

## ABSTRACT

Title of Document: PSYCHOTHERAPY ENGAGERS VERSUS NON-ENGAGERS: ATTACHMENT STYLE, OUTCOME EXPECTATIONS, NEED FOR THERAPY, SESSION DURATION, AND THERAPIST HELPING SKILLS IN INTAKE SESSIONS.

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The present study investigated client attachment style, outcome expectations, need for therapy, intake duration and therapist helping skills associated with psychotherapy engagement. Intake sessions of 16 adults (8 non-engagers, i.e., post-intake dropouts; 8 engagers, i.e., clients who attended at least 8 sessions) in individual long-term therapy were divided into thirds (beginning, middle, and end of session). Statistical controls for therapist verbal activity level and clients nested within therapists were employed for helping skills analyses. With non-engagers, compared to engagers, therapists used more approval-reassurance in the beginning third of intake sessions, but marginally more reflections of feeling and marginally less information about the helping process in the last third of intakes. Non-engagers had higher pre-therapy anxious attachment and pre-therapy self-rated need for therapy than engagers. In sum, non-

engagers versus engagers differed with therapist helping skills, client attachment style, and client need for therapy, but not intake duration or client outcome expectations.

PSYCHOTHERAPY ENGAGERS VERSUS NON-ENGAGERS: ATTACHMENT  
STYLE, OUTCOME EXPECTATIONS, NEED FOR THERAPY, SESSION  
DURATION, AND THERAPIST HELPING SKILLS IN INTAKE SESSIONS.

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## Table of Contents

List of Tables .....	v
List of Figures .....	vi
Chapter 1: Introduction .....	1
Chapter 2: Review of the Literature.....	5
Psychotherapy Dropout.....	5
Definition of psychotherapy dropout .....	5
Review articles about psychotherapy dropout .....	9
Summary.....	15
Early dropout .....	15
Summary.....	26
Therapist Techniques .....	27
Definition of therapist techniques.....	27
History and development of the HCVRCS/HSS .....	30
Studies using the HCVRCS/HSS.....	32
Summary.....	43
Intake Sessions.....	44
Conceptually-derived helping skills patterns expected in intakes .....	44
Summary.....	48
Studies reporting overall proportions of helping skills used in intakes .....	49
Summary.....	51
Studies reporting helping skills used in thirds of intakes .....	51
Summary.....	59
Adult Attachment Style: A Meta-Analysis.....	60
Chapter 3: Statement of the Problem .....	64
Research Question 1 .....	66
Research Question 2 .....	67
Research Question 3 .....	67
Research Question 4 .....	68
Research Question 5 .....	68
Research Question 6 .....	69
Research Question 7 .....	69
Research Question 8 .....	69
Research Question 9 .....	70
Research Question 10 .....	70
Additional Analyses.....	71
Chapter 4: Method .....	72
Power Analyses.....	72
Participants and Setting.....	72
Setting .....	72

Clients .....	73
Therapists .....	73
Judges.....	73
Measures .....	74
Client demographics .....	74
Therapist demographics .....	74
Judge demographics.....	74
The Helping Skills System.....	74
Client attachment style.....	75
Intake session duration.....	76
Client pre-therapy need for therapy .....	76
Client pre-therapy outcome expectations.....	76
Procedures .....	76
Client recruitment .....	76
Therapist recruitment .....	77
Judge recruitment.....	77
Intake sessions .....	78
Training for the HSS.....	78
Transcripts for the HSS.....	78
Unitizing for the HSS.....	79
Coding using the HSS.....	80
Chapter 5: Results .....	81
Descriptive Statistics.....	81
Preliminary Analyses .....	84
Main Analyses and Planned Comparisons.....	85
Research Question 1 .....	86
Research Question 2 .....	87
Research Question 3 .....	88
Research Question 4 .....	90
Research Question 5 .....	91
Research Question 6 .....	92
Research Question 7 .....	94
Research Question 8 .....	95
Research Question 9 .....	96
Research Question 10 .....	98
All Nine Subtypes of Helpings Skills for Engagers and Non-engagers .....	99
Additional Analyses.....	102
Client attachment style.....	102
Intake session duration.....	104
Client pre-therapy need for therapy .....	105
Client pre-therapy outcome expectations.....	105
Chapter 6: Discussion .....	107
Overall Helping Skills and Psychotherapy Engagement .....	107
First Third of the Intake: Helping Skills and Psychotherapy Engagement.....	108
Middle Third of the Intake: Helping Skills and Psychotherapy Engagement .....	109

Last Third of the Intake: Helping Skills and Psychotherapy Engagement .....	109
Additional Analyses .....	110
Anxious attachment .....	110
Avoidant attachment .....	111
Intake duration .....	111
Client pre-therapy need for therapy. ....	112
Client pre-therapy outcome expectations.....	112
Conclusions.....	113
Limitations .....	114
Implications for Practice and Research.....	116
Appendix A: Preliminary Tests of Therapist Effects.....	118
References .....	119

## List of Tables

Table 1: <i>Hill (1978) Mean Proportions and Standard Deviations of Helping Skills</i> .....	54
Table 2: <i>Lonborg et al. (1991) Means Numbers and Standard Deviations of Helping Skills</i> .....	56
Table 3: <i>Tryon (2003) Mean Number and Standard Deviations of Helping Skills</i> .....	58
Table 4: <i>Proportions of Helping Skills Used in Intake Sessions for Non-engagers</i> .....	82
Table 5: <i>Proportions of Helping Skills Used in Intake Sessions for Engagers</i> .....	83
Table 6: <i>Proportions of Helping Skills Used in Intakes for Both Engagers and Non-engagers</i> .....	84



## List of Figures

Figure 1: Approval-Reassurance.....	87
Figure 2: Closed Questions.....	88
Figure 3: Open Questions-Thoughts.....	90
Figure 4: Restatements.....	91
Figure 5: Reflections of Feeling .....	92
Figure 6: Disclosure-Miscellaneous .....	93
Figure 7: Immediacy.....	94
Figure 8: Information-Helping Process .....	96
Figure 9: Information-Facts/Data/Opinions.....	97
Figure 10: Information (all subtypes combined) .....	98
Figure 11: All 9 Helping Skills in the Intake Overall.....	99
Figure 12: All 9 Helping Skills in the First Third of the Intake .....	100
Figure 13: All 9 Helping Skills in Middle Third of the Intake .....	101
Figure 14: All 9 Helping Skills in the Last Third of the Intake.....	102
Figure 15: Anxious Attachment Style Results for Engagers Versus Non-engagers.....	103
Figure 16: Avoidant Attachment Style Results for Engagers Versus Non-engagers .....	104
Figure 17: Intake Session Duration Results for Engagers Versus Non-engagers.....	104
Figure 18. Engager versus Non-engager Pre-therapy Need for Psychotherapy .....	105
Figure 19. Engager versus Non-engager Pre-therapy Outcome Expectations.....	106

## Chapter 1: Introduction

Psychotherapy dropout is a widespread and serious problem that can result in adverse effects on clients, therapists, and the mental health system. The phenomenon of psychotherapy dropout is widespread: the most recent meta-analyses found overall dropout rates of 35% (Sharf, 2007) and 47% (Wierzbicki & Pekarik, 1993)—this means that about one-third to one-half of psychotherapy clients do not complete the full course of treatment. Clients who drop out of therapy prematurely often have poorer outcomes than clients who continue until treatment goals are achieved (Archer, Forbes, Metcalf, & Winter, 2000; Klein, Stone, Hicks & Pritchard, 2003; Moras, 1986; Pekarik, 1983). Therapists may experience increased financial pressure, especially those who work on a fee-for-service basis and are not paid for missed appointments, and may experience feelings of failure or decreased morale (Danzinger & Welfel, 2001; Klein et al., 2003; Motenko, Allen, Angelos & Block, 1995; Maslach, 1978; Pekarik, 1985; Sledge, Moras, Hartley, & Levine, 1990). The mental health system can also be negatively impacted when clients fail to show up for a scheduled therapy session, which poses a financial burden on staff salaries, overhead, and lost revenue, as well as personnel losses resulting from low morale and high staff turnover (Klein et al., 2003; Tantam & Klerman, 1979). In addition, missed appointments deny access to others in need and limit the number of people an agency or practice can serve (Joshi, Maisami, & Coyle, 1986).

One of the factors contributing to dropout may be the verbal behavior of the therapist during the initial sessions of therapy (Tryon, 2003). Specifically, the investigation of therapist verbal helping skills in relation to dropout is particularly important given that helping skills training is an integral part of training beginning

therapists (Hill & Lent, 2006), that therapists in training seem to have more difficulty retaining clients than do professional clinicians (Tryon 1989a, 1989b), and that only one study has been conducted thus far on helping skills and dropout (Tryon, 2003). Since only one study has been conducted thus far on helping skills and dropout, therapists-in-training, as well as those providing therapy training, have little guidance as to what helping skills may or may not be helpful for preventing dropout, or even what helping skills patterns are associated with dropout. Thus, the investigation of the timing and patterns of verbal helping skills in relation to psychotherapy dropout may help therapists to understand patterns of helping skills associated with dropout and to better prevent dropout.

Tryon (2003) began investigating the topic of therapist helping skills associated with a type of dropout referred to as ‘engagement.’ Engagement refers to the phenomenon of a client returning for therapy after the initial intake session (Tryon, 1985). In Tryon (2003), a ‘non-engager’ was defined as a client who failed to return for therapy after the initial intake session, whereas an ‘engager’ was defined as a client who returned for at least one therapy session after the intake session. In the present study, I use the terms ‘engagement’ and ‘non-engager’ based on Tryon’s (1985, 2003) definitions, but use the term ‘engager’ to refer to clients who continue therapy beyond eight sessions, in order to more sharply distinguish the intake-only dropouts from their counterparts.

Tryon (2003) found that therapists used less information-giving and more minimal encouragers during the intake session for non-engagers than compared to engagers. Tryon also found statistically significant differences between engagers

compared to non-engagers regarding the timing of therapist verbal interventions. For engagers, the number of closed questions decreased as the intake session progressed, while the number of information-giving statements increased as the session progressed. For non-engagers, the amount of closed questions increased and then decreased; information-giving showed the inverse pattern (initial decrease then later increase). Tryon proposed that clients returned for therapy when their problems had been sufficiently clarified to begin working on the problems (through the therapist's providing information in the latter part of the session).

