VARIABLES RELATED TO DURATION OF OUTPATIENT TREATMENT IN A COMMUNITY MENTAL HEALTH CENTER

by

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Abstract

The prediction of duration of outpatient treatment in a community mental health center was investigated by correlating number of treatment sessions with 22 defined variables. Fifty-one subjects were selected from a total of 228 clients contacting the Blue Ridge Mental Health Center during the month of April, 1973. Charts for all subjects were examined and information on the defined variables recorded. A Step-Wise Multiple Regression computer program was used to analyze the 18 scaled variables, while the four nominal variables were subjected to Chi Square Analysis.

The average number of treatment sessions was 3.41. Only negligible to moderate relationships between the dependent and independent variables were obtained. In the multiple regression analysis four variables (medication, patient responsiveness, condition at termination and participation by others) were related to duration in therapy, combining to form a multiple R of 0.621 ($p < .01$). Patient responsiveness and participation by others were the only scaled variables demonstrating any predictive utility.

The results of the Chi Square Anlaysis were not significant using the defined categories. A comparison of more general categories, i.e., physician and other institutional referrals, clinic

not notified and all other dispositions produced significant results ($p < .05$). Clients referred by physicians remain in treatment longer and clients not notifying the clinic regarding withdrawal from service are more likely to do so after only one or two visits.

The question of validity and reliability of the results was addressed along with general methodological problems. Finally, the use of medication, interagency referral policies and participation of significant others in the treatment were described as areas for future research.

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Introduction

The prediction of continuation in outpatient therapy is of major concern in the mental health clinic setting. Increasing case-load demands on therapists' time along with limited office facilities and clerical personnel make requisite the wise allocation of time and personnel. Recent research (Kline and King, 1973; McNair, Lorr and Callahan, 1963; Whitely and Blaine, 1967) has focused on variables associated with length of client contact at outpatient clinics. Generally, the rationale for producing such data is to make treatment available to those most likely to remain for more than only a few visits. The underlying assumption is that a certain (unspecified) amount of contact with a therapist is necessary in order for progress to be made (Garfield, 1971).

The mental health literature has stressed several major areas of concern related to continuation in treatment. These deal with the identification of variables related to : (1) duration of treatment (number of treatment sessions) eventually terminated by the clinic or therapist-client agreement, and (2) treatment attrition (client initiated withdrawal from treatment prior to successful remediation of the problem presented). Most research (Garfield and Affleck, 1959; Garfield and Kurz, 1952; Kurland, 1956;

Rosenthal and Frank, 1958) has concentrated on variables associated with client initiated termination (attrition or dropout studies), but information on the prediction of both cases is essential for the competent administration of therapists' time.

The issues of attrition from treatment and duration of treatment are closely related but the research designs in each type of study are constructed to answer different questions. The treatment attrition studies usually focus on who drops out of therapy without consultation with the therapist. The duration literature asks who stays in therapy for how long. The issues are frequently considered in the same studies by comparing those who drop out of treatment with those who remain.

In the attrition or "dropout" literature, withdrawal from treatment is usually a sudden, unilateral decision by the patient, made without consultation with the therapist (Jackson, 1968). A number of patients seem to "disappear"; they do not return even when there is some reason to believe that treatment may prove beneficial. Since treatment termination is abrupt and often occurs after only a few visits, information is minimal, making it difficult to hypothesize reasons for premature termination.

Most attrition studies define two distinct groups of terminators and remainers. This distinction is based on the number of treatment sessions attended. For example, terminators may leave treatment after 10 sessions or less, while remainers continue for 20 sessions or more. It is assumed that the two groups are comprised of distinguishable populations. These

groups are compared and contrasted on a number of variables in order to determine what attributes are characteristic of each. The variables are primarily descriptive, rather than predictive in nature. It should be pointed out that studies employ different criteria for defining terminators and remainers; and this is a source of difficulty in comparing the findings (Garfield, 1971).

The literature focusing on remainers in therapy (duration studies) examines variables selected from psychological tests, motivation, verbal ability, ability to introspect and attitudes toward psychotherapy (Whitely and Blaine, 1967; McNair, Lorr and Callahan, 1963). Generally, the psychological test variables have been most frequently utilized to predict duration in therapy. In this manner researchers have attempted to predict duration of stay on the basis of scores on various tests, scales or interviews. Such data combined with descriptive information could prove valuable in a clinic setting. Clinicians with some expectation of duration in treatment could economize on time, allocating it to potential remainers.

A variety of methods (Borghi, 1968) have been employed in mental health centers and outpatient clinics in an effort to isolate variables related to duration in treatment. Jackson (1968) has described four basic research strategies for investigating this issue. The first method makes use of factual, objectively-verifiable information. External criterion measures, such as demographic data, provide an example of this type of factual information which may be gathered on clients entering treatment. Since

the validity of these data is easily determined, the design does not face the methodological problems of non-objective data. The data are purely descriptive of who enters therapy and who stays for a certain length of time.

A second research approach uses descriptive "psychological" variables rather than demographic data. Patient motivation and expectations of therapy are examples of psychological variables. In this strategy diagnostic data may be collected for each patient before and after therapy, and then compared. Pre- and post-therapy measures may be compared within and between groups in order to differentiate dropouts from a comparable remainer population.

A third research strategy utilizes an observer of the therapy process. This observer is a third party whose task is to describe or rate the therapy process itself. For example, therapist traits such as positive empathy may be rated and correlated with length of stay or outcome.

A fourth approach relies on subject or therapist retrospective ratings of the therapy interaction. For example, the subject or therapist may be asked to rate the "quality of the relationship". Ratings are then correlated with the number of treatment sessions.

Obviously there are many biasing factors and methodological problems inherent in each of the four research designs. These include the fact that the client and therapist are involved in therapy and hardly "objective" in rating the therapy interaction. There are methodological problems in the reporting instruments used and inherent difficulties in using retrospective ratings and observations.

Even though there are problems in these research methods, there utilization can provide useful data in the present setting.

The Blue Ridge Mental Health Center is not unlike other facilities faced with the challenge of providing therapy to those most likely to profit from it. Clinicians frequently invest a great deal of time and effort into planning treatment, only to have the client fail to return for a scheduled appointment. This is not only frustrating but a waste of professional manpower. The isolation of variables associated with duration in outpatient therapy could prove beneficial in this setting.

