VARIABLES ASSESSABLE AT INITIATION OF THERAPY WHICH CONTRIBUTE TO CLIENT DROPOUT

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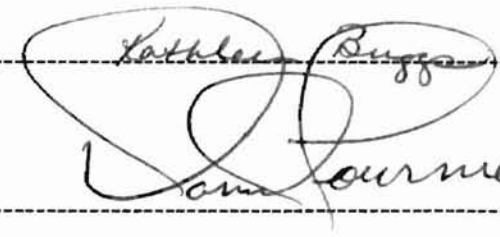

Dean of the Graduate College

PREFACE

Clients who dropout of therapy have long been a concern. Dropping out of therapy can create difficulties for therapists through wasted time and paperwork, disrupted schedules, forfeited income, and injuries to the therapist's well being and sense of competence (Bischoff & Sprenkle, 1993). More importantly, dropping out may be deleterious for clients. The loss of services may decrease the client's ability to cope with serious problems such as familial abuse or mental illness. Research assessing predictive variables of client attrition in family, marital, and individual therapy is needed to better equip therapists to serve their clients. The current study is composed of an ongoing database of more than 400 cases from a training clinic associated with a COAMFTE M.S. program. The purpose of this study is to identify client variables at initiation of therapy which will allow the clinician to efficiently distinguish between clients who are likely to dropout or continue in therapy. Related to this, is the objective of identifying how therapist variables and factors related to the process of therapy may contribute to the occurrence of dropout. Such information could be useful in helping the therapist to adjust his/her treatment plan, decreasing the likelihood of client dropout and thereby providing greater benefit to therapist and client.

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Chapter 1

Introduction

Clients who dropout of therapy, whether in the beginning phase of treatment or those who later terminate against the advise of their therapist, have long been a concern. Dropping out of therapy can create difficulties for therapists through wasted time and paperwork, disrupted schedules, forfeited income, and injuries to the therapist's well being and sense of competence (Bischoff & Sprenkle, 1993). More importantly, dropping out may be deleterious for clients. The loss of services may decrease the client's ability to cope with serious problems such as familial abuse or mental illness. In their analysis of factors contributing to successful outcomes, Luborsky, Auerbach, Chandler, Cohen, and Bachrach, (1971) found a positive correlation between number of sessions (duration of treatment) and successful outcome in therapy. Similar results were also found by Hampson and Beavers (1996) who found that not only was there a strong relationship between lower goal attainment and lower number of visits, but that, "63 families rated as not having met any goals (out of a total of 79) came to only the first session" (p. 354). Hampson and Beavers (1996) also found that "better functioning families fared better in therapy than did more dysfunctional families" (p. 358). Similarly, Anderson, Atilano, Bergen, Russell, and Jurich, (1985) found that couples who completed therapy reported greater life happiness and marital happiness prior to the initiation of therapy than those who terminated early. Such studies seem to indicate that clients who terminate therapy early may not have received what they needed, and may be the very families who need help the most.

Notable theorists have called attention to the importance of the initial phase of treatment in influencing successful outcomes in therapy (Haley, 1976; Napier & Whitaker, 1978; Minuchin & Fishman, 1981; Brock & Barnard, 1992). Minuchin and Fishman (1981) are especially clear to emphasize that enlistment in the therapeutic

process, or joining, is an essential element in bringing about enduring therapeutic change. Therapists must strive to attain the therapeutic leverage needed to first influence change, and then stabilize the client. Interestingly, Griffith and Coleman (1988) found that changing too fast in therapy results in increased chances of later relapse. And, as noted earlier, many studies have associated continuance in therapy with positive client outcomes (Hampson & Beavers, 1996; Luborsky et al., 1971; Anderson et al., 1985). These findings seem to suggest that a longer duration in therapy may give the therapist the influence to help the family not only create needed changes, but insure those changes are more lasting. Consequently, understanding the factors related to clients who dropout of therapy, which prevent meaningful engagement in the process of change, is essential.

As most dropouts occur in the initial phase of treatment (Fiester, Mahrer, Giambra, & Ormiston, 1974), information about dropouts must come from factors that can be assessed early in treatment for the information to be useful in intervening. Thus, the first question that needs to be asked is, what are the factors that can be assessed in the first two sessions of therapy that are related to dropping out? Other questions to be asked would be, what factors can be used to identify the "typical" dropout? What characteristics of the therapist contribute to the occurrence of client dropout? Are there factors related to the process of therapy that influence dropping out of therapy? And last, what can the therapist do to intervene in the process of client dropout?

A major purpose of this study is to identify client variables at initiation of therapy which will allow the clinician to efficiently distinguish between clients who are likely to dropout or continue in therapy. Additionally, this study will examine the association between client relationship variables and dropout. Bischoff and Sprenkle (1993), in a review of literature on dropout in therapy, noted that research in this area was deficient or non-existing, and challenged further studies to look into this area. Related to this, is the objective of identifying how therapist variables and factors related to the process of therapy may contribute to the occurrence of dropout. Such information could be useful in

helping the therapist to adjust his\her treatment plan, decreasing the likelihood of client dropout and thereby providing greater benefit to therapist and client, as well as increasing the likelihood of creating enduring change.

Additionally, in the existing research there is much variation in the ranges of client dropout rates within each of the different client system types (individual, family, marital). The rate of early termination for individual clients ranges from about 25% to 51% (Beckham, 1992; Hoffman, 1983; Richmond, 1992). Whereas for families the dropout rates spreads from 29 % to 62% (Shapiro & Budman, 1973; Talmon, 1990; Allgood, Parham, Salts, & Smith, 1995), and for couples the rate ranges from 37% to 57 % (Boddington, 1995; Anderson, et al., 1985). There are various reasons for these differences in dropout rates such as differences in client populations, use or non-use of medication in therapy, differences in interventions used, differences in therapy settings, and differences in definitions of what determines a dropout. All this variation clouds the picture of whether there are real differences in dropout rates associated with the different client system types (family, couple, or individual). The current study will investigate if meaningful differences occur by attempting to control some of the possible confounding variables through having all cases come from the same clinic sample, with equivalent clinical settings, and the same pool of therapists, with similar training.

Chapter 2

Review of Literature

Definitional criteria for a dropout

One challenge facing studies on client dropout is that current literature has failed to produce a consensus on the definitional criteria used to determine whether or not a client is a dropout (Bischoff & Sprenkle, 1993). A common definition for dropouts are those who discontinue against therapist desires after the first or second session (Epperson, Bushway, & Warman 1983; Davis & Dhillon, 1989; Hoffman 1983). Sledge, Moras, Hartley, and Levine, (1990) provide a different definition of dropouts as, "patients who unilaterally and abruptly stopped keeping appointments, either with or without notice to the therapist but without the therapist's concurrence" (p. 1343). The number of sessions was not part of their definitional criteria, but rather therapist concurrence with the client's decision to terminate therapy. Consequently, if a client that left therapy after the fifth session without therapist consent, he\she would be a dropout according to Sledge, Moras, Hartley, and Levine (1990), but not be a dropout according to Davis and Dhillon, (1989) or Hoffman, (1983). There are even more examples of different definitions such as Anderson et al. (1985), who defined dropouts as, "those clients who, in the therapist's assessment, discontinued treatment prior to accomplishing their original goals as established by both therapist and clients" (p. 42). In summary, there are many different ways to operationally define therapy dropout, and different procedures of classification can affect the results.

These differences in definitional criteria are especially important in light of the findings by Pekarik (1985) that differences in defining criteria for dropouts resulted in

different outcomes. Pekarik used two different definitions of dropout on the same sample, and found significant differences on 11 client variables when classified by therapist judgments, and no differences when classified by a cut-off number of sessions. As a result, he concluded that the classification for dropout based on therapist judgment, is a more sensitive measure. Clearly, the type of classification used to identify the dropout can meaningfully affect how one interprets the results.

Classifications of Variables

There are three major categories of variables that can be studied when attempting to understand the occurrence of dropout from therapy: client, therapist and therapy process variables (Bischoff & Sprenkle, 1993). First, in order to gain a clearer picture of the typical dropout, characteristics of the client should be studied. For example, alcohol use is a client characteristic that has been clearly linked to dropout from therapy (Friedman, Tomko, & Utada, 1991). Second, the characteristics of the therapist need to be examined to discover how he\she contributes to the occurrence of client dropouts. A case in point being Pekarik's (1985) finding that higher levels of therapist experience are associated with lower rates of client dropout. The third area to examine, would be the factors related to the process of therapy which contribute to dropout. An example of such a factor would be Russell, Lang, and Brett's (1987) finding that when a client of family/couple therapy is receiving individual mental health services elsewhere, the client is more likely to dropout of family\couple therapy. For this review, the latter category will be termed the therapy process variables. A limitation in existing literature that this study will attempt to correct is that studies up to this point have focused on only one of these areas, not addressing how these different areas fit together.

Client variables

Demographics. Most of the existing research on the occurrence of dropout in therapy has focused on the demographic variables of the client. Unfortunately, this category of variables was found to be the least reliably associated with dropout (Luborsky et al., 1971). Apparently, they found that the majority of studies examined client demographics, and many of the studies reported conflicting findings about significance of these variables. Overall, the client demographic that most consistently affects dropout rates is alcohol use (Baekeland & Lundwall, 1975). In their review of studies concerning dropping out of therapy, they concluded that alcohol use is negatively related to the number of sessions attended. This finding is still supported by current research (Friedman, Tomko, & Utada, 1991). Another client variable that has, in some studies, been linked to dropping out of therapy is socioeconomic status (SES). Previous findings generally show that those in the lowest socioeconomic bracket are the more likely to dropout of therapy (Fiester & Rudestam, 1975; Luborsky et al., 1971). Still, some studies have failed to replicate these results, and have found no association between SES and dropout (Gaines & Stedman, 1981; Slipp et al., 1974). Concerning age and likelihood of dropout, Luborsky, et al. (1971), and Brant (1965) both conducted critical reviews and found no conclusive relationship between age of the client and dropout rates in clients. Baekeland and Lundwall (1975) reported that those of a higher education bracket were more likely to remain in, and report more gains in therapy. However, this finding was not supported in other reviews of literature (Brant, 1965; Bischoff & Sprenkle, 1993). As for marital status, Sheehan (1980) found that married couples were less likely to dropout of therapy than cohabiting or common law couples. However,

Sledge, Moras, Hartley, and Levine (1990) found no such relationship. Only one study, Erdmann (1994), reported on the relationship between length of marriage and dropout. Erdmann (1994) reports longer marriages of clients in couples therapy are associated with a reduced likelihood of dropout. She proposes that longer marriages may indicate increased investment of the couple in the relationship, which leads them to be less likely to dropout of couple therapy. In summary, there appears to be little consensus in findings for the relationship between dropout and the listed client demographics, only alcohol/drug use and length of marriage represent the previously studied client demographics that appear to be consistently related to dropout.

Presenting problem

Several studies have examined how the type and severity, as well as attitudes toward the presenting problem of the client, relate to the occurrence of dropout in therapy. A consistent finding from existing literature is that the more severe or chronic the problem is, the less likely the client is to dropout (Kazdin, Mazurick, & Bass, 1993; McAdoo & Roeske, 1973; Gaines & Stedman, 1981; Hoffman, 1985). Hoffman (1985), in finding those of more serious or psychotic disorders were more likely to remain, states, "A person diagnosed as being psychotic is generally more impaired and uncomfortable than a non-psychotic; thus this person may be more likely to want treatment, to be encouraged to seek and stay with it..." (p.84). This suggests that those seeking therapy for minor problems or simply for enrichment, may have less motivation to remain in therapy than the severely disturbed. Two variables that can be investigated which focus on the relationship of dropout to severity of the problem, are type of presenting problem and the duration of time the problem has been experienced prior to initiation of therapy.

As for problem duration, Gaines and Stedman (1981) found that those who report a problem duration of greater than six months prior to initiation of therapy were much more likely to remain in treatment. They concluded that there was a "trend for chronic problem families to continue their treatment..."(p. 47). However, Gaines and Stedman (1981) only classified the families according to number of sessions attended during a 4 month period. There was no classification made of whether the clients completed therapy, ended therapy with therapist's concurrence, or simply dropped out of therapy after the sixth session. Additionally, one might question if the association between problem duration and dropout would a direct linear relationship. A re-examination of the association of problem duration and dropout would be helpful to discover if those with chronic problems are more likely to simply remain in therapy (a remainer), or actually complete therapy with concurrence of the therapist (a continuer).

Another set of findings related to presenting problem type, is that when the presenting problem was related to or attributed to only one person, dropout rate is higher (Allgood & Crane, 1991). They also found that those who identify children as the presenting problem are more likely to dropout. Additionally, in attempting to link pretreatment change with dropout, Allgood, Parham, Salts, and Smith (1995) found significant differences (X^2=39.09, df=11, $p < .01$) in whether termination would be planned therapist-client agreement or unplanned according to noted pretreatment change. However, they made no attempt to predict the number of sessions the client will attend before termination, only to describe whether or not the termination was planned or unplanned. In summary, an examination of previous findings seems to suggest that

differences in dropout rates will occur according to type of presenting problem, as well as severity of the problem (e.g. marital enrichment versus marital conflict).

A limitation of previous research is that for the most part the focus has been on the therapists' perceptions of the client, with no attention given to the client's perceptions of the problem (Gaines & Stedman, 1981). Two ways to investigate the client perception of the problem is by evaluating the seriousness of the problem and likelihood that the problem can be changed. As reported earlier, research shows that the more severe or chronic the problem is diagnosed to be by the therapist, the less likely the client is to dropout (Hoffman, 1985; Davis & Dhillon, 1989). Studying the client's perception of problem severity would be helpful to provide further support for existing research that clients with low levels of distress are less motivated to continue therapy. Additionally, only a few researchers have attempted to examine the client's attitude toward likelihood of problem change and outcomes in therapy. However, Baekeland, and Lundwall (1975) in their analysis of studies concerning dropping out of therapy did conclude that negative attitude toward therapy, in general, can increase likelihood of dropping out. In addition, Goldstein and Shipman (1961) found that greater expectation of symptom reduction in beginning of treatment was positively related to later symptom reduction in treatment. In conclusion, these findings seem to suggest that a positive client attitude toward change would be expected to be positively associated with continuance in therapy.

Client System Variables

As mentioned earlier, the rate of early termination for individual clients ranges from about 25% to 51% (Beckham, 1992; Hoffman, 1983; Richmond, 1992). Whereas for families the dropout rates spreads from 29 % to 62% (Shapiro & Budman, 1973;

Talmon, 1990; Allgood, Parham, Salts, & Smith, 1995), and for couples the rate ranges from 37% to 57 % (Boddington, 1995; Anderson, et al., 1985). A major limitation in previous research is that few studies have sought to investigate if differences in dropout rates occur for the different client types (e.g., family, couple, or individual). One similar study was that of Pekarik and Stephenson (1988) who investigated the differences between dropout rates for adult or child clients, with the conclusion that differences did occur and that children and adults should be classified differently. However, Pekarik and Stephenson failed to report whether client system type was family or individual when working with children. Consequently, differences according to the divisions of individual, marital or family therapy were not examined. As a result of limited research examining differences in dropout rates according to client system type, the picture still remains unclear. A study that examines whether differences occur for the client system types, while controlling for confounding factors, is needed to clarify the picture. This could be done by performing a study using similar therapy settings and the same pool of therapists for all client types. There are a number of possible ideas for why differences might occur among client system types. One potential view could be that dropout is more likely in couple and family therapy than individual therapy for the reason that when more than one client is involved, any one client can refuse therapy, ending therapy for all. This may be especially true when the identified client is not the paying customer seeking therapy. Allgood and Crane (1991) found that families with more than one or two children were more likely to dropout of therapy than those with less than two children. This may be true because having more members of the family might decrease the negative influence on the family of having one of those members decide not to continue.

On the other hand, in couples therapy, the loss of any member ends the possibility of continuing as a couple. Regardless, the picture remains unclear of why couples have higher average rates of dropout than families. Investigating for differences in dropout rates among the different client system types, while controlling for divergence by having all cases come from the same clinic with the same staff of therapists, would be essential to provide answers to the questions of does divergence occur, and if so, why.

Relationship Factors and Level of Functioning

An area that remains relatively unstudied is the association between client relationship variables and dropout. As mentioned earlier, Bischoff and Sprenkle (1993), in a review of literature on dropout in therapy, noted this deficiency in the existing literature and challenged further studies to look beyond the regularly studied demographic variables. Relationship functioning is one dimension that could be studied to provide variables beyond client demographics, which can be associated with dropout. One existing study that has attempted to examine relationship factors is that of Hampson and Beavers (1996). Their study examined five variables which represented family functioning. Gains in family functioning were measured by a combination of therapist ratings, observational ratings, and follow-up questioning. Hampson and Beavers (1996) found that families that were "better functioning families fared better in therapy than did more dysfunctional families" (p. 358). In other words, those with more optimal scores on the measures of family functioning did make greater gains in therapy. In addition, Hampson and Beavers note that there was, "a strong relationship between number of sessions and positive outcome" (p. 358). This information seems to provide a basis for the idea that there is likely to be a positive association between family functioning (as

measured variables such as health and competence, conflict, cohesion, leadership, and emotional expressiveness) and dropout.

