DETERMINANTS OF REMAINERS AND TERMINATORS
IN PSYCHOTHERAPY

(WITH SPECIAL REFERENCE TO CLIENT FACTORS)

by

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ABSTRACT

In the present investigation it was hypothesized that various client variables are determinants of Remainers and Terminators in psychotherapy i.e. distance travelled to the institute for treatment, financial burden, conflict with job timings, manifest anxiety level, attitude of the family, motivation level, referral source, socio-economic status, education level, and previous psychiatric experience.

In order to test these hypotheses a questionnaire was prepared and given to 11 student therapists of the Institute of Clinical Psychology, University of Karachi. 150 cases treated by these therapists were studied. Out of them 75 were REMAINERS and 75 were TERMINATORS. The various variables under study were assessed through the ratings obtained from their respective therapists.

Chi-Square test of Independence was applied to all the variables except for the variables of Financial Burden, on which the t-test was applied.

It was found that when the client is young, has a higher manifest anxiety level, the family acceptance is
present, is highly motivated, is sent by an authority figure, belongs to a higher socio-economic level, is highly educated, has previous psychiatric experience, and if the presenting symptoms are neurotic in nature, he/she is a REMAINDER in psychotherapy.

Whereas the clients who found psychotherapy as a financial burden, had to travel a greater distance for treatment and had a conflict with job timings, is a TERMINATOR in psychotherapy.
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CHAPTER I

INTRODUCTION

"Mental illness can be recognized in any society as persisting behaviour which is unnecessary or inappropriate in regard to environmental changes, which is ego-alien, felt beyond the person's control and possibly forced upon him/her by external agencies, which is repetitive, with needs for satisfaction unmet, which express incompatible strivings, which contributes to discomfort by a reduction of efficiency, contentment or relations with others, and which is disproportionately intense in reaction to an evoking stimulus." (Ross 1965)

Over the centuries, there has been a steady growth of scientific and medical concern with the nature and treatment of mental illness. Formerly the mentally ill were looked upon as sinful people possessed by demons, they are now considered as sick people, deserving of treatment and humane care. There has been a steady increase in the range of human problems which have come within the realm of the mental health. Overall, there has been a shifting of emphasis from psychological illness to psychological health. In part this reflects an optimistic attitude toward the
possibility of cure and in part reluctance to stigmatize the mentally ill.

Pakistani society being in a state of transition and subject to the stresses and strains typical of developing countries is witnessing an increasing incidence of mental illness. The need is more urgent than ever for identifying and implementing psychotherapeutic techniques and interventions that are uniquely suited to the Pakistani personality and Pakistani cultural conditions. Culture can affect the phenomenon of mental disorder in a variety of ways, and also several aspects of psychopathology. Culture can differ with respect to overall frequency of mental disorder, the range of psychopathological manifestations, the frequency of various psychological syndromes, the type and the content of symptoms. There are many factors which make Pakistani society different from other cultures. The most important among them are the Islamic ideology of Pakistan itself. Pakistan is predominantly an agricultural country. Hence Pakistani society is facing a conflict between its own agrarian culture and the culture imported from the west along with western technical tools and skills.

At present Pakistan has a fairly large industrial
complex, and an attempt is being made to pattern the economic and social life after Western industrial society. Thus the Pakistani society is undergoing change at a great speed due to industrialisation. Some changes are for the better, while others are for the worst. Another major source of major conflict appears when the basic Islamic concepts are threatened by the so-called progress in value systems by the influx of revolutionary ideas which are permeating the society due to the impact of the Western societies in Pakistan. People do not also feel happy about the way religious obligations are being overlooked. Due to the recent materialistic trends in the society, even in education there is only a craving for an academic qualification i.e. for a piece of paper which shows that they are academically qualified for better jobs and not for academic achievement itself. In social life there is indulgence in extravagance, physical pleasures and display of riches, and status is considered as a virtue by some.

Even the family system is undergoing a rapid change as a trend is growing rapidly in many households for status symbols, resulting in unnecessary stresses and strains in the family life and which leads to an unhealthy trend in society.
The experts in the mental health field i.e. psychologists and social workers generally have emphasized the role of socio-cultural factors as causes of mental disorders. In recent years there has been a definite trend in their minds to solve this problem. One of the many hypotheses concerning the relation between sociocultural change and mental disorders brings out the effects of the acculturation process on social disintegration, subcultural conflicts and a general state of frustration in society. There could be various other factors which could lead to stress e.g. like more liberalism. Conflict could also be created by the influence of Western ideologies which are creating a wide generation gap in our culture. In fact, some of the findings are disturbing, particularly because nothing much has been done in the recent past to tackle the problem in a serious and scientific manner so far. No scientific survey has been conducted so far at the nation wide level, although Ahmad, F.Z, (1971) mentions the relationship between mental illness and age, income level, neighbourhood, education and occupation in the city of Karachi, Pakistan. The main results show that there are definite associations between diagnostic categories and income level, neighbourhood, education and occupation. The
relationship between mental illness and age was not statistically significant. It was demonstrated that more psychotics came from the lower income level, lower neighbourhood areas and lower educational and occupational groups. More neurotics came from the higher income level, higher neighbourhood areas, higher educational and occupational groups. The prevalence of mental illness as a whole was found more in lower income levels, lower neighbourhood areas and lower occupations. This confirms the study of Hollingshead & Redlich, "Social class and Mental Illness" (1958) who demonstrated that a definite association exists between class position and being a psychiatric patient. At the same time there are basically two factors contributing to the increasing number of mentally disturbed people in Pakistan:

(1) The scarcity of qualified people in dealing with the mentally ill, which causes the problem of increased number of mentally ill unattended.

(2) General mishandling of the treatment of those afflicted.

A third one could be the society's unawareness of the possibility of the treatment of mentally ill because most of the people feel that these are minor
Idiocracies and not serious mental aberrations and are therefore ignored.

Due to the influence of Western ideologies, which are creating a wide generation gap in our culture, a lot of conflicts are created. In the west, attitudes towards the mentally ill have changed, thanks to the tremendous progress made in psychology and psychotherapy in the last 50 years or so, where a recognition of psychological disorder as an illness requiring treatment like any other disease has led to a greater stress on the mental well being of the people. Here in Pakistan, this field of treatment has remained low on the list of our treatment priorities. Except for a few neurological wards attached to some major public hospitals, no specialized institution for treating mental diseases exists so far in Karachi. There are however, two or three mental hospitals in Pakistan.

It is true that financial constraints limit the efforts to create the necessary services and facilities but there is a very poor ratio of psychologists to a population of 10.5 million people.

So far the medical field had the monopoly over the treatment of all types of illness including mental
illness. It is well known that medicine alone cannot treat mental illness because the root cause of many mental illnesses is in fact psychological in nature. Hence the mode of treatment for such diseases has to be psychological. Ahmad, F.Z. (1968) conducted a research showing that there are various factors which are responsible for a relapse of the mental condition. These relapses may take place due to environmental stresses after treatment or may be attributed to some inherent factors in the patient himself, the type of treatment they received, and his/her attitude towards the treatment process. It was noted that the greatest number of relapses occurred in those who had been given Electroconvulsive Therapy (E.C.T.) only; next highest numbers of relapses occurred in those given E.C.T. and drugs and the least number of relapses occurred in those patients who were given psychotherapy alone. This is due to the fact that E.C.T. is only given for a short period of time, from about 10 to 20 at a time. Drugs are more effective because they can be given for longer periods of time, six months or even longer if required, besides this also gives some support to the patient who remains in continuous contact with the psychiatrist. Ahmad also showed that psychotherapy alone is the most effective technique, because through this the basic
cause is found and eradicated. Though lengthy, it is much more profitable in the long run.

Even today not only the uneducated but also the educated are going to faith healers and religious leaders for seeking help for psychological problems. Most of the people are in fact helped by the religious leaders and the faith healers because of the religiously which prevails in our country and because of the utmost faith which people have in God Almighty for giving them cure. They are being helped because they are getting supportive psychotherapy. Especially in cases where conflicts and mental illness emanates from misunderstandings and faulty interpretation of religion itself, reeducation itself makes them feel relieved.

So, unlike the time past when it was believed that such patients needed institutionalized care, latest treatment methods of psychotherapy are based on the principle that psychotherapy as a rule is more effective when the patient continues to live in familiar surroundings. The existing law which defines all mentally disturbed persons as lunatics must also be suitably amended to provide for a more enlightened and humane basis for the treatment and care of the mentally
afflicted. An effort is being made to bring about this change in the recent mental health policy.

The national health policies have supported the pioneer work which is being done by the Institute of Clinical Psychology, University of Karachi, in bringing relief to the mentally disturbed people. People sometimes have difficulty living in our society as a result of many factors. Some are the consequences of inadequate early upbringing. Some are a result of current factors, poor relationships in interpersonal situations, or a distorted view of the world. The patient seeks help in order to resolve his/her distress. A given patient may seek to define and utilize the therapy in any one of the variety of ways. He may search for unqualified sympathy and acceptance. He may seek factual understanding and objectivity to help him evaluate his thinking and behaviour. He may yearn for a co-operation and take relationship without domineering or being dominated. The person with emotional problems seeks help through psychotherapy in terms which are meaningful to himself.
THE NATURE OF PSYCHOTHERAPY

Many people have given different definitions of psychotherapy according to their own theoretical framework of psychotherapy, but the most concise and comprehensive definition has been provided by Wolberg (1954) by saying that "Psychotherapy is a form of treatment for problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient, with the object of removing, modifying or diminishing existing symptoms, alleviating disturbed patterns of behaviour and promoting positive personality growth and development."

Weiner (1975) defines psychotherapy as "An interpersonal process in which one person communicates to another that he understands him, respects him, and wants to be of help to him."

Garfield (1980) defines it as; "Psychotherapy appears to be largely a verbal interaction between two people, a therapist and a client, by means of which the former somehow attempts to help the latter overcome his difficulties. People discouraged with their lives, depressed about their inability to attain their goals,
experience anxiety about their frustration and deprivation. One aim in psychotherapy might be to help such people, see their assets and liabilities realistically. To learn to cope with their frustrations and deprivations in a non-damaging manner might be a next step. Some people feel handicapped in trying to live their lives as they would want to. They seem unable to control their own lives, and to be constantly running into blocks that they say prevent enjoyment and satisfaction. Another goal in psychotherapy might be to help such people "actualize" or live to the fullest extent of their assets. Complete actualization is seldom achieved, but the closer a person comes to this goal, the more is attained out of living. Psychotherapy then may be seen as a method to aid individuals in recognizing potential, learning how to utilize this potential, and remaining or reducing handicaps or blocks. Still another goal might be to modify or alter behaviours that interfere with one's ability to function adequately on a day to day basis. They might be overt actions, feelings, or a way of looking at the world and other people. Whatever the behaviour is, wherever it has developed, the therapeutic goal might be to aid the individual to modify or remove symptoms and behaviour
that make it difficult to live satisfactorily and happily. Psychotherapy is directed at maximizing the person's capabilities to the fullest extent possible, bearing in mind the person's capabilities and the reality of the particular situation.

The aim of psychotherapy is to help individuals to improve their ability to live in society, and to help them to set attainable goals, to enjoy these goals, and to recognize when these are not possible to attain and also to be able to live with the fact that the goals may be beyond one's ability or to accept that the achievement of these goals is prevented by the reality of the situation and/or society. Luckily in our country, the sociological factors are such that the families and relatives of the patient, readily accept him/her in the family. The teachings and tenets of Islam, the official religion of our country further facilitates the acceptance of the patients by their families.

Another important purpose of psychotherapy would be to aid individuals in reducing or eliminating anxiety, and to cope with stress and the effects of stress. The stress and anxieties may be long standing or a result of current situations. The effects may
include emotional difficulties and/or physical symptoms that result in interference with body functioning. Whatever the history of the anxieties and/or stress, and whatever their current indications, psychotherapy is a process whereby a person, individually or in a group is helped through the interaction with a psychotherapist to reduce the anxiety and its effect to the extent possible. This can only be possible if the patient and his family is receptive and co-operative in the psychotherapeutic process.

Psychoanalytic theory, along with sociological theories have pointed to the family as one of the vital factors in the etiology of mental illness. Speigel and Bell (1959) have given a historical background related to the problem of the family as an etiological agent in mental illness. Ahmad, F.Z. (1968) concludes that there were more female psychotics, and parents of psychotics were closer together in age i.e. 1-5 yrs age difference that parents of neurotics who were farther apart in their age. Father's age at birth was less than 25 yrs most frequently for the psychotics and more than 25 years for the neurotic patients. More psychotics came from the eldest subjects than any other rank, and youngest siblings were in turn more neurotic. This study demonstrated that there was more psychopathology
in the families of psychotics than neurotic patients. Keeping all these problems in view, recently an institute of Clinical Psychology has been established in the University of Karachi in accordance with the Directive of General Muhammad Zia-ul-Haq, President of Islamic Republic of Pakistan. His interest in Clinical Psychology helped the experts to give it a respectable place while formulating mental health policy in Pakistan.

The outcome of psychotherapy obviously depends to a significant extent on patient characteristics. From the moment the therapist meets a patient, they seek to define the nature of the problem in need of treatment or amelioration. They become diagnosticians who attempt to identify a malfunction or a "problem" in order to take appropriate therapeutic steps. This requires an understanding of the vast array of individual differences among patients and how to deal with them.

The vital fact long recognised by clinicians, is that patients differ on a host of dimensions —— from intelligence, education, social class and age, to such variables as psychological mindedness, motivation for therapy, organisation of defences, and rigidity of character. (Strupp, H.H. 1978)
in our country people are now becoming more and more aware of the fact that mental problems and illnesses can be treated by psychotherapy, but since there is a dearth of qualified clinicians, hence it has become imperative that we define and identify those individuals who can or cannot benefit from particular forms of therapy. With it has come to recognition that therapy must be tailored to the patient, his problem and his needs rather than the reverse (Goldstein & Stein, 1976).

CONTINUATION IN PSYCHOTHERAPY:

One interesting aspect of psychotherapy pertains to the kinds of people who voluntarily seek out, or are referred for psychotherapeutic treatment, and even are considered appropriate for psychotherapy. Such patients at times turn down this opportunity. This becomes a vital problem in the practice of a clinician. Generally, such termination appears to be initiated by the client before there has been a mutual agreement that therapy has been completed. This has been a great problem in the developed countries as well.

The problem of discontinuing psychotherapy without the advise of the therapist (premature
termination) is very vital especially in our country because of the fact that the technique of psychotherapy is in its infancy and one wants that more people benefit by this new technique. This can only be possible if we select our patients, keeping in mind the various factors which are effecting the early termination of the patient.

These dis-continuers, premature terminators or dropouts constitute a large percentage of those who begin psychotherapy and several studies have been carried out in the developed countries to evaluate this problem. To evaluate some of them, Haddock and Mensh (1957) in a study of two University student health services, and one VA Mental Hygiene Clinic, certain findings were secured for three separate headings. About two thirds of the patients were seen fewer than 5 hours, and only one patient in 20 was seen for more than 20 hours. Furthermore, more than one-half of the veterans and one-third of the students terminated treatment on their own without discussing it with the therapist. In another study of 400 clinic patients, 45% were seen for less than five interviews, with a majority simply discontinuing treatment (Gabby and Leavitt 1970). Certain other studies in three urban mental health centers have also revealed that 37% to
45% of adult outpatients terminate psychotherapy after the first or second session (Flester and Rudestam 1975).

Another report from an inner city mental health clinics that only 57% of the patients admitted to the clinic remained for 4 or more interviews. (Craig and Huffine 1976) Elduson (1968), in a review of this problem, also concluded that "30% to 65% of all patients are dropouts in facilities representing every kind of psychiatric service." Furthermore, on the basis of these evidences, it appears that those who terminate psychotherapy early, rarely go on to seek therapy elsewhere (Garfield, 1963; Ries and Brandt, 1965.)

In the developed countries counseling psychologists have demonstrated a renewed interest in the premature self termination of clients from counseling, and three recent studies (Betz and Shullman, 1979; Epperson 1981; Krauskopf Baumgarten and Mandracchia 1981) focussed on a specific subset of premature terminations at university counseling centers. This subset, early premature termination (EPTs) included clients who failed to return for scheduled counseling sessions after their initial
contact with the counseling center e.g. intake interview or initial counseling session when intake procedures were not used. The results of these studies indicated that 19% - 25% of the clients failed to return for their next scheduled counseling session after an initial contact with the counseling center. Although not eliminated as a possibility in any of the three studies, client improvement as an explanation of the reported rates of EPTs was seriously questioned on the basis of tangential, but relevant evidence, and because clients classified as EPT's had only the briefest of exposure to counseling (Betz and Shullman, 1979; Epperson 1981). Given this state of affairs the phenomenon of EPT's at University counseling centers certainly warrants further investigation.

In general, the results of the three recent investigations of EPT's at university counseling centers have been inconsistent. Few variables have been documented as affecting EPT's from counseling, and none has proven to be generalizable to other populations of clients and counselors. Many of the variables investigated in these studies done in developed countries have been demographic in nature. Counselor - gender, for example, has produced a statistically significant, but inconsistent and non-
generalizable effect on EPT's from counseling.

However, reasons for failure to return for counseling following an intake interview may differ from the factors influencing premature termination after several sessions with a regularly assigned counselor (Baekland and Lundwall, 1975; Kirk and Frank 1976). In addition to the possible relationship of client sex, counselor sex, and counselor experience level to return rate after intake, certain characteristics of the referral itself may influence the probability that clients will return.