The focus of this study is to uncover both objective and subjective information associated with duration of stay in treatment. The first and fourth research strategies described by Jackson, i.e., those utilizing demographic variables and therapist ratings, are employed in determining what variables are important in the prediction of duration in treatment for clients of the Blue Ridge Mental Health Center.

Review of Related Literature

Three major literature reviews (Brandt, 1965; Garfield, 1971; and Jackson, 1968) have summarized the findings regarding continuation in psychotherapy. In general the research reviewed focuses on the psychotherapy process and treatment attrition rather than duration in therapy. Those studies that focus specifically on attrition and duration will be described later in this review.

In his review of 25 adult outpatient studies, Brandt raised several issues and criticized the research for a number of flaws, including inadequate descriptions of the clinic settings from which the research samples were drawn. It was suggested that in order to draw any conclusions from the literature, the type of therapy typically provided should be specified, (long or short term, client centered, analytic, behavorial, etc.) along with the usual frequency of sessions and treatment fees. The criteria used to define dropouts and remainers has varied and must be clearly defined. It must be reported whether the sample was restricted to those patients who terminated within a certain number of sessions, or included any dropout, regardless of duration in treatment. The literature frequently describes nonhomogenous samples of dropouts

in which therapist initiated termination is included in the dropout sample. Thus the definition of dropout varies from study to study.

Brandt noted that a lack of congruence existed between the definition of both independent and dependent variables and concluded that the studies could be compared only to a limited degree.

Five summary statements derive from the Brandt review. First, attempts at diagnostic categorization of therapy dropouts and remainers have usually failed to differentiate the two groups. The studies agree that personality characteristics do differentiate dropouts from remainers, but these characteristics vary from one study to another. Second, descriptive data such as sex, age, and marital status have generally failed to discriminate reliably between the two groups. Third, no consistent relationship was found between duration and reported incidence of previous therapy in the studies that reported this variable. Fourth, a relationship between clinic intake procedure and dropouts was noted. A longer intake procedure resulted in higher dropout rates and patients tended not to distinguish between the intake interview and therapy itself. Finally, when the complex categories of "pre-therapy dropout" or "refuser," "therapy dropout," "pseudorejector" and "remainer" were considered, no clear cut conclusions could be drawn as to who the premature terminators were or even whether they represented a distinct group. Investigators in this area must be extremely rigorous in defining their samples and cautious in generalizing from their findings.

Jackson (1968) in an unpublished master's thesis provided the most comprehensive review of the literature to date. Investigations were placed into four groups by methodological strategy employed (summarized in the introduction of this paper), even though many studies utilized elements from more than one strategy. She included both critical and integrative comments throughout her review and provided a number of summary statements following the categories of studies. First, dropout rates vary from one setting to another and also according to the criteria used for defining the dropout. Dropout rates are modified somewhat when "pseudorejectors" (those leaving therapy but returning later) are identified. Second, one therapy experience tends to lead to another, even among short-stay groups. The duration of later contacts is positively related to length of original stay among dropouts and previous therapy experience. Dropouts who later enter treatment remain longer than first timers. Third, the relationship between duration of therapy and rated improvement is generally positive. Fourth, both education and occupation are positively related to duration, although this finding is not consistent from one study to another. Social class is related to duration of stay in therapy. Fifth, there is speculation regarding the possibility that a "medical" rather than "psychiatric" (conceptually more sophisticated) approach toward therapy may be more effective in terms of reducing dropout rates in lower class patients. Sixth, the discrimination of terminators and remainers in therapy through the use of psychological assessment procedures, particularly Rorschach investigations, has been generally

unsuccessful. Seventh, attempts to distinguish terminators and remainers using standard psychiatric categories, i.e., psychotic, neurotic, personality disorder, have failed. Eighth, terminators and remainers can be discriminated on the basis of personality attributes. Remainers are described as more anxious, self critical, open, psychologically sophisticated, introspective and persevering. Terminators are delineated as defensive and rigid. The findings on "motivation for treatment" are inconsistent. Ninth, marked interest on the part of the therapist is associated with longer stay. Finally, therapist-patient expectancies are consistently related to improvement, and usually to duration as well.

Jackson concludes that the studies have contributed specifically to our terminology in this area, rather striking statistics on therapy attrition rates, a generally positive relationship between duration and improvement, some fairly consistent socio-economic relationships, and a few interesting tentative findings about characteristics of therapists who retain patients in treatment.

In a third major review, Garfield (1971) cites representative findings on the nature of the problem and categorizes the research findings into three broad groups, relating duration to: (1) social class and actuarial variables, (2) psychological test data, and (3) other variables. He also offers suggestions on ways of reducing dropout rates and provides summary and integrative statements.

In the studies reviewed by Garfield, most clinic clients leave therapy after only a few visits. In nearly all of the

clinics, this was seen to be a problem and not the result of therapist-client planned termination. In most cases, the patient simply failed to return for a scheduled appointment. Garfield noted the following general findings, citing references for each. First, middle class patients remain in therapy longer than lower class patients. Second, educational level, while not always related to length of stay, is found to have a significant relationship in most studies. Third, age does not appear to be an important variable, at least as far as continuation in psychotherapy is concerned. Fourth, psychiatric diagnosis as a means of classification appears to bear no relationship to continuation in outpatient psychotherapy. Fifth, the literature relating psychological tests and duration of therapy has provided few clear answers and conflicting or unreplicated findings. Sixth, mutuality of client-therapist expectations relative to duration in therapy is one hypothesis that has some empirical support. Finally, there is a positive correlation between I.Q. and duration in therapy. It is noted that I.Q. also correlates highly with social class.

Garfield criticizes the literature on a number of points, some mentioned earlier in the review of the study by Brandt (1965). He notes that psychotherapy is not a uniform process and that many studies do not specify the type of approach used. He also cites different samples of subjects, varying criteria, different statistical analyses and approaches to the data, different uses of the same test and variations in therapists and the therapeutic setting as sources of error.

Garfield and Jackson have noted that a number of studies have made use of the Rorschach Test as a predictor of length of stay in psychotherapy (Affleck and Mednick, 1959; Auld and Eron, 1953; Gibby, Stotsky, Hiler, Miller, 1954; Rogers, Krause, Hammond, 1951; Whitely and Blaine, 1967). These studies provide few clear answers and many unreplicated findings. Generally it may be concluded that psychological attributes as measured by the Rorschach are not clearly related in any systematic fashion to duration of stay in psychotherapy.

