

AN ABSTRACT OF THE THESIS OF

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Title: A Comparison of the Attendance and Dropout Rates Between Time-Limited and Time-Unlimited Psychotherapy

Abstract approved: 

In order for one to benefit from psychotherapy, one must attend. However, poor attendance and high dropout rates are frequently cited in the literature, but yet few suggestions are offered for improving them. This study attempted to increase attendance and reduce dropout rates by clearly informing clients of termination dates using time-limited therapy and then examined the attendance and dropout rates of 38 subjects seeking psychological services at an east-central Kansas mental health center. The subjects were randomly assigned to 12 time limited therapy sessions or time-unlimited therapy (open-ended therapy). Results indicated no significant differences in attendance for either time-limited or time unlimited therapy. A chi square also found no differences in dropout rates between the two groups. A post hoc regression analysis revealed fee and income combined accounted for 34% of the variance in attendance. Fee alone also was significant. As fee and income increased, attendance also increased.

A COMPARISON OF THE ATTENDANCE AND DROPOUT RATES
BETWEEN TIME-LIMITED AND TIME-UNLIMITED PSYCHOTHERAPY

A Thesis

Presented to

the Division of Psychology and Special Education

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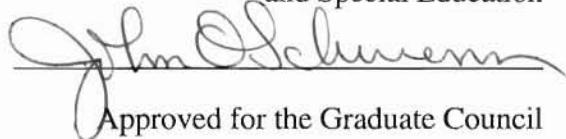
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CHAPTER ONE

INTRODUCTION

The economics of psychotherapy have become increasingly important as many individuals are limited in the number of therapy sessions allowed by insurance companies. Recently, insurance companies, legislators, and funding agencies have become increasingly concerned with efficacy and accountability regarding psychotherapy (Christoph, 1992). In addition, surveys suggest a substantial portion of mental health practice is brief in nature with the average client seen for under 10 sessions (Garfield, 1986). Restrictions in third party reimbursements, budget constraints affecting staffing patterns, and recent trends in managed mental health care suggest demands for brief psychotherapy and short-term interventions will continue to affect psychologists in the years ahead (Cummings, 1987).

Although the debate over the effectiveness of psychotherapy is beginning to wane (Smith & Glass, 1977), the duration and associated costs are being more closely scrutinized. A possible solution to this dilemma may be time-limited therapy (TLT). TLT is quick (usually under 12 sessions) and seems to have results similar to traditional open-ended therapy (Johnson & Gelso, 1980). A debate over the effectiveness of TLT versus time-unlimited therapy (TUT) exists, and, for those patients who have no insurance and must pay out of pocket for their treatment, cost containment and effectiveness are critical issues that have yet to be satisfactorily investigated.

Studies have shown psychotherapy suffers from high rates of dropout (Sharp, 1994). Other studies have suggested clients prefer short-term treatments (Cornfeld et al., 1993). Traditional psychotherapy does not address these expectations and may therefore unwittingly add to dropout rates. If the clients knew what to expect, they might remain in treatment longer. The purpose of this study was to examine the attendance and dropout rates of clients using TLT and the more traditional TUT.

Introduction of Time Limits

Establishing time limits in counseling and psychotherapy may have several benefits. Dworkin and Gelso (1983) showed TLT procedures save agency time and permit a greater number of clients to be treated with less delay, resulting in smaller client waiting lists. In fact, TLT procedures took an average of 4.1 fewer sessions to complete than open-ended therapy, a net savings of 35%. Other preliminary evidence has suggested that TLT, at least with less disturbed clients, may be as effective as open-ended treatment (Johnson & Gelso, 1980).

Kesilson (1974), however, suggests not all TLT will result in agency savings. He feels savings will only generalize to agencies who specialize in briefer therapies such as community mental health centers and university counseling centers as opposed to institutions providing longer term psychodynamic therapies.