On the basis of the above researches, it is apparent that contrary to traditional expectations concerning length of therapy, most clinic clients remain in therapy for only a few interviews. In practically all of the clinics studied in the developed countries, this pattern was viewed as a problem and was not the result of a deliberately planned brief therapy. Rather, in most instances, the patient failed to return for a scheduled appointment.

It can be stated with confidence, therefore that the findings of an unplanned and premature termination from psychotherapy on the part of many clients in traditional clinic settings in other countries has been
a reasonably reliable one. The apparent rejection of psychotherapy by a number of those who appear to be in need of it has been a somewhat surprising and perplexing finding.

It is a fact that mentally ill people are increasing due to the increase in stresses and strains in our culture. There is also a lack of qualified personnel to help and treat them. This situation has made it imperative to study the number of people who drop out from psychotherapy in order to give the maximum benefit to the most motivated and needy patients.

In the recent past we have started facilities to treat mentally ill but this will not help if patients do not take full advantage of it by starting psychotherapy and then continuing it till they are successfully terminated. Thus we need to identify those patients who will benefit most by continuing the treatment and also identifying those who will drop out by terminating the treatment unilaterally without the consent of the therapist.

This shows that, in addition to the patient variables, another important variable which needs to be studied, is the motivation of the patient and his
family involved in psychotherapy, which needs to be discussed at some length.

MOTIVATION FOR PSYCHOTHERAPY:

An example of a variable which is important is motivation of the patient for treatment. Motivation of a patient and his family is extremely important when change in behaviour is contemplated.

Motivation is a term commonly used by clinicians but it is not always clear what they mean by it. Often they are not as explicit as Minshull (1959) who worked with alcoholics and stipulated that the term include at least one of the following:

a) wanting to change beyond stopping drinking,

b) realising that one must take an active part in treatment, and

c) willingness to make sacrifices for the sake of treatment.

These are some of the conventional cannons of psychoanalytically oriented psychotherapy. The term "motivation" is often used in connection with positive accepting attitudes towards treatment and those who render it. In addition, a distinction should certainly
be made between "extrinsic motivation" (pressure from wife, boss, etc) which is what initially drives many patients into treatment, and "intrinsic motivation", a desire to get better for one's own sake, into which extrinsic motivation may be converted in the course of treatment. Finally, "motivation" in the above sense, and "motivation" as a personality trait in the sense of a general tendency to persevere in endeavors once they are undertaken, may be only distantly related.

The relative prognostic value of motivation in these various meanings of the word deserves to be investigated. While motivation has rightly been criticised as diffuse, poorly defined and partly circular concept in the developed countries (Holt, 1967; Pittman and Sterne 1965), it is clear that the strength of the patient's reasons for treatment, regardless of their source, influence whether he opts to stay in it. These may include his ability to endure frustration and from long range goals, his dissatisfaction with himself along with a need for change, the presence or absence of dysphoric symptoms, and a felt need for help on his part as opposed to that of a referring institution or agency.

Within the limits defined by leaving treatment with advice, having previously sought treatment is
correlated with dropping out since it is probably a measure of the patient's awareness of both his need for help and his desire for it.

Poor motivation or variables related to it have often been implicated in defection from treatment in the various research studies done in the developed countries. In fact 34 out of 41 studies (82.9%), surveyed, thought it important (Altman, Brown and Sletten 1972; Baekland et al. 1973; Caine et al. 1973; Drolet and Porter 1949; Frank et al. 1957; Goldfried 1969; Hellbrun 1973; Katkov 1958; Lake and Levinger 1960; Lewis et al. 1955; Mayer 1972; Mendelson and Geller 1967, E. Meyer et al. 1967; G.C. Meyer et al. 1967; Miller et al. 1968; Miller et al. 1970; Nagpaul et al. 1970; J. Newman and Sparer 1956; Perkins and Bloch 1971; Rickels 1968; Rickels and Anderson 1969; Ripple 1957; Ripple and Alexander 1956; Robinson et al. 1965; Rosenthal and Frank 1958; Ross and Lacey 1961; Shelton and Sparer 1956; Straker 1968; Weiss and Schale 1958; Wieland and Novack 1973; Williams and Johnston 1972; Williams and Pollack 1964; Zax 1962; Zax et al. 1961), whereas only 7 out of 41 studies (17.1%), cast dissenting votes, (Dodd 1971; Freedman et al. 1958; Garfield and Affleck 1963; Gerrein et al. 1973; Levitt 1958; Mayer et al. 1965; Sethna and Harrington 1971).
Several client factors were also effective predictors of dropping out in three-quarters or more of the available studies; drug-dependence, passive-aggressive personality, independence, low motivation, a lack of psychological mindedness, sociopathy and family system pathology. Finally client age, sex, social stability and socio-economic status were predictive in only about 50% of the relevant investigations done in the developed countries.
In some cases motivation was assessed in a global way, in others it was inferred by the authors or by Baekland and Lundwall in their article, "Dropping out of treatment," on the basis of the source of referral (institutional verses self); openly negative feelings about the form of treatment or the therapist attitudes of non-compliance and the like. In all these studies done there is a good deal of lack of conceptual clarity.

Motivation as a factor in our culture is very important because of the fact that we cannot afford to lose patients as there is a dearth of clinicians and abundance of patients in our country. It is better we give treatment to those patients who are motivated, both intrinsically and extrinsically, especially because we want to help the most needy patients. It will also help us in establishing the usefulness of psychotherapy in Pakistan.

It is true that there are various personality and other factors which are important on the side of the therapists which contribute to the termination of the clients. But in this research the author has just concentrated on the patient variables because it is difficult to study the therapist variables because of the dearth of therapists in our country.
CHAPTER II

PROBLEM

This study is undertaken in order to assess the determinants of Remainers and Terminators in Psychotherapy, in the Institute of Clinical Psychology, University of Karachi, (Karachi) Pakistan.

It is a well known fact that in every culture people are facing psychological problems due to stresses and strains in life. These stresses in turn cause psychological problems. Therefore mental illness needs to be treated by psychotherapy and not by medicines in order to eradicate the symptoms by removing their root causes. Psychotherapy is an interaction between the patient and the therapist. Therefore, the therapist variables are equally important in determining the premature termination of psychotherapy by the patient. Since an adequate number of therapists is not available therefore the study was restricted to the study of the patient variables only.

Pakistan is a developing country which is going through a transitional stage. Due to western influence we are beginning to recognize the importance of psychotherapy which is a scientific psychological way of treating psychological patients. Previously the only
treatment available was the use of psychotropic drugs for the treatment of psychological and emotional problems.

In the developed countries psychotherapy is an established mode of treatment for patients suffering from mental illness. But giving psychological help to our patients by means of psychotherapy has just started in our country. So it is imperative to find out what type of patients would be best suitable for psychotherapy and what factors could lead to premature termination.

Early termination (premature termination) is of practical interest since the patient has made an investment of time and some money, yet withdraws from the enterprise which they entered voluntarily.

This study is especially undertaken to find out if it is indeed possible to identify the factors relating to Remaining and Terminating from psychotherapy. It has become essential to study these factors because of the fact that

a) psychotherapy is a very young mode of treatment in Pakistan

b) there is dearth of clinicians

c) there is an increase in the level of awareness of people of Pakistan about the etiology, symptomatology and treatment of mental illness.
Psychotherapy is a new discipline therefore it is important to know the various factors which effect the motivation of the patient and the family of the patient, for psychotherapy. Clients in our culture are usually dependent on their family members i.e. parents, grandparents, in-laws, spouse, siblings or relatives. These family members are usually responsible for motivating and bringing the client for the treatment. Therefore, the unique aspect of this research is that it is designed to study not only the needs of the patients but the requirements and attitude of the family towards bringing the client for psychotherapy which may be a major factor in termination of psychotherapy in our culture. All this can only be studied if we undertake to understand and examine the various kinds of factors which have become a hinderance in the continuation of psychotherapeutic treatment.

In the developed countries psychologists have conducted researches to study the type of patients who remain or terminate from psychotherapy. They have come to certain conclusions with respect to their own cultures i.e. Schofield (1961) has given a formula that only YAVIS (Young, Affluent, Verbal, Intelligent and Social) can be treated successfully by psychotherapy in the United States of America. It will be interesting
to know whether we can rely on these findings about American population in our country or not, as it is a well known fact that our culture is basically different in many ways from the American culture. It will be also interesting to know as to who stays in psychotherapy and who stays out of it, because psychotherapy may not be a treatment of choice for all mentally ill persons. In order to establish the credibility of psychotherapy in Pakistan we will have to demonstrate positive outcome of psychotherapy.

Success in psychotherapy is usually positively correlated with length of stay in it. Taylor (1956) reports that the longer the patient stays in psychoanalytically oriented therapies the greater are the chances of success. Most of the studies which have been done in other cultures regarding dropping out of treatment in psychotherapy clinics have defined the dropout or terminator, and the remainder in terms of the number of visits he makes, with a cut off point that has ranged from 3 to 10 visits. Most often the choice seemed arbitrary, but on occasions it has been explicitly determined by the median number of visits. Another strategy has been to exclude the middle range of 13 to 21 visits. This includes the so-called "failure zone", in which the linear relationship
between outcome measures and numbers of sessions apparently drops sharply (Cartwright 1955; Standal and Vander Veen 1957; Taylor 1956). Theoretically, the greater the difference in the number of sessions between remainers and dropouts, the sharper the difference between them with respect to variables associated with dropping out of treatment. However, this approach runs the risk of overlooking the existence of different kinds of dropouts. Baekland & Lundwall (1973) study, which trichotomized dropouts attendance scores has tried to take this possibility into account.

Instead of number of visits, some investigators have preferred to analyse their data in terms of the length of time in treatment. However, the corelation between the number of interviews and the number of weeks in treatment is not as high as one might assume. In fact only about 0.60 in one study (Lorr Katz and Rubinstein 1958). Thus two patients who have attended a clinic for the same length of time may have had a very different number of treatment sessions, so they may be at rather different stages of improvement. Since the number of visits directly measures the patients exposure to treatment, it is to be preferred to time in treatment as a measure of dropping out (Baekland and Lundwall, 1975).
There is a similar problem posed at the Institute of Clinical Psychology, Karachi, Pakistan, where it has also come to light that some of the patients go through the admission procedures of the Institute, begin a course of psychotherapy, but discontinue treatment after only a few sessions. An informal survey shows that despite the fact that very nominal amount of money is charged at the Institute of Clinical Psychology, some of the patients terminate the treatment within the first 10 sessions of psychotherapy. Obviously, if the patient does not stay in treatment the desired effects cannot be obtained.

In the light of the above facts and after carefully studying the results of the criteria kept in all the researches done in the developed countries, the author exercised great care in defining the term "Terminators" and "Remainers". Care was taken to see that the termination is unilateral i.e. when the patient stops psychotherapeutic sessions and the therapist feels that the patient still needs psychotherapy.

The "TERMINATORS" are defined as those cases who leave psychotherapy without the advice of the therapist and those who terminate during the 10 sessions of psychotherapy.
The "REMAINERS" are defined as those cases who continue to remain in psychotherapy for at least 30 sessions and/or are successfully terminated under the advice of the Director of the Institute of Clinical Psychology.

In this study the following patient variables will be studied as possible correlates of Remainers and Terminators:

- Age
- Education
- Distance required to travel at the place of treatment
- Financial burden
- Manifest anxiety level
- Attitude of the family towards psychotherapy,
- Motivation of the patient
- Referral source
- Socio-economic level
- Previous psychiatric experience
CHAPTER III

LITERATURE REVIEW

This chapter consists of a review and discussion of the literature on psychotherapy research which is relevant to the present problem. In particular the following topics are considered:

1) Client Variables in Psychotherapy.
2) Therapist Variables in psychotherapy.
3) Process variables in Psychotherapy.

CLIENT VARIABLES IN PSYCHOTHERAPY

Whether our concern is research or practice, the client is clearly an important variable in psychotherapy and is the focus of many research investigations.

In any conceptualization of the psychotherapeutic process, it is apparent that three categories of variables are involved: those related to

1) the client or patient
2) the therapist, and
3) the resulting interaction of these two variables.
Ideally each of these variables should be studied in their natural interacting state and should be evaluated in relation to significant criteria of therapy.

The client variables are those factors in the patient, in his personality organization and in the structure and dynamics of his illness which we believe are relevant to the course and outcome of his/her treatment.

Some of these, such as the nature and severity of his symptoms or the intensity and manner of manifestation of anxiety are directly reportable by the patient. Others such as the nature of the core neurotic conflict, or the patterning of ego defences, or the anxiety tolerance are complex assessments arrived at via the clinical inferential process from a consideration of the total available clinical data in each case.

A variety of students have attempted to relate differing client attributes to selected variables. Among the client attributes have been social class variables, personality variables, diagnosis, age, sex, intelligence and the like. These have been related to outcome, continuation in psychotherapy, therapy behaviour and similar variables.
The list of potential client characteristics is endless. Consequently, it has been difficult to synthesize or even compare research in this area. After a comprehensive review of the literature, Brandt (1965) concluded that there was no clear picture of the premature terminator because of inconsistent and contradictory results in the research area. Some eighteen years later, this statement is still accurate (Hoffman 1985).

Luborsky (1971) presented four factors influencing the outcome of psychotherapy:

1) patient factors
2) therapist factors
3) the match between therapist and patient, and
4) treatment factors.

This structure may be usefully applied to the study of mental health clients who prematurely terminate treatment.

Brandt (1965) reviewed the relationship of 13 client variables related to premature termination. He found:

a) neither subject's sex nor age differentiated terminators from remainers in the majority of studies.
b) Education was significant in five of seven studies with remainers having more education.

c) Race significantly differentiated in one of four studies.

d) The evidence was inconclusive on income and occupation, but lower class clients were significantly more likely to terminate than upper or middle class clients in all studies.

e) Referral source, previous therapy and presenting problem were all variables that differentiated in some studies, and not in others.

f) Intake data (history) successfully differentiated remainers from terminators in four of six studies.

g) Data on diagnosis and prognosis was inconclusive.

h) Personality characteristics were found to successfully identify the two groups in each of seven studies.

PATIENT FACTORS INVOLVED IN DROPPING OUT OF TREATMENT

AGE

In 16 out of 51 studies (31.4 %), (Bakeland and Lundwall; 1975) in which it was taken into account, the age of the patient proved to be an important clue to his/her persistence in treatment.
who are lost to followup in epidemiological studies. (Turner et al., 1970), in which patient attrition has in part been attributed to the greater geographical mobility of the younger person, who is less likely to have nuclear family and community ties or relatively binding obligations to aged parents.

SEX.

Out of 31 investigations, 13 (44.8 %), (Bakeland and Lundwall;1975) reported that the sex of the patient helped to determine whether he would stay in treatment. (Altman, Angle, Brown and Sletten 1972; Altman, Brown & Sletton, 1972; Brown and Kosterlitz 1964; Cartwright 1955; Lowinger and Doble 1968; McNair et al., 1967; R.G. Newman and Kagen 1973; Raynes and Patch 1971; Rickels 1968; Rosenthal and Frank 1958; Sethna and Harrington 1971; Weiss & Schaeie 1958; Williams and Pollack 1964).

Out of 31 studies 18 (55.2 %) failed to relate it to persistence in treatment (Adams et al., 1971; Affleck and Garfield 1961; Cusky et al., 1971; Daniels et al., 1963; Dodd 1971; Downing et al., 1970; Errera et al., 1967; Freedman et al., 1958; Greenwald and Bartemeier 1963; Hellbrun 1971; Hunt 1962; Levitt 1957; Mayer
et al. 1965; G.C. Meyer 1967; Nagpaul et al. 1970; Raynes et al. 1972). It appears that female patients are more likely to drop out of outpatient treatment. One factor which may be responsible is that of patient-therapist mismatches on the A-B variable. While its significance has been shown only in drug treatment, there is no reason why it could not be important elsewhere. This is an issue that deserves research in our culture.

That female patients are more likely to drop out of treatment may also be related to their greater field dependence (Kapp, Poster and Goodman, 1963; Witkin et al. 1962). Perceptual and behavioural dependence are related (Witkin et al. 1962), and both were apparently involved in dropping out in a number of studies (Blane and Meyers, 1963; Frank 1963; Strickland and Crowne 1963; Voth, 1965). In alcoholics and addicts, at least the different dropout rates of men and women may reflect the fact that alcoholism and addiction in women implies a greater degree of social deviancy than in men, who may hence be less psychiatrically impaired than women in clinic populations. Indeed, hospitalized female alcoholics do worse on follow-up than do male patients with the same age, duration of heavy drinking and number of prior hospitalizations.
Socio-economic status.