The reviews cited here note relationships between a number of variables and duration in therapy. These variables include social class, personality attributes, clinic intake procedures, rated improvement, therapists' reported interest in the client, educational level and I.Q. No clear relationships are noted between duration and standard diagnostic categories, descriptive data (age, sex, marital status, etc.), psychological test data and previous therapy experiences. Variables related to duration which may prove fruitful for future research include therapist-client expectations and therapist level of experience.

Studies Focusing on Attrition from Treatment

In a 1973 study, Kline and King compared 321 patients who withdrew from treatment without clinic consent with 607 clients having favorable discharge dispositions. Number of treatment sessions was not the criterion used to define dropouts and remainers but rather disposition at termination. The treatment dropouts differed significantly from the comparison group on 39 demographic,

mental status and social history variables. Dropouts were characterized as more impaired psychologically, more angry and with a greater tendency to act out. Dropouts were also younger and less likely to need custodial care. The authors considered that dropping out of treatment was probably influenced by a large number of interacting factors including the patient's background, family constellation, personality and current symptomatology. They suggested that efforts be made to engage and provide effective therapeutic service for these individuals.

Rosenthal and Frank (1958) obtained concurrent data over a three year period on 3,413 patients which generated the following findings. Most of the dropouts occurred during the first five hours of treatment and only one out of every six patients treated remained for 20 interviews or longer. Length of stay was positively related to class (lower class patients were more likely to refuse treatment), race (blacks tended to discontinue), and referral source (referrals from psychiatrists were associated with longer duration). More dropouts than remainers were noted as "unimproved" and age was not significantly related to stay.

Kogan (1957) emphasized the importance of the initial casework interview and concluded that clients who abruptly terminated were less likely to see their problems emerging during the first interview. This finding underscores the need for rapid problem identification and suggests that patients seeing a possible source of their problem may return for follow-up treatment more often.

Freedman, et. al. (1958) divided 54 ambulatory, outpatient schizophrenics into two groups - those who voluntarily dropped out of treatment after eight sessions or less (N=25) and those who remained for nine sessions or more (N=29). The first clinic contact was the source of information in an attempt to differentiate the groups along two parameters - the patient's personality characteristics and the doctor-patient relationship at the first contact. They concluded that: (1) Dropout patients were rated as slightly higher on adaptive responses (personality characteristics) than were active patients; (2) the differentiation between patients along personality dimension is of greater use in explaining continuation, rather than dropping out; (3) patients denying mental illness and encountering a "warm" relationship tended to drop out, whereas the reverse was true for those patients encountering a "warm" relationship and accepting their mental illness; and (4) in order to avoid dropouts, the patient-doctor perception of treatment must be similar in terms of the type of relationship developed.

Patient Reports on Reasons for Leaving Psychotherapy

A number of studies have relied on subject reports of reasons for terminating treatment. This research contains numerous methodological problems (some mentioned in the introduction of this paper), including inherent difficulties in relying on "consumer reports" when there may be a large investment (in terms of money, time and psychological energy) in the treatment procedure. However, the conditions of the laboratory are not easily transferred to the

clinic, and even though there are problems in clinical research, the need for "natural setting" studies is recognized. Some of the following provide examples of research of this nature.

Garfield (1963) in an attempt to discover patient reasons for terminating therapy examined 11 terminators who had dropped out of therapy prior to the seventh interview and 12 patients who had remained for seven or more interviews. Of the terminator group, six gave external difficulties as reasons for termination, e.g., no transportation, no babysitter, inability to get away from work, etc.; three felt therapy was not helping and/or they did not like the therapist; and two said they had improved. In general, the terminators gave external causes or lack of satisfaction with therapy as reasons for leaving treatment. In the remainer group, eventual termination occurred for a number of reasons. Two members of this group were still in therapy at the time of the study; three said it was the therapist's decision to terminate; two questioned the initial need for therapy or felt they could handle the matter themselves; two could give no reason; one moved; one stated he had no time; and in one case a change of therapists was anticipated. Only one in this group gave an external reason of the type given by the majority of terminators. Interestingly, both groups were getting along quite well, with the reports of the terminators more favorable in this regard than the remainers! We might speculate that better screening procedures could have reduced the size of the terminator group appreciably.

Maudgie (1967) examined 15 cases of premature termination of psychotherapy and suggested four main reasons for this. These include poor motivation, an inability to accept the psychological basis of the complaint, lack of faith in psychotherapy, and other strong resistances.

A study conducted by Gebbie (1968) used follow-up telephone calls in order to explore reasons why seven "consultees" seen by the author (in a clinic using "crisis intervention" as a mode of treatment) dropped out of therapy. She defined four categories of dropouts including patients frustrated at the therapist's inability to identify a precipitating crisis (behavioral event), patients with financial problems, patients deciding to seek help elsewhere, and clients reaching stability during the course of intervention. Several suggestions aimed at reducing premature termination were made. First, proper referral of patients is a necessity. Second, active involvement of the patient in the treatment plan is needed. Finally, use of telephone contacts to do termination and preventive work for persons who have missed appointments could prove helpful.

Jackson (1968) in an unpublished master's thesis reported data on 31 subjects at an outpatient clinic. She defined two groups - remainers with 20 or more therapy sessions and terminators with 10 or fewer sessions and collected descriptive information and patient reports regarding therapy. She reported several interesting findings. First, the groups differed in reports of subjective distress prior to treatment, change as a result of treatment and satisfaction with therapy (remainers recording higher scores on

each measure of these variables). Second, dropouts were less willing to endorse favorable attitudes toward therapists. Finally, therapists of dropouts had poorer ratings from professional raters.

Studies Focusing on Duration in Treatment

Frank, Gliedman, Imber, Nash and Stone (1957) with a sample of 91 outpatients found that stay in therapy was related to higher educational, occupational and social class levels and to previous therapy. Also remainers were described as having fluctuating illnesses with manifest anxiety, a readiness to communicate distress, influenceability and perseverance. Diagnosis and length of stay were not significantly related. The relationship to previous therapy conflicts with the conclusion drawn by Brandt in his review of the literature.

Bailey, Warshaw and Eichler (1959) found a highly significant relationship between length of stay and improvement for those patients in psychotherapy (N=211). A positive relationship was also found with education and previous experience in therapy. No significant findings were noted for occupation, religion and diagnosis.

Robertson (1965) in comparing first time patients (N=95) with another group of 49 patients previously participating in therapy found that those who had previously begun and discontinued treatment persisted longer in subsequent therapy than did first timers.