However, Tryon (2003) is the only study thus far that has been conducted on therapist helping skills associated with engagement, and her findings about the amounts and timing of helping skills associated with engagement may not apply to therapists or clients other than the one therapist and eleven clients investigated in her study. In addition, the investigation of the timing of helping skills in Tryon (2003) failed to control for therapist verbal activity level. The value of controlling for therapist verbal activity level is illustrated in the following example: if a therapist uses 5 closed questions with a non-engager but uses 10 with an engager, it may appear that s/he used more closed questions with the engager, but if the therapist spoke twice as much with the engager than with the non-engager, the therapist verbal activity level may have accounted for the differences rather than the raw number of times a skill was used.

Additional non-laboratory studies that look at helping skills in the initial intake sessions of therapy in real life settings and account for therapist verbal activity level are needed to advance knowledge in understanding psychotherapy engagement. Therefore, the purpose of the present study is to examine whether the timing (first, second, or last

third of the intake) and types of therapist helping skills differ between engagers (clients who attended at least 8 sessions) versus non-engagers (clients who did not return for therapy after the initial intake session), when controlling for therapist verbal activity level.

## **Chapter 2: Review of the Literature**

In this chapter, I review the literature in three sections: psychotherapy dropout, therapist techniques, and helping skills in intake sessions. Within the first section on psychotherapy dropout, I discuss the definition of psychotherapy dropout, review the most recent review articles on dropout, and review the literature specifically on early dropout. Within the section on therapist techniques, I discuss the definition of therapist techniques, provide historical background for the measure of therapist techniques being used in the present study, and review the literature on therapist helping skills. Within the section on helping skills in intake sessions, I review the literature on intake sessions, review articles reporting overall proportions of helping skills used in intake sessions, and review articles that report the amount of helping skills used in thirds of intake sessions (including the only article on helping skills in relation to psychotherapy dropout).

### **Psychotherapy Dropout**

**Definition of psychotherapy dropout.** Psychotherapy dropout can be defined as occurring when a client has left therapy before completing therapy treatment (Hatchett & Park, 2003). Although the conceptual definition of psychotherapy dropout is not difficult to understand, the operational definition of psychotherapy dropout poses a more complicated undertaking for researchers. Since the definition implies that a client has begun treatment but did not finish treatment, exactly how one defines when treatment has begun can vary – for example, it could be defined as when the client makes the initial call to seek treatment, as after an intake appointment has been scheduled, as after the first appointment has begun, or even only after the first therapy session has begun (not counting intake). Even more complicated is the question of what would count as

“completed treatment” – from a client’s perspective, perhaps she or he has obtained the treatment goals from his/her perspective, but the therapist may perceive that client as a dropout if the therapist does not think the client has completed the full course of the therapy. Indeed, the authors of the most recent review of the dropout literature noted that one of the largest methodological issues in studying psychotherapy dropout is the wide variation in operational definitions found in the literature (Barrett et al., 2008). The variation in operational definitions of psychotherapy dropout complicates the findings of psychotherapy dropout research (Barrett et al., 2008). Differing operationalizations result in differing rates of psychotherapy dropout reported (Wierzbicki & Pekarik, 1993), and may even represent contradictory constructs, as at least one study has found (Hatchett & Park, 2003). Many studies define dropout in terms of a specified number of sessions or treatment duration (Sharf, 2007; Barrett et al., 2008). However, the actual cut-off varies between and within studies (Barrett et al., 2008). For example, one study defined dropout as a failure to return after an intake assessment (Longo, Lent, & Brown, 1992), whereas another author defined it as occurring when a client has attended fewer than 6 or 8 sessions (Phillips, 1985). Yet other studies have defined it as termination of therapy any time within the first 9 months (Frayn, 1992), or even failure to attend the last session (Hatchett, Han, & Cooker, 2002). Thus, there is a wide variability in how psychotherapy dropout is defined, even within studies that use a cut-off point. Other studies that do not use a cut-off point have defined psychotherapy dropout as client-initiated termination without therapist agreement regardless of the number of sessions completed (Berrigan & Garfield, 1981; Pekarik, 1992; Richmond, 1992; Tutin, 1987). Some studies use a combination of a cut-off point and therapist judgment to define dropout (see Sharf, 2007).

Definitions of dropout based on number of sessions can potentially misclassify clients who have achieved sufficient clinical change, and definitions of dropout based on therapist judgment can vary depending on the therapists' ideas about what counts as a dropout. Though definitions of dropout using a cut-off number of sessions combined with therapist judgment decrease the likelihood of misclassifying clients as dropouts, they still have the potential to misclassify clients who actually have made sufficient clinical improvement (they may take a standardized outcome measure and score in the clinically healthy range—therapist judgment can be subjective and could differ from the results of a standardized outcome measure).

Swift, Callahan, and Levine (2009) proposed a definition of dropout based on clinically significant change and/or reliable change to address the misclassification problem. They defined clinically significant change as having been attained when “(a) the client obtains a score within the nonclinical range on a standardized outcome measure and (b) the change in score reflects reliable improvement” (p. 330). Reliable change is a less stringent operationalization that can be useful since few clients obtain clinically significant change through therapy (Swift et al.). In their study, Swift et al. use a cut-off score of 63 on the Outcome Questionnaire 45.2 (OQ-45.2; Lambert et al., 1996; Lambert, Okiishi, Finch, & Johnson, 1998) as the indicator for clinically significant change and a change of 14 points on the OQ-45.2 as the indicator for reliable change. These operationalizations were based on the OQ-45.2 manual (Swift et al., 2009).

Although Swift et al. (2009) made a convincing argument for using clinically significant change and reliable change to define dropout, clients can be misclassified under their system. We can use the example of a client who scored in the nonclinical



range on the OQ-45.2 when beginning therapy and made at least 14 points of change according to his/her OQ-45.2 scores, and both client and therapist agreed that the treatment goals had not been met yet, but the client and therapist experience a rupture in the therapeutic relationship and the client leaves to seek therapy elsewhere. Under the clinically significant and/or reliable change definition, this client would not be classified as a treatment dropout even though both the therapist and client would agree that the client did indeed drop out of therapy with this particular therapist. Furthermore, an additional problem with using the clinically significant change and/or reliable change method is that it does not distinguish between different sub-types of dropouts. Some studies may want to look at certain types of dropouts based on particular clinical phenomena observed. For example, intake-only dropouts may differ in important ways from later dropouts; perhaps the early dropouts were never 'hooked in' whereas the later dropouts experienced ruptures in the therapeutic alliance.

Early dropouts, such as intake-only dropouts, may be especially important to examine not only because early dropout may result from a differing set of factors than later dropout (Barrett et al., 2008), but because clients who drop out early on in therapy (e.g., after only one or two visits) have poorer outcomes than those who drop out later in therapy (Pekarik, 1983, 1992). Thus, the present study will focus on psychotherapy dropout occurring in the early phase of therapy rather than later on in therapy.

Since the focus of the present study is on psychotherapy dropout occurring after intake, the definition of dropout that will be used for the present study refers to clients who did not return for therapy after the initial intake session and have not reached their therapeutic goals as determined by therapist judgment. Similarly, in previous studies,

dropout has been most commonly defined as leaving therapy before a specified number of sessions (see Sharf, 2007; Barrett et al., 2008). My definition is also consistent with research findings that a minimum of 11 to 13 sessions of evidence-based interventions are needed for 50-60% of clients to be considered recovered (Hansen, Lambert, & Forman, 2002; Lambert, 2007). The intake-session cutoff is also consistent with findings that, on average, clients had not yet reached 50% improvement until after the fourth session of individual psychotherapy (Lutz, Lowry, Kopta, Einstein & Howard, 2001). This finding held for all types of client disorders represented in the Lutz et al. (2001) study: adjustment disorder, depression, bipolar disorder, obsessive-compulsive disorder, and anxiety. The intake-session cutoff is also consistent with literature suggesting that the working alliance is not well-established until the third session or so (Ligiero & Gelso, 2002; Hersoug, Høglend, Monsen, & Havik, 2001). Finally, although it may be possible for clients to obtain their desired amount of recovery with just the intake session, the data for the present study was collected at a clinic that follows a long-term psychodynamic/interpersonal orientation, and all the clients had at least one interpersonal issue as a presenting problem and had been screened for their appropriateness for long-term therapy. Thus, in the present study it is very unlikely that clients would have obtained a desirable amount of recovery in just the intake session.

**Review articles about psychotherapy dropout.** In the past 15 years there have been two major reviews of the literature on psychotherapy dropout: Wierzbicki and Pekarik (1993) and Barrett et al. (2008). In this section, I review these two articles, and then summarize the findings and limitations of these articles at the end of the section.

Wierzbicki and Pekarik (1993) conducted a meta-analysis on 125 studies and found an overall psychotherapy dropout rate of about 47%, when “dropout” was defined in whatever way each individual study defined it. There were only three statistically significant predictors of psychotherapy dropout found in this meta-analysis: racial status, education, and income. Higher rates of dropout were found for African-Americans (and other minorities), less-educated clients, and lower income groups, when compared to their counterparts (Wierzbicki & Pekarik, 1993). However, psychotherapy dropout rates were also significantly influenced by the way dropout was defined. Lower dropout rates occurred when dropout was defined as failure to attend a scheduled session than when dropout was defined either by therapist judgment (29 studies,  $M = 48\%$ ) or attending a minimum number of sessions. The average dropout rate was 36% when defined as failure to attend a scheduled session (based on 23 studies), 48% when defined by therapist judgment (based on 29 studies), and 48% when defined by a minimum number of sessions (based on 69 studies) (Wierzbicki & Pekarik, 1993). Limitations of this meta-analysis include a lack of sufficient data from the individual studies to calculate effect sizes for as much as 25% of the effect sizes for each demographic variable examined, and that the statistical analyses of effect sizes focused solely on client demographic variables.