In 22 out of 57 studies (58.1%), socio-economic status was found to be irrelevant (Blane and Meyers 1964; Brown and Kosterlitz 1964; Cartwright 1955;
Errera et al. 1967; Garfield and Affleck 1959; Gerard and Saenger 1966; Hellbrun 1961; Kissin et al. 1970; Lorr et al. 1958; Lorr and McNair 1964; Meyer et al. 1965; G.C. Mayer et al. 1967; Miller et al. 1970; Nagpal et al. 1970; J. Newman and Sparer 1956; Quatrone 1973; Raynes et al. 1972; Ross and Lacey 1961; Sells, Chatham and Joe 1972; Tuckman and Lavell 1959; Williams and Pollack 1964; Zax et al. 1961). It is not at all surprising that socio-economic status should be so important in the patient's dropping out of or staying in treatment. First of all, therapists are usually middle class people (Bakeland & Lundwall). Hence, they may only very imperfectly understand many facets of the life of lower class (class 4, class 5) persons, who make up the bulk of hospital and clinic populations in public facilities. Therefore, their values and their implicit (if not explicit) expectations about the patient's life goals and conduct of his treatment may differ greatly from the ideas the patient himself has about such matters. For example, the lower class individuals puts much more emphasis on the present than on the future (Gurssilin, Hunt and Roach 1959-60; Hollinshead 1949; Hyman 1953; Seward and Marmor 1956) is more concrete and task oriented. He is also more apt to have physical as opposed to
psychological symptoms and is less psychologically minded (Hollinshead 1958). Finally, he is more poorly motivated, less patient and less discontented and dissatisfied with himself (Schmidt, Smart and Moss 1968) than the middle class patient.

Brill and Storrow (1960) attempted to replicate some aspects of Hollinghead and Redlich's (1958) research. They confirmed that patient's in the upper social classes applying for therapy at a low-cost psychiatric outpatient clinic were more likely to be accepted for therapy than were those in the lower class group. Rightly or wrongly, there is a pronounced tendency to view the lower class patient's as less suitable for psychotherapy than the upper class patients. In the above study, there are statistically significant relationships between low social class and lower estimated intelligence, less education, a tendency to see the presenting problem as physical rather than emotional, a desire for symptomatic relief vs overall help, lack of understanding of the therapeutic process, and lack of a desire for psychotherapy. Unrelated to social class were anxiety and amount of obvious secondary gain from the illness.

Baum and Feizer (1964) in a metropolitan psychiatric training center, assigned residents to only
lower class patients, and tried to help them to deal constructively with them. The patients' motivation were low; for the most part they were referred to the psychiatry department and they had little availability of fantasy. Therapists were encouraged to meet the patients on their own level, to explain the purpose of psychotherapy and to get a dynamic material. Of the 119 patients included in this report, only 35% dropped out before the sixth session.

Albronda, Dean and Starkweather (1964) from another training center with similar clientele, assigned patients to senior medical students and found a similar low dropout rate. Dividing the patients at the median of the social class measure, they did not find the expected difference in remaining or dropping out of therapy, or in improvement as rated by the therapist or his teacher. One difference did appear: self-referrals are more numerous among the relatively higher social class patients. In a study by Gunzburger (1981) on social class and therapeutic outcome, reports that social class was not found to relate to premature termination or therapeutic expectancies. Premature termination was found to relate to psychotherapeutic efficacy rating of therapists, but not to ratings of clients.
Falkin, J. (1979) identified patient variables related to dropping out. Among patient demographic variables, only socio-economic status has been reported to be consistently related to every aspect of therapy, including dropout rate. The literature also reveals some suggestive data relating dropout rates to the personality characteristics of: expression of and tolerance for anxiety, persistence, hopefulness a low incidence of impulsivity and anti-social acting out, self-doubts, suggestibility, flexibility, psychological mindedness, dependency, verbal fluency, defensiveness and hostility. The variable of the patient's motivation as reported in the literature was vague, poorly defined and had a history of non-replicatability. The diagnoses of depression or anxiety reactions have been found to be related to staying in treatment. Presenting problems of psychological vs somatic distress was related to remaining in therapy.

Rapoport, E. (1976) studied lower class patient attitudes and expectations related to drop out from psychotherapy, had a sample of 90 class IV and V patients applying for treatment to a Mental Hygiene Clinic. The patients were were divided into 3 groups
of 30. Group one was a non-treatment group, composed of patients who did not return after an intake interview. Group two was a dropout group; six or less therapy sessions. Group three was a remainder group; more than 6 therapy sessions. Attitudes were significantly related to receptivity to and continuation in treatment for all 3 groups, with the remainders having most positive attitude. Dropouts had a larger discrepancy between initial expectations of treatment and observations of the initial therapy session. The nature of lower class patient's attitude was found to be more positive than previous studies had indicated. The importance of looking at this lower socio-economic group as composed of individuals with a range of attitudes and expectations, rather than a homogeneous group with negative attitudes and naive expectations was stressed.

Mollica, Richard. F, and Milic (1986) conducted a follow-up study on 467 patient's who were admitted to the community mental health center (CMHS). Subjects were from lowest social class. Results show that more than half of the lower class subjects were discharged without a treatment assignment. Many lower class subjects, however, gained access to the CMHS, psychotherapy unit. Most of these S's were females,
explored and diagnosed as psychoneurotics. It was concluded that the effect of social class on psychiatric care is less complete than Hollingshead and Redlich originally demonstrated. Flester and Rudestam (1975) also found a relationship between social class status on the Hollingshead Index and premature termination in one clinic but not in a hospital based community health center.

Another study investigated the relationship between values, social class and duration of psychotherapy, and found a relationship between the interaction of social class and the discrepancy between patient and therapist values and continuation (Pettit, Pettit and Weikowitz 1974). The relationship reported between social class variables and continuation in psychotherapy researches done so far in the developed countries, thus may be a function of several variables acting independently or in interaction with each other. The attributes and expectations of the client clearly contribute one source of variance to this problem, while the personality and attitudes of the therapist contribute another. These variables, furthermore, may act singly or in combination.
PSYCHOLOGICAL MINDEDNESS:

Lack of psychological mindedness has monotonously been invoked or reinvoked as a major factor in investigations done in the developed countries of dropping out of psychotherapy. It turned out to be important in 24 out of 26 studies (92.3 %), (Bakeland and Lundwall; 1975) that considered it (Blenkner 1954; Brown and Kosterlitz 1964; Chappel et, al. 1973; Errera et, al. 1967; Freedman, et, al. 1958; Garfield et, al. 1963; Gibby et, al. 1951; Heilbrun 1962; Heine and Trosman 1960; Hewitt 1969; Hiller 1959; Katz and Solomon 1958; Kissen et, al. 1973; Lake and Levinger 1960; E. Meyer et, al. 1967; Miller et, al. 1968; Mozdzie et, al. 1973; Nelson and Hofffman 1972; Pittel et, al. 1972; Rickels 1968; Robson et, al. 1965; Taubbee 1958; Wittkower and Russell 1956 ) and irrelevant in only 2 out of 24 studies (8.3 %) (Affleck and Garfield 1961; Lorr et, al. 1958).

Like motivation, psychological mindedness is a complex and probably multifactorial construct. It is often, though not invariably connected with socio-economic status, and as used by clinicians, usually connotes an ability both to see causal relationships between ideas, feelings and behavior and to recognize and label them in the first place.
Surely, a certain amount of psychological mindedness would seem to be a *sine qua non* of insight oriented psychotherapy, although its importance in more directive forms of treatment is open to question. Yet, a number of the studies that implicated poor psychological mindedness in dropping out were not performed in the setting of pure outpatient psychotherapy (Chappel et al. 1973; Freedman et al. 1958; Wittkower and Russel 1956).

**CLIENT EXPECTATIONS AND OTHER DEMOGRAPHIC VARIABLES IN RELATION TO CONTINUATION IN PSYCHOTHERAPY.**

Another area of investigation has been the relationship of the client’s expectancies concerning therapy to duration of stay. The client may have various expectations about being helped or about what will take place in therapy. If these are completely incongruent with what occurs it is conceivable that the client may be dissatisfied and more inclined to withdraw.

Heine and Trosman (1960) conducted an investigation of the initial expectations of the doctor-patient interaction. 46 patients were given a
questionnaire to tap attitudes towards psychiatric treatment, and the total group was dichotomized in terms of those still in treatment after six weeks. The two groups of patients did show some differences. The terminators tended to emphasize passive co-operation as a means of reaching their goal in treatment, and sought medicine or diagnostic information. The remainders on the other hand, emphasized active collaboration and advice or help in changing behaviour. By contrast, the type of presenting complaint, whether somatic or emotional, or the degree of conviction that treatment would help, was unrelated to continuation.

In another study, patients who came for 12 or less interviews expressed some significantly different expectations of their therapists than did those who remained for 13 or more interviews (Heine, 1962). More terminators expected specific advice on their problems in the first therapy interview than did the continuers, and the latter more frequently expected a permissive attitude on the part of the therapists than did those who discontinued. In these respects, the continuers were more similar in their expectations to the therapists than were the discontinuers. In addition, patients who tended to leave therapy did not differentiate sharply the role of the psychotherapist
from that of other medical experts.

In another study, 40 lower class patients were given a questionnaire to ascertain their expectations about therapy and were re-evaluated after the first interview in terms of their perception of the interview (Overall and Aronson 1962). The results indicated that these patients tended to expect a "medical-psychiatric" interview, with the therapist assuming an active supportive role. Furthermore, the patients whose expectations were generally least accurate in terms of therapist role were significantly less likely to return for treatment. In a somewhat different type of study, Garfield and Wolpin (1963) evaluated the expectations of 70 patients referred for outpatient psychiatric treatment. The median level of education was 12 years, and none of the patients had had previous psychiatric treatment. In general these patients indicated psychotherapy as the treatment of choice (88%) and a majority of them saw emotional factors as important in their difficulties.

In order to study the clients own reason for terminating their psychotherapy, Garfield 1963a in one small follow-up study of 12 individuals who dropped out of psychotherapy before the 7th session has reported
that on sending a social worker to contact them on the reasons for dropping out, have given external difficulty, such as lack of transportation, no baby sitter, and inability to get away from work.

Frank et al. (1957) suggest that those who remain have manifest anxiety, readiness to communicate about stress and personal liabilities, have shown social integrity, and have histories of being influenced. Standel et al. (1957) find that personal integration predicts longer duration.

Gallagher (1954) concluded that greater anxiety is related to remaining in treatment, where as defensive patients tend to terminate early. Wallach and Strupp (1960) studied this problem experimentally by presenting in written form to medical psychotherapists two case histories of neurotic patients. Significant associations were found between the patient's motivation and such estimates as ego strength, insight, social adjustment, prognosis and therapists willingness to accept the patient for therapy.

In a related study Strupp and Williams (1960) ratings were obtained from two psychiatrists who independently interviewed 22 psychiatric patients.
Both interviewers tended to see the same set of variables as interrelated: non-defensiveness, insightful, likable and well motivated patients were seen as most likely to improve and remain in psychotherapy, with motivation being the most independent predictor.

Further confirmation was found in a study by Raskin (1961) based on therapist's rating of patients in two Veterans Administration samples. Patient's education, occupational level, awareness of psychological difficulties and type of treatment expected correlated significantly with therapist's ratings of the patients motivation to enter therapy.

Hiller (1959) examines the factor of initial complaint as a predictor of continuation in therapy. Results indicated that remainers had presenting problems more often including obsessions, phobias, depression, poor concentration and anxiety. The terminators had presenting problems which included acting out, ideas of reference and other paranoid and schizoid ideation.

Taulbee (1958) in a study of psychoneurotic patients attending an outpatients clinic, concluded that those who continue in treatment have stronger
feelings of inadequacy, inferiority and depression. They also had better potential for self-appraisal, emotional responsiveness, and more of an introspective attitude. They are less defensive, more persistent, more sensitive and more dependent than the terminators.

Gallagher and Kanter 1961; Garfield and Affleck 1959; Katz and Solomon 1958; Rosenthal and Frank 1958; found psychiatric diagnosis to be unrelated to duration of treatment. However, Frank et al. 1957; Lorr et al. 1958; Straker et al. 1967; found that four diagnostic features were related to dropping out of psychotherapy: low levels of anxiety and/or depression, paranoid symptoms and sociopathic features evidenced by aggressive behaviour, legal trouble or hostility to authority.

Fouks, Edward F. et al. (1986), studied the "effect of patient's belief about their illnesses on compliance in psychotherapy ". Sixty, 17-67 years old treated in the outpatient psychiatric clinic of a large urban teaching hospital were surveyed, using an inventory developed by the authors, regarding their beliefs about the causes of their illness. Subjects beliefs were found to be related to 2 measures of compliance, i.e. number of visits, & manner of termination from therapy. Subjects endorsing more
medical and fewer non-medical explanations for their illness made more visits to the clinic and ended treatment in a more compliant manner than did subjects who endorsed more non-medical beliefs about the causes of their illness. Results also show that, except for age, demographic and diagnostic variables were not related to compliance.

CLIENT EDUCATION/PARENTS INVOLVEMENT & MOTIVATION.

A related patient variable is educational level. Patients with best prognosis are those who have a high education and, in a corollary fashion high intelligence. Unfortunately, psychotherapists in the developed countries have not paid attention to the intellectually low functioning patient. Therapists frequently find such individuals unattractive and poor candidates for psychotherapy (Nash, Hoehn - Saric, Battle, Stone, Imber and Frank 1965).

Bailey, Warshaw and Eichler (1959) report a comparison of patients in one centre assigned for psychotherapy vs psychosomatic treatment. The therapy assignees were younger and higher in educational and
occupational level. Another factor in this study which was reviewed was the patient's interest in receiving psychotherapy vs receiving medication. A markedly larger proportion of the younger and more highly educated patients requested psychotherapy, while a very large majority of patients receiving medication alone requested just that.

In another study done by Miller, and Phillips (1982) on children report that the parents educational levels were found to correlate with the premature terminators and the continuers. Parents with less education were associated with families who prematurely terminated, and parents with more education were associated with families who continued. The results of the discriminant analyses indicated that the variables of "father's education and parental involvement" were different between the premature terminators and the continuers in two parent families. Those families in which the father had less education were more likely to prematurely terminate and those families in which the father had more education were more likely to continue. Families which had less mutual parental involvement were more likely to premature termination than families who had more mutual parental involvement.

Affleck and Mednick (1959) in a study at various
mental hygiene clinics, report that it is the parents motivation which is the determining factor, but the parents must not only have the motivation to bring or send the patient and support his treatment experience, but they must also have the capacity to involve themselves actively in a therapy program.

It has become more universally recognized that the father plays an important and often crucial role in the treatment of children (Rubenstein and Levitt 1957). The findings reported here strongly support and suggest that when father is not in treatment, he may either actively sabotage treatment efforts or by failing to support the mother and the child in their treatment experiences, materially undermine the process.

Another indirect reflection of parental involvement and motivation may be the fact that remaining was positively related to histories of developmental difficulties. A patient with such a history may be assumed to have a psychological problem of long standing so that his parents might be more aware of it, more distressed by it, and thus more highly motivated to remain in treatment. In addition, a mother's report of difficulties in her child's early years may represent her awareness of her own
contribution to the problem, an awareness Lake and Levinger (1960) report as a factor in continuance. They report that terminators are more often referred by an authority such as juvenile court or school, while remainders were more often referred by friends, social agencies or themselves (X² = 3.77, p < 0.10)

Morris and Boroker (1953), Fanshel (1958) studied dropouts from family agencies and guidance clinics. There, the decision to begin and to end treatment is generally made by the parent.

PATIENTS MOTIVATION.

According to Lambert and DeJulio (1978), the most influential factors in determining either successful or unsuccessful treatment outcome are contributed by the patient. Psychotherapy appears to be most effective when the patient is amply motivated to undergo intensive self-scrutiny and modify his/her own behaviour. The unmotivated, non insightful patients is also amenable to psychotherapy, however (eg. Garfield 1980; Goldstein 1973; Karon and Vandenbos 1981).

Patient who do poorly or dropout of treatment seem to enter therapy with a negative disposition
towards its effectiveness and resistant to persuasion messages, and filter their view of the therapist through their own negativistic perspective, remaining relatively intransient to the therapist’s effort. Even as rated by outside observers, attributed therapist qualities vary from moment to moment and patient to patient (Beutler, Johnson, Neville and Workman, 1973; Beutler 1976; Gurman 1973)

Several authors like Baer et al 1980; Gomes - Schwartz 1978; Kolb 1981, have determined that among a variety of process dimensions, patients involvement/motivation most consistently predicts therapy outcome.

OTHER REMAINING VARIABLES.

Nathan, L.S. (1982) reports the factors associated with the premature termination of adults in an inner city outpatient psychiatric clinic. An adult was defined as a male or female 22 years of age or older. The results of the study indicated that unmet expectations about the therapeutic encounter was the reason provided most frequently by the sample as contributing to their premature terminations;
environmental factors and therapist factors followed in that order. Those clients who had been referred involuntarily for treatment cited this as influencing their decision to terminate outpatient care.

In a study by Magnavita and Jeffrey Joseph (1981) which was an investigation of the relationship between attitudes towards help-seeking, and the early premature termination of psychotherapy, report that the first discriminant analysis showed that the variables, which were entered in the following order, attitudes towards help-seeking, clients previous history of psychological consultation, familial history of help seeking and age of the client, were able to correctly classify 69.2% of the subjects into the criterion groups. The results of the second discriminant analysis, using the subscales from the attitude survey, accurately classified 57.6% of the cases. This was 14% over and above the prediction based on chance alone, and was significant (p < 0.10).

White, Fichtenbaum and Dollard (1964) scored the content of transcriptions of recordings of initial interviews with 70 patients at a psychiatric outpatient clinic. It was used to predict whether a patient would come back for at least 3 more interviews if offered treatment. Each sentence unit or 5 seconds of silence
was assigned rating of + (favourable to continuation) or - (unfavourable) or 0 (irrelevant). Excess of plus over minus units predicted continuation, excess of minus over plus units predicted dropping out. Coefficients of reliability of ratings by 3 pairs of scores were significant at 0.001 level. Individual scorers predicted correctly 73 %, 81 % and 80 % of cases; averages of paired scorers predicted 81 % correctly; averages including scores of mediator predicted 83 % correctly.

