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OBSERVABLE CLIENT RESISTANCE AND EARLY PSYCHOTHERAPY DROPOUT

presented by

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Ph.D. degree in Psychology

Major Professor's Signature

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OBSERVABLE CLIENT RESISTANCE AND EARLY PSYCHOTHERAPY DROPOUT

By

Jonathan N. Weller

A DISSERTATION

Submitted to
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ABSTRACT

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This study sought to establish a link between patient resistance and dropout. A 1993 meta-analysis investigating psychotherapy dropout reported an overall psychotherapy dropout rate of 47% with most attrition occurring within the first couple of sessions. Psychotherapy dropouts represent a significant public health concern and pose a variety of problems for psychotherapists. Patient dropout can be considered an extreme form of resistance. When a patient is unwilling to engage in the therapeutic process despite having sought treatment, it may be the result of intense resistance. While this is supported by theoretical writings, the relationship between resistance experienced early in treatment and dropout has not been established empirically.

Participants of this study were forty clients (twenty dropouts and twenty persisters matched demographically) of the MSU Psychological Clinic. A ten-minute sample from the first and third sessions of participants' treatment were coded by two independent raters using the Client Resistance Scale (CRS) and the Client Resisance Code (CRC) to evaluate the level of resistance early in treatment. It was hypothesized that dropouts would exhibit more resistance early in treatment, resistance would increase between sessions with dropouts outpacing persisters, and a discriminant function capable of predicting early dropout could be developed using resistance data.

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As predicted, dropouts tended to have a higher proportion of resistant responses (48.2% vs. 34.4%) as measured by the CRC. CRS data failed to find statistically significant differences, though dropouts expressed greater intensity of resistance.

The anticipated increasing levels of resistance were exhibited on both measures of resistance, though statistical analyses failed to reach levels of significance. One CRS subscale, Opposing Recollection of Material, produced a statistically significant pattern of growth between sessions $F(1, 38) = 4.25$, $p<.05$.

Discriminant function analysis produced a model that predicted group membership from the scores of four variables (CRC resistance proportion, CRS Opposing the Therapist, third session CRS Opposing Expression of Painful Affect, and third session CRS Opposing Recollection of Material). This discriminant function was significantly associated with group membership ($X^2(4) = 11.37$, $p < .05$). The discriminant function an overall classification accuracy of 77.5%.

To Raini and Lincoln

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I would also like to extend my gratitude to Ken Murray and Patrick Perkins for their assistance in coding the numerous hours of psychotherapy samples that made this study possible. I would further like to acknowledge the support, encouragement and informal assistance of many friends and colleagues, including David Cordry, Quinn Bastian, and Ted Moore amongst many others. Finally, I must also recognize the consistent support and inspiration provided by my wife, children, and family members.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

Historically psychotherapy research has been dominated by studies of process and outcome with clients who complete treatment or who remain in therapy long enough to provide sufficient data. Somewhat less inquiry and investigation has been spent examining premature termination of psychotherapy (or psychotherapy dropout), despite this being a widespread and fundamental obstacle to the successful and effective delivery of mental health services. A recent meta-analysis of 125 studies on psychotherapy dropout by Wierzbicki and Pekarik (1993) reported an overall mean dropout rate of approximately 47%. Most psychotherapy studies of process and outcome, typically report dropout rates between 30% and 60% with a majority of the attrition occurring within the first couple of sessions. This is particularly troubling considering only 25% of the people in the U.S. with a diagnosable mental disorder seek treatment (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993). Not only do psychotherapy dropouts represent a significant public health concern, but they also pose clinical, financial, and morale problems for mental health professionals. Without a better understanding of the underlying dynamics of such enormous attrition rates, clinical psychologists have little power to make informed decisions with regard to how to respond to or prevent them.

Until very recently, most studies on psychotherapy dropout have focused on the easily obtainable demographic characteristics of clients and therapists. However, despite the ease of securing such data, the research findings have been equivocal and sparsely informative, lending little insight into how to decrease the frequency of this problem.

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Increased risk for dropout has been found to be associated with minority race, low level of education, and low Socio-Economic Status (SES). However, effects sizes for such findings have been relatively small. This prompted Wierzbicki and Pekarik (1993) to recommend the investigation of more complex psychological variables in relation to dropout. Despite this suggestion, a minimal number of studies investigating potential client and therapist factors related to dropout have ensued. Among the variables suggested for further investigation are client factors (e.g., personality traits, health of interpersonal relationships, expectations, and level of psychopathology), therapist factors (e.g., level of warmth, empathic failures, level of training, conceptualization accuracy), treatment factors (e.g., theoretical model, directivity), and interactions between these.

While only a few studies have looked directly at the relationship between client personality variables and premature termination (Hilsenroth, Hanler, Toman, & Padawer, 1995; Walters, Solomon, & Walden, 1982; Budman, Demby, Soldz, & Merry, 1996), more have been conducted that investigated the impact of personality factors on therapeutic alliance development (Mallinckrodt, 1993). Recently, investigators have also found significant relationships between the pattern of a patient's pre-therapy interpersonal relationships and the therapeutic alliance established in treatment (Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). This is important and may be especially helpful in the pursuit of variables related to therapy dropout, as a negative therapeutic alliance is likely associated with attrition (Mallinckrodt, 1993).

The lack of a positive therapeutic alliance could be associated with a variety of variables ranging from lack of clinician skill, poor client engagement, pathological

personality traits to client resistance. One interesting and theoretically-based way to understand patient dropout would be to consider it an extreme form of resistance (Beutler, Rocco, Moleiro, & Talebi, 2001). The fact that a patient is no longer willing to engage in the therapeutic process, despite their having just begun treatment, may be an indication of intense resistance. And yet, the relationship between level of resistance experienced early in treatment and patient attrition has yet to be firmly established. This study sets out to establish a link between patient resistance and dropout.

LITERATURE REVIEW

Resistance: Theoretical Background

Freud (1920) emphasized the importance of resistance. For example in his "Introductory Lectures on Psychoanalysis," he stated, " when we undertake to restore a patient to health, to relieve him of the symptoms of his illness, he meets us with a violent and tenacious resistance, which persists throughout the whole length of treatment. (p.354)" Freud's contemporaries have since expanded and elaborated the construct of resistance. According to Greenson (1967), resistance refers to all forces within the client which are in opposition to the process and procedures of psychoanalysis. This view has also been extended to include many other forms of psychotherapy (e.g., cognitive-behavioral, gestalt, and rational emotive therapy) with an emphasis being placed on the client's defense of the "status quo" of their condition. Patients may employ any variety of psychological defenses to resist treatment. These resistances can be both consciously and/or unconsciously determined and driven.

Interestingly, despite its being a central issue in arguably all forms of psychotherapy, client resistance has received little empirical attention concerning its relation to therapy process, outcome, or attrition. Many theorists have indicated that certain transference reactions can lead to a specific form of resistance referred to in the literature as "flight into health," which causes the client to exit therapy prematurely with relatively little therapeutic gain. (Greenson, 1967) Here the client is denying the reality of their internal state and seeking to avoid the pain of approaching their affects, experiences, and treatment issues. It is not uncommon for flight into health to occur early in

treatment, while ambivalence toward therapy, the therapist and change are typically intense.

In Strean's (1985) text on resistance, he proposed that it has been theoretically understood for decades that clients enter therapy with a great deal of ambivalence. Despite their unhappiness, life dissatisfaction, or painful internal state the idea of seeking therapy as a solution is still often frightening and aversive. However, while much theoretical attention has been given to this phenomenon it has been infrequently examined empirically, due in great part to difficulties in operationalizing and measuring ambivalence and resistance (Strean, 1985).

Resistances are founded on many fears, negative fantasies, and cultural influences. These include (particularly in the U.S. and other Western cultures) the cultural value placed on independence and self-sufficiency; fears of being infantilized, placed in a submissive position to the therapist, or treated like a child; and negative fantasies of being exploited, seduced, or rejected by the therapist to name only a few. (Strean, 1985)

As resistance is naturally activated by thinking of or beginning therapy, it should not be surprising, to those that understand and recognize it, that clients are quick to delay, postpone, or even drop out of treatment. Perhaps then a certain portion of clients will be destined to leave treatment prematurely. However, armed with an understanding of this dynamic and how to effectively respond could potentially aid clinicians from all theoretical orientations in helping clients or prospective clients remain in treatment long enough for it to benefit them. (Strean, 1985). Patton et al. (1997) highlighted the point that resistance is both an obstacle and an opportunity in therapy. They emphasize that if it

is not recognized and highlighted by the therapist and then understood and worked through by the client, less therapeutic change is likely to occur. Perhaps in the worst case scenario, clients' resistance and a lack of understanding of its function by the therapist can lead to the client leaving treatment prematurely. Berrigan and Garfield's (1981) study of the relationship between missed therapy appointments and premature termination bears this out. They suggest that clients missing therapy sessions may be manifesting their initial disillusionment with the process of treatment (it can also easily be interpreted as resistance), but noted that little attention was given to the missed sessions by the therapists treating the clients who eventually dropped out. The authors go on to suggest that these therapists ought to have at very least explored the absences with their clients as a first step toward increasing the probability of their continuing in treatment.

Although there are many forms of resistance that may be inaccessible to an observer, the measures that will be employed in the current study have been shown to reliably measure episodic (transient/limited interruptions) and tactical (immediate, objectively observable behaviors) resistances (Kavanagh, et al., 1982; Schuller, et al., 1991; Mahalik, 1994). Although episodic and tactical resistance do not reflect the deepest levels of client resistance, it has been suggested that successful handling of resistance at this level is important, as it helps clients feel safe and understood and provides a model for dealing with more difficult issues (Schuller et al., 1991).

Empirical Research on Resistance

In Hill, Corbett, Kanitz, Rios, Lightsey, and Gomez' (1992) development of a pantheoretical measure of client behavior they found that resistance or defensive verbal responses, as measured by the Client Resistance Code (Kavanagh, et al., 1982), accounted for 11% of their sample's behavior during the middle stages of psychotherapy. However, they noted difficulty in obtaining high levels of reliability while coding resistance. This was likely due to the most common and difficult challenge presented to researchers of resistance, that of defining and operationalizing the construct. Additionally, the prior research done in this area has frequently failed to recognize the multidimensional nature of resistance and rarely formulated the measurement of the construct based on a comprehensive theory. Further evidence suggests that measuring client resistance on a moment-to-moment or speaking turn basis lends itself to greater reliability and less "observer bias" than global (e.g., entire session) ratings (Chamberlain, Patterson, Reid, et al., 1984).

Chamberlain, et al. (1984) studied resistance exhibited by participants in a behaviorally oriented, parent training intervention. Using an observational system they developed to measure client resistance, the Client Resistance Code (CRC), they found statistically significant relationships between the levels of resistance exhibited and the stage of therapy, the completion of therapy, and whether clients were self or agency referred. Their findings were supportive of the proposition that resistance first increases, peaks, and then diminishes over the course of treatment, for clients who complete

treatment. They also reported clients who dropped out of treatment exhibited a significantly higher frequency of resistant responses than those who completed the treatment did. In relation to this finding, they also reported that agency-referred clients were more resistant and more likely to dropout of treatment than self-referred clients.

Schuller, Crits-Christoph, and Connolly (1991) in developing their Resistance Scale, found four principle dimensions or subtypes of resistance: Abrupt/Shifting, Flat/Halting, Oppositional, and Vague/Doubting. They also found that a majority of the variance in resistance was related to within session fluctuations and client differences. Surprisingly, they found little support for the influence of therapist intervention differences. These findings were suggestive of the Resistance Scale tapping stable characteristics of the client, what might be referred to as character resistances, as well as in session resistance fluctuations.

Of particular interest for the purposes of the current study, was the development of the Client Resistance Scale (CRS) by Mahalik (1994). He took Greenson's definition and operationalization of resistance and expanded it to make it inclusive of nonanalytic approaches and the motivational aspect of the concept (i.e., the avoidance of painful affect), which fits well with the aims of this study. The formulation of resistance used to develop the CRS and which will be applied in the current study was:

"With its motivation being the avoidance of painful affect, resistance opposes the client's recollection of the therapeutic material, as well as, the therapist's efforts, change, and insight."

From this basic formulation, Mahalik elaborated on the multi-dimensional nature of resistance using Greenson's (1967) work as a starting point. These five dimensions, which will be of particular interest in the present study are described below:

Opposing Expression of Painful Affect: This form of resistance has as its primary aim the avoidance of experiencing or expressing any unpleasant emotion, most commonly depression, anxiety, and aggression. It is most typically exhibited when a client communicates their experience verbally, but with an absence of affect, in spite of the fact that what they are sharing would be expected to be highly emotionally charged.

Opposing Recollection of Material: As the client's primary task of psychotherapy is openly discussing their experiences and feelings as freely as possible, all activity and motivation to do otherwise could be broadly labeled resistance. It has been said that resistance acts against speaking and results in the failure to share relevant information. As such, the most obvious and transparent expressions of this kind of resistance include when the client states they don't feel like talking, they remain silent, or says, "I don't know." In other cases, the client may talk about superficial or insignificant events, use nondescript language, or summarize events in broad outlines lacking details all in the service of hiding from the pain that a more in depth or descriptive account may precipitate.

Opposing the Therapist: This dimension of resistance involves the degree of client compliance with therapist instruction, direction, or ground rules. The uncooperativeness exhibited can take the form of contrary responses to the therapist's request or intervention, non-acceptance of the therapist's influence, or a negative interpersonal dynamic. This form of resistance is thought to originate out of self-protection on the part of the client, where they may experience the therapist as an attacker or intruder. Their uncooperative behavior is thus a means of fending off further intrusion. Resistance of this kind is often, but not always, a product of therapist errors (e.g., poorly timed interventions, moving in a direction that does not meet the current needs of the client, etc.).

Opposing Change: Here a client's opposition to change disrupts the therapeutic process and can be viewed as their wish to maintain "status quo," despite the recognition that it is maladaptive, limiting, and painful. Fear, the search for security, and secondary gain keep the client stuck in their familiar, maladaptive patterns.

