major Field: Family Relations and Child Development

Biographical:

Personal Data: Born in Ponca City, Oklahoma on October 16, 1968, the daughter of Dr. and Mrs. J.C. Trotter.

Education: Attended University of Tulsa 1987-1989, and graduated from Oklahoma State University with a Bachelor of Science degree in Psychology and a minor in English in 1992. Completed the requirements for the Master of Science degree in Family Relations and Child Development with a Specialization in Marriage and Family Therapy at Oklahoma State University December, 1999.

Work Experience: Internship at The Center For Family Services, Stillwater, 1995-1999; internship at Family and Childrens' Services, Tulsa, 1996-1997. At Family and Childrens' Services, Tulsa, affiliate therapist, 1997-present; Family Support Specialist Supervisor for Head Start Families, 1998-1999; Family Resource Coordinator, 1999-present. Presenter of Helping Children Cope with Divorce and Surviving High Conflict Divorce for Family and Childrens' Services, 1999-present.

Honors and Activities: Member, American Association of Marriage and Family Therapy, 1996-present; Member, Oklahoma Association of Marriage and Family Therapy, 1996-present; Vice-President, Graduate Student Council of the College of Human Environmental Sciences, 1996-1997; Member, Kappa Omicron Nu Honor Society, 1996-present, Sponsorship/Donations Chairman, 1997 OAMFT Conference, Exhibit Hall Coordinator, 1996 OAMFT Conference.