The idea that relationship functioning can be related to dropout also seems to find support in the study of Baekeland and Lundwall (1975) who reported that clients who were more socially isolated from family and friends, were more likely to dropout of therapy. Being able to maintain a close relationship outside therapy might possibly provide experience which helps the client better maintain his\her therapeutic relationship. A concept that is used to represent a measure of the degree of relationship closeness and distance is *cohesion* (Olson, Sprenkle & Russell, 1979). Olson, Sprenkle and Russell (1979) define cohesion as "the emotional bonding members have with one another and the degree of individual autonomy a person experiences in the family system" (p. 5). They further explain that extremely high family cohesion could be characterized by an excessively close alliance with the family with limited individual autonomy and is termed enmeshment. Conversely, very low cohesion, termed disengagement, represents little family bonding and extreme individual autonomy. Olson, Sprenkle, and Russell (1979) propose that a "balanced degree of family cohesion is the most conducive to effective family functioning and individual development" (p. 6). Accordingly, clients who exhibit *extreme* cohesion may dropout of therapy either as a function of low cohesion, being too distant to effectively engage others in therapy, or excessively high cohesion having ties too strong to permit the therapist to enter their system.

Another relationship variable that was found to have a significant association with dropout is the level of authoritarianism (Slipp et al., 1974). They compared couples in which both spouses were lower in authoritarian attitudes to couples where one or both

members were higher in such attitudes, finding the couples with high authoritarianism were significantly more likely to dropout. In discussing why these findings might occur, Slipp et al. (1974) stated that, "authoritarianism is associated with rigidity, a tendency to think dogmatically in black and white terms, and intolerance of ambiguity" (p. 415). They further propose that the, "patterns associated with authoritarianism also appear to contrast with the democratic group structure of family therapy which emphasizes open dialogue, recognition and negotiation of differences, and shared decision-making" (Slipp et al., 1974, p. 415). A well-known concept that refers to the degree of openness to change and rigidity of rules or interactions within a relationship is *flexibility* (Olson, 1991). He states that the concept of flexibility in relationships refers to the, "system's ability to alter its internal structural relationships" as a response of a system in times of stress (p. 5). A family that was extremely low on flexibility would be identified by fixed, inflexible rules and leadership style and is termed rigid. Conversely, Olson (1991) suggests that a family that is very high in flexibility, termed chaotic, would be characterized by low stability and high variability. Again, Olson, Sprenkle, and Russell (1979) propose that extreme high or low flexibility can inhibit optimal relationship functioning and individual development. Accordingly, clients with extreme adaptability may dropout as a function of rigid resistance to change, low adaptability, as suggested by the findings of Slipp et al. (1974). Or, on the other extreme, they may be lost due to difficulty maintaining sufficient family organization to handle demands of therapy (high adaptability).

Other variables that have been recognized for their importance in relationships are communication and satisfaction (Olson, Fournier, & Druckman, 1987). Anderson et al.

(1985) also studied marital happiness finding that a pre-therapy score of high marital happiness is associated with continuance in therapy. This association was true for both high individual and relationship happiness or satisfaction. As for communication, no has been located that has examined the relationship between communication capability of the client and dropout from therapy. However, some studies have examined the association between an aspect of functioning of the client and dropout, generally finding that lower client functioning is positively associated with better outcomes in therapy (Hampson & Beavers, 1996; Baekeland & Lundwall, 1975; Friedman, Tomko, & Utada, 1991). Considering these findings, one could suggest that higher functioning on communication skills of the client would be positively associated with dropout. However, a study examining the relationship between communication skills and classification of dropout of the client would be necessary to confirm the suggestion that these variables are associated with each other.

Any relationship is greatly influenced by characteristics of the members who create, or are part of, that relationship. An assessment of the individual functioning of the members of the relationship can give an indication of how the relationship functions. In addition, the direct relationship between individual functioning and dropout has gone relatively unstudied. Similar work has been done by McAdoo and Roeske, (1973); Gaines and Stedman, (1981); and Hoffman, (1985) who studied the length, type and severity of the presenting problem of the client. They found that clients with more severe, chronic, or psychotic problems tend to remain in therapy. However, while the type and severity of the presenting problem is related to functioning of the individual, they do not include areas of functioning such as work performance, or social skills of the

client. In short, they are not direct measures of the overall functioning of the client. Investigating the global assessment of functioning or GAF (American Psychiatric Association, 1994) of the individual clients would be essential in providing a direct measure of their functioning.

Another variable that can provide a measure of functioning of the client is the number of health symptoms reported on a client checklist. McDaniel, Hepworth, and Doherty (1992), state that, "...patients frequently do not differentiate between emotional and physical experience and do not use emotional language to express emotional distress. Instead, they use somatic language to describe all difficulties, whether physical or emotional (p. 122)." In investigating the association of health symptoms and dropout, one can suggest that more health symptoms (unexplained worry, frequent headaches, tiredness, trouble sleeping) can be associated with difficulties in emotional functioning. In addition, when assessing functioning the clients that report they have more health symptoms such as unexplained worry, trouble sleeping, frequent headaches, frequent fatigue/tiredness, or dizziness/lightheadedness, will generally be viewed as lower in functioning. As previously mentioned, literature on client functioning shows that lower functioning clients will have worse outcomes in therapy (Hampson & Beavers, 1996; Baekeland & Lundwall, 1975; Friedman, Tomko, & Utada, 1991). From this information one can then suggest clients who dropout of therapy would be more likely to report higher numbers of health symptoms. Additionally, a paper presented at a conference included statistics that examined the relationship between reported health symptoms and dropout, and appeared to find this trend of more symptoms related to higher incidence of dropout (Fournier, Hendrix, & Briggs, 1997).

Therapist Variables

The occurrence of client attrition from therapy is, in essence, a study of the break-up of the therapeutic relationship. Although one person may terminate a relationship, generally there are actions of both parties that have contributed to either the maintenance or dissolution of that relationship. Consequently, for a complete picture of why clients leave therapy, variables related to the therapist must be studied.

Variables obtainable prior to the initiation of therapy that have been studied previously are the gender, age, experience, empathy, concern, and attractiveness of the therapist (Epperson, Bushway, & Warman, 1983; Pekarik, 1985; McKee & Smouse, 1983; Fiester, 1977). While the findings are not wholly consistent, generally, older (Pekarik, 1985), male (Epperson, Bushway, & Warman, 1983), higher experienced (Pekarik, 1985; McKee & Smouse, 1983) therapists who are higher in empathy, concern, and attractiveness (Fiester, 1977), are less likely to have their clients dropout of therapy. Relatively few studies (Epperson, Bushway, & Warman, 1983) have examined the differences in therapist gender and client dropout rates, with little or no explanation given for as to why the different rates occur. Additionally, therapist age and professional degrees are often considered together as indicators of the more meaningful variable of therapist experience.

There are many possible explanations for why therapist experience is linked to continuance in therapy. McKee and Smouse, (1983) state that counselor experience as evidenced by higher degrees may increase the client's perception of expertness of the therapist, and the client's ability to trust the therapist. An interesting finding related to

this is that of Fournier, Briggs, and Hendrix (1997) who reported on co-therapy with trainees and outcomes in therapy. In their study, a co-therapy team of two beginning trainees appeared to have better outcomes than a team of two advanced trainees or an individual therapist. Additionally, co-therapy teams in general appeared to have more favorable outcomes than individual therapists. In attempting to describe why such finding occur, one can consider Fiester's (1977) report that higher levels of therapist empathy, concern, attractiveness lead to lower dropout rates. Co-therapy teams could provide increased resources to furnish these qualities, and hence, be associated with lower incidence of dropout.

Therapy Process Variables

Fiester (1977) found in his analysis of different variables related to therapy outcome that therapy process variables had a greater explanatory importance as to the phenomenon of client dropout rates than do client characteristics. The first set of therapy process variables that has been linked to the occurrence of dropout are those dealing with the client's previous and concurrent therapy experiences. Several studies have found that clients with previous therapy experience have higher completion rates in therapy (Allgood & Crane, 1991; Hoffman, 1985; LeFave, 1980). There are many possible reasons for these findings. Those who return to therapy after having previous experience with therapy, are most likely those who found therapy helpful in their prior experiences. Also, returning clients may have a better idea of what they want from therapy or their therapists, and make a more informed selection of therapeutic services at the onset of therapy. Related to the idea that more experience with therapy can lead to different choices, is Russell, Lang, and Brett's (1987) finding that when one or more members of a family/couple are receiving individual therapy services elsewhere, they are more likely to dropout of couple/family therapy. Again, there are different possible explanations for

this finding. One possibility is to suggest that the alternatives for the therapeutic relationship would be easier to obtain for an individual who is receiving concurrent services elsewhere. Whatever the reasons for these findings, a study designed to replicate previous findings and link them with other client and therapist variables would provide a clearer picture of why they occur.

A final variable relating to the context in which therapy occurs that could be associated with dropout is that of psychosocial stressors affecting the client who seeks treatment. The DSM-IV includes a section listing psychosocial stressors (American Psychiatric Association, 1994). The DSM- IV states that, "A psychosocial or environmental problem may be a negative life even, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed" (American Psychiatric Association, 1994, p. 29). Considering this these problems in the context of therapy, inferring that a greater number of stressors could interfere with the client's ability to maintain a therapeutic relationship, seems reasonable. However, a study would be needed to fill the gap in existing research and provide information about the association between psychosocial stressors and dropout.

Theory

Considering the many inconsistencies and limitations outlined in the findings of existing reviews of dropout literature (Brant, 1965; Bischoff & Sprenkle, 1993), the need for theory to guide research is especially important. Consequently, the hypotheses and conclusions for study will be guided by theory. As the client systems will include individual, couple, and family, the theories used must be broad enough to encompass multiple subjects and the interactions that occur. Two theories that best explain the

break-up and maintenance of relationships, especially where multiple players are involved, are General Systems Theory and Social Exchange Theory.

General Systems Theory

Speaking generally, the word system refers to a group of members that are interrelated to each other in a somewhat enduring way. The members are interrelated in that significant actions of any one member can influence the other parts or group as a whole. In essence, systems theory is a way of thinking that demands consideration of the relationship between different people and objects. As such, General Systems Theory provides a framework for exploring the dynamics of a therapeutic relationship and what contributes to the dissolution of the relationship. Each person brings something with them, which will contribute to the overall composite of the relational ambiance. The idea that members of the system contribute together in creating what happens is often represented by the construct of circular causality. With many psychological theories, the focus is on the individual and ignores the system. Systems theory is different in that one cannot assign the cause of a problem to a part of the system. This is because each action within the system affects the others. So any problem, whether client dropout or something else, is part of the system. An excellent example of circular causality is where you have a cycle of the wife nagging and the husband avoiding responsibility. He says he will not respond because he cannot stand her nagging. She says she nags because he never responds. In other words 'nagging' begets more 'no response' which begets more nagging which begets no response and so on. Here both members of the couple are contributing to the difficulty. Blaming one person as the source of the problem is not congruent with what is occurring in the system. Likewise, client dropout from therapy cannot be explained by solely examining the client or the therapist. Both the client and therapist may believe the fault for dissolution of the relationship lies with the other. Systems theory would hold that to some degree, both the client and the clinician would be responsible for the dissolution of that relationship. Hence, this provides the basis for the

first two categories of "client characteristics" and "therapist characteristics." Interestingly enough, this also may give understanding to the finding reported in Bischoff and Sprenkle's (1993) review of literature that the higher the therapist and client agreement on the nature of the presenting problem, the lower the client attrition from therapy.

With any relationship, there will be emergent factors which are unique to that relationship, which cannot be explained by solely examining the parts. Emergence refers to the idea that when you put the parts together, you get something more than just adding up their individual properties. The best example is the marriage of a couple. Even if you know the characteristics of the two individuals, you will still not be able to completely predict what kind of marriage they will have. If you get two individuals together, there will be the third new element composed of the interaction of the two. This provides the rational for a set of variables termed therapy process variables. These variables are not simply characteristics of a client or therapist, but rather reflect characteristics of the relationship or therapeutic setting.

Systems theory is broad enough to include factors outside the therapeutic relationship which may affect the relationship such as social expectations or environmental factors. Examples of possible factors which could have an effect on a therapeutic relationship might be the client loosing his\her job, the client's husband\wife getting a job offer out of state, or the client's husband\wife being killed in a car accident. Interestingly, Baekeland and Lundwall (1975) found that interruptions in the delivery of treatment such as vacations, illnesses, or emergencies contribute to higher dropout rates. Any person is a part of greater systems such as his\her family, community, society, and nation, and a significant action in the greater system (such as illness of child) can affect that person. In addition, any system has smaller components, like members within a family. Although these levels of systems are different, they still affect each other. A person's position at work or even in society, such as a mayor, may influence how he\she

acts at home, in his\her community, or in therapy. For example, therapy may be viewed socially desirable among some, yet be viewed as socially undesirable among some minority cultures. Consequently, variables such as socioeconomic status, drug use, and education, of the client can be factors that can affect the therapeutic relationship.

Social Exchange Theory

Social Exchange Theory is an attempt to explain relationships according to the effects or consequences they have on their participants. Whether or not we engage in a certain relationship including a therapeutic relationship, is related to the amount of reward compared to cost, or *profit*, that relationship provides. George Holmans said, "...the open secret of human exchange is to give the other man behavior that is more valuable to him than it is costly to you, and to get from him behavior that is more valuable to you than it is costly to him" (1961, as cited in Boss et al., 1993, p.385). Accordingly, any client who engages in therapy only does so because he\she feels that what he\she receives from therapy is more valuable than the emotional, social, and monetary, price he\she pays for therapy. When the cost exceeds the benefit of the relationship, termination of the relationship will occur. Also, within the framework of Social Exchange is the concept of Comparison Level (CL). This is the standard by which one judges a relationship. This evaluation is placed on the rewards and costs of a relationship, in terms of previous experience, and what one feels is realistically obtainable. For example, a client that is of a low economic status may see the cost of therapy as higher than one of a high economic status, even though the monetary price is the same for both. Also, one's CL of a particular relationship will be adjusted by that relationship's intrinsic value and by societal norms (Floyd & Wasner, 1994). For example, a male therapist may possibly have higher value according to social norms than a female, which may provide understanding into the finding of Epperson, Bushway, and Warman, (1983) that female counselors had higher rates of premature termination than male counselors.

A concept related to CL is that of Comparison Level for Alternatives (CLalt). CLalt can be defined as the lowest level of profit a person will accept from the relationship, considering the best possible alternatives to the relationship (Thibaut & Kelley, 1959). CLalt can be determined by comparing the best alternative to one's present relationship. The more attractive an alternative, the higher CLalt will be. This may explain the finding by Russell, Lang, and Brett (1987) that involvement with concurrent individual therapy contributes to higher dropout rates in clients of couples therapy. Factors such as barriers to separation and personal resources affect CLalt. Some barriers to separation may be investment in the relationship, social expectations, and reactions of spouse. This may give a greater theoretical base to the hypothesis that longer married individuals would be less likely to dropout of marital therapy.

One last concept that relates to relationships is that of the principle of least interest. According to the principle of least interest, the person in a relationship, who is less interested in what happens in that relationship, will have more power and control over what happens in that relationship. Accordingly, if a client is less interested than the therapist in a therapeutic relationship, the client will have greater control over how long the relationship continues and how that relationship ends.

Hypotheses

In using Social Exchange and General Systems theories to understand the phenomenon of client dropout in therapy, there are at least three categories of variables to address. First, in order to gain a clearer picture of the typical client dropout, the characteristics of the client should be studied. Second, the characteristics of the therapist need to be examined to discover how he\she contributes to the occurrence of client

dropouts. The third area to examine, would be therapy process variables which include the interaction of the therapist, client, and therapeutic setting.

Hypothesis 1: The demographic variables that will be associated with different classifications of dropout are alcohol use and length of marriage.

H 1.1: The greater the alcohol use, the more likely the client is to dropout of therapy.

H 1.2: Couples most likely dropout of therapy, will be those married for shorter time periods.

Hypothesis 2: The greater the severity of the presenting problem, the less likely the client is to dropout of therapy.

H 2.1: Clients classified by the different categories of presenting problems will have differences in rates of dropout.

H.2.2: Clients most likely to dropout of therapy, will have experienced their problem for a shorter duration prior to initiation of therapy.

H 2.3: The less likely the client feels the problem is to change, the more likely the client will dropout of therapy.

H 2.4: The more serious the client perceives the problem (very serious vs. not at all serious), the less likely the client is to dropout of therapy.

Hypothesis 3: Differences will occur in the dropout rates for the different client system types (individual, family, couple).

Hypothesis 4: Level of functioning at intake is related to classification of dropout in therapy.

H 4.1: Clients with the greatest likelihood of dropping out of therapy, will have lower GAF scores.

H 4.2: Clients more likely to dropout of therapy, will report a higher numbers of health symptoms.

H 4.3: The more balanced a client is on the FACES III scales of cohesion and adaptability, the lower the likelihood the client will dropout of therapy.

H 4.4: Clients with the greatest likelihood of dropping out of therapy, will have lower the scores on their communication and satisfaction scales.

Hypothesis 5: Differences in therapist variables will be significantly related to different classifications of dropout.

H 5.1: The higher the level of experience of the therapist, the lower the likelihood the client will dropout of therapy.

H 5.2 Co-therapy teams will have lower client dropout rates than individual therapists.

Hypothesis 6: Therapy process variables will be related to the choice of dropping out or continuing in therapy.

H 6.1 Clients with previous experience in therapy will be less likely to dropout of therapy.