Setting definite time limits for mental health treatment has become a widely used technique and a topic for psychological researchers. However, TLT was used early in the history of modern psychotherapy by such pioneers as Rank, Ferenczi, Stekel, and Freud (Barten, 1969).

TLT involves an agreement between client and therapist at the beginning of therapy. A set amount of sessions, usually 12 or less, is agreed upon between the dyad, and when this goal is reached, therapy is discontinued. In contrast, brief psychotherapy includes treatment extending from 10 to 25 sessions, but a number is not specifically set nor any exact times given (Fisher, 1984a).

Mann (1973) suggests the therapeutic alliance is enhanced by the setting of time limits at the outset of therapy. He further elaborated that time limits encouraged clients' optimism and created more structure for ensuing therapy. Flegenheimer and Pollack (1989) agree and suggest both the therapist and client are forced into taking more active roles and working more effectively in the time available when using time limits.

Ethics and Stages Involved in TLT

Ethics would suggest not treating a severely disturbed individual with short-term therapy. Excluding severely disturbed patients from time-limited studies is also warranted based on the findings of Gelso, Spiegel, and Mills (1983). In comparing TUT to 8 and 16 session TLT, they discovered less well-adjusted clients tend to have lower evaluations of their counseling when it is TLT, especially after termination. This occurs especially when those in the less well-adjusted group rate their therapists in terms of the therapist's helpfulness in generating self understanding and in creating a safe psychological atmosphere.

Steenbarger (1992) agrees and states the outcome literature clearly suggests TLT is not equally effective for all. He states clients with "more substantial deficits" require TUT. He identified these high risk clients as those whose "impairment level prevents alliance formation, those who display psychosis, major affective or interpersonal disturbances, unwillingness to engage in therapy, and are unable or unwilling to tolerate experiencing" (p. 430).

De Shazer (1988) points out that when using TLT, a set of solution-based principles should guide the therapeutic enterprise. He asserts that (a) the major task of counseling is to help the person do something different; (b) the focus on the problem is redirected towards solutions already existing; (c) only small change is necessary because any change, no matter how small, creates the context for further changes; and (d) goals are framed in positive terms with an expectancy for change.

Overall, the process of TLT often occurs in distinct stages. Miller et al. (1983) found certain client and therapist behaviors occur regularly at particular times during TLT. In the first three sessions of TLT, discussion of time-limits and counseling goals occurs with high frequency. The next three sessions are often characterized by scheduling problems. The next three sessions involve a high percentage of resistance behaviors in

session noticeable to the therapists. However, client satisfaction with therapists and with sessions is not lower in the third quarter. Finally, time limits and termination issues are frequently discussed in the final three sessions.

The importance of these results lies in the empirically demonstrated occurrence of the TLT stages across diverse types of therapists. The stages seemed to occur without the therapists making explicit efforts to produce them. Thus, the stages may be more a function of the impact of the time limit than of a particular model of TLT or type of therapist (Miller et al., 1983).

Effectiveness of TLT

Time limits have been advocated for their ability to speed up the pace of treatment and increasing the number of clients served (Meltzoff & Kornreich, 1970). Mann (1973) has also shown TLT to decrease client dependency on the therapist, sharpen the focus on major therapeutic issues, and increase the patient's hope and expectations for success.

In contrast, Fisher (1984a) presents research involving family therapy at a guidance clinic. He suggests families that received treatment fared better than those on the waiting list, but no significant differences between TLT and open-ended therapy were found. The real difference, he contends, is the cost involved not the effectiveness.

A prospective study, conducted by Smyrnois and Kirkby (1993), randomly assigned 37 children and parents seeking mental health treatment to 6 session TLT, 12 session TLT, TUT, or a control group (no treatment). Their results suggested long-term therapy does not necessarily provide more effective therapy yet is more expensive. However, due to the small sample size, the results should be considered only tentative.