A 1962 study conducted by Cole, Branch and Allison focused on socioeconomic data from 322 applicants for treatment at an outpatient clinic. They found social class a significant variable

while age and sex were not related to stay. Using the Hollingshead and Redlich scale, it was found that interviews prior to termination dropped as class levels dropped. It was noted that fewer class V patients (the lowest class represented) were offered therapy and the upper class patients tended to be treated by more experienced therapists.

Winder and Hersko (1955) analyzed the records of a sample of 100 V. A. clinic outpatients on variables of social class, length of stay in therapy and psychotherapeutic approach. They found that the "middle class" patients (50% of the sample was designated "lower class") remained in therapy longer, and more of these received "analytically-oriented" therapy than their lower-class counterparts.

Blenker in 1954 conducted a study which resembles the research reported here in that information from patient charts was collected and used retrospectively to form hypotheses regarding duration in treatment. She rated interview transcripts of 338 treatment cases who had attended at least one interview; and reported four factors as important in discriminating the one interview clients from those who returned for additional sessions. The returners (attending more than one session): (1) saw their problems as psychological or interpersonal, (2) responded positively to the therapists' suggestions for solutions to their problems, (3) conceived of the workers' role as one of "counseling" rather than rendering "concrete services" at the beginning of therapy, and (4) came to accept the workers as counselors by the end of the initial interview.

An interesting study by Conrad (1954) secured check list ratings of the "mental health" from therapists of 100 patients prior to treatment. Paradoxically, the patients who received the most favorable ratings also remained in therapy the longest.

A study undertaken by Rubenstein and Lorr in 1956 with V. A. outpatients defined two samples for comparison: (1) 60 remainers (six months or more in treatment) and (2) 60 terminators (less than five interviews). The remainers were judged sicker, more self-dissatisfied, more intelligent, less impulsive and less rigid than the terminators who in turn were judged more defensive and rigid. The authors also noted that the remainers were better educated than the terminators.

Hiler (1958) was concerned with the relationship of the Wechsler-Bellvue I.Q. to continuation in outpatient psychotherapy. The remainers in this study (participation in 20 or more sessions) secured a mean I.Q. of 112, while the terminators (five or fewer sessions) had an average of 102. While a number of studies have related education to duration, this was the only study reviewed utilizing I.Q. as an independent variable.

A study of 353 clinic patients by Katz and Solomon in 1958 discovered that those patients who had remained in treatment for more than five interviews were more aware of the psychological nature of their problems and could communicate in those terms.

McNair, Lorr and Callahan (1960) studied a sample of 106 terminators and 170 remainers with a cutoff point of 16 sessions. Remainers were characterized as more anxious, self-critical, motivated

and better educated. They were also noted to have better vocabularies and to be less antisocial. The researchers concluded that terminators and remainers represent two distinct populations. Other therapist related findings include: (1) those therapists who were markedly interested in their patient's problems kept more in treatment; and (2) the therapist's sex, profession and personal therapy were not related to duration.

Therapist-Client Expectations

Garfield's review of the literature concludes that the area of therapist-client expectations regarding therapy may provide clues to the reasons for premature treatment termination. Several studies are cited here.

In 1957 Gliedman, et. al. divided a sample of 91 outpatients into remainer and non-remainer groups with a cutoff point of four sessions. It was found that patients' initial incentives for treatment were not related to their actual continuation. Initial expressed motives were termed either good (congruent with the therapists) or poor (non-congruent). Neither category was related to actual length of stay, rated improvement upon termination, nor to the patient's social class level. Gliedman concluded that therapists should encourage their "non-congruent" patients to remain in therapy even though they may appear to be unsuitable.

Apfelbaum (1958) with a sample of 100 patients isolated three dimensions of therapist role expectations which patients may bring to treatment. Patients who expect nurturance anticipate a

protective, giving therapist; "model" expectors foresee a listening, non-judging therapist; while "critic expectations" involve an analytical and critical role of the therapist. Of the original sample, 34% dropped out of therapy. The author reported fewer "model" expectations among the group of dropouts and also noted lengthy duration of therapy by nurturance expectors.

In his 1962 publication, Therapist - Patient Expectations in Psychotherapy (an excellent review of the literature), Goldstein concluded that the relatedness of duration and patient prognostic expectancies is equivocal at best. He suggested that both therapist and combined therapist and patient prognostic expectancy do covary in a significant and positive manner with the length of treatment. He cited a number of individual studies which suggest the following hypothesis: (1) if remaining in treatment has a favorable effect on the equilibrium of a patient's present pattern of living, he is likely to remain in treatment and vice versa; (2) mutuality of expectations between the therapist and client is a significant variable for continuation in psychotherapy; and (3) expectations of duration affect outcome of treatment.

Frank (1959) summarized this line of investigation with the following statement, "These studies all suggest that speed of improvement may often be largely determined by the patient's expectations, as conveyed to him by the therapist, as to duration of treatment, and that a favorable response to brief therapy may be enduring." (p. 33).

Overall and Aronson (1962) were interested in class differences and client expectations as they related to duration of therapy. They administered a questionnaire to 40 lower class patients before and after a first therapy session to determine expectations and perceptions of therapy. The results show that these patients expected a "medical-psychiatric" interview with the therapist assuming an active-supportive role. Those patients whose expectations were less accurate in terms of therapist role were significantly less likely to return for treatment.

Garfield, Affleck and Muffly (1963) investigated selected behaviors and perceptions of patient and therapist in a first therapy interview and related these to duration of stay. Most of the ratings obtained bore little relationship to continuation in psychotherapy. None of the ratings made by the patients had any predictive value for continuation. For example, ratings on the patient-therapy evaluation scale yielded no differences between the defined groups. A few of the ratings by the therapist (i.e., an overly positive view of therapy or the therapist's part, relative to the clients rating may be related to termination) and the overall ranking of the therapist's competence did bear some relationship to this criterion. In concluding, the author suggests attempts at appraising congruence of patient and therapist as promising for further investigation.

Hoehn-Saric, Frank, Imber, Nash, Stone and Battle (1964) developed a "Role Induction Interview" to give the patient appropriate expectations about certain aspects of psychotherapy. They

Therapist Variables

Several studies have concentrated on therapist variables and their relation to duration in psychotherapy. Meyers and Auld (1955) have included data on the relationship between experiences and training levels of the therapist and treatment outcomes. They examined termination patterns for two groups of patients - those seen for less than 10 interviews and those seen for 20 or more sessions. Results were: (1) more patients in the first group were classified as "dropped out" or "discharged as unimproved" than in the second; and (2) experience level and training of the therapist was not related to termination in the short stay patients, but it was positively related to successful termination for longer stay patients.