Barrett et al. (2008) did a practice review highlighting methodological challenges in studying psychotherapy dropout, reviewing current interventions for reducing psychotherapy dropout, and providing recommendations for implementing these interventions into psychotherapy practice. The methodological problems reviewed include the range of definitions investigators use for psychotherapy dropout, and differing therapist and client perceptions of treatment or outcome. The definitional difficulties are

discussed in previous paragraphs above. Differing perceptions of treatment or outcome may complicate the definition of dropout, since clients may believe that additional therapy sessions will not be helpful and end treatment, whereas therapists may consider such clients to have dropped out. However, it is not clear whether a client should be considered a dropout if the client does not consider himself or herself a dropout – perhaps the client felt that enough help was obtained and ended treatment. Thus, it is unclear how much therapist judgment should play a role in determining whether a client is a drop out, especially when there are no clearly observable markers for seeing whether the client has achieved their therapeutic goals (Barrett et al., 2008).

Predictors of psychotherapy dropout in the Barrett et al. (2008) paper were discussed using Andersen's (1968, 1995) model that focuses on four broad categories of influence on patient use of services: patient characteristics, enabling factors/barriers, need factors, and environmental factors. Patient characteristics (i.e. patient demographic variables) have been the most frequently studied client factors (Barrett et al., 2008). Mixed findings have been found for age; most research has shown minimal relationship between dropout and age (Cartwright, 1955; Craig & Huffine, 1976; Frank, Gliedman, Imber, Nash, & Stone, 1957; Rubenstein & Lorr, 1956), but two recent studies (Edlund et al., 2002; Thormahlen et al., 2003) have found that clients younger than 25-30 years old are more likely to drop out than older clients. More consistent findings have been found for socioeconomic status. Clients with lower socioeconomic status are more likely to drop out than those with higher socioeconomic status (Baekeland & Lundwall, 1975; Wierzbicki & Pekarik, 1993).

Enabling factors or barriers refer to the influence of external factors on an individual's ability to show up for sessions or continue in treatment (Barrett et al., 2008). An example of an enabling factor is referral source. Clients referred by outside agencies or hotlines were more likely to not show up at the first treatment session than those referred by religious groups, friends, or insurance companies (Hampton-Robb, Qualls, & Compton, 2003). Barriers such as difficulty finding mental health services (Parker & McDavis, 1983), greater distance traveled (Fraps, McReynolds, Beck, & Heisler, 1982), placement on waiting lists (Festinger, Lamb, Marlowe, & Kirby, 2002; Stasiewicz & Stalker, 1999), and longer waiting times from intake to first treatment session (Rodolfa, Rapaport, & Lee, 1983) have been repeatedly linked with treatment dropout (Barrett et al., 2008).

Need factors (i.e. severity of psychiatric condition) have had mixed findings in the literature (Barrett et al., 2008). Although some studies suggest that psychotic clients are less likely to drop out early on in the process compared to clients with less severe diagnoses (Craig & Huffine, 1976; Dodd, 1970; Hoffman, 1985), other studies have found that patients with more severe diagnoses are more likely to drop out (e.g., Sue, McKinney, Allen & Hall, 1974). In looking at how severity of psychiatric condition relates to dropout, it is difficult to determine whether improvement, or lack thereof, has influenced a client's decision to drop out without documentation of client distress before, during, and after treatment (Hunsley, Aubry, Verstervelt, & Vito, 1999).

Environmental factors also have been examined in relation to psychotherapy dropout (Barrett et al., 2008). Staff attitudes, the setting of the clinic, or clinic facilities are more likely to affect clients in the initial phone call or intake evaluation than after

treatment has begun (Gunzburger, Henggeler, & Watson, 1985). Other environmental factors such as lack of transportation and difficulty getting time off work or school (Beck et al., 1987; Cross & Warren, 1984) have surprisingly not had consistent relation to dropout (Barrett et al., 2008).

Strategies for reducing psychotherapy dropout that were discussed in the Barrett et al. (2008) paper included: role induction (i.e. clarifying therapist and client roles), motivational interviewing, changing the treatment services model to better meet the changing demands of mental health treatment and managed care, therapist feedback, and strengthening the therapeutic relationship. Role induction (also referred to as pretherapy preparation) has been shown to improve client attendance (Walitzer, Dermen, & Connors, 1999). 11 of the 16 studies reviewed by Walitzer et al. (1999) found that pretherapy training reduced rates of dropout. Techniques that clarify the therapist and client roles and give an overview of therapy have been found to improve attendance (Hoehn-Saric et al., 1964) and decrease dropout (Jacobs, Charles, Jacobs, Weinstein, & Mann, 1972).

Brief motivational interviewing (brief MI; Rollnick & Heather, 1992), when integrated into the initial intake evaluation, has been related to nearly 50% reductions in dropout rates (Carroll, Libby, Sheehan, & Hyland, 2001), as discussed in the Barrett et al. (2008) paper. For example, Carroll et al. (2001) investigated the effects of brief MI intake evaluations on dropout. Dropouts for this study (Carroll et al., 2001) were individuals who did not begin treatment sessions after attending an initial intake evaluation. 60 individuals referred for a substance abuse evaluation by a child welfare worker were randomly assigned to one of two conditions: either a standard evaluation or an evaluation enhanced by brief MI techniques. The participants who received the brief

MI evaluation were statistically significantly more likely to attend at least one additional treatment session after the initial evaluation (59% versus 29%), than compared to the participants who received standard intake evaluations (Carroll et al., 2001).

Barrett et al. (2008) also pointed out that Barkham, Shapiro, Hardy, and Rees (1999) from the University of Leeds in England have developed an ultrabrief model of treatment. Clients attend two sessions of therapy one week apart, and then attend a booster session three months later. Brief or ultrabrief models of therapy may be useful for economically disadvantaged individuals and for individuals with a “crisis-reactive” approach to mental health treatment (Barrett et al., 2008).

Therapist feedback about how much progress clients are making may help therapists determine which interventions are more effective for a particular client, and may provide valuable information on whether treatment needs to be altered and/or how the treatment might be altered to better serve the client (Barrett et al., 2008). An example of a therapist feedback instrument is the Outcome Questionnaire-45 (Lambert & Ogles, 2004). In an analysis of four studies on the outcome of therapist feedback with over 2,500 clients, Lambert, Harmon, Slade, Whipple, and Hawkins (2005) found that when therapists received information about clients who were not progressing or were worsening, these clients showed significantly better outcomes than clients whose therapists did not receive this feedback (Barrett et al., 2008).

Although the therapeutic relationship is not a specific technique per se, the authors (Barrett et al., 2008) felt it was important to include the therapeutic relationship in a discussion of strategies for reducing psychotherapy dropout because they viewed it as central to nearly all of the domains influencing dropout. Recent research has

increasingly demonstrated that weak or poor therapeutic alliances are related to increased dropout (Tryon & Kane, 1993; Johansson & Eklund, 2005; Lingiardi, Filippucci, & Baiocco, 2005; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006; Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Samstag, Batchelder, Muran, Safran, & Winston, 1998). Consequently, several researchers have suggested attentiveness to the presence of alliance ruptures or weakenings as a promising strategy for decreasing early treatment withdrawal (Castonguay et al., 2004; Safran, Muran, Samstag, & Stevens, 2001).

**Summary.** In summary, the two major reviews of the literature on dropout found that psychotherapy dropout occurs frequently (as evidenced by the 47% dropout rate found by Wierzbicki and Pekarik, 1993), is affected by many factors (e.g., client demographics, enabling factors/barriers, need factors, and environmental factors; Barrett et al., 2008), and that there are a number of strategies for reducing dropout (e.g., role induction, motivational interviewing, changing the treatment services model, therapist feedback, and strengthening the therapeutic relationship; Barrett et al., 2008).

Limitations of the research on psychotherapy dropout include the lack of conclusive findings on the factors causing psychotherapy dropout due to the differing definitions used across different studies. In addition, little research has been done thus far on determining whether specific therapist helping skills, or the timing of those skills, are related to dropout.

**Early dropout.** It is important to examine early dropout separately from dropout occurring later on, because early dropout may occur for a different set of factors than



later dropout (Barrett et al., 2008). In this section, I review the literature on early dropout, as the present study will focus on early dropouts from psychotherapy.

Pekarik (1983) examined termination status (i.e., early dropout, late dropout, and appropriate termination) in relation to the post-therapy adjustment of outpatient psychotherapy clients. Clients were 64 outpatients at four clinics of a community mental health center. Therapists were 12 psychotherapists (3 Ph.D. psychologists, 6 with M.A.s in psychology, 1 M.S.W., 1 B.S.W., and 1 with a B.A. in human services) who described themselves as eclectic in orientation. Therapists had an average of five and a half years of professional experience. Six therapists were male; six therapists were female. The measure of post-therapy adjustment was the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982), which clients completed pre-therapy (prior to their intake session) and post-therapy (3 months after the intake date). Results of the study indicated that appropriate terminators had better BSI scores than dropouts at follow-up,  $t(63) = 4.80, p < .001$ , and that later dropouts were better adjusted than early dropouts who had attended only one or two sessions,  $\chi^2(1) = 6.88, p < .01$ . Limitations of the study include that the adjustment measure was not administered closely to the dropout date (thus, other factors may have affected the adjustment score), that the findings may not apply to other types of therapists who are not eclectic in theoretical orientation, and that no effect-size information was reported.

Tryon (1986) investigated client and counselor characteristics in relation to whether clients returned for therapy after completing an initial intake session in a university counseling center. Counselors were 9 practicum trainees (5 female, 4 male). Clients were 203 people (128 female, 75 male) who had come to a university counseling

center for the first time. Clients and counselors completed questionnaires after the initial intake session. Client questionnaires asked clients to rate their counselor's interest, helpfulness, competence, warmth, genuineness, and the extent to which counselors identified concerns for which the clients did not initially seek counseling, on a 5-point scale. Counselor questionnaires asked them to rate the client's verbalness, intelligence, capacity for insight, likeability, severity of clients' problems, and the counselor's interest in seeing the client, on a 5-point scale. There was no statistically significant relationship between gender match of the client and counselor to engagement. Results indicated that client return for additional counseling after the intake session was positively related to: counselors' perceptions of clients as having more severe concerns, counselors' interest in seeing the clients, and more identification of concerns for which the clients did not initially seek counseling. All three of these variables were analyzed with a stepwise multiple regression analysis, and were statistically significant to the  $p < .001$  level. These three predictors accounted for 31% of the variance in engagement status. Limitations of the study include that the client sample was limited to university students, and the counselors were all practicum trainees, so the results may not generalize to other non-university-student populations, or to other counselors with more experience (e.g., professionally licensed counselors). In addition, the psychometric validity of the measures used is unknown; thus, the measurement of the variables in this study (including counselor identification of client concerns, counselor rating of severity of client concerns, and counselor-rated interest in seeing the client) may not be robust.