Kesilson (1974) suggested that eight session TLT was a viable treatment for clients who are not severely disturbed. TLT produced as much change as TUT in a university counseling center setting, and the change appeared to be durable. This is valuable

information because many clinicians have simply assumed briefer therapies were not as effective as longer therapies or their effects would only be of limited duration.

Follow-up Studies on TLT

Results of follow-up studies involving TLT (Fisher 1984b) indicated no evidence exists for deterioration after termination for clients who had received either 6 or 12 session limits as opposed to those with unlimited sessions. The findings indicated while the effectiveness of time limits was not significantly greater than unlimited sessions, time limits were successful in shortening treatment and reducing expense without disrupting the durability of outcomes.

Adelstein, Gelso, Haws, Reed, and Spiegel (1983) refuted past claims that brief TLT serves only as a temporary solution to clients' problems. They demonstrated clients who continue in TLT beyond the initial stage begin to set a change process in motion that continues up to one year following termination. The amount of overall change as well as the amount of change on dimensions such as emotional improvement, behavior change, and self-understanding is indeed not dramatic. Yet, according to clients and their therapists, change does occur during treatment, and the clients claim it continues.

Gelso (1992) agreed the data regarding the durability of improvement were insufficient. He elaborated that a greater percentage of clients in TLT (33%) returned for more therapy within 18 months than in the TUT group (23%). However, he also pointed out that even when considering the mean return rate and added sessions, TLT still results in fewer total sessions than the number of TUT sessions.

Evaluation of TLT Therapy

An interesting study examining TLT and TUT showed TLT clients are not unhappy with the length or duration of the treatments, at least not more than TUT clients (Gelso et al., 1983). In addition, although clients placed in an 8 session treatment mode were more likely to seek additional counseling in the 18 months between termination and follow-up,

data suggest the additional counseling they did receive was of briefer duration than the additional counseling received by clients in the TUT condition. Perhaps brief TLT teaches clients to conceptualize their concerns in a more structured manner and to take a problem-solving orientation (Gelso et al., 1983). In addition, maybe when brief TLT clients come back for therapy after termination, they may try to avoid long-term treatment.

Not all clients want or expect to be in long-term therapy when they enter counseling. Cornfeld et al. (1983) showed the great majority of clients in their particular study indicated before beginning counseling they wanted or needed fewer than 12 sessions, and very few, after being informed of the time limit, believed that 12 sessions would be inadequate.

Therapists should probably focus on their clients' perceptions of counseling rather than their own (Cornfeld et al., 1983). Cornfeld et al. (1983) showed clients' initial duration expectancies involving TLT were unrelated to overall post-counseling satisfaction. In general, clients and counselors were similarly satisfied with counseling and had similar perceptions of the client's likelihood of seeking further counseling. However, clients tended to be more satisfied with the time limit than their counselors and wanted significantly fewer additional sessions when dissatisfied, a logical consequence considering a dissatisfied client is unlikely to want additional counseling.

Client Dropout Rates

A 1986 review of research regarding patient dropout rates indicated more than 50% of outpatients withdraw before the eighth session (Garfield, 1986). In addition, the median attendance of psychotherapy sessions is generally around five or six (Garfield, 1978). Patient dropout often results in ineffective use of time by therapists and other trained personnel, especially in the public sector and probably other mental health settings as well.

Sharp (1994) indicated roughly one third of all patients seeking therapy will drop out after only one session, regardless of the method of treatment. Sharp also noted two-thirds average six or fewer sessions.

While several studies have examined the effectiveness of TLT, little evidence has been presented as to the attendance and/or dropout rates. Instead, prior studies have relied on a combination of self-reports, personal interviews and self-rating scales rather than examining or including the attendance and dropout rates of clients in TLT and TUT formats.