Opposing Insight: This dimension of resistance acts to oppose client self-knowledge, particularly the ability to make connections between their experiences, thoughts, feelings, and behaviors. This allows the client to "not know," which helps them avoid painful feelings that may accompany insight.

Mahalik (1994) effectively applied his scales to the analysis of the process in six classic and well-documented sessions of therapy between expert therapists (Beck , Ellis, Meichenbaum, Perls, Rogers, and Strupp) and two clients (Gloria and Richard). The scale was found to be sensitive to differing therapeutic approaches (therapist responses),

clients, therapists, and within session shifts. The utility of a measure able capable of capturing different subtypes of client resistant behavior will hopefully be of value in the current study. These dimensions of resistance are readily applied to factors previously found to be predictive of dropout, as a review of past attrition research will bear out.

Finally, in their study of process dimensions within the context of psychodynamic counseling, Patton, Kivlighan, and Multon (1997) found that during the course of counseling there was a linearly decreasing growth pattern of client resistance. They also found that the mid-treatment (at on average the eighth session) level of client resistance was related to client outcome, with less resistant clients showing greater levels of change following treatment. Finally, they were able to lend further evidence of the low-high-low curve of resistance being related to positive outcomes.

Psychotherapy Dropout

As stated previously, psychotherapy dropout has most commonly been studied from the standpoint of easily obtainable demographic information. However, following the admonitions of researchers interested in preventing this phenomenon, there have been an increasing number of studies conducted that have taken more complex variables into account (e.g., a process or client-therapist interaction approach). Less common are studies that take into account variables (i.e., resistance, transference, attachment) that can be derived from or grounded in well-established psychological theory. Occasionally, the demographically oriented studies have included resistance relevant tidbits of information (e.g., client-therapist differences), but this data has not been elaborated on or interpreted from such a theoretical perspective. Additionally, much research indicates that the early phase of therapy is crucial with regards to client continuation, with dropout rates

lessening significantly when clients remain beyond four sessions (Reis & Brown, 1999). Thus, the following review of dropout studies attempts to summarize a broad base of studies in an effort to provide a large pool of evidence from which theoretically and empirically grounded hypotheses can be drawn linking early psychotherapy dropout to client resistance.

In Hilsenroth, et al.'s (1995) study of Rorschach and MMPI-2 correlates of early psychotherapy termination, they found that patients who terminated prematurely (before the eighth session) from dynamically oriented psychotherapy, had fewer texture responses, more cooperative movement responses, and fewer aggressive movement responses, compared with patients staying in treatment. This suggests that individuals who dropout of treatment prematurely are somewhat less psychologically disturbed, less aggressive, more capable of establishing cooperative relationships, and have less need for close interpersonal contact, than those patients remaining in treatment. In viewing these results from the perspective of resistance, it follows that clients who fit this particular profile may find the process of psychotherapy particularly intrusive and thus, "oppose the therapist" in an effort to ward off the intrusion. Further, such clients may be fairly satisfied with the status quo of their situation, since their life is not marked by extreme pathology, overt conflict, or relationship difficulties. Thus, by dropping out of treatment they "oppose change," leaving everything as it was before they entered treatment.

Tian and Kazmierczak (1997) found that cognitive-behavioral group therapy clients' level of participation within therapy sessions was significantly related to early dropout, while demographic and pathology factors were not. Dropouts in this study tended to be withdrawn and less able to freely express themselves within the group. This

could be indicative of any number of the Greenson (1967) categories of resistance, most obviously "opposing recollection of material" and "opposing insight."

Beckham (1992) in looking for predictors of dropout at a medical school outpatient mental health clinic, found that a negative impression of therapist by the patient was the singular variable that reliably predicted attrition. Beckham further suggested that dropouts may have a sensitivity to whether or not their therapist's personality and style will meet their needs. This could be another indication of how resistance can take the form of opposing the therapist. Missed and cancelled appointments early in treatment were also negatively prognostic for staying in treatment. In some cases particularly in those of the "no show," these incidents may represent the most extreme form of avoidance of painful affect. In essence, the client by not attending their session, completely avoids the possibility of confronting painful emotions and experiences.

In an intriguing descriptive study of thirty independent practice patients who dropped out prematurely, Levinson, McMurray, Podell, and Weiner (1978) found that reactive factors were common (e.g., fear of loss of defenses, fear of dependence, fear of aggression, transference) as well as intrinsic factors (e.g., self-defeating behavior, negativism, suspiciousness). Reactive factors were found with 87% of the patients that dropped out, while intrinsic factors were influential 57% of the time. These results seem to be consistent with Stone's (1973) two dimensions of resistance, with the reactive factors being similar to the tactical resistance (situational) dimension and intrinsic factors being similar to what Stone and others have labeled characterological resistance. Tactical resistances are those that are readily observed in outward behaviors. They serve

immediate "tactical" functions such as avoiding painful affects, shifting the focus of discussion to something less threatening, and keeping the therapist at a distance. Characterological resistances on the other hand are much less overt and/or situationally bound. These are long term patterns of behavior that again serve a defensive/protective function for the client, but that are much more generalized across situations and time. In other words, a much more static and global approach to the world.

Cartwright, Lloyd, and Wicklund (1980) attempted to develop a rapid method for identifying patients not likely to stay in psychotherapy. Their goal was to develop a screen that was easy to administer and score and that could then be used to direct a subset of clients into a program designed to increase psychological mindedness and motivation prior to treatment. They found that they could predict with moderate reliability those clients likely to drop out using a cutoff score on the Counseling Readiness Scale in combination with intaker ratings on two scales, "difficulty of remaining in treatment" and "patient's ability to generate inner life data in interview." The latter item is of particular relevance to the present studies aims in that low ratings on the patients' ability to generate "clinical material" from their inner experience was predictive of dropout. This item seems to coincide with another of Mahalik's (1994) dimensions of resistance, specifically the opposition to the recollection of material. Again, part of what is being reported here may be an observable expression of resistance.

Dubrin and Zastowny (1988) found similar results to Levinson, et al. (1978), noting a connection between attrition and client character structure and personality characteristics. These authors strongly suggested that researchers turn their attention

toward the specifics of the therapy encounter, so called "microanalytic process" variables, which could better capture client-therapist interactions and relatedness.

In a study of ninety-one adult therapy clients at a university training hospital, Kolb, Beutler, Davis, Crago, and Shanfield (1985) found that premature terminators rated their therapists as having fewer facilitative relationship skills. They also found that the therapists of the dropouts rated their clients as having been less involved in the therapeutic process. Finally, the investigators also reported that those clients, who remained in treatment made significantly greater positive changes in comparison to dropouts, based on therapist ratings. Ironically, the dropout clients themselves rated their improvement as being relatively high, despite their negative perceptions of the therapist. In viewing these result from the perspective of resistance theory, it seems feasible that these clients may have been engaging in classic defensive behavior with the aim of resisting change and the perceived intrusion of the therapist. Thus, they exit therapy and endorse having somehow benefited in spite of dissatisfaction with the therapist and a lack of engagement in the therapeutic process, a somewhat suspicious outcome that seems to fit well with the concept of "flight into health."

In their study of therapeutic alliance and interpersonal behavior variables, Samstag, Batchelder, Muran, Sufran, and Winston (1998) found a few factors that distinguished between their dropout and good outcome groups (comprised of 25 and 28 subjects, respectively). Therapeutic alliance ratings by both the client and therapist from early in treatment were able to discriminate between dropout and good outcome clients, with scores being significantly worse for the dropouts. Further, therapist ratings of client hostility and session smoothness and client ratings of therapist friendliness and session

depth were also able to successfully discriminate between the dropout and good outcome groups. Patients seen as most hostile paired with therapists viewed as unfriendly were typical of the dropout scenario, as was a lack of session depth and smoothness. These variables also appear to have good potential for relating to resistance. Schuller, et al.'s (1991) measure of resistance was found to have four factors descriptive of differing manifestations of client resistance, Abrupt/Shifting, Oppositional, Flat/Halting, and Vague/Doubting. It would seem that the lack of therapeutic alliance development and hostility observed by Samstag, et al. would be indicative of potentially oppositional behavior. Additionally, the variables related to session depth and smoothness could easily be correlated with the abrupt-shifting and/or flat/halting resistant behaviors.

Brogan, Prochaska, and Prochaska (1999) used measures based on the transtheoretical model of change to predict termination/continuation status of sixty clients from a community mental health center, university counseling center and a doctoral training clinic. They found that when compared to client who either terminated therapy appropriately or continued treatment, premature terminators were more oriented toward changing their environment rather than themselves. They look to change the environment because they do not view themselves as having a problem. Thus, they are unable to face the necessary therapeutic issues, which may inevitably lead to their dropping out. This lack of desire to change oneself is not unlike the previously mentioned Opposing Change dimension of resistance established by Mahalik (1994) in his Client Resistance Scale.

Reis and Brown (1999) conducted a very thorough review of 30 years worth of psychotherapy dropout research. They concluded that divergent expectations for each

other and the therapy process between client and therapist, a weak working alliance, and client dissatisfaction all increase the likelihood of unilateral termination. These factors seem to at least have the potential to be related to resistance, especially the dimensions of opposing the therapist and opposing change.

While the previously summarized group of studies varies greatly with regard to the independent variables of interest and treatment setting, each of them has at least one variable that could be conceptualized in terms of client resistance. Thus, there is previous empirical evidence, from which theoretically sound hypotheses can be derived. Further, because there has been conflicting evidence with regard to the level of psychopathology present with psychotherapy dropouts, I have made this an additional variable of interest. Little has been written suggesting whether there may be differences in the level of resistance present dependent upon the level of pathology individuals are experiencing. Therefore, there are multiple reasons to include a measurement of psychopathology.

RATIONALE

Its important to remember that how one views and interprets client behavior may be very different depending on whether one looks at manifest behavior on a molecular level versus when attempting to understand the same behavior from the informed perspective of an inclusive and broad-based theory. Drawing on theory helps the clinician draw meaningful links between otherwise isolated behaviors. This is well illustrated in VanDenberg and VanDenberg's (1992) exploration of a single case of premature termination from three different theoretical perspectives.

Some authors have also criticized studies that operationalize premature termination based on a cutoff of number of sessions attended. However, while this may not be an all inclusive way to capture every premature terminator, it is likely that many, if not a majority of the clients qualify as dropouts based on this criteria, especially when viewed from a dynamic/analytical theoretical perspective. Again, without a guiding theoretical perspective, it may be easy to accept that a client leaves treatment early because "they got what they needed" in a couple sessions, when in actuality it may be a manifestation of "flight into health" or an extreme expression of resistance. Indeed, there is fairly strong empirical evidence to suggest that there is a minimal amount of therapy by which clients show improvement. In a meta-analysis of outcome studies by Howard, Kopta, Krause, and Orlinsky (1986), they found that with a sample of 2,400 patients, eight sessions was the point by which 50% of them began showing improvement. Many other studies have found that early dropout is especially associated with lack of improvement, worse outcome, and in some cases even an increase in symptomology (Reis & Brown, 1999). Chamberlain, et al. (1984) defined dropout as any clients who

completed a minimum of two, but not more than four, sessions of treatment. They then made successful hypotheses based on the presumption that clients who leave therapy prematurely are more resistant to treatment than those who stay. Thus, in the case of the present study where resistance (and its varied expressions) will be used to attempt to predict early dropout, the use of a minimum number of sessions attended prior to termination to define "prematurity" is appropriate and has some precedence. Simply stated, the broadest application of resistance will be used, meaning anything that leads to a client entering therapy only to exit soon thereafter could theoretically be termed resistance. As so defined, there may be other forms of premature termination or other critical periods of client resistance that cannot be addressed by this study. However, the benefit of making an empirically-based link between early dropout and resistance theory outweighs these limitations.

Thus, this study aims to respond to the suggestions of reviewers such as Mennicke, Lent, and Burgoyne (1988), Wierzbicki and Pekarik (1993), and others that have indicated the need for more complex, theory-based models of therapy process and attrition be examined by applying a broad-based theory of resistance, similar to that employed by Mahalik (1994) and Schuller et al. (1991) in their development of resistance measures, to attempt to differentiate between those clients who dropout of therapy early versus those who continue to the point of mutual termination.

HYPOTHESES

Hypothesis 1:

Psychotherapy clients prematurely terminating during the early phase of treatment without discussing it with their therapist (Dropouts) will not differ significantly from clients who continue in treatment beyond twenty sessions (Persisters) with regard to their self-reported level of psychopathology at intake as measured by the SCL-90R global severity index (GSI).

Hypothesis 2:

Psychotherapy dropouts will differ significantly from Persisters on measures of quantity, intensity and quality of resistance they exhibit during their first and third sessions of psychotherapy. The differences in estimated frequency (quantity) of resistant responses as a proportion of overall coded responses will be measured by the Client Resistance Code (CRC) (Kavanagh, et al., 1984). It is hypothesized that Dropouts will tend to respond with a higher proportion of resistant responses than Persisters. The overall intensity and quality of the two groups' resistance will be measured by the Mahalik (1994)Client Resistance Scale (CRS). It is hypothesized that Dropouts will exhibit higher overall levels of resistance and that they will specifically score higher on the Opposing Change, Opposing Recollection of Material, and Opposing the Therapist scales.

Hypothesis 3:

Dropouts and Persisters will both exhibit a growing level of resistance between the first and third sessions, with Dropouts beginning at a higher level and outpacing the Persisters in amount of increase in resistance between sessions. Persisters will exhibit a slower level of resistance growth between sessions, as measured by the Client Resistance Scale (Mahalik, 1994) and Client Resistance Code (Kavanagh, et al., 1984).

Hypothesis 4:

By evaluating levels of resistance in two groups of patients (Dropouts vs. Persisters) with multiple, multidimensional measures (CRS and CRC) and then entering these variables into a discriminant function, a model that predicts group membership can be achieved that will consistently exceed the expected chance rate of prediction for two groups (50%).

