AN INVESTIGATION OF TREATMENT ATTRITION
IN PSYCHOTHERAPY

by

John Henry Borghi

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I hereby recommend that this dissertation prepared under my direction by John Henry Borghi
entitled AN INVESTIGATION OF TREATMENT ATTRITION IN PSYCHOTHERAPY
be accepted as fulfilling the dissertation requirement of the degree of Doctor of Philosophy

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SIGNED: John H. Boughi
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ABSTRACT

The Minnesota Multiphasic Personality Inventory was employed as a potential predictor of treatment attrition. Twenty-nine patients (Terminators) who had prematurely discontinued from psychotherapy after an average of two sessions were compared with 29 patients (Remainers) who had stayed in therapy an average of 36 sessions. Terminators and Remainers were matched with respect to age, sex, and therapist. The traditional scales of the MMPI failed to distinguish between Terminators and Remainers, nor were there any systematic differences between the two groups with respect to diagnosis, socioeconomic status, education, marital status, time spent waiting for treatment or referral source. Special scales designed to measure anxiety, dependency, and ego strength also failed to differentiate Terminators from Remainers. However, eight MMPI items were found which significantly differentiated the two groups, although this empirical scale is viewed as tentative and in need of extensive cross-validation.

Terminators, on home interview, gave a variety of reasons for their premature termination. These reasons were ordered into four categories: (a) Seven patients who expressed dissatisfaction with the services received, (b) Twelve patients who maintained their termination was the result of factors independent of the therapy, (c) Four patients who denied they had discontinued, and (d) Six patients who expressed unique or atypical reasons. Several case illustrations of these Terminator home interviews were presented.
The tentative hypothesis was offered that the area of mutual patient-therapist expectations is the crucial variable in treatment attrition. Detailed examination of the 58 patient records plus the Terminator home interview data revealed: Remainders voiced expectations which were generally congruent with those of the therapist, while Terminators expressed incongruent expectations. Although expectations for only about one-third of the patients could be clearly determined, in no instance did a Terminator exhibit expectations which were congruent with those of the therapist and, similarly, there were no instances in which a Remainer exhibited expectations incongruent with those of the therapist. Patient expectations were ordered into four categories: (1) Unrealistic expectations, (2) Expectations of advice, (3) Expectations that "something be done" about the spouse, and (4) Expectations concerned with an answer to the question, "Am I mentally ill?"

A review of the limited research in expectations revealed the need for a method of ordering expectations, as well as additional investigation of the full range of both patient and therapist expectations before meaningful dimensions might be delineated. Methods of quantifying patient expectations were also reviewed and a series of quantitative measurement scales proposed. The need for further research investigating role performance, changing expectations, expectations among differing populations, cultural influences, and unconscious expectations was also stressed.
INTRODUCTION

Treatment attrition refers to the premature termination of patients from psychotherapy. It is a problem common to all agencies or persons offering psychotherapy from the large metropolitan mental health center to the private practitioner in the community. Attrition rates vary, depending upon the population involved and the criteria employed to define the Terminator. Rogers (1960), reporting on government aided mental health clinics and one VA clinic, found only 37 per cent of the cases referred actually entered into treatment. Other reports (Guilford, 1950; Frank et al., 1957; Lief, Lief, Warren, and Heath, 1961; Kamin and Caughlan, 1963) of attrition rates range from 6 to 60 per cent. A recent and higher estimate, based on a population similar to the present study, is reported by Pfouts, Wallach, and Jenkins (1963). They found that only one-fourth of their adult outpatients seen in diagnostic evaluation remained for more than five therapy sessions. In a survey of the literature, Rosenthal and Frank (1958) report the overall attrition rate to be around 50 per cent. As Levinson (1962) has commented,

Since the supply of psychotherapists is so small as compared to the number of persons needing help, it becomes especially important to allocate it wisely—to make it available to those most likely to profit from it. (p. 15)

It is obvious that the first logical step to assure a wise allocation of this supply is an investigation of the factors involved in treatment attrition and, in particular, identifying the Terminator, if indeed
the probability of termination has its locus within the individual.

The Search for a Predictor

Clinical predictions of those who will terminate prematurely are usually inaccurate. Garfield and Affleck (1961) had staff members, psychiatric residents, and social work students make estimates of duration of stay for 57 patients in an outpatient setting. Marked inaccuracies in the prediction of the early Terminator were found for all three groups, with both the staff and social work students being especially over-optimistic. In another study, Affleck and Garfield (1961) also found that while therapists exhibit agreement in their preferences and personal feelings for patients, such ratings do not predict duration of stay. Similarly, Rosenthal and Frank (1958) report clinical judgments of motivation for psychotherapy fail to predict Terminators from Remainers.

Use of Psychological Tests: A review of the prognostic use of psychological tests by Fulkerson and Barry (1961) reveals the repetitive pattern of initial positive results followed by contradictory or indeterminate findings in later cross-validation. This is especially true of the Rorschach, although the number of responses (R) has usually stood up as a predictor of premature termination. However, as Fulkerson and Barry point out, administering the Rorschach to obtain this measure is probably a needlessly laborious chore. Gallagher (1954), for example, found the Mooney Problem Check List to be an even better predictor than R. In 1957, Libo, using a Picture Impressions test, was able to significantly predict who would return after the first
Interview. His prediction was based on references in the stories told, indicating a move toward the therapist or anticipated satisfactions from the therapy. With this technique he was able to label as Terminators six of the nine patients who did not return and 24 of the 31 Remainers who did return. Using the Wechsler-Bellevue, Hiler (1958) found his Remainers achieved higher scores, the sub-test Similarities tending to be elevated over those of Digit Span or Digit Symbol.

Anxiety (for the most part as measured by Taylor's 1953 Manifest Anxiety Scale) has been thought to be related to treatment attrition. The general hypothesis is one in which Terminators are seen as possessing relatively less anxiety and, hence, lacking in motivation to remain in treatment. As part of a larger battery of tests, McNair, Lorr, and Callahan (1963) found Terminators had significantly lower manifest anxiety scores. This difference confirmed similar results in an earlier study by this group (Lorr, Katz, and Rubinstein, 1958). In contrast to these findings and using Welsh's (1956) Factor A scale of anxiety, Sullivan, Miller, and Smelser (1958) found Terminators scored significantly higher on anxiety, but no difference was found when the N (VA outpatients) was increased.

Ego strength (often measured by Barron's 1953 scale) has been used primarily as a predictor of improvement, although it has also been suggested that Terminators have less ego assets to cope with a prolonged therapeutic relationship. Thus, Sullivan, Miller, Smelser (1958) initially found Remainers to be higher on Barron's scale, but again there was no significant difference between Terminators and Remainers when the N was increased.
The test evidence, then, is inconclusive as to whether "personality" variables are reliable in distinguishing Terminators from Remainers.

**Demographic Variables**: Auld and Myers (1954) examined social class as a variable in determining length of stay and concluded that the middle class patient (using the Hollingshead Index) tended to remain longer. They suggest that by determining the patient's social position one can then predict how long he will remain in therapy. Rosenthal and Frank (1958) have found patients of lower social class are least likely to accept or remain in psychotherapy, although those who remained appeared to obtain as much benefit as those patients of higher social class. Schaffer and Myers (1954) report that the higher the patient's social class position the greater his chances of being accepted for treatment and maintaining contact with the clinic. Gallagher and Kanter (1961) have also found higher class patients tend to remain longer in treatment than do lower class patients. Lief, Lief, Warren, and Heath (1961) report an unusually low (6 per cent) drop-out rate from a University clinic and explain this as being due to the fact that their patients come from higher social position (Class 2 and 3 of the Hollingshead and Redlich 1958 index). Hollingshead and Redlich (1958) explain the high attrition rates among lower class (especially class V) patients as being due to a discrepancy of values between these patients and their therapists.

**Non-test Predictors**: An ambitious attempt to identify the type of individual who drops out of psychotherapy is that of White, Fichtenbaum,
and Dollard (1964). Their approach involves a detailed content analysis of initial interviews and is based on the system developed by Dollard and Auld (1959) to score human motives. White and his associates score each five-second unit of speech with respect to its being favorable, unfavorable, or irrelevant for remaining in therapy. Although the authors maintain accurate prediction in eight out of ten cases, they also admit their scoring system is extremely cumbersome and "in its present form . . . cannot be used by clinical personnel to make swift appraisals" (p. 332).

Conrad (1954) rated VA outpatients, using a mental health checklist which contains statements related to positive mental health (ex.: "Has insight into difficulties"), social conformity (ex.: "Supports wife and children"), and pathology (ex.: "Characterized by overt hostility"). She finds Remainders rate high on positive mental health, exhibit a greater discrepancy between positive mental health ratings and behavior pathology, and are rated as having a sense of humor and as being contemplative about meanings and values. Patients with a low degree of rated social conformity try therapy for a short period of time and then discontinue. Pathology recorded during the first interview fails to predict length of stay.

Hiler (1959) examined initial complaints as possible predictors of termination or continuance. Remainders complained more of obsessions, phobias, depression, poor concentration, and anxiety. Terminators presented more acting-out types of behavior, such as assaultiveness, and were also generally troubled more by ideas of reference, irrational suspicions, and other paranoid and schizoid ideation. Terminators
tended to complain only of somatic symptoms, while Remainners presented purely psychological symptoms or a combination of both. Hiler (1954) has also pointed to education, level of ambition, tendency to be introspective, psychological sophistication, anxiety, and felt dissatisfaction as important variables.

Interaction Predictors: In a qualitative attempt to evaluate treatment attrition among outpatient veterans, Dengrove and Kutash (1950) list factors which are attributable to (1) the patient, (2) the therapist, and (3) management. Important factors which may be attributable to the patient include poor motivation, dissuasion by others, an inability to withstand treatment, inadequate personality, antagonism to doctors, the fact that treatment is free, and situational conflicts. Factors attributable to the therapist include errors in technique as well as various kinds of countercathexes, such as ill-concealed hostility and constant moralizing. Factors attributable to management include passing through too many hands, lack of appropriate facilities and means, missed appointments by therapists, short duration of interviews, violation of confidences, and the false promise of rapid cure.

Examining the variable of dependency, Winder, Ahmad, Bandura, and Rau (1962) found that when patient expressions of dependency are approached by the therapist, the patient will remain in treatment. Conversely, when expressions of dependency are infrequently approached, the patient tends to prematurely terminate.

Combinations of Measures: The hypothesis that Remainners and Terminators reflect two distinct patient populations has led other
investigators to develop elaborate scales in an attempt to distinguish these two groups. One such effort is a series of tests (TR battery) developed by Lorr, Katz, and Rubinstein (1958) and later refined and cross-validated by McNair, Lorr, and Callahan (1963). In its present form the TR battery is composed of three scales based on the Manifest Anxiety scale, a Behavior Disturbance scale, and the F (authoritarianism) scale. In addition, McNair and his associates employed seven other predictors which significantly differentiated between Terminators and Remainers. (These included a 30-item vocabulary test, a nine-point education scale, a modified form of Taylor's MA scale, 50 questionnaire items designed to measure psychopathic tendencies, etc.) All of these various patient predictors supported the hypothesis that Remainers are less anti-social and impulsive, but more anxious and self-critical than Terminators. Remainers are also seen as less rigid, as having better vocabularies, rated as being more highly motivated and, finally, as being more retiring in personal relations and better educated. The authors find the TR battery itself to be the best predictor of duration plus therapist ratings of motivation for treatment. They conclude that people who remain in therapy and those who drop out early form two distinct groups, but caution that cross-validation of the TR battery has involved only veterans and the results may not hold true for other populations.

A series of papers (Imber, Nash, and Stone, 1955; Imber et al., 1956; Nash et al., 1957; Frank, et al., 1957) by the Phipps Clinic Psychotherapy Research Group investigated the problem of treatment attrition as well as related areas. One of their approaches was designed
to identify patient attributes which would predict premature termination; a variety of measures were included in the test batteries, including the Sway test. This extensive study reported a large number of factors related to remaining in therapy or terminating, such as degree of suggestibility, sociability, socioeconomic status, education, occupation, degree of stability of illness, readiness to communicate distress, social integrity, and perseverance.

**Summary:** A search of the literature reveals that a large and varied number of variables have been suggested as predictors of premature termination. A partial list includes sex, age, education, diagnosis, occupation, socioeconomic status, intelligence, anxiety, ego strength, dependency, verbal ability, social attitudes, social behavior, motivation, marital status, severity of illness, suggestibility, sociability, kinds of symptoms, defensiveness, prior life adjustment, onset and length of illness, impulsivity, persistency, dependability, readiness to communicate distress, sense of humor, social conformity, level of ambition, psychological sophistication, felt dissatisfaction, and introspective tendencies. To add further to the confusion, there is the recurring observation that predictor variables probably cannot be generalized to differing patient populations. However, the more basic question would seem to be: Is it even meaningful to talk of "The Terminator" and "The Remainer" as specific entities? Or posed another way: Are there genuine differences between patients who remain in therapy for many sessions and those who discontinue early? This study attempts to answer the question.
The Minnesota Multiphasic Personality Inventory (MMPI) as a Predictor:
The MMPI is an easily administered test which takes little training to score and a short amount of time to interpret. Its potential value as a predictive instrument could, therefore, be considerable. Being able to identify the Terminator by means of the MMPI would have important implications for determining the composition of psychotherapy groups as well as providing clues to preventing attrition. Ideally, an empirical treatment attrition scale might be derived similar to the variety of special MMPI scales already available (Dahlstrom and Welsh, 1960). Since the present investigation employs the MMPI, a more detailed consideration will be given to studies using this test.

Taulbee (1958) chose the MMPI on the assumption that there are identifiable personality variables associated with premature termination and that these variables would be reflected in the test. His Remainers (45 VA outpatients who remained in treatment for 13 or more sessions) exhibited greater elevation of the MMPI symptom scales (Hs, D, Pa, Pt, and Sc) when compared to the Terminators. (All differences were significant at the .05 level or less except for Hs which was in the predicted direction.) Using an objective configural analysis after Sullivan and Welsh (1952), eight scale pairs were then assigned weighting coefficients corresponding to the degree of differentiation between Remainers and Terminators. Taulbee thus presents eight prognostic signs which might be used to distinguish Terminators from Remainers: scale 4 greater than 7 (weight 1); scale 3 greater than 8 (weight 1); scale 3 greater than 6 (weight 3); scale 4 greater than 7 (weight 3); scale 4 greater than 8 (weight 4); scale 9 greater than 6 (weight 1); scale 9
greater than 7 (weight 2); scale 9 greater than 8 (weight 3); high scores are predictive of Terminators with a total possible of 18 points. Prior to the present study there has been no cross-validation of Taulbee's index.

Other investigators have used the MMPI with somewhat conflicting findings. Sullivan, Miller, and Smelser (1958) were unable to find any distinguishable differences on the MMPI between Remainers and Terminators. Instead, education and occupational level, using Warner's (1949) code, emerged as differentiating. MMPI differences were initially found with a small sample but washed out when the N was increased. The authors make the point that the findings in this research area must be regarded as highly tentative until thoroughly cross-validated. They also comment that local norms might be necessary for sufficiently accurately prediction and add "it may be . . . our efforts will be best expended in developing norms for our particular settings, patient populations, and possibly therapists" (p. 8).

Gallagher (1953) postulated that the more anxious the individual, the more likely he would be to remain in therapy. Indeed, with a college population, he found Terminator manifest anxiety (Taylor, 1951) to be lower than Remainer At scores, although not significantly so. The traditional scales of the MMPI, however, failed to differentiate the two groups. The most definite result was that Terminators were no less maladjusted than Remainers and presumably were in just as much need of psychotherapy.

Hecht and Kroeber (1955) found that MMPI profiles of college students who came four sessions or less reflected hypomanic defenses,
masculinized attitudes against dependency, acting out of hostility, repression, defensiveness, and psychosomatic solutions to conflict. Remaininers showed obsessive-compulsive defenses, introspection, depressive reactions, alternating periods of compulsivity and acting out of hostility and passive-dependent patterns. The authors conclude that Remaininers possess more ways of handling conflict which are compatible with the requirements of psychotherapy than do Terminators. Thus, two studies find the MMPI useful in predicting treatment attrition, and two studies find it of no use.