Van Dam Baggen, Rien and Kraalmaat (1986) studied, a group social skills training program with psychiatric patients. They investigated the effectiveness of a social skills training program with socially - anxious psychiatric inpatients and outpatients aged 16 - 50 years. 76 subjects completed the treatment program and 35 subjects were randomly assigned to the control group. Results indicate that social skills training resulted in a decrease in social anxiety and an increase in social skills. Treatment effects were maintained when measured 3 months after treatment. Results from an analysis of treatment outcome predictors immediately after treatment and after the 3 month follow-up indicate that pretreatment predictors for negative outcomes included
hospitalization and high social anxiety, while post treatment negative predictors included hospitalization, lack of employment and high general anxiety.

Rapaport, Ross J., Rodolfa, Emil R. and Lee, Virginia E. (1985), did a study on, "Variables related to premature terminations in a university counseling service: A reply to Saltzman's (1984) comment". The authors responded to comments by C. Saltzman regarding their examination of variables related to premature termination in a university counseling service. Specifically discussed are Saltzman's concerns regarding the meaningfulness of the results, the citation of previous research, the definition of premature termination, and the operational definitions and procedures used.

Greenspan, Marie and Kulish, Nancy,M. (1985), in an article "Factors in premature termination in long-term psychotherapy", have examined the relationship between patient and therapist variables and the incidence of premature termination at a private outpatient psychotherapy clinic. Using a qualitative rating scheme, 718 long term psychotherapy cases were reviewed to determine whether termination had been premature. The 273 cases judged to be premature terminations were compared with the patient population as a whole on 10 patient variables.
Results indicate that premature patients terminators differed significantly on race, age, source of referral, type of payment, employer, presenting complaint and diagnosis. Psychologists were found to have significantly lower rates of premature termination among their patients than psychiatrists or social workers. Therapists who had undergone personal therapy showed significantly lower rates than those who had no therapy.

Hoffman, Joseph J. (1985), in a "Client factors related to premature termination of psychotherapy", have investigated client factors related to the premature termination of counseling or psychotherapy. A review of 267 mental health center client files revealed 3 variables that were found to be significantly related to premature termination: diagnosis, presenting problem and previous psychiatric experience. Early terminators had less previous contact with psychiatric services, were usually not psychotic, and presented with problems in the area of interpersonal relationships. Results suggest that community education activities, informed consent procedures, therapists knowledge of the early terminator's profile and a wider range of services, including more groups, may prove community mental health center service delivery to these clients.
Pekarik, G. (1985) studied, the effects of employing different termination classification criteria in dropout research. The author compared the differences between therapy terminations categorized by duration and those categorized by therapist judgement in 152 consecutive mental health center outpatient (average age 27 years) treatment terminations, in order to demonstrate distinctions between early dropouts and early completers. The sample was first divided based on treatment duration. Terminated subjects who had made 1-5 visits (early terminators) were compared to those with 6 or more visits (late terminators). Early dropouts were then compared to early completers by comparing therapist-classified dropouts who attended 1-2 visits with therapist-classified completors who attended 1-3 visits. Significant differences were found between dropouts and completers on 11 to 18 client and therapist variables when classified by therapist judgements; no differences were found when the groups were classified using duration criteria. Within the therapist-classified groups low visit dropouts were found to differ from low visit completors on 8 of 18 variables. The pattern of results strongly supports the superiority of the therapist classification procedure.
Fraps, C.L. (1982) has supported the contention that situational and behavioural variables are associated with outpatient psychotherapy attendance. Adults who requested outpatient psychotherapy completed a pre-treatment questionnaire after admission and a post treatment questionnaire immediately after the first therapy session. Questionnaire items concerned the client's situation at the time of the request for treatment (e.g. distance travelled to the clinic), past behaviour in fulfilling commitments, self prediction of session attendance and reaction to the initial interview. Five items were related significantly to continuation in two separate subjects samples. i.e. Sex (females, longer stay), Education (higher, longer stay), Occupation (higher, longer stay), Involvement in organization activities (more active, longer stay), distance travelled to the clinic (greater distance, shorter stay), and ease in getting to clinic (more difficult, shorter stay).

In an effort to identify potential premature terminators Keiner, F.A. (1982) conducted a study on, "An evaluation of Jochim's PT (premature termination) Scale in the prediction of premature termination from outpatient psychotherapy".
Using Jochim's cut-off points, the PT Scale was able to accurately identify 44.7% of the total sample, 77.4% of the remainders, and 10.0% of the terminators.

Hellbrun, A.B. (1982), studied, cognitive factors in early counseling termination. The relations between two cognitive variables and scores on a validated scale for predicting early dropout or continuation in counseling were investigated. Social insight, a cognitive skill variable, and psychological defensiveness, a cognitive style variable, were considered for a sample of 48 college males and 86 college females. A three way interaction was found for defensiveness, social insight, and sex, continuing the long-standing trend of sex differences in the factors relating to early dropout or continuation in insight-oriented counseling. The major contributor to the triple interaction was an opposite effect of social insight for males and females under the high - defensive condition, a pattern not apparent for less defensive subjects. Continuation in counseling would be predicted for the highly defended but less insightful male and for the highly defended but more insightful female.
PERSONALITY:

A number of studies have been carried out in the developed countries regarding the personality profile of those who remain and those who terminate from psychotherapy. A significant percentage of them deal with personality and test patterns of clients. Since different tests have been used in different combination and with different interpretative schemes, it is frequently difficult to group them together.

Out of 11 studies that looked at factors related to aggressive and passive-aggressive behavior, 9 (81.8 %), (Bakeland and Lundwall; 1975) indicated that the highly aggressive or passive-aggressive patients tends to dropout of treatment. (Allen and Dootjes, 1968; Bakeland et al., 1973; Downing et al., 1970; Kendig, 1956; Levine et al., 1972; Miller et al., 1968; Wilkinson et al., 1971; Williams and Johnston 1972; Wittkower and Russell 1956), whereas 2 out of 11 (18.2 %) ruled it out as unimportant (Gallagher and Kanter 1961; Lorr et al., 1958). This is not surprising in as much as the openly resentful and aggressive patient will probably antagonize his therapist. If covertly resentful, he tends to forget appointments and to take medication improperly, (Howard et al., 1970), and his
unverbalized hostility and resentment, all the more difficult to deal with for being subrosa, may swell to the point at which he has no alternative but to leave treatment. This seems to be a particularly common personality pattern among alcoholics, in whom the identification, expression and control (or overcontrol) of aggressive or hostile wishes in an especially striking clinical feature (Blane 1968; Hayman 1966).

Sociopathic features were related to dropping out in 14 out of 19 studies reviewed (73.7 %) that concerned themselves with this aspect of patient behaviour and personality. (Altman, Angle, Brown and Sletten 1972; Altman, Brown and Sletten 1972; Babst et.al., 1971; Bakeland et.al., 1973; Goldfried, 1969; Greenwald and Bartemeyer, 1963; Hellbrun, 1971; Hiier 1969; Miller et.al., 1968; Perkins and Bloch 1971; Pokorny et.al., 1968; Quantrone 1973; Ross and Lacey 1961; Williams and Johnston, 1972) and appeared unrelated in only 5 out of 19 studies (18.2 %) Freedman et.al., 1958; Kissen et.al., 1970; Sells, Chatnam and Joe 1972). In some cases the sociopath was labeled as such, while in others the investigator focused on arrests, truancy, or other kinds of legal difficulties.

Dengrove and Kutash (1950) found that patient's
with many somatic symptoms leave early after being antagonistic towards physicians and other VA personnel.

Rubenstein and Lorr (1956) report a study drawing cases from VA outpatient clinics. Remainders were characterized as less nomadic, less impulsive, less rigid in personal attitudes and more self-dissatisfied.

Lorr, Katz and Rubenstein (1958) tested the hypothesis that early terminators are more likely to show impulsivity, are less dissatisfied, more likely to report anxiety, have more limited vocabularies and are more authoritarian.

Kirtner and Cartwright (1958a) rated patient behaviour during the initial client centered sessions and related this to both length of stay and ratings of effectiveness of treatment. If the patient tended to deal with feelings about problems of relationship to others, and tended to see the problem as external to himself and to want something done about his situation, then he tended to terminate early or failed to improve.

In another study Kirtner and Cartwright (1958b) found that successful cases had less disturbance of their impulsive life, a strong need to relate to other, sought internally for causes and resolution of felt
discomfort and tended towards self-oriented attitudes. These inferences were based on analysis of thematic tests administered before treatment and first psychotherapy session behaviour.

Kirtner and Cartwright (1958b) studied the outcome of psychotherapy as a function of personality variables measured by Thematic Apperception Test analysis. The method of analysis involved 6 scales. Outcome was divided into five categories. With only 26 subjects, the large number of variables and categories could hardly be expected to achieve stable and clear cut results. The authors feel the study indicates that therapy length by outcome is related to the personality structure of clients at the beginning of therapy. A patient who appears more highly motivated for therapy may engender more positive attitudes in the therapist, which in turn may be correlated with more favourable clinical evaluation and, possibly a more benign therapeutic climate.

In a study Zolik and Hollon (1960) investigated the relationship between length of therapy and personality factors of the patients prior to treatment. Patients were divided into 3 groups: non beginners (who refused therapy after it was offered or who
discontinued after 2 interviews), brief term patients (between 12 and 30 interviews), and long term patients (between 40 and 95 therapy sessions). The results showed that non-beginners dealt with their problems as if the sources were external, they avoided discussing their feelings and utilized denial, evasion and projection to a marked degree. By contrast, brief term patients felt more inadequate, more self conscious, blamed themselves rather than others and were more anxious and less defensive. Long term patients were more similar to the brief term patients than to the non beginners who were rated as having the highest degree of overall pathology.

Strickland and Crowne (1963) report a study which suggests that one patient characteristic which is associated with early termination is "need for approval". Thus, in such patients, defensiveness and avoidance of self-criticism may constitute a major determinant of abrupt termination of psychotherapy.

In the same study Strickland and Crowne (1963) tested the hypothesis that approval dependent individuals:

a) tend prematurely to terminate psychotherapy, and
b) are rated by therapists as more defensive and less improved than patients less approval-dependent.

85 psychiatric outpatients completed the Marlowe and Crowne Social Desirability Scale (the measure of need for approval) and rated their improvement in psychotherapy. Therapists rated 30 of these patients as defensiveness, attitude toward patient, patient's attitude towards therapist, improvement and satisfaction with therapy. Additional measures included diagnosis, social class and ordinal position. Results confirmed the hypotheses. The high need for approval group terminated significantly \( p < 0.005 \) earlier. Approval motivated patients were generally given more negative ratings by therapists. Approval motivated females rated themselves as more improved. Ordinal position and social class failed to predict stay in therapy.

Zuckerman, Prusoff, Weissman and Padian (1980) studied the aspect of personality as a predictor of psychotherapy and pharmaco-therapy outcome for depressed outpatients. In a double blind, randomized clinical trial, depressed outpatients were randomly assigned to one of four treatment groups: psychotherapy, pharmaco-therapy, combined psychotherapy
and pharmacotherapy, and non scheduled treatment (control). Before treatment began, patients were assessed on three personality inventories and four outcome scales. The patients were reassessed on the outcome measures at termination (after 2 - 16 weeks of termination) and one year later. The pretreatment personality scores were not significantly related to improved outcome scores at termination either as a main effect or for the interaction with treatment group. However, low neuroticism and high extroversion on the Maudsley inventory were associated with improved social adjustment one year later.

PSYCHOMETRIC INDICES AND CONTINUATION IN PSYCHOTHERAPY:

Psychologists in the developed countries showed considerable interests in the past years in attempting to find predictive variables selected from psychological tests for assessing continuation in psychotherapy. This work was undoubtedly related to the emphasis on diagnostic testing in the post war development of clinical psychology.

The Rorschach test is one technique which, because of its wide use in the past in the developed
countries, has been investigated with regard to continuation in therapy. Overall, the findings have been contradictory.

An early study by Rogers, Knauss and Hammond (1951) secured negative results, with a number of Rorschach scores. However, Kotkov and Meadow (1953) found that a weighted combination of three Rorschach scores (FC - CF, R and D %) was able to discriminate significantly those patients who continued for at least nine interviews. Auld and Eron (1953) attempted to replicate this study but secured negative results. On a sample of 23 patients, the correlation between I.Q. and continuation was 0.71.

Gibby, Stotsky, Miller and Hiler (1953) also compared two groups of patients on various Rorschach scores and secured a number of significant findings. However, many of the separate scores were significantly correlated with R, and they used more extreme groups of subjects. The terminators had less than 6 sessions, whereas continuers were those who remained for 20 or more sessions.

These investigators then carried out another study (Gibby, Stotsky, Hiler and Miller (1954) as a followup of their first one. By utilizing the method
of discriminant function on the scores of 84 patients they secured a formula that was then applied to 75 continuers and 110 terminators. However, in this study, they utilized 19 sessions or less to designate the group of terminators, a cutoff point that differs noticeably from those used in most other studies. In this investigation, a combination of 3 Rorschach scores were used (R and total K and M). When applied to the second sample, 67% of the patients were correctly categorized. The formula is more predictive of terminators than it is of remainers. It appeared also the R, or number of responses alone would have also predicted continuation with an accuracy of 69%.

Hiler (1958b) reported a separated investigation of the same samples of subjects that were used in two preceding studies. This study evaluated the relationship of Wechsler - Bellevue I.Q. to continuation in outpatient psychotherapy. Terminators were defined as those quitting therapy within 5 sessions and remainers as those who continued for 20 or more session. Remainders secured an average I.Q. of 112, which was 10 points higher than the average I.Q. of the terminators.

Another comparable study in a VA outpatient
clinic was reported by Affleck and Mednick (1959). They used a discriminant function of three Rorschach variables, including R, to predict continuation after the third interview and cross validated their initial findings on another sample. While the measure used would have increased the accuracy of prediction 13% over the base rate, its practical value appears limited since terminators at the fourth and fifth interview, labeled remainers in this study, would, of course, not have been predicted.

A study by Hiller (1959b) attempted to predict continuation in therapy through the use of a sentence-completion test. He found that, out of 100 test items, 15 discriminated significantly between terminators and remainers. Content analysis of the items indicated the following characteristics: remainers are more willing to reveal personal feelings, had more psychological sophistication, had a high need for achievement and status, and made frank admissions of inferiority feeling. He cites a 71% prediction accuracy on the cross validation sample and suggests the utility of the test for selecting therapy patients.

Taulbee (1958), on the basis of selected MMPI and Rorschach variables, concluded that those who continue
In therapy beyond the 13th interview are less defensive and more persistent, dependent, anxious and introspective than are those who terminate early. These results, however, were not cross validated, and in another study no significant differences on the MMPI were found between continuers and terminators (Sullivan Miller and Smelser, 1958).

Wirt (1967) secured significant modest correlations between continuation and 3 MMPI scales for 24 female patients, but no such relationship was secured for 33 male subjects. The small sample and lack of replication obviously limit these findings. In the study and cross validation by Dodd (1971) MMPI scores did not differentiate between continuers and remainers. Similarly, scores on the Barron Ego Strength Scale were not significantly different from continuers and remainers in group therapy, although the number of patients studied was small (Rosenweig and Folman 1974) Imber, Frank, Gilessman, Nash and Stone (1956) studied the relationship of suggestibility, as measured by the Sway test, to length of stay in psychotherapy. They found that 77% of the swayers remained for 4 or more interviews, whereas 54% of the non-swayers terminated before the fourth interview.
They also found that suggestibility and social class were practically independent of each other (r = 0.16). Stern, Moore and Gross (1975) utilized 3 of the Terminator - Remainder tests and found no significant relationship between predictions and continuation in therapy.

In the light of the above mentioned studies it has come to light that while conflicting and unreplicated findings have been frequent the reasons for them are quite apparent. The studies have utilized different definitions of early termination, the samples and methods of appraisal have differed, therapeutic conditions and frequency of therapy have not been consistent, comparable information on certain variables has not been available, and a number of similar types of difficulties have been encountered. Variations of this kind, of course, make reliable or clear cut generalizations difficult. At the present time, therefore, we have a relatively few reliable findings in the developed countries but studies of such a nature have not been done in our culture. Therefore it was considered appropriate to study these important variables in Pakistan.
THERAPIST VARIABLES IN PSYCHOTHERAPY

Another area of investigation which has been studied in the developed countries is the fact that not only are certain kinds of patients are more likely to drop out of treatment, but certain kinds of therapists or treatments are more likely to have dropouts.

Some of the research which has been conducted in the developed countries shows the outcome of psychotherapy which is directly related to continuation of psychotherapy as only those patients who will continue the treatment up to the satisfaction of the therapist are going to show the positive outcome in therapy. Hence the studies related to the outcome of treatment are also included in this literature review.

In his early work, Rogers (1957) speculated that certain characteristics of the therapist were both necessary and sufficient to produce positive treatment gains. These characteristics included being able to accurately understand and empathize with the patient, to accept the patient, and his dilemma unconditionally, and to remain consistent with one's own feelings during the course of therapeutic communication. Much research has now been devoted in the developed countries to a
consideration of these issues but with some inconsistent findings.