METHOD

Data

The present study utilized data, which had been collected for research purposes at the Michigan State University Psychological Clinic (The MSU Psychotherapy Research Project). The clinic is a training and research facility and is part of the Michigan State University Department of Psychology. Doctoral-level clinical psychology graduate students, who are under the supervision of Ph.D. clinical psychologists, staff and provide services at the clinic. The clinic is a non-profit, fee for service setting which provides low-cost outpatient psychotherapy to residents of the Mid-Michigan region (greater Lansing, MI) and to MSU students who have been referred from the university's counseling center for long-term psychotherapy, a service that is generally unavailable there. The clientele served typically presents with a wide variety of psychopathology including, but not limited to moderate to severe depression and anxiety, eating disorders, anger control difficulties, and interpersonal relationship difficulties. The data was originally collected with the purpose of gathering relatively unintrusive information on the clinic's clientele and their experiences in psychotherapy, which could be utilized in later research endeavors.

Participants

The participants for the current study were selected from the pool of clients who had previously volunteered to take part in the MSU Psychotherapy Research Project. During initial intake interview at the MSU Psychological Clinic, these participants were asked to take part in the ongoing therapy research project. They were informed that their choice to participate or not would not affect the services they were receiving. A small

incentive was offered. If they chose to participate and completed the necessary pre- and post-therapy forms (consent form, SCL-90R, Interpersonal Checklist, and Dream Questionnaire), they were given a refund equal to ten percent of their fees paid for therapy up to a maximum of eighty dollars. Historically, over ninety-five percent of incoming clients at the MSU Psychological Clinic have agreed to participate.

The participants of this study were 40 clients (20 early treatment dropouts and 20 persisters matched by demographic information) of the Michigan State University Psychological Clinic. This study's "Dropout" group was created from participating clients who completed the consent form and initial battery of questionnaires and returned them at their first session of psychotherapy only to later drop out of treatment prior to their eighth therapy session (m=5.55 sessions attended; SD=2.06). Considerable efforts were made to ensure that individuals terminating treatment due to a medical condition, hospitalization, unexpected financial hardship, relocation, or who left to seek treatment from an alternative mental health facility or professional were not included in the dropout group. These efforts included listening for mention of such information in audio taped sessions, reviewing research follow-up questionnaires, and looking for any available data or information contained in the research database (e.g., notes to research coordinator from therapists).

After identifying twenty participants for the dropout group, each of the members of that group were matched with a participating client who persisted in treatment beyond a minimum of twenty sessions of therapy (m=24.9 sessions attended; SD=3.55), thus creating an equal sized "Persister" comparison group. An extensive effort was made to match these groups as closely as possible based on demographic information (sex, age,

SES, racial group, etc.). These efforts were generally successful in regard to sex, age, and SES data, but were less successful in matching on racial group due to limited minority-group representation in the overall sample.

The sample of 40 clients consisted of 28 females and 12 males ranging in age from 20 to 57 years old with an overall mean age of 31 years. This was a predominantly Caucasian sample (37 of 40 participants) with minorities underrepresented (only one African-American and two Asian-American participants total). Reported yearly income ranged from $0 to $42,000. Marital status of clients broke down as follows: seven married; twelve never married; eleven divorced; nine lived with a partner; and one was widowed. The participants' education levels ranged from nine to twenty years with two years of post-secondary education being the modal level.

Therapists

All the participating clients were treated by graduate student clinicians with experience ranging from one to four years of formal training in psychological assessment and intervention. The therapists were beginning practicum students, advanced practicum students, and students who were serving half-time clinical assistantships within the clinic, many of whom had completed a Master's degree. Despite the clinicians in this study being made up of doctoral candidates in training, their level of training and education is fairly comparable to that found in community mental health centers and other agencies that provide similar therapy services. Specific demographic data and experience levels for these clinicians was not available as it was not included in the data set.

Therapy Dyads

Not only were subjects matched by demographic data, but efforts were made to match subjects also based on their having the same type of therapy dyad pairings (e.g., male therapist-male client, female therapist-female client, etc.). This was successfully achieved for all subjects. Their were eighteen clients who were paired with a male therapist and twenty-two clients paired with a female therapist. The percentages for the four types of dyads broke down as follows: Four male therapist-male client dyads (10%); 14 female therapist-female client dyads (35%); 14 male therapist-female client dyads (35%); and eight female therapist-male client dyads (20%). Again, fifty percent of each of these dyad types belonged to the dropout and persisting client comparison groups.

Tape Recorded Therapy Samples

All clients (and therapists) who participated in the therapy research project agreed to have periodic therapy sessions audio taped. The student clinicians involved in treating the participants aided in data collection by turning in tape recordings from the first and third sessions of therapy (and beyond for those clients who remained in treatment). These recordings were assigned a numeric identification number to provide anonymity to participants and protect the clients' confidentiality. They were then compiled into a library of therapy tapes used for research. The therapy samples for the present study were collected between January of 1994 and June of 1998.

Following the identification of and creation of an equal sized comparison groups of early dropout and persisting participants, a ten-minute sample from both the first and third sessions were duplicated from each of the participants' therapy tapes. In order to

avoid unintended effects due to the stage of the session sampled from entering into data collection and analysis, the ten-minute sample of session material was randomly selected from either the first, middle or last twenty minutes of the session. Again, matched subjects had similar stages of their therapy sessions sampled.

In order to ensure uniformity of the samples and to provide the coders with the context of the initial client material presented in the recording, samples always began with a clinician speaking turn. Samples were ended as closely to ten minutes as possible without destroying the codeablity of the final client speaking turn. The samples were digitized and attempts were made to improve the sound quality for optimal audibility during coding. These individual samples were assigned a specific sample number to help identify the resulting data and allow it to be assigned to the appropriate subjects during data entry.

The sequence of the samples was randomized and recorded to compact disc (CD) to create a "master" digital recording that allowed the raters to be blind to which group the session material came from, as well as, whether the material was from the first or third session. The same master recordings were employed by both trained coders to produce the resistance data for statistical analysis.

Measures

SCL 90-R: The Symptom Checklist 90 Revised. Derogatis' (1983) Symptom Checklist 90-Revised (SCL-90) was used to measure participants' number of symptoms, level of self-reported intensity of symptoms and global psychopathology and at the time of their entering therapy. It is a 90 item self-administered questionnaire composed of

nine subscales measuring nine symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. Participants are instructed to read each of the items, which ask to what degree are they distressed by particular symptoms (e.g., headaches, nervousness, shakiness, etc.) and then to rate each item on a Likert type scale that ranges from 0, not at all, to 4, extremely. Means are then computed for each of the nine subscales. A Global Severity Index (GSI) is computed as the sum of all item responses divided by 90. According to Derogatis (1983), the GSI is the best single indication of the current level of pathology.

Internal consistencies for the SCL-90 subscales were reported to range between a low of .77 for psychoticism to a high of .90 for depression. The test-retest reliability for the SCL-90 was reported as ranging from .78 for hostility to .90 for phobic anxiety (Derogatis, Rickels & Rock, 1976). Convergent validity has been supported (Derogatis, et al., 1976) by successfully comparing the dimensions scores of the SCL-90 with the scale scores of the MMPI.

CRS: The Client Resistance Scale. Mahalik's (1994) Client Resistance Scale (CRS) was used to measure participants' level of resistance at two points early in treatment (first and third therapy sessions). The CRS is a process measure of five dimensions associated with client resistance. Trained judges use this rating system to judge the level of "observable" resistance present across the five dimensions during a therapeutic interaction between a client and therapist dyad. The CRS's 5 subscales are based on R.R. Greenson's (1967) formulation of client resistance. These scales are Opposing Expression of Painful Affect, Opposing Recollection of Material, Opposing

Therapist, Opposing Change, and Opposing Insight. Judges rate the client portion of recorded (audio- or videotaped) interactions on each subscale according to a 7-point Likert scale with higher ratings reflecting the presence of greater amounts of those variables. These ratings are then summed to produce a global resistance scale score.

Reliabilities for each of the five resistance subscales using two judges ranged between .92 for Opposing Recollection of Material to .71 for Opposing Insight. Reliability increased across all subscales, as three and four judges were employed. Intercorrelations between subscales ranged from .31 to .62, indicating that the CRS is unidimensional. However, there were meaningful differences in level of resistance found based on the assessment of different clients, which suggests an examination of the subscales has qualitative value and supports the view that resistance, as a construct, is multidimensional.

Client Resistance Code (CRC). Kavanagh, Gabrielson, and Chamberlain's (1982) Client Resistance Code was used to measure the frequency of participants' resistant responses during segments of their first and third sessions of psychotherapy. The CRC is a seven-category coding system that was designed to measure resistance during single therapy sessions. The system has five categories that are used for coding resistant client behavior (e.g., Interruptions/talking over, Not tracking, and Negative attitude) and two for coding cooperative behaviors. For the purpose of the current study only the five categories of resistant behaviors will be used and as in the case of Chamberlain, et al.'s (1984) study these five categories will be collapsed into a single global scale of resistance. This scale measures the total number of resistant behaviors observed during a

given therapy session, which is then divided by the total number of minutes coded to produce a rate per minute score. Rather than just counting the number of resistant responses and then dividing them by the same ten minute intervals, this study will tally the number of resistant responses and then look at what the proportion of responses during that coded segment were resistant (CRC resistant responses + Total client speaking turns). Inter-rater reliability was reported to be r=.98, $p<..001$, for the resistance scale. The successful application of this coding system to corroborate theoretically based assumptions about resistance during differing stages of treatment, resistance and dropout, and resistance levels in self vs. agency referred clients provides support for its construct validity (Chamberlain, et al., 1984).

Raters

The primary research investigator trained two raters to employ the CRS and CRC using clinical material, prior to their employing these measures with the actual research therapy samples. Both raters were male graduate students in clinical psychology who had completed their second year of graduate level coursework and a year of clinical practicum. Initially the raters were given readings to familiarize them with the background theory from which the resistance scales were developed. Following this, the raters met with the primary researcher and were given basic instruction with regard to the standardized procedures for employing each of the resistance measures. A number of additional samples of therapy sessions were obtained from the therapy tape library and used for a series of rating practice sessions. These practice sessions were held until adequate(r>=.80) inter-rater reliabilities were achieved. Post-training inter-rater reliability

for each rater considered singly with a Pearson's Product Moment Correlation achieved r_1=.82, p<.05 levels. The aggregate or effective reliability that considers both raters simultaneously by using the Spearman-Brown formula achieved r_k=.90, p<.05 levels. Both raters coded all of the selected therapy samples (80 ten-minute samples) using both the CRC and CRS. Coding was completed over the course of approximately six weeks. Raters averaged spending three minutes per minute of therapy sample to code the data.

Procedures

Upon agreeing to take part in the psychotherapy research project, participants completed a consent form and the Symptom Checklist-90 Revised (SCL-90R). These forms had to be completed prior to their first therapy session. The forms were returned to the student clinician by which they were treated at the commencement of treatment. The student clinician in turn passed these forms and designated session tape recordings to a graduate student who independently managed the data collection for the ongoing project. This study did not use recently collected data, rather all the data was archived at minimum three years prior to its initiation.

The archived data did have to be checked for completeness and sound quality. Following the training of raters and initial reliability checks, the pre-therapy SCL-90 questionnaires were compiled and scored for the two groups and entered into a computer database.

Coding of the ten-minute segments of both the first and third therapy sessions commenced shortly after training sessions were completed. Coders were blind to whether the segments were from first or third sessions and client group assignment (dropout vs.

persister), only identifying the segments by an identification number. They were instructed not to discuss their ratings with each other and were assigned a different sequence of the segments to follow. The raters coded the therapy samples independent from each other following the directions outlined in the Manual for the Client Resistance Scale (Mahalik, 1994) and as described by the authors of the Client Resisance Code (CRC) in the Manual for Coding Client Resistance (Kavanagh, Gabrielson, & Chamberlain, 1982). The coders rated each therapy segment with both measures simultaneously, though this typically required multiple reviews of the segments. The coders rated each speaking turn independently, but these individual speaking turn ratings were later summarized into segment averages for each of the CRS scales. An accounting of how many speaking turns per segment was maintained which allowed for the proportion of CRC resistant responses to be calculated for each segment.

A mid-coding reliability check was conducted using non-research therapy session samples to ensure that inter-rater reliability was being maintained. Reliability showed some decline with the Pearson correlation slipping to $r_1=.72$, $p<.05$ and the Spearman-Brown correlation falling to $r_k=.83$, $p<.05$. However, with the aggregate correlation (Spearman-Brown) still above the .80 level, this was still considered acceptable to the primary researcher. Further practice coding and discussion was conducted in addition to the reliability check to "recalibrate" the reliability of the coders with the hopes of improving the reliability of the remaining ratings.

Following the completion of all session sample coding, the sample ratings were reorganized back into appropriate group (dropout and persister). The data was then entered into an SPSS spreadsheet for statistical data analysis. A combination of chi-

squared analysis, correlations, one-tailed t-tests, one-way analyses of variance, 2x2 mixed (within-between) subjects analyses of variance, and discriminant function analyses were applied to the data set to evaluate the accuracy of a priori hypotheses.

RESULTS

Demographic comparisons between groups

The presence of possible confounds was investigated prior to performing the pre-planned data analyses. A combination of one-way analysis of variance (ANOVA) and Chi-squared analysis was used to check if there were significant differences between the Dropout and Persister groups on any demographic variables that may have impact on the other analyses, as prior research has shown such variables to have weak, but statistically significant relationships to dropout . As stated previously, subjects were paired specifically by sex and and the dyad pairing (e.g., male client-male therapist, etc.), therefore there was no need to measure differences in these categories. Statistically significant differences were not found between groups on other potential confounding demographic variables (See Tables 1 and 2). Therefore, the data analysis proceeded as planned.