The Present Study

In addition to the traditional scales of the MMPI, three special scales - the Anxiety, Dependency, and Ego Strength scales - are also employed in this study since several investigators suggest these three variables are important. The area of this study has been limited to treatment attrition during the early stages of treatment after the evaluation and following the patient's acceptance into treatment. We are not concerned with candidates who were refused treatment or referred elsewhere, nor are we concerned here with the many questions relating to outcome.

The population studied involves individuals accepted for treatment by the Southern Arizona Mental Health Center located in Tucson, Arizona. This facility, formally opened in September of 1962, is an outpatient clinic primarily serving Pima County. At the time of this study (November, 1963), there were 1,386 patient charts and an active caseload of 112 patients, with approximately 112 patient contacts made
per week. The professional staff included a director, two staff psychiatrists, four consulting psychiatrists, three psychiatric social workers, two part-time psychologists, and five psychology trainees. Services offered were limited to outpatient psychotherapy, group therapy, and chemotherapy.
METHOD AND PROCEDURE

The charts of all patients staffed by the Southern Arizona Mental Health Center during the one-year period from November, 1962, through November, 1963, were examined. Forty-six patients were initially found who had prematurely terminated from psychotherapy and also met the criteria.

Experimental (Terminator) Group Criteria

Terminator Ss were those patients who prematurely terminated from psychotherapy (having been evaluated and accepted for treatment) after 0 to 8 sessions. This included patients who had (1) failed to keep appointments, (2) indicated by telephone call or letter that they were no longer interested or in need of treatment, or (3) discontinued (with either therapist or patient stating that termination preceded the achievement of successful amelioration). Patients who had not taken the MMPI or whose MMPI was invalid were not included in the Terminator group. Mexican-Americans were excluded because of the difficulty in interpreting MMPI profiles of this sub-cultural group.

Further criteria excluded patients who had been hospitalized as well as patients who had moved out of the city. Although this latter criterion reduced the total N considerably, their exclusion (unlike other studies) completely eliminates those instances in which the "Terminator" is forced to leave therapy by external circumstances, such as the husband obtaining a better job in a different city, severe physical
illness, etc. From the original population of 46 Ss, 14 patients were clearly established as having left the city. The exact whereabouts of three were undetermined. Home interviews were conducted with the remaining 29 patients, who thus constituted the Terminator group.

Characteristics of the Terminators

The Terminators included twenty-four females and five males. This imbalance reflects the general disproportionate number of females to males in this particular Center's total patient population. For the males, ages ranged from 17 to 42, with a mean age of 30.6. Female ages ranged from 21 to 59 with a mean age of 37.96. Mean age, both sexes, equaled 36.69. The male patients were seen an average of three therapy sessions ranging from one to five sessions. Females were seen an average of 1.6 sessions ranging from no therapy sessions to a maximum of eight. Average number of therapy sessions, both sexes, equaled 1.9.

During the intake process at the time of this study, patients were routinely interviewed for a minimum of two hours; first for approximately one hour by a psychiatric social worker and then also by either a psychiatrist or psychologist for a minimum of one hour. Thus, all patients, prior to beginning formal treatment, were seen for at least two hours on two separate occasions. In addition, the MMPI was routinely administered to patients, usually between the social history interview and the psychiatric evaluation. Finally, a disposition was reached for each patient at the weekly meeting of the professional staff which always included at least one psychologist, one psychiatric social worker, and a psychiatrist presiding. In some instances,
further psychologic testing might be recommended in which case the pa-
tient would be re-staffed. After staffing, the patient was usually
placed on a treatment waiting list until beginning formal treatment.

Sources of referral were varied: family physician, private
psychiatrist, pastor, friends, social agencies in the community. The
majority of the patients were self-referrals. In no instance did the
referral source represent a threat or coercion to the patient to apply
for treatment (as far as can be determined).

The Home Interviews

All of the interviews were conducted by the author during the
summer of 1964. After introducing himself by name the interviewer ex-
plained:

I am representing the Southern Arizona Mental Health Center
and conducting a survey to help the Center improve its services
to the Community. Since you had some contact with the Center,
you could be of great help if you would answer a few brief ques-
tions. Let me assure you that your answers will be held in
strict confidence and will only be used for statistical purposes.

After obtaining agreement from the individual -- and there were
no frank refusals of cooperation although a small number of Ss were
terse and unfriendly -- the following questions were posed:

1. Who referred you to the Center?
2. Were the services you received satisfactory or unsatisfactory?
3. What were your reasons for discontinuing at the Center?
4. Have you had any psychiatric contact since you left the
   Center?
5. Would you have any suggestions for improving facilities at
   the Center?

Our main interest was in the third question and the remaining
questions were included in order to facilitate rapport and permit
possible elaboration of reasons for discontinuing. The fourth question permitted more exact determination of whether or not the S fulfilled the criteria. (Actually none of the Terminators had sought further psychiatric contact.) The length of the interviews ranged from just four or five minutes to as long as an hour and a half, and the amount of information obtained varied greatly.

The Control (Remainer) Group

All Remainer Ss were selected from the same one-year period as the Terminators with the exception of four individuals (R.J., M.V., H.K., and D.I.). These four Remainers were seen from two to eleven months earlier than the other patients. However, the evaluation process was identical at this time, and there is no reason to suspect these four Ss were atypical in other respects.

In selecting Remainers the initial concern was to include patients who had been seen for a relatively large number of therapy sessions beginning on at least a weekly basis. Since this study was designed to investigate treatment attrition and does not deal with therapeutic outcome, no attempt was made to assess relative therapeutic success or failure of Remainers. Thus, although for the Terminators therapy did not succeed, the degree of therapeutic success for Remainers probably varied. Their common element was the relatively long period of time in which they remained in therapy. From this pool of approximately 50 patients, 29 Ss were selected who most closely resembled the Terminators with respect to age, sex, and therapist (see Table 1). An exact match of Remainers and Terminators was made.
# TABLE 1

AGE, SEX, AND THERAPIST FOR ALL PATIENTS

<table>
<thead>
<tr>
<th>Terminator's Age</th>
<th>Remainder's Age</th>
<th>Sex</th>
<th>Therapist</th>
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<td>1. G.M. 31</td>
<td>H.M. 31</td>
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</tr>
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<td>2. V.R. 38</td>
<td>R.J. 32</td>
<td>F</td>
<td>#2 Psychiatrist</td>
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<td>4. H.J. 36</td>
<td>K.J. 32</td>
<td>F</td>
<td>#5 P.S.W.</td>
</tr>
<tr>
<td>5. F.J. 42</td>
<td>Z.S. 44</td>
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<td>#7 Psychologist</td>
</tr>
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<td>6. N.D. 59</td>
<td>K.D. 48</td>
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<td>#9 Psychologist</td>
</tr>
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<td>M</td>
<td>#6 P.S.W.</td>
</tr>
<tr>
<td>8. R.E. 25</td>
<td>W.N. 26</td>
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</tr>
<tr>
<td>9. A.K. 40</td>
<td>R.C. 45</td>
<td>M</td>
<td>#5 P.S.W.</td>
</tr>
<tr>
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<td>C.O. 23</td>
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</tr>
<tr>
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<td>16. B.R. 18</td>
<td>B.C. 46</td>
<td>F</td>
<td>#3 Psychiatrist</td>
</tr>
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</table>

Group Therapy

| 17. S.S. 21      | T.A. 21         | F   | Both seen by P.S.W. #6 |
| 18. B.S. 28      | G.J. 26         | F   | Same Psychiatrist #3 |
| 19. C.E. 29      | S.R. 30         | F   | Same Psychiatrist #2 |
| 20. T.O. 31      | C.M. 30         | F   | Same P.S.W. #5 |
| 21. D.C. 32      | J.P. 32         | F   | Same Psychiatrist #3 |
| 22. M.J. 32      | H.L. 25         | F   | Same P.S.W. #6 |
| 23. H.C. 34      | K.R. 35         | F   | Same Psychologist #9 |
| 24. Z.E. 40      | S.D. 43         | F   | Same Psychologist #10 |
| 25. P.I. 43      | L.M. 40         | F   | Same P.S.W. #5 |
| 26. B.M. 45      | B.P. 36         | F   | Same P.S.W. #6 |
| 27. S.S. 49      | H.H. 141        | F   | Same P.S.W. #6 |
| 28. D.G. 49      | D.I. 62         | F   | Same P.S.W. #11 |
| 29. J.H. 53      | K.R. 58         | F   | Same Psychologist #8 |

* Negro
+ Psychiatric Social Worker
© Control S not seen by the same therapist as Experimental S but both Ss seen by same P.S.W. during Evaluation.
For the Center's intake or evaluation procedure, see p. 14.
with respect to sex. The average age of all Remainers was 35.6 and the average age for all Terminators was 36.7 (not a statistically significant difference). The male Remainers were seen an average of 38.8 therapy sessions ranging from 30 to 45 sessions. Females were seen an average of 35.5 sessions ranging from 15 therapy sessions to a maximum of 65. The average number of therapy sessions for both sexes was equal to 36.1, although some patients were still in therapy at the time this study was completed.

The Therapist Variable

All Remainers were seen by at least one staff member who had also seen the matching Terminator. For those 16 Terminators who actually had begun formal treatment, exact matchings were made for therapist.* The therapists included three psychiatrists and three psychiatric social workers. One staff psychologist and three advanced psychology trainee students were also involved in the evaluation procedure. Although this study does not focus on the therapist as a variable, the general theoretical orientations of the twelve therapists and evaluators are catalogued in Appendix A.

Additional Important Variables

Since all patients were most often placed on a treatment waiting list following staffing and prior to beginning formal treatment, a tally was made to determine whether one group had to wait longer than another. Table 2 shows the respective weeks of delay (Waiting Period) between

*With the exception of Remainer S 15 (M.V.).
TABLE 2
WAITING PERIOD, EDUCATION, MARITAL STATUS AND THERAPY SESSIONS FOR ALL PATIENTS

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<tr>
<th>S No.</th>
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<th>Education (Warner)</th>
<th>Marital Status</th>
<th>Therapy Sessions</th>
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</table>

* Still in therapy
# Includes some group therapy
staffing and the next contact. Terminators, on the average, did wait to begin treatment about one week longer than did the Remainers. However, it is unlikely that this relatively short period of time was a major factor in the reasons for discontinuing. The interview data tend to confirm this impression. Table 2 also contains the education and marital status of each patient. Education level was determined by using Warner's (1949) seven-point scale which ranks college education as two, high school graduate as three, etc. (Appendix B contains the complete scale.) The mean education level for Terminators equals 3.2 and for the Remainers equals 2.9, or a difference of .3 (not statistically significant). With respect to marital status, five more Terminators than Remainers are found to be married. Three more Remainers than Terminators are single, one more Remainer is separated and one more widowed. Divorced patients are equal to both groups. There does not appear to be any systematic difference in the two groups in terms of marital status.

Table 3 shows the three major diagnostic categories within which all Ss fall. (Appendix C contains the diagnosis of each patient.) Table 3 also shows that approximately one-half of all the patients are included in four diagnostic categories with Depressive Reaction, Neurotic Type being the most popular. From inspection of this table it appears that the two groups are diagnostically equivalent. Several studies (Auld and Myers, 1954; Schaffer and Myers, 1954; Hollingshead
**TABLE 3**

**DIAGNOSTIC CATEGORIES REPRESENTED**

<table>
<thead>
<tr>
<th>DIAGNOSTIC CATEGORIES</th>
<th>Terminators</th>
<th>Remainers</th>
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<tbody>
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<td>Personality Disorders</td>
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<td>N=29</td>
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**The Four Most Common Diagnoses**

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<th>Remainers</th>
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<td>Depressive Reaction (Neurotic Type)</td>
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<td>Passive-Aggressive Personality</td>
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<td>4</td>
</tr>
<tr>
<td>Schizoid Personality</td>
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and Redlich, 1958; Gallagher and Kanter, 1961) have suggested that socioeconomic status is an important variable in determining therapeutic outcome as well as treatment attrition. Although for this study it was impossible to make an accurate assessment of socioeconomic status, a partial control is achieved since this particular Center referred patients with a yearly income of over $8400 to a private psychiatrist. In addition, the large majority of patients listed their occupation as housewife, so both groups are relatively homogeneous with regard to socioeconomic status.

Statistical Procedures

The major statistical approach was an analysis of variance between the Terminator and the Remainer groups involving the 14 traditional scales of the MMPI in addition to Barron's (1953) ego strength scale and Navran's (1954) dependency scale. This resulted in a 16 x 58 matrix of converted T scores which were punched on IBM cards and analyzed by a 7072 IBM computer, operated by the Numerical Analysis Laboratory of the University of Arizona.

A second statistical approach involved the development of an empirical scale which might provide MMPI items which would hopefully differentiate the Terminators from the Remainers. All 566 true or false MMPI answers for the 58 patients were first tabulated. Each item was then tested by means of Chi Square for any significant difference between Remainer responses and Terminator responses. An IBM computer (1101) was utilized for this Chi Square analysis.

#Primarily because the occupation of many Remainer spouses was unavailable as well as the absence of a reliable assessment of ecological area.
RESULTS

The primary and initial aim of this study was to develop a patient predictor based on the MMPI which would differentiate Terminators from Remainers. In addition, several other scales were employed as potential predictors. Finally, an empirical scale was to be derived, based on all 566 MMPI responses for the 58 Ss.

Traditional Scales of the MMPI

The analysis of variance for the 15 x 58 matrix of converted T scores does not yield a significant F. Inspection of Figures 1, 2, and 3 shows the marked similarity in mean profiles for both Remainers and Terminators. Table 4 presents mean T scores for each of the ten scales and respective code profiles for both sexes.

Certain investigators (Taulbee and Sisson, 1957; Taulbee, 1958) have followed the lead of Sullivan and Welsh (1952) who suggest some manner of objective configural analysis in dealing with MMPI scores. This approach emphasizes inter-scale comparison as opposed to intra-scale comparison and focuses on the overall profile configuration rather than absolute elevation. To this end, an overall configural analysis involving the relative scale point positions of Terminators versus Remainers was performed. No significant difference was found using Chi Square, \( \chi^2 = 7.12 \) with 6 degrees of freedom. Further analyses, in which Terminator high and low point pairs were compared to Remainer high and low point pairs, failed to indicate any systematic
# TABLE 4

MMPI T Scores

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<td>72.55</td>
<td>75.48</td>
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<td>9</td>
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<td>62.14</td>
<td>63.38</td>
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</tbody>
</table>

Males: 28 Males: 28

Females: 24 Females: 24

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<th>216-</th>
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<tr>
<td>AX</td>
<td>29.34</td>
<td>28.66</td>
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<tr>
<td>ES</td>
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<td>52.21</td>
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<tr>
<td>DY</td>
<td>59.59</td>
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* Raw score since T score conversion scores have never been published.
differences. Despite extensive analyses employing a variety of methods, it must be concluded that there is no valid method of distinguishing Terminators from Remainers via MMPI standard scales or configural analysis.

**Anxiety, Ego Strength, and Dependency Scales**

It will be recalled from the Introduction that Terminators have been characterized as being less anxious, possessing fewer ego strengths and being less dependent when compared to Remainers. Table 1 shows there are no significant differences between Terminators and Remainers on any of the three variables. In fact, even the hypothesized direction is opposite from that predicted. Terminators on the three variables are slightly more anxious, possess more ego strength, and are more dependent.

**Taulbee's Prognostic Index**

Only the MMPI segment of this index was used, and it must be pointed out that exclusion of the Rorschach prognostic signs is probably not a fair test of Taulbee's (1958) measure. Nevertheless, employing the weighting coefficients for the MMPI scales does not differentiate between Terminators and Remainers. The difference is in the predicted direction (Terminator Mean = 9.28 and Remainer Mean = 7.55), but this is not a statistically significant difference.