H 6.2: Families/couples in which one or more members are receiving individual services elsewhere, will be more likely to dropout of family/couples therapy.

H 6.3: Clients with the greatest likelihood of dropping out of therapy, will report a greater the number of psychosocial stressors.

Chapter 3

Methods

The methods section of this study will describe how experimental evidence will be gathered to further test the hypotheses supported in the review of literature. The research design is explained, setting the framework for the choice of subjects and experiment setting. The sampling techniques and sample description are then outlined. Finally, the instruments and procedures matched to the study are described.

Research Design

The research method consists of a quasi-experimental, time-series design with all clients attending at least one session. This study will attempt to account for the limitation of previous studies by using three different subcategories to classify the type of termination. Specifically, as reported earlier there has been much confusion due to different studies using only one definition of dropout that is different from other studies. This study will classify results using the three most common definitions, which will allow comparisons of results on the same sample. The study will also partially replicate Pekarik's (1985) results by using two different measures, completion of therapy and number of sessions, to classify dropouts. First, dropouts will be those who choose to discontinue against therapist desires before the third session. The second classification, termed a remainer, are those who remain for three or more sessions yet terminate without the concurrence of the therapist. The third subcategory, termed a completer, are those who complete therapy with the concurrence of the therapist. Completion of therapy is not dependent on number of sessions attended. For example, engaged clients may come in to take the PREPARE, and terminate therapy with concurrence of the therapist having

completed goals after only two sessions. The subjects will be grouped into these different groups (dropout, remainer, or completer) depending on their type of termination.

The data were collected from June 1994 to January 1998 as part of an ongoing process of record keeping of client and therapist characteristics in a university based Marriage and Family Therapy program. Hence, the study will be retrospective as the information will come from existing clinic data. This research is descriptive as the major purpose of the study is to describe the client and therapist characteristics as well as therapy process variables that contribute to client attrition from therapy. The study will be longitudinal, as the information will be gathered at the initiation of therapy and at the end of therapy.

Sampling

The target population will be all clients attending, and all therapists and interns providing mental health services. The sampling frame will be all clients and therapists at a medium-sized south-central state university marriage and family therapy clinic for which records exist during the period of June of 1993 to January of 1998. The number of cases was approximately 419 (237 couples, 97 individuals, and 85 families) involving over 745 clients who completed at least some portion of the paper work. Additionally, the number of therapists was 44 (3 faculty supervisors and 41 interns). The sampling unit will be the individual client, the client system, and the therapists. The sampling procedure will be purposive, yet also convenience as every client that sought therapy and attended at least one session during the specified time was included. The sample should be relatively representative of the target population as every client in the sampling frame will be studied, except for a very small number (about 5%) for which records are missing,

or incomplete due to recording errors. The limitation of this study is that attempting to generalize the findings beyond the limited sampling frame could be misleading for some clinical sites. For instance, therapeutic techniques and settings will vary depending on where the client seeks therapy.

Instrumentation and Measurement

Intake report form. As stated earlier, this study will examine the association of problem duration and dropout to test the hypothesis that greater problem duration will be associated with continuance in therapy. The intake form provides information about the length of time the problem has been for the client. The question for length of problem simply states, "How long has it been a problem?" The time for the problem is recorded in months with rounding up for partial months. The intake form is filled out by a therapist intern at the clinic from information gained from the call requesting therapy. The intake form's face validity was established by the collaboration of the three faculty supervisors who direct the clinic.

Background questionnaire. This form includes information concerning the age of the client, health symptoms, alcohol use, reason for seeking services, presenting problem, attitudes of change, seriousness of problems and previous and concurrent mental health services of the client. As brought out in the review of literature, studying the association between dropout and these variables will provide information essential for understanding why client dropout occurs. Packets of information that contained the background questionnaire were mailed to those who had sufficient time for the mailing to arrive before the first session. Those who received the mailing were instructed to fill the forms out and bring them to the initial session of therapy. All persons were asked to arrive

about 15 minutes prior to their first session. At that time they were greeted by their assigned therapist(s) who obtained the filled out form or administered the form to those who had not received the mailing. All background forms, whether mailed out or administered at the clinic, were completed before the beginning of the first session of therapy. As with the intake form, there are no previously reported measures of reliability. However, the background form's face validity was also established by the collaboration of the three faculty supervisors who direct the clinic.

Several questions regarding demographic variables are listed on this form. The two hypothesized to be significant are alcohol use and length of marriage of the client. The question on the form for alcohol use specifically states, "Do you drink alcohol? If yes, How much?" The coding for the answer is first 1= yes, and 2= no. If the client drinks alcohol the amount is coded according to the scale of, 0) Never/Do not use, 1) On occasion, 2) 1-3 times weekly, or 3) 4+ times weekly. Again higher alcohol use is hypothesized to be positively associated with dropout. The question for length of marriage is stated, "Number of years married?" This answer is coded by the therapist according to number of months the person is currently married. This study will investigate the hypothesis that a longer duration of marriage, will be positively associated with continuance in therapy.

The health symptoms checklist contains 12 items of possible symptoms currently experienced by the client including selections, such as "Severe Headaches" or "Trouble Sleeping." The respondent is asked to check all listed symptoms he\she has experienced in the last six months. This question will provide a measure of the health symptoms experienced by the client at intake. In being consistent with associated literature on client

functioning and dropout (Hampson & Beavers, 1996; Baekeland & Lundwall, 1975; Fournier et al., 1997), this study hypothesizes that more client reported health symptoms will be positively related to dropout. This study will investigate the association of client reported health symptoms using this hypothesis.

The question on the background questionnaire covering client attitude toward problem severity states, "How serious would you say this problem is right now?" The subject is asked to respond by circling one of the four possible answers, 1) Not at All Serious, 2) Slightly Serious, 3) Moderately Serious, 4) Very Serious. The seriousness of the problem will be coded according to the scale above. This study will investigate the hypothesis that the more serious the client perceives the problem (very serious vs. not at all serious), the less likely the client is to dropout of therapy. Attitude toward the likelihood that the problem will change is measured with the question, "How likely do you think the problem is to change?" The subject is asked to respond by circling one of the four possible answers: 1) Not at All Likely 2) Slightly Likely 3) Moderately Likely 4) Very Likely. Considering that Goldstein and Shipman (1961) found greater expectation of symptom reduction in beginning of treatment was positively related to later symptom reduction in treatment, this study will investigate the hypothesis that the less likely the client feels the problem is to change, the more likely the client will dropout of therapy.

The background form contains a 22-item checklist of several possible reasons for seeking therapy such as "Personal Enrichment," "Marital Conflict," "Child Behavior Problem," or "Adjustment to Loss." An examination of previous findings seems to suggest that differences will occur according to type of presenting problem, as well as severity of the problem (e.g. marital enrichment versus marital conflict). This study will

also investigate the relation of classification of the presenting problem to dropout using the hypothesis that differences will occur according to type of presenting problem.

Two questions concerning concurrent and prior experience with therapy are also part of the background form. The first question states, "Are you currently receiving services from another therapist/counselor?" This will be coded according to a yes/no response and then answers will be compared to the dropout/continuance status of the client to examine the hypothesis that families/couples in which one or more members are receiving concurrent individual services elsewhere, will be more likely to dropout of family/couples therapy. The second question is stated, "Have you ever been treated by another therapist/counselor?" This question will be coded the same as the question for current services and will be compared to the client dropout/continuance status to examine the hypothesis that clients with previous experience in therapy will be less likely to dropout of therapy.

FACES III , Communication, and Satisfaction Scales

This study will use FACES III, communication, and satisfaction scales to examine how level of functioning at intake is related to dropping out or continuing in therapy. As outlined earlier, this study hypothesizes that the more balanced a client is on cohesion and adaptability scales, and the higher the scores on the communication and satisfaction scales, the lower the likelihood the client will dropout of therapy.

FACES III, Communication, and Satisfaction scales were administered prior to the first session upon arrival of the clients to the clinic. The clients were instructed to fill out the paperwork in the waiting room with the therapist watching behind the one-way mirror in case a question should arise. The subjects were given as much time as needed

to fill-out the forms. These instruments describe important concepts that are unique to relationships, yet measured at the individual level.

Cohesion and Flexibility. FACES III (Olson, 1991) was used to assess cohesion and flexibility dimensions as a measure of the level of relationship functioning of the client at initiation of therapy. The measures of cohesion and adaptability are plotted on scales ranging from one extreme to the other with the middle range representing balanced functioning. This 20-item questionnaire contains ten items from both cohesion and flexibility scales presented in alternating order. Respondents choose an answer from a five-point Likert-type scales ranging from 1=almost never to 5=very often. The FACES III instrument has excellent face and content validity according to Olson et al. (1985) as well as high test-retest reliability. In describing how to interpret the results of the FACES III instrument, Olson, Sprenkle, and Russell (1979) propose that a "balanced degree of family cohesion and flexibility is the most conducive to effective family functioning and individual development" (p. 6). This study will examine the hypothesis that the more balanced a client is on the FACES III scales of cohesion and adaptability, the lower the likelihood the client will drop out of therapy.

Communication and Satisfaction. The Circumplex Model of Marital and Family Systems which describes cohesion and flexibility, also includes the dimensions of communication and satisfaction (Olson, 1991). Communication provides the basis for movement within the scales of cohesion and adaptability. Satisfaction is important as Olson (1991) discusses that a meaningful measurement of family functioning is how satisfied the family is with their current level of cohesion and adaptability. The communication scale is concerned with an individual's feelings and attitudes toward the

communication in their relationship (Olson, Fournier, & Druckman, 1987). The 10 items focus on the level of ease one feels in sharing and receiving emotional and cognitive information from a family member. High scoring subjects usually feel understood by their family members and can discuss most topics freely. Low scoring subjects are usually concerned about not being able to express feelings with other family members. A description of the communication scale that was administered to clients seeking family or individual therapy can be found in Olson's (1983) book, *Families, What Makes Them Work*, while a description of the scale administered to the couples is found in Olson, Fournier, and Druckman's (1987), *PREPARE ENRICH Counselor's Manual*. The satisfaction scale is concerned with the individual's perceptions and attitudes of satisfaction he\she derives in his\her family relationships (Olson, Fournier, & Druckman, 1987). Items focus on the degree of happiness or contentment one feels when considering his\her relationship with family members or the personal characteristics of those family members. High scoring subjects are generally well pleased with their relationship as well as the characteristics of their family members, whereas low scoring subjects are not. The satisfaction scale for couples is described by Olson, Fournier, and Druckman, (1987) and the scale for families is outlined by Olson (1992). The Communication, and Satisfaction scales consists of two ten item scales covering couple/family communication and satisfaction. The Communication, and Satisfaction scales include a five-point Likert-type scale with an identical range of responses, 1=almost never to 5=very often, as is used by the FACES III. Both scales also contain items that are reverse scored so that when items are calculated, high scores represent more optimal levels of perceived communication and satisfaction (Olson, Fournier, &

Druckman, 1987). Both the communication and satisfaction scale have high Cronbach's alpha reliability scores respectively, r=.73, .81, (Fournier, Olson, & Druckman, 1983).

Those who place on the extremes of cohesion and adaptability dimensions are more likely to also be low in relationship communication and satisfaction (Olson, Fournier, & Druckman, 1987). This is consistent with the finding of Hampson and Beavers (1996) that higher functioning on the variables of family communication and satisfaction are predicted to be associated with better functioning and outcome in therapy. Also, supporting this is Anderson et al.'s (1985) finding that couples who reported greater marital happiness and communication abilities at initiation of therapy, fared better in therapy, and stayed longer. Consistent with related literature, this study will examine the hypothesis that higher scores on relationship satisfaction and communication at intake will be positively associated with continuance in therapy.

Treatment Plan/Diagnosis. Before or at the end of the third session, the therapist is responsible for filling out a treatment plan which includes a diagnosis on axes one through five of the DSM-IV (American Psychiatric Association, 1994). The fifth axis provides for a numerical calculation of the GAF for the client as described in the DSM-IV (American Psychiatric Association, 1994, p. 32). The GAF is for, "reporting the clinician's judgment of the individual's overall level of functioning" (American Psychiatric Association, 1994, p. 30). The GAF is a general rating of the client's psychological, social, occupational, and school functioning, with direct instructions to, "not include impairment in functioning due to physical (or environmental) limitations" (American Psychiatric Association, 1994, p. 30). The GAF score recorded on the treatment plan reflects the current functioning of the client at the third session of

treatment. The score is recorded on a scale ranging from 1 to 100, with the higher scores representing high or excellent functioning in many or all areas, and lower scores representing more impairment in psychological, social, occupational, and school functioning, (American Psychiatric Association, 1994, p. 30). Some existing studies have examined the association between dropout and certain aspects of functioning such as relationship functioning (Hampson & Beavers, 1996) or social and occupational stability (Baekeland & Lundwall, 1975). These studies have found that lower functioning on one of these variables, was associated with higher rates of dropout. This study will attempt to directly link the global functioning of the client to classification of dropout, with the hypothesis that lower GAF scores will be associated with greater likelihood that the client will dropout of therapy.

The fourth Axis of the DSM-IV is also listed on the treatment plan and includes a section listing nine possible categories of psychosocial and environmental stressors (American Psychiatric Association, 1994). The list of possible psychosocial stressors includes: problems with primary support group, problems related to the social environment, educational problems, occupational problems, housing problems, economic problems, problems with access to health care services, problems related to interaction with the legal system/crime, and other psychosocial and environmental problems. In addition to providing information that should be considered when determining a treatment plan, these psychosocial problems often provide information about the development and maintenance of a mental disorder, as well as information about possible outcomes of the mental disorder. On the treatment plan used in this study, the therapist checks the box for all current psychosocial stressors the client has reported that the

therapist judges to be relevant. After checking the box for each relevant item, the therapist fills out a description of the problem under the categories he\she has marked. This study will use the assumption that greater numbers of psychosocial stressors will interfere with the client's ability to maintain a therapeutic relationship, thereby increasing likelihood of dropout, to investigate the association between psychosocial stressors and dropout.

Termination Report. The termination report is filled out by the therapist upon closure of the case. This report contains information concerning the experience of the therapist, the number of sessions, the type of sessions (family, couple, individual, group), the reason for leaving therapy, and the date of first and last session. Therapist experience is determined by subtracting the date the therapist was first admitted to the clinical portion of the program, from the date of the first session of the particular case being examined. A classification of the dropout will be determined from data on the sections, "number of sessions" and "reasons for termination" listed on the termination report. To answer the question of reasons for termination, the therapist checks one of four responses: 1) completion of therapy, 2) client request, 3) no shows/cancellations, or 4) other, please explain. The therapist then gives a description of the presenting problem at beginning of therapy and upon closure of therapy. From this information, three classifications of termination will be determined. First, dropouts will be those who choose to discontinue before the third session with some reason other than completion of therapy. The second classification of remainers will be those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy. The last classification will be completers, who end therapy with the designation of completion of therapy. As

for the validity of the form being used, the content and face validity of the item questions being used seems readily apparent and again, face validity of this form was established by the collaboration of the three faculty supervisors who direct the clinic.

Chapter 4

Results

The primary means of analysis used to evaluate the relationship between dropout classification and the variables studied were Chi-square and One-way ANOVA statistics. The notable exception was the analysis of hypothesis 2.1 concerning the relationship between the different classifications of presenting problems and dropout which used percentile rankings.

Hypothesis 1

Hypothesis 1 states that the demographic variables that will be associated with different classifications of dropout are alcohol use and marriage. Support for this hypothesis was mixed with alcohol use significantly (X^2=15.209, df=6, $p < .01$) associated with classification of dropout and length of marriage was not, $F(1, 2)=1.728$, $p > .10$ (see Tables 1 & 2).

Table 1

Chi-square Analysis of Client Alcohol Use as Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	X^2	Significance
DRINKS CONSUMED						
Non-drinker	379	16.9%	53.8%	29.3%	15.209	p < .01*
Occasional Drinker	225	24.9%	48.0%	27.1%		
1-3 times weekly	67	23.8%	38.8%	28.4%		
4 or more time weekly	36	19.4%	63.9%	16.7%		

*Indicates the score is significant

Results show that drinking is significantly related to dropout classification in therapy (X^2=15.209, df=6, $p < .01$). More specifically, the data seems to show that moderate (1-3 times weekly) and occasional drinkers tended to have higher rates of completion (see Graph 1 in appendix H). Also, the non-drinkers and heavy drinkers are more likely to remain in therapy. Interestingly enough, while the relationship between

alcohol use and classification of termination is significant, hypothesis 1:1 stating that higher drinking will be associated with higher rates of dropout was not confirmed. Rather, a possible trend in the opposite direction appears to be evident. This variable, drinking, was coded using four categories, consequently, Chi-square analysis was used as the means of analysis.

Hypothesis 1:2 stating that the greater the length of marriage, the less likely the couple is to dropout of therapy, was not significant, $F(1, 2)=1.728$, $p > .10$. However, there does seem to be a non-significant relationship supporting the hypothesis in that longer married clients are more likely to remain in therapy. Last, the final trend noticeable is that clients who have been married for less time, are more likely to drop out of therapy (see Table 2).