As part of Hiler's 1950 study, he reported finding no relationship between the therapist's profession and duration of therapy. He did find that analytically-oriented therapists lost fewer patients and that intake and screening procedures in the clinic may have influenced this, as well as how analytically-oriented therapists were selecting patients.

Heine (1962) reported data on dropout rates among his sample of 111 patients treated by medical students with various levels of experience. Dropout rates were not related in any systematic fashion to the different levels of experience.

At this time the relationship between therapist experience and profession and duration in treatment is unclear, although there is some evidence to suggest that experienced therapists are better able to end treatment with long-term clients.

Method

Clinic Setting and Description of Services

The setting for this study was the Blue Ridge Mental Health Center located in Asheville, North Carolina. This facility provides mental health services for Buncombe, Yancey, Madison and Mitchell counties. The service area includes rural, small town and urban populations totaling approximately 190,000 people. A variety of services are offered by the Center including inpatient, outpatient, partial hospitalization, consultation and education, and emergency services.

The outpatient service operates on a "crisis intervention model" based on the theory first proposed by Lindemann in the 1940's. Generally, crisis intervention refers to the employment of direct services intended to relieve an immediate failure of an individual or family to cope with some stress, internal or external. The term crisis intervention is interpreted loosely in the sense that all people that contact the Center are viewed as experiencing a "crisis". Thus, a formal intake procedure followed by a lengthy wait before therapy is avoided; all approaching the clinic are seen immediately. This method of intervention has been in effect since November of 1972.

The crisis service is organized into a total of five crisis teams comprised of two or three members each. These teams function on an on-call basis for a particular day of the week. Team members operate as intake personnel, referral agents and both short and long term therapists. Psychiatric and psychological consultation is available to the crisis team members and is used frequently.

The 12 members of the crisis service have varied educational backgrounds and include five masters of social work, two mental health associates, one Ph.D. in counseling psychology, two college graduate level social workers, one mental health nurse, one psychiatric physician's assistant and one intern in clinical psychology.

Fees charged at the Clinic are based on a sliding scale and generally range from one to ten dollars, with a few falling above or below this range. The fee range reflects the fact that the majority of the clients seen at the Blue Ridge Mental Health Center are of lower socioeconomic class.

Due to the large number of clients handled by the Clinic, typical treatment duration is short (one to five sessions). Generally, treatment sessions occur once per week, although in some cases contact may be as often as once per day or as infrequent as three times a year.

Subjects

During the month of April, 1973, 228 people contacted the Mental Health Center. Of this number, less than one half (N=109) entered into a formal treatment contract. Formal treatment

typically began when a case was officially opened by a therapist. The opening of a case is a procedure whereby certain demographic information is collected, patient fees are set, and an official record of patient contacts with the Center is established. As a general policy, cases are opened: (1) for all patients seen at the Center and subsequently sent to Broughton State Hospital or the psychiatric unit of St. Joseph's Hospital, (2) when it is anticipated that a patient will return for follow-up care after a hospitalization at the Alcholoic Rehabilitation Center, (3) when the therapist requests that the patient be seen more than once or twice, and (4) whenever medication is prescribed. Of the 109 clients entering treatment, 58 were eliminated from this study for a number of reasons including: (1) insufficient information contained in their charts, i.e., no social history, (2) a primary problem of alcoholism or drug addiction, (3) a psychotic condition, and (4) patients still in therapy at the time of data collection. Fifty-one clients served as subjects and remained in treatment from 1 to 25 sessions.

Procedure

Charts for all subjects were examined and the relevant information recorded. In order to decrease experimenter awareness of the number of contacts clients had with the Mental Health Center, contact sheets were removed from all charts. Subjective information was then collected form the clinical notes, social history and closing summary. When this data was recorded, the more objective data, i.e., demographic information, was gathered and finally the number of patient

contacts noted. These sources yielded the following 22 variables which are described in detail in Appendix A:

Scaled Variables

1. Education
2. Occupation
3. Income
4. Age
5. Sex
6. Race
7. Employment Status
8. Condition at Termination
9. Previous Outpatient Treatment
10. Previous Inpatient Treatment
11. Precipitating Event
12. Onset of Problem
13. Medication
14. Participation by Others
15. Patient Responsiveness
16. Clarity of Goals
17. Length of Treatment
18. Therapist Experience

Nominal Variables

19. Marital Status
20. Disposition at Termination
21. Referral Source
22. Presenting Problem

Analysis of Data

The 18 scaled variables were coded and punched on computer cards for a Step-wise Multiple Regression analysis designed to determine which combination of variables could predict duration in therapy. The four nominal variables were subjected to Chi Square analysis.

Results and Discussion

The average length in treatment (Table 1, variable 19) was 3.41 interviews, approximating the findings of several investigations (Affleck and Mednick, 1959; Kurland, 1956) carried out at different Veterans' Administration clinics. This number is somewhat lower than that reported in a majority of studies (Garfield, 1971) and may reflect the "crisis intervention" model employed at the Blue Ridge Mental Health Center. This model stresses brief, intense involvement aimed at restoring the client to pre-crisis levels.

The data analysis yielded only negligible to moderate relationships between the dependent and independent variables (Table 2). This was also the finding when all the variables were intercorrelated. Given this finding, interpretations are speculative, the data being only suggestive. For this reason, only those variables that were significantly related to the dependent variable and a combination of these variables were discussed.

Four variables were significantly related ($p < .01$) to duration in therapy, combining to form a multiple of R of 0.621 (Table 6). Medication, patient responsiveness, condition at termination,

Table 1 - Averages and Standard Deviations of All Variables

Variable	Average	Standard Deviation
1	3.11	1.27
2	2.09	1.48
3	1.92	1.49
4	25.58	13.38
5	1.72	0.45
6	1.88	0.32
7	2.01	0.96
8	2.45	0.54
9	1.01	2.67
10	0.33	0.71
11	2.13	0.98
12	2.74	0.62
13	1.33	0.47
14	1.90	0.94
15	2.76	1.15
16	2.01	0.90
17	1.66	0.90
18	1.76	0.83
19	3.41	3.97

Table 3 - Multiple Regression Analysis - Step One

Variable		13
Standard Error of Estimate	=	3.455
Multiple Correlation Coefficient	=	*0.507
Goodness of Fit, F (1, 49)	=	17.0262
Constant Term	=	-2.352