**Empirical Scale**

A Chi Square analysis of all 566 MMPI items for the 58 Ss provided eight items which statistically differentiated Terminators from
Remainers. (The eight items are presented in Appendix D.) This, of course, is only a very tentative scale and the need for cross-validation is obvious. It is perhaps interesting to speculate that on the basis of content, Terminators in this sample admit to family discord, are relatively more defensive, and would appear to use denial to a greater extent than do Remainers. However, an eight item scale, with inevitable problems of reliability, cannot generate much optimism.

Home Interviews

The reasons for discontinuing psychotherapy, as stated by the 29 Terminators on interview, can be ordered into four categories.

1. Patients who were frankly dissatisfied with the service.
2. Patients whose premature termination was determined, according to their account, by action independent of the therapy.
3. Patients who denied they had quit at all.
4. Patients who terminated for a variety of rather atypical reasons.

This classificatory system is somewhat arbitrary since the stated reasons for discontinuance actually covered a very wide range—all the way from a dislike of the therapist's personality to one woman who commented she was "too upset" for psychotherapy. In addition, a given patient tended to give a variety of explanations for discontinuance rather than one specific reason. Nevertheless, certain similarities do appear. It should be noted that in the illustrative cases which follow, no attempt is made to estimate the truthfulness or accuracy of the reasons stated for termination and, indeed, many people
appeared defensive about the interview. At the same time, certain pa-
tients seemed to welcome the opportunity to express their views.

(I) Seven patients stated they were dissatisfied with some fea-
ture of the services rendered. Several patients in this category com-
plained they did not get any direction or advice from the therapist and
felt they weren't getting anywhere. Some patients found the thera-
pist's personality to be disappointing -- he was cold, aloof, unfriend-
ly, disinterested, judgmental, or inactive. Generally, patients fall-
ing into this category presented criticisms of either the therapist or
his method of conducting treatment.

Case Illustration: Mrs. Grace Martin (S-1-T), a 31-year old housewife
came to the Center complaining of depression, nervousness, and irrita-
bility. She tended to focus most of her difficulties around a poor
sexual adjustment with her husband. After the usual social work in-
take, psychiatric evaluation and, in this case, psychological testing,
the staff recommended psychotherapy and she subsequently began indivi-
dual treatment with a psychiatrist (#1 in Appendix A). After five
sessions, the patient failed to return. Eleven months later she was
interviewed in her home and explained that she had failed to return
because of the therapist's personality. In her words,
I didn't like his personality. It was very blah. He didn't have any personality. I don't know if he was a psychiatrist. I suppose he was the closest thing to it. When I left I really felt worse than when I went in.

I couldn't talk to him. I didn't feel free to talk to him. I finally had to make up my mind that I could help myself. I still get periods of depression when I feel unloved.

And, also, he couldn't remember what I had told him before! A person needs to feel special. So it's good to know everything that you can about an individual if you're the doctor so the patient can feel special.

His opinions were different than mine. I argued with him quite severely. He was strong on telling me how I felt, but I didn't feel that way. It was like he was trying to change my way of thinking.

Oh, and another thing! He never said goodbye. He just kept watching the clock and then suddenly he would get up and leave and sometimes I would still be talking. He was a continual clock watcher and it was probably unconscious, I guess.

Case Illustration: Mrs. Beatrice Mason (S-13-T), a 27-year old mother of two, presented initial complaints of tension, anxiety, and apprehension. After the usual intake procedure, Mrs. Mason was accepted for treatment and was seen for her first therapy session by a psychiatric social worker (#6 in Appendix A). After two more therapy sessions she failed to return. During the home interview, seventeen months later, Mrs. Mason explained her premature termination primarily in terms of having received no advice, although she also commented on the therapist's qualifications.

The main reason is that it seemed that I was just reconfirming what I had already said. There were no suggestions. I would say, "Do you have any suggestions?" And he would say, "This is up to you. It's your problem."
The atmosphere when I went was like this: Quiet, very cold; you just sat there, I'd talk and then there would be silence. He'd be looking at you and I'd feel like a fool. I didn't know whether to talk or not. I guess I paid for what I got. It was very cheap. They weren't really professionals. They couldn't suggest or evaluate or anything. To me, the fellow I talked to seemed like a student -- a non-professional. I didn't know him. He was like a robot. There was something about it all that was very aloof and cold. It was just somebody there to sit and listen. It takes two to get something going. I could talk to a wall as far as that goes. There was just no effect on me. I really think some of those fellows are college students.

(II) Twelve patients stated they discontinued because of some action or event independent of the therapy. This category can be further delineated into four subdivisions. (a) Four patients who stated that they had worked things out by themselves, (b) Three patients who stated a new job had helped them get better, (c) Two patients who stated that a divorce had improved the situation, and (d) Three patients who maintained that a time/job conflict had prevented their continuing therapy.

Case Illustration (worked things out by self): Mrs. Vivian Rayburn (S-2-T) a 38-year old married mother of four, first came to the Center complaining of a "sense of futility" which dated back to three years ago. She was referred to the Center by a private clinic where she had been hospitalized for a week because she felt that she might commit suicide. After the usual intake evaluation, Mrs. Rayburn was seen by a psychiatrist (#1) for individual treatment, but after three sessions
she discontinued without further notice. Fourteen months later, Mrs. Rayburn was interviewed in her home and explained her reasons for stopping treatment.

I wanted an answer. I was looking for a magic way without getting a divorce. But then I finally realized I was in a box. But I was able to figure it out by myself. I will say this: If there was some way to tell the patients that all the yack does mean something, that would be a good thing. Through the yack, I came to realize I'd have to do something myself.

Luckily, Dr. ______ didn't show any sympathy. Somehow this made me face things! Before I went and during the time I was going, I felt the whole thing was worthless. Then I realized -- I faced the fact that I had failed in the marriage and I went in one direction. I went back to teaching, I went to my attorney, and I got a divorce. I became positive! I had been in a negative cloud.

Case Illustration (new job helped get better): Mrs. Donna Golding (S-28-T), a 49-year old married mother of a teen-age boy, came to the Center complaining of dizzy spells, blackouts, and depression. The staff recommended treatment, but before her first therapy session the patient came into the Center and requested the secretary to remove her name from the waiting list. Eighteen months later the interviewer had this to say about Mrs. Golding.

The patient states she was "satisfied" with the services received, adding quickly, "I got ahold of myself." Mrs. Golding goes on to explain that she got a job and this solved her problems. Therefore she notified us that she did not wish to be seen for her first treatment appointment. In her words, "I'm so worried about other people's problems now, I don't have time to worry about myself . . . I'm a jack-of-all-trades. I guess you could call me kind of a girl-Friday."

Mrs. Golding's primary reason then for discontinuing is that she simply got better. "I went to work. I wasn't around the house to worry about myself. It's good therapy to do that. Any psychologist will tell you that."
Case Illustration (divorce improved situation): Mrs. Catherine Ellis (S-12-T), a 29-year old woman with two children first came to the Center presenting symptoms of depression. She was characterized by the psychiatrist during intake as "well-motivated towards treatment." At the staffing conference it was noted that Mrs. Ellis "generally seems to desire" treatment. However, the patient failed to respond to her first therapy appointment letter and sixteen months later in her home she told the interviewer her reasons.

Mrs. Ellis explains that she came first to the Mental Health Center after her husband had a nervous breakdown and spent some time at Pima County Hospital. With a grin, she states that the Center told her to come back for treatment but she did not do so. Essentially, she feels that her personal problems were activated by a bad marital situation and once this was solved (that is, she obtained a divorce), everything was all right.

"I just felt it was strictly marital difficulties and once I got out of the marriage, I mean since my divorce, my personal problems have disappeared." Mrs. Ellis went briefly into some details of the marriage, explaining that her second husband drank continually and again reiterating that her difficulties were activated by this "unwise" marriage. Although Mrs. Ellis mentioned that she had had a previous breakdown some years ago, she feels that this time she was able to work things out on her own.

The patient states that she was satisfied with the services received and has had no psychiatric contact since leaving the Center.

Case Illustration (time/job conflict): Mrs. Heather Jones (S-4-T), a 36-year old divorced mother of three, came to the Center with an history of two suicidal attempts. The three staff members who interviewed the patient all found it difficult to ascertain her specific reasons for applying for treatment. Mrs. Jones did comment that she felt that she had problems of an emotional nature about which
something must be done. After her first therapy hour (with psychia-
trist #2) Mrs. Jones notified the Center that she was unable to contin-
ue because the hours of her job conflicted with therapy appointments.
Five months later, and without further word from Mrs. Jones, the case
was formally closed. Eleven months after her last contact with the
Center, Mrs. Jones was interviewed in her home.

The patient characterizes the services received as, "Fine, I
think." As if to anticipate the next question, she quickly
adds, "I didn't go back because of work. I couldn't get off the
necessary time. You see, I work from 8:30 to 5:00 and I
couldn't take the time off."

The patient goes on to explain that she previously had been
a switchboard operator and since this had changed, she now has
the time to make visits to the Center. However, after this
statement Mrs. Jones did not indicate that she plans to resume
treatment.

Returning to her basic reason for discontinuing, the patient
states, "It was the time element. I was really very anxious to
go regularly, but I couldn't."

The patient has had no formal psychiatric contact in the in-
terim although recently she took her son to a private clinic
because he wanted to run away from home. Here, she was not seen
by a psychiatrist but instead a social worker took the necessary
background information while her son was being seen by the psy-
chiatrist. However, the patient and her son never followed up
this contact because it was "too expensive."

(III) Four patients denied they had quit therapy at all, main-
taining either that the Center had referred them elsewhere or that the
Center had not offered any further appointments. A distortion on the
patient's part (as opposed to any genuine misunderstanding) is clearly suggested by closer examination of all four of these cases.

Case Illustration: Mr. Andy Kellog (S-9-T), a 40-year old man, first came to the Center along with his wife because of marital problems. During the evaluation he was described as a very passive and dependent individual who gave some indications of possessing latent homosexual traits. Individual psychotherapy was recommended and Mr. Kellog met with psychiatrist #3 for his first therapy session. However, after two more sessions the patient discontinued without any notification. The home interview was conducted six months later.

The patient states that he "volunteered" on his own rather than being referred by some agency and imagines that he read about the Center in the newspaper. He states that he was "quite satisfied" with the services offered and then went on to offer some information that was in direct contrast to that found in the clinical record.

For example, Mr. Kellog maintains that the therapist informed him that his problem was essentially one for marriage counseling and that his wife was the one who needed treatment. According to the record, the therapist explicitly told Mr. Kellog that since his wife had been the way she is for so many years, perhaps any changes which were to occur would be in him. Mr. Kellog's statement that he and the therapist "agree my wife was the problem and I could come back if I wanted to" is to be contrasted with the therapist's notes stating, "I suggested that if any change were to take place, that it seemed up to him to make the changes."

(IV) Six patients gave reasons for discontinuing which do not fit into any of the above categories. They included a young man who
missed several sessions and stated he was afraid the therapist would be angry, a woman who discontinued because the Center was unable to see her husband, a woman who simply stated she didn't have to go if she didn't want to, a young woman whose mother disapproved of her visits and, finally, the last case illustration.

Case Illustration: Mrs. Julia Higgins (S-29-T), a 53-year old widow, presented initial complaints of a loss of strength, inability to function, and depression. During the evaluation it was noted that Mrs. Higgins exhibited some degree of paranoid ideation. Treatment was recommended, but the patient failed to respond to her first therapy appointment. Twelve months later she was interviewed in her home.

Mrs. Higgins reports that she read about the Mental Health Center in the newspaper and at the time was "having trouble" and still is having trouble. She states that she was generally "satisfied" with the services and then goes on to list some of her dissatisfactions. The patient states that her chief "trouble was that I needed a job. I went for an evaluation and it developed that I was emotionally disturbed." Mrs. Higgins goes on to complain that in the first two interviews the "men were too young. I didn't think that their clinical methods would do me any good. They were too young. Later, an older man took my case. I was at the point where I needed some physical help for a job."

"I didn't feel that I could get myself across. I am at the end of my rope. I couldn't get myself together to go down. I'm like the mouse in a maze; for a minute I don't know which way to go.

"In my mental state, things happen to me. I'm a classic example of someone who doesn't tell their troubles. Now, nobody can understand me. It takes a long time to realize the basic reason you are where you are."
A Transition

We must conclude that for this particular sample of outpatients no patient predictor was discovered which distinguishes between Terminators and Remainers. An empirical scale based on the MMPI was derived, but cross-validation is imperative, and it is distressingly short of items. The null hypothesis cannot be rejected. There are no differences between the two "groups."

Instead of looking for patient predictors, we now turn our attention to the transaction between the patient and the therapist—and more specifically to the mutual expectations of the patient and the therapist.

Patient-Therapist Expectations

If we begin to examine in greater detail the specific expectations of the 58 patients in this study, a most interesting and very simple trend becomes readily apparent: Our Remainers voice expectations which are generally congruent with the expectations of the therapist, while our Terminators consistently exhibit expectations which are incongruent.

In the case illustrations which follow, an attempt will be made to demonstrate this hypothesis in a qualitative and admittedly post hoc fashion. Unfortunately, no quantitative measures were employed which might assess patient-therapist expectations, and so we
must rely primarily on the detailed records which exist for each patient. Clear-cut expectations for both patient and therapist could not be uncovered for all of the 58 cases involved. However, in no instance did a Terminator show expectations which were congruent with those of the therapist, and, similarly, there were no instances in which a Remainer exhibited expectations incongruent with those of the therapist. In addition, we do have the home interview data which, in some cases, clearly reveal the original expectations of the patient. In examining these cases, approximately four kinds of patient expectations were recognizable:

1. Unrealistic expectations
2. Expectations of advice
3. Expectations that "something be done" about the spouse
4. Expectations concerned with an answer to the question, "Am I mentally ill?"

In addition, a fifth category might be delineated relating to patients with vague or nonexistent expectations.

I. Unrealistic Expectations:

Among the kinds of expectations which patients bring to therapy are those which might be classified as unrealistic. These are expectations which are impossible to meet within the generally accepted paradigm of psychotherapy. Often the patient will continue to mention these unrealistic expectations during the evaluation procedure and even into the therapy itself. This is especially so for the Terminator. When the therapist fails to take note of these unrealistic expectations
and, moreover, expresses divergent expectations of his own to the pa-
tient, premature termination appears likely.

Case Illustration: Mrs. Grace Martin (S-1-T), who will be recalled
(p. 31) as the 31-year old housewife who said she discontinued because
she didn't like the therapist's personality, is illustrative of the pa-
tient with unrealistic expectations. A more detailed examination of
Mrs. Martin's presenting complaints reveals that in addition to focusing
her problems around a poor sexual adjustment, the patient stated
that she felt her husband was lacking in sexual drive. She charged
that her husband would go from 4 to 6 weeks without having intercourse
with her. At the time of the psychiatric evaluation, Mrs. Martin
stated of her husband:

He never wants to do anything; my husband tells me it's all
in my imagination, but I mark it on the calendar, and it's not
normal for me.

During the evaluation, Mrs. Martin also mentioned she wished
"someone would show" her husband "all the tricks," meaning of a sexual
variety. At another point, she commented with regard to the husband,

I think he should come down here; there is something very
much wrong with him sexually and a great many feelings bottled
up inside.

When asked how she felt the Center might be of help to her,
Mrs. Martin replied,

I really was hoping more that he'd come. If he would
straighten out sexually, everything would be all right.

*Additional data on this patient may be found in Tables 1 and
2 and Appendix C.
Psychological testing, recommended by the staff, indicated that she was an individual of average intelligence with no gross psychopathy. The psychologist described Mrs. Martin as a very narcissistic and immature individual who utilized denial and projection. A diagnosis of Passive-Aggressive personality, Passive-Aggressive type was suggested, with the possibility of decompensation into a schizophrenic reaction also being noted. For our purpose, it is most interesting to note the comment of the psychologist who administered the tests.