The most salient research relating to this issue is that conducted by Sledge, Moras, Hartley, and Levine (1990) who found the dropout rate for TLT was 32%, about one-half the rate for brief psychotherapy (67%) and open-ended psychotherapy (67%). In the above study, chi square tests revealed no statistically significant differences in dropout based on gender, age, race, marital status, or education among the clients in the three types of psychotherapy. The explanation for lower dropout rates offered by these researchers was that making the ending explicit and definite may help to reduce client tendencies to enact conflicts or fears concerning termination. A limited duration and definite ending prescribed at the beginning may provide a psychological structure that helps a client remain in therapy even in the face of frustrating, stressful, frightening, or otherwise problematic feelings and experiences. The clients may be more willing to "stick it out" when they realize the therapy will end soon (Sledge et al., 1990).

While several studies have assessed the effectiveness of TLT, none have been designed a priori to assess the attendance rates or dropout rates of TLT versus TUT. Thus, for one to benefit from psychotherapy, one must attend sessions. However, little evidence has been presented regarding attendance rates. Instead prior studies have focused on the effectiveness of TLT and have focused on a combination of self reports, personal interviews and self rating scales of overall outcome.

The results to date on the differential effectiveness of TLT and TUT are still inconclusive. Clients informed of TLT therapy may be less likely to drop out prematurely (June, 1975), decrease dependency, and sharpen the focus on major therapeutic issues (Mann, 1973). A few reports also attest to the value of TLT in decreasing waiting lists and increasing the number of clients served (Johnson & Gelso, 1981; Meltzoff & Kornreich, 1970). Thus, time limits may have a beneficial effect on the attendance, the process of therapy, and the service delivery.

Hypotheses

This study assessed the dropout and attendance rates of TLT as opposed to open-ended therapy. Based on studies that examined dropout rates post hoc, higher client attendance should be obtained with TLT as compared to open-ended therapy. A second hypothesis is that TLT relative to TUT should produce lower dropout rates.

CHAPTER TWO

METHOD

Treatment Facility

This study was conducted at Franklin County Mental Health Center located in Ottawa, KS. Franklin County has a population of about 22,500 and serves only Franklin County residents. It is a small, rural mental health facility serving all clients who seek psychological service without regard to diagnosis. Planned brief therapy is commonly practiced, although firm time-limits are not often established.

Therapists

A total of five therapists participated in this study. Four are master's level therapists (one man and three women) who are regular members of the clinic's staff. The range of experience of the therapists is from two to eight years with none having had formal training in TLT. In addition, one intern participated in the study. The intern had over six months of counseling experience and also had no formal training in TLT. Although all of the participants had experience with brief therapy, they were less accustomed to the use of explicit time limits set at the beginning of treatment. Therefore, once the time limits were set, therapy was conducted as usual with each therapist employing their preferred orientation.

Participants

The sample consisted of persons (14 years or older) who sought treatment at Franklin County Mental Health Center in Ottawa, KS. The clients were assigned to one of the two treatment conditions prior to the completion of an intake interview. Due to the nature of the study, and to prevent any biasing effects, clients were asked if they were willing to participate in an evaluation of clinic services. The clients were randomly assigned to one of two groups. The first group consisted of those clients receiving clear, spelled out time limits of 12 sessions. Aside from being informed of the number of

sessions, psychotherapy was conducted as usual. The second group consisted of those clients receiving treatment as usual. If a client asked what the evaluation was about, a short description was given without using the words TLT or open-ended therapy.

The criteria used for participation in the study were: (a) the client was native English-speaking; (b) the client had at least an eighth grade education; (c) if a child, not a ward of the court or state; (d) the case was not considered an emergency as ordinarily defined by the clinic; (e) the client was not currently involved in psychotherapy; (f) the client had no suicidal, homicidal, or runaway ideation; (g) the client exhibited no severe psychotic symptoms. In addition, the following clients were excluded: those who were or would be receiving another form of therapy concurrently (group, family, etc.), clients who were diagnosed with mental retardation, clients diagnosed with an organic mental disorder, and those who had histories consistent with a chronic psychotic condition or had psychological services more than three times in the past two years.