More specifically in a review of facilitative therapist attributes, Gurman (1977) has observed that when the patient makes judgements of the therapists empathy, regard, acceptance, and genuineness, there is a consistent correlation between the level of these variables and treatment outcome. The fact that these characteristics represent the contribution of both the patient and the therapist (eg Frank 1981, Strupp 1981b) is therefore significant. While it is difficult to specify the manner in which empathetic understanding affects treatment gain, if the patient perceives such empathetic understanding (present or not) the likelihood of gain will ordinarily be facilitated. Moreover, research in the developed countries is increasingly shedding light on ways in which such perceptions can be facilitated. The effective therapist has the ability to communicate warmth, acceptance, and empathetic regard to patients. While methods of communicating these qualities may not be recognized when observed by experienced clinicians, the dimensions are nonetheless important to the treatment process. Indeed, many authors (eg. Neuhaus and Astwood, 1980; Storr 1980) suggest that acceptance,
understanding, and empathy are the most important qualities of the treatment relationship.

In addition to the conditions originally detailed by Rogers, credibility, trustworthiness, and attractiveness all appear to have some importance in facilitating treatment gains (Beutler 1978). Like beauty and empathy, attractiveness and trustworthiness are in the eyes of the beholder. Attractiveness may be facilitated by personal and demographic similarities and may exert its greatest impact during the early stages of therapy as a catalyst for establishing trust and commitment in the treatment process. On the other hand, credibility and "expertness" tend to have more long-term effects on the treatment process and are primarily a function of the therapist being perceived as a knowledgeable, educated and helpful individual who has both the skill and training to bring to bear on the patient's dilemma. A patient's perception of these qualities can also be enhanced by certain structures of the treatment relationship itself or by the setting in which it occurs. For example, a relatively formal office decor complete with diplomas and certificates may facilitate the initial perception of credibility and expertness (Bergin 1962). Likewise, therapist language expression (Schmidt and Strong 1971), style of
dress (Amira and Abramowitz 1979), interpersonal distance (Hall 1961; Sommer 1969), and posture (Harper, Wiens and Matarazzo, 1978; Mehrabian, 1972; Mehrabian and Williams, 1969) are used as cues in the patient's development of a positive perception of the therapist.

EXPERIENCE OF THE THERAPIST

One of the first characteristics usually considered in discussions of the factors influencing a therapist's effectiveness is the amount of experience that the therapist has had. As with any trained skill, it is generally assumed that experience must enhance the "expertness" with which the therapist piles his/her trade. With experience, the therapist learns about many different kinds of patients and gets feedback on what approaches seem to work best with them.

Auerbach and Johnson (1977) pointed out more experienced therapists are usually older and often have integrated valuable life experiences with their philosophy about therapy.

The role of the therapist's experience is somewhat more clearcut than the issues of formal training.
It has long been assumed that experience both homogenizes therapists (Fieldler, 1950) and facilitates treatment gains. A research by (Auerbach and Johnson, 1977) tends to confirm this point of view but not as strongly as it was previously believed. Experience tends to smooth out the differences that exist among individuals adhering to different philosophies (Sloane et al., 1975) and experienced therapists behave considerably differently in therapeutic relationships than inexperienced ones (Beutler and Anderson, 1979; McCarron and Apple, 1971; Strupp and Hadley 1979)

Parloff et al., (1978) pointed out that variables such as personality, sex, experience and race are not likely to be the relevant therapeutic variables that characterize therapists. Instead, factors such as the congruence of clients and therapist values, expectations and cognitive styles, are viewed as offering a more promising research directions. (Berzins 1977; Parloff et al., 1978)

A study by Leroy (1981) investigated the relative effects of different intake procedures in a private psychiatric outpatient clinic, with a staff of a psychiatrist, psychologists and social workers.
Conclusions were that it is better for the patient to be seen on intake by the therapist with whom they will continue treatment and that a double length intake session reduces the early dropout rate.

In another study by Blair (1981) on "Psychotherapeutic effectiveness: Is training necessary?". The results were as follows: 1. The main hypotheses that the greater the degree of therapist WOE (warmth, openness and empathy) during the pre-training phase, the more effectively he would function as a therapist was not confirmed. There was, however, some support for the notion that those less possessed of relevant personal qualities of relating ability are more affected by training and experience than those more gifted, and for the notion that formal training is not necessary for effective therapeutic functioning.

Steven Reinhold (1982) studied the impact of specialized intake procedures upon clients attendance and dropout rates in psychotherapy. This study represents an effort to improve attendance and decrease dropout rates at a community mental health center by incorporating specialized intake procedures. Sixty four (64) clients were randomly assigned to one of four intake conditions: traditional (control), procedures
incorporating an information packet (E1), procedures incorporating a treatment contract (E2) or procedures incorporating both conditions (E3). Attendance and dropout rates were tabulated for the client's first six regularly scheduled sessions after the intake.

The major results were as follows:

1. On attendance, all three experimental groups were superior to the control groups on all four rates, and a number of those differences were significant.

2. On attendance, the combined intervention was superior to the other conditions on all but one measure. It was significantly better on the most comprehensive measure, overall attendance.

3. On dropout, the experimental groups collectively displayed a lower rate than the control groups throughout the first six sessions. The superiority generally became better with each subsequent session, and by the 6th session bordered on statistical significance.

4. On dropout, the combined intervention was superior, although not significantly so, to the other conditions throughout the first six sessions.

THERAPIST BELIEFS, VALUES AND ATTITUDES:

While we may all agree that it is "bad" for a psychotherapist to have severe emotional problems, it is a more unlikely judgement for us to suggest that his values are per force "inappropriate", facilitative,
or interruptive of the treatment relationship. Nonetheless, research suggests that relatively ineffective therapists have different attitudes toward their patients and themselves than more effective ones. An examination of therapists selected because of their variability in judged competence (Beutler et al., 1980; Strupp, 1981b) has revealed that therapists judged to be highly skilled and effective tend also to be relatively consistent and realistic in their views of their own success rates. They are characterized by their sensitivity to patient's dysphoria and hold non-defensive attitudes that allow them to focus on the therapeutic relationship and directly approach areas of resistance and defense (Strupp, 1981b). In contrast, less effective therapists are more variable. Like successful therapists, some appear to be relatively realistic in their judgements of their own lack of treatment effectiveness, while others show significant, protective distortion in their views of therapy-induced change. This factor may account for the observation that therapists frequently provide incongruous judgements of treatment effects when these judgements are compared with those of the patient (Garfield 1977).

Psychotherapy literature is also becoming increasingly attentive to issues of belief systems.
moral values, and interrelationships between cultural and personal values. Bergin (1980) has strongly asserted that psychotherapists must be more cognizant and accepting of their patient's theistic belief system.

Beutler 1971, 1979a; Beutler et al., 1974, 1975; has indicated that patients and therapists do not need to share a common theistic belief system in order to be compatible. Therapists are well-advised to be accepting of their patient's belief systems, nonetheless.

Although looked at principally, but not exclusively, in the content of outpatient psychotherapy, therapist attitude and behaviour seem to loom even larger than socioeconomic status and motivation in determining whether a patient will stay in treatment. Indeed, they were implicated in 35 out of 35 studies done. Baum et al., 1966; Caracena, 1965; Dinnen, 1971; Dodd, 1971; Feldman et al., 1958; Frank et al., 1957; Garfield et al., 1963; Gibby et al., 1953; Goldstein, 1960a; and 1960b; Greenwald and Bartemeier, 1963; Hellbrun, 1961a; Hiler, 1958a; Howard et al., 1970; Katz and Solomon 1958; Koumans and Muller 1965; Koumans, Muller and Muller 1967; Lowinger and Dobie 1968; McNair et al., 1967; McNair et al., 1963;
Mendelsohn 1966; Mendelsohn and Geller 1963, 1967; Moos and Schwartz 1972; Myers and Auld 1955; Panepinto and Higgins 1969; Poser 1966; Rickels, Raab, Gordon, Laquer, Disilverio and Hesbacher 1968; Sethna and Harrington 1971; Stieper & Wiener 1959; Sullivan et al., 1958; Wedel 1965; Wilmer 1956; Winder et al., 1962; Yamamotot et al., 1967) and disqualified in none.

Some of the characteristics of the therapist who is apt to drive his patients out of treatment include the following: ethnocentrism, unconcern for, dislike of, or boredom with the patient; and negative feelings about the use of medication and/or reluctance to give it. He is also apt to be male, to instruct his charge inadequately (especially with regard to the use of medication), to cancel appointments and to be permissive, introverted and detached. The kind of person to whom this therapist is most likely to give short shrift is the lower socioeconomic status patients, who, if we recall, is more apt to drop out of therapy. How much the patient's propensity to drop out is simply the result of attitudes he brings with him and how much it is a reaction to boredom, incomprehension and dislike on the part of the person who is treating him is a matter for investigation in our culture.
SEX:

The demographic characteristics of the therapist (race, sex, and socioeconomic status) have generally been studied in relationship to the corresponding characteristics of their patients.

Some of the researches have studied the effects of the sex of the therapist independent of the patients treated. Seven studies have investigated the relationship between therapist sex and outcome of therapy; in five of these, no differences were found attributable to this characteristic (Geer and Hurst 1976; Grantham 1973; Sullivan, Miller and Smelser 1958; Pardes, Papernik and Winston 1974; Scher 1975).

In another study (Hill, 1975) clients of female counselors reported significantly more satisfaction after the second counseling interview.

Epperson, Bushway, and Warman (1983), studied, "Client Self Terminations After One Counseling Session: Effects of Problem Recognition, Counselor Gender and Counselor Experience", indicated that clients were more likely to self terminate after one session when problem recognition was absent. This relationship was more pronounced for experienced counselors that it was for
trainees, suggesting a possible explanation for the lack of a direct relationship between counselor experience and continuation in counseling in recent studies. Consistent with earlier research at this agency, female counselors had higher rates of early premature terminations than male counselors.

Andrews, S. (1976), studied, "the effect of sex of therapist and sex of client on termination from psychotherapy". Three independent variables of therapist sex, client sex and client readiness for therapy were studied. The results were that analytic therapists tend to lose clients who are low on counseling readiness much faster than non-analytic therapists; and secondly, therapists who have little need for succorance tend to lose low counseling ready clients faster than other therapists.

Carpenter, P.J. and Range, L.M. (1982), predicted psychotherapy duration from therapist's sex, professional affiliation, democratic values and community mental health ideology, for 166 outpatients. A four way ANOVA revealed only a significant main effect for the CMHI (Community Mental Health Ideology) scale. Thus, low scoring, CMHI therapists had significantly more therapy sessions with their clients
than high scoring CMHI therapists. The latter may emphasize briefer treatment approaches that stress outside resources and primary prevention.

Rodolfa, Rapaport and Lee (1983) studied variables related to premature terminations in a University Counseling Service. They investigated the influence of sex and experience level of intaker and assigned counselor, sex of client and administrative variables (length of initial interview, days from intake to assignment and days from intake to first session) on premature termination. Administrative variables were the major factors related to premature termination. There was no significant difference between the return rate of females and male clients. Also, no significant difference was found for intaker gender or experience level. Further, clients assigned to female counselors returned at a similar rate as did clients assigned to male counselors.

Besides these important variables of the therapist which have an effect on psychotherapy, there are other factors like the personality of the therapist, mental health of the therapist and therapist style which also have an effect on the psychotherapy outcome. These variables may be reviewed at length by the interested researcher who would be interested to study the therapist variables in our culture.
PROCESS VARIABLES IN PSYCHOTHERAPY OUTCOME

Process studies in psychotherapy deal with the interaction of therapist and patient or with the patient's behaviour in psychotherapy as a function of some more or less controlled stimulation. Such investigations are quite popular in an attempt to breakdown what happens during psychotherapy for the purpose of obtaining a better understanding of behaviour change as a result of treatment.

The effort by researchers in the developed countries to discover combinations of therapists and patients that are predictive of positive therapeutic outcome is usually traced to the work of Whitehorn and Betz (1954, 1957, 1960). Since their investigations with the A - B scale, which was designed to differentiate therapists in terms of their ability to work well with schizophrenic patients, a sizable number of studies have been conducted in other countries in an effort to discover maximal matches of patients and therapists.

Such a research strategy assumes that felicitous combinations of therapists and patients might be formed on the basis of some general, characterological
tendencies of the participants, which are independent of the treatment setting but which, nevertheless, make their inevitable appearance throughout the course of therapy. The meshing of these characteristics is then presumed to lead to the enhancement of positive therapeutic changes in the patient. By inference, it is also presumed that an inappropriate "match" of therapist and patient may block or limit the therapist's effectiveness with that particular patient.

The idea of therapist - patient matching, however, is one with very uncertain conceptual boundaries. In its broadest meaning, it suggests only that certain therapist - patient combination are better than others. It gives no immediate hint regarding which dimensions are most suitable for matching or whether it is better for the participants to be very much alike or very different on a particular dimension.

In a recent review of research on the effects of psychotherapeutic persuasion (Beutler, 1981) has documented a consistent and relatively strong relationship between the degree to which a patient acquires the therapist's attitudes (convergence) and the amount of therapeutic improvement attained.
McNair, Lorr and Callahan (1963) studied, Patient and therapist influences on quitting psychotherapy, on a group of 106 Terminators and 176 Remainers. The results indicate that Terminators and Remainers form distinguishable outpatient populations. The former reject psychotherapy, perhaps because they lack the behavioral repertoire required for participation.

Folman, R.Z. (1973) in a study, "Therapist - Patient perceptual style, interpersonal attraction, initial interview, behavior and premature termination", concluded that:

a) premature terminators of therapy are more field dependent than remainers:

b) highly attracted therapist - patient pairs are more similar in perceptual style than low attraction pairs; and

c) therapist - patient pairs more similar in perceptual style have lower premature termination rates than do dissimilar pairs.

Vall, A.F. (1974) in his study, "Drop-out from psychotherapy as related to patient - therapist discrepancies, therapist characteristics and interaction in race and sex", predicted that the greater the similarity between patient and therapists
in race and in sex; the longer the patients would be likely to continue in treatment.

Sandler, W.J. (1975) studied the, "Patient - Therapist dissimilarity of role expectations related to premature termination of psychotherapy with student - therapists". 97 patients applying for psychotherapy at two university psychological centers were included in the sample.

The results provided support for the hypotheses that terminators manifested higher initial dissimilarity of role expectations than Remainers, and that dyads demonstrated reduced dissimilarity of role expectations as therapy continued.

Hoffman & Summers (1982) investigated the relationship between patient and therapist role expectancies and preferences and premature termination. The results were that both student - patient's and therapists pretherapy role expectancies and preferences were significantly different prior to therapy and became significantly more congruent at post third session. No relationship was demonstrated between patient - therapist role expectancy or role preference congruence and premature termination.
Timothy and Ann Marie's (1981) study was an investigation of the joint interaction of patient input variables (including demographic information, pretherapy expectations and initial perspective of the psychotherapy process), therapist input variables and situational variables as these related to the outcome of premature psychotherapy termination. Results indicated that the best predictors of dropout are to be found by considering all the factors which impinge upon the process of psychotherapy. The findings indicated that those factors which discriminate treatment dropouts and remainers are not unidimensional characteristics but rather a set of highly correlated interacting variables.

Terrell, and Terrell, (1984) studied the, race of counselor, client sex, cultural mistrust level and premature termination from counseling among black clients. The results were that significant percentages of shared variance were found between termination rates and the predictor variables of counselors race and trust level as well as the interaction of counselor's race and trust level. No significant amount of shared variance was found between sex of clients and termination rates.
Kolb, et al. (1985) investigated the relationship between pretherapy patient's and process variables relating to dropout and change in 91 adults who received psychotherapy from 26 trainees at a University teaching hospital. Results indicate that process variables rather than preexisting traits were the best predictors of outcome. Therapist ratings of subjects' involvement in therapy were the best single predictor of symptomatic change.
CHAPTER IV
HYPOTHESES

One type of response made to the problem of premature termination is that a more careful screening should take place before clients are assigned for psychotherapy. With the large demand for services, premature termination from psychotherapy has been viewed as a waste of time and professional manpower. This solution thus stresses the more careful selection of cases in terms of accepting those who may be seen as being more amenable to psychotherapy and those who may be "unsuitable clients".

Since psychotherapy is a new technique in our culture, we cannot afford to waste time and professional manpower. Keeping the above aspect under consideration the author has framed the following hypotheses to screen out the patients who have a greater chance of remaining and benefiting in psychotherapy and those who are more likely to terminate prematurely. The following hypotheses were framed in the light of the research review and evaluation of cultural patterns and various other environmental factors prevalent in Pakistan.
HYPOTHESES NO: 1:
If coming for psychotherapy involves travelling a greater distance then there will be a greater likelihood of termination.

HYPOTHESES NO: 2
If coming for psychotherapy involves a greater financial burden, then there will be a greater likelihood of termination.

HYPOTHESES NO: 3
If coming for psychotherapy involves greater conflict with job timings then there will be a greater likelihood of termination.

HYPOTHESES NO: 4
If the patients have a higher manifest anxiety level, then they will remain longer in psychotherapy.

HYPOTHESES NO: 5.
If the attitude of the family towards psychotherapy is favourable then the patients will remain longer in psychotherapy.

HYPOTHESES NO: 6.
If the patients come voluntarily for psychotherapy then they will remain longer in psychotherapy.

HYPOTHESES NO: 7
If the patients are referred by doctors, hospitals, schools and organizations, then they will remain longer in psychotherapy.
HYPOTHESES NO: 8. If the patients are sent by religious leaders (pirs and spiritual leaders) then they will remain longer in psychotherapy.