It appears that her entire thought process is tied up in the achievement (by fantasy) of a sexual Utopia which she expects to obtain through treatment by the Center.

Mrs. Martin was placed on the treatment waiting list for individual psychotherapy and after a period of three weeks was seen by a psychiatrist (#1) for her first therapy appointment. (Table 5 treats the Patient-Therapist Expectations in tabular form.)

With the orientation of "what is the patient expecting," one begins to see after two hours of intake interviews and several hours of psychological testing that Mrs. Martin somehow wanted the Center to improve her husband's sexual performance. In her very first therapy session, Mrs. Martin made her expectations even more explicit.

I've never had anyone to love me. I guess I want to love like I see in the movies and read in the books. Maybe it doesn't happen, but I want to.

The therapist described Mrs. Martin as a narcissistic character disorder who was harboring a great deal of rage toward parental figures whom she felt abandoned by as a child. The therapist saw her as utilizing any method possible to obtain narcissistic gratification for needs of which she was deprived as a child.
TABLE 5

MUTUAL EXPECTATIONS OF GRACE MARTIN AND THERAPIST

<table>
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<tr>
<th>GRACE MARTIN (S-L-T)</th>
<th>THERAPIST #1</th>
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| 1. "I just wish I could get over feeling that everyone is picking on me, everything is personal."

"I was hoping that he'd come," (i.e., the husband).

...patient sees the Center as...functioning to straighten out her husband sexually (e.g., "I wish someone would show my husband all the tricks."). (Evaluator)

It appears that her entire thought process is tied up in the achievement (by fantasy) of a sexual Utopia which she expects to obtain through treatment by the Center. (Evaluator)

2. In therapy: "I've never had anyone to love me. I guess I want to love like I see in the movies and read in the books. Maybe it doesn't happen but I want to." (1st Session)

1. Treatment will be largely supportive... (1st Session)

2. ...I mentioned that she would have to look at herself and her own feelings and examine them... (2nd Session)

3. The patient seemed to seek, in therapy, reassurance for her own domineering, castrating behavior as well as reassurance that she was not to blame for the tensions at home. The patient was disappointed and frightened when her demands to the therapist were not met and when it became necessary for her to look at her own feelings and her own motivation. (After premature termination.)

TOTAL SESSIONS: 5
In the second session, the therapist is quite explicit in delineating his expectations, and they are widely divergent from those of the patient.

I mentioned that she would have to look at herself and her own feelings and examine them.

Even more important than the unrealistic nature of the patient's expectations is the fact that the therapist expresses expectations which are clearly divergent. The patient wants "love like I see in the movies" and the therapist wants Mrs. Martin "to look at herself and her own feelings."

By way of comparison, we might now look at the matching Remain­er patient, a woman very similar to Mrs. Martin except for the crucial dimension of mutual expectations between the patient and her therapist.

**Case Illustration:** Mrs. Harriet Miles (S-L-R), also 31 years old, likewise related most of her problems to an unsatisfactory marital situation. When first seen, Mrs. Miles complained that she and her husband were just going through the motions of being married. She noted that initially there had been a great sexual attraction between herself and her husband, but that gradually this attraction had declined. Mrs. Miles described her husband as being weak, passive, and emotionally immature. So far, Mrs. Miles, in terms of her complaints as well as other demographic variables (see Tables 1 and 2 and Appendix C), seems very much like Mrs. Martin.

However, when we begin to examine in detail the mutual expectations (presented in Table 6), we find most important differences.
TABLE 6

MUTUAL EXPECTATIONS OF HARRIET MILES AND THERAPIST

<table>
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<tr>
<th>HARRIET MILES (S-1-R)</th>
<th>THERAPIST #1</th>
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<tr>
<td>...she would like to be efficient like her mother and kind-like her father... (Evaluator)</td>
<td>Therapy will be directed to shoring up her defenses... (1st Session)</td>
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<tr>
<td>...one of the concerns that she seeks to have resolved is whether she is unable to get along with her husband because of her experiences with her parents. (Evaluator)</td>
<td>I reassured her that psychotherapy was often uncomfortable... (3rd Session)</td>
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1. Mrs. Miles' expectations of the clinic were that she "might learn something of herself"...She feels that she is capable of "sublimating" herself to (her husband's) needs and will be able to do so with better self-understanding. (Evaluator)

2. The patient went on stating that she wanted to build her home in a different way. (1st Session)

She...stated she wanted to be a better person. (2nd Session)

...patient stated she wanted to feel better about her husband... (2nd Session)

1. I...pointed out to the patient that...her keen sense of observation would be helpful in observing herself. (1st Session)

...I explained that perhaps the fact that she was doing well out of the home especially in school and could be...independent was causing part of her anxiety. (3rd Session)

2. I...pointed out to her...that she had a choice as to what she wanted to do, whether she wanted to continue her relationship with this other man and thus expose herself to the risk of breaking up her marriage, whether she wanted to break up her marriage directly by getting divorced, or whether she wanted to preserve her marriage. She...replied that she wanted to preserve her marriage. I then suggested that if this was her wish, then she would have no alternative than to break up the relationship with this man. The patient seemed relieved and nodded in agreement. (4th Session)

TOTAL SESSIONS: 45 (Still in therapy)
During the evaluation we find Mrs. Miles stating that one of the concerns she seeks to have resolved is "whether she is unable to get along with her husband because of her experiences with her parents." An even more precise expectation, still during the evaluation, is expressed by Mrs. Miles when she states she expects to "learn something" of herself. Already, with respect to expectations, we see that Mrs. Miles possesses very explicit ones (and expectations which are generally in line with what is traditionally understood to take place in psychotherapy).

The staff recommended individual psychotherapy for Mrs. Miles, and after a waiting period of six weeks she was seen for her first therapy appointment (with the same psychiatrist as that of Mrs. Martin). In this first therapy session it was felt by the psychiatrist that the patient was defending against a severe underlying depression. His diagnosis was that of Depressive Reaction in an hysterical character disorder, and he noted that his therapy would be directed to shoring up her defenses in order to avoid a more severe type of depression. More important, however, the therapist expressed some expectations of his own which were directly complementary to those of the patient. At one point in the first session, the patient mentioned that she had a tendency, perhaps, to be too observant. The therapist replied that this keen sense of observation would be helpful in observing herself.

The patient earlier expressed her desire to learn something about herself. In the third therapy session, we find the therapist meeting this expectation by passing along to her a small bit of interpretation. The patient talks about how she never realized how stupid
her husband was until she started once again to continue her education. The patient mentions her mounting anxiety, plus the fact that she seems to be doing well in school. The therapist at the end of this third session notes:

I explained that perhaps the fact that she was doing well out of the home, especially in school, and could be independent was causing part of her anxiety.

The accuracy of this interpretation is probably irrelevant. What is important is that this explanation meets the expectation of the patient to learn something about herself. Similarly, at a point still early in the therapy, the patient expresses a number of expectations concerning her home and her husband. She states that she wants to build her home in a different way, to be a better person, and to feel better, somehow, about her husband. In this connection, the patient mentions her extra-marital affair. The patient wants to feel better about her husband and preserve her marriage, and the therapist clearly tells her what she can do about this by pointing out that if she wants to preserve her marriage there is no other alternative but to break off with the other man.

In looking at just these few beginning sessions, we see that the patient is seeking self-understanding, and the therapist wants to help her toward this goal via the patient's own observations of herself and his interpretations. In the case of Mrs. Martin, there is no such common meeting ground. Expectations are incongruent. However, with Mrs. Miles the therapy can progress, or at least contact can be maintained, since both participants have very similar expectations of what constitutes psychotherapy.
II. Expectations of Advice:

One of the more common patient expectations is that of receiving advice. This may take many forms but always includes the patient's expectations that advice, information, and suggestion will be forthcoming from the professional staff member. It usually involves the patient's assuming that once the staff member is informed of the patient's history and presenting complaints, some solution will be immediately offered. This is, of course, a very common conception; namely, one goes to get "treatment" which consists of being told what to do. This expectation often meets with frustration, especially when the patient comes into contact with a professional person who has even a moderate degree of non-directive proclivities.

Case Illustration: The case of Vivian Rayburn (S-2-T), whom we have already seen as a Terminator able to "work things out" by herself, illustrates the instance of a patient who, on closer examination, seems to expect a direct solution and explicit advice on what to do about her husband. It will be noted that this is not an especially unrealistic expectation, except for the fact that this patient wants the advice immediately and really does not care to involve herself in the therapy. Moreover, her expectations of receiving advice are quite clear and in marked contrast to the expectations of the therapist (See Table 7). Again, as we examine this case, we will devote all of our attention to isolating the mutual expectations of patient and therapist.

In her very first intake interview with the psychiatric social worker, Mrs. Rayburn expressed the general theme of her expectations
TABLE 7
MUTUAL EXPECTATIONS OF VIVIAN RAYBURN AND THERAPIST

VIVIAN RAYBURN (S-2-T)

1. "...one possibly ominous sign is her feeling..."there is no way out" and her concomitant challenge that, "Now that you have the facts, it is up to you to find me a solution." (Evaluator)

...the patient notes she feels better but doesn't know (and expects to be told) what would be best for her. (Evaluator)

When asked how she feels the Center might help her, Mrs. R. replies, "I don't honestly think you can unless you do something for my husband." When asked, "What?" she frankly confesses, "I don't know how you can restore self-confidence in a 43-year old baby. He's never taken his rightful place in society... (Evaluator)

She...complained that no one has given her any help and no advice. She then asked, "When do we start with treatment?" (1st Session)

2. She ...voiced her wishes to give up her marriage and then asked me whether I could give her any direction on this issue. (1st Session)

3. "I wanted an answer. I was looking for a magic way without getting a divorce." (Home Interview)

THERAPIST #1

1. I tried to have her express thoughts and feelings about herself and whether she had any problems. (1st Session)

2. I told her that the purpose of her coming here was not to receive advice, but that perhaps we could help her to understand herself better... (1st Session)

3. Therapy will be largely supportive, but also confrontation will have to be used and the patient given the feeling that she can handle her hostile feelings... (1st Session)

TOTAL SESSIONS: 3
which were to be reiterated throughout her evaluation and beginning therapy when she commented:

Now that you have the facts, it is up to you to find me a solution.

This expectation was echoed by the next interviewer who commented:

... the patient notes she feels better but doesn't know (and expects to be told) what would be best for her.

In her very first therapy session the patient complained that no one had given her any help and she had so far received no advice. She asked of the therapist, "When do we start with treatment?" The therapist was impressed with the patient's long-standing problem of rebellion against an authoritarian father. His attempts were directed to getting the patient to express how she felt about herself.

I tried to have her express thoughts and feelings about herself and whether she had any problems.

The patient in the first session is still looking for some advice. She voices her wishes to give up the marriage and asks the therapist whether he can give her any direction on this issue. The therapist reiterates his expectations that the patient will be reflective and think about herself.

I told her that the purpose of her coming here was not to receive advice, but that perhaps we could help her to understand herself better...

After three sessions Mrs. Rayburn discontinued. The home interview conducted fourteen months later is most revealing. The patient has divorced her husband and remarried. The patient appears to realise that her expectations were not those of the therapist. She states at the time of the home interview:

I was looking for an answer. I was looking for a magic way without getting a divorce.
Mrs. Rayburn wanted advice and counsel. Very early, she demanded that the Center provide her with a solution. She complained in her first therapy session that she was not getting advice. The therapist's expectations, on the other hand, were exactly opposite. He expected the patient to provide her own solutions, urging her to express feelings about herself. These expectations are clearly in conflict, and it is not surprising that the therapy never went beyond three sessions.

Case Illustration: By way of contrast, Mrs. Rose Jackson (S-2-R), a Remainer who stayed in therapy for a total of 37 sessions, expresses expectations which coincide with those of the therapist.

Mrs. Jackson, a 33-year old housewife, the mother of a 7-year old adopted son, came to the Center because of her desire to "learn more about myself" and "to find out why I do things." The latter proved to include why she had indulged in an extra-marital affair which, when discovered by the husband, had resulted in a constant source of quarrels and recriminations. The patient described feelings of shame and remorse over this affair and noted that she was finding it most difficult to adjust to the present situation with her husband. Mrs. Jackson was staffed with a diagnosis of Emotionally Unstable Personality. Her expectations (See Table 8) even during the evaluation are quite specific and generally in agreement with the traditional goals of psychotherapy. Moreover, the therapist (#1) repeatedly fulfills the patient's wish to "learn more about myself." He tells Mrs. Jackson such explicit things about herself as (a) she seems to be
<table>
<thead>
<tr>
<th>ROSE JACKSON (S-2-R)</th>
<th>THERAPIST #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. She gives the reasons for desiring psychiatric treatment as being her desire to &quot;learn more about myself&quot; and to &quot;find out why I do things.&quot; (Evaluator)</td>
<td>1. I commented that it seemed as if she was concerned mainly in confessing her sins as if in front of a priest or minister. (1st Session)</td>
</tr>
<tr>
<td></td>
<td>It is evident that this patient needs a great deal of support at the beginning of therapy...and later on she can be confronted with the tremendous hostility and gradually therapy will be led into the insight giving type. (1st Session)</td>
</tr>
<tr>
<td></td>
<td>I suggested that at this point she was struggling with her very intense mixed feelings for her father. (2nd Session)</td>
</tr>
<tr>
<td></td>
<td>I summarized the hour by making the statement that she could now see that her problem did not really begin with her unhappy traumatic experience with her father...but that actually it had its roots at the time of her conception or at least she felt that she had been rejected from that moment, that she was &quot;a mistake,&quot; and that on the one hand she got her way from her parents which she is unable to have with her husband but on the other hand she felt that she was never loved. (5th Session)</td>
</tr>
<tr>
<td>2. ...she is anxious to find out why she...engaged in...an affair and apparently is working for some means of alleviating some of her guilt. In addition, she would &quot;like to change&quot; in order that such a thing would never happen again. (Evaluator)</td>
<td>2. She asked self-reflectively what she was trying to do. She then answered her own question by stating that, &quot;I've proved that men can't be trusted.&quot; (6th Session)</td>
</tr>
<tr>
<td></td>
<td>After mentioning other incidents in which the husband needles her she made the observation that, &quot;That's how I get even, by having these affairs.&quot; (11th Session)</td>
</tr>
</tbody>
</table>

**TOTAL SESSIONS: 37**
"confessing," (b) she has mixed feelings about her father, (c) she feels rejected, (d) she would like to feel clean and independent, etc. Mrs. Jackson would also like insight into why she does things, particularly why she engaged in an illicit affair. The therapist expects to give the patient this insight and in sessions six and eleven we find that the therapy has arrived at this goal. Here, initial mutual expectations as well as what actually occurs in the therapy are virtually identical.