Procedure

Prior to the intake assessment, clients meeting the inclusion criteria but not the exclusion criteria were randomly assigned to either TLT or open-ended treatment by flipping a coin. The clients then underwent a customary intake interview and, in turn, received a DSM-IV diagnosis from the intake clinician. If during the intake exclusion criteria were met, the client was dropped from the study.

With four to six new clients per week, the study gathered the largest sample possible over a four month period and then a three month treatment period. Once a client was assigned to one of the two conditions, attendance and dropout rate were recorded. Dropout was defined in this study as a client who did not attend for three or more consecutive sessions or decided not to return to therapy with or without notification to the therapist.

Clients in the TLT group were notified of the time limit in the first session after the intake interview. This was explained in a positive and supportive manner (see Appendix A for text). For the open-ended therapy group, no mention was made as to the number of sessions, and psychotherapy proceeded as it usually did at this particular mental health center. By using random assignment (and checking statistics) all therapists treated clients using both open-ended therapy and TLT to prevent any biasing effects for differing styles/orientations of psychotherapists. The information was then recorded on an outcome sheet (Appendix B)

CHAPTER 3

RESULTS

The sample consisted of 38 clients seeking psychological services at an east-central Kansas mental center. The age range of the sample was 14 to 53 with a mean of 28.20 and standard deviation of 14.00. The sample included 19 males and 19 females. Other demographic information is presented in Table 1. Marital status included 23 single clients, 9 married, and 6 divorced. Diagnostic category included 16 clients with adjustment disorders, 14 with mood disorders, 5 with impulse control disorders, 2 with anxiety disorders, and 1 substance abuse disorder (primary diagnosis).

To ensure homogeneity among the therapists, the mean attendance rates of each therapist in each condition of time-limited therapy and time-unlimited therapy were analyzed in a 2 (treatment condition) X 5 (therapist) factorial analysis of variance (ANOVA). This was performed to determine if there were any effects due to a specific therapist. Comparison of the five therapists revealed no significant differences in attendance rates based on treatment condition, $F(1, 28) = .01, p > .05$; therapist, $F(4, 28) = .88, p > .05$; or the interaction of these two variables, $F(4, 28) = .52, p > .05$.

A t-test was performed to examine the first hypothesis of the study. The mean attendance rates of those participants randomly assigned to time-limited therapy and time-unlimited therapy were examined (See Table 2). The t-test was not significant, $t(36) = 1.72, p > .05$.

A chi square was then performed to examine the second hypothesis regarding dropout rate of those clients in time-limited therapy versus those in time-unlimited therapy. The analysis was not significant, $X^2(2, N = 38) = 1.72, p > .05$.

Table 1

Means, Standard Deviations and Ranges for Several Demographic Variables

Variable	Time Limited Group			Time-Unlimited Group		
	<u>M</u>	<u>SD</u>	Range	<u>M</u>	<u>SD</u>	Range
Sessions Attended	6.90	4.89	1-12	4.60	3.68	1-12
Prior Therapy Hours	12.33	21.19	0-78	8.05	16.31	0-68
Amount of Fee	14.83	11.26	3.00-45.00	12.40	8.83	0-31
Education (years)	11.78	2.62	8-16	11.35	2.21	8-17
Age	26.22	10.28	14-53	30.00	16.73	14-53
Monthly Income	1028.67	853.16	0-2500	904.15	750.18	0-2200

Table 2

Means and Standard Deviations for the Number of Sessions Attended by Therapist and Treatment Condition

Therapist	Time-limited (n=18)			Time-unlimited (n=20)		
	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>
1	10	7.73	6.21	11	5.10	4.00
2	2	6.33	.58	3	4.00	2.80
3	2	5.00	0	2	2.50	2.10
4	2	7.00	0	2	7.00	5.21
5	2	5.00	0	2	2.33	.58
Total	18	6.90	4.89	20	4.60	3.68

Table 3 displays the dropout rates broken down by the treatment condition. The chi square results indicated no significant differences between the observed and expected frequencies for dropout rates and treatment conditions.