Tryon and Tryon (1986) examined various counselor factors associated with client engagement in therapy. Therapists were 43 practicum trainees (29 female, 14

male) at a university counseling center. Clients were university students; no demographic data for clients was reported. The study has two parts. For the first part, data was collected for the trainees during the academic years of 1978-1979 and 1983-1984. This data included: number of clients seen for 1, 2, 3-4, 5-10, and more than 10 sessions; total number of clients seen; total number of clients engaged for more than one session; and the trainees' engagement quotient (EQ; defined as the percentage of clients who returned to that therapist for more than one session; Tryon, 1985). The results of the first part showed that trainees who had a higher percentage of clients returning for counseling for more than one intake session also had more clients who continued for more than 10 sessions ( $r_{pbi} = .44, p < .01$ ). These findings support the view that trainees have differing levels of skill at engaging clients to take part in the process of therapy.

For the second part of the Tryon and Tryon (1986) study, the researchers looked at EQs of the trainees compared to seven predictor variables: age, Graduate Record Examination Verbal (GREV) scores, Graduate Record Examination Quantitative (GREQ) scores, how much better the trainees did on the Verbal rather than the Quantitative section of the GRE (GREV - GREQ), Millers Analogies Test (MAT) scores, grades in a clinical diagnosis course, and grades in an advanced clinical diagnosis course. Six of these seven predictor variables correlated significantly with EQ (the only one that didn't correlate was GREQ scores). The results indicated that practicum trainees who were older ( $r_{pbi} = .50, p < .01$ ), did well on the GRE Verbal section ( $r_{pbi} = .48, p < .01$ ), did better on the GRE Verbal section than the GRE Quantitative section ( $r_{pbi} = .33, p < .05$ ), had higher scores on the MAT ( $r_{pbi} = .32, p < .05$ ), had higher course grades in Clinical Diagnosis ( $r_{pbi} = .43, p < .01$ ), and had higher course grades in Advanced Clinical

Diagnosis ( $r_{pbi} = .39, p < .05$ ), also had higher EQs. Thus, trainees with higher standardized test scores and higher course grades may have better ability to engage clients in counseling. Limitations of the study include that the clients were all university students, all therapists were trainees, and most clients had a 13-session maximum, so the results may not generalize to other types of clients (e.g., non-university student clients), or other types of therapists (e.g., non-trainee therapists), or to other types of therapy settings, such as longer-term therapy settings. In addition, no effect-size information was reported.

Tryon (1989a) investigated client engagement, post-engagement premature termination, and mutual termination in relation to counselor understanding of, preparation for, and teaching of the client, as well as counselor attractiveness, expertness, and trustworthiness, and duration of the intake interview. Counselors were 5 practicum trainees (4 female, 1 male) and 4 PhD psychologists (3 female, one male). Clients were 308 college students (203 female, 105 male). After the intake session, counselors completed the *Counseling Service Questionnaire – Counselor Version (CSQ-CO)*; Tryon, 1989b), which measures: (a) counselor *understanding* of client experiences and feelings, (b) how *prepared* the counselor is for providing service to the particular client, and (c) how much the counselor *educated* the client or identified additional concerns for which clients had not originally sought counseling. Clients also completed a form after the intake session assessing counselor attractiveness, expertness, and trustworthiness (*Counselor Rating Form-short version; CRF-S*; Corrigan & Schmidt, 1983). In addition, the duration of the initial interview was recorded. Results indicated that the professionals, compared to the trainees, had higher rates of engagement,  $\chi^2(1 \text{ df}, N = 308)$

= 12.3,  $p < .001$ , and lower rates of premature termination,  $\chi^2(1 \text{ df}, n = 150) = 4.94, p < .03$ . Practicum students were more likely to engage clients who had previously sought help at the counseling center,  $\chi^2(1 \text{ df}, n = 212) = 5.02, p < .03$ . Professionals were just as likely to engage new clients as those who had been counseled previously,  $\chi^2(1 \text{ df}, n = 96) = 0.74, ns$ . Significantly more clients returned for counseling after the intake session when counselors rated themselves as having understood the client more,  $F(1, 287) = 13.99, p < .001$ , taught the client more,  $F(1, 287) = 22.91, p < .001$ , and when the intake interviews were longer,  $F(1, 282) = 27.74, p < .001$ . Premature termination was negatively associated with counselor attractiveness, expertness, and trustworthiness for the trainee counselors. However, for the professional counselors, premature termination was *positively* related to counselor attractiveness, expertness, and trustworthiness. This surprising finding may have occurred because the professionals failed to live up to their initially high ratings (premature terminators may have been disappointed in the subsequent sessions after the intake session), or because the clients who terminated prematurely were adequately helped (2 of the 21 premature terminators for professionals wrote thank-you notes indicating they had been helped considerably). Limitations of the study include the small therapist sample; also, the client sample was limited to university students, so the results may not generalize to other non-university-student clients. In addition, no effect-size information was reported. Furthermore, the psychometric properties of the measures (both counselor and client measures) had not been well-established. The measurement of counselor understanding, preparing, and teaching was only rated from the counselor perspective, and does not provide the client perspective on those variables.

Tryon (1989b) investigated the engagement of clients for more than one session in relation to counselor understanding of, preparation for, and education of clients, and duration of the initial interview. In addition, the study investigated the differences between professionals and practicum trainees in the percentage of clients who returned for therapy after the intake session. The study was conducted in a university counseling center. Counselors were 4 practicum trainees (2 male, 2 female) and 5 professional psychologists (2 male, 3 female). Clients were 238 college student clients (154 women, 84 men). After the initial interview, clients and counselors each completed a questionnaire investigating the therapists' understanding of, preparation for, and teaching of the client. In addition, duration of the intake session was recorded by the receptionist from the time the client entered the interview room to when s/he left the room. Results indicated that the professionals had significantly more clients returning for therapy after the initial intake session,  $\chi^2(1, N = 300) = 5.20, p < .03$ . On average, professionals engaged 52% of their clients, whereas practicum trainees engaged 39% of their clients. The professional female counselors were the highest engaging therapists (they had EQs of over 60%, while all other therapists, both professional and practicum, had EQs below 50%). Practicum counselors were more likely to engage clients who had been helped at the counseling center before,  $\chi^2(1 \text{ df}, n = 173) = 5.68, p < .02$ . Professionals were just as likely to engage clients seeking help for the first time as they were to engage clients who had been to the center previously,  $\chi^2(1 \text{ df}, n = 127) = 2.36, ns$ . Results also indicated that therapists perceived themselves as teaching engaged clients more than nonengaged clients,  $F(1, 255) = 16.11, p < .001$ . Engagement interviews (about 52 minutes on average) lasted longer than non-engagement interviews (about 40 minutes on average),

$F(1, 261) = 40.64, p < .001$ . Limitations of the study include the small sample of therapists, that the client sample was limited to university students (the results may not apply to non-university-student populations) in a medium-sized private university counseling center, and that no effect-size information was reported.

Tryon (1990) investigated the relation of client and counselor evaluations of the initial intake interview to client engagement (i.e. client return for another session). The study was conducted in a university counseling center. At the end of the initial session, 5 professionals (3 female, 2 male), 5 practicum trainees (3 female, 2 male), and their 290 college student clients (187 female, 103 male) completed the depth and smoothness indexes of the Session Evaluation Questionnaire (SEQ; Stiles, 1980). Clients also completed the Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979), and counselors completed items from the Pre-Counseling Assessment Blank (PCAB; Gelso & Johnson, 1983). In addition, the duration of the intake interview was determined. Significantly more clients returned for counseling after the intake session when they had longer intake interviews [ $F(1, 237) = 10.63, p < .002$ ], deeper interviews [as rated by both client and counselor;  $F(1, 237) = 7.33, p < .008$  for clients,  $F(1, 237) = 33.88, p < .001$  for counselors], greater client-rated satisfaction [ $F(1, 237) = 6.61, p < .02$ ], greater counselor-rated severity of problems [i.e., disturbance,  $F(1, 237) = 6.81, p < .01$ ], and greater counselor-rated motivation [ $F(1, 237) = 17.69, p < .001$ ]. Limitations include the small therapist sample and the restriction of the client sample to college students, so the results may not apply to non-college student clients. Another limitation was that no effect size information was reported.

Tryon and Kane (1990) examined the relationship between strength of the helping alliance and type of client termination at a university counseling center. Counselors were 5 PhD psychologists (1 male, 4 female) with 9 to 19 years of counseling experience and 10 practicum trainees (7 women, 3 men). Clients were 102 college students (74 female, 28 male). All clients and therapists completed helping alliance measures during the same week during the semester, regardless of how many sessions had progressed in the therapy. The measures were completed after an average of eight sessions. Clients completed an average of 19 sessions. Clients completed the Penn Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986). Counselors completed the Penn Therapist Facilitating Behaviours Questionnaire (TFB; Alexander & Luborsky, 1986). Clients who terminated with mutual agreement of their counselors gave significantly higher alliance ratings than did clients who terminated unilaterally and prematurely,  $F(4, 70) = 3.03, p < .03$ . Notably, counselor ratings of helping alliance were only modestly related to client ratings of alliance,  $r(87 \text{ df}) = .46, p < .01$ , and were not significantly related to the type of client termination. The results indicated that the clients' ratings were predictive of premature terminations,  $F(1, 73) = 9.4, p < .003$ , but counselors' ratings were not. Limitations of the study include the non-standard timing for the completion of the helping alliance measures (e.g., some clients may have completed it after the first session whereas other clients may have completed it after 15 sessions), the results may not apply to non-college student clients, the small sample of therapists, and that no effect-size information was reported.