Interrater Reliabilities

The interrater reliabilities for the Client Resistance Scale (CRS) and Client Resistance Code (CRC) ratings are shown in Tables 3 and 5, respectively. Pearson product-moment correlations give the measure of reliability for each of the individual judges independently, these ranged from .51 (Opposing Change) to .76 (Opposing Recollection of Material) for the CRS subscales with an overall correlation of r=.71 for the subscales collapsed into a single measure of resistance. The CRC had Pearson correlations of .78 and .85, for the resistance and cooperative scales respectively. These correlations were a bit lower than hoped for by the investigator. To improve the

reliability of these ratings, the ratings for each scale were averaged to produce a single score for each session-segment rated. By treating the data in this way, it allows the investigator to amplify reliability data through the application of the Spearman-Brown formula for estimating "effective" or aggregate reliabilities:

$$R = \frac{\text{number of raters} * (\text{average of individual correlations})}{1 + (\text{numer of raters} - 1) * \text{average of individual correlations}}$$

(Rosenthal & Rosnow, 1991). This procedure is essentially the same as that used for determining split-half reliabilities, only in this case the two raters are treated as if they were the halves. By looking at the interrater effective reliabilities, the CRS subscale reliabilities improved to a low of .68 (Opposing Change) to a high of .86 (Opposing the Recollection of Material) and an overall correlation of .83 for the subscales collapsed into a single measure. These reliabilities were significantly lower than those reported by Mahalik, the CRS author, who had achieved subscale reliabilities that ranged from .71 to .92. However, as the overall correlation exceeded .80 this was viewed as acceptable by the primary investigator. Effective reliability conversions improved the correlations on the two CRC scales to .88 and .91, for the Resistance and Cooperative response scales respectively, which is an acceptable rate by most research standards.

Overview of Resistance Variables

Subcale intercorrelations were statistically significant between all possible combinations of CRS subscales (correlations ranged from r= .33 to .45), with the exception of Opposing the Expression of Painful Affect scale and Opposing the Therapist which were found to have little relationship (r=.07, non-significant at $p<.05$). This pattern of intercorrelation supports Mahalik's (1994) conclusion that the CRS is

generally a unidimensional scale, though the subscales are worthy of consideration individually to add to qualitative understanding of the different facets of resistance. It was quite discrepant for the Opposing Expression of Painful Affect and Opposing the Therapist scales to be uncorrelated using this sample's ratings as Mahalik had found this combination of subscales to be the most related of all subscale combinations ($r=.62$).

The two scales of the CRC were found to have no relationship ($r=.08$, nonsignificant at $p<.05$) and are therefore viewed as independent variables. This was as expected due to the mutually exclusive nature of the two scales and this allowed the investigator to focus analysis on the resistant response scale alone.

Concurrent validity between the two measures of resistance was calculated using Pearson product-moment correlations between the overall and subscale scores of the CRS and the resistant response scale of the CRC. Table 6 summarizes this analysis. The correlation between the CRS and CRC was statistically significant ($r=.46$, $p<.05$) suggesting that these two measures are moderately related. Intercorrelations between the CRC and the CRS subscales were statistically significant for four out of five of the subscales, ranging from .29 (Opposing Experiencing Painful Affect) to .53 (Opposing the Therapist), only the Opposing Change subscale was not correlated. This is consistent with the view that these two measures are measuring different parts of the same thing (frequency/quantity (CRC) vs. intensity/quality of resistance (CRS)).

Hypothesis I

Psychotherapy clients prematurely terminating during the early phase of treatment without discussing it with their therapist (Dropouts) will not differ significantly from clients who continue in treatment beyond twenty sessions (Persisters) with regard to their self-reported level of psychopathology at intake as measured by the SCL-90R global severity index (GSI).

In order to evaluate possible differences between the dropout and persister groups in initial level of psychopathology, a one-tailed, independent samples t-test was conducted comparing group means on the SCL-90R global severity index. In addition to the global severity index, additional t-tests were also conducted to explore possible differences on the positive symptom index and the nine subscales of the SCL-90.

Results of the statistical analysis confirmed the hypothesized lack of differences between dropouts and persisters on presenting level of psychopathology. Global Severity Index scores for the two groups did not significantly differ, t (38) = -0.282, p=.78. Dropouts actually had a slightly lower average GSI score (m=1.16; SD=.67) than the persister group (m=1.23; SD=.78), but again these differences were unable to achieve statistical significance. Further analysis of SCL-90R data was unable to produce any positive results. Neither the positive symptom index nor any of the nine SCL-90R subscales produced significant mean differences between the two groups. Point-biserial correlations between the groups and SCL-90R scales further failed to establish any relationships.

As the study's focus was on resistance levels, correlations between the SCL-90R global severity scale and CRC and CRS scales were also evaluated. First session

resistance scores on both the CRC and CRS (including all subscales) did not produce any significant Pearson correlations. Out of the analysis of third session variables, only levels of Opposing Insight correlated with the SCL-90R global severity index (r=.29, p<.05, one-tailed).

Hypothesis II

Psychotherapy dropouts will differ significantly from Persisters on measures of quantity, intensity and quality of resistance they exhibit during their first and third sessions of psychotherapy.

Independent samples t-tests were conducted in order to evaluate differences between dropout and persister groups on the Client Resitance Code resistant response proportions, the total Client Resistance Scale scores, and the CRS subscales. T-test results for the CRC resistance response proportion scores for both the first and third sessions approached statistical significance, t (38) = 1.83, p=.075 and t (38)=1.98, p=.056, respectively. Confirming hypothesis two, when the overall proportion for both sessions combined was evaluated the t-test was found to be statistically significant, t (38) =2.70, p = .01. As predicted, participants in the dropout group tended to have a higher proportion of resistant responses (46.26 % vs.33.45 % in the first session and 51.54% vs. 37.39% in the third session). The overall percentage of resistant responses for both sessions were 48.2% (SD=18) for dropouts and 34.4% (SD=14) for persisters. The strength of this relationship between group and CRC resistant response proportion as indexed by η was .40 indicating a moderate effect size. The effect size as estimated

by the *d* statistic was .86 for CRC resistant response proportion. See Table 7 for summary of CRC t-test data.

Contrary to predictions, the effect for group (dropout vs. persister) did not achieve significance for overall CRS scores, t (38) = .387, $p > .05$. On average participants in the dropout group demonstrated slightly higher scores on the CRS but this difference was not significant. The strength of the relationship between group and CRS scores as indexed by *d* was .12 indicating a small effect size. See Table 8 for summary of CRS t-test data.

Further analyses of group differences on the CRS subscales failed to reveal any statistically significant results. Figures 1 and 2 provide graphic depiction of mean comparisons for both first and third session ratings on the CRS subscales. The lack of positive results is likely influenced by small sample size. Three non-significant results are of note due to effect size estimates that are suggestive of a relationship between these variables and group membership. First session Opposing the Therapist scores produced near significant results, t (38) = 1.78, p=.08 with effect size estimates of η =.27 and d = .56. Third session Opposing Recollection of Material and Opposing Change also approached statistically significant mean differences, t (38) = 1.43, p=.16 and t (38) = 1.52, p=.14, respectively. Effect size estimates for these two scales were η =.22 and d = .45 and η=.24 and d = .46, respectively. Seven out of the ten subscale measurements (first and third sessions for each of the five subscales), produced mean differences in the predicted direction (dropout group higher score). Three subscales interestingly produced mean differences that were in the opposite direction of the hypothesis, first session Opposing Recollection of Material, third session Opposing

Expression of Painful Affect and third session Opposing Change. Only the third session Opposing Change differences approached statistical significance.

Hypothesis III

Dropouts and Persisters will both exhibit a growing level of resistance between the first and third sessions, with Dropouts beginning at a higher level and outpacing the Persisters in amount of increase in resistance between sessions. Persisters will exhibit a slower level of resistance growth between sessions, as measured by the Client Resistance Scale (Mahalik, 1994) and Client Resistance Code (Kavanagh, et al., 1984).

In order to evaluate differences in the change in resistance over time between dropout and persister groups, 2x2 within subjects ANOVAs were conducted. Means and standard deviations for CRC and CRS data in sessions 1 and 3 are summarized in Tables 7 and 8 . Graphical depiction of the between session growth on the two resistance measures is shown in Figures 3 and 4.

Contrary to the hypothesis, dropout and persister groups demonstrated fairly similar levels of CRS measured resistance at session one and did not demonstrate significant differences in patterns of resistance growth (Group X Session) F (1,38) = .039, $p > .05$. The within-subjects main effect for session supported the hypothesis that there would be increasing levels of resistance, though this analysis failed to reach statistical significance F (1,38) = 2.166, p =.15. This is likely due to insufficient sample size and there being a relatively small effect, eta was estimated to be .23. Observed power estimate was beta equals .30 for this main effect analysis.

Additional analysis of CRS subscales only produced one statistically significant main effect for Opposing Recollection of Material (See Figure 5) F (1, 38) = 4.25, p<.05. There was a medium effect size of eta=.32 and power was estimated to be beta equals .52. This same variable produced an interaction (Group X Session) that approached significance F (1, 38) = 2.05, p=.16. Effect size of the interaction was estimated to be eta equals .23 representing a relatively small effect and power was very low for this analysis at beta equals .29.

Consistent with the hypothesis, dropout and persister groups demonstrated differences that approached statistical significance on CRC resistant proportion scores at both first and third sessions. The within subjects main effect for session demonstrated the anticipated increasing levels of resistance, though this analysis failed to reach statistical significance F (1,38) = 1.05, p =.31. This is likely due to insufficient sample size and there being a relatively small effect, eta was estimated to be .16. Observed power estimate was beta equals .17 for this main effect analysis. Dropout and persister groups did not demonstrate significant differences in patterns of resistance growth (Group X Session) F (1,38) = .022, p > .05.

Hypothesis IV

By evaluating levels of resistance in two groups of patients (Dropouts vs. Persisters) with multiple, multidimensional measures (CRS and CRC) and then entering these variables into a discriminant function, a model that predicts group membership can be achieved that will consistently exceed the expected chance rate of prediction for two groups (50%).

A step-wise discriminant function analysis was conducted to develop a mathematical equation capable of classifying participants into either the dropout or persister groups using the resistance variable data. The group variable degrees of freedom value for this two-group design is one; so one discriminant function was calculated. The analysis produced a model that predicted group membership from the scores of four variables (overall CRC resistant response proportion across both sessions, overall CRS Opposing the Therapist across both sessions, third session CRS Opposing Expression of Painful Affect, and third session CRS Opposing Recollection of Material). The single discriminant function was significantly associated with group membership [$X^2(4) = 11.37, p < .05$] and the canonical correlation coefficient related to this function was $r = .52$. Standardized discriminant function coefficients for the four variables included in the analyses following the step-wise procedure are presented in Table 9.

The classification accuracy of the discriminant function is shown in Table 10. The discriminant function achieved sensitivity, or a true positive rate for dropouts of 70% and a specificity, or true negative rate for persisters of 85%, with an overall classification accuracy of 77.5%. Furthermore, the use of the discriminant function results in a decrease in error rate of 27.5% compared to decisions of group membership based on sample size alone. Cross-validation was conducted for all the cases in the analysis. In cross validation, each case was classified by the functions derived from all cases other than that case, the cross-validation yielded an overall accuracy of 72.5%. The reduction in accuracy from the original discriminant function analysis was due to

misclassification of two persister group participants, results for classification of dropouts remained the same (70%).

Each predictor variable increased the overall classification rate as it was added to the function. The combined CRC resistance response scale was the most influential predictive variable, as when it was used alone, it was able to successfully classify 62.5% of the subjects into their correct group. Upon adding the third session CRS Opposing Recollection of Material variable to the discriminant function, the overall classification rate rose to 65%. Followed by a 5 % increase to 70% with the addition of third session CRS Opposing Expression of Painful Affect and finally, a 7.5% increase when combined first and third session CRS Opposing the Therapist was added. When all of the variables are entered together, the contribution of each variable becomes more apparent. In Table 11 pooled within-groups correlations between discriminating variables and standardized canonical discriminant functions are displayed. This matrix provides another way to study the usefulness of each variable in the discriminant function when all variables are entered simultaneously.

The intercorrelations between the variables of interest in this study revealed significant correlations ranging from .07 to .53. The intercorrelations and redundancy of many of the variables entered into the model likely contributed to the final discriminant function using only four variables out of a possible 18. Although the variables account for different facets of resistance, different periods of resistance expression (1^{st} or 3^{rd} session), and differing ways of applying these measures (combined versus individual sessions measures) the resultant overlap in variance accounts for the limited discriminating power of some of the variables during the step-wise procedure.

DISCUSSION

This study set out to establish further empirical evidence of a link between observable forms of client resistance and premature termination from psychotherapy. This was pursued using two previously created measures of client resistance, the Client Resistance Code (CRC) and the Client Resistance Scale (CRS). The CRC was chosen for its ease of application and previous success at providing evidence of the link between resistance and dropout. It functioned as a measure of the quantity or proportion of resistant responses given by the research participants. The CRS, on the other hand was selected due to its theoretical relevance to Greenson's (1967) writings and for its demonstrated broad applicability to samples from a variety of theoretical orientations. The CRS was viewed as a measure of the quality and intensity of resistance exhibited by the subjects. It provided more specific information regarding how the participants manifested their resistance to treatment. It was hoped that by applying these instruments in tandem to samples of psychotherapy sessions of both dropouts and a comparable group of patients who remained in treatment, new insights into the relationship between resistance and dropout would emerge and a model capable of predicting group membership would be developed. What follows is an explanation and an integration of the reported results with the extant literature on resistance and dropout.

Hypothesis I

Hypothesis I was included to address the influence of psychopathology levels on dropout. The hypothesis in this case was that there would be no difference in initial levels of psychopathology between the dropout and persister groups. This hypothesis was tested to rule out potential confounding variables that might interfere with the ability to assess the influence of resistance on dropout. Had there been differential levels of pathology between the groups, level of initial psychopathology would have been covaried in the statistical analysis implemented in Hypotheses II and III and entered into the stepwise discriminant function analysis in Hypothesis IV.

Hypothesis I was confirmed with there being little difference in initial levels of pathology between groups as measured by the SCL-90 Global Symptom Index. In fact, additional statistical analyses were unable to produce any significant differences between the dropout and persister groups when looking at SCL-90 subscales or the Positive Symptom Index, lending additional strength to the hypothesized lack of difference in initial pathology.

There have been many studies with conflicting outcomes that address the influence of pathology on premature termination. Strongly supporting the present study's findings, a sizable study of 815 outpatients at a federally funded community mental health center by Stahler and Eisenman (1987) also found no difference between dropouts (patients attending less than three sessions) versus non-dropouts on initial self-reported levels of symptomology as measured by the SCL-90. However, they did find that patients differed on diagnoses with the non-dropout group containing more psychotic patients .