Case Illustration: Still another and even clearer example of the patient who expects advice, fails to get it, and discontinues therapy, is the case of Donald Rogers (S-3-T). Mr. Rogers, a 32-year old married machinist and the father of one child, was described by the staff as suffering from feelings of detachment, unreality, depersonalization, and withdrawal. He was diagnosed as Schizophrenic Reaction, Acute Undifferentiated Type and treatment was recommended. His expectations (See Table 9) of receiving some kind of an explanation or answer were voiced on several occasions. He expected to get an answer to (1) whether he needed psychiatric care, (2) if so, the severity of his illness, and (3) just what was wrong with him that he felt so ill. The therapist's (#2) comments, on the other hand, rather ominously suggest that no interpretive "uncovering" type explanations will be forthcoming. The home interview is especially helpful in this instance as Mr. Rogers clearly states that he went into therapy expecting an answer and didn't get any.
TABLE 9

MUTUAL EXPECTATIONS OF DONALD ROGERS AND THERAPIST

<table>
<thead>
<tr>
<th>DONALD ROGERS (S-3-T)</th>
<th>THERAPIST #2</th>
</tr>
</thead>
<tbody>
<tr>
<td>His initial complaint was that he wasn't sure what was bothering him but he was suffering with a lot of imaginational nonsense and &quot;I wonder if I need psychiatric care.&quot; (During evaluation)</td>
<td>1. Treatment...should not be uncovering but should aid the patient in his reality testing so that he can become more aware of how he alienates people. (1st Session)</td>
</tr>
<tr>
<td>1. He indicated that he was very concerned about his seizures of panic and was expecting to find some kind of answer from psychotherapy. (1st Session)</td>
<td>1.</td>
</tr>
<tr>
<td>He...questioned what I thought was wrong with him and wondered if I felt he was as ill as he felt. (2nd Session)</td>
<td>Treatment...should not be uncovering but should aid the patient in his reality testing so that he can become more aware of how he alienates people. (1st Session)</td>
</tr>
<tr>
<td>&quot;I found no reason or explanations...I got nothing from the therapist...&quot; (Home interview)</td>
<td></td>
</tr>
<tr>
<td>Returning to his reasons for discontinuing Mr. R. states that he supposes he went into this &quot;wanting an answer and I didn't get any answer...I went expecting an explanation or an answer and didn't get any.&quot; (Home interview)</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL SESSIONS: 5
Although this writer, for the present, is simply attempting to define the variables involved in premature termination, one additional comment cannot be resisted. For Mr. Rogers to have received definite answers to his questions may very well have had disastrous effects and been therapeutically unwise. However, it is suggested that for Mr. Rogers even to remain in therapy some attempt had to be made to deal with his expectations directly. This might simply have involved telling the patient that explanations would come later. There is no evidence to suggest Mr. Rogers expected the therapist to aid him in his reality testing so that he might "become more aware of how he alienates people."

Appendix E contains the expectations of four additional Terminators who were seeking advice and whose expectations were not met.

III. Expectations that "Something Be Done" about spouse:

From the case illustrations already presented it is clear that the expectations of the outpatients (in this sample) often involve changing the marital situation. However, our third category is devoted to a very specific kind of expectation — those individuals who expect the Mental Health Center to effect some kind of direct intervention into the unsatisfactory behavior or attitudes of a spouse.

Case Illustration: Mrs. Hilda Cummings (S-23-T), a 34-year old, twice-married mother of four children, first came to the Center with marital problems. She was seen by the staff as an extremely religious woman who had placed herself in a martyr's role by marrying sociopathic men.
who exploited, abused, and neglected her. She was diagnosed Psycho-
neurotic Reaction, Other, and psychotherapy of a supportive nature was
suggested. If, however, we look at Mrs. Cummings' expectations (See
Table 10), we see that she felt her husband really needed the treatment
and she had come only as a way of getting him into treatment. The
staff did finally see the husband but referred him elsewhere and offered
treatment to Mrs. Cummings. She refused any psychotherapy appointments,
commenting that she no longer "needed or desired" treatment. One year
later, at the time of the home interview, Mrs. Cummings maintained the
Center had referred both her and Mr. Cummings elsewhere and, moreover,
had failed to see the "seriousness of the problem"; (i.e., had failed
to meet her expectations).

They didn't spend enough time with him at the Center. His
problem is that he blames me for everything. Nothing is ever his fault. The Center didn't follow through long enough with him.

Focusing just on Mrs. Cummings' expectations we see that she
wanted the Center to intervene somehow and do something about her hus-
band's behavior. The offer of psychotherapy to this woman did not
meet her expectations and when this became obvious to her, Mrs. Cum-
mings decided she was no longer in need of treatment.

Case Illustration: Mrs. Zelda Erickson (S-24-T) illustrates the danger
of becoming pre-occupied with dynamics and intra-psychic phenomena to
the extent of missing some of the more mundane intentions and expecta-
tions of the patient. Mrs. Erickson, a 40-year, twice-married but
childless woman, impressed the staff initially as a passive, dependent
# TABLE 10

**MUTUAL EXPECTATIONS OF HILDA CUMMINGS AND EVALUATOR**

<table>
<thead>
<tr>
<th>HILDA CUMMINGS (S-23-T)</th>
<th>EVALUATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. She believes her husband should come in to treatment...she feels that the emphasis should be on (her husband)... (Evaluator)</td>
<td></td>
</tr>
<tr>
<td>She felt the only way to get her husband to the Center was to come herself. (Evaluator)</td>
<td></td>
</tr>
<tr>
<td>1. ...it is felt she will derive some benefit from psychotherapy — particularly of a supportive nature... (Evaluator)</td>
<td></td>
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**TOTAL SESSIONS: 0**
individual who "seemed to want to talk about her husband and his problems." A complete psychological evaluation was recommended due to a discrepancy between the clinical impression (Passive Dependent Personality) and the MMPI (Sociopathic Disorder). Isolating Mrs. Erickson's expectations (See Table 11) provides an interesting contrast. The patient repeatedly suggests she wants some help with her husband. The psychological evaluation completely ignores these requests and concentrates instead on the dynamics.

The patient was given the WAIS, Rorschach, and TAT and the test results indicated conflicts not atypical of a career woman torn between dependent and independent needs. There is a good deal of neurotic anxiety and tension and no evidence of psychosis or severe personality disorder.

A dynamic interpretation of Mrs. Erickson's problems and an offer of psychotherapy does not meet her expectation that something be done about her husband. The staff's expectations of treatment include providing support and perhaps some manner of interpretive statements. Mutual expectations are not in agreement and understandably enough, Mrs. Erickson never returns.

Case Illustration: The expectation that something be done about the spouse can be met by the therapist with positive results. A Remainder, Mrs. Sally Eagan (S-11-R), illustrates the patient whose expectations are initially congruent with those of the therapist, but whose expectations change during the course of therapy. When Mrs. Eagan's expectations change to include her husband, the therapist moves to meet them and the therapy continues (See Table 12).

Mrs. Eagan, a 39-year old married mother of a ten-year old daughter, wants to "talk herself out" and this matches exactly with
<table>
<thead>
<tr>
<th>ZELDA ERICKSON (S-24-T)</th>
<th>EVALUATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ...she wants to lay the foundation now for getting some help. Hopefully, she plans that her husband will also come into treatment.</td>
<td>(Evaluator)</td>
</tr>
<tr>
<td>Mrs. E. is going through intake hoping it will encourage him (husband) to apply also.</td>
<td>(Evaluator)</td>
</tr>
<tr>
<td>The patient's primary motive for coming here is to get her husband to come.</td>
<td>(Evaluator)</td>
</tr>
<tr>
<td>1. The patient responds positively to attention and appears to want help to move out of an unhappy marriage. She would probably benefit from individual psychotherapy, supportive at first, and then if indicated, on a more interpretive level.</td>
<td>(Psychological Evaluation)</td>
</tr>
</tbody>
</table>

TOTAL SESSIONS: 0
TABLE 12
MUTUAL EXPECTATIONS OF SALLY EAGAN AND THERAPIST

<table>
<thead>
<tr>
<th>SALLY EAGAN (S-11-R)</th>
<th>THERAPIST #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. She feels she is a very &quot;nervous&quot; person and that she should be getting some help for her nerves. (Evaluator) She says she comes to the Clinic to find out why everyone has tricked her all her life. (1st Session) She says she wants to &quot;talk herself out&quot; and get help to have a different kind of life. (3rd Session)</td>
<td>1. It seems that Mrs. E. would benefit from the opportunity for some ventilation, although it is not certain she is a good candidate for depth therapy. (Evaluator)</td>
</tr>
<tr>
<td>2. Most of this depression seems to concern her relationships with her husband... a few months ago, Mrs. E. says she seriously considered divorcing her husband as she told of having to carry all the load... She says that in addition to her husband resenting the fact that he has not been able to make it and be a big-shot, he also terribly resents being ill and can't limit his goals in a realistic manner. (16th Session)</td>
<td>2. During the course of our conversation, it became fairly obvious that what Mrs. E. was in need of was some help with her husband... I told Mrs. E... the best idea was that Mr. E. apply (here)... and that we would consider him then for such programs as chemotherapy and perhaps some of the day hospital programs. (16th Session)</td>
</tr>
</tbody>
</table>

TOTAL SESSIONS: 21
the staff recommendation of ventilative type psychotherapy. By the
16th session she begins to talk more of her husband and his pathology.
The therapist makes some very concrete suggestions and helps arrange
that "something be done" about Mr. Eagan. Early expectations of pa­
tient and therapist are mutual and when the patient voices new requests
the therapist meets them and the therapy continues.

Case Illustration: A final example of the patient who expects that
something be done about the spouse, has this expectation met, and con­
tinues therapy is the case of Mrs. Hortense Hickman (S-27-R). Her ex­
pectations (See Table 13) are elicited and met early in the therapy.
She expects to have her fears allayed regarding possible commitment
by the husband. The therapist continually gives her assurance this
will not happen and even writes a letter to this effect to her attorney.
At a later point in the therapy when the patient encounters difficulty
with her daughter, the patient expresses her concern over this treat­
ment and the therapist obliges by calling in the daughter.

IV. Am I Mentally Ill?:

Although a concern for one's emotional balance reoccurs through­
out the narrative of many patients, some individuals would appear to
focus solely on this question and, indeed, expect some answer as well.
When this expectation is not met, the patient may discontinue the
therapy.

Case Illustration: Mrs. Heddy Alton (S-11-T), a 41-year old, thrice­
marrried mother of a 5-year old girl, first came to the Center
### TABLE 13

**MUTUAL EXPECTATIONS OF HORTENSE HICKMAN AND THERAPIST**

<table>
<thead>
<tr>
<th>HORSENSE HICKMAN (S-27-R)</th>
<th>THERAPIST #12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In answer to my question as to what she wanted from this Clinic, Mrs. H. said that she would like a psychiatric evaluation to determine her sanity for purposes of preventing commitment, and to satisfy her own doubts about her mental equilibrium. (Evaluator)</td>
<td>1. She was assured that if her husband attempted to have her hospitalized, that the Clinic would support her in whatever way was possible. (1st Session)</td>
</tr>
<tr>
<td>2. It appears that her primary reasons for her coming to the Clinic centered around her fears that her husband will attempt to have her committed if she seeks a divorce from him, and she is seeking an armor of protection to avoid this happening. (Evaluator)</td>
<td>2. She was reassured...that it seemed most unlikely that commitment to the State Hospital would be effected. (1st Session)</td>
</tr>
<tr>
<td>3. She still expresses concern about the possibility of her husband's attempting to get her into the County Hospital ... (6th Session)</td>
<td>3. ...she was again reassured of the Clinic's support. (6th Session)</td>
</tr>
<tr>
<td></td>
<td>(Letter to patient's attorney)</td>
</tr>
<tr>
<td></td>
<td>It was apparent that Mrs. H. was not psychotic or in need of hospitalisation.</td>
</tr>
<tr>
<td>4. The daughter apparently accuses the patient of various things pointing out her weaknesses and making very uncomplimentary remarks to her and to the other children. (15th Session)</td>
<td>4. ...eventually it was decided that it might be worth trying to have the daughter in for an interview so that the situation might be laid directly to her. (15th Session)</td>
</tr>
</tbody>
</table>

**TOTAL SESSIONS: 24 (Still in therapy.)**
complaining of "nervous problems" which had affected her marriages and job adjustment. The history suggested she might have suffered transient psychotic episodes with hallucinations and confusion. On several occasions during the evaluation (See Table 14) she expressed expectations regarding an answer to whether or not she was mentally ill. At one point she frankly stated she had come to prove to herself she wasn't crazy. Just prior to discontinuing therapy, the patient reported a dream in which she saw a mad woman's face. Mrs. Alton reported to the therapist that this face was either her mother's face or her own, but she really didn't know which one.

Mrs. Alton's expectation is that someone will tell her whether she is crazy or not. The therapist's expectations involve giving the patient support, presumably so she might be able to achieve a more independent existence. Mrs. Alton's expectations are not met, although it is conceivable that had the patient been assured she was not crazy or even had the issue of her "craziness" received some focus, the therapy could have continued.
## TABLE 14

**MUTUAL EXPECTATIONS OF HEDDY ALTON AND THERAPIST**

<table>
<thead>
<tr>
<th>HEDDY ALTON (S-11-T)</th>
<th>THERAPIST #5</th>
</tr>
</thead>
</table>
| 1. The patient wanted to be told whether or not she should have come in view of the story that she related and impression she made. (Evaluator)  
...relating to her hospitalization...for a kidney disorder...the patient made up her mind...that the whole thing could have been of a psychosomatic nature and that in any event the amount of nervousness and anxiety she tolerated at the hospital was so unpleasant that she wanted...to get help with this. (Evaluator)  
"I decided to come in and find out about my nervousness to prove to myself that I'm not crazy like my brother says." (During evaluation) | 1. Mrs. A. seems to be looking for support. (1st Session) |
| 2. She expressed fear again of being "crazy"... (3rd Session) | 2. ...she has enough insight to say that she wants to become independent... (2nd Session) |

TOTAL SESSIONS: 8
RELEVANT RESEARCH IN EXPECTATIONS

The general area of expectancies covers a wide range of anticipations a given individual might possess about an equally wide variety of situations. For our purposes, the following discussion will be limited to research involving patient and therapist expectations with respect to psychotherapy and the relation of these expectations to treatment attrition.

Patient Expectations

George Kelly's (1955) theory of personal constructs considers in some detail the patient's perception of psychotherapy. Kelly is emphatic in pointing to the necessity of taking into account the patient's initial expectations, calling them "preconstructions."

The psychotherapist must, therefore, take the view that he starts with whatever limited conceptualization of psychotherapy the client is initially able to formulate. The evolution that is psychotherapy itself must first operate within this frame (p. 567).

Kelly goes on to list several types of preconstructions (or expectations in our language) which patients bring to therapy, such as (1) psychotherapy as an end in itself (one of the "good things" in life), (2) psychotherapy as the way to attain a "healthy" state of mind, (3) psychotherapy as a virtuous act, (4) psychotherapy as confirming one's illness, (5) psychotherapy as proof of the objective difficulty of one's circumstances, (6) psychotherapy as a clarification of issues (a relatively sophisticated expectation), (7) psychotherapy as offering
a place where already decided-upon life changes may take place, (8) psychotherapy as the ultimate state of passivity, (9) psychotherapy as a means of altering circumstances (an expectation that the therapist will change the unpleasant circumstances in which the patient finds himself). This last Kellian preconstruction would seem to parallel this writer's category of patients who expect that something will be done about the spouse. (See Mrs. Cummings, Mrs. Erickson, Mrs. Eagan, and Mrs. Hickman.) Kelly notes that these individuals expect the therapist "to tell them how to manipulate their circumstances without in any way changing their outlook," (p. 571). Kelly's real point, however, is that the therapist must deal with these expectations.

While it is not necessary for the client to share the clinician's construction of psychotherapy, it is important for the clinician, if he is to play a role in relation to the client, to make an effort to subsume the client's construction of psychotherapy . . . this does not mean that the clinician must adopt the client's construction of psychotherapy, but it does mean that he must be able to utilize it (p. 567).

Kelly concludes that the therapist may have to accept a wide variety of patient expectations as a point of departure and, we might add, if he fails to do so, premature termination is a likely possibility.

A distinction can be made between expectations patients have about the therapy and expectations patients have concerning the role of the therapist. In addition to listing expectations patients have about the therapy, Kelly (1955) goes on to cite initial conceptualizations patients possess regarding the therapist. The therapist may be cast in the role of parent, protector, absolver of guilt, authority figure, or prestige figure; he may be viewed as a possession, a
stabilizer, as a temporary respite, a threat, an ideal companion, a foil, or a representative of reality.

Apfelbaum (1958) has made a more systematic attempt to clarify these role dimensions. He employed a Q sort which represented a wide variety of transference attitudes. Immediately prior to the onset of psychotherapy and immediately after termination 100 university clinic outpatients were administered the Q sorts. A cluster analysis of responses indicated three independent dimensions of pre-therapy expectations concerning the role of the therapist.