Pekarik (1992) investigated the post-treatment adjustment of early dropouts versus late dropouts. Clients were 94 outpatients (47 adults, 47 children) at a public



clinic in a medium-sized Midwestern city. Thirteen therapists (mostly master's level) treated the clients. Eight of the thirteen therapists had 4 or more years of experience; the experience level was not reported for the other five therapists. Five therapists had a humanistic orientation and five had a family systems orientation; the other two therapist's orientations were not reported. Adult measures of post-treatment adjustment were: the BSI, a client rating of overall improvement, and a therapist rating of overall improvement. Clients completed the BSI at intake; all the measures of adjustment were completed at a 4-month follow up. In the following report of the results, I only include the results for adults (not the children), since the present study will sample only adults. Results for the BSI indicated that significantly more late dropouts (3 or more visits) were better (his or her score improved from intake to follow up by at least half of his or her gender's intake standard deviation), in comparison to early dropouts (one or two visits),  $\chi^2(1, n = 33) = 3.13, p < .05$ . Results for the BSI scores also indicated that a higher percentage of early drop-outs were worse (by at least half of his or her gender's intake standard deviation) compared to late dropouts at follow-up,  $\chi^2(1, n = 33) = 7.59, p < .01$ . Results for the therapist ratings of overall improvement found that early dropouts had significantly lower ratings than late dropouts,  $t(26) = 2.02, p < .025$ . Results for the adult clients on client ratings of overall improvement comparing the early dropout, late dropout, and completer groups was not significant,  $[F(2, 39) = 1.78, p = .18]$ . Limitations of the study include the limited sample size of clients and limited therapist sample (need to sample therapists with other levels of experience and theoretical orientations). Another limitation was that better statistical methods could have been used for the BSI analyses. The chi-square analyses did not provide information about whether

the scores between the three groups differed on the BSI (which is something that a few t-tests would have done).

Tryon (1992) examined the relationship between engagement and client attractiveness, and also investigated the relationship between therapist EQ, client attractiveness, and client return status. The study was conducted in a university counseling center with 9 female therapists (5 practicum trainees; 4 doctoral-level counseling and clinical psychologists), 1 male therapist (doctoral-level psychologist), and 110 female and 53 male college student clients. Client attractiveness was measured using 7 items from a 15-item modification of the Therapist Personal Reaction Questionnaire (TPRQ) by Davis, Cook, Jennings, and Heck (1977). Clients rated as more attractive were more likely to return after intake,  $F(1, 141) = 5.31, p < .03$ . The investigation of the interaction between therapist EQ, client attractiveness, and client return status showed that therapists with a higher EQ had a greater number of less-attractive clients return for another session than would be expected by chance, while lower-engaging therapists had fewer less-attractive clients return than expected,  $\chi^2(n = 159) = 8.88, p < .04$ . Thus, the less-attractive clients were more likely to return for therapy after seeing therapists who are more skilled at engaging clients than after seeing less-engaging therapists.

Limitations include that the measurement of attractiveness may not be entirely accurate; no psychometric properties were given beyond the alpha coefficient of .89, which indicates that the seven items generally measure the same construct. Additionally, the client sample was again limited to college students, so the results may not be applicable to non-college-student clients.

*Summary.* In summary, there are several things we can learn from the literature on early dropout. First, when dropout occurs, the timing of the dropout makes a difference. Clients who drop out earlier in therapy have worse post-therapy adjustment than clients who drop out later in therapy (Pekarik, 1983, 1992).

Second, an overarching theme in the literature supports the idea that some counselors may be better than others at engaging clients. Counselors who had a higher percentage of clients returning for counseling after the intake session also had more clients who continued for more than ten sessions (Tryon & Tryon, 1986). Furthermore, one study found that higher-engaging counselors had a greater number of less-attractive clients return for another session than would be expected by chance, while lower-engaging counselors had fewer less-attractive clients return than expected (Tryon, 1992).

Third, other counselor variables also influence whether early dropout occurs. Counselors who did better on standardized tests (Tryon & Tryon, 1986), who had higher grades in clinical diagnosis courses compared to their counterparts (Tryon & Tryon, 1986), who were more able to identify additional concerns for which the client had not originally sought therapy (Tryon, 1986), who were more interested in seeing the client (Tryon, 1986), who were more understanding of their client (Tryon, 1989a), and who taught and instructed their clients more during the intake session (Tryon, 1989b), had lower rates of dropout.

Fourth, factors such as client, session, and therapeutic relationship factors also affect early dropout. Clients who had greater severity of client concerns (as rated by counselors; Tryon, 1986, 1990) and greater motivation (as rated by counselors; Tryon, 1990) were more likely to return for therapy after attending an initial intake session.

Sessions that were longer (Tryon, 1989a, 1989b, 1990), deeper (Tryon, 1990), and more satisfying to clients (Tryon, 1990) were more likely to result in clients returning for therapy rather than dropping out. Higher client-rated helping alliances also made early dropout less likely (Tryon & Kane, 1990).

Several limitations can be noted in the existing research on early dropouts. The studies have all been conducted at university counseling center settings with university student samples, so the results may not apply to long-term therapy settings. In addition, few of the studies reported enough information to determine effect-sizes, so it is difficult to estimate how large of an effect the studies found. Furthermore, of the studies using intake-only dropouts, continuers were defined as those attending therapy beyond one session after the intake, which is a poor indicator of whether the continuers actually “bought” into the therapeutic treatment. Furthermore, few studies have investigated therapist verbal behavior in intake sessions, which is an important predictor variable given that therapists can only influence their clients through their verbal or nonverbal behaviors.

### **Therapist Techniques**

**Definition of therapist techniques.** Therapist techniques are defined as tools or methods employed by therapists to facilitate effective therapy or positive behavior change in clients (Harper & Bruce-Sanford, 1981). Therapist techniques can be operationalized in various ways (e.g., Highlen & Hill, 1984; Schaffer, 1982): in terms of type or content, verbal versus nonverbal expression, intentionality, the manner in which the technique is implemented (e.g., level of warmth, empathy, and genuineness), and the

quality of the technique (e.g., appropriate timing, matching the needs of the client) (Hill, 2005).

Hill (1982) proposed that one can analyze therapist behaviors at six levels, ranging from the most observable and easily rated to the more abstract and inferential categories. The six levels are: (a) ancillary behaviors (extralinguistic, linguistic, nonverbal, and physiological), (b) response modes (i.e., helping skills), (c) content (topic of discussion), (d) ratings of behavior (attituded, involvement), (e) covert behaviors (thoughts, perceptions, feelings, attitudes), and (f) clinical strategies (interventions, techniques). Overriding these six levels would be the philosophical or theoretical approach of the therapist (Hill, 1982). Thus, verbal response categories (or helping skills) are among the more observable and easily rated methods for analyzing therapist behaviors.

There are two common ways of systematizing therapist techniques: molecular methods (examining therapist techniques on a phrase, sentence, or speaking-turn level) and molar or global methods (examining therapist techniques across larger segments or sessions) (Hill & Williams, 2000). The most typical molecular method for measure therapist techniques focuses on verbal response modes, which are types of therapist verbal responses independent of the topic or content of the speech (Hill, 1986). Examples of verbal response modes are: open questions, reflections of feeling, interpretation, and direct guidance (Hill & Williams, 2000). Elliot et al. (1987) compared six widely used response modes systems and found that six response modes (question, information, advisement, reflection, interpretation, and self-disclosure) were included in all six systems and could be reliably assessed.

Molar or global methods, on the other hand, assess therapist techniques through global ratings after watching entire counseling sessions, or larger segments of sessions. Examples of molar methods include measures that estimate how frequently techniques were used in entire sessions (e.g., The Therapeutic Procedures Inventory-Revised; TPI-R; McNeilly & Howard, 1991), and rankings of how much each technique is used relative to other techniques (e.g., Q-Set; Jones, Cumming, & Horowitz, 1988).

Heaton, Hill, and Edwards (1995) compared the molecular (HCVRCS; Hill, 1993) and molar (TPI-R and Q-Set) approaches and found that the directive, paraphrase, and interpretation clusters of items on the two molar measures (Q-Set and TPI-R) were significantly related to each other, but neither were related to the corresponding HCVRCS categories, which suggests that the molar and molecular methods assess different things. Molecular methods allow for greater specificity than molar measures and allow researchers to study the immediate effects of interventions, while molar methods allow for the assessment of variables that occur across longer periods of time (Hill & Williams, 2000). Molecular methods of teaching therapist techniques may be beneficial for doctoral training programs in therapy. Indeed, Hill, Stahl, and Roffman (2007) point out the usefulness of teaching therapist techniques at a micro level since it allows students to learn or improve their abilities in a helpful manner while decreasing problematic or unhelpful behaviors (e.g., interrupting, excessive talking, promiscuous self-disclosure, and advice-giving).

Thus, there are both advantages and limitations when using the Helping Skills System (HSS; Hill, 2009). Advantages include that it allows for greater specificity than more global methods of analyzing therapist techniques, it allows for micro-analysis of

therapist behaviors which may be beneficial for the training of therapists, and since it is an observer-rated measure, the ratings may be more objective. However, the HSS does have limitations as well. Since it only measures verbal response modes, it does not provide information about therapist non-verbal behavior, the topic of what is being talked about during therapy sessions, or covert processes (attitudes, intentions, etc.). In addition, since the HSS is an observer-rated measure, it does not provide information from the perspective of the therapist or the client.

**History and development of the HCVRCS/HSS.** The HSS was originally developed in 1978 as the Counselor Verbal Response Category System (Hill, 1978). The system was developed to classify the different types of therapist verbal responses during a counseling session. The categories are intersubjective, meaning that they are based on the syntactic or grammatical structure of the language, which implies a relationship between the communication and the recipient (e.g., a question), rather than based on the topic of discussion or the extralinguistic characteristics (e.g., vocal noises, tonal qualities, speech disfluencies) of therapist verbal communications (Hill, 1986).