Table 2

One-way ANOVA testing for Linear Relationship between Years Married and Dropout Classification

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	6.02	6.29	5.06	5.90

ONE-WAY ANOVA

Source of Problem			Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)		156.297	2	78.149	1.728	.179
Linear Term		Unweighted	63.157	1	63.157	1.397	.238
		Weighted	76.936	1	76.936	1.701	.193
		Deviation	79.361	1	79.361	1.755	.186
Within Groups			26138.305	578	45.222		

POST HOC LSD

(I) Dropout Classification	(J) Dropout Classification	Mean Difference (I-J)	Std. Error	Sig
Completer	Remainer	-.26	.721	.716
	Dropout	.96	.813	.238
Remainer	Completer	.26	.721	.716
	Dropout	1.22	.663	.065
Dropout	Completer	-.96	.813	.238
	Remainer	-1.22	.663	.065

As length of marriage was coded into the number of months, which is a continuous variable, a One-way ANOVA was used as the means of analysis.

Hypothesis 2

Hypothesis 2 states that the greater the severity of the presenting problem, the less

likely the client is to dropout of therapy. There were many interesting findings dealing with hypothesis 2 (see Tables 3, 4, 5 and 6).

Table 3

Percentile Ranking of Dropout Rates of Different Presenting Problems

		Dropout Classification							
Presenting Problem	N	Dropout-rank		Remainer-rank		Completer-rank		X^2	Significance
Sexual Abuse	17	41.2%	1	35.3%	18	23.5%	3	1.466	p >.10
Divorce Adjustment	44	40.9%	2	47.7%	16	11.4%	12	4.430	p >.10
Other Problem	51	39.2%	3	35.3%	17	25.5%	1	12.080	p <.001*
Physical Abuse	44	31.8%	4	56.8%	10	11.4%	12	3.065	p >.10
Marital Conflict	273	29.7%	5	54.2%	15	16.1%	8	7.946	p <.05*
Family Conflict	164	29.3%	6	59.8%	8	11.0%	14	12.127	p <.001*
Personal Enrichment	153	27.5%	7	55.6%	11	17.0%	6	1.490	p >.10
Single Parenting	41	26.8%	8	61.0%	6	12.2%	11	0.599	p >.50
Relationship Enrichment	270	26.7%	9	55.2%	13	18.1%	5	2.825	p >.10
Sex Problems	101	26.7%	10	63.4%	4	9.9%	16	6.694	p <.05*
Marital Enrichment	252	26.6%	11	55.2%	14	18.3%	4	3.000	p >.10
Kid Behavior Problem	95	26.3%	12	60.0%	7	13.7%	10	4.536	p >.10
Two Parenting	58	25.9%	13	63.8%	3	10.3%	15	4.514	p >.10
Family Stress	284	23.9%	14	59.2%	9	16.9%	7	7.839	p <.05*
Drug Abuse Adult	17	23.5%	15	76.5%	1	0.0%	18	6.776	p <.05*
Family Enrichment	195	22.6%	16	61.5%	5	15.9%	9	8.098	p <.01*
Adjustment to Loss	38	21.1%	17	55.3%	12	23.7%	2	0.262	p >.50
Step-Parenting	62	19.4%	18	71.0%	2	9.7%	17	9.360	p <.01*
Complete Sample	***615***	***19.7%***		***52.5%***		***27.8%***	-	-	-

*Indicates the score is significant

Hypothesis 2.1 states that clients classified by the different categories of presenting problems will have differences in rates of dropout. This hypothesis is more exploratory in nature in that the major purpose was simply to identify the different patterns of dropout classification associated with certain presenting problems. Listed are the different rankings according to highest percentage of dropout, as well as an independent Chi-square score for the association of dropout classification with each problem.

Examination of the results show that first, dropout rates for the different problems clients marked as reasons for seeking therapy ranged from 41.2% to 19.4%. Also, completion rates for the different reasons for seeking therapy ranged from 25.5% to

0.0%, and remainer rates ranged from 76.5% to 35.3%. An interesting note is that problems that were marked by fewer numbers of clients as the reason for seeking services (lowest n's), were the more likely to be on the extreme ends of the ranges in percentages of dropout classification. On the other hand, those who were marked by more clients (larger n's), were more likely to approximate the sample total. This appears to follow the concept of central tendency, as larger samples more closely resemble the mean. Additionally, four categories with sample sizes (n's) of less than 10, were not included in Table 3 due to the consideration of small sample size increasing chance for bias in the results. Some additional findings to note are first, those who marked sexual abuse as one of the problems for which they are for seeking therapy, were most likely to dropout of therapy at 41.2%, least likely to remain in therapy at 35.3%, and also highly likely to complete in therapy 23.5%. Second, those who marked step-parenting were the least likely to dropout of therapy 18.8%, very likely to remain in therapy 71.0%, and not very likely to complete therapy 9.7%. Last, those who marked the category of "other problem were most likely to complete therapy 25.5%, very likely to dropout of therapy 39.2%, and not very likely to remain in therapy 35.3%.

As for hypothesis 2.2 which states that clients most likely to dropout of therapy, will have experienced their problem for a shorter duration prior to initiation of therapy, a one-way ANOVA showed no significant effects, $\underline{F}(1, 2)= .634$, $p > .50$. However, even though hypothesis 2:2 was not supported, there did appear to be a trend in that direction as the mean problem time for dropouts was less than the means for completers and remainers (see Table 4).

Table 4

One-way ANOVA testing for Linear Relationship between Client Prior Problem Duration in Months and Dropout

CLASSIFICATION

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	26.12	25.84	21.91	24.78

ONE-WAY ANOVA

Source of Problem			Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)		1168.582	2	584.291	.634	.531
Linear Term		Unweighted	772.910	1	772.910	.839	.360
		Weighted	874.757	1	874.757	.949	.331
		Deviation	293.825	1	293.825	.319	.573
Within Groups			324375.717	352	921.522		

Additionally, One-ANOVA statistics were used to evaluate hypothesis 2.2 as the dependent variable of problem time is coded in months, and is a continuous variable.

While hypotheses 2:2 was not significant, hypothesis 2:3 which states that the less likely the client feels the problem is to change, the more likely the client will dropout of therapy, did show significance (X^2=15.498, df=6, $p < .01$). Table 5 shows the results and general trends and Graph 2 found in appendix H also shows a clear, easy to see picture.

Table 5

Chi-square Analysis of Client Perceptions about Presenting Problem as Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	X^2	Significance
CLIENT PERCEPTION OF LIKELIHOOD OF PROBLEM CHANGE						
Not at all Likely	66	33.3%	33.3%	33.3%	15.498	p < .01*
Slightly Likely	135	24.4%	48.9%	26.7%		
Moderately Likely	245	18.0%	54.3%	27.8%		
Very Likely	174	20.7%	58.0%	21.3%		
CLIENT PERCEPTION OF PROBLEM SEVERITY						
Not at all Serious	32	25.0%	34.4%	40.6%	16.929	p < .01*
Slightly Serious	101	28.7%	45.5%	25.7%		
Moderately Serious	247	25.1%	53.4%	21.5%		
Very Serious	283	16.3%	53.0%	30.7%		

*Indicates the score is significant

The analysis of client perception of likelihood of problem change and client perception of problem severity as compared to dropout was done using Chi-square statistics as these variables are coded into categories. Results show that, those who perceive their problem

as less likely to change are more likely to either dropout or complete of therapy. Conversely, those who perceive their problem as more likely to change are more stable and likely to remain in therapy, even if they do not complete therapy.

Hypothesis 2.3 which states that the less likely the client feels the problem is to change, the more likely the client will dropout of therapy, was also significant (X^2=15.498, df=6, $p < .01$). A more detailed view of the results can be gained by examining Table 5 and/or Graph 3 (see appendix H for graphs). Results show that first, there appears to be a curvilinear relationship between perceived problem severity and dropout, where those who see the problem as not at all severe or extremely severe are more likely to dropout of therapy. Second, there was also straight linear relationships in that first, those who see the problem as more severe are more likely to remain in therapy. Last, those who complete therapy are more likely to see their problem as less serious or moderately serious.

Hypothesis 3

Results for Hypothesis 3 which states that differences will occur in the rates of dropout classification for the different system types, was supported (X^2=9.477, df=4, $p < .05$), although support just barely achieved significance (see Table 6).

Table 6

Chi-square Analysis of Client System Type Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	X^2	Significance
TYPE OF CLIENT SYSTEM						
Individual	91	29.7%	41.8%	28.6%	9.477	p < .050*
Couple	445	21.6%	52.4%	26.1%		
Family	171	15.2%	52.6%	32.2%		

*Indicates the score is significant

The analysis of client system type severity as compared to dropout was done using Chi-square statistics as these variables are coded into categories. An examination of the

results shows that first, completers in therapy are most likely to be individuals, and are least likely to be families. Last, remainers are more likely to be families and couples, and are least likely to be individuals.

Hypothesis 4

Hypothesis 4 which states that level of functioning at intake is related to classification of dropout in therapy was supported with sub-hypotheses 4:1 ($\underline{F}$ (1, 2)= 6.911, $p < .001$), 4:3 (X^2=35.324, df=4, $p < .001$, X^2=10.731, df=4, $p < .05$), and 4:4 ($\underline{F}$ (1, 2)= 15.920, $p < .001$; $\underline{F}$ (1, 2)= 22.005, $p < .001$), but not significantly supported by sub-hypotheses 4.2, ($\underline{F}$ (1, 2)= .767, $p > .10$). Overall, many interesting results can be seen in the association between functioning of the client at intake and dropout classification (see Tables 7, 8, 9, 10, 11, & 12). A clear and easy view of the results of significant hypotheses 4.1, 4.3, and 4.4 can be seen in Graphs 4-8 in appendix H.

Table 7

One-way ANOVA testing for Linear Relationship between Client GAF Scores and Dropout Classification

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	69.12	63.86	63.84	65.26

ONE-WAY ANOVA

Source of Problem			Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)		1504.593	2	752.296	6.911	.001*
Linear Term		Unweighted	759.465	1	759.465	6.976	.009*
		Weighted	1060.293	1	1060.293	9.740	.002*
		Deviation	444.300	1	444.300	4.081	.044*
Within Groups			29936.760	275	108.861		

POST HOC LSD

(I) Dropout Classification	(J) Dropout Classification	Mean Difference (I-J)	Std. Error	Sig
Completer	Remainer	5.26	1.465	.001*
	Dropout	5.28	2.001	.009*
Remainer	Completer	-5.26	1.465	.001*
	Dropout	2.61E-02	1.791	.988
Dropout	Completer	-5.28	2.001	.009*
	Remainer	2.61E-02	1.791	.988

*Indicates the score is significant

As the variable of client GAF score is continuous, a One-way ANOVA was used as the means of analysis. Additionally, as the findings were significant, post hoc measures were

conducted to determine which classifications of dropout had means that were significantly different. As noted earlier, there were significant interactions associated with hypothesis 4:1, $\underline{F}$ (1, 2)= 6.911, $p < .001$. However, while hypothesis 4.1 which states that clients with the greatest likelihood of dropping out of therapy will have lower GAF scores had significant interactions, a post hoc test using least significant difference (LSD) revealed almost no difference between remainers and dropouts (χ^i-χ^j= .0261, $p >$ .50, see Table 5). The significant difference came from comparing completers with remainers (χ^i-χ^j= 5.26, $p < .001$) and dropouts (χ^i-χ^j= 5.28, $p < .001$). Clearly, the results show that the higher the GAF score, the more likely the client is to complete therapy.

Interestingly enough, the results for hypothesis 4.2 which states that clients more likely to dropout of therapy will report a higher numbers of health symptoms, followed the predicted trend, but was not significant, $\underline{F}$(1, 2)= .767, $p >$.50, (see Table 8).

Table 8

One-way ANOVA testing for Linear Relationship between Number of Symptoms Reported and Dropout Classification

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	2.10	2.34	2.38	2.30

ONE-WAY ANOVA

Source of Problem			Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)		7.646	2	3.823	.767	.465
Linear Term		Unweighted	6.414	1	6.414	1.286	.257
		Weighted	5.805	1	5.805	1.164	.281
		Deviation	1.840	1	1.840	.369	.544
Within Groups			3510.784	704	4.987		

As the number of health symptoms was counted ranging from 0 to 11, the counted intervals are equal making the variable continuous. Consequently, a One-way ANOVA was used as the means of analysis. As can be seen on Table 8 the mean number of health symptoms reported by dropouts was greater than the mean numbers reported by

completers or remainers. Additionally, health symptoms, had one striking point in that, of the subjects who reported eight or more out of a possible eleven symptoms, none completed therapy. However, the group size that reported this high number of symptoms was very low (N=14).

As reported earlier, the remaining two sub-hypotheses 4.3 and 4.4 clearly supported the main hypothesis 4 which states that significant differences would occur in the comparison of functioning and dropout classification. However, both sub-hypotheses were not wholly supported themselves (see Table 9). Hypothesis 4.3 states that the more balanced a client is on the FACES III scales of cohesion and adaptability, the lower the likelihood the client will dropout of therapy. Cut-off scores for the extreme high and low scores on cohesion and adaptability were determined using suggested norms listed by Olson (1991). Clients with extreme high and low cohesion scores were more likely to dropout of therapy than clients with balanced scores and Chi-square analysis of classification of dropout was significant (X^2=35.324, df=4, $p < .001$). However, clients with extreme adaptability scores, both high and low, appeared about as likely to dropout of therapy as did clients with balanced scores (see Table 9).

Table 9

Chi-square Analysis of Client Cohesion and Adaptability Scores Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	X^2	Significance
CLIENT COHESION SCORES						
Low 10-34	376	14.6%	56.9%	28.5%	35.324	p < .001*
Medium 35-44	232	26.7%	48.3%	25.0%		
High 45-50	86	37.2%	27.9%	34.9%		
CLIENT ADAPTABILITY SCORES						
Low 10-19	89	11.2%	57.3%	31.5%	10.731	p < .030*
Medium 20-28	376	19.9%	51.6%	28.5%		
High 29-50	235	27.2%	46.8%	26.0%		

*Indicates the score is significant

What appeared more noteworthy were the very clear trends that those who scored higher

on cohesion and adaptability were more likely to complete therapy, while those who scored lower on cohesion and adaptability were more likely to remain in therapy. These trends appear to be responsible for the significant Chi-square score (X^2=10.731, df=4, $p < .05$), associated with hypothesis 4.3. Further investigation on this finding reveals that Olson (1991) reports that self-report measures on cohesion and adaptability tend to follow a more linear relationship with functioning. Whereas observational measures tend to follow the conceptualized curvilinear relationship with functioning where extreme high cohesion, as well as low cohesion, are considered as lower functioning. As the measures used in this study were self report, this could explain why the more linear relationships of those who scored higher on cohesion and adaptability were more likely to complete therapy, while those who scored lower on cohesion and adaptability were more likely to remain in therapy, were observed.

Sub-hypothesis 4:4 which predicted that lower communication and satisfaction scores would be more likely to dropout of therapy, also did not appear to be wholly supported. As the variables of client communication and satisfaction are continuous, a One-way ANOVA was used as the means of analysis. Additionally, as the findings were significant, post hoc measures were conducted to determine which classifications of dropout had means that were significantly different (see Tables 10, 11, 12).

Table 10

One-way ANOVA testing for Linear Relationship between Client Communication Scores and Dropout Classification

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	33.51	29.45	30.16	30.52

ONE-WAY ANOVA

Source of Problem			Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)		1750.588	2	875.294	14.916	.001*
Linear Term		Unweighted	934.163	1	934.163	15.920	.001*
		Weighted	781.727	1	781.727	13.322	.001*
		Deviation	968.862	1	968.862	16.511	.001*
Within Groups			40078.584	683	58.680		

POST HOC LSD

(I) Dropout Classification	(J) Dropout Classification	Mean Difference (I-J)	Std. Error	Sig
Completer	Remainer	4.06	.751	.001*
	Dropout	3.35	841	.001*
Remainer	Completer	-4.06	.751	.001*
	Dropout	-.71	.692	.306
Dropout	Completer	-3.35	.841	.001*
	Remainer	.71	.692	.306

*Indicates the score is significant

First, for communication scores, the category remainers had a lower mean scores than did dropouts. This relationship, however, was not significant using LSD post hoc measures (χ^i-χ^j= -.71, $p > .10$). In attempting to discover why this outcome of low scores for remainers occurred, a Chi-square analysis was performed where communication scores were broken down into sample specific quartiles, (each category comprising roughly 25% of this sample) and compared to dropout classification. This analysis showed interesting results (see Table 11).

Table 11

Chi-square Analysis of Client Communication Scores Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	χ^2	Significance
COMMUNICATION SCORES						
Communication Scores 10-25	185	11.9%	56.2%	31.9%	28.510	$p < .001$*
Communication Scores 26-30	165	20.0%	53.9%	26.1%		
Communication Scores 31-35	164	21.3%	54.3%	24.4%		
Communication Scores 36-50	172	33.7%	39.0%	27.3%		

*Indicates the score is significant

The Chi-square analysis of communication scores and dropout classification was

significant (X^2=28.510, df=4, p < .001), and revealed some interesting trends. Specifically, there appeared two straight linear relationships were completers were more likely to have higher communication scores and remainers were most likely to have lower scores. More importantly, however, was the trend that Post hoc test revealed of completers having higher communication scores (see Table 8). Specifically, completers had communication scores that were significantly higher than remainers (χ^i-χ^j= -.71, p > .10) or dropouts (χ^i-χ^j= -.71, p > .10).

As for the second part of hypothesis 4.4 predicting that clients who dropped out of therapy would have lower satisfaction scores, this was also not supported (see Table 12). Specifically, dropouts had a higher mean score than did remainers and this relationship, however, was not significant using LSD post hoc measures (χ^i-χ^j= 1.04, p > .10).