A stepwise regression analysis was then performed to examine the predictors of attendance rates. Table 4 displays the correlation matrix and Table 5 displays the results of the regression analysis. The analysis found fee and income together accounted for 34% of the variance of attendance rates ($R^2 = .34$). Examination of beta values indicated that as fee increased, so did attendance with income having a suppressor effect. Fee by itself was also a significant predictor of attendance rates ($R^2 = .26$). This suggests that as fee increased, so did attendance.

Table 3

Crosstabulation of Dropout Rates by Treatment Condition

	Time Limited	Time Unlimited
Dropout	15	18
Continued	3	2

Table 4

Correlation Matrix of Variables

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
1. Sessions Attended					
2. Prior Therapy Hours	-.48				
3. Amount of Fee	.51**	-.25			
4. Education (years)	.01	-.02	-.20		
5. Age	-.15	-.07	-.11	.31	
6. Monthly Income	.11	-.30*	.64**	-.18	.04

* p < .05

** p < .01

Table 5

Multiple Regression Analysis Examining Predictors of Attendance

<u>Step</u>	<u>Beta</u>	<u>t</u>	<u>R²</u>	<u>F</u>
1. Fee	.51	3.50*	.26	12.54*
2. Fee	.75	4.16**	.34	9.00**
Income	-.37	-2.08		

* p < .01

** p < .001

CHAPTER FOUR

DISCUSSION

The purpose of this study was to examine the attendance records of psychotherapy sessions when clients were limited to 12 psychotherapy sessions or could have unlimited psychotherapy sessions. Attendance records of 38 clients seeking mental health services at an east-central Kansas mental health center according to 12 session time limit or open ended, unlimited number of psychotherapy sessions.

The hypothesis that clients in the time-limited treatment group would attend more sessions than the time-unlimited group was not supported. Time-limited therapy appears no better or worse than time-unlimited therapy, although such a conclusion must be tempered by the low sample size. Although not expected, this result may be viewed as positive from a clinical perspective because it gives the therapist more flexibility in conducting and structuring psychotherapy since time limits do not seem to improve or reduce attendance rates.

No statistical differences were found using a chi square to examine dropout rates between the two groups. All but five (three in time-limited and two in time-unlimited) of the 38 participants dropped out of therapy prematurely. This finding is consistent with current literature (Garfield, 1986; Sharp, 1994; Sledge et al., 1990) indicating most clients dropout before the ninth session.

The post hoc stepwise regression analysis found fee and income to be significant predictors of attendance. Fee and income combined accounted for 34% of the variance in attendance. Note income is a suppressor variable in that income has a low correlation with attendance ($r = .11$) but has a high correlation with fee ($r = .65$). The inclusion of income increases the partial correlation because it suppresses irrelevant variance that is shared with fee but not attendance.

Overall, fee was a better predictor of attendance and as fee rose so did the number of sessions attended. This may suggest the amount clients pay could be a form of self-investment or self-motivation. Hence, the more they pay, the more motivated and helpful they may perceive psychotherapy and, as a result, reap more benefits and attend more sessions.

Limitations

The participants drawn for this study all resided in a 22,500 person, rural county, located in east-central Kansas. Even if the sample represents that from which it was drawn, it may not be representative of the population at large. Participants' level of education, income, past therapy hours, amount of fee, marital trends, age, and diagnostic trends may be quite different than that of the general population.

The five therapists who participated in this study were also from the same small rural county, and while four had master's degrees in clinical psychology, one (the researcher) was an intern. This may also not be indicative of the practicing psychologists in the population at large.

A particular weakness of the study was its limited ability to detect whatever treatment effects might have been present. The sample consisted of only 18 participants in time-limited therapy and 20 in time-unlimited therapy. Although a much larger sample would have been preferred, the time involved would have been prohibitive.