They also found that therapist ratings of the patients' level of functioning at intake were higher for the dropout group, suggesting they were higher functioning than the non-dropout group. While this study's results appear to closely approximate those of the present study, especially regarding SCL-90 scores, it must be noted that the dropout patients in the present study would have been considered non-dropouts using Stahler and Eisenman's dropout criteria, as all of the present study's subjects attended a minimum of three sessions of therapy.

In Smith, Koenigsberg, Yeomans, Clarkin, and Selzer's (1995) study of psychodynamic psychotherapy for borderline personality disorder with thirty-six patients, dropout versus continuation in treatment was studied using demographic, prior treatment, and clinical variables (including the SCL-90R Global Severity Index). SCL-90R GSI scores failed to contribute successfully to the prediction of group membership (dropout vs. continuer). The only clinical variable that contributed was a measure of hostility (Buss-Durkee Hostility Inventory). These findings appear consistent with those of the present study and in this case, the type of psychotherapy being employed by the therapist, as well as the length of treatment received by dropouts closely approximates those found in the present sample.

Some additional studies also reporting corroboratory findings include Martin, McNair, and Hight (1988) who studied 148 student clients at a university counseling center. Their study specifically found that State-Trait Anxiety Inventory (STAI) scores did not differ between early prematurely terminating (EPT) clients (those unilaterally discontinuing treatment after one or two sessions) and non-EPT clients. Additionally, Oei and Kazmierczak (1997) using a variety of intake assessment measures were not able to

predict group membership between dropout and completer clients (n=131) from cognitive-behavioral group therapy for mood disorders. Further Mosher-Ashley (1994) found no significant differences between groups of elderly psychotherapy patients who dropped out versus those completing treatment with regard to diagnosis, severity of symptoms at intake, and level of discomfort caused by the reported symptoms.

The present study's results were contrary to those of four dropout studies reviewed that considered the influence of initial levels of pathology on premature termination (Richmond, 1992; McCallum, Piper, & Joyce, 1992; Hilsenroth, et al., 1995; and Hatchett, Han, & Cooker, 2002). Richmond (1992) conducted a dropout study with 624 individual adult therapy clients at a nonprofit outpatient mental health clinic. Advanced doctoral students with a primarily psychodynamic theoretical orientation staffed this clinic. The results of this study found evidence of differences between therapy completers and dropouts on a variety of initial symptomatic measures including: DSM III-R Axis II diagnoses, grandiosity, and guilt. This study's findings are of note due to its large sample size and the similarity to the patient population and setting to the present study. As noted in the literature review, Hilsenroth et al. (1995) found that dropouts were less disturbed, more capable of establishing cooperative relationships, and had less need for interpersonal contact. McCallum, Piper and Joyce's (1992) study of dropout from short-term group therapy successfully employed SCL-90 scores as one of three predictors that differentiated dropouts (n=17) from remainers (n=38) at an overall seventy-two percent success rate.

While there appears to be more studies that support a lack of differences in initial pathology between therapy dropouts and persisters, the previous review illustrates well

the problems that arise from the different approaches employed by researchers in defining dropout and premature termination. As there is such a lack of consistency in the supporting research and there are weaknesses and limits to the current study, the present results should be interpreted with caution and cannot be viewed as unequivocal. The reviewed literature would also suggest that factors such as the type of treatment setting, the kind of intervention employed (e.g., individual vs. group therapy), and therapist factors (e.g., theoretical orientation, training level) may have interactive or moderating influences on the eventual persistence or premature termination of a patient. Improving definitions of dropout and collecting follow up data directly from those patients who dropout would likely clarify this and improve the quality of future research.

Something to be considered regarding the present study's negative findings is that despite a lack of differences in initial psychopathology endorsed, we know nothing regarding the differential impact of the psychotherapy (3-8 sessions) received by these patients on their pathology. This issue was addressed by Pekarik (1992) in an outcome study evaluating differences between 94 dropout and completing outpatients (47 child and 47 adult cases) at a public mental health clinic in a mid-sized Midwestern city. One focus of Pekarik's outcome study was that early (1-2 sessions) and late dropouts (3 or more sessions) differed in their differential response to therapy, with the early dropouts continuing to exhibit a greater lack of adjustment than patients from the later dropout group. Little difference in response to treatment as measured by self-reported pathology could be detected between the late dropout group and those that completed treatment. The present study's dropout group was more similar to Pekarik's late dropout group and the lack of differences in initial pathology are consistent with his study's findings. Had post-

dropout follow up measures of pathology been collected on the present study's dropout group, there may have been similar lack of differences in response to treatment. This leads to speculation that the further a patient proceeds in the treatment process prior to dropping out, the more likely it may be that they are leaving treatment due to actual symptomatic relief rather than a conscious or unconscious resistance to treatment. However, caution regarding such speculation should still be taken, as self-reported level of pathology could also be an outward manifestation of a patient's denial and/or resistant "flight into health." Clearly this is an aspect of psychotherapy dropout that warrants continued research attention, but that will likely continue to pose a challenge to investigators with regard to deriving clear and interpretable results.

For the purposes of the present study, the fact that there were not differences in initial pathology endorsed by members of the two groups was considered fortuitous, as it provided a natural control for a potentially confounding variable. Since this study was employing a quasi-experimental design with a convenience sample, where random assignment and a control group could not be employed, being able to rule out at least one potentially influential external source of variance on the variable of interest (observable resistance) was very helpful.

Hypothesis II

This hypothesis tested the primary contention of the study that there would be differences in the quality, quantity, and level of resistance observed between dropout and persister subjects. It was contended that dropouts would exhibit a higher proportion of resistant responses as measured by the Client Resistance Code (CRC), with greater

intensity and predictable patterns of subscale elevations on the Client Resistance Scale (CRS). Statistical analysis confirmed that the dropouts in this sample responded to their therapists with a higher proportion of resistant responses than persisters. This is consistent with the results of Chamberlain, et al.'s (1984) study in which the CRC was originally applied to adults participating in parent-training. Chamberlain found that significantly more "high resistant" participants dropped out of the parent training program than "low resistant" participants (54% vs. 14%, respectively). The present study demonstrated the utility of the CRC to other forms of treatment beyond didactic parent-training.

Statistical analysis of the Client Resistance Scale (CRS) and its subscales was met with less success than that of the CRC. Two problems existed that likely undermined the ability for this study to confirm the hypotheses related to differences on the CRS measures. First, the complexity of the CRS is much higher than that of the CRC. It required the research coders to simultaneously assess five coexisting subcategories of resistance for every client speaking turn versus only two mutually exclusive categories with the CRC. The difficulty of this task contributed to increased variance and less than ideal reliability rates on some of the CRS subscales (see Table 3). This combined with a relatively small sample size made it difficult to attain statistical significance when making comparisons between groups on the CRS subscales. Those subscales where results seemed to approach significance were very likely the victim of small sample size and inadequate power for the size of effects exhibited. There is still value in evaluating the trends found in the results of the present data analysis and comparing it with existing research results, as meta-analyses or future prospective studies may find such information

of value. However, interpretation and generalization of such findings should be done tentatively with an emphasis on encouraging further confirmatory research that will overcome the aforementioned shortcomings of this study.

While the CRS subscale scores did not differentiate between dropouts and persister groups, they provide some interesting insight into the quality of the observed resistant behaviors amongst this sample of psychotherapy clients. Overall, there appears to be a somewhat consistent pattern to the resistance exhibited in early sessions of psychotherapy (See Figures 1 and 2). Avoiding expression of painful affect seems to be the most intensely experienced form of resistance for all patients, followed by resistance to change and difficulty making connections between the past and present (opposing insight). Most patients at least initially are able to verbalize personally relevant material and follow the lead of their therapist, though they may not elaborate or pursue greater depth of discussion.

Opposing expression of painful affect was the most strongly manifest subtype of resistance amongst this sample and there was the least amount of difference between the dropout and persister groups on this measure. This is very consistent with the well-accepted theoretical view of resistance as an inherent, unconscious striving to avoid thoughts and feelings that cause discomfort (Beutler, Rocco, Moleiro, & Talebi, 2001). The subjects' scores on the Opposing Change and Opposing Insight subscales were not far behind opposition to expression of painful affect in level of intensity exhibited. These three subscales were moderately intercorrelated (ranging from .38 to .45). The elevation on the Opposing Insight scale could represent an extension of the client's avoidance of uncomfortable thoughts and feelings (Opposing Expression of Painful Affect). Making

connections between present experiences and feelings to historical events in one's life require first, identifying and recognizing current (possibly painful) emotions. The insight process then intensifies those emotions and experiences by requiring the patient to look at unresolved conflicts, past traumas, etc. that contribute to these in a way that is likely to enlist and engage the patient's psychic defenses. However, variations in patients' level of psychological mindedness and/or lack of experience or development of the ability to make such connections early in treatment may artificially inflate their scores on this subscale.

The elevated initial scores for both groups on the CRS Opposing Change subscale can be interpreted as representing the well-established theory that Strean (1985) details in his text on resistance. He asserts that all clients enter therapy with a great deal of ambivalence despite their acknowledged difficulties and presenting problems. The idea of seeking therapy as a solution is still often frightening and aversive. Interestingly, in the current study resistance to change was almost unchanged between sessions one and three for the dropout group, while it increased between sessions for the persister group. The difference between dropouts and persisters on the third session Opposing Change scale approached statistical significance. This is contrary to findings that are suggestive of opposition to change having an influence on dropout in psychotherapy. Brogan, Prochaska, and Prochaska's (1999) study successfully used the transtheoretical model of change to develop a discriminant function that correctly classified 92% of the sixty patients in their study into two groups (premature and appropriate terminators). Premature terminators exhibited a "precontemplation profile," which could be considered

similar to the CRS subscale of opposing change, as it is indicative of a lack of recognition for the need to change and tends to hinder movement away from the status quo.

CRS subscales that were less intensely expressed were the Opposing Recollection of Material and Opposing the Therapist forms of resistance. However, when looking at group differences these two scales tended to be more differentially expressed and between session growth and predictive power of these scales seemed to be higher than the other three subscales, as will be discussed later.

The first session Opposing the Therapist scale scores came closest to achieving statistical significance, with dropouts exhibiting higher levels of this type of resistance than persisters. This is consistent with other studies that address the development of therapeutic alliance and/or client reactions to the therapist. Kolb et al. (1985) reported that in their sample of 91 outpatients, those who dropped out were less involved in and less changed by their treatment and tended to view their therapist as less supportive and facilitative. In looking at initial session process variables within a sample of 32 outpatients, Bottari and Rappaport (1983) found that patient perceptions of the therapists' style of relating and affect, related to the number of therapy sessions attended and benefit derived from treatment. Beckham (1992) also reported negative client impressions of the therapist are predictive of early dropout. Martin et al. (1988) reported that at least a subset of their early premature terminators left due to negative feelings toward their therapist (e.g., not liking them, feeling they were close-minded, etc.) These past studies as well as the literature on the importance of the therapeutic alliance lend support to the "nonsignificant" results of the current study regarding direct opposition/resistance to the

therapist and would further imply the need for further research as has been suggested by prominent figures in this field of study (Beutler, et al., 2001).

The Opposing Recollection of Material and Opposing the Therapist subscales were also moderately correlated (r=.40). It makes intuitive sense that a client's resistance to their therapist will influence their openness and willingness to produce personally relevant material. Beutler et al. (2001) in reviewing previous resistance research reported evidence that directive and nondirective therapeutic interventions were differentially responded to by patients with differing levels of trait and state resistance. He indicated that more resistant patients responded better to nondirective interventions and vice versa. Differences on third session scores on the Resisting Recollection of Material subscale approached statistical significance, with dropouts having higher levels than pesisters. It may be that the mediating effects of different therapist styles are coming into play in this situation, as they seem especially relevant to the measure of opposing recollection of material. This alludes to the importance of pursuing such interactional data in future research, as will be discussed later.

Again, data analysis failed to find statistically significant differences between the dropout and persister groups on the CRS summed scores for both first and third sessions. Analysis of the individual subscales also failed to find statistically significant results, however, in a few cases the results approached significance. In attempting to understand the pattern of results on the qualitative CRS measures of resistance a couple ideas emerge for consideration. First, it may be that patients who have become engaged in the work of psychotherapy will exhibit qualitatively similar resistant behaviors to those exhibited by dropouts, but less frequently and in the process of actually approaching and dealing with

the psychological issues that brought them into treatment. Whereas the dropouts employ these defenses more readily and frequently, with the goal being to maintain the status quo by keeping the therapy from moving forward. The persisting patients are in essence taking the previously mentioned "opportunity" of working through their resistance, while the dropouts (consciously or unconsciously) are attempting to frustrate and "challenge" their therapist and the process of psychotherapy. Second, it seems that the scales (Opposing the Therapist and Opposing Recollection of Material) where greater differential expression existed between dropouts and persisters may tap into factors that have been both theoretically and empirically supported to be especially relevant to the success of the early phase of psychotherapy (e.g., development of therapeutic alliance, expectations for treatment, match between therapist style and client presentation, etc.). Overall, the present study's findings seem fairly congruent with Beutler et al.'s (2001) report that most studies that investigated the prognostic value of patient resistance found that it had a negative impact on treatment outcome.

Hypothesis III

The purpose of this hypothesis was to address within-subjects changes in level of resistance between sessions, as well as, to analyze possible differential growth rates between the dropout and persister groups. The Client Resistance Code (CRC) measured growth in frequency of resistant responses, while the Client Resistance Scale measured changes in intensity and quality of resistance between sessions. Contrary to expectations, data analysis revealed very little difference in resistance growth rates between the dropout and persister groups (See Figures 3 and 4). As expected dropouts did exhibit

higher initial levels of resistance and reached higher levels by session three on both measures. Within-subjects resistance growth approached statistical significance, with average levels of resistance on both measures increasing noticeably. This trend of progressively increasing resistance levels during the early phase of treatment is consistent with both theoretical and empirical expectations.