Table 12

One-way ANOVA testing for Linear Relationship between Client Satisfaction Scores and Dropout Classification

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	34.10	29.35	30.39	30.67

ONE-WAY ANOVA

Source of Problem		Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)	2357.992	2	1178.996	22.005	.001*
Linear Term	Unweighted	1141.676	1	1141.676	21.309	.001*
	Weighted	942.398	1	942.398	17.589	.001*
	Deviation	1415.594	1	1415.594	26.421	.001*
Within Groups		36379.117	679	53.577		

POST HOC LSD

(I) Dropout Classification	(J) Dropout Classification	Mean Difference (I-J)	Std. Error	Sig
Completer	Remainer	4.75	719	.001*
	Dropout	3.71	.804	.001*
Remainer	Completer	-4.75	719	.001*
	Dropout	-1.04	.663	.119
Dropout	Completer	-3.71	.804	.001*
	Remainer	1.04	.663	.119

*Indicates the score is significant

Interestingly, the results of the comparison of satisfaction and dropout classification

resembled those of communication and dropout in almost every aspect. First, as just previously noted, dropouts had a higher mean score than did remainers. Next, completers had a significantly higher mean satisfaction score than did remainers (χ^i-χ^j= 4.75, p < .001) or dropouts (χ^i-χ^j= 3.71, p < .001). Last, these trends seem very strong and quite apparent (see Graphs 7 & 8 in appendix H).

Hypothesis 5

Hypothesis 5 which states that differences in therapist variables will be significantly related to different classifications of dropout, appeared to be partially supported (see Table 13) as sub-hypothesis 5:1 was significant (X^2=27.179, df=4, p < .001), while sub-hypothesis 5:2 was not significant (X^2=4.074, df=2, p > .10).

Table 13

Chi-square Analysis of Therapist Experience and Co-therapy Versus Single-therapist as Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	X^2	Significance
EXPERIENCE OF THERAPIST						
High = Over 1yr and 3 months	94	38.3%	42.6%	19.1%	27.179	p < .001*
Medium = 8 to 16 months	212	16.5%	46.2%	37.3%		
Low = 7 months or less	113	24.8%	55.8%	19.5%		
CO-THERAPY/SINGLE-THERAPIST						
Co-therapy	208	26.0%	50.0%	24.0%	4.074	p < .130
Single-therapist	211	21.3%	46.0%	32.7%		

*Indicates the score is significant

Important to note is that the analysis for hypothesis 5, including the sub-hypotheses, was done on a case level instead of on the outcomes of the individual client. Hence the sample size for hypothesis 5, is 419, where for all other hypotheses the sample size is dependant upon the number of clients, out of a possible 745, who completed the measure asking the appropriate question. Sub-hypothesis 5.1 which states that the higher the level of experience of the therapist, the lower the likelihood the client will dropout of therapy, was not supported. Graph 9 in appendix H shows a clear graph of these results

of therapist experience and classification of dropout. Specifically, medium level therapists had the highest rate of dropout at 37.3%, where high and low experienced therapists had rates of 19.1% and 19.5%, respectively. Furthermore the relationship between experience level and dropout classification was significant by Chi-square analysis. What emerged instead of the predicted trend for sub-hypothesis 5:1, was a clear curvilinear trend where high and low experience levels were associated with low rates of dropout, and medium experience level therapists had a high level of dropout. Also noteworthy is that this curvilinear trend continued across the different classifications of dropout with high and low experience therapists resembling each other in results, and medium experience level therapists being different in the percentage rates for the different classifications.

The reasoning for how levels of experience were determined should be noted for understanding the results of hypothesis 5:1. The experience of the therapist was divided into the three different classifications by year of education in their masters degree program. Students are typically admitted into the clinical portion of their experience in June near the end of their first year of courses. Those still in their first four semesters of college and first year of clinical experience were considered low experience therapists. Medium level therapists were in their third year of coursework and had generally received outside internship, while those in their third year and beyond were considered high experience level therapists.

Interestingly enough, while sub-hypothesis 5:2 stating that co-therapy teams would have lower dropout rates than single therapists was not significant (X^2=4.074, df=2, $p > .10$), results did seem to follow the predicted trend (see Table 13). Co-therapy

teams had lower rates of dropouts, and higher rates of completers and remainers than did single therapists. In general, co-therapy teams appear to be more effective than single therapists.

Hypothesis 6

As a whole, hypothesis 6 stating that therapy process variables will be related to the choice of classification of dropout was not well supported (see Table 14 & 15). Sub-hypothesis 6:1 was significant (X^2=10.377, df=2, p < .01), but sub-hypotheses 6:2 (X^2=3.108, df=2, p > .10) and 6:3 (F (1, 2)= 1.926, p > .10) were not significant.

Table 14

Chi-square Analysis of Client Other Therapy Experience Compared to Dropout Classification

Variable Studied	n	Completers %	Remainers%	Dropouts %	X^2	Significance
CLIENT PREVIOUS THERAPY EXPERIENCE						
Yes	328	19.5%	57.3%	23.2%	10.377	p < .01*
No	374	22.7%	45.5%	31.8%		
CLIENTS RECEIVING CONCURRENT THERAPY						
Yes	83	16.9%	61.4%	21.7%	3.108	p > .10
No	528	20.3%	51.1%	28.6%		

*Indicates the score is significant

The analysis of client previous therapy experience and concurrent therapy experience were coded as "yes" or "no" categorical responses Chi-square statistics were used to analyze as these variables.

Sub-hypothesis 6:1 which states that clients with previous experience will be less likely to dropout of therapy was supported by Chi-square analysis (X^2=10.377, df=2, p < .01). This relationship can clearly be seen on Graph 9 in appendix H. Additionally, experienced clients are more likely to remain in therapy than clients with no previous therapy experience. However, clients with no previous experience appear slightly more likely to complete therapy than clients with previous experience.

As for sub-hypotheses 6:2, the predicted trend that families and couples in which

one or more members are receiving concurrent services elsewhere would be more likely to dropout of therapy, was not significant (X^2=3.108, df=2, p > .10). In fact, there appears to be a trend in the opposite direction in that any therapy experience is associated with a lower likelihood of dropout, higher rates of remaining in therapy, and lower rates of completion of therapy by clients (see Table 14). Specifically those with concurrent therapy experience dropout at the rate of 21.7% where those without such experience dropout at the rate of 28.6%.

Sub-hypothesis 6:3 which states that clients with the greatest likelihood of dropping out of therapy, will report a greater the number of psychosocial stressors, was also not significant (F (1, 2)= 1.926, p >.10). As the number of psychosocial stressors was counted ranging from 0 to 9, the counted intervals are equal making the variable continuous. Consequently, a One-way ANOVA was used as the means of analysis.

Table 15

One-way ANOVA testing for Linear Relationship between Psychosocial Stressors Reported and Dropout Classification

DESCRIPTIVES

	Completer	Remainer	Dropout	Complete Sample
Means	2.22	2.54	2.39	2.43

ONE-WAY ANOVA

Source of Problem			Sum of Squares	df	Mean Square	F	Sig.
Between Groups	(Combined)		5.427	2	2.714	1.926	.148
Linear Term		Unweighted	.799	1	.799	.567	.452
		Weighted	1.684	1	1.684	1.195	.275
		Deviation	3.743	1	3.743	2.656	.104
Within Groups			388.96	276	1.409		

Further, as can be seen in Table 15, the predicted trend that the more psychosocial stressors reported, the greater the likelihood that the client will dropout of therapy also was not evident as remainers clearly had a higher mean number of reported psychosocial stressors than did completers.

Chapter 5

Discussion

This study covers only a few of the many factors that can affect how a client chooses to end therapy. The list of possible factors that could affect whether or not any given client drops out, remains in, or completes therapy, is very large. However, this study appears to have accomplished the purpose which was to identify some important variables assessable at initiation of therapy which will allow the clinician to efficiently assess which clients are more likely to dropout or continue in therapy.

Client Demographics

The first notable finding of this study was that alcohol use as the only client demographic that proved to be a significant predictor of client dropout status. This finding is not new as previous reviews of dropout have come to this same conclusion (Luborsky et al., 1971). Interestingly enough, however, is that even during the course of this study the author has heard therapists offer explanations upon loosing a client to dropout such as, "Oh, that's because he (the client) is young and young clients are always more likely to dropout of therapy" or "That's why he dropped out, because the client was low educational status." These statements are not statistically supported by previous and current research (Luborsky et al., 1971; Bischoff & Sprenkle, 1993). The problem may be that statements may not be wholly inaccurate, as there are slight trends in these areas. Even length of marriage, which was examined in this study followed the predicted trend that clients with longer marriages were less likely to dropout, however, such variables have failed to be reliably related to different dropout classifications at a level of significance.

What is a more interesting question to consider when discussing client demographics and their association with dropout classification, is the speculation that such trends may be influenced by therapist expectations or actions toward the client. For example, do lower socioeconomic status (SES) clients tend to dropout more for personal reasons? Or do they dropout because the therapist is less interested in such clients and makes less of an effort to keep them connected to therapy than the high SES clients who may have a higher fee? Would the therapist make extra efforts to persuade the low or high SES client to return to therapy? What if the high SES has good insurance and the low SES is on a sliding fee scale? Another example might be the question of does the therapist expect the older, more mature looking client to dropout of therapy, or the adolescent? Again, none of these variables as well as others such as race and education level have been reliably significant predictors of dropout. There are at least two possible suggestions that can be made when considering the issues of demographic variables, therapist biases, and dropout. First, a greater effort to educate the average clinician on which variables actually are *significant* predictors of dropout, and which are not, is needed. Second, therapists need to continually be aware that they do not let their biases affect their ability to give all clients quality treatment.

The one client demographic that has proven to be reliably associated with dropout, both in this study and in previous studies, is alcohol use (Friedman, Tomko, & Utada, 1991; Luborsky et al., 1971). An important question concerning this finding is whether those that have higher use of alcohol are just poor candidates for therapy, or whether dropout occurs due to the problem of alcohol is not being handled properly. Also, where alcohol use is clearly a problem, does alcohol need to be addressed first

before other treatment issues are considered? Do clients with high alcohol use need to be referred to specialists in this area? Or is it possible that the use of alcohol is associated with other more pertinent variables? These are questions that have been asked before (Bepko & Krestan, 1985), and seem to have proponents on both sides of the issue. The one matter that is clear, however, is that therapists need to be aware of alcohol use in their clients and have a reasonable plan for addressing this concern.

Presenting Problem

Having already touched on the idea that therapist biases about dropout could affect the treatment clients receive, there is some consternation on the part of the author in discussing the results of comparing classification of presenting problem and dropout classification. As the nature of hypothesis 2.1 was exploratory and descriptive rather than explanatory, the different presenting problems are simply ranked by rate of dropout, and the rankings are not statically compared with other rankings. The Chi-square statistic presented for hypothesis 2.1 are from each class of problem being compared individually to dropout classifications. Hence, the first recommendation would be to not use these rankings as reliable significant predictors of dropout. As seen in Table 2, the clients who marked as reasons for seeking therapy the four categories of sexual abuse, divorce adjustment, other problem, and physical abuse were most likely to dropout. Two of these categories include abuse, which may serve as an indicator that problems of abuse can be especially precarious to treat in therapy. Possibly, a referral to known experts who specialize in these areas would benefit both clinician and client. Another observation is that some of the problems that ranked high in dropout, such as sexual abuse, also ranked high in completion rates. Interestingly enough, in a study of sexual abuse groups and

outcome, Fisher, Winne, and Ley, (1993) found that those who had poorer outcomes in sexual abuse groups were more likely to have been beaten as children, to have been sexually abused only within their family and to be more actively enmeshed in the abuse cycle at the time of therapy. Conversely, they found that those completing therapy were more likely to have been multiply offended both by intrafamilial and extrafamilial perpetrators. Such findings may point to the idea that sexual abuse clients may have specific needs, which if understood may lead to higher rates of completion, but if not recognized may lead to higher dropout. At any rate, there are a number of different speculations that can be made from examination of the results of linking classification of a presenting problem to dropout. Further studies into these areas would be helpful in clarifying these questions.

In *Mind and Nature,* Gregory Bateson (1979) reports the story of the tick that climbs the tree and waits for the smell of sweat, at which point the tick drops on the unsuspecting prey. However, if after a certain time the tick does not smell sweat, the tick drops anyway, and finds another tree. This example brings out the idea that even when one realizes what he\she expected to happen did not, this is still valuable information. Hopefully this is what the reader will understand about the failure of hypotheses 2:2, and others, to be significantly supported. There appeared to be a slight trend where clients who have experienced their problem for a shorter length of time prior to beginning therapy are more likely to dropout, however, the relationship was not significant. Hence, clinicians might do well to concern themselves with other aspects of the presenting problem when considering dropout.

As mentioned earlier, there appears to be a curvilinear aspect to perceived problem severity and dropout. One possible explanation for this could be that such clients dropout because they either see the problem as so severe that they loose hope, or not severe enough to merit therapy. This curvilinear feature also appears in connection with dropout as compared to cohesion, communication, and GAF scores. The same possible explanation seems to fit all these findings in that those who are extremely high functioning may be more likely to dropout as they do not see the need for therapy and those who are extremely low functioning may dropout as they do loose hope that therapy can be effective. Also, there appeared to be straight linear relationships between client perceived problem severity and the categories of completion or remaining in therapy. Those who see their problem as generally more severe are more likely to remain in therapy and less likely to complete therapy, while those who see their problems as less severe are more likely to complete therapy, and less likely to remain in therapy. Although these relationships are linear, they also seem to fit explanation given for curvilinear dropout in that such client may either see the problem as so severe that they have little hope of completion, or not severe enough to merit continuing with therapy. Regardless of whether this explanation is accurate or not, when the therapist discovers that a client sees their problem as extremely serious, or not all serious, the therapist is would do well to discuss with the client why the client feels the way he\she does.

This concept that the amount of hope a client has can affect whether or not they dropout, also seemed evident in the comparison of client perception of likelihood of problem change and dropout classification. There was a clear relationship in that those who perceive their problem as less likely to change are more likely to dropout of therapy,

whereas those who perceive their problem as more likely to change are more likely to remain in therapy. What was more interesting, however, is that a certain percentage of those completed therapy were also in the category of those who marked their problem as not at all likely to change. A possible explanation for the finding could be that some clients may be coming to therapy only for enrichment may not feel they have a problem, and consequently, they see no change necessary in their problem. In fact, in reviewing the files of clients that marked extremely low likelihood of change and completed therapy, a large percentage were seeking only enrichment (specifically, 31.3% marked relationship enrichment, 43.8% marked marital enrichment, and 25.0% marked family enrichment). This subset of clients may represent those who do not feel they have problems, hence see no likelihood of change, yet complete therapy. Excluding this subset clients and reexamining the statistics of whether a client will either remain or dropout appears to produce the similar trends and fit the same possible explanations as the comparison of problem severity and dropout. First, clients who respond with "not at all likely to change" are more likely to dropout, possibly because they see their problem as so severe and unchangeable they loose hope. And second, clients who respond with "very likely to change" are more likely to remain in therapy, possibly because they have much more hope that their problems can be resolved.

Client System Type

The fact that hypothesis 3 which predicted that differences will occur in the rates of dropout classification for the different system types was barely supported (X^2=9.477, df=4, $p < .05$), seems to leave more questions than answers. Even more confusing is that in the category of dropout, individuals seemed just as likely to dropout as couples and

families. These results of this study seem to contradict the previous findings that rates of dropout for individuals was very low (Beckham, 1992; Richmond, 1992), whereas for families and couples the dropout rates seemed somewhat higher (Shapiro & Budman, 1973; Talmon, 1990; Boddington, 1995; Anderson, et al., 1985). A possible reasoning for this difference is that some of the previous studies used a different classification of dropout that was not dependant on number of sessions attended, only on whether the client ended therapy with concurrence of the therapist. Two trends, however, did seemed to have reasonable explanations. First, was in the category of completion, where individuals were most likely to complete, followed by couples, and last by families. This seemed reasonable in that the fewer members there are to a system, the less complex the system is and the more likely for all members of the system to agree that the goals of therapy have been met. Second, remainers were least likely to be individuals, and are more likely to be families and couples. This also seemed reasonable as in that more members of the system allow for therapy to continue even with the loss of any one member. Be that as it may, picture of whether dropout rates are different for the different client system types is still quite indeterminate. Further studies focused and designed toward answering this question could be helpful.

Level of Functioning and Relationship Factors

The strongest, and probably the most important, results of this study came in response to hypothesis 4 concerning the relationship between level of functioning of the client at intake and classification of dropout. In attempting to interpret the results of level of functioning and dropout, three salient trends emerged. First, the results followed the trend observed in earlier studies such as Hampson and Beavers (1996) where they found

"better functioning families fared better in therapy than did more dysfunctional families" (p. 358). This relationship was manifest in this study where clients that were higher functioning at intake, were the most likely to complete therapy in all categories of functioning studied (see Graphs 4,5,6, & 7 in appendix H). The second meaningful trend that seem to be apparent was that the more severe or chronic the problem is, the less likely the client is to dropout (Kazdin, Mazurick, & Bass, 1993; McAdoo & Roeske, 1973; Gaines & Stedman, 1981; Hoffman, 1985). As quoted earlier in the review of literature, Hoffman (1985), states that a person, "more impaired and uncomfortable...may be more likely to want treatment, to be encouraged to seek and stay with it..." (p.84). In the measures of functioning examined in this study, clients classified as remainers had lower mean scores of functioning than the other classifications of dropout (see Graphs 4,7, & 8).