The original HCVRCS (Hill, 1978) was developed by incorporating components from 11 existing systems in six stages. In the first stage, two people examined similarities and differences between the categories in the 11 systems and found that all the categories in the 11 systems could be covered by 25 distinct categories (e.g., reassurance, persuasion). Definitions were written for each category, and several examples from the 11 systems were included in the description of each category. In the second stage, two judges used the 25-category system to categorize counselor responses on two practice sessions and deleted two categories and added one category (deleted

inaccurate clarification of feelings because judges felt accuracy could not be determined and interpretive summaries because they could not be differentiated from interpretations, and added nonverbal referents because of the frequency with which counselors referred to nonverbal behavior), resulting in a second version with 24 categories. In the third stage, two judges categorized responses from tapes and transcripts of five additional practice sessions, refined the definitions, added additional examples from the sessions, and added an additional category. When using the third version of the system with two additional practice sessions, the same two judges obtained an 80-90% interjudge agreement on categorizations. In the fourth stage, three experienced PhD counseling psychologists were given the definitions and asked to match the examples with the appropriate definitions. Since only half of the examples were matched to the same definition by at least two of the three psychologists, a revised fourth version was made by integrating the categories with least agreement (reassurance, asides, persuasion, direction within the session, probe for feelings, noninterpretive summary, clarification of un verbalized feelings, and immediacy) into other categories. In the fifth stage, the same 17 categories were retained and slightly reworded, while only the examples with the highest interjudge agreement were kept. The fifth version was given to 10 counseling psychology graduate students who matched the examples to the definitions. Only the examples with at least 8 out of the 10 graduate students matching the same definition to the example were retained; 83% of the examples were kept in the fifth version. The fifth version had 17 mutually exclusive categories with at least minimal face and content validity. The fifth version was used to rate 3,866 counselor response units from 12 personal/emotional intake sessions, with inter-judge kappas of .79, .78, and .81 for all three possible pairings



of the three judges. Based on an examination of the results, the category of Structuring was collapsed into the category of Information, while Friendly discussion, Criticism, and Unclassifiable were collapsed into a category called Other. Thus, the 1978 published version of the HCVRCS contained 14 categories: minimal encourager, approval-reassurance, information, direct guidance, closed question, open question, restatement, reflection, nonverbal referent, interpretation, confrontation, self-disclosure, silence, and other.

The HCVRCS was revised a number of times before the most recent 2009 version. A 1981 version appeared as the *Manual for Hill Counselor and Client Verbal Response Modes Category Systems* (Hill et al., 1981). In 1985, a revised version appeared as the *Manual for Counselor Verbal Response Modes Category System (revised version)* (Hill, 1985). In 1993, the updated version appeared as the *Manual for Hill Counselor Verbal Response Category System* (Hill, 1993). Another revision of the system was included in the publication of the first Helping Skills textbook (Hill & O'Brien, 1999) and the name of the system changed from the HCVRCS to the Helping Skills System (HSS). In 2009, for the third edition of the Helping Skills book, four subtypes of open questions and three subtypes of self-disclosures were added, resulting in the Hill (2009) system. The most recent version of the HSS (Hill, 2009; see Webform E at <http://forms.apa.org/books/supp/hill3/index.cfm?action=students&article=3>) will be used for the present study.

**Studies using the HCVRCS/HSS.** In this section I describe some of the studies that have been done using the HCVRCS/HSS to provide some context for understanding the HSS. This section will not contain studies using the HCVRCS/HSS that investigate

helping skills used in intake sessions; those studies will be included in later sections. At the end of this section, I provide a summary paragraph of the findings and limitations in the literature.

Hill, Thames, and Rardin (1979) compared three male therapists, Rogers, Perls, and Ellis, using the HCVRCS (Hill, 1978). There was just one female client, Gloria. Rogers, Perls, and Ellis each conducted separate demonstration first sessions with Gloria. Three judges (one male graduate student, one female graduate student, one female faculty member in counseling psychology) were trained until they reached 95% agreement on practice transcripts from another study. Rogers used mainly minimal encouragers, restatements, interpretations, reflections, and information. Perls employed mostly direct guidance, information, interpretations, open questions, minimal encouragers, closed questions, confrontations, approval-reassurance, and nonverbal referents. Ellis seemed to be the most active compared to the other counselors, using mostly information, direct guidance, minimal encouragers, interpretations, closed questions, and restatements. Relatively high inter-judge agreement levels were obtained (interrater kappas for all possible combinations of the three judges were .68, .71, and .73). The results provide evidence that the HCVRCS is able to distinguish behavioral differences in theoretical orientations between counselors. Limitations include the very small sample size – there was only one female client with her unique presenting concerns, so the results may not be applicable to other women (because she is only one woman out of millions of women in the United States), or to male clients, or to clients with other presenting concerns or other individual client differences. Since only one therapist from each theoretical orientation was represented, the results may not generalize across all therapists for a particular

theoretical orientation. Furthermore, since all the therapists were men, it is possible that the results would not be applicable for female therapists.

Hill, Carter, and O'Farrell (1983) was the first study to use predominant coding with the HCVRCS/HSS. This study examined the process and outcome of a 12-session case of counseling. The client was a 20-year-old white female senior at a large university. The counselor was a 31-year-old PhD counseling psychologist with 5 years of postdoctoral experience in counseling. The HCVRCS (Hill, 1978, Hill et al., 1981) was used to analyze counselor response modes each of the 12 sessions. The Client Verbal Response Category System (Hill et al., 1981) was used to analyze client response modes in each of the 12 sessions. The client response mode measure includes nine nominal, mutually exclusive categories: simple responses, requests, description, experiencing, insight, discussion of plans, discussion of client-counselor relationship, silence, and other. The Client Verbal Response Category System has demonstrated adequate face and content validity, and high inter-rater agreement levels have been obtained in previous studies. Other process and outcome measures were also used but are not as relevant to the present study; they can be found in the original Hill et al. (1983) article.

For the Hill et al. (1983) analyses, the regular unitizing method was used with the HCVRCS for comparing the first four sessions to the last eight sessions; predominant coding was used only for sequential analysis of the immediate effects of the counselor response modes on the client responses. Results indicated that counselors used more minimal encouragers in the first four sessions compared to the last eight sessions, and more information and interpretation in the final eight sessions compared the first four sessions (here, "more" means the difference exceeded one standard deviation). Minimal

encouragers decreased from the first four sessions to the last eight sessions,  $t(11) = 6.49$ ,  $p < .01$ . Counselor use of silence increased from the first four to the last eight sessions,  $t(11) = 2.38$ ,  $p < .01$ . Counselor use of interpretation also increased from the first four sessions compared to the last eight sessions,  $t(11) = 3.87$ ,  $p < .01$ . Counselor verbal activity level (i.e., the ratio of the number of words spoken by the counselor to the total number of words spoken by both client and counselor) also increased from the first four sessions compared to the last eight sessions,  $t(11) = 4.80$ ,  $p < .01$ .

Predominant coding in the Hill et al. (1983) study was used for simplifying the statistical sequential analysis of the immediate effects of counselor response modes on client response modes. For predominant coding with the HCVRCS, when the counselor used more than one response unit in a speaking turn, and the units were of different categories, the last response mode of the series was used (unless it was a tacked-on question, such as, “isn’t it?”) and the more complex response (for example, interpretation rather than a closed question) was selected. For this analysis, only the first two client response units following the counselor response were analyzed. For the counselor response modes, minimal encouragers (which seem to have a different linguistic structure than other counselor response modes), nonverbal referent, self-disclosure, and other were excluded in the analysis (the latter were excluded due to their infrequent occurrence). For the client response modes, simple responses, requests, discussion of plans, discussion of client-counselor relationship, silence, and other were excluded for similar reasons.

Results of the Hill et al. (1983) sequential analysis found that: Description was most likely to occur after closed questions and least likely to occur after direct guidance and interpretations, Experiencing was most likely to occur after silence and least likely to

occur after closed questions, and Insight occurred rarely – when it did occur, it was in the first unit after silence or the second unit after open question or confrontation. Limitations of the Hill et al. (1983) study include the sample size of just one client and one therapist in a time-limited therapy setting, so the results might not apply to long-term therapy settings, and the results may not apply to clients or therapists of: other genders (i.e., male clients or male therapists), other ages, different therapy experience backgrounds (for clients, amount of previous therapy experience; for therapists, amount of experience providing and receiving therapy), different presenting problems (for clients), and various other demographic differences.

Elliott et al. (1987) examined six therapist response-mode rating systems to (a) compare their interrater reliabilities, (b) seek a common set of primary modes, and (c) assess the discriminant validity of the primary modes. Seven therapy sessions with seven different therapists were rated: (1) an initial session demonstrating deconditioning of stuttering with a young woman using a *behavioral* approach (Brady, 1983), (2) the 15<sup>th</sup> session of a *rational-emotive* therapy with a young male homosexual (Ellis, 1983), (3) the 5<sup>th</sup> session of a 12-session time-limited *relationship-insight-oriented* treatment of a female college student (Hill et al., 1983), (4) an initial session of *conversational* therapy (a relationship-dynamic treatment conducted by its originator; Hobson, 1982), (5) a Jungian *dream analysis* with a male client (Progoff, 1983), (6) the 17<sup>th</sup> session of a *client-centered* treatment with a young woman (Rogers, 1983), and (7) an intake session conducted by a *gestalt-dynamically* oriented counseling center therapist with a male client who had procrastination problems (Hill, 1978). The six response mode systems that were used in the study included: (1) Hill's Counselor Verbal Response Mode

Category System (Hill, 1978), (2) Friedlander's (1982) refinement of Hill's (1978) rating system, (3) Stiles' Verbal Response Mode System (Stiles, 1978, 1979), (4) Elliott's Response Mode Rating System (Elliott, 1985), (5) The Conversational Therapy Rating System (i.e. the Margison system; Goldberg et al., 1984), and (6) Mahrer's Taxonomy of Procedures and Operations in Psychotherapy (Mahrer, 1983).

The Hill (1978) system used in the Elliot et al. (1987) study included 14 mutually exclusive categories and each response unit was defined as a grammatical sentence (with brief phrases such as "mm-hmm" and "yes" treated as separate units). Unitized transcripts were rated independently by three trained undergraduates and final ratings were based on agreement by two of the three judges with three-way disagreements resolved by discussion.

Friedlander's (1982) rating system that was used in the Elliot et al. (1987) study included nine mutually exclusive categories and had the same scoring units as the Hill (1978) system except each unit must contain a verb phrase (phrases like "uh-huh" were not rated and compound predicates were scored separately). Unitized transcripts were rated by three raters and procedures for resolution of disagreements were identical to those of Hill (1978).

Stiles' (1978, 1979) system that was used in the Elliot et al. (1987) study included eight mutually exclusive categories with the unit defined as the independent clause or nonrestrictive dependent clause; three trained undergraduates unitized and rated transcripts, and two-out-of-three convention was used for final ratings with three-way disagreements defined as unclassifiable.