Reviewed theoretical and practical writings on resistance (Greenson, 1967; Teyber, 2000; Gabbard, 1990; Benjamin, 2003) suggest that intensification of resistance is an expected and typical pattern of patients during the early phase of treatment. From a psychodynamic perspective, patients entering treatment progressively intensify their resistance against approaching emotionally laden issues by employing a variety of intrapsychic defense mechanisms. This intensification continues as the therapist moves the patient toward "working through" the resistance. The origins of the resistance (and transference) are explored and often addressed with repetitious interpretation during the "working through" phase, until eventually insights and understanding are eventually integrated into the patient's conscious awareness. At this point, the level of resistance will subside.

Chamberlain et al.'s (1984) study found this pattern in their initial application of the CRC to parent-training therapy with adults with child management problems. They reported significant within-subjects changes in overall frequency of resistant responses between early treatment (average of first two sessions') scores and mid-treatment (average of seventh and eighth sessions') scores. They further observed a progressive decrease in resistance from mid-treatment to late treatment/termination. Patton, et al. (1997) also reported a low-high-low pattern of resistance, as measured by Schuller, et

al.'s Resistance Scale, amongst clients described as having better outcomes. Further, they reported that clients with lower levels of midtreatment resistance showed greater change from counseling.

In both of the previously cited studies, measurements of change in resistance level were assessed further apart (on average more than five sessions apart) than those made in the present study (two sessions apart). The added time and further progression of treatment in these studies allowed for additional manifestation of resistance growth, thus increasing their probability of reaching statistically significant levels of change. When comparing the current study's average per session change on the CRC with those reported by Chamberlin et al. (1984), the slope of resistance growth was actually steeper in the present study. Small sample size (relatively low statistical power) and a relatively brief pre-/post-measurement interval in the present study likely explains the lack of statistically significant results. However, the overall trend observed amongst this sample is consistent with the previous research. Not only was there an increase in frequency of resistance, there was also increase in intensity of the resistance exhibited.

In pursuing additional understanding of the pattern of resistance growth, further data analysis looking at the CRS subscales was conducted. This was to provide additional information on the quality of the changes in resistance growth. Of the five subscales, only the Opposing Recollection of Material scale produced statistically significant results. Growth of this particular subset of resistant behavior was significant between sessions. Initially the persister group exhibited slightly higher levels of resisting recollection of material. However, persisters scored similarly on this scale in both the first and third sessions. Whereas in the third session, dropouts experienced a fairly dramatic increase

that outpaced the persister group. Dropouts thus ended up with higher scores on this scale by the third session as mentioned in discussion of Hypothesis II (See Figure 5 for graphic illustration). The substantial increase in resisting recollection of material by dropouts represents a shift away from discussing self-focused material to focusing on others or verbally shutting down altogether.

Supporting the present findings, Piper et al.'s (1999) study of 44 patients (22 dropouts and 22 matched completers) in time-limited individual psychotherapy found that in the last session prior to dropping out, the patients resisted their therapists' attempts to focus on painful affect, opposed the therapist directly through arguing or becoming silent, and resisted "dynamic exploration." Oei and Kazmierczak's (1997) study of dropout from group cognitive behavioral therapy found that dropouts participated much less than those who completed treatment. This lack of participation also seems similar to resisting recollection of material, as it appeared to involve the patients engaging in less verbalization and production of clinical material.

There would appear to be a fairly simple explanation for the relationship between patients' resisting recollection of material and dropout. From the time of Freud's original development of psychoanalysis and it's being labeled the "talking cure" until present day, free association and/or discussion of clinical material has been viewed as the central mechanism of psychotherapy. Therefore, it would follow that those who refuse to engage in such behavior or who do it in a less than therapeutic way (e.g., remaining focused on external problems and/or refusing to take personal responsibility), may find participation in treatment less than helpful and eventually dropout. By behaving in such a manner these patients are undermining the curative process. Without a change in patient

behaviors, the therapist will not have the opportunity to address any other forms of defense or resistance. This counterproductive stance is analogous to a person taking their car to a mechanic for engine problems, but refusing to open the hood or put the car up on a hydraulic lift.

There is a major difference between someone being initially guarded and slow to pursue depth of clinical material and someone who either refuses to talk, responds minimally with short utterances, or someone who turns attention away from themselves. Over time the initially guarded person may begin approaching more threatening material, while the person intensely resisting production of appropriate therapeutic material will find little benefit or reinforcement for remaining in treatment. There are ways therapists can either facilitate communication (e.g., active listening) or aid the pursuit of clinical material (e.g., asking open ended questions). However, the patient is able to exert their greatest degree of control over therapy by deciding how much or little they are going to talk and which topics they are willing to pursue. Relevant to these issues, Beutler et al.'s (2002) chapter on resistance related the social psychology theory of "psychological reactance" to the resistant patient's behavior in treatment. He reports that this theory suggests the patient perceives a threat to their "legitimate freedom," motivating them to restore this thwarted freedom through oppositional behavior, noncompliance, and rigidity. This facet of resistance as well as the relevance of this body of psychological theory is deserving of further research and exploration.

Hypothesis IV

Building upon the findings of the previous hypotheses, Hypothesis IV's purpose was to attempt to develop an discriminant function using the CRC and CRS resistance variables that could then be used to predict group membership. This hypothesis was further attempting to validate empirically the predictive utility of resistance theory, as it relates to dropout from psychotherapy. Specifically, the notion that dropout may represent an extreme form of resistance or "flight into health." By identifying specific variables that could be useful to clinicians hoping to identify patients at risk for early therapy dropout, this hypothesis was also attempting to make a practical contribution to the dropout literature.

The prior t-test and ANOVA comparisons of the dropout and persister groups were able to speak to differences in quantity and quality of resistance exhibited in the sample of clients used. However, these forms of statistical analysis were not able to address the predictive utility of the two measures. Thus, this was the added benefit of conducting a discriminant function analysis.

The prior hypotheses' data analyses were used to inform the researcher in establishing which variables to enter into the discriminant function. Following multiple iterations of entering the resistance variables in a step-wise fashion into equations aimed at predicting group membership (dropout vs. persister), a model emerged that employed four variables successfully to predict group membership at an overall rate of 77.5%. The four predictor variables were: 1) the combined first and third session CRC resistant response proportion; 2) third session CRS Opposing Recollection of Material; 3) third session CRS Opposing Expression of Painful Affect; and 4) combined first and third

session CRS Opposing the Therapist. Three out of the four variables had a positive relationship to dropout, while third session CRS Opposing Expression of Painful Affect had a negative relationship with dropout. These findings suggest that not only the quantity, but the specific quality of resistance exhibited influences dropout and that some forms of resistance may aid rather than hinder the therapeutic process.

The success of these variables to predict dropout versus continuation status was not only statistically significant, but also has potential practical significance. The ability to potentially identify growing resistance prior to its influencing a client to dropout of therapy can help guide clinical interventions in a way that will potentially reduce overall dropout rates. The results of the discriminant function analysis suggest the development of clinical guidelines that address both the overall amount and types of resistant behavior engaged in by the client will be most helpful. Specifically, at the outset of psychotherapy therapists should emphasize the development of a collaborative working alliance, wherein discussion of real life, personally relevant material is facilitated, and where the expression of painful affect can be contained and supported in a somewhat controlled fashion. As the early stage of psychotherapy proceeds, adjustments (informed by relevant theory and empirical research) should be made on the part of the therapist if and when, 1) the client begins to shut down and/or moves away from discussing, self-focused clinical material; 2) the client refuses to follow the therapists direction, becomes tangential, or actively blocks the therapist's direction; or 3) the patient has difficulty modulating and/or containing their expression of painful affect. By the predictive model drawing on multiple dimensions of resistance (quantity, quality, intensity), it is able to more specifically guide and direct clinicians to relevant practical, research and theoretical

literature for tailoring their approach in the clinical setting. More specific discussion of this literature will be addressed later.

The present predictive model was better at correctly classifying persisters than dropouts (85% vs. 70%, respectively). In looking at the impact of the associated error rates, misclassification of persisters as dropouts has less potential for negative consequences than that of misclassifying dropouts as persisters. It is difficult to think of what harm could be done should specific interventions aimed at reducing resistance be overapplied early in treatment with patients who would persist in treatment anyway. However, in pursuing clinical efficiency and congruence between intervention and client presentation, such overapplication of technique or specialized intervention should be avoided. Misclassification of dropouts into the persisting group was done 30% of the time using this model. The obvious result of not detecting "at-risk" resistant clients is that they end up dropping out of treatment. While this is the undesirable result that the current study set out to address, it is unlikely that interventions, no matter how well developed and tested, will ever fully prevent dropout. Even the best clinicians will make strategic technical errors and in some cases the patient dropping out may truly believe they have gotten their maximal benefit from treatment. Prior research that has focused on demographic variables in predicting dropout has failed to provide the mental health provider with clinically relevant and changeable factors to target. Thus, in this case a 70% success rate of classifying dropouts using resistance variables still moves us toward the goal of realistically reducing the rate of premature termination, by at least identifying relevant theoretically-based process and client variables that are amenable to change through clinical intervention.

Practical Implications of the Findings

Despite the mixed results and sometimes lack of statistical significance this study produced, there appears to be support of previous findings in similar research that suggests high client resistance levels will negatively impact treatment outcomes (Beutler, Moleiro, & Talebi, 2002). This study was also able to develop a predictive model of dropout using resistance variables. As such, treatment will be more effective, if therapists can either avoid stimulating excessive levels of resistance within their patients or effectively address the resistance in ways that temper and/or suppress the effects of the resistance expressed (Beutler, Clarkin, Bongar, 2000). In order to be most clinically effective, it is necessary for therapists to recognize, identify, and respond to different types and styles of resistance.

The Client Resistance Scale (CRS) and Client Resistance Code (CRC) both provide organized and systematic approaches to identifying and tracking both episodic and tactical forms of resistance, allowing a clinician or researcher to assess the quantity and quality of resistance being manifest. Though regular use of these measures would likely prove cumbersome in clinical practice, clinicians (particularly trainees/students) familiarizing themselves with them will likely find themselves more attune to resistance in their patients aiding their awareness and ability to respond therapeutically. Beutler et al. (2001) made recommendations for responding to state (episodic/tactical) resistance including, acknowledging and reflecting the patient's concerns, directly discussing the therapeutic relationship, and making modifications/adjustments to therapeutic goals. These recommendations are aimed at returning a sense of control to the patient thus

defusing the effects of resistance.

Previous research (Beutler, et al., 2002; Piper, et al., 1999) suggests that it is also important for clinicians to make adjustments to their therapeutic approach upon evaluating their patient's level of resistance in order to avoid impasses in treatment and/or dropout. This is particularly true when dealing with patients who present with high levels of trait or character resistance. Evidence suggests that such highly resistant patients respond better to less directive interventions, while less resistant patients respond well to higher levels of directiveness. In dealing with resistant patients, Beutler and Harwood (2000) specifically recommend employing a treatment approach that de-emphasizes therapist authority and that bolster patient self-direction. Therapists should do more listening and avoid giving too many instructions. Rigid homework assignments are to be avoided and assignments that require minimal overt behavior are suggested to reduce opportunities for oppositional behavior. Thus, self-directed assignments and reading might replace more highly structured and specific tasks. It has further been suggested that paradoxical interventions (e.g., discouraging rapid change, symptom prescriptions, encouraging the exaggeration of symptoms) may have some benefit in dealing with some resistant patients. Here the patient's tendency toward violating directives and oppositional impulses are enlisted to aid their movement toward change and/or symptom improvement.

In his book on interpersonal processes in psychotherapy, Teyber (2000) provides a number of suggestions for responding to resistance at differing stages of treatment. He recommends inviting a new patient to express all of their concerns regarding entering treatment. He then encourages the therapist to explore these concerns in a nonjudgmental

way that leaves the patient in control and responsible for making the decision regarding continuation of treatment. As therapy proceeds, he further encourages therapists to empathize with the patient's resistant stance, "honoring (the origins of) their resistance" and then giving them permission to discuss their reticence and doubts about entering treatment openly and directly. Teyber also suggests educating the patient in a way that will aid their having realistic expectations and help them understand the ambivalence they are experiencing (for further details see Chapter 3 of Teyber's (2000) text). Similarly, Reis and Brown's (1999) research also suggested that preparing patients prior to therapy by providing them with information and addressing their expectations tended to reduce dropout rates. There is additional empirical evidence for following Teyber's recommendations as Patton et al. (1997) found that therapist that adhered to psychoanalytic techniques aimed at highlighting and exploring client resistance were more successful at reducing the overall level of resistance exhibited across sessions. This reduction in resistance was associated with better patient outcomes in treatment. As such, it may be to the advantage of therapists of all theoretical orientations to read and familiarize themselves with psychoanalytic theory as it relates to resistance (e.g., Greenson (1967)) and then incorporate these nondirective, interpretive approaches aimed at 'working through' with their more resistant patients.

In an era of managed care and emphasis on short-term treatment, it is important that training programs and currently practicing professionals not ignore resistance and the theory and writing that informs this topic. In fact, the effective management of patient resistance (with its empirically proven ability to negatively impact treatment) may be as relevant as ever, particularly in light of the emphasis being placed on treatment efficacy

and efficiency. If we can continue to predict the majority of premature terminations and develop appropriate interventions and responses, we will then have the potential to reduce the impact of dropout on public health, as well as, reducing the related financial and morale issues posed by dropout to mental health professionals.

Limitations of the Present Study

The design of the present study had some significant challenges, weaknesses and limitations that ought to be considered. The archival nature of this study presented some specific challenges in gathering data. One of the most difficult challenges was establishing a large enough sample of demographically matched clients who had complete SCL-90R data and whose therapy sessions were tape recorded with sufficient audio quality as to render codeable samples. Despite extensive measures being utilized to enhance sound quality, a small percentage of the therapy samples remained difficult to hear clearly. In these cases, coders were encouraged to code the portions they could hear adequately and/or attempt to make single ratings based on the entire sample rather than individual speaking turns. Again, this was done with less than five percent of the samples. However, such deviation from standard procedure may have contributed to decreased reliability and accuracy in these cases. A related weakness is the fact that the present study employed audiotaped session samples for its observations of client resistant behavior. As this is a "single channel" approach to assessing qualitative aspects of communication exchanges between therapists and clients, it is less than ideal. Social psychologists have suggested that a large proportion of communication is nonverbal and therefore, a sizable portion of potentially codeable resistant responses are being lost due

to the researchers having access only to the verbiage and tonation of communications between the clients and therapists in this study.