The third and final trend has to do with client functioning and dropouts. The preliminary results of some of the one-way ANOVAs put dropouts as generally lower in functioning, almost as low as remainers. In fact, in post hoc measures of the means on scores of functioning of remainers and dropouts there was not a significant difference. The difference became apparent when the levels of functioning were categorized and compared to dropout classification using Chi-square analysis. What became evident was that dropouts were most likely to be the very high and low extremes, especially low, in functioning (see Table 11). Dropouts were least likely to be in the mid-range, however, these extremes usually cancelled each other out and resulting in a mean more near the midrange in one-way ANOVA analysis (see Graphs 4, 7, & 8).

The most direct measure of overall functioning of the client, at least by conception, used in this study was that of the GAF score of the client (American Psychiatric Association, 1994). The GAF is for, "reporting the clinician's judgment of the individual's overall level of functioning" (American Psychiatric Association, 1994, p. 30). The GAF scores provided a good representation of all the variables of functioning, both on the individual and relationship level, and were significant ($\underline{F}$ (1, 2)= 6.911, $p < .001$). The GAF score also followed the three basic trends just noted about the relationship between client functioning and dropout. What is especially important about this rating is that GAF score is a rating of the client, given by the *therapist*. All other measures of functioning were directly reported by the clients. Although direct reported measures of client functioning are needed and meaningful, the therapist judgements of functioning appeared quite representative of the clients in this study. Hence, a suggestion that follows is that the therapist may want to give serious consideration his\her own judgements of functioning when considering the dangers of dropout, especially when direct report measures are not available.

The results concerning dropout classification and number of health symptoms reported followed the predicted trend that more symptoms would be associated with higher rates of dropout. However, this was the only variable concerning functioning that failed to reach significance ($\underline{F}$ (1, 2)= .767, $p > .10$). One interesting note was that the mean number of symptoms reported (complete sample mean of 2.3) was much less than norms previously reported in clinical populations (McDaniel, Hepworth, Doherty, (1997). As this sample consisted of clients who were mostly residents of a rural community and college students, they may have different characteristics than other clinical populations.

This may have affected the results and skewed them so that significant differences were less likely to occur. However, rather than trying to offer different explanations for why this finding occurred, what seems to be important is that health symptoms were not significantly associated with dropout classification in this study.

Sub-hypothesis 4:3 followed the predicted direction that clients who were balanced on levels of cohesion and adaptability would be less likely to dropout. However, what also is important is that those who score in the extreme high range on cohesion and adaptability were more likely to complete therapy or dropout, while those who scored on the extreme low range on cohesion and adaptability were more likely to simply remain in therapy. Essentially the extreme ranges, especially high cohesion high adaptability, represent clients with unique opportunities. The therapist dealing with such clients might do well to take time to explore how these areas of functioning are affecting the clients' lives. Is the client is happy with their current level of cohesion and adaptability, or is this one of the areas in which the client is looking for change? Answers to these questions could provide some clear directions for therapy. In summary, adaptability and cohesion appear to be important predictors of dropout classification and extreme scores should be explored by the therapist.

Of the different measures of dropout classification, differences in levels of communication ($\underline{F}$ (1, 2)= 15.920, $p < .001$) and satisfaction ($\underline{F}$ (1, 2)= 22.005, $p < .001$) scores appeared to be among the most significant set of variables studied. In the same manner as adaptability and cohesion, clients who completed therapy were had a higher mean score on communication and satisfaction than clients who remained or dropped out. In fact, LSD post hoc measures found the communication and satisfaction scores of

clients who to completed therapy to be higher than scores of remainers and dropouts at the $p < .001$ level of significance (see Tables 10 & 12). Communication and satisfaction clearly followed the three trends of functioning outlined at the beginning of this section. Again on further analysis, there also appeared the slight curvilinear trend were very extreme high scores were likely to dropout (see Table 11). A possible reason could be that those who are extremely high functioning may dropout as they do not see the need for further therapy. Interestingly enough, Shapiro and Budman (1973) found in their follow-up questioning of dropouts that a certain portion of those who dropped out reported that they felt treatment was no longer necessary. This same sub-group was also likely to report satisfaction with treatment received. Such a finding may indicate that there is a sub-group of clients may need only one or two sessions, and this brief treatment may give them enough to handle problems on their own, regardless of whether the therapist concurs with their decision to end therapy. In summary, however, generally higher scores on communication and satisfaction are significant predictors of successful completion of therapy, but extremes on either end of communication or satisfaction are at risk for dropout. Therapists would be advised to explore with clients any noted extreme in these areas.

Therapist Factors

There were a few hypotheses that had surprising results, and hypothesis 5:1 was one of them. As noted in the results section, the predicted trend that higher therapist experience would be associated with lower rates of dropout did not appear to be wholly supported (see Table 6, Graph 7). What emerged instead was a very clear curvilinear trend where high and low experience levels were associated with low rates of dropout,

and medium experience level therapists had higher levels of dropout.

When attempting to interpret these findings, the context in which the study took place is very important. The data was collected in a training facility for a masters degree program in marriage and family therapy. The low experience therapists were in their first year of clinical experience and second year of coursework and had relatively few cases to work with. The medium experience level therapists generally had more cases, were in their third year of coursework, had received outside internship placement, and were under increased pressure to work on their theses. With these being the conditions, low level experience therapists may had greater time to devote to each case, more opportunity to receive specific supervision or feedback about each case, and more importance placed on each case. In addition, low level experience therapists may have been more cautious about attempting more powerful and risky interventions, as opposed to simply listening, than medium experience level therapists. Considering this context, attempting to generalize beyond setting of this study could lead to erroneous conclusions. However, the results do bring up the question of whether there is a similar trend in the career of most therapists. Do therapists hit a comfortable level of experience where they do not devote as much time and effort to their work, hence they have poorer outcomes than beginners, till their experience reaches a high level? Or is the beginning of their career more closely supervised and there is a drop in effectiveness when supervision ends. A study devoted to exploring these issues would be both interesting and meaningful.

One finding that was not surprising was that high experience level therapists did have the highest rate of completers and the lowest rate of dropout. There seems to be a clear relationship between high levels of experience and positive outcomes in therapy,

even if the "high" level of experience is only three or more years of clinical practice. This finding brings into question the idea of cost effectiveness. If high experience therapists are able to help more clients achieve completion of therapy and avoid dropout, would paying higher experienced therapists a higher salary be not only justified, but also cost effective? While there is probably not enough evidence in this study to answer this question, there does appear to be sufficient grounds for raising the question again.

On the topic of cost effectiveness, co-therapy teams also had lower rates of dropout, and higher rates of completion and continuation than did single therapists. In fact, co-therapy teams were more effective than single therapists on all levels (see Table 13). However, the difficulty with asserting that co-therapy teams are better, is that these findings failed to reach significance using Chi-square statistics (X^2=4.074, df=2, $p > .10$). So, in summary, while co-therapy teams appear somewhat more effective, this trend is not strong enough to reach significance, and hence, not powerful enough to make any solid conclusions.

Therapy Process Variables

The last set of findings in this study are those that deal with therapy process variables. Two of these variables concern therapy experience of the client, other than the therapy currently received at the clinic being studied. Interestingly enough, results showed that any therapy experience of the client increases the likelihood that the client will not dropout of therapy. Clients with prior therapy experience were more likely to remain in therapy and less likely to dropout, than clients with no previous experience. The same effect holds true for clients receiving concurrent therapy, although the relationship failed to show significance (X^2=3.108, df=2, $p > .10$). This latter finding

concerning concurrent therapy and dropout was contrary to previous findings by Russell, Lang, and Brett (1987). They found that when one or more members of a family/couple are receiving individual therapy services elsewhere, they are more likely to dropout of couple/family therapy. There appears to no solid explanation for why the difference in findings occurred other than possibly, therapists in this study may have worked to ensure a coordination of services so that there was less disturbance in delivery of treatment. Whatever the reason, however, this study did not replicate the findings of Russell, Lang, and Brett (1987).

Implications

In their analysis of patient attrition in medical, psychiatric, and drug treatments, Baekeland and Lundwall (1975) asked the questions, "Who is the dropout? In other words, is there such a thing as a typical dropout or are there rather a number of different *kinds* of dropouts?" (p. 739). At the end of this study the answers to both of these questions seems to be "yes." First, in a way, there is a "typical dropout," in that there are certain clearly identifiable characteristics of the dropout. The typical dropout is more likely to present problems of abuse for treatment, perceive the problem as not at all likely to change, see the problem as not at all serious, be low functioning on GAF scores, be low on communication and satisfaction scores, extreme on cohesion and adaptability scores, and not have had previous therapy experience. In that we can identify these attributes about dropouts, we can say, "Yes, there is a typical dropout." What also can be said is that, "yes, there are factors that contribute to dropout that are worth knowing, and practical applications that may reduce dropout."

However, there was no factor that predicts dropout with 100% accuracy, and

research on dropout has sometimes failed to be replicated. Further, there have even appeared to be trends of extreme sub-groups within some larger groups that run contrary to the different main sets of findings. Last, there are really so many different factors that could possibly contribute to dropout, that discovering and considering them all would not only be impossible, but impractical. So in the sense that we consider these issues, we must also say "yes" to the question of is there a number of different kinds of dropouts. The implication that comes from a positive answer to this question, is that the therapist should be cautious about immediately acting on his\her knowledge of dropout just because a client fits the criteria. Even with a correct assessment of the factors of dropout, the therapist may create a self-fulfilling prophecy were the therapist recognizes a client as likely to dropout and does not invest much energy, or take the regular measures to keep the client in therapy, so the client drops out. What's worse is this effect of self-fulfilling prophecy may already be happening with unreliable information about age, education level, and certain presenting problems. How much more likely is this to happen with accurate information? To not give equal services to a client based on personal assumptions, even if based on accurate information, is discrimination. So again, the caution is to remember that while we can predict certain trends with large numbers there is no way to truly tell how any one client will behave.

Baekeland and Lundwall (1975) follow their first set of questions with another, probably more important, question. They ask, "What can be done about dropping out..." (p. 739)? The review of literature and discussion sections already have provided some answers to this question, however, there are still a few suggestions that can be given in answer to this question. First, the therapist should make the effort to educate him\herself

on what factors accurately predict dropout. This will allow him\her to base his\her actions on knowledge and rather than hearsay. Second, once the therapist knows the indicators of dropout, take time to explore any red flags that indicate a high likelihood of dropout. Again, every individual client is different, and the red flag of high likelihood of dropout, may or may not indicate a problem depending upon the client's perceptions and other mediating factors.

Results of this study also show there some specific things that can be done to counter the effects of client dropout. First, the therapist should seek to identify the amount of alcohol use of the client and make addressing concerns about alcohol a priority. Also, if alcohol use is a serious concern, the therapist would do well to consider referring the client to a specialist in this area or to a detoxification unit before proceeding with therapy. Second, the therapist should seek to be aware of clients who present problems for therapy that may require special concerns and specific needs such as sexual abuse or divorce adjustment. Such clients appear to represent unique opportunities and challenges when considering the areas of dropout and completion in therapy. Third, take time to explore the client's perceptions about the severity of their problems and the likelihood that the problems can be changed. Those who see their problems as not at all likely to change, and/or not all serious or extremely serious, are at risk for dropout.

The fourth suggestion is that the therapist needs to consider the functioning of the client. A finding of this study that has been repeatedly noted in literature on dropout is that clients that are *extremely* low functioning at initiation of therapy, tend to dropout of therapy more frequently and generally have poorer outcomes in therapy (Hampson & Beavers, 1996; Luborsky et al., 1971; Anderson et al., 1985). The therapist needs to be

aware of extreme low functioning clients and would do well to put an emphasis on quick symptom relief. Also, in considering client functioning, the therapist needs to especially consider relationship functioning, as relationship cohesion, adaptability, communication, and satisfaction were the strongest predictors of dropout classification. However, when considering client functioning, the therapist should also to be aware that extremely high functioning clients are also at risk for dropout. This area of functioning actually provides a general representation of the majority of findings of this study on dropout, in that clients who are extreme is some dimension, are usually the ones who are at greater risk for dropout. Therapists would do well to be aware of such clients and help them examine their perceptions of areas that are extreme. Is the client concerned about his\her functioning in these extreme areas? Does the client hope for change or relief in these extreme areas, or does he\she prefer his\her current level or style of functioning. By examining such perceptions, the therapist may discover issues of concern before the client drops out of treatment.

Fifth, in training situations, the supervisors may do well to examine how they train and interact with therapists of different experience levels. Are they insuring that trainees are gaining adequate support throughout their program? Are the trainees that have internship placements receiving the extra support at their internship, or in their collegiate program, that they need to be successful at their work? The reasons for the finding that medium experience level therapists had a higher incidence of dropout are not clear. What is important, however, is that therapist training programs may want to examine their plans for addressing the needs of the different experience level therapists.

Sixth, take time to examine the client's previous and/or concurrent experiences

with therapy. What did the client like about other therapy experiences? What did the client find helpful about other therapy experiences? These questions can provide for the therapist answers of how to best help the client. Also, what did the client not like about other therapy experiences? Has the client dropped out of therapy before? If so, why? Answers to these questions can help the therapist to not repeat such problems. If the client is in concurrent therapy, what specific problems is he\she seeking help for that requires concurrent therapy. Also, how are the services you are offering different from the concurrent therapy the client is receiving? These are just a few suggestions of questions that can be used to explore other therapy experience, and are not meant to be the right or only way to explore this topic. However, regardless of the therapist's personal preferences on how to explore the client's other therapy experiences, time spent in this activity can provide worthwhile results.

Last, as mentioned earlier, each client has individual needs which will be specific to him\her. Being flexible in treatment and being able to offer a variety of treatment options can open the door to more clients having favorable outcomes in therapy. Also, taking time as a therapist to briefly explain or give an overview to clients of what the therapist feels are the goals, scope, roles, possible results, and/or duration of treatment could be helpful. This may allow the both the client and therapist to decide if they are a working match, and gracefully provide a referral if they feel that working together will not lead to the desired outcome.

In summary, there are important indicators of whether a client will dropout, remain or complete therapy. Taking the time to educate oneself about these factors and

the possible suggestions for working with at risk clients can provide beneficial results for both therapist and client.

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APPENDIX A

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?

Center for Family Services, 103 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058.

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 #_____

Center for Family Services, 103 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058.

APPENDIX B

Background Form

FOR OFFICE USE ONLY

ID #_____

FAMILY MEMBER_____

TODAY'S DATE_____

Center for Family Services
104 Human Environmental Sciences West
Stillwater, Oklahoma 74078
(405) 744-5058

BACKGROUND FORM

(This information will remain part of your confidential file and will be available to CFS staff for research purposes)

NAME_____BIRTHDATE_____

ADDRESS_____ETHNICITY_____

HOME TELEPHONE_____WORK TELEPHONE_____

SOCIAL SECURITY NUMBER_____RELIGION_____

HIGHEST LEVEL OF EDUCATION COMPLETED_____PRIMARY OCCUPATION_____

NUMBER OF YEARS MARRIED_____EVER MARRIED BEFORE?_____

ARE YOU A MILITARY VETERAN? YES NO YEARS OF SERVICE _____TO_____

FOR IMMEDIATE FAMILY MEMBERS (SPOUSE, CHILDREN, AND STEP-CHILDREN) PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP, AND CURRENT RESIDENCE.

NAME	GENDER	AGE	RELATIONSHIP	RESIDENCE
SELF				

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	RESIDENCE	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 OF 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 FEARFULNESS
___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 SYMPTOMS 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
___RELATIONSHIP ENRICHMENT
___MARITAL ENRICHMENT
___FAMILY ENRICHMENT
___MARITAL CONFLICT
___FAMILY CONFLICT
___SEXUAL PROBLEMS
___PHYSICAL ABUSE
___SEXUAL ABUSE
___DIVORCE ADJUSTMENT
___ADJUSTMENT TO LOSS
___SINGLE PARENTING
___PARENTING-TWO PARENT FAMILY
___STEP-PARENTING
___CHILD BEHAVIOR PROBLEMS
___ADOLESCENT BEHAVIOR PROBLEM
___ALCOHOL ABUSE-CHILD/ADOLESCENT
___DRUG ABUSE-CHILD/ADOLESCENT
___ALCOHOL ABUSE-ADULT
___DRUG ABUSE-ADULT
___FAMILY STRESS
___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 C

Couples Communication, Satisfaction, Adaptability and Cohesion Form

FOR OFFICE USE ONLY
ID # _____
FAMILY MEMBER _____

Center for Family Services
103 Human Environmental Sciences West
Stillwater, Oklahoma 74078
(405) 744-5058

Using the following scale please answer the questions below.

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

COUPLE COMMUNICATION

_____ 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 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 am afraid he/she will get angry.