(1) Nurturant. Patients with this kind of role expectation anticipated a giving, protective, and guiding therapist.

(2) Model. These patients expected a well-adjusted and diplomatic therapist who would be a permissive listener.

(3) Critic. In this group, patients expected a critical and analytical therapist who would want the patient to take a large part of the responsibility. The assumption is that the therapist would be businesslike and impersonal.

Patients who expected a Model type therapist proved to be least maladjusted as measured by the MMPI when compared to Nurturant and Critic cluster patients. Apfelbaum describes these Model cluster patients as,

... coming to the clinic for "self-improvement," apparently expecting this to take place in the presence of a tolerant, non-intrusive therapist. Unlike patients in the other two clusters, they did not present the therapist with lists of problems or symptoms, instead simply presenting themselves and their interest in a beneficent experience (p. 76).
Model cluster patients also had a lower drop-out rate (15% compared to 39% in the Nurturant group and 36% in the Critic group), but this difference was not significant. However, when total number of therapy hours are compared between groups, the Nurturant group patients were seen a significantly greater number of hours than were the other two groups. This may mean that although Model group patients tend to have low termination rates, the Nurturant group patients who do remain stay in for a longer period of time. The Q sort item most frequently checked by patients falling into the Nurturant group describes the prospective therapist as being "likely to give advice and guidance." This type of Nurturant therapist would seem to parallel the kinds of expectations exhibited by many of the Terminators in the author's study, especially those classified as "expecting advice." Apfelbaum concludes by acknowledging that his attempt has been to isolate basic dimensions of patient expectations rather than to identify the full spectrum of expectations.

Nevertheless, Goldstein (1962), in his recent book reviewing the entire area of patient-therapist expectations, points to the already existent data which tends to confirm the usefulness of Apfelbaum's three-fold classificatory system. He sees a patient sample presented by Erika Chance (1959), for example, as falling into the nurturant role expectancy category. Similarly, a study by Ruesch (1948) on expectations of ulcer patients regarding their doctor can be seen as yielding three clusters which closely parallel Apfelbaum's dimensions. Goldstein and Heller (1960), attempting to elaborate on Apfelbaum's study, have developed two inventories to measure patient and therapist expectations, respectively. Their results indicated that the two inventories
"measure polar and independent role expectations in a manner congruent with Apfelbaum's original cluster analysis," (Goldstein, 1960, p. 62). The inclusion of the expectations of the therapist is a relatively unusual feature of this latter study, since it is most often the expectations of the patient which receive concentrated attention. The hypothesis which we have presented all along is that the combined or mutual expectations of patient and therapist is the crucial variable related to treatment attrition. With this in mind, we turn to the few studies dealing with the expectations and goals of the therapist. A distinction needs to be made between goals and expectations. The therapist's expectations are usually limited to his goals for the patient. But the therapist also has a variety of expectations which go beyond just goals. These expectations (how much he will talk, how much the patient will talk, when and how interpretations will be offered the patient if at all, the use of medication, etc.) are usually neglected by investigators. The attempt to order expectations and goals for both patient and therapist will be postponed for later discussion.

**Therapist Expectations**

The treatment expectations or goals of the psychotherapist would seem to depend in large part on his theoretical orientation. Therapy goals range from those expressed in terms of reducing symptoms to goals involving an experience of growth or becoming. For example, a behavioristic type of goal might involve reducing a patient's anxiety via conditioning methods, while a Kellian goal with the same patient might be to help him realize there are alternative ways of
looking at his situation. Similarly, the existentialist's goal would be to help the patient experience his existence as real.

McNair and Lorr (1961) have made one of the few attempts to quantify the goals of the psychotherapist. They constructed a thirty-item Goal Statement Inventory and requested 259 therapists to report their specific treatment goals for 523 VA outpatients. An earlier study (Michaux and Lorr, 1961) had suggested that therapist goal statements could be classified as: (1) Reconstructive (change with insight), (2) Supportive (strengthening current adjustment), or (3) Relationship (adjustment through patient-therapist interaction). Factor analysis, however, failed to confirm the Relationship category, although the Reconstructive category was found to be a distinct, independent goal dimension. The Supportive goal was found to involve two separate factors — Stabilization and Situational Adjustment. In what way these three dimensions of therapist expectations might be correlated with Apfelbaum's three dimensions of patient expectations is not clear. The patient expecting the Critic type therapist probably matches with the Reconstructive type therapist goal, but the other two pairs of expectations are not so easily matched. The most plausible conclusion is that the total number of patient-therapist expectation dimensions is not yet known.

Mutual Expectations

The author has presented the tentative hypothesis that premature termination is a result of an incongruence between patient and
therapist expectations. There are a small number of studies in the literature which support this conclusion.

With an outpatient schizophrenic population Freedman et al. (1959) found that premature termination was related to the mutuality of patient-therapist expectations. When the relationship in the very first interview was consistent with the patient's expectations about treatment, the patient tended to remain. When the relationship was inconsistent with expectations, the patient tended to terminate. The authors distinguish two kinds of Terminators; those who terminate due to extinction and those who terminate by avoidance. Thus, the patient who comes with an awareness of some disturbance and meets with a constrained therapist does not have his expectations met and his interest is extinguished. The patient who denies his illness and is faced with a therapist who demands relationship and involvement likewise fails to have his expectations met and leaves the field. Although there are undoubtedly many more kinds of expectations which patients bring to treatment, the main point is that so-called therapist warmth or detachment by itself seems not to be the important variable but rather what the patient is expecting along this dimension. The authors conclude:

To avoid drop-out, the doctor must establish that type of relationship which is consistent with the patient's perception of treatment (p. 665).

Further evidence that mutuality of expectations is the crucial variable (rather than patient or therapist expectations considered separately) is provided by Goldstein (1960). Using a 48-item set of Q sorts drawn from the Mooney Problem Check list, Goldstein asked both
patients and therapists to order statements regarding the patient's present personality problems and the anticipated nature and intensity of problems upon the completion of therapy. No significant relationship was found between duration and patient expectation of improvement. A significant relationship was obtained, however, between combined patient and therapist expectations of improvement and duration of therapy. (A significant relationship was also found for therapist expectation and duration.) In his book Goldstein (1962) terms these mutual patient-therapist expectations "participant expectancies" and concludes the "evidence points to a relatively strong influence of participant expectancies on continuance in and duration of psychotherapy," (p. 82).

Lennard and Bernstein (1960) collected over 500 tape recorded sessions with the aim of describing the interaction of patient and therapist along the dimensions of communication and expectations. Although no formal attempt was made to relate expectational systems to treatment attrition, the authors did measure by content analysis the frequency of concern about goals and expectations. They found a consistent downward trend in frequency of concern as therapy progressed which dropped to less than one-half of the original amount by the fourth month of treatment. They point to the necessity of "socializing" the patient by informing him of what is expected in the therapy hour, and add,

To resolve the problem of what a patient may expect and what may be expected of him appears to be an indispensable requisite for maintaining the therapeutic system from one session to the next. We would guess that, without at least minimal resolution of this problem, continuation of the therapeutic process would become impossible, (pp. 69, 70).
The authors go on to state that high attrition rates in clinics with patients of low socioeconomic class may be related to a failure to instruct these patients as to what is expected.\footnote{The evidence pointing to higher attrition rates among people of lower socioeconomic class can be explained in terms of their possessing even greater misconceptions of psychotherapy than do middle or upper class patients (Overall and Aronson, 1963). Hence, the probability that mutual expectations will be incongruent is much greater.} Extensive analyses of the sessions for eight patients and four therapists in this study revealed that when patient-therapist expectations were dissimilar, manifestations of strain appeared in their interpersonal relations. Expectations were approached along dimensions of (1) Activity (who shall speak? how much?), (2) Selectivity (what will be talked about?), (3) Differentiation (at what point in time will certain communications take place?), and (4) Progress and duration of the therapy. Questionnaires relating to these dimensions were administered to both patient and therapist at various times before and during the treatment. All of the participants expected that the patient would do most of the talking, but patients tended to expect exclusion of more subject areas from discussion than did therapists. The authors suggest that when the patient's expectations are not met he becomes disappointed and frustrated.

If the patient expects to make rapid progress within a few sessions and does not learn that this expectation is unrealistic, he may become so discouraged that he will terminate treatment when the expected progress does not materialize... (p. 118).

Heine and Trosman (1960) have tested the hypothesis which most closely parallels that of the present author; namely,
patients and therapists may entertain expectations which are not complementary and, hence, are particularly disruptive in the early stages of a therapeutic relationship (p. 275).

They administered a questionnaire to 146 clinic outpatients which measured expectations along four dimensions: (1) Reasons for seeking psychiatric help, (2) Expectations regarding the kind of help they would receive, (3) How the help would be given, and (4) Degree of conviction that treatment would help. Dichotomous arrangements were then made for the four expectational areas. Reasons for seeking help were divided into (a) primarily somatic complaints and (b) primarily emotional complaints. Expectations regarding kind of help or means were divided into (a) passive cooperation with the therapist and (b) active collaboration with the therapist. How the help would be given was divided into (a) medicine or diagnostic information and (b) advice or help in changing behavior. Degree of conviction that treatment would help was divided into (a) moderate or great belief and (b) little or no belief.

A series of Chi-square analyses revealed that neither presenting complaint nor degree of conviction in the potential efficacy of treatment was related to continuance. However, expectations regarding the kind of help to be received (passive cooperation or active collaboration) were significantly related to continuance as were expectations regarding how the help would be given (medicine-diagnostic information or advice/help in changing behavior). More specifically,

The variable which appears to be significant for continuance is that of mutuality of expectation between patient and therapist (p. 278).
The authors found modal expectations of their therapists to be: (1) Patients should want a relationship in which they may talk freely, (2) the patients should see this relationship as instrumental in bringing about relief from discomfort, and (3) thus, the patient should see himself in some degree responsible for the outcome. The authors add,

Therapists also had well defined reservations in advance of meeting their patients. For example, they did not intend to give diagnostic information or drugs, nor did they intend to be led into an active, directive role if the patient adopted a passive attitude. Thus a situation is created in which a patient with one set of expectancies is rewarded with the therapist's interest and attention while a patient with another set of expectancies -- no less realistic in a medical setting -- is, in effect, rejected (p. 278).

Several criticisms of this study emerge. First, the expectations measured are too global. Specific expectations of single patients are not compared with the expectations of the corresponding therapist. The crucial variable is not the expectation of the patient but its degree of congruence with the corresponding expectation of the therapist. Thus, even grossly unrealistic patient expectations may not be disruptive if they are met or at least recognised by the therapist. All patients who expect drugs or plan to cooperate passively will not necessarily prematurely terminate because there are therapists who will either meet these expectations directly or, at the minimum, attempt to socialize the patient into other expectations, and when successful, thereby insure continuance. However, the full spectrum of patient expectations must first be known. As Heine and Trosman correctly conclude,
even experienced therapists may sometimes not take patients' initial expectations sufficiently into account in the crucial early hours of therapy, and thereby may "lose" the patient before a pattern of mutual collaboration can be firmly established. Thus, in training therapists, it is perhaps useful initially to direct attention to the variety of possible conceptions and expectations of therapy which patients may bring to initial hours... (p. 276).

Ordering the Expectations

From the studies just cited involving mutuality of expectations, it is clear that most investigators recognize the need to classify expectations. There must first exist, however, some orderly way of conceptualizing expectations before dimensions can be delineated. That is, there must first be some framework within which dimensions of expectations can then be clarified.

Social psychologists as well as anthropologists have provided such a foundation primarily in terms of defining the concepts of role, status and role, and role expectations. Linton (1936), for example, is usually given credit for the first elaboration of the concepts of status and role in studying social organization. Status is the name of a position occupied, (e.g.: lawyer, therapist, patient, etc.). Role refers to the activities or behavior associated with the status and any role consists of a series of rights and duties. The form of role behavior includes spatial arrangements, time relations, initiator of action, frequency of action, and the nature of verbal behavior. Linton (1945) repeatedly emphasized the importance of the reciprocal nature of status-role as involving mutual expectation. Sarbin (1954), in a similar vein, has defined role expectations as involving rights (e.g.: the child's right to be protected by mother) and obligations (mother's...
obligation to protect her child). Other investigators (Stein and Cloward, 1959; Sarbin and Jones, 1955) have also developed theories centered around role constructs as well as emphasized the importance of the mutuality of role expectations (Parsons and Shils, 1951; Chance, 1959; Goffman, 1959; Tharp, 1963).

Table 15 shows a beginning attempt to provide a framework of mutual expectations within the therapeutic setting. It will be noted that only pre-contact expectations are considered. Once the principal parties come into contact, it seems reasonable to assume that expectations change and the complexity of the issue becomes greatly compounded. The examples provided in Table 15 are limited and obviously do not include the vast multitude of patient and therapist expectations which might range from such a global expectation as "What effect will psychotherapy have on loved ones?" to a more specific expectation such as "What part will medication play in the treatment?" A distinction is also made between goals and expectations, with the latter serving as a more inclusive concept. This tentative framework hopefully provides a model within which the full range of expectations can be conceptualized.

**Dimensions of Expectations**

The dimensions of patient and therapist expectations refer to those clusters or parameters which might be derived after systematic investigation of the full range of expectations. Several suggested dimensions have already been cited: (a) Kelly's variety of preconstructions patients entertain about psychotherapy and patient expectations about the role of the therapist, (b) Apfelbaum's Nurturant, Model
<table>
<thead>
<tr>
<th>TABLE 15</th>
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</thead>
<tbody>
<tr>
<td>MUTUAL EXPECTATIONS FRAMEWORK</td>
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<table>
<thead>
<tr>
<th>PATIENT HAS</th>
<th>THERAPIST HAS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. EXPECTATIONS ABOUT PSYCHOTHERAPY.</strong></td>
<td><strong>1. EXPECTATIONS ABOUT PSYCHOTHERAPY</strong></td>
</tr>
<tr>
<td>Ex.: (a) &quot;Why am I coming to psychotherapy?&quot;</td>
<td>Ex.: (a) &quot;Why am I here with this patient?&quot;</td>
</tr>
<tr>
<td>(b) &quot;How can psychotherapy help me?&quot;</td>
<td>(b) &quot;How can psychotherapy help the patient?&quot;</td>
</tr>
<tr>
<td>(c) &quot;What will psychotherapy do for me?&quot; (Goals)</td>
<td>(c) &quot;What will psychotherapy do for the patient?&quot; (Goals)</td>
</tr>
</tbody>
</table>

| **2. EXPECTATIONS ABOUT HIS ROLE IN PSYCHOTHERAPY.** | **2. EXPECTATIONS ABOUT HIS ROLE IN PSYCHOTHERAPY.** |
| Ex.: (a) "How will I act?" | Ex.: (a) "How will I act?" |
| (b) "What will I do?" | (b) "What will I do?" |

| **3. EXPECTATIONS ABOUT THE THERAPIST AND THE THERAPIST'S ROLE IN PSYCHOTHERAPY.** | **3. EXPECTATIONS ABOUT THE PATIENT AND THE PATIENT'S ROLE IN PSYCHOTHERAPY.** |
| Ex.: (a) "What will the therapist be like?" | Ex.: (a) "What will the patient be like?" |
| (b) "How will he act?" | (b) "How will he act?" |
| (c) "What will he do?" | (c) "What will he do?" |
and Critic cluster types, (c) McNair and Lorr's Reconstructive, Situational Adjustment and Stabilization goals of therapists, (d) Lennard and Bernstein's dimensions of Activity, Selectivity, Differentiation, and Progress and Duration, and (e) Heine and Trosman's dimensions of Reasons, Aims, Means, and Strength. Only one study (McNair and Lorr) deals with therapist dimensions and only Lennard and Bernstein's classificatory system handles mutual expectations, while the remaining three studies deal solely with dimensions of patient expectations. 