Elliott's (1985) system used in the Elliot et al. (1987) study consisted of 10 nonmutually exclusive dimensions rated using 0-3 confidence ratings; although the unit is flexible, for this study Hill's (1978) units were used; unitized transcripts and tapes were rated by rescaling confidence ratings to 0-1 scales, then averaging the ratings across four raters (3 undergraduates and coauthor Friedlander).

The Margison system (Goldberg et al., 1984) used in the Elliot et al. (1987) study included 11 mutually exclusive function categories rigidly defined by formal cues. Final ratings represented a combination of ratings by two judges (a research assistant and a coauthor Margison).

The Mahrer (1983) system that was used in the Elliot et al. (1987) study contained 35 mutually exclusive categories with the unit defined as the therapist's speaking turn. Eight to 12 raters (graduate students and coauthor Mahrer) rated each session from tapes and transcripts, and disagreements (less than 50% agreement) were resolved by re-rating responses or by labeling responses as unclassifiable.

Results of Elliot et al. (1987) showed that interrater reliabilities for the six systems generally were similar when used to rate the seven diverse therapy sessions (correlations were calculated between each pair of raters for each category or dimension in each system, then the means were calculated for each category from each system). Results of Elliot et al. also demonstrated moderate to strong convergence for the six modes that were rated in all of the systems (question, information, advisement, reflection, interpretation, and self-disclosure). Reassurance, confrontation, and acknowledgment were not rated by all six systems.

Furthermore, the results of Elliot et al. (1987) indicated that these six modes did discriminate among the seven diverse therapeutic approaches – each of the seven therapists showed a unique pattern of response modes that differed significantly from the other therapists. Brady (a behavior therapist) used more information and advisement but less reflection, interpretation, and confrontation compared to the other therapists. Progroff also used more information but less advisement and confrontation compared to the other therapists. Tanney (gestalt/dynamic therapist) used more information, self-disclosure, and questions, and avoided using reflections and interpretations, compared to the other therapists. Rogers used more reflection than any other therapist. Hill had relatively high use of interpretation and reflection which is consistent with her bridging of the relationship and dynamic therapy traditions. Ellis had a uniquely high use of reassurance and confrontation but gave less information and self-disclosures. Hobson did not use any particular response mode more often, but did use less information compared to the other therapists.

Limitations of the Elliott et al. (1987) study includes its limited sample size of seven therapy sessions, and non-standardized use of coauthors as raters (the latter three systems used a coauthor as a rater but the first three systems used mainly undergraduate student raters, which may affect how accurately the raters used the system). In addition, only one client per therapist was used, and the clients were not comparable in age, gender, and presenting problem(s).

Hill et al. (1988) studied the effects of counselor response modes in brief psychotherapy. 8 therapists (4 male, 4 female) served as counselors for this study; their ages ranged from 34 to 78 years, and they had 5 to 42 years of experience. Clients were



8 women who were interviewed to determine whether they were appropriate and motivated for brief therapy; all 8 women had valid profiles on the MMPI and elevated scores on the scales of Depression and Psychasthenia. The primary diagnoses as judged by the researchers based on the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1981; *DSM-III*) were dysthymic ( $n = 5$ ), generalized-anxiety ( $n = 2$ ), and cyclothymic ( $n = 1$ ) disorders. Judges for the therapist response modes were 9 undergraduates (6 women, 3 men). Counselors conducted 12 to 20 counseling sessions (about 50 minutes per session) with their assigned clients. All sessions were videotaped. After each session, clients and counselors watched the videotape of the session. Both clients and counselors rated the helpfulness of each therapist speaking turn on a 9-point scale (Helpfulness scale; Elliott, 1985; Elliott, Barker, Caskey, & Pistrang, 1982). Clients also rated their reactions from the Client Reactions System (Hill et al., 1988), whereas counselors indicated up to five intentions for each speaking turn (Therapist Intentions List; Hill & O'Grady, 1985), and observers rated the peak client experiencing level on a 7-point scale (Client Experiencing scale; Klein, Mathieu, Gendlin, & Kiesler, 1970; Klein, Mathieu-Coughlan, & Kiesler, 1986). Results indicated that response modes were significantly related [Pillai's  $F(24, 48780) = 23.46, p < .001$ ] to the three immediate outcome measures. Self-disclosure, interpretation, approval, and paraphrase were the most helpful response modes. The amount of unique variance accounted for by response modes was about 1%, which is substantial considering that frequently more than one type of response mode was used per counselor speaking turn, that other process variables that interact with response modes (such as counselor intentions, counselor nonverbal behaviors, etc.) were not considered,

and that contextual variables (e.g., stage in therapy, client state) were not considered. Results also showed large individual differences in the frequency of use and effectiveness of the response modes for different clients. Limitations of the study include its limited sample size of 8 female clients in brief therapy, which means the results may not apply to female clients in general, male clients, or clients in long-term therapy.

Hess, Knox, and Hill (2006) studied the effects of three types of training (supervisor-facilitated training, self-training, and biblio-training) on graduate student therapists' use of reflections and immediacy with videotaped vignettes of angry clients. 62 (40 female, 22 male; age range 22-57 years old) master's and doctoral graduate student therapists from counseling-related programs in three universities served as participants. Three female European American faculty members (the authors of the study) served as supervisors. The supervisors were primarily humanistic in their theoretical orientation. Judges consisted of three female master's degree students in counselor education with prior helping skills training. The average kappa between pairs of judges was .91. The Hill and O'Brien (1999) version of the HSS was used; this study focused only on the proportions of reflection of feelings and immediacy because these were the focus of the supervision. The therapists were randomly assigned to one of six different sequences for types of training. After each type of training, therapists watched a randomly assigned vignette and wrote interventions at each of the five pauses in the vignette. Results showed that for reflections, supervisor-facilitated training led to more reflections than self-training (there were no statistically significant differences found for the other two comparisons). For immediacy, no statistically significant differences between the three types of training were found. Limitations include that the training only

lasted 20 minutes for each type, trainees wrote rather than verbalized their interventions, trainees only had 30 seconds to write their interventions, the client situations were simulated rather than actual clients, there was no control condition (i.e. a group that received no training whatsoever), and the results may not apply to actual psychotherapy cases due to the analogue design of the study.

Goates-Jones and Hill (2009) examined the timing and effectiveness of therapist response modes. Clients were 26 female undergraduate students, and all clients were moderately anxious on the Beck Anxiety Inventory (Beck & Steer, 1990). Therapists were 13 female doctoral student therapists, who had received at least one semester of pre-practicum training in the Hill (2004) helping skills model. Judges were six upper level undergraduates (five female, one male), and the primary investigator (female). Average kappas between pairs of judges for the predominant judgments were .98. Each therapist saw two clients for one session that lasted 60-90 minutes. Clients and therapists rated the helpfulness of each therapist response unit on a 9-point scale when reviewing the sessions on videotape. Three judges coded client narrative modes for each client speaking turn using the *Narrative Process Coding System* (NPCS; Angus, Hardtke, & Levitt, 1996). There are three narrative types in this coding system: external (providing an overview of events), internal (elaborating on experiences and feelings), or reflexive (giving and interpretive analysis of events or experiences). Results showed a statistically significant overall association between therapist response modes and subsequent client narrative modes, [ $\chi^2(8) = 93.46, p < .001$ ]: clients used more internal or reflexive narrative processing modes when therapists used open questions about feelings and reflections of feelings. Clients often used an internal mode in response to therapist use of reflections of

feelings (31% of the cases, with no cases showing the opposite pattern) or open questions about feelings (15% of the cases, with no cases showing the opposite pattern). No overall association was found between client narrative processing modes and subsequent therapist verbal response modes. No differences in client and therapist helpfulness rating for the therapist response modes or the client narrative process modes were found. Limitations include that the significant findings only were driven by the data for less than one-third of the cases. Also, since the sample was limited to female clients and female therapists, the results may not be applicable with male clients and/or male therapists.

*Summary.* In summary, studies using the HCVRCS/HSS have examined the effects of helping skills on a number of variables. Helping skills have been shown to have a significant relationship with immediate outcome (Hill et al., 1988). Certain types of helping skills have been shown to increase or decrease over the course of therapy (Hill et al., 1983), and are related to client response modes (Hill et al., 1983; Goates-Jones & Hill, 2009).

In addition, the HCVRCS/HSS has demonstrated good psychometric properties. Evidence that the HCVRCS/HSS is able to distinguish behavioral differences in theoretical orientations between therapists is supported by the Hill et al. (1979) finding that the HCVRCS was able to distinguish different response mode styles between Rogers, Perls, and Ellis (each therapist used response modes that were generally consistent with their theoretical orientations), and by the Elliot et al. (1987) finding that the HCVRCS was able to distinguish unique patterns of response modes for seven therapists of differing theoretical orientations. Convergence validity was demonstrated in the Elliot et al. (1987) study, which found that six of the response mode categories from the HCVRCS

corresponded to similar categories in five other response modes systems. High inter-rater reliability has been found with using the HSS – average kappas between pairs of judges was .91 in one study (Hess et al., 2006) and .98 in another study (when using predominant units; Goates-Jones & Hill, 2009).

Another finding is that some training methods may be more effective than others. Supervisory training, rather than self-training or biblio-training, was more effective at training counselors to use reflections and immediacy (Hess et al., 2006).

However, a limitation is that many of the studies have small sample sizes, in part due to the amount of time it takes to do studies using the HCVRCS/HSS. In addition, few studies have investigated helping skills in relation to dropout, or in relation to early dropout.

### **Intake Sessions**

**Conceptually-derived helping skills patterns expected in intakes.** In this subsection, I summarize what several authors have written about the process of intake sessions and synthesize their perspectives with the helping skills system by indicating what helping skills I would theoretically expect in intake sessions based on their perspectives. Concluding this subsection is a paragraph synthesizing the various predictions based on what the various authors have written about the process of intakes.

According to Willer (2009), the four most important goals for seeing a client for the first time are to: establish rapport, obtain informed consent including providing information on confidentiality, determine the presenting problem, and evaluate the client for suicidality and other crises. Also, three additional goals should be accomplished in most initial sessions: diagnose any mental illnesses, give feedback to the client about

diagnosis and treatment, and make referrals. Willer also included two additional goals if there is time after covering the first seven goals: obtain an overview of current life problems the client is having, and gather social, medical, and mental health histories (includes information-gathering about psychological symptoms over time and past involvement in mental health care). According to Willer, the order of the tasks would ideally proceed according to the following: start the session, obtain informed consent/provide information about confidentiality and provide an opportunity for questions; establish rapport; determine the presenting problem; obtain an overview of client's current life problems; diagnose any mental illnesses; assess for suicide and other crises; obtain social, medical, and mental health histories (including information about psychological symptoms over time and past mental health care); provide feedback to client about diagnoses and treatment; make referrals; and end the session.