_____ 10. My partner is always a good listener.

COUPLE SATISFACTION

_____ 1. I am not pleased with the personality characteristics and personal habits of my partner.

_____ 2. I am very happy with how we handle role responsibilities in our marriage.

_____ 3. I am not happy about our communication and feel my partner does not understand me.

_____ 4. I am very happy about how we make decisions and resolve conflicts.

_____ 5. I am unhappy about our financial position and the way we make financial decisions.

_____ 6. I am very happy with how we manage our leisure activities and the time we spend together.

_____ 7. I am very pleased about how we express affection and relate sexually.

_____ 8. I am not satisfied with the way we each handle our responsibilities as parents.

_____ 9. I am dissatisfied about our relationship with my parents, in-laws and/or friends.

_____ 10. I feel very good about how we each practice our religious beliefs and values.

FOR OFFICE USE ONLY
ID # _____
FAMILY MEMBER _____

Center for Family Services
103 Human Environmental Sciences West
Stillwater, Oklahoma 74078
(405) 744-5058

COUPLE RELATIONSHIP

Please indicate how you <u>typically operate as a couple:</u>

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

_____ 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 other than to people outside our family.
_____ 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.

APPENDIX D

Family Communication, Satisfaction, Adaptability and Cohesion Form

FOR OFFICE USE ONLY
ID #_____
FAMILY MEMBER_____
DATE TAKEN_____

Center for Family Services
103 Human Environmental Sciences West
Stillwater, OK 74078
(405)744-5058

Using the following scale please answer the questions below.

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

FAMILY COMMUNICATION

How well do your family members communicate with each other?

_____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.

FAMILY SATISFACTION

How satisfied are you with:

_____1. The degree of closeness between members of your family?
_____2. Your family's ability to cope with stress?
_____3. Your family's ability to be flexible?
_____4. Your family's ability to share positive experience?
_____5. The amount of arguing that occurs between family members?
_____6. Your family's ability to resolve conflicts?
_____7. The amount of time you spend together as a family?
_____8. The way problems are discussed?
_____9. The fairness of the criticism in your family?
____10. Your family's concern for each other?

FOR OFFICE USE ONLY
ID # _____
FAMILY MEMBER _____

Center for Family Services
103 Human Environmental Sciences West
Stillwater, Oklahoma 74078
(405) 744-5058

DATE_____

FAMILY RELATIONSHIP

Please indicate how you <u>typically operate as a family:</u>

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

____ 1. Family member 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 together as a family.

____ 16. We shift household responsibilities from person to person.

____ 17. Family members consult other 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.

APPENDIX E

Diagnosis and Treatment Plan

Case # _____

DIAGNOSIS AND TREATMENT PLAN

Date of First Session _____ **Diagnosis for Session** _____

Family's Definition of the Problem:

Diagnosis: _____ **Family Member Diagnosed:** _____

Axis I: Clinical Disorders or Other Conditions That May Be a Focus of Clinical Attention

___ ___ ___ . ___ ___

___ ___ ___ . ___ ___

Axis II: Personality Disorders or Mental Retardation

___ ___ ___ . ___ ___

Axis III: General Medical Conditions

___ ___ ___ . ___ ___

Axis IV: Psychosocial and Environmental Problems (check applicable and specify)

☐ Problems with primary support group: _____

☐ Problems related to the social environment: _____

☐ Educational problems: _____

☐ Occupational problems: _____

☐ Economic problems: _____

☐ Housing problems: _____

☐ Problems with access to health care services: _____

☐ Problems related to interaction with the legal system/crime: _____

☐ Other psychosocial and environmental problems: _____

Axis V: Global Assessment of Functioning **GAF =** ___ ___ ___

Proposed Treatment:

_____
Therapist

_____ _____ _____
Therapist Supervisor Date

Center for Family Services, 103 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058.

APPENDIX F

Termination Report Form

FAMILY ID# _____

CENTER FOR FAMILY SERVICES

103 Human Environmental Sciences West
Stillwater, Oklahoma, 74078
(405) 744-5058

TERMINATION REPORT

Date of Intake:_____ Date of First Session:_____

Date of Last Session:_____

Number of Sessions:_____ Official Termination Date:_____

Therapist(s) :_____

_____

Type(s) of Therapy and Number of Sessions:

____ Individual Therapy

____ Couple Therapy

____ Family Therapy

____ Group Therapy

Reasons for Termination:

____ Completion of Therapy

____ Client Request

____ No Shows/Cancellations (Letter sent by therapist)

____ Other, Please explain

Were the clients referred to another agency/professional?

____ Yes. Where? _____

_____ No

_____
Therapist

_____ _____ _____
Therapist Supervisor Date

Give a brief description of the presenting problem at the beginning of therapy and a description of the problem upon closure of therapy on the back of the report.

APPENDIX G

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.

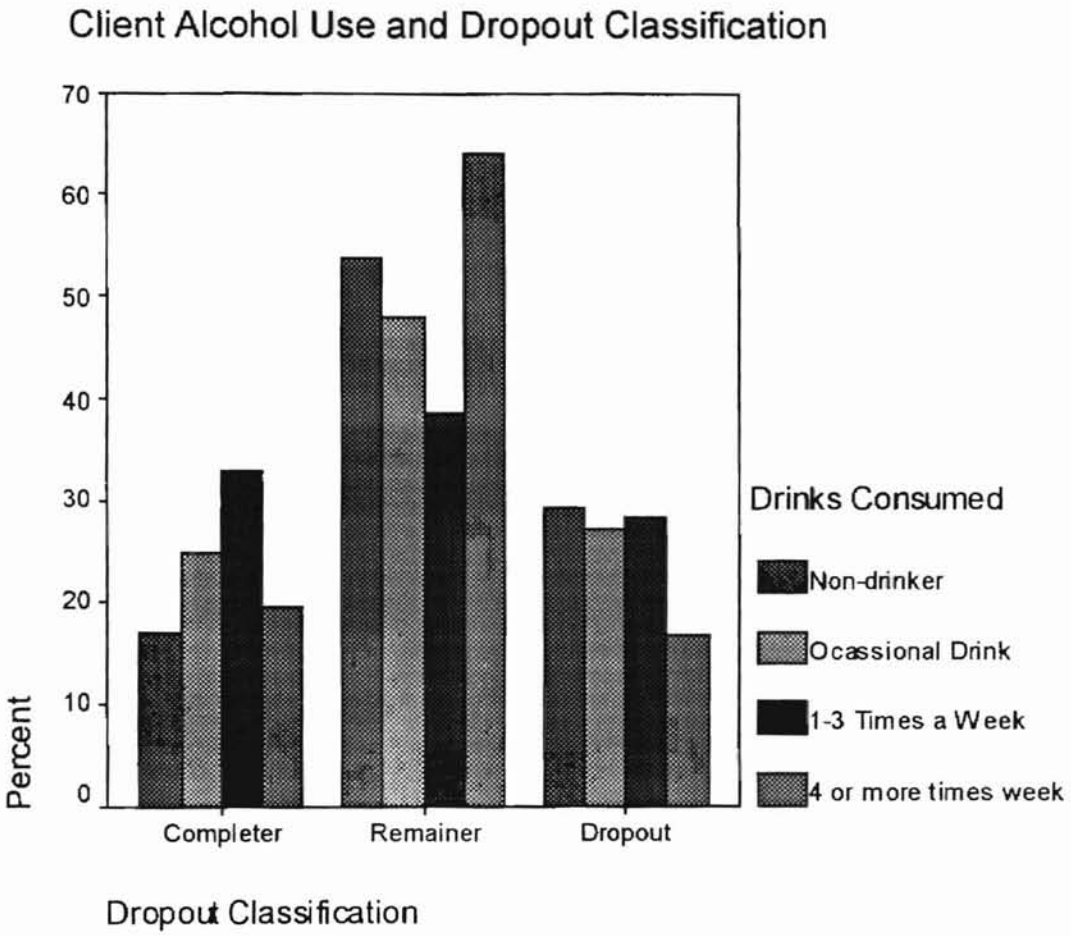
My (our) rights and responsibilities as client(s) of the Center for Family Services and the procedures and treatment modalities used have been explained to me (us) and I (we) understand and agree to them.

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

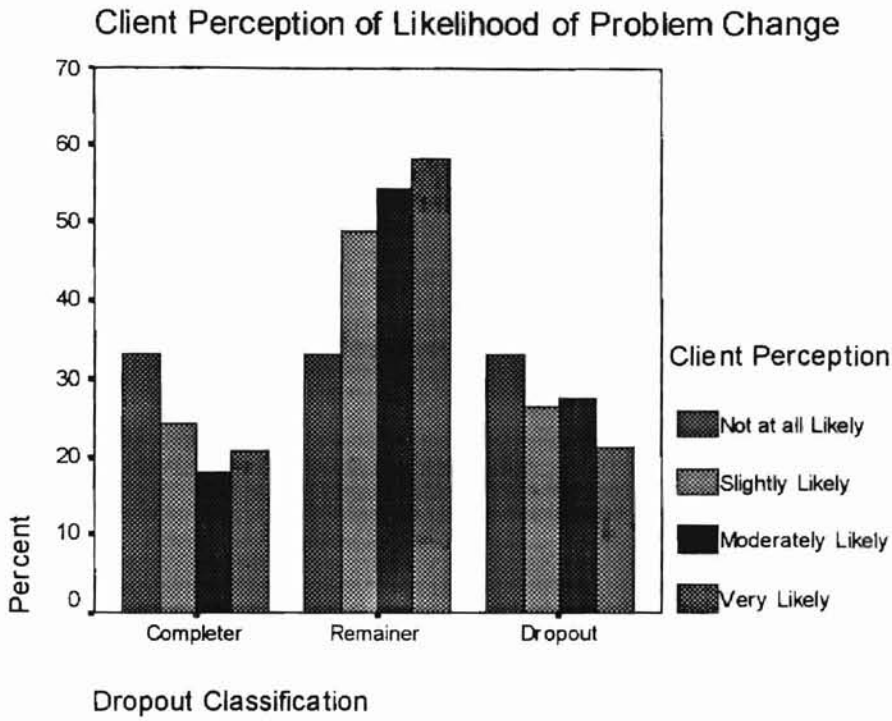
APPENDIX H

Statistical Graphs

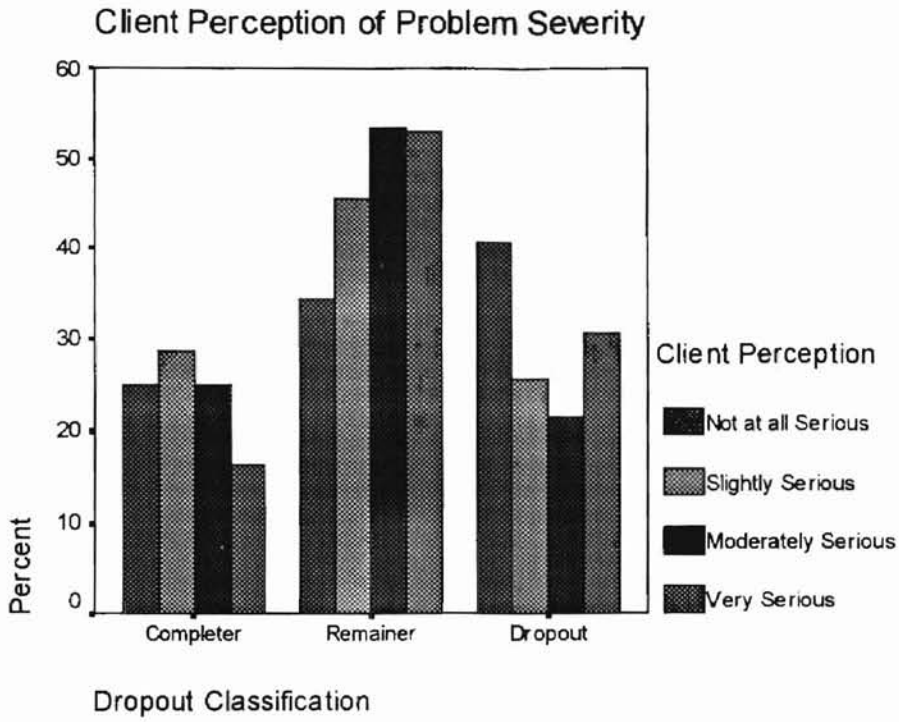
Graph 1


Client Alcohol Use and Dropout Classification
70
60
50
40
30
20
10
0
Percent
Completer
Remainer
Dropout
Dropout Classification
Drinks Consumed
Non-drinker
Ocassional Drink
1-3 Times a Week
4 or more times week

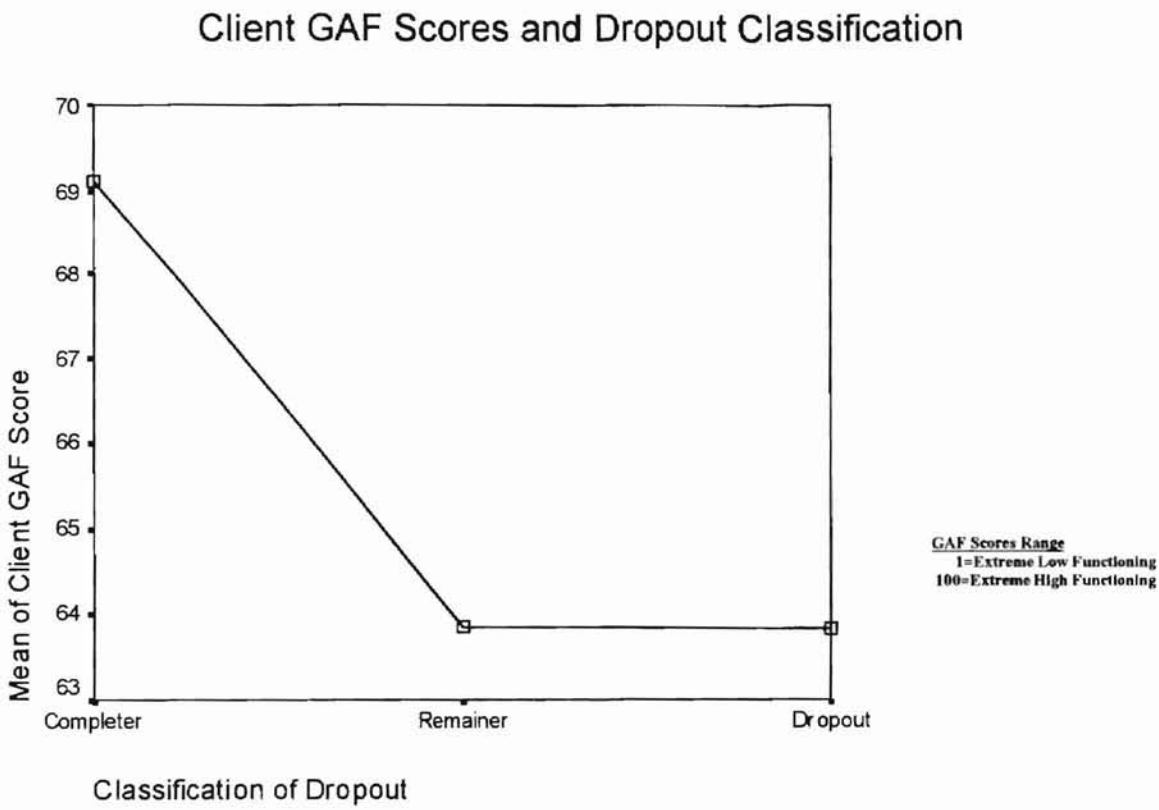
Graph 2


Client Perception of Likelihood of Problem Change
70
60
50
40
30
20
10
0
Percent
Completer
Remainer
Dropout
Dropout Classification
Client Perception
Not at all Likely
Slightly Likely
Moderately Likely
Very Likely

Graph 3

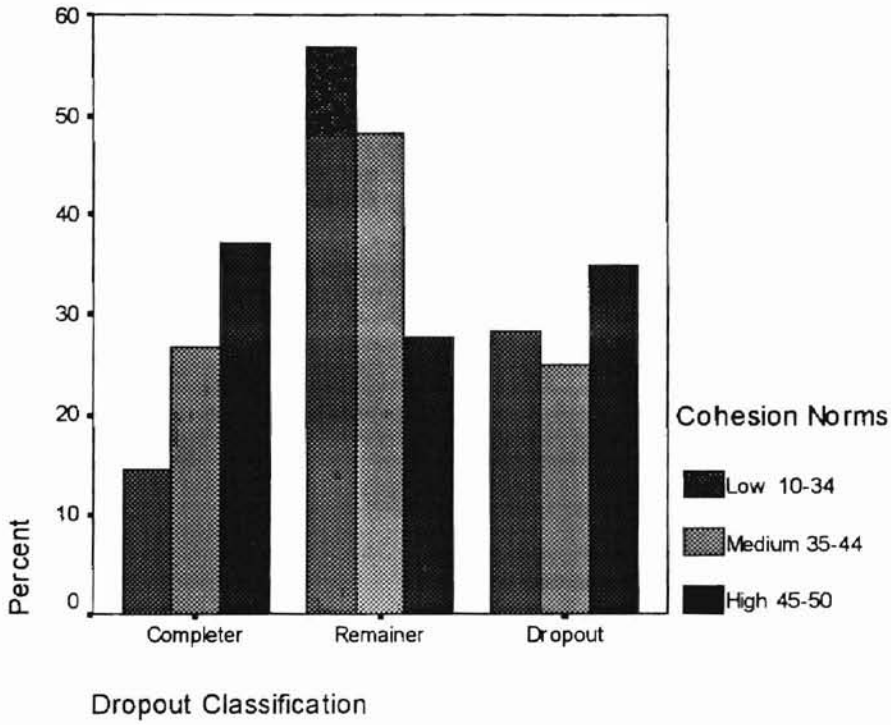

Client Perception of Problem Severity
60
50
40
30
20
10
0
Percent
Completer
Remainer
Dropout
Dropout Classification
Client Perception
Not at all Serious
Slightly Serious
Moderately Serious
Very Serious