Implications

The results of this study shed some light on the problems of psychotherapy attendance and premature dropout. While the present study did not find statistical significance, a trend emerged when comparing attendance rates between time-limited therapy and time-unlimited therapy. Therefore, a larger study (e.g., 60 subjects) with a more homogenous sample of clients and clinicians might detect a difference. That is, a study with greater statistical power would be better able to detect a treatment effect if one exists.

An interesting post hoc finding was that as fee increased, so did attendance across both treatment groups. This may suggest higher fees might increase attendance in psychotherapy. That is, increasing the fee indirectly increases the clients' perceptions of the helpfulness and value of psychotherapy. Perhaps with a perception of greater value and overall rating of psychotherapy, the client will perceive that he or she is getting more out of therapy and will attend more sessions. However, the current data do not justify raising clients' fees due to its limited sample size and possible external validity. If the relationship between fee and attendance is curvilinear, then as fee increases (for example, up to \$40.00) the hypothesis may hold, but as fee increases further, clients may regard the fee as prohibitive and stop attending psychotherapy sessions. This study is unable to offer firm answers to this question as the fees ranged only from \$0.00 to \$31.00.

Suggestions for Future Research

The results of the effects of setting time limits in psychotherapy is still inconclusive. Further investigations following a similar format are warranted.

One problem with this study is its lack of statistical power due to a small sample size. Designs similar to this one but with a larger sample and more representative locations in the United States may hold more promise.

Another suggestion might include eliminating the multicollinearity between fee and income. In this study, the amount the client paid was determined by consulting a table using monthly income as the reference. Fee was therefore linearly dependent on income. Randomly assigning the amount of the fee would be beneficial in determining whether fee or income level (which is often correlated with increased responsibility, education, age, and marital status) affects attendance rates. A study designed to accomplish this might provide more definitive answers regarding the effect of fee on attendance.

All the psychologists involved in this study had little or no formal training in time-limited therapy prior to this study. While the emphasis of this study was investigating

whether a measurable difference in attendance rates would be produced based on clients' perception of time limits, the psychotherapeutic process may be altered by the therapist receiving formal training in time-limited therapy. An inservice of some type with a professional trained in using time limits may be beneficial to incorporate in a future study to determine if there is a difference in attendance.

Although extensive research on the effectiveness of psychotherapy exists, very little describes how to increase attendance at psychotherapy sessions. The lack of attendance and high dropout rates in psychotherapy is clearly documented, but few suggestions are offered for improving it. Exploratory studies aimed at increasing attendance would logically enhance the psychotherapeutic process.

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Appendix A

These instructions will be read to all subjects that are randomly assigned to time-limited therapy:

"After reviewing your intake, our treatment team has decided that you would be best served if we contracted for 12 therapy sessions. We feel that 12 sessions is an appropriate number and should be adequate. Is this agreeable to you?"

If a client responds negatively or asks if they will be given more sessions if they want more, the clinician shall respond:

"At the end of our contracted sessions we will reevaluate the situation and if needed, we will continue with more sessions, but we currently feel that twelve session should be adequate"


For clients in the time-unlimited treatment group:

No mention of time limits are made and they are verbally told that they will receive psychotherapy on as needed basis. This will usually consisting of weekly sessions and no definite time line will be given.

Appendix B

Name: _____
Id Number _____
Method (1 or 2) _____
Number Attended _____
Age _____
Income (month) _____
Gender (1 or 2) _____
Marital Status (1-5) _____
Prior MH hours _____
Amount of fee _____
Education Level _____
Diagnosis (1-9) _____

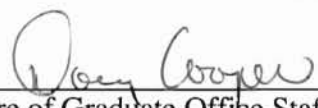
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John P. Killoy

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Date

A Comparison of the Attendance and Dropout Rates Between Time-Limited and Time-
Unlimited Psychotherapy
Title of Thesis Project



Signature of Graduate Office Staff Member

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Date Received