The use of archival data established limits to the sample size that introduced a number of additional weaknesses into the present study. When using a "convenience sample," researchers are not able to establish and maintain, as many controls as ideally would exist in a pure experimental design. Subjects were assigned to naturally occurring groups in this study. There was no random assignment or control group. Instead, a group of treatment dropouts were matched with a similar group of persisting clients. Even if this had been a prospective study, resistant traits/behaviors cannot be randomly assigned to subjects. Also, there was limited data available on the therapists that treated these subjects and other than their sex none of this data was taken into consideration. As such, many unintended sources of systematic error and variance may have entered into the data analysis. However, there seems to be a fair amount of consistency between this study's findings and previous research on the effects of resistance on psychotherapy dropout and outcome.

An additional sampling issue was the impact that available data had on the establishment of the criteria for dropout status. This study's intent was to address early dropout. It is debatable whether or not the present sample truly represents a group of "early" dropouts. All of the subjects in the dropout group unilaterally discontinued treatment and generally would meet most definitions of premature termination and/or dropout. However, due to the desire to improve statistical power by achieving a minimum sample size of forty subjects, the number of sessions attended prior to dropping out exceeded five sessions amongst half of the dropout group. Previous research studies (e.g.,

Pekarik,1992) have provided some evidence of there being significant differences on a number of factors between subjects that dropout early (less than three to five sessions) versus those that dropout later. Stahler and Eisenman (1987) also suggested that a few sessions of therapy may benefit a subset of patients that are either in acute crisis or who have better ego resources that allow them to benefit from the briefer exposure to treatment. Some patients may also come into therapy never intending to pursue long-term treatment. Therefore, closer evaluation of such factors may improve a study's ability to pinpoint differences between patients.

This issue notwithstanding, it was important to achieve a reasonable sample size, as without sufficient statistical power even moderate to large effects may be missed due to Type II error. Small samples are also more vulnerable to the effects of outliers, measurement error/reliability, and differences in variance between groups. Thus, the compromise in number of sessions attended by dropouts was considered worthwhile in the service of improving statistical power. Some additional exploratory data analysis where the dropout group was divided into two groups (less than or greater than five sessions attended) suggested that future research should pursue expanding sample size and delineating between the stage at which dropouts terminate. In discussing their findings, Martin, et al. (1988) also suggested that the assumption of uniformity or homogeneity amongst premature terminators may not hold and that clients who dropout of psychotherapy may be quite a diverse population with different motivations influencing their decisions to leave treatment.

An additional area of weakness of this study was the use of only two therapy sample coders and the resulting diminished reliability levels obtained. Client Resistance

Code (CRC) interrater reliabilities were high enough as to not consider them a significant liability, while Client Resistance Scale (CRS) reliabilities were lower than desired, particularly on the subscales. Mahalik (1994) had recommended the use of three or more judges when using the CRS, as this was found to significantly enhance reliability across the subscales. Unfortunately, due to the limited resources of the primary researcher, only two judges were used in the present study. There were also significant time constraints that led to less time being spent on training the judges than may have been optimal. More mid-coding reliability checks would have been helpful as well, but again limited availability on the part of the judges made this unfeasible. The reliabilities on the CRS Opposing the Therapist and Opposing Change subscales are low enough that there is concern regarding measurement error.

When interpreting and attempting to generalize the present study's findings, one must consider a number of potential confounds and limitations. A limitation to the generalizability of the present study was its clinical setting, a training clinic that was staffed by graduate student clinicians. Additionally, psychodynamic psychotherapy was the most common form of therapy offered, but not the only kind offered. Future research should attempt to address these limits of external validity by employing carefully controlled combinations of therapists and settings (e.g., licensed psychologists in a variety of treatment settings including college counseling centers, community mental health centers, and outpatient hospital clinics). It would also be advantageous to be more systematic about the inclusion of therapies, either restricting the research to one form of therapy or being more inclusive and tracking the impact of type of therapy as an additional variable of interest. The present sample was also somewhat homogenous with

regard to ethnic/racial representation, as only three minorities were included. Thus, generalizations to minority psychotherapy clients must be made very cautiously.

A final concern is the fact that some therapists could have more than one client in the study. This factor could be seen as increasing the possibility of chance findings. As such, the successful t-test results and discriminant function need to be replicated and cross-validated in future studies.

Directions for Future Research

As is frequently the case in psychological research, the present study's findings created as many or more questions than it answered. The present study's limitations also prompt the need for further validation and replication. An initial recommendation would be to conduct similar research with a more diverse sample and employing a variety of therapist with broader variance of training level and theoretical orientations.

Building upon the results and discussion of this study's first hypothesis that addressed initial pathology levels in the sample, research looking into differential patterns of symptom response between dropouts and persisters would be highly recommended. Of great interest would be how levels of psychopathology in dropouts change as they approach the point where they exit treatment. Arguments have been made speculating both increase and decrease in disturbance. It would be additionally important to not only rely on patient self-reported symptomology, but to also incorporate therapist ratings of pathology and dysfunction. This would help address concerns over the manifestation of "flight into health" by highly resistant patients.

This study's application of the Client Resistance Scale (CRS) (Mahalik, 1994) and the Client Resistance Code (CRC) (Kavanagh, et al., 1982) to individual psychotherapy samples collected in a natural setting was something that has not been done but a relatively few times in the present psychological literature. Therefore, much more research with larger and more representative samples is needed in order to strengthen the external validity and generalizability of these measures. The positive results from the present study combined with those reported by the authors of these two measures, suggests these measures hold promise for broader application. Another issue related to the use of the CRS and CRC is that these measures tend to emphasize the more observable and transient forms or "tactical" subtypes of resistance. Further exploration of unconscious and/or character resistances using measures such as Schuller et al.'s (1991) Resistance Scale or additionally developed measures could provide additional empirical insights and understanding of the effects of resistance on the treatment process and premature termination. Also, future research that further elaborates the patterns and qualities of resistance exhibited over a greater period of treatment would help guide the development of more precise interventions for responding most appropriately.

The current study was limited by its strictly addressing client pathology and resistance, as it related to dropout without looking at therapist and interactive variables suggested by theorists and other studies that may also contribute to attrition (Beutler, et al. 2002; Bischoff & Tracey, 1995). It would be very helpful to examine such therapist variables in tandem with client variables and then enter this data into a discriminant function equation simultaneously. In theory such a multivariable, multimethod approach

should increase positive predictive power. Future research should incorporate measures of both client and therapist behaviors to address this issue.

As specific recommendations for addressing resistance have been suggested both in this study and theoretical writings (see Practical Implications section), it would be of great value to empirically validate the efficacy and utility of these recommended responses in reducing client resistance and dropout. Further development and testing of additional new interventions that address the interaction between resistance and dropout, perhaps, drawing further on social psychology and other subfields of psychology outside of psychoanalytic and psychodynamic theory would also be welcome in expanding breadth of understanding within this area of research. Of additional interest, especially within in the context of today's biologically dominated mental health field, would be the impact of psychotropic medications on resistance levels and whether this impact would facilitate or hinder progress in psychotherapy.

Finally, arguably the most practical and useful results from the present study, were those from the discriminant function analysis that were successful at developing a predictive model of dropout using resistance variables. In order for these results to be generalizable and applied with any degree of confidence, this model must be tested by applying the present study's discriminant function to data from a new sample. Such cross-validation is viewed as an essential step for furthering this area of research.

TABLES

Table 1. Sample Demographic Descriptive Statistics and ANOVA's.

	N	Mean	SD	F (df)	*p*
AGE					
Dropout	20	31.30	11.06	.00 (1)	.99 (ns)
Persister	20	31.26	6.41		
Total	40	31.28	8.98		
EDUCATION (years)					
Dropout	20	14.20	2.24	3.87(1)	.056 (ns)
Persister	20	15.55	2.09		
Total	40	14.88	2.24		
INCOME ($ per year)					
Dropout	20	10995.00	6560.45	2.573	.117 (ns)
Persister	20	15610.53	10973.24		
Total	40	13243.59	9166.21		

Table 2. Sample Demographic Descriptive Statistics: Crosstabulations and Chi-square estimates.

OCCUPATIONAL LEVEL X GROUP ASSIGNMENT

	Dropout	Persister	Totals
Executive	0	1	1
Manager	0	2	2
Small business owner	1	5	6
Skilled worker	2	3	5
Semiskilled worker	6	1	7
Homemaker	1	2	3
Student	5	6	11
Disabled	3	0	3
Totals	18*	20	38*

Pearson $\chi^2 = 12.793$, df=7, p=.077 (ns)
* 2 missing cases

MARITAL STATUS X GROUP ASSIGNMENT

	Dropout	Persister	Totals
Never married	5	7	12
Living with	7	2	9
Married	2	4	6
Divorced	5	6	11
Widowed	1	0	1
Totals	20	19*	39*

Pearson $\chi^2 = 4.846$, df=4, p=.303 (ns)
*1 missing case

Table 3. Sample Means, Standard Deviations, and Interrater Reliabilities: Client Resistance Scale (CRS).

	Client Resistance Code					
	EA	RM	T	C	I	Summed Scale
Means	5.19	3.97	3.82	4.75	4.79	90.14
Standard Deviations	.75	.91	.86	.66	.96	7.76
Pearson Product-Moment Correlations	.72	.76	.52	.51	.68	.71
Spearman-Brown Effective Reliability	.83	.86	.68	.68	.81	.83
Mahalik's reported Effective Reliabilities Using two raters	.88	.92	.84	.81	.71	

All correlations significant at $p<.05$ (two-tailed)

EA= Opposing Expression of Painful Affect, RM=Opposing Recollection of Material, T=Opposing Therapist, C=Opposing Change, and I=Opposing Insight

Table 4. Client Resistance Scale: Subscale Intercorrelation Matrix

Subscale	1	2	3	4	5
1. Expression of Affect	-	.344	.066	.448	.391
2. Recollection of Material		-	.407	.323	.434
3. Therapist			-	.332	.422
4. Change				-	.410
5. Insight					-

All intercorrelations were significant at $p<.01$ (two-tailed).

Table 5. Sample Means, Standard Deviations, and Interrater Reliabilities: Client Resistance Code (CRC)

	Speaking Turns/per session	Client Resistance Code	
		Resistant %	Cooperative %
Means	9.5	41.3	58.7
Standard Deviations	4.42	17.4	17.4
Pearson Product-Moment Correlations	-	.78	.84
Spearman-Brown Effective Reliability	.-	.88	.92

All correlations significant at $p<.05$ (two-tailed)
Intercorrelation between scales was r=.08 and non-significant

Table 6. Concurrent Validity Correlations:
Client Resistance Scale (CRS) and Client Resistance Code (CRC)

	Client Resistance Code					
	EA	RM	T	C	I	Summed Scale
Client Resistance Code Resistance scale	.29*	.39*	.53*	.09	.45*	.46*

EA= Opposing Expression of Painful Affect, RM=Opposing Recollection of Material, T=Opposing Therapist, C=Opposing Change, and I=Opposing Insight

*Correlation significant at $p<.05$ (two-tailed)

Table 7. Group Means, Standard Deviations, and t-test for Client Resistance Code Resistant Response Proportions.

CRC Resistant Response Proportion (%)		Mean	SD	t	p(2-tailed)	η
Session 1	Dropout	46.26	23.48			
	Persister	33.45	20.61	1.83	.075	.28
Session 3	Dropout	51.54	26.82			
	Persister	37.39	17.37	1.98	.055	.30
Sessions Combined	Dropout	48.21	18.03			
	Persister	34.41	14.05	2.69	.010	.40

Table 8. Group Means, Standard Deviations, and t-test for Client Resistance Scale Summed Scores.