Graph 4

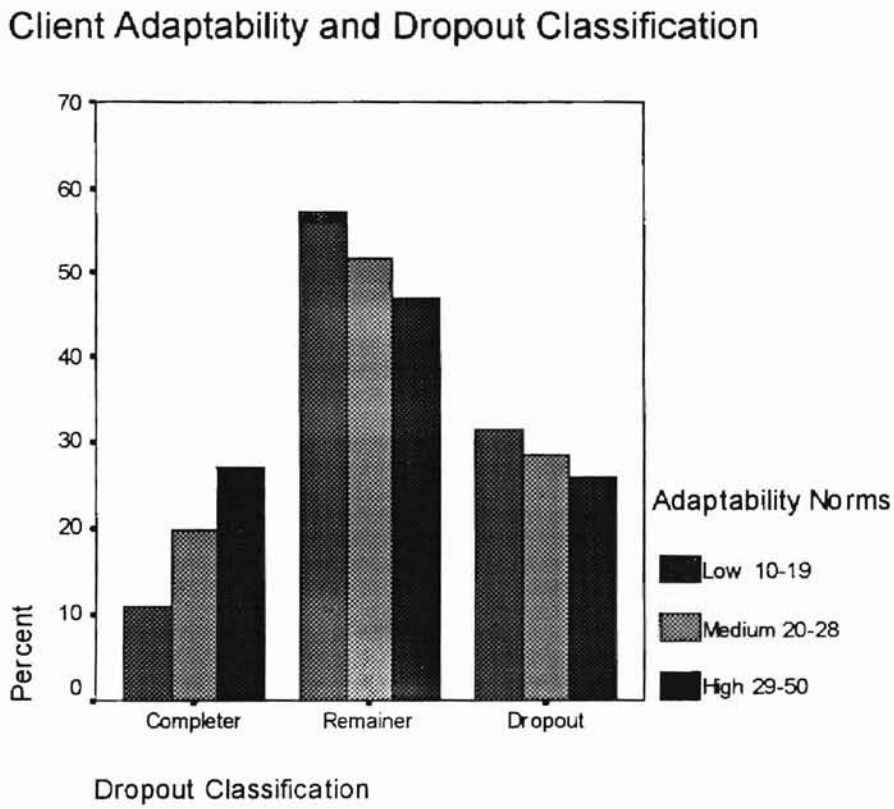

Client GAF Scores and Dropout Classification
70
69
68
67
66
65
64
63
Mean of Client GAF Score
Completer
Remainer
Dropout
Classification of Dropout
GAF Scores Range
1=Extreme Low Functioning
100=Extreme High Functioning

Graph 5

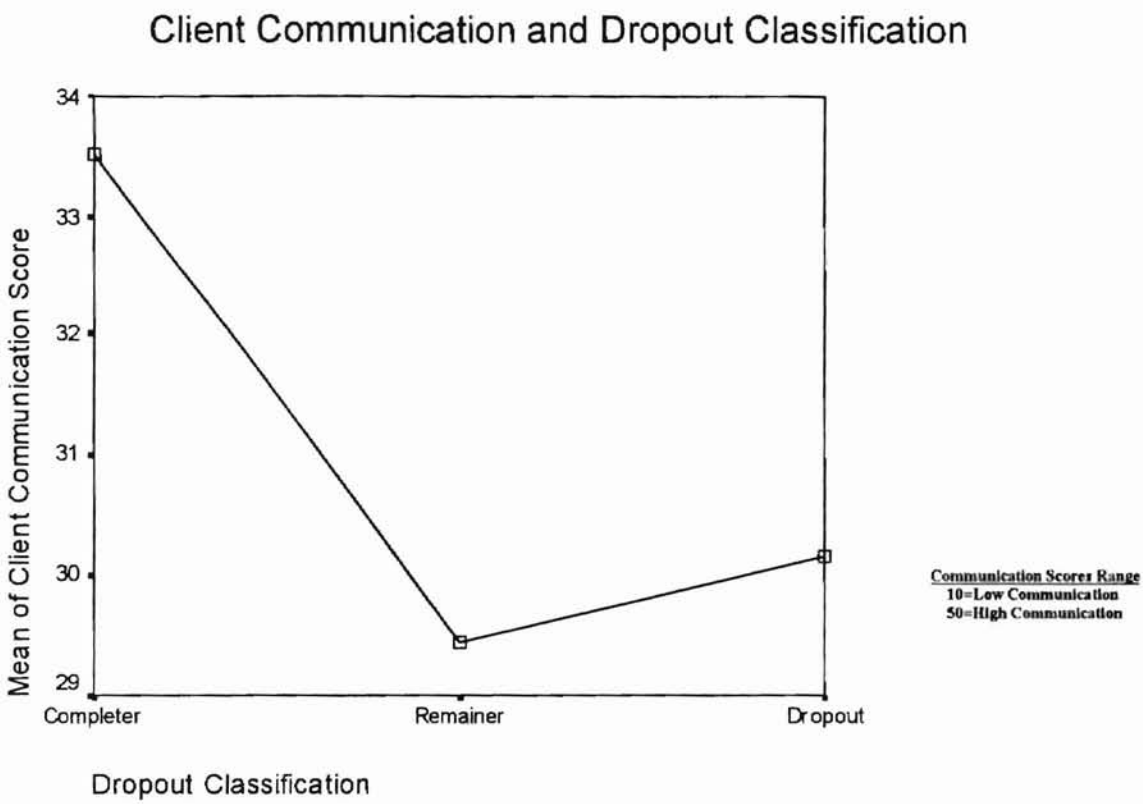
Client Cohesion and Dropout Classification



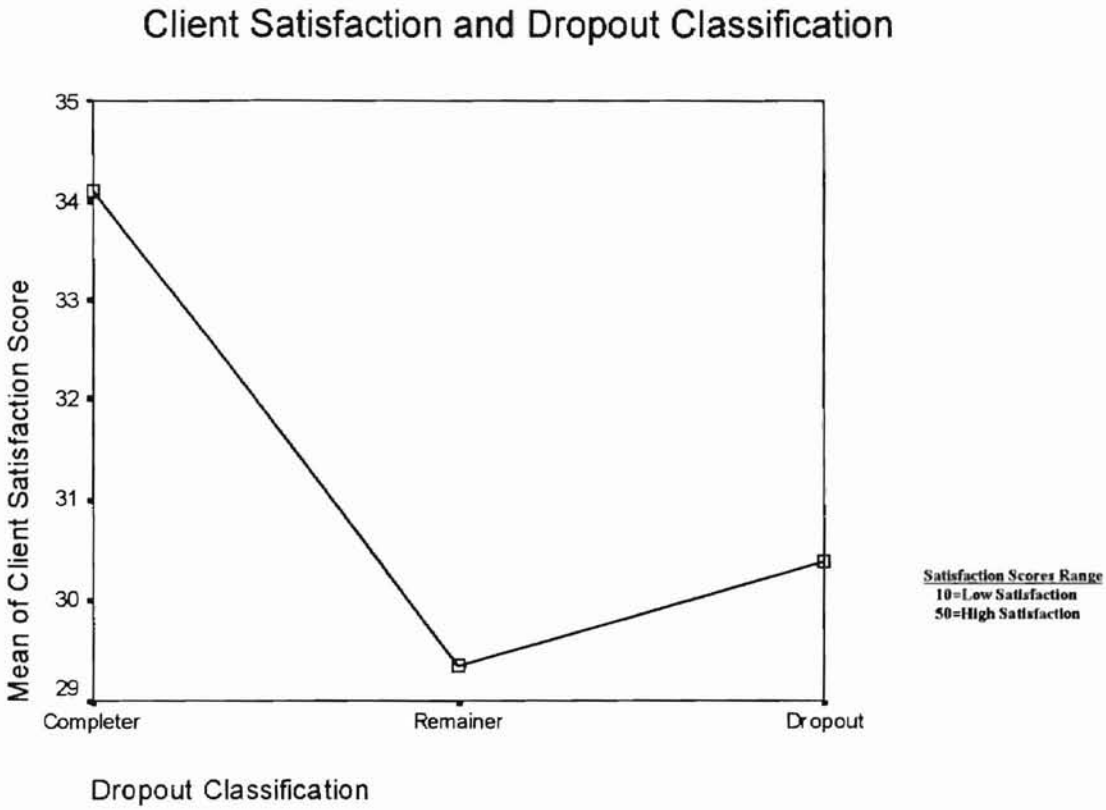
Graph 6


Client Adaptability and Dropout Classification
70
60
50
40
30
20
10
0
Percent
Completer
Remainer
Dropout
Dropout Classification
Adaptability Norms
Low 10-19
Medium 20-28
High 29-50

Graph 7

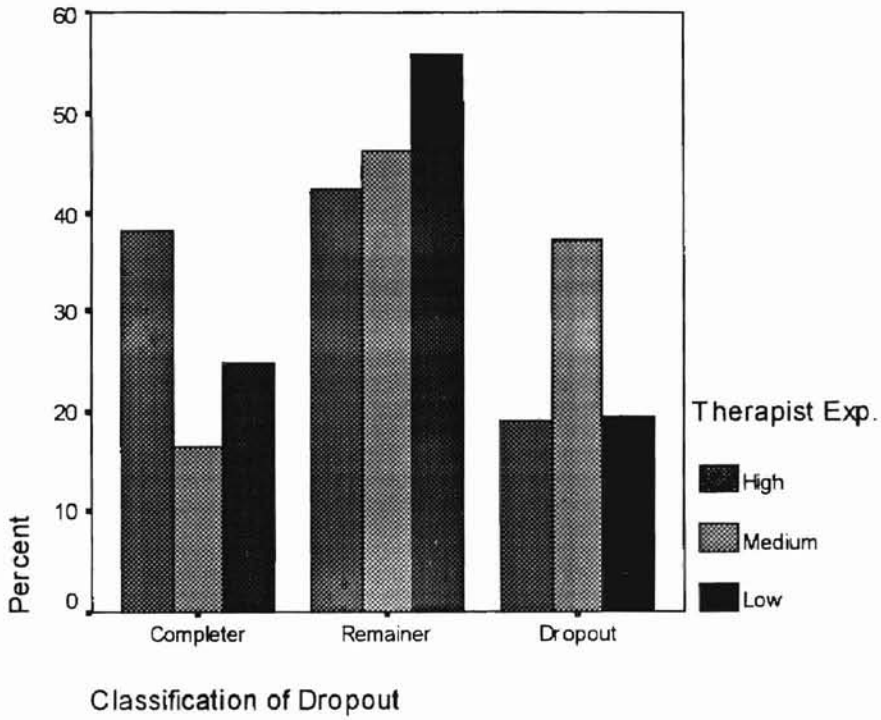

Client Communication and Dropout Classification
Mean of Client Communication Score
34
33
32
31
30
29
Completer
Remainer
Dropout
Dropout Classification
Communication Scores Range
10=Low Communication
50=High Communication

Graph 8


Client Satisfaction and Dropout Classification
Mean of Client Satisfaction Score
35
34
33
32
31
30
29
Completer
Remainer
Dropout
Dropout Classification
Satisfaction Scores Range
10=Low Satisfaction
50=High Satisfaction

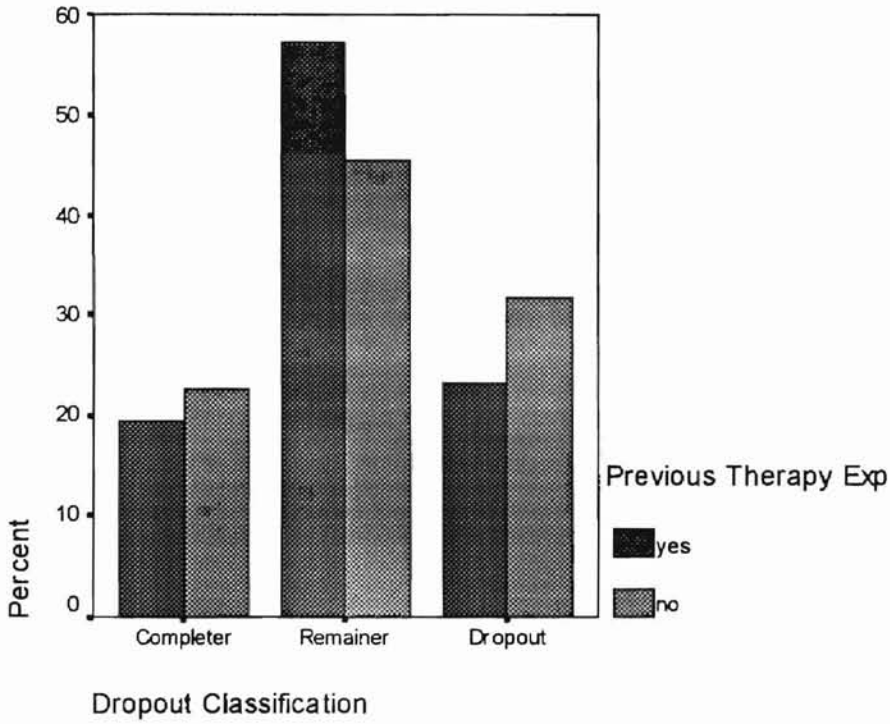
Graph 9

Therapist Experience and Dropout Classification



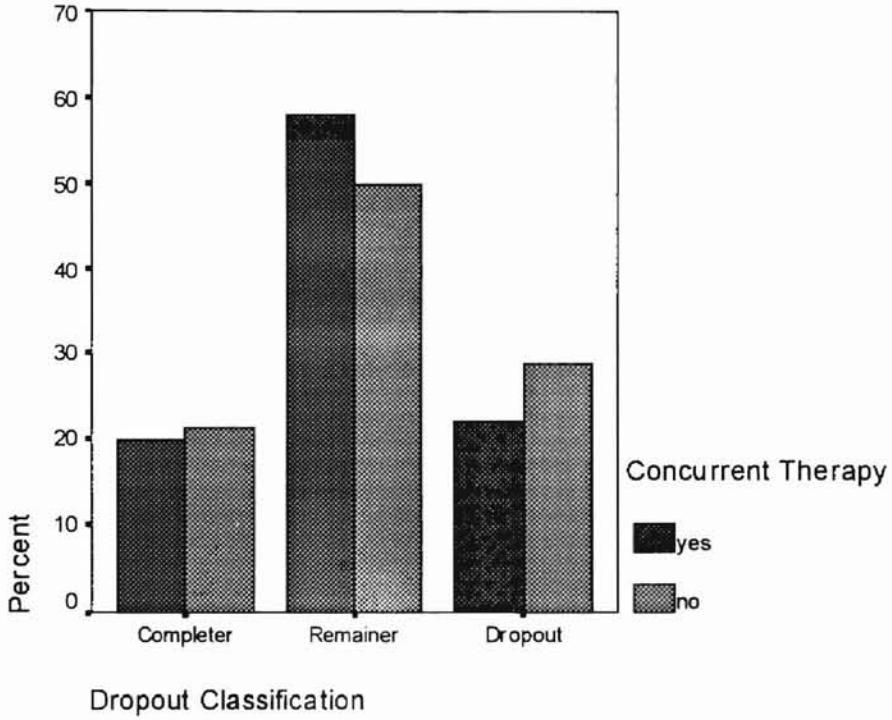
Graph 10

Client Previous Therapy Experience and Dropout Classification



Graph 11

Client Concurrent Therapy Experience and Dropout Classification



APPENDIX I

Institutional Review Board Consent

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

09-17-98 **IRB #: HE-99-013**

Proposal Title: VARIABLES ASSESSABLE AT INITIATION OF THERAPY WHICH CONTRIBUTE TO CLIENT DROPOUT

Principal Investigator(s): Charles Hendrix, Jim Grigg

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

Signature: Carol Ellis Date: October 2, 1998

Director of University Research Compliance
cc: Jim Grigg

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

Jim Grigg

Candidate for the degree of

Master of Science

Thesis: VARIABLES ASSESSABLE AT INITIATION OF THERAPY WHICH CONTRIBUTE TO CLIENT DROPOUT

Major Field: Family Relations and Child Development
Specialization: Marriage and Family Therapy.

Biographical:

Born in Westminister California, on December 8, 1968. Husband of Shelise Grigg, father of Robert and Jessica Grigg.

Education:

Graduated from Kuna High School, Kuna, Idaho in May of 1987; received a Bachelors of Science Degree in Psychology from Brigham Young University, Provo, Utah in December 1995. Completed requirements for the Masters of Science Degree in Family Relations and Child Development, from Oklahoma State University, Stillwater, Oklahoma, in December 1998.

Experience:

Marriage and Family Intern from May 1998 to December 1998 at Family and Children Services in Tulsa, Oklahoma. Graduate Research Assistant from August 1996 to December 1998 for the Center for Family Services, Oklahoma State University, Stillwater, Oklahoma. Teacher of Church Education from August 1995 to June 1996 for the LDS Seminaries, Spanish Fork High School, Spanish Fork, Utah. Research Assistant from August 1994 to June of 1995 for the Department of Clinical Psychology, Brigham Young University, Provo, Utah. Defense Acquisition Radar Operator from July 1987 to July 1990 for the United States Army.

Professional Affiliations:

American Association For Marriage and Family Therapy (1997-1998)
Oklahoma Association for Marriage and Family Therapy (1997-1998)
Oklahoma Counsel on Family Relations (1998)