Variable	Coefficient	Standard Deviation Coefficient	T Value	Beta Coefficient
13	4.2352	1.0264	*4.1262	0.5078

*$p < .001$

Table 4 - Multiple Regression Analysis - Step Two

Variable		15
Standard Error of Estimate	=	3.374
Multiple Correlation Coefficient	=	0.553
Goodness of Fit, F (2, 48)	=	6.6066
Constant Term	=	-3.8286

Variable	Coefficient	Standard Deviation Coefficient	T Value	Beta Coefficient
13	3.8255	1.0270	**3.7247	0.4586
15	0.7738	0.4218	*1.8344	0.2259

*p < .05
**p < .001

Table 5 - Multiple Regression Analysis - Step Three

Variable		8
Standard Error of Estimate	=	3.309
Multiple Correlation Coefficient	=	0.589
Goodness of Fit, F (3, 47)	=	8.3300
Constant Term	=	-6.9528

Variable	Coefficient	Standard Deviation Coefficient	T Value	Beta Coefficient
8	1.5330	0.8955	*1.7109	0.2088
13	3.3829	1.0397	**3.2535	0.4056
15	0.7583	0.4137	*1.8330	0.2213

*$p < .05$
**$p < .005$

Table 6 - Multiple Regression Analysis - Step Four

Variable		14
Standard Error of Estimate	=	3.244
Multiple Correlation Coefficient	=	0.621
Goodness of Fit, F (4, 46)	=	7.2256
Constant Term	=	-9.0075

Variable	Coefficient	Standard Deviation Coefficient	T Value	Beta Coefficient
8	1.5791	0.8788	*1.7968	0.2150
13	3.6062	1.0277	**3.5088	0.4323
14	0.8380	0.4921	*1.7029	0.1991
15	0.7764	0.4057	*1.9134	0.2266

*$p < .05$
**$p < .001$

Table 7 - Multiple Regression Analysis - Step Five

Variable		9
Standard Error of Estimate	=	3.208
Multiple Correlation Coefficient	=	0.642
Goodness of Fit, F (5, 45)	=	6.3169
Constant Term	=	-9.6947

Variable	Coefficient	Standard Deviation Coefficient	T Value	Beta Coefficient
8	1.6865	0.8723	*1.9332	0.2297
9	-6.2563	0.1798	+-1.4258	-0.1725
13	4.0029	1.0538	**3.7985	0.4799
14	0.8583	0.4869	*1.7627	0.2039
15	0.8191	0.4024	*2.0356	0.2391

\+ N.S
*p < .05
**p < .001

and participation by others were related serially; medication had the strongest positive correlation with the dependent variable.

Variable 13 (medication) was the first entered in the Stepwise Multiple Regression analysis. Table 2 shows that medication and number of therapy sessions, or duration, (variable 19) correlate positively at 0.51. The t value of the regression coefficient (under the null hypothesis that the true coefficient is zero) was recorded as 4.1262 ($p < .001$) using a one tailed test of significance (Table 3). Also reported in Tables 3, 4, 5 and 6 are the subsequent steps in the regression analysis.

Several explanations for this finding are feasible. First, medication may be distributed only to those clients who attend two or three sessions. Therapists may spend several evaluation sessions with clients before deciding that medication is indicated. Thus, clients are required to remain in treatment as a condition for receiving medication. Since the data does not say when medication was introduced into the treatment plan, the question of whether the medication or the sessions come first cannot be answered.

Second, a number of clients who remain in treatment for more than several sessions are referred by physicians (Table 8) and may be on medication when they first contact the Mental Health Center. This is a realistic possibility given the proliferation of prescription drugs produced to combat depression, anxiety, agitation and "nervousness". Again, from the data, it cannot be determined who introduced medication to the client.

Finally, there is some evidence (Jackson, 1968; Overall and Aronson, 1963) indicating that a "medical" rather than "psychiatric"

(conceptually more sophisticated) approach toward therapy may be more effective in terms of engaging lower class clients in treatment. Averages on variables one, two, and three--education, occupation, and income--provide a crude socioeconomic status estimate and indicate that the population had a number of lower class clients. In this case, medication would assume the primary treatment position, with counseling an adjunctive ingredient. The client returns for his medication or "Doctor's appointment," relying on the drug as the therapeutic agent.

The second variable entered in the analysis was patient responsiveness. Alone, patient responsiveness correlates at 0.33 (Table 2) with the dependent variable. Medication and patient responsiveness together yield a multiple R of 0.553 ($p < .01$). The t values for variable 13 and 15 at this step are 3.7247 ($p < .001$) and 1.8344 ($p < .05$) respectively (Table 4).

Of the four factors contributing to the multiple R, patient responsiveness was the only variable relying on subjective information. As noted in the method section, this variable was defined as the experimenter's estimate of patient responsiveness from the information in the charts. Given this data, it is difficult to tell what the patient is responding to--perceived therapist's interest, attraction to the therapist, suggested problem solution presented by the therapist, etc. Blenker's (1954) retrospective research concluded that clients who were most likely to return were those who responded to therapist-suggested solutions to their problems. Clients may be looking for answers and respond positively to an active, directive counseling approach.

In the third step of the analysis (Table 5), condition at termination (variable 8) was combined with 13 and 15 to form a multiple R of 0.589 ($p < .01$). When correlated with the dependent variable a correlation coefficient of 0.330 was obtained (Table 2). The t values for 13, 15 and 8 at this step were 3.2535 ($p < .005$), 1.8330 ($p < .05$) and 1.7109 ($p < .05$).

Improved condition at termination for clients remaining in treatment has been a finding in a number of studies (Bailey, Warshaw, Eichler, 1959; Garfield, 1971; Garfield and Affleck, 1959; Jackson, 1968; Rosenthal and Frank, 1958). The same relationship between condition at termination and duration was found here. A number of factors may have affected this finding including therapist bias and a tendency to see length of stay as an independent measure of improvement. Even though these factors may contaminate the specific relationship between duration and terminating condition, the direction of the relationship suggests that generally clients who remain in treatment make some improvement.

In step four (Table 6), variable 14 (participation by others) combined with 13, 15 and 8 to form a multiple R of 0.621 ($p < .01$). Alone, variable 14 correlates 0.107 with number of therapy sessions (Table 2). In Table 6, t values for variables 13, 15, 8 and 14 were recorded as 3.5088 ($p < .001$), 1.9134 ($p < .05$), 1.7968 ($p < .05$) and 1.7029 ($p < .05$).