Clearly, there is a need for dimensions which include both patient and therapist expectations as well as a more systematic investigation of the full range of expectations before any dimensions can be sensibly delineated. Finally, it is likely that expectations vary from population to population; thus, dimensions of expectations for outpatients are probably different than those of inpatients, and veterans' expectations are different than those of the patients in this study.

Methods of Measuring Expectations

A variety of ways have been employed to measure expectations including Q sorts (Goldstein, 1960; Apfelbaum, 1958), content analysis (Lennard and Bernstein, 1960), questionnaires (Heine and Trosman, 1960), inventories (Goldstein and Heller, 1960), open-ended questions (Michaux and Lorr, 1961), and factor analysis (McNair and Lorr, 1964). Again, most efforts have been directed to determining patient expectations with therapist expectations receiving little or no attention, but the

As does the author's attempt to quantify dimensions found in Appendix F.
relatively small amount of evidence available points to the importance of mutual expectations including those of the therapist. At this stage of the research it would seem imperative to first discover the full spectrum of patient and therapist expectations in various populations. To this end, open-ended questionnaires would seem the most appropriate approach as opposed to such "closed" methods as the Q sort.

Complexity of the Issue and Further Research

Most of our attention has been focused on initial, overt, or stated expectations. We have not even considered the area of possible unconscious expectations. The difficulty of demonstrating, much less measuring, their existence is obvious. It is the author's opinion that unconscious expectations do exist and are phenomena which eventually must be reckoned with. However, we would contend that initial, conscious patient-therapist expectations must first be investigated. Cultural influences, changing expectations, and population differences likewise all need further elaboration.

Nor has the area of role performance (or what actually happens in the therapy through time) been fully explored. Appendix C presents three cases illustrating the complexities involved in role performance. Generally, it appears that individuals with vague or unstated expectations may take on the expectations of the therapist and continue in therapy. (See the cases of Roger White and Wilmer Norton in Appendix C.) Conversely, the therapist may take on the expectations of the patient (especially when the patient's expectations are firmly held) and thus, since mutual expectations are congruent, the therapy can
continue (See the case of Felicia Drake in Appendix G). The next logical line of investigation is to determine the full range of patient and therapist expectations in a variety of populations and their changing nature through time. We also agree with Goldstein (1960) that further research should be aimed at greater specificity of expectation. When the full spectrum of specific expectations is known, extracting dimensions of expectations will be more meaningful. When this task is accomplished, more precise tests can be made regarding the influence of mutual expectations on attrition and the much broader area of treatment outcome.
CONCLUSIONS

1. The traditional scales of the MMPI fail to distinguish between Terminators and Remainers. Scales measuring anxiety, dependency, and ego strength similarly fail to differentiate the two groups.

2. No systematic differences are found between Terminators and Remainers on the variables of diagnosis, socioeconomic status, education, marital status, time spent waiting for treatment, or referral source.

3. Eight MMPI items significantly differentiate the two groups but such a scale must be regarded as highly tentative.

4. The notion that Terminators or Remainers can be identified by their respective personality attributes should probably be discarded.

5. The area of mutual patient-therapist expectations is offered as the crucial variable in treatment attrition. In this study, Terminators consistently voiced expectations which were incongruent with those of the therapist, while Remainers exhibited expectations generally congruent with those of the therapist. It is suggested that the mutual expectations of patient and therapist are too often neglected and probably have critical implications for all phases of the psychotherapeutic process.

6. A more extensive investigation of the full range of patient and therapist expectations is needed before meaningful dimensions of expectations can be delineated. Further research should also involve
role performance, changing expectations, expectations among differing populations, cultural influences, and unconscious expectations.
APPENDICES

Appendix A. Therapists' Theoretical Orientation

#1. This 36-year old psychiatrist sees himself as "basically Freudian" in theoretical orientation with "emphasis on the ego-psychology of Hartman and Kris as well as Anna Freud." He also places some reliance on the inter-personal formulations of Harry Stack Sullivan and the ideas of Freida Fromm-Reichman.

#2. This psychiatrist, age 30, characterises himself in theoretical orientation, simply as Freudian.

#3. A psychiatrist, age 29, states his "orientation is psychoanalytically based with Freudian emphasis." He adds that he is "influenced by the Meyerian holistic approach through Karl Menninger's Unitary Concept of Mental Illness." He concludes by noting that he tries to "understand a patient as an individual in his unique environment and take into account both conscious and unconscious factors."

#4. This 30-year old psychiatric social worker considers himself to be "eclectic," although he characterises his primary orientation as including the ideas of Freud, Rogers, and Erikson.

#5. A female staff member, a 26-year old psychiatric social worker describes her orientation as "largely analytical" but in a broad
sense. She does not consider herself to be orthodox Freudian nor does she identify with any particular neo-Freudian group. She characterizes her technique as "strictly eclectic."

#6. A 30-year old psychiatric social worker, this staff member depicts his orientation as "orthodox Rogerian."

#7. This psychologist, age 27, considers himself "eclectic" but emphasizes the ideas of Albert Ellis, Sullivan, and psychoanalytic views.

#8. A 25-year old psychology trainee notes that he is influenced by two major trends in psychological theory: (1) Psychoanalytic, "insofar as many of the concepts may be used as shorthand statements of more involved and far-reaching psychopathological dynamics," and (2) Humanistic, client-centered, holistic trends. "From these trends I take the real basis of my approach; the concern and respect for human individuality, and for the premise that a therapist must, in general, form a close relationship with the patient on the mutual basis of self-regard. Along with this, I have a deep concern for the relevance of social, familial, and cultural factors as regards the etiology and symptomatology of psychological disorders." In summary he describes his approach "as a holistic and eclectic one, influenced also by cultural anthropology and sociology."
#9. This 29-year old female psychology trainee describes herself as "problem oriented" rather than adhering to one theoretical position. She states that her "approach depends on the age of the person, type of problem, assets, and a realistic appraisal of the socioeconomic circumstances surrounding the individual." It is her feeling that "no one theoretical orientation can be used with all patients and in all phases of their treatment." If pressed she would describe herself as "an eclectic Regerian with a sprinkle of psychoanalytic theory, a dash of existentialism, and a strong belief in the importance of interpersonal theory."

#10. A 26-year old psychology trainee characterizes his position as existential-analytic oriented but with strong emphasis on the needs of the patient.

#11. This 37-year old psychiatric social worker considers himself to be "eclectic" but notes that his training was primarily Freudian in nature.

#12. The orientation of this 40-year old psychiatrist was unavailable.
Appendix B. Warner's (1949) Education Scale

1. Professional or graduate school

2. College education (1 to 4 years)

3. High school graduate

4. One to three years of high school

5. Grammar school graduate (finished 8th grade)

6. Four to seven years of school

7. Zero to three years of school
### Appendix C. Terminator and Remainer Diagnoses

<table>
<thead>
<tr>
<th>No.</th>
<th>S</th>
<th>Diagnosis</th>
</tr>
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<tbody>
<tr>
<td>1T</td>
<td>G.M.</td>
<td>Passive-Aggressive Personality, Passive-Aggressive Type.</td>
</tr>
<tr>
<td>2R</td>
<td>H.M.</td>
<td>Possible Cyclothymic Personality.</td>
</tr>
<tr>
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<td>V.R.</td>
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</tr>
<tr>
<td>2R</td>
<td>R.U.</td>
<td>Passive-Aggressive Personality, Passive-Aggressive Type.</td>
</tr>
<tr>
<td>3T</td>
<td>D.R.</td>
<td>Schizophrenic Reaction, Paranoid Type.</td>
</tr>
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<td>3R</td>
<td>U.R.</td>
<td>Passive-Aggressive Personality, Passive-Aggressive Type.</td>
</tr>
<tr>
<td>4T</td>
<td>H.J.</td>
<td>Sociopathic Personality, Anti-Social Type.</td>
</tr>
<tr>
<td>4R</td>
<td>K.J.</td>
<td>Anxiety Reaction with Depressive Features.</td>
</tr>
<tr>
<td>5T</td>
<td>F.J.</td>
<td>Depressive Reaction, Neurotic Type.</td>
</tr>
<tr>
<td>5R</td>
<td>Z.S.</td>
<td>Depressive Reaction, Neurotic Type.</td>
</tr>
<tr>
<td>6T</td>
<td>N.D.</td>
<td>Involutional Depressive Reaction.</td>
</tr>
<tr>
<td>6R</td>
<td>K.D.</td>
<td>Emotionally Unstable Personality.</td>
</tr>
<tr>
<td>7T</td>
<td>P.D.</td>
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</tr>
<tr>
<td>7R</td>
<td>M.W.</td>
<td>Schizophrenic Reaction, Chronic Undifferentiated Type.</td>
</tr>
<tr>
<td>8T</td>
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<tr>
<td>8R</td>
<td>W.N.</td>
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</tr>
<tr>
<td>9T</td>
<td>A.K.</td>
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</tr>
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<td>9R</td>
<td>R.C.</td>
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<td>G.C.</td>
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</tr>
<tr>
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<td>C.C.</td>
<td>Psychoneurosis, Other.</td>
</tr>
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<td>11T</td>
<td>H.A.</td>
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</tr>
<tr>
<td>11R</td>
<td>S.E.</td>
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<tr>
<td>12T</td>
<td>J.D.</td>
<td>Schizoid Personality.</td>
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<tr>
<td>12R</td>
<td>R.W.</td>
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</tr>
<tr>
<td>13T</td>
<td>R.M.</td>
<td>Schizophrenic Reaction, Chronic Undifferentiated Type.</td>
</tr>
<tr>
<td>13R</td>
<td>F.D.</td>
<td>Conversion Reaction with Hysterical Deafness, Fainting.</td>
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<td>B.T.</td>
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</tr>
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<td>15R</td>
<td>M.V.</td>
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<td>R</td>
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<td>18T</td>
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<td>18R</td>
<td>C.J.</td>
<td>Sociopathic Personality, Anti-Social Type.</td>
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<td>29R</td>
<td>K.R.</td>
<td>Depressive Reaction.</td>
</tr>
</tbody>
</table>
Appendix D. Treatment Attrition Scale (8 items)

216 (T) There is very little love and companionship in my family as compared to other homes.

293 (F) Someone has been trying to influence my mind.

298 (T) If several people find themselves in trouble, the best thing for them to do is to agree upon a story and stick to it.

314 (F) Once in a while I think of things too bad to talk about.

411 (F) It makes me feel like a failure when I hear of the success of someone I know well.

522 (F) I have no fear of spiders.

527 (F) The members of my family and my close relatives get along quite well.

545 (F) Sometimes I have the same dream over and over.

*Significant at the .01 level. All other items are significant at the .05 level.
Appendix E. Mutual Expectations of Four Terminators Expecting Advice and Their Therapists

BEATRICE MASON (S-13-T)

1. The patient is seeking help for what she described as "stage fright." (Evaluator)

She hoped that therapy will enable her to have enough self-confidence to undertake something significant other than getting a job. Her concern was more with improving her self-image than it was to move to some particular end. (Evaluator)

2. Mrs. M. Feels that with the kind of problems she had she "needed more suggestion rather than re-verifying." (Home Interview)

"There were no suggestions. I would say, 'Do you have any suggestions?' And he would say, 'This is up to you. It's your problem.'" (Home Interview)

THERAPIST #6

1. I told her...that I did not know what kind of a life she was forced to adjust (to) or what kind of problems she was trying to cope with (and) that I felt it rather foolish to try to judge another person without being able to really know their situation from their own unique point of view. (1st Session)

2. The patient states...she was feeling some hostility toward the problems in general that she was having and also felt some towards me because of my passive attitude and reluctance to advise her or recommend any type of behavior...(3rd Session)

TOTAL SESSIONS: 3

SUMMARY

Mrs. Mason will be recalled (p. 32 in text) as the housewife presenting complaints of tension and anxiety who terminated after three sessions. The home interview clearly reveals her expectations and the therapist notes his own conflicting expectations. In fact, these incongruent mutual expectations are even commented upon during the final session. The patient expected advice, counsel, and suggestion. The therapist explicitly told her he did not expect to be giving any recommendations. Here, mutual expectations are definitely at opposite poles.
DOROTHY NELSON (S-6-T)

1. "I could have clawed his eyes out he made me so mad just sitting there... I thought they would counsel me or give me advice." (Home Interview)

2. ...Mrs. N. feels we should "do more counseling in talking to the patient instead of sitting there." (Home Interview)

TOTAL SESSIONS: 2

SUMMARY

This is a 59-year old twice-married woman who presented complaints of nervousness and depression. She had been married 24 years to her second husband and had a 17-year old adopted son who was the result of one of the husband's numerous extra-marital affairs. Mrs. Nelson described a variety of physical ailments accompanying her depression and was diagnosed Involutional Depressive Reaction. Treatment was recommended but after two individual sessions of psychotherapy, Mrs. Nelson failed to return.

The home interview reveals that Mrs. Nelson's expectations of advice were frustrated. The interviewer described Mrs. Nelson as a "very friendly, exceedingly hypochondrical and noticeably rural" lady who complained that she didn't know what to talk about during her
therapy sessions and received no guidance along these lines. At one point in the home interview she commented:

Either him or me was crazy! It just made me more nervous him staring at me...I vomited when I came home and I vomited before I went! I would have been in a nuthouse proper if I had kept going.

Clearly, Mrs. Nelson wanted to be given specific suggestions and when the therapist failed to meet this expectation, she became angry, upset, and finally discontinued the therapy.

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**ROBIN EMERSON (S-6-T)**

1. She feels that at this point she has to do something about her own situation and what she calls her "nerves." (Evaluator)

2. ...the patient went on to give further reasons for her discontinuing, including stating she "thought after I told my problems they would give me suggestions or tell me the reasons I was feeling so bad." (Home Interview)

**THERAPIST #3**

1. ...the patient should be offered treatment aimed at relieving the more recent symptoms of depression and anxiety... (Evaluator)

**TOTAL SESSIONS: 1**

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**SUMMARY**

The expectations for this 25-year old married housewife are sparse, but from the home interview it is obvious that she anticipated advice. It appears that when Mrs. Emerson stated she had "to do something" what she intended was to come to the Center, unburden her soul,
and get the recommendations. Her expectations were not met nor apparently even discussed.

FRANK JORDAN (8-5-7)  

Mr. J. seemed motivated to explore his psychological difficulties hoping that he could feel less depressed and less likely to react violently when things within the family situation annoy him. (Evaluator)

1. Mr. J. seemed to want some kind of statement as to whether he was mentally ill and if so, what he might do about it. (Home Interview)

"There was no information, no suggestion. I found out nothing about what I thought I should find out... I wanted to know what was wrong and what could be done." (Home Interview)

1. Recommendation: Supportive psychotherapy. (Evaluator)

TOTAL SESSIONS: 1

SUMMARY

Mr. Jordan, a 42-year old married father of three boys, came to the Center seeking help for control over his temper, his intolerance of his wife and children, and his occasional thoughts of suicide. He remained in therapy for only one session, and the home interview reveals that he felt his expectations of advice and suggestion were not met.
Appendix F. Dimensions of Patient Expectations and Scales

The following rating scales are intended to provide a quantitative method for measuring patient expectations. There are four scales representing the dimensions of (1) Degree of formulation (clarity of expectations), (2) Degree of appropriateness (realism of expectations), (3) Strength of expectations (to what degree the patient expects to gain benefit), and (4) Number of expectations (the quantity of expectations expressed). In their present form, the respective scales should not be regarded as continua but as classificatory systems. They are intended to be filled out by the interviewer following an evaluation session. The author has used these scales with a limited number of patients and conducted "Expectation Interviews," (see an example of such an interview below). Using such a classificatory system, it would be possible to relate level of expectations to treatment attrition, outcome, etc. in a relatively quantitative fashion.
I - Degree of Formulation (Clarity):

Level 1 - (NON-EXISTENT)
Ex.: There were often pauses during which she asked, "What do you want of me?"

Level 2 - (POORLY FORMULATED)
Ex.: She stated her reason for coming to the clinic was the fact that she has problems of an emotional nature about which something must be done (without further elaboration).