HYPOTHESES NO: 9. If the female patients are sent by their in-laws, then they will remain longer in psychotherapy.

HYPOTHESES NO: 10. If the patients belong to the higher socio-economic level, then they will remain longer in psychotherapy.

HYPOTHESES NO: 11. If the patients are educated, then they will remain longer in psychotherapy.

HYPOTHESES NO: 12. If the patients have had previous psychiatric experience then they will remain longer in psychotherapy.
CHAPTER V

METHOD

Adults who started individual psychotherapy in the Institute of Clinical Psychology, University of Karachi, Karachi, served as subjects. These patient's were registered for psychotherapy from January 1985 to December 1986.

A total of 150 patients were selected for the study which included 75 REMAINERS and 75 TERMINATORS. This sample consisted of 88 Males and 62 Females with a combined mean age of 33.6 years (S.D. = 14.8). As a total group, the patients were heterogenous with respect to demographic characteristics:

- 51.6 % were married, 18.3 % were divorced or widowed and 30.1 % never had been married.

- Diagnostically the patients represented a broad range of psychological diagnosis.

There were 11 student therapists who were requested to provide information about their respective patients.

This information was collected on the basis of a questionnaire which was prepared in consultation with
an experienced and qualified clinical psychologist along with many other Ph.d. candidates of Clinical Psychology. Then the above mentioned therapists were requested to fill in the questionnaire (given in the Appendix I) provided to them by the author and the data was recorded for each subject as follows:

a. Remainor or Terminator
b. Sex
c. Age
d. Occupation
e. Marital Status
f. Monthly Income
g. Education
h. Family size and number of dependents
i. Source of referral
j. Previous psychiatric experience.
k. Distance travelled to the institute.
l. Conflict with the job
m. Anxiety level
n. Attitude of the the family towards psychotherapy
o. Motivation level

The number of patients were limited because of the availability of all the variables required for the research.
OPERATIONAL DEFINITION OF VARIOUS VARIABLES

a. The REMAINDER cases are defined as those cases who continue to remain in psychotherapy for atleast 30 sessions and/or are successfully terminated on the recommendations of the Director of the Institute.

The TERMINATOR cases are those cases who leave psychotherapy without the advice of the therapist and those who terminate before 10 sessions of psychotherapy.

b. OCCUPATION was defined according to Hollinshead & Redlich's scales. Details of the criterion used by Hollingshead and Redlich is given in Appendix 1.

c. INCOME was defined as the number of earning members and their respective monthly income.

d. FINANCIAL BURDEN was defined as the per capita income and the percentage of fees charged on it by the Institute per session from the patient.

e. SOCIO-ECONOMIC STATUS was defined according to Hollingshead and REDLICH's 2 Factor Index of Social position.
f. EDUCATION was defined on a 7 point rating scale given in the Appendix 1.

g. DISTANCE was defined according to the number of kilometers the patient had to travel to reach the Institute of Clinical Psychology (scale given in the Appendix 1).

h. CONFLICT WITH JOB was defined in accordance with the assessment made through the questionnaire as EASY (no conflict with housework, job or education timings) and DIFFICULT (conflict with housework, job or education timings).

i. ANXIETY LEVEL OF THE PATIENT was defined on a 5 point rating scale (given in the Appendix 1). The respective therapists were asked to rate their patients on the same anxiety scale.

j. ATTITUDE OF THE FAMILY was defined as the extent to which the family of the patient demonstrated favourable attitude towards psychotherapy by showing kindness, encouragement, approval and by promoting convenience and was rated by the therapist on a 5 point scale given in the Appendix 1.
K. MOTIVATION LEVEL was defined as the extent to which the internal states of the individual lead to the instigation, persistence and included the goal direction and energizing of behaviour for coming to psychotherapy. This was measured on a 5 point rating scale given in the Appendix 1.

I. SOURCE OF REFERRAL was defined as to who referred the case to the Institute of Clinical Psychology. Details given in the appendix.

M. PREVIOUS PSYCHIATRIC EXPERIENCE was defined whether or not the patient has had any previous treatment with a psychiatrist before coming to the Institute.

A chi square test of independence was computed between the actual frequency of terminators and remainers for all the variables except the variable of FINANCIAL BURDEN on which a t-test of 2 independent samples was applied because of the continuous data available. In those variables where chi square was applicable, the expected overall frequency based on the frequency of remainers and terminators in the total sample population was calculated.
Chi square was computed for each column in which there was significant difference between the expected frequency and the observed frequency within the dependent variables.
CHAPTER VI
RESULTS

An overall dropout or premature termination rate of the patients who were registered at the Institute of Clinical Psychology, University of Karachi, Karachi, during January 1985 to December 1986 was 40.32% and this is generally consistent with the literature obtained from the developed countries. Elduson (1968) in a review of this problem, concluded that 30% to 65% of all patients are dropouts in facilities representing every kind of psychiatric service.

HYPOTHESES NO: 1: If coming for psychotherapy involves travelling a greater distance then there will be a greater likelihood of termination.

The results of the statistical analysis are shown in Table No 1 and graph A.

It may be noted that the Chi-square ($X^2 = 12.62$, df=4, $p < .05$ level) indicates that it is a useful predictor of Termination. Subjects who have to travel a greater distance in order to reach to the Institute for psychotherapy are significantly more likely to be terminators.
The required chi square is $X^2 \geq 9.49$, df=4, $p < .05$.

The same results are further highlighted by the use of graph A.

HYPOTHESES NO: 2. If coming for psychotherapy involves a greater financial burden, then there will be a greater likelihood of termination.

The results of the statistical analysis are shown in Table No 2 and graph B1 and B2.

It is indicated that the 't' obtained is 8.18, df=148, $p < .001$ level which is pointing to the fact that it is a powerful predictor of early termination. Those patients for whom psychotherapy involves a greater financial burden, they are significantly more likely to be terminators.

The required 't' level is 3.09, and $p < .001$ level. The same results are further highlighted by the use of graph B-1 & B-2. The graph B-1 indicates that the mean financial burden of Remainders is 5.1 % whereas mean financial burden of Terminators is 10.5 %. Graph B-2 indicates that the total percentage of
financial burden on Terminators is 67.3% whereas for Remainders is 32.7%.

HYPOTHESES NO: 3. 
If coming for psychotherapy involves greater conflict with job timings then there will be a greater likelihood of termination.

The results of the statistical analysis are shown in Table No 3 and graph C. It may be noted that the chi square, \( \chi^2 = 19.56, \text{ df}=1, \ p < .001 \text{ level} \) indicates that it is a useful predictor of early termination. Those patients who have a greater conflict with job timings, education timings or with housework, in coming for psychotherapy are significantly more likely to be terminators.

The required chi-square is \( \chi^2 = 10.83, \text{ df}=1, \ p < .001 \text{ level} \). The same results are highlighted by the use of graph C.

HYPOTHESES NO 4. 
If the patients have a higher manifest anxiety level, then they will remain longer in psychotherapy.
The results of the statistical analysis are shown in Table No 4 and graph D. The obtained chi-square \( (X^2 = 22.54, df=4, p < .001 \text{ level}) \) is indicating that it is also a useful predictor of remaining in psychotherapy.

Those patients who have a high manifest anxiety level, are significantly more likely to be remainers. The required chi-square is \( X^2 = 18.47, df=4, p < .001 \text{ level} \). The same results are highlighted by the use of graph D.

HYPOTHESES NO. 5:

If the attitude of the family towards psychotherapy is favourable then the patients will remain longer in psychotherapy.

The results of the statistical analysis are shown in Table No 5 and graph E. It may be noted that the chi-square \( (X^2 = 21.36, df=4, p < .001 \text{ level}) \) indicates that it is a useful predictor of remaining in psychotherapy.

Those patients whose family had a favourable attitude towards psychotherapy, were more significantly likely to be remainers.
The required chi-square is $X^2 = 18.47$, $df=4$, $p < .001$ level. The same results are further highlighted by the use of graph E.

HYPOTHESES NO 6. If the patients come voluntarily for psychotherapy then they will remain longer in psychotherapy.

The results of the statistical analysis are shown in Table No 6 and graph F. It may be noted that the chi-square ($X^2 = 31.76$, $df=1$, $p < .001$ level) indicates it as a useful predictor of remaining in psychotherapy. Those patients who come voluntarily for psychotherapy were more significantly likely to be remainers. The required chi-square is $X^2 = 18.47$, $df=4$, $p < .001$ level. The same results are further highlighted by the use of graph F.

HYPOTHESES NO 7. If the patients are referred by doctors, hospitals, schools and organizations, then they will remain longer in psychotherapy.

The results of the statistical analysis are shown in Table No 7 and graph G-1 and G-2.
The chi-square obtained is $X^2 = 6.14$, df=5, $p < .02$ level. This indicates that it is also a useful predictor of remaining in psychotherapy. Those patients who are referred to the Institute by doctors, hospitals, schools and organizations i.e. authority figure are significantly likely to be remainers.

The required chi-square is $X^2 = 5.11$, df=1, $p < .02$ level. The same results are highlighted by the use of graph G-1 and G-2.

HYPOTHESES NO 8. If the patients are sent by religious leaders (pirs, and spiritual leaders) then they will remain longer in psychotherapy.

This variable could not be studied due to non-availability of data.

HYPOTHESES NO 9. If the female patients are sent by their in-laws, then they will remain longer in psychotherapy.

No statistical analysis could be conducted because of the non-availability of data. There were only two female patients who fell in this category.
HYPOTHESES NO 10: If the patients belong to the higher socio-economic level, then they will remain longer in psychotherapy.

The results of the statistical analysis are shown in Table No 8 and graph H-1 and H-2.

It may be noted that the chi-square obtained is \( \chi^2 = 12.98, \) df=2, \( p < .01 \) level. This indicates that it is a useful predictor of remaining in psychotherapy. These patients who belong to a higher socio-economic level are significantly more likely to be remainers. The chi-square required is \( \chi^2 = 9.21, \) df=2, \( p < .01 \) level. The same results are further highlighted by the use of graph H-1 and H-2.

HYPOTHESES NO. 11. If the patients are educated then they will remain longer in psychotherapy.

The results of the statistical analysis are shown in Table No 9 and graph I.

The chi-square obtained \( \chi^2 = 16.82, \) df=6, \( p < .01 \) level is an indication of education being a powerful predictor of early termination. Those
patients who are educated are significantly more likely to be remainers. The required chi-square is 16.81, df=6, p < .01 level.

The same results are further highlighted by the use of Graph 1.

HYPOTHESES NO. 12. If the patients have had previous psychiatric experience then they will remain longer in psychotherapy.

The results of the statistical analysis are shown in Table No 10 and graph J.

It may be noted that the chi-square $\chi^2 = 19.56$, df=1, p < .001 level is indicating that it is a powerful indicator of early termination. Those patients who had been using psychotropic drugs before they are referred for psychotherapy are significantly more likely to be remainers.

The required chi-square is $\chi^2 = 10.83$, df=1, p < .001 level. The same results are further highlighted by the use of graph J.
Table No: 1.

"THE EFFECT OF DISTANCE TRAVELLED ON REMAINDERS AND TERMINATORS IN PSYCHOTHERAPY."

<table>
<thead>
<tr>
<th>Distance (KMs)</th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3</td>
<td>21 (16.5 fe)</td>
<td>12 (16.5 fe)</td>
<td>33</td>
</tr>
<tr>
<td>3 to 6</td>
<td>27 (21.5 fe)</td>
<td>16 (21.5 fe)</td>
<td>43</td>
</tr>
<tr>
<td>7 to 10</td>
<td>15 (16.5 fe)</td>
<td>18 (16.5 fe)</td>
<td>33</td>
</tr>
<tr>
<td>11 to 15</td>
<td>8 (14 fe)</td>
<td>20 (14 fe)</td>
<td>28</td>
</tr>
<tr>
<td>16 &amp; above</td>
<td>4 (6.5 fe)</td>
<td>9 (6.5 fe)</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
X = \frac{\sum (F_o - F_e)^2}{\text{Fe}}
\]

\[
X = 12.62
\]

Significant at 0.05 level
Effect of DISTANCE TRAVELLED on Remainers and Terminators in psychotherapy

LEGEND
- REMAINERS
- TERMINATORS

NUMBER OF REMAINERS & TERMINATORS

3 TO 6
7 TO 10
11 TO 15
DISTANCE TRAVELLED in kilometers

0 TO 3
10 TO 15
16 & ABOVE
"THE EFFECT OF FINANCIAL BURDEN ON REMAINING AND TERMINATING IN PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th>Sample</th>
<th>Remainer</th>
<th>Terminator</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>M</td>
<td>5.1 %</td>
<td>10.5 %</td>
</tr>
<tr>
<td>S.D.</td>
<td>3.384</td>
<td>4.654</td>
</tr>
<tr>
<td>t</td>
<td>8.18</td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>148</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>&lt; 0.001</td>
<td></td>
</tr>
</tbody>
</table>
Effect of FINANCIAL BURDEN on Remainers and Terminators in psychotherapy

LEGEND
- REMAINDER
- TERMINATOR

NUMBER OF REMAINERS AND TERMINATORS

FINANCIAL BURDEN (in percentage)
"THE EFFECT OF CONFLICT WITH JOB TIMINGS ON REMAINERS & TERMINATORS IN PSYCHOThERAPY"

<table>
<thead>
<tr>
<th></th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>EASY (No conflict with housework, job or education timings)</td>
<td>48 (34.5 fe)</td>
<td>21 (34.5 fe)</td>
<td>69</td>
</tr>
<tr>
<td>DIFFICULT (Conflict with housework, job or education timings)</td>
<td>27 (40.5 fe)</td>
<td>54 (40.5 fe)</td>
<td>81</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
x = \frac{(F_o - F_e)^2}{F_e}
\]

\[
x = 19.56
\]

Significant at 0.001 level
Effect of CONFLICT WITH JOB TIMINGS on Remainders and Terminators in psychotherapy

LEGEND
- REMAINDER
- TERMINATOR

NUMBER OF REMAINERS AND TERMINATORS

Easy Difficult

CONFLICT WITH JOB TIMINGS
Table No: 4.

"THE EFFECT OF MANIFEST ANXIETY LEVEL ON REMAINERS & TERMINATORS IN PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practically never</td>
<td>4 (7 fe)</td>
<td>10 (47 fe)</td>
<td>14</td>
</tr>
<tr>
<td>Occasionally</td>
<td>12 (21.5 fe)</td>
<td>31 (21.5 fe)</td>
<td>43</td>
</tr>
<tr>
<td>Moderate</td>
<td>9 (10.5 fe)</td>
<td>12 (10.5 fe)</td>
<td>21</td>
</tr>
<tr>
<td>Frequent</td>
<td>28 (21 fe)</td>
<td>14 (21 fe)</td>
<td>42</td>
</tr>
<tr>
<td>Very frequent</td>
<td>22 (15 fe)</td>
<td>8 (15 fe)</td>
<td>30</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
X^2 = \frac{(\text{Fo} - \text{Fe})^2}{\text{Fe}}
\]

\[
X^2 = 22.54
\]

Significant at 0.001 level
Effect of MANIFEST ANXIETY LEVEL on Remainers and Terminators in psychotherapy

<table>
<thead>
<tr>
<th>MANIFEST ANXIETY LEVEL</th>
<th>Number of Remainers and Terminators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practically never</td>
<td></td>
</tr>
<tr>
<td>Occasionally</td>
<td></td>
</tr>
<tr>
<td>Frequent</td>
<td></td>
</tr>
<tr>
<td>Very frequent</td>
<td></td>
</tr>
</tbody>
</table>

**LEGEND**
- REMAINER
- TERMINATOR
"THE EFFECT OF ATTITUDE OF THE FAMILY ON REMAINERS AND TERMINATORS IN PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th>ATTITUDE</th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly Favourable</td>
<td>24 (17.5 fe)</td>
<td>11 (17.5 fe)</td>
<td>35</td>
</tr>
<tr>
<td>Favourable</td>
<td>31 (24.5 fe)</td>
<td>18 (24.5 fe)</td>
<td>49</td>
</tr>
<tr>
<td>Neutral</td>
<td>8 (9 fe)</td>
<td>10 (9 fe)</td>
<td>18</td>
</tr>
<tr>
<td>Unfavourable</td>
<td>6 (15.5 fe)</td>
<td>25 (15.5 fe)</td>
<td>31</td>
</tr>
<tr>
<td>Antagonistic</td>
<td>6 (8.5 fe)</td>
<td>11 (8.5 fe)</td>
<td>17</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>75</strong></td>
<td><strong>75</strong></td>
<td><strong>150</strong></td>
</tr>
</tbody>
</table>

\[
X = \frac{2}{(Fo - Fe)} \cdot Fe
\]

\[
X = 21.36
\]

Significant at 0.001 level
Effect of ATTITUDE OF THE FAMILY on Remainers and Terminators in psychotherapy

Legend
- Remainers
- Terminators

Number of Remainers and Terminators

Favourable
- Highly favourable
- Neutral
- Antagonistic

Unfavourable

Attitude of Family
Table No: 6.