Even though the relationship between duration and participation by others is almost negligible, it was noted. These data indicate that if the identified patient is accompanied in therapy

by family members or friends, he is more likely to remain in treatment longer. A number of factors could account for this finding. First, the identified patient may be coerced into treatment by accompanying friends and relatives. Secondly, the identified patient may be a child, always accompanied by his parents. Third, significant others may provide encouragement and support during the treatment sessions facilitating continued involvement. Finally, the therapist may require a spouse and/or family members to accompany the identified patient in treatment. This is not unlikely given the "family orientation" of a number of therapists at the Blue Ridge Mental Health Center. Using this approach, presenting problems are often defined in terms of a social system that serves to maintain disruptive behavior. In order to change the behavior in question, additional system elements are included in the treatment process.

This finding is particularly significant in that it may have specific treatment implications. Clinicians may use this information to include part of the clients' "social system" in the treatment program. The involvement of family members, friends or teachers in the treatment process could encourage continued involvement by the identified patient.

Step five (Table 7) entered variable nine (previous outpatient treatment) into the multiple regression analysis. Since the t values for this variable and those subsequently entered into the equation were not significant, data beyond this point was not recorded here.

While the four variables that combine to form the multiple R do allow for a reduction of the error variance by approximately 36%, their predictive utility for the purpose noted in the introduction is limited. Several considerations are important here. First, condition at termination is estimated after the client has terminated involvement with the Center and cannot be used as an indicator of potential to remain in treatment. However, it does suggest that client engagement in treatment could result in progress. Second, while the use of medication was predictive of duration, clinicians would hardly medicate in order to increase the possibility of continuation in treatment.

Patient responsiveness and participation by others are variables that may have some usefulness in terms of assessing clients' potential for continuing in treatment. These variables can easily be recorded at the initial contact and influenced by the counselor. Patient responsiveness is related to the client-therapist interaction and difficult to consider independently. Perhaps, an operational definition of this variable might enable the counselor to make a crude judgment of responsiveness at the first contact. Counselors might begin to allocate planning time to those cases indicating at least a minimal response. Also, a counselor might suggest that significant others become involved in the treatment regimen. In this manner, support from the clients' immediate social system would be utilized.

The Chi Square Analysis

The four nominal variables (marital status, referral source, nature of presenting problem and disposition at termination) were not entered into the multiple regression analysis. In order to use chi square tests of significance, the subject population was divided into two groups, Short-Stay (SS ≤ two sessions) and Long-Stay (LS > two sessions) clients. The results of these tests (Tables 8, 9, 10, and 11) were not significant. When the categories in referral source and disposition at termination were broken down further to compare physician with other institutional referrals and the clinic not notified with all other dispositions, significant results ($p < .05$) were obtained (Tables 12 and 13). It is noted that a total of 29 subjects remained for the physician, institution comparison, a number of subjects being eliminated since they did not fall into either category.

The comparison of physician and other institutional referrals yields interesting data. Ninety percent of the clients referred for treatment from other institutions did not stay beyond the second contact (Table 12). This suggests a need to question the appropriateness of interagency referrals and educate other institutions to the services provided by the Blue Ridge Mental Health Center. Also, exploration of the mechanisms whereby clients are referred from one agency to another could prove enlightening.

Looking at the data from another perspective, over one-half of the physician referrals remained in treatment for more than two sessions. A suggestion from a physician seems to be a powerful

Table 8 - Contingency Table for Referral Source

		Referral Source						Totals
		Phys.	Sch.	Ct.	Fr.	Fam.	Oth.	
Duration in	L S	10	4	0	2	0	4	20
Therapy	S S	9	1	1	7	0	13	31
Totals		19	5	1	9	0	17	51

Table 9 - Contingency Table for Martial Status

		Marital Status					Totals
		Sin.	Mar.	Wid.	Div.	Sep.	
Duration in	L S	3	11	3	3	0	20
Therapy	S S	6	18	2	4	1	31
Totals		9	29	5	7	1	51

Table 10 - Contingency Table for Nature of Presenting Problem

		Nature of Problem						Totals
		Mar. Fam.	Adult Sit.	Child	Ger.	Drug	Dys. Adult	
Duration in	L S	4	7	4	1	2	2	20
Therapy	S S	2	11	10	0	1	7	31
Totals		6	18	14	1	3	9	51

Table 11 - Contingency Table for Disposition at Termination

		Disposition at Termination				Totals
		Clin Not Notif.	Clin. Notif.	Further Care Not Indic.	Not Ready For Trtmnt	
Duration in	L S	7	2	7	4	20
Therapy	S S	22	2	4	3	31
Totals		29	4	11	7	51

Table 12 - Revised Contingency Table for Referral Source

		Referral Source		Totals
		Physician	Other Institutions	
Duration in	L S	10	1	11
Therapy	S S	9	9	18
Totals		19	10	29

Table 13 - Revised Contingency Table for Disposition at Termination

		Disposition		Totals
		Clinic Not Notified	All Other	
Duration in	L S	7	13	20
Therapy	S S	22	9	31
Totals		29	22	51

inducement to enter and continue treatment at the Mental Health Center. The medical model, viewing mental distress as an illness or disease, is influential in initiating and prolonging client contact with the Mental Health Center.

Several explanations of this finding seem reasonable. First, the concept of a foreign agent within the body causing psychological stress allows the patient to avoid taking responsibility for the problem state. Clients complaining of "nerve" problems provide a good example of the patient searching for a somatic explanation for psychological stress. Second, the influence of the physician appears to play a big role in Mental Health Center involvement. This finding is not surprising given the high status afforded physicians in this society. Many clients continue in treatment simply because "my doctor said I should," regardless of their own preference.

The results of the chi square test for disposition at termination indicate that the majority of clients (nearly 75%) unilaterally withdrawing from treatment, do so following the first or second contact. Those clients remaining beyond the second session tend to terminate contact with this Center in a manner more acceptable to the counselor, i.e., a verbal agreement is reached. Perhaps treatment is offered indiscriminately by counselors to those who cannot benefit from this type of experience; and a "natural selection" process is occurring whereby those who cannot be helped in treatment drop out. In this case it may prove more efficient for counselors to offer treatment less, recognizing the limitations of conventional therapy with lower class clients.

Consequently, there was wide variability in the quantity and quality of the data contained in the files.