Level 3 - (SOMewhat FORMULATED BUT GENERALLY VAGUE)
Ex.: She feels that at this time she has to do something about her nerves (without further elaboration).

Level 4 - (CLEARLY FORMULATED BUT SPECIFIC EXPECTATIONS LACKING)
Ex.: Mrs. M.'s expectations of the clinic were that she might learn something of herself.

Level 5 - (CLEARLY AND HIGHLY FORMULATED)
Ex.: She is anxious to find out why she engaged in an affair.
II - Degree of Appropriateness (Realism):

Level 1 - (TOTALLY UNREALISTIC EXPECTATIONS)
Ex.: "I guess I want to love like I see in the movies and read in the books."

Level 2 - (UNREALISTIC EXPECTATIONS WHICH CANNOT OR WILL NOT BE MET)
Ex.: She voiced her wishes to give up her marriage and then asked me whether I could give her any direction on this issue. (when during evaluation or early in therapy).

Level 3 - (EXPECTATIONS WHICH MAY OR MAY NOT BE REALISTIC DEPENDENT ON OTHER FACTORS)
Ex.: Patient stated she wanted to feel better about her husband.
OR: "I was hoping my husband would come."

Level 4 - (RELATIVELY REALISTIC EXPECTATIONS)
Ex.: She gives the reasons for desiring psychiatric treatment as being her desire to "learn more about myself" and to "find out why I do things."

Level 5 - (EXPECTATIONS IN LINE WITH WHAT CAN BE PROVIDED)
Ex.: She says she wants to talk herself out and get help to have a different kind of life.
III - Strength of Expectations (Benefit):

Level 1 - (VERY DOUBTFUL OF RECEIVING ANY BENEFITS)
Ex.: She minimized the help she hoped to receive and rejected the possibility of intervention in her suicidal attempts.

Level 2 - (EXPRESSES SOME NEGATIVE FEELINGS ABOUT BEING HELPED)
Ex.: Patient commented that she had had this problem for a long time and wondered if we would be able to help her.

Level 3 - (UNDECIDED OR UNCOMMITTED)
Ex.: Patient was unsure if her problem merited psychiatric attention and wondered if her referral here was appropriate.

Level 4 - (HOPEFUL OF BENEFIT)
Ex.: Patient expressed the desire to be rid of her symptoms and felt that we might be able to help her.

Level 5 - (CONVINCED GREAT BENEFIT WILL RESULT FROM THERAPY)
Ex.: Patient indicated great relief at being accepted for treatment and noted she knew we would be able to help her.
IV - Number of Expectations (Quantity):

Level 1 - (NONE)
  Ex.: Patient stated she was unsure why her family doctor had sent her to the Center, and really has no idea of what the problem might be.

Level 2 - (ONLY ONE, AND POORLY ARTICULATED)
  Ex.: Mrs. C. thinks the Center might help her with her "nerves" but she cannot elaborate on this.

Level 3 - (ONLY ONE, BUT WELL ARTICULATED)
  Ex.: He describes in some detail his failure to perform sexually and wants help to overcome this problem.

Level 4 - (THREE TO FOUR EXPECTATIONS)
  Ex.: Mrs. R. states she expects to get help from the Center with regard to getting along better with her husband, on the job, and being able to sleep at night.

Level 5 - (FIVE OR MORE SPECIFIC EXPECTATIONS)
  Ex.: Patient has a variety of complaints which she feels we might help her with including irritability, depression, nervousness, temper outbursts, anxiety, and weight loss.
EXPECTATION INTERVIEW
Mrs. Betty Jansen

When asked how the Mental Health Center might be of service to her, the patient resorts to recalling what previous doctors have told her. "The doctors thought I had some kind of emotional block and psychiatric treatment might help." She recalls that in March of this year, she started on a medication program with Dr. ____ and he told her that since this was unsuccessful, the basis of her illness must be emotional. The patient reminds the interviewer, "Glands control emotional reactions." When pressed, she states that she hopes she can find out what is causing her panic attacks if, indeed, it is emotional. She herself does not know if it is emotional and is undecided due to the many contradictory opinions she has received from various doctors.

With regard to whether or not we can help her, she feels "half and half." She feels "hopeful" that she will get rid of her attacks but "experience or common sense tells me I won't." She expects that what we have to offer is the same thing that Dr. ____ did; mainly, to "get the patient to talk and the doctor asks leading questions so as to try and find out what is causing the trouble." The patient adds, "I can't say it would be of help, really, but I'd try."

More directly, the patient expects from us, in addition to medication, psychotherapy which involves "trying to dig out what's causing this." The patient adds that her reading of psychological texts have created the image in her mind of the human brain being sectioned off into the conscious and the unconscious, and she assumes that whatever
is bothering her is "subconscious" and psychotherapy would involve getting this subconscious material out to where she could observe it. Once this was accomplished, she might then begin to look at things differently and perhaps change some of her perspectives.

She would expect to accomplish through psychotherapy the achievement of a "normal life" including the usual family activities of shopping, going to a movie, a party, etc. She would not expect to be completely free from sickness, but she would like to "stop complaining about how I feel and go to bed at night without a sleeping pill."

Mrs. Jansen has no specific expectation of the kind of therapist she might work with, although she notes that she found Dr. ____ more satisfactory than Dr. ____ because of the former's personality and the questions he asked, which seemed "thought-provoking." She has no special expectations of how often she would like to come in and doesn't think she can expect to set a time limit on her therapy.

In summary, the clarity of the patient's expectations are generally vague, level three. The doctors have told her that there is a possibility of emotional factors but she is not quite sure if this is true or not. Once one gets past her vacillation over the etiology of her illness, Mrs. Jansen's expectations are relatively realistic, at level four. She would hope to uncover unconscious material so that she might perhaps change her perspective on certain things. Strength of expectations is quite low, at level one. She hopes she could get better, but her better sense tells her she will not get better. Quantity of expectations is at level three, really only one -- that she get over her attacks and it is well articulated.
Appendix G. Role Performances

ROGER WHITE (S-12-R)  THERAPIST #6

The patient began the interview by announcing, "I need help." (During evaluation)

When asked how he felt the Center could help him, Mr. W. replied:
"I don't know. I want help. I don't like this constant fear and about writing the checks. I want to tell the truth. I want to lead a normal life." (During evaluation)

1. The patient...feels that there is some key or secret to his difficulties and feels that through therapy we will magically find this key and all will be well. (1st Session)

1. I told him that I could not advise him because I honestly ... did not know the best action for him. (1st Session)

I felt that the best way I could be of help would be by exploring the situation with him and helping him come to his own solution to these various difficulties. (1st Session)

I communicated to him that it was his responsibility and his choice... (4th Session)

He did mention the fact that his mother and wife have commented on the very dramatic and sudden change in his behavior, even in his mannerism, speech and dress. He...states that I have done a great deal to help him. I replied that as far as I was concerned I had done very little except enable the patient to explore his own situation and decide what, if anything, he wanted to do relative to that situation. (6th Session)
Appendix G—Continued

He... made the point that he was not sure what he really wanted. (7th Session)

"I know that you can't give me advice and direction that this stuff has to come from me, but I get pretty impatient and I just have doubts sometimes about whether I will be capable of thinking these things out." (17th Session)

... one of the major reasons for his decision to leave (the job) was the fact that through therapy he had increasingly discovered... he was bringing home much hostility and frustration and was taking this out on his family. (25th Session)

TOTAL SESSIONS: 31

SUMMARY

This case is illustrative of the instance of a patient adopting the expectations of the therapist. Mr. W., a 25-year old married father of four children, came initially to the Center with few concrete expectations except to receive some kind of "help." The therapist is most explicit in outlining what he expects from the patient. He tells Mr. W. that he will receive no advice but instead will be expected to make his own decisions and find solutions for himself. And by the 17th session, the patient's expectations are indeed more in line with those of the therapist. Later in the therapy he comes to his own decision
regarding a change in jobs. In this case, Mr. W.'s expectations were fluid enough (if not simply non-existent) to enable him to adopt the clearly stated expectations of the therapist.

WILMA NORTON (S-8-R)  

1. "I'm sure they feel there's no hope for our marriage so they sent me down here."  
(During evaluation)

2. As the patient came into the room, she brought with her a daily schedule.  
(5th Session)

3. She said that she had been trying to think about what her problem was.  
(3rd Session)

4. The patient again mentioned concern about being changed by therapy. She apparently does not want to become aggressive and outgoing because she finds these characteristics distaste-ful in her husband's family and in her younger daughter. She does wish to gain confidence.  
(2nd Session)

She again brought up her concern about changing.  
(4th Session)

THERAPIST #3  

1. I encouraged the patient to express her own feelings...  
(1st Session)

2. I suggested that the patient write out a detailed daily diary of her activities and bring it in...  
(1st Session)

3. I tried to explore with her some of her feelings, and thoughts...and...how she must...learn to explore experiences in the therapy hours.  
(2nd Session)

4. I pointed out to her...that if she changed it would be after very careful examination and understanding and that she would change very specifically into something satisfying through her own efforts.  
(4th Session)
The patient spoke of her insecurity, of her feelings of worthlessness as a woman and stated that one reason that she didn't get along with her daughter was that she wanted a boy. (9th Session)

The patient then said that her feelings about herself seem very important (and) she wondered why she couldn't overcome her feelings. She spoke more about certain early feelings that she had which made her feel unwanted. She spoke about having the feeling that she broke up her mother's first marriage... (18th Session)

She went on to say that she remembers that she had just had an argument with her stepfather before she went out with her husband the first time she ever had sexual relations...The patient then states that she felt quite guilty, quite bad and said that the reason she guessed she submitted to sexual relations was that she thought she might as well go on and be completely bad. (18th Session)

The patient went on to say that she had this extreme hate toward her stepfather and wondered whether or not she didn't carry over this feeling toward all men. (21st Session)

I discussed with her the importance of first identifying feelings and then trying to understand how such feelings develop. (5th Session)

I pointed out to her that understanding of emotion more than intellectual understanding is required and that she would have to re-express some of the feelings and then decide whether or not they derive from rational situations. (6th Session)

TOTAL SESSIONS: 65 (Still in therapy)

SUMMARY
Mrs. N., a 26-year old mother of two children, illustrates another instance in which the patient's initial expectations are
unstated or vague. She doesn't really know what she wants. However, her expectations develop in accord with the therapist's expectations. He is most explicit in telling her what he expects and she goes along with him.

In the second session, for example, the therapist expects the patient to explore her feelings and experiences. The patient complies with this by the very next (third) session. Similarly, she complies with the therapist's expectation that she bring in her daily schedule.

Actually, the entire issue of patient-therapist expectations is a focal point. Mrs. N. wants to know what to do -- what to expect. She is concerned about the possibility of change. The therapist assures her on this expectation -- that she will change in the direction she wants. They are working in the area of mutual expectations.

Indeed, the therapist is unusually explicit in telling the patient what he expects. For this particular patient, it seems to provide guidelines. She strives to conform to his expectations of what to do in the therapy. As the therapy progresses, the therapist tells the patient he expects her to "re-examine" her feelings. She begins to do exactly this, reconstructing her feelings surrounding pre-marital sexual relations with the husband. The patient shapes her expectations to conform with those of the therapist.
FELICIA DRAKE (S-13-R)

1. The patient hopes that the Center will be able to find out "just why I feel depressed, then maybe I won't be so de­pressed." (Evaluator)

1. The therapist explained to the patient that one of the reasons he did not give her advice was because he did not know himself what she should do. The point was also made that if the patient was to receive any real and lasting benefits from therapy she would have to learn to independently make decisions and handle situations without looking to someone else for guidance. (7th Session)

"...patient...stated that she understood that I was somehow "making me see things." I told the patient that this was not exactly what was happen­ing; as far as I was concerned she was gaining clarity into her situation herself and that I was learning of it only after she chose to communicate it to me. (9th Session)

...she stated that when we began she was quite pessimistic especially when I seemed to have no professional recommendations or diagnostic material to present to her. She doubted whether I was competent to do this type of work but stated that as the therapy sessions began to develop, her ideas in this connection changed quite a bit. (10th Session)

Patient (stated) that I was much more effective in helping her than any other previous people she had contacted. She felt this was mainly because I kept quiet and let her explore her thoughts to a conclusion. Heretofore she
states that most people in a well-meaning manner have intervened trying to point out where her thinking was not logical or where she was unrealistically evaluating some environmental situation...Patient felt that this was what counseling really was and what they were supposed to do and therefore had no particular criticism at the time. She stated it was only after entering therapy here that she really realized there was a different way to approach her emotional problems. (10th Session)

2. She also worries that I will take her case too much to heart... (2nd Session)

2. (Patient calls threatening suicide.) Patient was told mainly that we could continue to involve ourselves therapeutically with the task of understanding her emotional reactions and modifying them. Patient talked for better than an hour over the telephone... (12th Session)

I told the patient that her narration had frightened me and that I was gravely concerned for her. (17th Session)

3. Patient told me that after talking with me on the telephone she went over to the couch and lay down. Some peculiar sensation in her back caused her to feel around and try to locate it. She described this as a little spot in her back that was particularly irritated. She did locate this spot and touched it and there were a variety of feelings and sensations that occurred and the patient at the height of these feelings lost consciousness and did not awaken again until about four hours later. When describing

3. Patient started out this hour by telling me how deeply grateful she was for my helping her. As she talked, it developed that the patient was really telling me how much she appreciated the fact that although we had dealt with very personal and intimate matters, I had not developed an unprofessional emotional attachment to her and I had more important ly made no sexual pass at her. (18th Session)
this situation to me, the patient leaned towards me and with one of her hands felt around between her shoulder blades and stated that she couldn't seem to find the spot in question. (5th Session)

...the patient made a very open sexual bid to me. In a fit of very hysterical crying and weeping, she sat very far forward on the edge of her chair and bent her head forward between her legs with her hair cascading over her head. Since we were sitting close together, her head was only inches away from my legs and it was obvious she was inviting physical gesture of support and sympathy on my part. (18th Session)

TOTAL SESSIONS: 31

SUMMARY

Mrs. Drake, a 31-year old married housewife, clearly stated early in her contacts with the Center that she wanted to find out why she underwent periods of depression. The therapist, on the other hand, clearly refused to provide such an explanation, although he did make it explicit that she must discover these answers for herself. The patient admits that her ideas (expectations) changed in this regard, suggesting that at one point it was beneficial for her to take the responsibility of deciding what to do. It is suggested that this patient changed her expectations to be more in line with those of the therapist as the therapy progressed. (10th Session)
One expectation — expressed by the patient as something she worried about — was overly involving the therapist in her problem. She worries that he "will take her case too much to heart." It is interesting to note that the therapist spent considerable extra time on this case (although quite aware of her sexual and demanding overtones to him), making many calls to the husband regarding patient's suicide attempts and spending on one occasion well over an hour on the telephone with the patient. (See also the therapist's "grave concern" for her.) She expected to get preferential treatment from a concerned therapist and actually did despite the therapist's attempts to avoid doing so! (When the patient's expectations are strong enough, one might conjecture, she will force them to mesh with what the therapist is doing by distortion or persistent, irresistible manipulation.)

Clinically, most prominent of this woman's expectations is to enter into sexual relationship with the therapist -- the history revealed that this had happened before with ministers and other men friends who had tried to help. And although she never received any direct encouragement from the therapist, he was constantly aware that he felt very attracted to the patient and even wondered, on one occasion, if he were being unfriendly and cold to her in order to be doubly sure these erotic feelings of his own did not intrude in the therapy. So, actually, her expectations were met. Much of the work of the therapy, as she expected, was played out in sexual terms. In this case, the patient got what she expected because her expectations were so strong that she forced the issue and kept the therapy laden with sexual material.
Although the patient changed her expectations of getting direct advice from the therapist, Mrs. D. forced the therapist to conform to her two other main expectations; namely, that he would become quite concerned about her as well as make some reply (even if a negative one) to her sexual invitations.
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