"THE EFFECT OF MOTIVATION LEVEL OF THE PATIENT ON REMAINERS & TERMINATORS IN PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th></th>
<th>Remain</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very highly motivated</strong></td>
<td>18 (12 fe)</td>
<td>6 (12 fe)</td>
<td>24</td>
</tr>
<tr>
<td><strong>Highly motivated</strong></td>
<td>35 (24.5 fe)</td>
<td>14 (24.5 fe)</td>
<td>49</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>11 (13.5 fe)</td>
<td>16 (13.5 fe)</td>
<td>27</td>
</tr>
<tr>
<td><strong>Less motivated</strong></td>
<td>6 (12 fe)</td>
<td>18 (12 fe)</td>
<td>24</td>
</tr>
<tr>
<td><strong>Least motivated</strong></td>
<td>5 (13 fe)</td>
<td>21 (13 fe)</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
x = \frac{2}{\text{Fe}} (\text{Fo} - \text{Fe})
\]

\[
x = \frac{2}{\text{Fe}}
\]

\[
x = 31.76
\]

Significant at 0.001 level.
Effect of MOTIVATION LEVEL OF THE PATIENT on Remainers and Terminators in psychotherapy

LEGEND
- REMAINDER
- TERMINATOR

NUMBER OF REMAINERS AND TERMINATORS

MOTIVATION LEVEL OF THE PATIENT

Highly motivated

Moderate

Least motivated

Very highly motivated
Table No: 7

"THE EFFECT OF REFERRAL SOURCE ON REMAINING AND TERMINATING FROM PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>Remain</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors &amp; Therapists, Hospitals</td>
<td>40 (33.92fe)</td>
<td>24 (30.08fe)</td>
<td>64</td>
</tr>
<tr>
<td>Organizations &amp; Teachers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(social workers)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends &amp; Miscellaneous</td>
<td>13 (19.08fe)</td>
<td>23 (16.92fe)</td>
<td>36</td>
</tr>
</tbody>
</table>

| TOTAL                         | 53     | 47         | 100   |

\[
x = \frac{\chi^2}{\text{Fe}}
\]

\[
x = \frac{2}{\text{Fe}}
\]

\[
x = 6.44
\]

Significant at 0.02 level
Effect of REFERRAL SOURCE on Remainders and Terminators in psychotherapy

LEGEND
- Remainder
- Terminator

NUMBER OF REMAINERS AND TERMINATORS

REFERRAL SOURCE

Authority
Non-Authority
Effect of REFERRAL SOURCE on Remainers and Terminators in psychotherapy

- Authority: 37.5%
- Non-Authority: 63.9%
- Remainder: 62.5%

- Authority: 36.1%
- Non-Authority: 63.9%
- Remainder: 36.1%
Table No: 8.

"THE EFFECT OF SOCIO-ECONOMIC STATUS ON REMAINERS & TERMINATORS IN PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th>Levels</th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher status 70 - 98</td>
<td>45 (35.5 fe)</td>
<td>26 (35.5 fe)</td>
<td>71</td>
</tr>
<tr>
<td>Middle 42 - 69</td>
<td>20 (21 fe)</td>
<td>22 (21 fe)</td>
<td>42</td>
</tr>
<tr>
<td>Lower 14 - 41</td>
<td>10 (18.5 fe)</td>
<td>27 (18.5 fe)</td>
<td>37</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
X^2 = \frac{(O_{i} - E_{i})^2}{E_{i}}
\]

\[
X^2 = 12.98
\]

Significant at 0.01 level

<table>
<thead>
<tr>
<th>Education</th>
<th>7 point scale</th>
<th>Max</th>
<th>Min</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X = 5</td>
<td>35</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupation</th>
<th>7 point scale</th>
<th>Max</th>
<th>Min</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X = 9</td>
<td>63</td>
<td>9</td>
</tr>
</tbody>
</table>

98 14
Effect of SOCIO–ECONOMIC STATUS on Remainers and Terminators in psychotherapy

![Graph showing the number of remainers and terminators across different socio-economic classes.]

**Legend:**
- REMAINERS
- TERMINATORS

**Socio-economic classes:**
- Higher class
- Middle class
- Lower class

**Number of Remainers and Terminators:**
- Higher class: 45
- Middle class: 25
- Lower class: 10
Effect of SOCIO-ECONOMIC STATUS on Remainers and Terminators in psychotherapy

REMAINERS 63.4%
TERMINATORS 36.6%
Higher class

REMAINERS 47.6%
TERMINATORS 52.4%
Middle class

REMAINERS
TERMINATORS
Lower class
### THE EFFECT OF EDUCATION ON REMAINERS & TERMINATORS IN PSYCHOTHERAPY

<table>
<thead>
<tr>
<th></th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illeterate</td>
<td>5 (8 fe)</td>
<td>11 (8 fe)</td>
<td>16</td>
</tr>
<tr>
<td>Elementary</td>
<td>5 (10 fe)</td>
<td>15 (10 fe)</td>
<td>20</td>
</tr>
<tr>
<td>Middle</td>
<td>5 (7.5 fe)</td>
<td>10 (7.5 fe)</td>
<td>15</td>
</tr>
<tr>
<td>High</td>
<td>12 (10.5 fe)</td>
<td>9 (10.5 fe)</td>
<td>21</td>
</tr>
<tr>
<td>Inter</td>
<td>10 (11 fe)</td>
<td>12 (11 fe)</td>
<td>22</td>
</tr>
<tr>
<td>Graduate</td>
<td>23 (17.5 fe)</td>
<td>12 (17.5 fe)</td>
<td>35</td>
</tr>
<tr>
<td>Post Graduate</td>
<td>15 (10.5 fe)</td>
<td>6 (10.5 fe)</td>
<td>21</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
X = \frac{(\text{Fo} - \text{Fe})^2}{\text{Fe}}
\]

\[
X = 16.82
\]

Significant at 0.01 level
Effect of EDUCATION on Remainders and Terminators in psychotherapy

LEGEND
- REMAINS
- TERMINATORS

NUMBER OF REMAINERS AND TERMINATORS

EDUCATION
- Illiterate
- Elementary
- Middle
- High
- Inter
- Post Graduate
- Graduate

[Bar chart with education levels and corresponding numbers of remainders and terminators]
Table No: 10.

"THE EFFECT OF PREVIOUS PSYCHIATRIC EXPERIENCE ON REMAINERS & TERMINATORS IN PSYCHOTHERAPY"

<table>
<thead>
<tr>
<th></th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Psychiatric Experience</td>
<td>54 (40.5 fe)</td>
<td>27 (40.5 fe)</td>
<td>81</td>
</tr>
<tr>
<td>No previous Psychiatric Experience</td>
<td>21 (34.5 fe)</td>
<td>48 (34.5 fe)</td>
<td>69</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
X^2 = \frac{(O - E)^2}{E}
\]

\[
X^2 = 19.56
\]

Significant at 0.001 level
Effect of
PREVIOUS PSYCHIATRIC EXPERIENCE
on Remainders and Terminators
in psychotherapy

Legend:
- REMAINERS
- TERMINATORS

Number of Remainders and Terminators

Experienced
Non-Experienced

PREVIOUS PSYCHIATRIC EXPERIENCE
THE EFFECT OF AGE ON REMAINERS & TERMINATORS IN PSYCHOTHERAPY

<table>
<thead>
<tr>
<th>Years</th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - 35</td>
<td>61 (48.5 fe)</td>
<td>36 (48.5 fe)</td>
<td>97</td>
</tr>
<tr>
<td>36 - 60</td>
<td>14 (26.5 fe)</td>
<td>39 (26.5 fe)</td>
<td>53</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>75</td>
<td>150</td>
</tr>
</tbody>
</table>

\[
X = \frac{2}{(\text{Fo} - \text{Fe})} \frac{2}{\text{Fe}}
\]

\[
X = 18.22
\]

Significant at 0.001 level
Effect of AGE on Remainders and Terminators in psychotherapy

<table>
<thead>
<tr>
<th>AGE</th>
<th>Remainders</th>
<th>Terminators</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-35</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>36-60</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

LEGEND
- REMAINERS
- TERMINATORS
### STATEMENT OF PRESENTING SYMPTOMS

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Remainder</th>
<th>Terminator</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurotic</td>
<td>54 (43.8 fe)</td>
<td>32 (42.12 fe)</td>
<td>86</td>
</tr>
<tr>
<td>Psychotic</td>
<td>21 (31.12 fe)</td>
<td>40 (29.8 fe)</td>
<td>61</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>72</td>
<td>147</td>
</tr>
</tbody>
</table>

\[
X = \frac{\sum (O - E)^2}{E}
\]

\[
X = 11.58
\]

Significant at 0.001 level
CHAPTER VII
Discussion

Both practical and theoretical considerations have brought about an increased interest in identifying variables which influence patients to accept psychotherapeutic treatment. The relative scarcity of trained psychotherapists in proportion to the large number of patients seeking their services indicates the desirability of therapists expending their efforts and time more economically. Those patients who leave treatment very early without apparent benefit and without the therapists approval in particular are sources of frustration both to themselves and their therapists.

This study was undertaken to investigate client factors related to the premature termination of psychotherapy.

Results obtained, indicate, that there are certain factors which contribute highly towards remaining and terminating from psychotherapy.

In the previous chapter the statistical results of the various hypotheses have been demonstrated and this chapter will be devoted to the discussion of the various hypotheses in the light of the results obtained in this research.
The hypothesis No 1 states that:

"If coming for psychotherapy involves travelling a greater distance then there will be a greater likelihood of termination."

This hypothesis is supported by the data and was significant at $p < .05$ level.

It is interesting to note that the greater the distance travelled for coming to psychotherapy, the more are the numbers of terminators.

According to Table No 1 and Graph A, it is quite clear that if the distance is less than 3 kilometers than there are larger number of Remainders.

In Karachi there are various modes of transportation, but most of the patients who come to the Institute of Clinical Psychology for treatment, come through the public transport and very few come by their private cars or motor cycles. People normally have to wait for a long time for public transport and even if they do get the transport, they have to stand in the bus throughout their journey in order to reach their destination. Obviously, a person suffering from emotional problems, normally avoids to travel in such an inconvenient manner.
Another factor which affects the distance involved is that the patient does not come alone and is accompanied most of the time by one of the family members. Therefore, it is all the more difficult to get public transport for more than one person in the same mode of transportation.

In the light of the results obtained it is obvious that people who have to go through all these difficulties will avoid psychotherapeutic treatment specially because they have to come frequently i.e. 3 or 4 times a week. In addition to this factor the outcome of treatment is also not visible during the first few sessions. Hence, it leads to the termination of psychotherapy.

The hypotheses No 2 states that:

If coming for psychotherapy involves a greater financial burden, then there will be a greater likelihood of termination.

This hypothesis has proved to be highly significant. As seen from Table No 2 that it is significant at p < .001 level. The Mean financial burden (in percentage) for the Remainders is 5.1%
compared to Terminators whose mean financial burden is 10.5%. This indicates that financial burden is a very important factor in premature termination of psychotherapy. Pakistan is a developing country and many people cannot afford to pay for treatment like psychotherapy as it does not give them immediate satisfaction by means of quick relief of symptoms. People in Pakistan can give a large amount of money to a surgeon for a minor surgery because it ensures a comparatively total cure within a weeks time, but it is hard for the families to pay for a mentally sick person for a continuous treatment which does not give immediate relief to the symptoms. So even a smaller amount of money given for psychotherapy becomes a burden.

Secondly, in a family where there are many dependants, a treatment like psychotherapy receives secondary importance because the awareness of psychopathology and psychotherapy as a mode of treatment is lacking due to the lack of education in the country. Last but not the least, it requires some amount of motivation on the part of the family members to bring the patient for treatment especially if they are not an earning member. The family may give their precious time to an earning member but a non-earning member is not given much importance and is usually
neglected. Such a member is considered to be a liability for the family. Therefore it is quite apparent from the results that the hypothesis concerning financial burden is statistically significant and important factor in the continuation of psychotherapy.

The hypothesis No 3 states that:

"If coming for psychotherapy involves greater conflict with job timings then there will be a greater likelihood of termination."

The effect of conflict with job or education timings on Remainders and Terminators is also quite significant as shown in Table NO III. The obtained chi-square is significant at p < .001 level.

In Pakistan it is difficult to get good and permanent jobs. There is a lot of hue and cry about joblessness due to lack of job opportunities. Therefore, those people who have the job consider it a great privilege and give it more importance than their personal ailments because it actually becomes a question of their survival. It is easier for an individual to ask or a weeks leave at a time for some
physiological illness, but it is difficult for them to explain to their employers that they have to go at a fixed time for some urgent piece of work twice or thrice a week. This problem also comes up because it is difficult for them to tell their employers that they or their dependants are suffering from psychological problem due to the stigma attached to such ailments. It is also observed that most of the patients who come for psychological treatment to the Institute of Clinical Psychology, prefer to take a certificate from a medical doctor for any kind of physical illness rather than taking a certificate for leave, from a psychotherapist. Therefore, in the light of the results obtained it can be concluded that the above hypothesis is significant and the factor of conflict with job timings will effect the longevity of treatment is highly significant.

The hypothesis No 1 states that:

"If the patients have a higher manifest anxiety level, then they will remain longer in psychotherapy."

As it is clear from Table NO 4 that the effect of manifest anxiety, is very significant on Remainers and
Terminators. The obtained significance is $p < .001$ level. This is quite consistent with the literature review and the observations of the author as people who have high manifest anxiety benefit more from psychotherapy because an immediate change in the level of anxiety is seen during the first few sessions of psychotherapy.

Hence people with higher manifest anxiety gain more confidence in psychotherapy as a technique of treatment and therefore remain longer in psychotherapy than others who have a lower manifest anxiety level. Even the families of such patients note a significant change in the patient and feel that the trouble they are going through by bringing the patient for treatment is not wasted because they are satisfied with the initial progress of the patient. This primary effect causes them to stay longer in psychotherapy and hence a better result.

The hypothesis NO 5 states, that:

"If the attitude of the family towards psychotherapy is favourable then the patients will remain longer in psychotherapy."
It is clear from Table No 5 that there is a profound effect of the attitude of the family members towards psychotherapy on Remainders and Terminators. The observed level of significance is $p < .001$ level. This factor is very important because in Pakistani culture it is not only the patient who has to be motivated but also the families because the patient invariably is dependent on the family for treatment. So the family members feel that they are responsible for the well being of the patient and should look after their member who is mentally sick. Since they are also responsible for bringing the patient for treatment, it is imperative that they are satisfied with the results of psychotherapy and are aware of the fact that psychotherapy is a scientific technique which will help the patient in a favourable manner. At times some of the family members are also asked to see the therapist in the institute if the therapist feels that the problem also lies with them specially the parents. This gives vent to their own emotional conflicts and they feel themselves motivated to come for psychotherapy for their own sake.

The patient also feels that it is not he/she alone who suffers from mental illness but it is the problem of the entire household and hence takes greater interest and remains longer in psychotherapy.
The hypothesis No 6 states that:

"If the patients come voluntarily for psychotherapy then they will remain longer in psychotherapy."

Coming voluntarily for treatment has been defined as an index of the motivational level of the patient by the author in the scale used to assess the source.

Motivation has been mentioned frequently as an important variable in psychotherapy. (Garfield 1980; Malan, 1976). It is clear that the strength of the patient's reasons for treatment regardless of their source, influence whether he opts to stay in it or not. These may include his ability to endure frustration and form long-range goals, his dissatisfaction with himself along with a need to change, and a felt need for help on his part as opposed to that of a referring institution or agency.

Motivation as a variable related to remaining in treatment is a measure of the patient's awareness of both his need for help and his desire for it. So, as per Table No 6, the effect of the motivation level of the patient on Remainders and Terminators in psychotherapy has proved to be highly significant. The significance level obtained is \( p < .001 \) level.
Patient who come voluntarily for treatment, are highly motivated because of the fact that they have the conviction that therapy is going to help them. These patients come for psychotherapy with the expectation that they are going to see an expert in therapy. This expectation reflects their level of dependency even prior to their contact with the therapist. This dependency level ensures longevity of stay in psychotherapy.

In case the patient is not motivated the first few sessions are devoted in creating a rapport and hence a very important period of time is spent on creating the level of motivation conducive to continuation of therapy. Therefore it can be concluded that coming for treatment voluntarily plays a vital role in continuation of psychotherapy.

The hypothesis No 7 states that:

If the patients are referred by doctors, hospitals, schools and organizations, then they will remain longer in psychotherapy.

It was hypothesized that those patients whose referral source would be authority oriented figures,
they would be compelled indirectly to stay in treatment for a longer time. This hypothesis has proved to be significant at \( p < .02 \) level. As clear from Table No: 7 that referral source is also an important determinant of Remainders and Terminators in psychotherapy. Remainders probably stay longer in therapy due to the role induction already done by the authority figures prior to the beginning of psychotherapy.

The hypothesis No 8 states that;

"If the patients are sent by religious leaders (pirs and spiritual leaders) then they will remain longer in psychotherapy."

Although considering the culture and its trends it was hypothesized that since most of the patients go to the pirs and religious leaders, there will be some who will be referred by the pirs and these patients will stay in therapy for a longer time because of high religious sanctity associated to the religious leaders and pirs. But unfortunately, while collecting the data, not a single case was found who was referred to the Institute of Clinical Psychology by such religious leaders, possibly due to the fact that the institute is a relatively new place for the treatment of mentally
and the religious leaders are not aware of the objectives and working of the Institute of Clinical Psychology. Besides this, the Institute has not been advertised at all as a place of treatment for the mentally ill.

The hypothesis No 9 states that:

"If the female patients are sent by their in-laws, then they will remain longer in psychotherapy."