CRS Summed Score		Mean	SD	t	p(2-tailed)	d
Session 1	Dropout	44.56	4.71			
	Persister	43.85	5.98	.419	.67	.13
Session 3	Dropout	46.05	6.32			
	Persister	45.81	4.32	.144	.88	..05
Sessions Combined	Dropout	90.62	8.51			
	Persister	89.66	7.12	.387	.70	.12

Table 9. Canonical Discriminant Function Coefficients

Standardized Canonical Discriminant Function Coefficients	
CRS: Opposing Recollection of Material -- 3rd Session	.943
CRC-Resistant Response Proportion 1st and 3rd sessions combined	.958
CRS: Opposing the Therapist—1st and 3rd sessions combined	-.689
CRS:Opposing Expression of Painful Affect—3rd Session	-.746

Table 10. Discriminant Classification Results

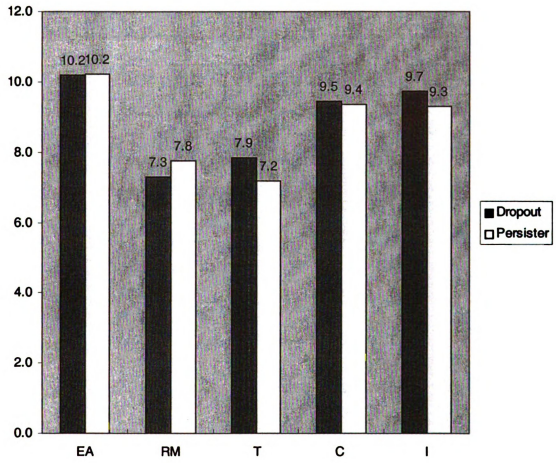
GROUP		Predicted Group Membership		Total
		Dropout	Persister	
Count	dropout	14	6	20
	persister	3	17	20
%	dropout	70	30	100
	persister	15	85	100

Table 11. Pooled Within-Groups Correlations Between Variables and Canonical Values

Structure Matrix	
	Discriminant Function
CRC-R%1st + 3rd	.718
Recollection Material 3rd	.382
Therapist 1st+ 3rd	.301
Expression Affect 3rd	-.213

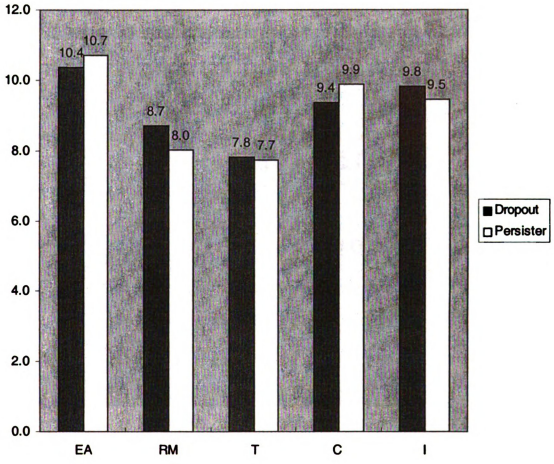
FIGURES

Figure 1. CRS Subscale Means: Dropout vs. Persister Group (Session 1)



Scores reported represent the sum of both raters average rating for each scale. All t-tests failed to find significant differences between dropout and persister groups across all subscales. .EA= Opposing Expression of Painful Affect, RM=Opposing Recollection of Material, T=Opposing Therapist, C=Opposing Change, and I=Opposing Insight

Figure 2. CRS Subscale Means: Dropout vs. Persister Group (Session 3)



Scores reported represent the sum of both raters average rating for each scale. All t-tests failed to find significant differences between dropout and persister groups across all subscales. EA= Opposing Expression of Painful Affect, RM=Opposing Recollection of Material, T=Opposing Therapist, C=Opposing Change, and I=Opposing Insight

Figure 3. Change in CRS Total Means Between Sessions 1 and 3: Dropout vs. Persister Group

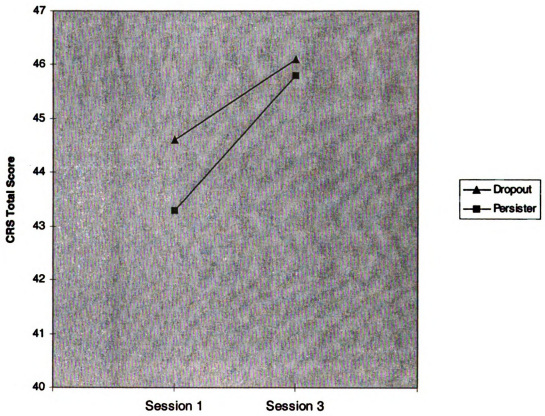


Figure 4. Change in CRC Resistant Response Proportion Means Between Sessions 1 and 3: Dropout vs. Persister Group

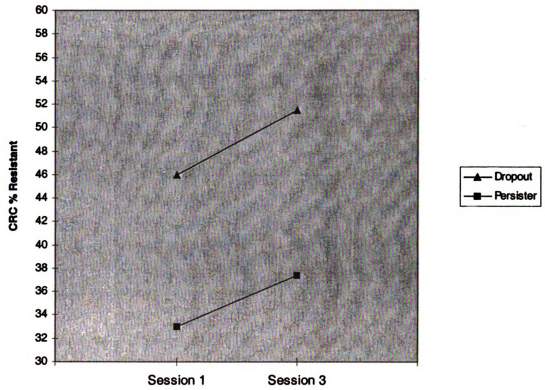
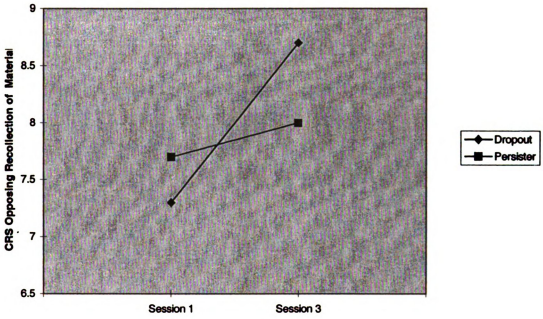


Figure 5. Change in CRS Opposing Recollection of Material Means Between Sessions 1 and 3: Dropout vs. Persister Group



APPENDICES

APPENDIX A

Client Resistance Scale
(Mahalik, 1994)

Opposing Expression of Painful Affect

Raters examine to what extent the emotions HURT—DEPRESSION (i.e., themes of actual or perceived loss, feeling down, disappointed, or down on self), ANGER (i.e., themes of wanting to strike back or stand up to protect), and/or ANXIETY (i.e., themes of concern or uneasiness over anticipated loss) are present.

- 1 = Reporting experiencing painful feelings (current or past) by using emotional words with (a) uncontrollable or overwhelming sobbing (almost or cannot speak through the tears), (b) shouting tirade, or (c) where anxiety is the dominant theme and material causes panic.
- 2 = Reporting experiencing painful feelings (current or past) by using emotional words with (a) lots of tears (talking while weeping), (b) shouting (short burst), and/or (c) anxiety is the dominant theme of the client's material and client has difficulty speaking because of anxiety.
- 3 = Reporting experiencing painful feelings (current or past) by using emotional words with (a) a welling of tears or tears (talks through the tears), (b) raising voice, and/or (c) where anxiety is the dominant theme of client's material.
- 4 = Reporting experiencing painful feelings (current or past) by using emotional words (e.g., "I feel said," "I feel angry," "I feel scared" that indicate he or she is or was feeling hurt/angry/anxious).
- 5 = Indirect indications of hurt (e.g., discusses struggling through the day, withdrawing, sounds hurt, depressed, or down without directly using those words), anger (e.g., uses insults–"he was a jerk"–or profanity, sounds angry or worried without directly using those words, uses sarcasm and/or has an edge to his or her voice, expresses frustration, uses punctuated speech), or anxiety (e.g., lists worries or concerns, sounds anxious or worried without directly using those words, has pressured speech, is starting to hear stress, is starting to hear concern/anxiety, client material has themes of anxiety, fidgeting, restlessness).
- 6 = Intellectualizing, translating painful emotions into cognitions (e.g., "although I may have had hurt/angry/anxious feelings after that happened, they were due to the inevitable let down following my heightened expectations"); laughter that covers painful affect.
- 7 = Other work than painful feelings, informational responses, not dealing with subject of negative feelings, laughter, matter of factness to expression, conversational.

Opposing Recollection of Material

- 1 = Client is the clear focus of the material and the material is a reporting of real life events for the client. That is, client gives specific occurrences in daily life with examples. These examples are made up of identifiable people, specific actions, and descriptions of specific events in a verbatim fashion.
- 2 = Client is the clear focus of the material and majority of material is detailed. Examples are used, but they are not an accounting of real life events.
- 3 = Client is the clear focus of the material and describes material in both vague and detailed terms. The client may use an example (or examples), but it is not an accounting of real life events.
- 4 = Client is the clear focus of the material, but client material is not a report of real life events. The client recollects material in a vague, general way, void of details, and without examples. There must be some material present.
- 5 = Material is half self-focused and half other-focused, or client talks about self entirely in the third person.
- 6 = Client material is mostly or totally other focused. Other client responses that are minimal or simply a closed response to counselor's closed question (i.e., "yes" or "no," or gives a long-worded yes or no response, or responds to a closed question).
- 7 = Client does not provide any material. Client says, "I don't know," says "I don't remember," is silent, or provides material that is completely tangential so that the material is totally nonresponsive (e.g., word salad, responding with weather).

Opposing Therapist

- 1 = Follows therapist's direction and deepens the material significantly (i.e., as client talks material becomes much more emotionally meaningful/impactful to the client).
- 2 = Follows therapist's direction and elaborates a great deal (i.e., gives a great deal more information), and/or client deepens material somewhat (i.e., as client talks material becomes more emotionally meaningful/impactful to the client).
- 3 = Follows therapist's direction and elaborates material (i.e., gives some more information) but does not deepen material.
- 4 = Follows therapist's direction but does not elaborate. This occurs most often when the client simply gives the minimal amount of material that answers a question or replies no further than the therapist's lead.
- 5 = Client responds to the therapist's direction by following direction for half of the client material, then going in a direction different from the therapist for the other half of the client material.
- 6 = Tangential to therapist's direction (e.g., acknowledging topic, then proceeding in totally different direction).
- 7 = Actively blocking therapist's direction.

Opposing Change

- 1 = Appears to be very uncomfortable with the status quo and expresses desire to change.
- 2 = Appears to be uncomfortable or dissatisfied with the status quo and expresses desire to change.
- 3 = Appears to be slightly uncomfortable or slightly dissatisfied with the status quo of life circumstances and expresses desire to change.
- 4 = Appears to be uncomfortable/very uncomfortable or dissatisfied/very dissatisfied with status quo but does not directly express a desire to change.
- 5 = Appears to be slightly uncomfortable or slightly dissatisfied with status quo but does not directly express a desire to change.
- 6 = Appears to be comfortable or satisfied with the status quo of life circumstances and is characterized by neutral statements or by those not reflecting satisfaction or dissatisfaction with the status quo; gives informational responses.
- 7 = Expresses opposition to change (e.g., "It's not my problem, he's got to be the one to change," "I like myself just fine the way I am," or "I don't want to be here, I was sent here").

Opposing Insight

- 1 = Verbalizing understanding and/or making connections between experiences, feelings, thoughts, and behaviors. In addition, the client provides older historical references to illustrate the understanding.
- 2 = Verbalizing understanding and/or making connections between experiences, feelings, thoughts, and behaviors. In addition, the client introduces recent historical references.
- 3 = Verbalizing understanding and/or making connections between experiences, feelings, thoughts, behaviors.
- 4 = Agreeing with counselor's insights; may add new material but does not add new connections.
- 5 = Expresses willingness or desire to understand. This may be implied by phrases such as "and I don't know why!" The client must be pursuing understanding not just complaining.
- 6 = Client does not verbalize any self-understanding in material. May be reporting material in matter-of-fact way or discussing material in such a way that does not indicate attempt to gain insight.
- 7 = In response to counselor or material brought up by client, the client actively opposes self-understanding (e.g., "I don't even want to think about it"; "I don't have a problem"; "The problem is out there, not in me").

APPENDIX B

Client Resistance Code Categories
(Kavanagh, et al., 1984)

Resistant responses

1. Interrupt/talkover	Coded only when the client is obviously cutting the therapist off or talking over the therapist.
2. Negative attitude	Responses indicating unwillingness/inability to cooperate with therapist's suggestions (e.g., blaming others, statements of hopelessness, defeat, disagreement)
3. Challenge/confront	Responses challenging the therapist's qualifications and/or experience; responses that indicate that the therapist doesn't know what s/he is doing.
4. Own agenda	Bringing up new topics/concerns to avoid discussing or to block the issue(s) that the therapist was on.
5. Not tracking	Inattention, not responding, disqualifying a previous statement.

Cooperative responses

6. Nonresistant	All responses that are neutral, cooperative, or following the directions set by the therapist.
7. Facilitative	Short utterances indicating attention or agreement.

APPENDIX C

Symptom Checklist 90--Revised
Derogatis, et al. (1983)

Instructions: Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please rate the item according to HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST WEEK INCLUDING TODAY, according to the following scale: 0-NOT AT ALL; 1-A LITTLE BIT; 2-MODERATELY; 3-QUITE A BIT; 4-EXTREMELY. Use only one number to rate each item.

1. Headaches
2. Nervousness or shakiness inside
3. Repeated unpleasant thoughts that won't leave your mind
4. Faintness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. The idea that someone else can control your thoughts
8. Feeling others are to blame for most of your troubles
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in heart or chest
13. Feeling afraid in open spaces or on the streets
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Hearing voices that other people do not hear
17. Trembling
18. Feeling that most people cannot be trusted
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. Feelings of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Feeling afraid to go out of your house alone
26. Blaming yourself for things
27. Pains in lower back
28. Feeling blocked in getting things done
29. Feeling lonely
30. Feeling blue
31. Worrying too much about things
32. Feeling no interest in things
33. Feeling fearful
34. Your feelings being easily hurt
35. Other people being aware of your private thoughts
36. Feeling others do not understand you or are unsympathetic
37. Feeling that people are unfriendly or dislike you
38. Having to do things very slowly to insure correctness
39. Heart pounding or racing

40. Nausea or upset stomach
41. Feeling inferior to others
42. Soreness of your muscles
43. Feeling that you are watched or talked about by others
44. Trouble falling asleep
45. Having to check and double check what you do
46. Difficulty making decisions
47. Feeling afraid to travel on buses, subways or trains
48. Trouble getting your breath
49. Hot or cold spells
50. Having to avoid certain things, places, or activities because they frighten you
51. Your mind going blank
52. Numbness or tingling in parts of your body
53. A lump in your throat
54. Feeling hopeless about the future
55. Trouble concentrating
56. Feeling weak in parts of your body
57. Feeling tense or keyed up
58. Heavy feelings in your arms or legs
59. Thoughts of death or dying
60. Overeating
61. Feeling uneasy when people are watching or talking about you
62. Having thoughts that are not your own
63. Having urges to beat, injure, or harm someone
64. Awaking in the early morning
65. Having to repeat the same actions such as touching, counting, or washing
66. Sleep that is restless or disturbed
67. Having urges to break or smash things
68. Having ideas or beliefs that others do no share
69. Feeling very self-conscious with others
70. Feeling uneasy in crowds, such as shopping or at a movie
71. Feeling everything is an effort
72. Spells of terror or panic
73. Feeling uncomfortable about eating or drinking in public
74. Getting into frequent arguments
75. Feeling nervous when you are left alone
76. Others not giving you proper credit for your achievements
77. Feeling lonely even when you are with people
78. Feeling so restless you couldn't sit still
79. Feelings of worthlessness
80. The feeling that something bad is going to happen to you
81. Shouting or throwing things
82. Feeling afraid you will faint in public
83. Feeling that people will take advantage of you if you let them
84. Having thoughts about sex that bother you a lot
85. The idea that you should be punished for your sins
86. Thoughts and images of a frightening nature
87. The idea that something serious is wrong with your body
88. Never feeling close to another person
89. Feelings of guilt
90. The idea that something is wrong with your mind

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