Second, the variables defined were necessarily imprecise due to the source of information being utilized. This was particularily noticeable in the subjectively defined variables i.e., precipitating event, onset of problem, patient responsiveness and clarity of goals following the initial contact. Due to this imprecision, the validity of the categories is in question.

Finally, the subject population was very small, making it difficult to generalize these results. A larger sample size could have yielded more subtle relationships between the dependent and independent variables.

In addition to these considerations, the questions of reliability and validity are crucial. The degree of attenuation suggests unreliability of the measurements, accounting for a reduction in the correlation coefficient. The validity of the subjectively defined variables and particularly patient responsiveness, constitutes a most serious difficulty with this study.

Future Research

While the results of this study are not conclusive they do suggest several areas for future research. Specifically, investigation into medication practices and the appropriateness of referrals to this Center could yield interesting data. Also, the effect of significant others in sustaining client involvement may prove to be a fruitful area for study.

Appendix A

Description of Variables

Scaled Variables

1. Education - This variable is recorded as a number, indicating the last complete year of schooling. The following categories (from Hollingshead and Redlich) are used for the purpose of presentation.

   (1) Less than seven years
   (2) Junior high school (seven to nine years completed)
   (3) Partial high school
   (4) High school graduate
   (5) Partial college training
   (6) Limited college or university degree
   (7) Graduate or professional training

2. Occupation - The categories are taken from Hollingshead and Redlich and proceed from unskilled to skilled positions.

   (1) Unskilled workers
   (2) Semiskilled workers
   (3) Skilled workers
   (4) Owners of little businesses, clerical and sales workers, technicians
   (5) Administration personnel of large concerns, owners of small independent businesses and semi-professionals
   (6) Managers and proprietors of medium sized businesses and and lesser professionals
   (7) Executives and proprietors of large concerns and major professionals

3. Income - A total of six income brackets have been designated in order to account for the data. The principle wage earner in the home is the source of this information.

   (1) Less than 4999
   (2) 5000 to 7499
   (3) 7500 to 9999
   (4) 10000 to 12499
   (5) 12500 to 14999
   (6) 15000 or more

4. Age - A raw number has been recorded. This variable is self-explanatory.

5. Sex - The two categories designated for this variable are self-explanatory.

   (1) = M
   (2) = F

6. Race - Two categories were generated for this variable in view of the client population at the Blue Ridge Mental Health Center. Patients were either white or nonwhite, with almost all nonwhite patients being black.

   (1) = NW
   (2) = W

7. Employment Status - Three scaled categories have been generated in order to take this variable into account.

   (1) Unemployed
   (2) Part-time employment
   (3) Full time employment

8. Condition at Termination - At the time that a case is closed, the therapist makes a judgment regarding the patient's condition. These judgments are coded as follows:

   (1) Worse
   (2) Unchanged
   (3) Improved
   (4) Recovered

   A fifth category is supplied and designated as "undetermined". To facilitate the analysis of the data this category was combined with number two, "unchanged".

9. Previous Outpatient Treatment - This variable takes account of the total number of patient contacts with the Blue Ridge Mental Health Center or any other agency offering mental health care on an outpatient basis. This variable has been recorded as a raw number.

10. Previous Inpatient Treatment - Total number of previous hospitalizations is recorded here.

11. Precipitating Event - This is recorded by the experimenter from information taken from the clinical notes of patients. It is the experimenter's estimate of the degree to which the patient is aware of a specific event leading to the problem specified.

    (1) Not at all (unaware of any event)
    (2) Somewhat aware (notes event(s) but not sure of how it relates to the problem situation)
    (3) Clearly aware (specific event)

12. Onset of Problem - Refers to the rapidity with which the problem in question developed. The following scaled categories are used with examples for each.

(1) Sudden (development of problem occurring within two weeks)
(2) Slow (development of problem occurring from two weeks to one month)
(3) Gradual (development of over one month)

This information is collected from the patients' charts and represents the experimenter's estimate from the data.

13. Medication

(1) No
(2) Yes

14. Participation in Treatment by Others - This variable refers to the degree that someone other than the designated patient participated in the treatment process. This does not include a co-therapist but rather a family member or friend. Three categories are described.

(1) Not at all (client always seen individually)
(2) Some of the time (occasional session with others present)
(3) Always (patient always accompanied by another during the therapy sessions)

15. Patient Responsiveness - This information is based on the experimenter's impression of patient responsiveness as indicated in the charts. Therapists occasionally provide specific statements indicating degree of responsiveness, but for the most part it was necessary to estimate the degree of this variable from the information provided in the charts.

(1) Not at all
(2) Very little
(3) Some
(4) Pretty much
(5) Very much

16. Have Goals Been Clearly Set at Initial Contact - Refers to the therapist-patient agreement on (a) goal (s) following the first contact. This is another variable that is recorded by the experimenter as an impression gained from the patient's chart.

(1) Not at all
(2) Somewhat clear
(3) Very clear

17. Is There a Clear Statement of Length of Treatment - Frequently, clients and therapists agree on a certain specified length of treatment. This is generally recorded in the form of a contract following the first session.

(1) Not clear
(2) Some expectation of length
(3) Clear statement of length of treatment

18. Therapist Experience - This variable measures the amount of therapist clinical experience, including practicum training while in school. Part-time clinical placements were combined to furnish an approximation of the number of full time years of experience, i.e., a therapist having a 12 months half-time placement plus a six month full time work would have a total of one year of clinical experience. Three categories have been defined.

(1) One to two years
(2) Two to four years
(3) Four plus years

Nominal Variables

19. Marital Status - This variable has been recorded as a number of categories.

(1) Single
(2) Married
(3) Widowed
(4) Divorced
(5) Separated

20. Disposition at Termination - These data are recorded on all patients at the time their case is officially closed and refer to the status of the case at that time. General disposition categories include:

(1) Patient withdrawal from clinic service - clinic not notified
(2) Patient withdrawal from clinic service - clinic notified
(3) Further care not indicated at this time
(4) Patient not ready for treatment at this time

21. Referral Source - Generally, each patient seen at the Center has been referred for treatment by a physician, friend, family member, etc. This variable consists of a number of categories and was recorded at the initial patient contact.

(1) Physician
(2) Schools
(3) Court
(4) Friend
(5) Family member
(6) Other

22. Nature of Presenting Problem - A number of broad categories have been generated to account for this variable. Therapists opening cases with patients record this information as a matter of routine. These categories include the following:

(1) Marital-family conflict
(2) Adult-situational conflict
(3) Child
(4) Geriatric
(5) Drug
(6) Dysfunctional adult

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