Considering the clinical experience of certain therapists it was hypothesized that if the female patients were referred by their in-laws, they would be forced to stay in treatment. If married females in our culture are mentally sick, there is a tendency in the in-laws to disassociate the patient for ever by giving a divorce. But unfortunately the family attitude is such that out of the total sample of 150 patients only 2 female patients were referred by the in-laws, out of which one was categorized as a Remainer and the other terminated psychotherapy in 4 sessions. Therefore due to unavailability of sufficient data, statistical analysis could not be computed.
The hypothesis No 10 states that;

"If the patients belong to the higher socio-economic level, then they will remain longer in psychotherapy."

According to Table No 8, it is evident that those patients who belong to the higher socio-economic level remain longer in psychotherapy. This hypothesis has proved to be significant at \( p < .01 \) level.

The socio-economic level was derived by taking into account, both the education and occupation of the patient. This indicates that if people are highly educated and have psychological awareness about the efficacy of psychotherapy they tend to remain longer in it.

As evident from graph H2; there were 71 patients who were in the category of higher socioeconomic class. Out of them 63.4 % were Remainders and 36.6 % were terminators. In the middle class group there were 42 patients, out of which 47.6 % were Remainders and 52.4 % were Terminators. In the lower class group there were 37 patients, out of which 27 % were Remainders and 73 % were Terminators.

It is not at all surprising that socio-economic
status should be so important in the patients dropping out of or staying in treatment. The higher class patients frequently are found to have some sophisticated understanding of the methods and goals of psychotherapy. Their expectations and anticipations are, therefore, likely to be met. The higher class patients are predisposed towards the acceptance of psychotherapy even before they arrive at the clinic. Their positive attitude will obviously be reinforced if they happen to be suggestible and find an authority figure recommending a course of action to which they already are positively attracted.

Lower class patients on the other hand are much more likely to come to the clinic either unaware of the essentials of psychotherapy or with a distorted conception of it. Many cannot easily tolerate a non-medical type of treatment with its implication that their complaints may not be "real" since they are not treated on a physical basis.

The lower class patient puts much more emphasis on the present than on the future (Gursslin, Hunt, & Roach, 1959-60) and is more concrete and task oriented (GURSSLIN et al, 1959-60) and is less others directed and less likely to conform to social and expert opinion
(Hyman, 1953). He is also more apt to have physical as opposed psychological symptoms and is less psychologically minded (Hollingshead, 1958).

Finally, he is more poorly motivated, less patient, and less discontented and dissatisfied with himself (Schmidt, Smart and Moss, 1968) than the middle class patient. Hence, it is not hard to understand why forms of treatment which emphasize long-range goals and self understanding via psychological constructs may seem to him bewildering, if not downright irrelevant and nonsensical.

It is also likely that the lower class patient, concrete and task oriented as he is, should feel that further treatment is unnecessary and irrelevant once his symptoms have somewhat abated. Furthermore, because of their different expectancies and social class background they are likely to find communication with the therapist a difficult matter.

Hence, the lower class patient is less often favourably disposed towards psychotherapy. If, in addition, he is not accessible to authority influence, the possibility of his terminating psychotherapy early is quite large.

Another reason why patients from higher class are
more likely to be Remainers in Pakistan is because of the fact that they are more influenced by Western culture and hence are aware of the usefulness and benefits of psychotherapy. Moreover, they do not face the problems of financial burden and other factors which contribute to the early termination of psychotherapy as mentioned by this research. At times they also consider going for psychotherapy as a symbol of prestige. People from lower class are not highly educated and hence do not readily understand the value of just talking to them as a technique of treatment.

The relationship reported between social class variables and continuation in psychotherapy thus may be a function of several variables acting independently or in interaction with each other.

The hypothesis No 11 states that:

"If the patients are educated, then they will remain longer in psychotherapy."

It is evident from Table No 9 that the effect of education on Remainers and Terminators in psychotherapy is quite significant. The statistical significance obtained is p < 0.01 level.
Here again there are certain factors which are working independently and in interaction with one another.

Firstly, the more educated the person, the more he is psychological minded and is aware of problems having an emotional origin rather than all problems having a physical origin. They also have an understanding of the psychotherapeutic process and have a desire for psychotherapy.

Secondly, the highly educated people have a lesser fear of the stigma which is attached to mental illness. Higher education usually connotes an ability both to see causal relationships between ideas, feelings and behaviour and to recognise and label them. Therefore education is an important factor which has proved to be a determinant in continuation of psychotherapy.

The hypothesis No 12 states:

"If the patients have had previous psychiatric experience then they are more likely to remain longer in psychotherapy."
As seen from Table No 10 that the effect of previous psychiatric experience on Remainders and Terminators is highly significant. A statistical significance obtained is $p < 0.001$ level.

Many people in our culture have now realized after the exposure from outside world that drugs alone cannot treat mental illness and psychotherapy has become a known mode of treatment for psychological problems.

Although it is a well known fact but these people who have had a long prior experience of going from one psychiatrist to another and having to take very high dosages of medication realized more than others the evil of over medication which results in lethargy, incapacitation and worthlessness in the patient. Therefore, when they come to psychotherapy and get relief without having to take larger doses of psychotropic drugs and even in some cases total elimination of drugs due to the effectiveness of psychotherapy. Even the families of the patient are tired of the drug treatment and are more than pleased to have a treatment which does not involve extra expenditure of drugs and ill effects of the medication.
There are certain variables which have been found to be important during the collection of data which were not hypothesized, but it was felt that it is worthwhile to mention them as they seem to reflect a vital role in the issue of remaining and terminating from psychotherapy.

AGE

As per table No 11 it is evident that age is an important determinant of Remainders and Terminators in psychotherapy. After seeing the trends it was decided to compute the statistical significance and found it significant at p < 0.001 level. It has been proved that the younger patients (18-35 years) are more likely to remain longer in psychotherapy as compared to elder patients (36-60 years).

It has generally been assumed that older people tend to be more rigid and fixed in their ways. Their patterns of behaviour have a longer reinforcement history and supposedly their defences and character structure are more resistant to change. We know from some of the systematic studies that older patients show
some decline in mental functioning (Matarazzo, 1972) and that they may not learn new skills as readily as younger individuals. Consequently, the older patients terminate earlier from psychotherapy.

It is also important to note here that in the Institute of Clinical Psychology most of the therapist are student therapists and therefore the older people find it hard to maintain confidence in the capability of the therapist especially in a culture like Pakistan where respect for age is tremendous.

PRESENTING SYMPTOMS:-

In the case of presenting symptoms it was found that there is a trend effecting the Remainders and Terminators in psychotherapy. Therefore, statistical significance for the same was tested and it is evident from Table No 12 that people who present neurotic symptoms remain longer in psychotherapy than the ones who present psychotic symptoms.

This obviously is expected because psychotherapy is mostly more effective with the psychoneurotics patients than with the psychotic patients. At the time
when the study was being conducted the Institute of Clinical Psychology did not have a medical doctor on its staff, therefore, the psychotic patients had to be sent to the psychiatrists for the prescription of medicines. They apparently found some relief by just taking drugs and did not find it important to continue psychotherapy. This point needs more exploration and can now be studied effectively at the Institute of Clinical Psychology as the patients would not have to go out for drug treatment.

The results of this study appear to be very informative for the Institute of Clinical Psychology and its psychotherapists, specially because they can benefit from its result while selecting their patients for psychotherapy. This is imperative as there is a dearth of criterion and one would like to provide maximum benifit to maximum number of people.

RECOMMENDATIONS FOR FURTHER RESEARCH.

Various improvements on this study can be made in future research.
Firstly, this research may be conducted on a larger sample in order to further substantiate the results.

Secondly, in order to get a complete profile of the premature terminator it is advisable that future research may be conducted on therapist variables and process variables along with the client variables. A synthesis of the results of client factor studies with the other two factors would give a better profile of Remainders and Terminators.

Thirdly, it is also imperative that the personality variables of the client which have been left out in this research for unavoidable reasons should also be studied in order to get an authentic picture of all the factors which influence termination and remaining in psychotherapy.

Fourthly, on the basis of the results obtained from such researches valid psychological tests for predicting the Remainders and Terminators in psychotherapy be constructed in order to screen out the patients who are definite terminators in psychotherapy.

Finally, it will also be worthwhile to study the modes and the media by which we can motivate the
population of Pakistan to become aware of psychotherapy as a mode of treatment and after seeking psychotherapeutic help remain in psychotherapy for a long enough time and attain the maximum benefit from it.
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Appendix 1.

QUESTIONNAIRE

NAME OF THE THERAPIST.

To,

The Respective Therapist.

I am conducting a research on the "Client Factors as Determinants of Terminators and Remainders in Psychotherapy," (The Terminators are defined as those cases who leave psychotherapy without the advice of the therapist and those who terminate before 10 sessions of psychotherapy; whereas the Remainder cases are defined as those cases who continue to remain in psychotherapy for at least 30 sessions and/or are successfully terminated on the recommendations of the Director of Institute.) This questionnaire has been prepared to determine the causes of the above. Your cooperation will be highly appreciated. Please fill up the questionnaire as per the information gained from your patient and also note that this information will remain absolutely confidential.

PARTICULARS OF THE PATIENT

NAME: ...............................................................

AGE: .......................... CASE NO: ..........................

SEX: .......................... MARITAL STATUS: .................

EDUCATION: ..........................

OCCUPATION: ..........................
1. Please mention the number of psychotherapy sessions you have had with the patient so far.

2. In case you are not seeing the patient right now, please mention the number of psychotherapy sessions you had with the patient.

3. Address:
   i) Residential:.................................
      ...........................................
   ii) Official:.....................................
      ............................................
   iii) Permanent:...................................
      .............................................

4. Where does the patient normally come from for Psychotherapy?
   (i) Residence (ii) Office (iii) Any Other

5. How many Kilometre approximately the patient has to travel to reach to the Institute?
   (i) Less than (ii) From (iii) From (iv) From (v) Above
      3 Km 3 to 6 6 to 10 10 to 15 15 Km

6. Transport usually used by the patient.
   a) PUBLIC     i) Direct  ii) Indirect
   b) PRIVATE     i) Direct  ii) Indirect
   c) ANY OTHER(Remarks)..............................
7. Time required to reach the Institute.
   (a) Less than  10 mins  (b) From 10 to 30  (c) From 30 to 60  (d) From 60 to 90  (e) Above 90 mins

8. Number of people living in the patient's house. Please mention their relationships and ages.

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<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
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<tbody>
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<td>7.</td>
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</table>

9. Number of Dependents of the patient.

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<tr>
<th>Dependents</th>
<th>Age</th>
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<tbody>
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<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>7.</td>
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<td>8.</td>
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</tbody>
</table>
10. Number of Earning members in the family.

<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3.</td>
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</table>

11. Is the patient doing any job, If yes, What is his monthly income?

Rs. ............... per month.

12. If the patient is not working, where does he/she get the money for payment of therapy charges?

..............................................................
..............................................................

13. How much financial contribution does he/she makes to the family?

Rs. ....................... per month.

14. Charges taken from the patient per session. Rs. .............

15. How many sessions per week do you take with the patient ?

16. What are the timings of work of your patient ?
17. Nature of work done by your patient.

Executive, Proprietor of concern & Major Professional.

Manager, Proprietor of medium concern & lesser Professional.

Administrative personnel & small business & semi-professional.

Clerical & sales workers, Technicians & white collar worker.

Skilled worker

Semi-skilled worker.

Un-skilled worker.

18. Is the coming to psychotherapy easy or difficult? Please Mention the type of difficulty.

<table>
<thead>
<tr>
<th>Easy</th>
<th>Difficult</th>
</tr>
</thead>
<tbody>
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19. Any cancellation with the patient of appointment by the therapist. (Specify method of cancellation; was the patient informed before any cancellation of appointment?)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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20. Did you cancel any appointment during the first 6 sessions?

Yes  No

If yes, how many and could you specify reasons for it.

.................................................................
.................................................................
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.................................................................

21. Attitude of the patient’s family towards going for Psychotherapy? (According to the attached rating scale)

Highly favourable

Favourable  Unfavourable

Neutral  Antagonistic

22. If not, which member of his/her family does not approve of it & mention reasons for this attitude.

Mother

Father

Spouse

Sister  Birth order

Brother  Birth order

Others (please specify)

Remarks.................................................................
.................................................................
23. Motivation of the patient:— Please rate it according to the 5 point rating scale attached.

Very highly motivated

Highly motivated

Moderately motivated

Less motivated

Least motivated

24. Source of motivation:

Self

Any other (Please mention name & relationship)

..........................................................

25. Referral.

a) Doctor

b) Hospital

c) School

d) Organization

e) Self

f) Family

g) Patient

h) Friend

i) Religious leader

j) In-laws

k) Any other (Pl specify)

..........................................................

..........................................................
26. Any physical/medical treatment received prior to psychotherapy.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</table>

In case yes, then

1. **E.C.T.**  
   i) Frequency  
   ii) Duration

2. **DRUGS**  
   i) Source of getting drugs.
   
   a) Doctor  
   b) Homeopath  
   c) Hakim  
   d) Self  
   e) Psychiatrist  
   f) Any other (pl specify) ...........................................

   ii) Mention duration, quantity & name ................................

3. Any other (specify) ..............................................

   .................................................................
   .................................................................
   .................................................................
27. Please rate your patient on a 5 point Anxiety scale as given below:

"Anxiety may be defined psychoanalytically as the unpleasure experienced when the object is unknown and the anticipation of being overwhelmed by an internal or external force is present. The individual's inability to differentiate between the wish and the action, when the wish is repressed and is thereby unconscious i.e. libido of the repressed wish changes into anxiety."

1. Practically never feels unpleasant about the future, never mentions that he feels threatened, apprehensive, uncertain or nervous about anything to happen in the future, no difficulty in sleeping, very much satisfied with the world situation and his family. Has no concern about his own health problem. Able to cope up with the life, self-control, considerate of others and has high regard for his or her social reputation.

2. Occasionally feels unpleasant about the future, sometimes he feels threatened, apprehensive, uncertain, or nervous about things to happen in the future, occassional difficulty in sleeping, less satisfied with the world situation and his family and is worried about his health, not able to cope up with life, less self control, not considerate of others and has low regard for his or her social reputation.

3. Moderately feels unpleasant about the future, feels threatened, apprehensive, uncertain and nervous about things to happen in the future. Moderate difficulty in sleeping and is not satisfied with the world situation and his family, to some extent worried about his health, feels difficulty to cope up with life, low self control and has low regard for his or her social reputation.

4. Frequently feels unpleasant about the future and feels threatened, apprehensive, uncertain and nervous about things to happen in the future, difficulty in sleeping, unsatisfied with the world situation and his family, very much worried about his health, and feels great difficulty to cope up with life, low self-control, and has low regard for his or her social reputation.
5. Very frequently feels unpleasant about the future, always mentions that he or she feels threatened, apprehensive, uncertain or nervous about anything to happen in the future, feels too much difficulty in sleeping, extremely unsatisfied with the world situation and his family, has greater concern about his own health problem, unable to cope up with life, low self control, inconsiderate of others and has low regard for his or her social reputation, highly emotionally unstable, unequal to the challenges of daily life and easily gets down hearted and remorseful. Cries easily, tense, feelings of guilty and easily annoyed by greater number of things than the average person.

Specify in detail the presenting complaints:

.................................................................
.................................................................
.................................................................
.................................................................
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.................................................................
Favourable

1. Favourable. This scale is concerned with the extent to which the family of the patient shows favourable attitude towards the patient with kindness, encouraging, friendly approving, promotes convenience and the expression of favourable and positive opinion of psychotherapy for the patient.

i) Highly Favourable: Very frequently shows strong positive attitude with extreme kindness and encouragement, indulging, friendly approving, and gives full support and convenience to the patient, expresses the favourable opinion of psychotherapy for the patient.

ii) Favourable: Frequently shows positive attitude with kindness, encouraging, indulging, friendly approving, gives support and convenience to the patient.

iii) Neutral: Neither encourages nor discourages the patient to go for psychotherapy.

iv) Unfavourable: Occasionally shows favourable verbal attitude but without kindness and encouragement to the patient. Ignores to provide convenience to the patient for psychotherapy, opposes Psychotherapy for the patient.

v) Antagonistic: Practically never shows favourable attitude and do not encourage or approve psychotherapy for the patient, no efforts to provide convenience to the patient for psychotherapy; completely hates psychotherapy for the patient.
Motivation

This scale measures the extent to which the internal states of the individual leads to the instigation, persistence and includes the goal direction and energizing of behavior of coming to psychotherapy.

1) **Very Highly Motivated**: Extremely worried about his/her problems, intense urge and willingness to come for psychotherapy voluntarily, seeks strong approval, acceptance and is very much concerned about his/her problems.

2) **Highly Motivated**: Frequently worried about his/her problems, strong urge and willingness to come for psychotherapy voluntarily, always seeks approval and acceptance and is quite concerned about his/her problems.

3) **Moderately Motivated**: To some extent worried about his/her problems, moderate urge and willingness to come for psychotherapy voluntarily, sometimes seeks approval and acceptance and is concerned about his/her problems.

4) **Less Motivated**: Not quite worried about his/her problems, very little urge and willingness to come for psychotherapy voluntarily, does not seek approval and acceptance and is unconcerned about his/her problems.

5) **Least Motivated**: Not worried about his/her problems, complete absence of urge and willingness to come for psychotherapy voluntarily, ignores approval and acceptance from others, unconcerned about his/her problems and fully satisfied with the present situation.
Education

This scale was classified as follows:

1. Illiterate.
2. Elementary.
3. Middle.
4. High.
5. Inter.
6. Graduate.
7. Post graduate.