Based on Willer (2009), I can make several predictions about the helping skills patterns to be expected in intake sessions. Open questions and closed questions might especially be used early on when obtaining information about the client's problems, symptoms, and histories. Information about the process of helping may be used early on when obtaining informed consent and providing information about confidentiality. Establishing rapport might occur throughout with self-disclosures of facts, (e.g., "I have 3 years of experience providing psychotherapy"), restatements, reflections, or interpretations. Information in the form of facts/data/opinions may be used toward the end to provide information about diagnoses, treatment, and referrals. Perhaps clients would be more likely to drop out if the therapist asks too many closed as compared with open questions; does not provide facts about him/herself that help to establish credibility;

does not provide restatements, reflections, or interpretations; and does not provide information relevant to the treatment of the client's problems.

Cavanagh and Levitov (2002) also discussed intake sessions. They located intake interviews as part of the information-gathering stage among six stages of counseling: Therapeutic Alliance (Stage 1), Information Gathering (Stage 2), Evaluation and Feedback (Stage 3), Counseling Agreement (Stage 4), Change(s) in Behavior (Stage 5), and Termination (Stage 6). They stated that an intake interview is one of the most common ways of obtaining information from clients, and that the intake process may take three sessions (gathering information, making diagnoses and formulating treatment recommendations). They noted that closed questions can be efficient and direct, but can limit the amount of information gathered: "the posing of specific questions illuminates some aspects of the client's life but leaves others in darkness" (p. 27). In contrast, open questions that are non-directive allow more of the client's values and priorities to surface, and allow clients to provide the information in the way that is most meaningful to them, rather than in a form structured by the counselor. Closed questions may be necessary to obtain specific, important pieces of information (for example, with a potentially suicidal client, asking whether a client has weapons in his/her home), whereas open questions may allow clients to explore their thoughts and feelings about their issues in more depth.

Based on Cavanagh and Levitov (2002), I surmise that the basic tasks of the initial intake session might involve alliance-building (Stage 1), information gathering (Stage 2), as well as making diagnoses and formulating treatment recommendations. Alliance-building could involve restatements, reflections, self-disclosure of facts enhancing a counselor's credibility, approval-reassurance, interpretations, information in

the form of facts/data/opinions relevant to helping the client with his/her presenting concerns, or information on how therapy might help the client. Information-gathering, making diagnoses, and formulating treatment recommendations might involve using open and closed questions to gather the required information. Communicating diagnoses and treatment recommendations might involve providing information to the client about the process of helping, or providing information in the form of facts, data, or opinions.

Hill (2009) also discussed the sequential tasks involved in a first session as well as an intake protocol for helpers (“helpers” is the term used in Hill, 2009 to refer to counselors or psychotherapists). In starting a first session, the helper first provides information about the helping process (e.g., “We have 30 minutes to talk today, and we can talk about whatever you would like to talk about”), then they might briefly self-disclose about their credentials or background as helpers, explain the logistics of therapy (confidentiality, length of sessions, cost, etc.), ask clients whether they have any questions about what to expect from the helping process and answer questions about the helping process, and then ask an open question (e.g., “What would you like to talk about?”) to encourage clients to share their concerns. Helpers might provide encouragement via approval and reassurance at any time that seems clinically appropriate. After starting the session, helpers clarify the client’s goals and expectations for the helping process. Next, helpers focus on a particular problem to work on. Finally, helpers end the session by leaving 5 or 10 minutes for allowing the client to express important feelings s/he hasn’t expressed thus far, or ask how clients felt about the session and the work that was done. In intake sessions done in many mental health clinics, Hill noted that the purpose of the intake is to gather information (about client demographics,



presenting concerns, psychosocial history/background information pertinent to presenting problem, health and medical history, defining the client's problem, and risk factors), but she also noted that it is important to use attending and exploration skills (e.g., reflections of feelings, restatements) to help the client to feel comfortable.

Based on Hill (2009), certain patterns of helping skills might be expected in a good intake session. In the first third of the session, it makes sense that therapists would use information about the process of helping, self-disclosure of facts, and a few closed questions and open questions. In the middle of the session, open and closed questions might be used to gain information about the client, while reflections, restatements, and approval-reassurance might be used for exploring the client's concerns and history and discussing the presenting problems. In the last part of the session, some open questions about feelings or thoughts about the helping process, a summary of what was accomplished in the session, and/or information in the form of facts, data, or opinions relevant to the client's presenting concerns might be provided.

**Summary.** In sum, based on these three how-to descriptions of intake sessions, it appears that is important to: establish rapport/build an alliance; explain important aspects about the therapy process (confidentiality, informed consent, etc.); gather information and history relevant to the client's problems; assess for suicidality/other crises; and provide diagnostic, treatment, and/or referral information as appropriate. The helping skills that might be expected to occur in the first third are: information about the therapy process (for informing the client about confidentiality, informed consent, or therapy logistics), self-disclosure of helper's background (as relevant to building credibility or building the alliance), approval-reassurance (for alliance building; communicates

acceptance of the client), reflections and restatements (for alliance building and to facilitate information-gathering; if done well help the client feel understood and facilitate information-gathering), closed and open questions (for information-gathering), and information in the form of facts/data/opinions (for diagnostic, treatment, and/or referral information conveyed to the client). Helping skills that might be expected in the middle third of the intake include open and closed questions (to gain information about the client), and reflections, restatements, and approval-reassurance for exploring the client's concerns, history and presenting problems. Skills that might be expected in the last third of the session include: some open questions about feelings or thoughts about the helping process, restatements of what was accomplished in the session, and/or information in the form of facts, data, or opinions relevant to the client's presenting concerns. With intake-only dropouts, perhaps certain skills may be used in too small quantities or may have been poorly timed.

**Studies reporting overall proportions of helping skills used in intakes.** In this section, I review articles that report overall proportions of helping skills used in intake sessions. After reviewing each article in turn, I then summarize the findings and limitations of this literature.

Friedlander (1982) revised the HCVRCS. The revision of the HCVRCS contained nine categories: encouragement/approval/reassurance, reflection/restatement, self-disclosure, confrontation, interpretation, providing information, information seeking, direct guidance/advice, and unclassifiable. Clients were 17 undergraduates seeking help for personal and vocational problems, and counselors were 11 doctoral student trainees at a counseling psychology training agency. No other demographic data on clients or

counselors was reported. Minimal face and content validity was achieved by having three psychologists match samples to the definitions with near perfect agreement. Cohen's kappa for the two judges was .83 on the practice data and .85 on that actual data. Results indicated that, in the intake interviews, encouragement/approval/reassurance was used 34% of the time, reflection/restatement 21% of the time, self-disclosure 2% of the time, confrontation 3% of the time, interpretation 3% of the time, providing information 17% of the time, direct guidance/advice 6% of the time, information seeking 38% of the time, and unclassifiable less than 1% of the time. Thus, the most used skills in the intake sessions were information-seeking, reflection/restatement, providing information, and to some extent, encouragement/approval-reassurance. Limitations of the study include the small sample size, the use of only doctoral therapists-in-training for the therapist sample, very little information about the judges (the article did not indicate the gender, age, or theoretical orientation information for the judges), the lack of demographic information reported for clients and therapists, and the lack of information about therapists' theoretical orientations and experience levels.

Lee, Uhlemann, and Haase (1985) used the HCVRCS-R (Friedlander, 1982) in investigating counselor verbal and nonverbal responses in relation to client-perceived expertness, trustworthiness, and attractiveness. Clients were 47 first-year university students (20 male, 27 female) who volunteered to participate in the study. Counselors were 47 volunteer counselor trainees (17 male, 30 female; age ranged from 23 to 35, median age of 25.3, experience in counseling ranged from 0 to 5 years; all had completed at least one counseling practicum course) in their first or second year of master's level training in counseling. Clients and counselors were randomly matched. The initial

intake interviews lasted 20 minutes – however, only the first 15 minutes of each interview was videotaped and analyzed. Judges were one male and one female graduate student, who were trained until they agreed on 85% of the units classified. Agreement levels between judges prior to discussion ranged from 71% to 98% on individual transcripts, with a median of 89%. After discussion, inter-judge agreement ranged from 91% to 100% on individual transcripts.

Analyses of the verbal response category data in Lee et al. (1985) found that the beginning counselors primarily used reflection/restatement (43%), information seeking (29%), and providing information (14%). Compared to well-known counselors such as Rogers, Perls, and Ellis (see Hill et al., 1979), the beginning counselors in this study used more information-seeking responses. Limitations of the study include that only the first 15 minutes of the sessions were analyzed, that the intake sessions only lasted 20 minutes in duration, and that both clients and counselors were volunteers for the study (the findings might not represent real-life therapy settings).

***Summary.*** In sum, the most-used skills in intake sessions with doctoral student counselors are information-seeking and reflection/restatement (Friedlander, 1982; Lee et al., 1985). The third most-used response mode in both studies was providing information (Friedlander, 1982; Lee et al., 1985). Limitations in both studies include the small sample size of clients, a lack of information about the theoretical orientation of the judges, and that the therapist sample was limited to counselors-in-training.

**Studies reporting helping skills used in thirds of intakes.** In this section I review the literature on helping skills used in thirds of intake sessions. I only found three articles: Hill (1978); Lonborg, Daniels, Hammond, Houghton-Wenger, and Brace

(1991); and Tryon (2003). At the end of this section, I summarize the relevant findings and limitations of this literature.

Hill (1978) examined helping skills used over thirds of intake sessions. Counselors were six PhD counseling psychologists (3 male, 3 female) with 1 to 11 years of full-time postdoctoral experience; their theoretical orientations were as follows: two were mostly phenomenological, one was mostly gestalt, one was mostly psychoanalytic, and two were combinations of phenomenological, gestalt, and psychoanalytic orientations. Clients were 12 university students (6 male, 6 female). Three judges (one female PhD counseling psychologist, two female undergraduate psychology majors) categorized the therapist verbal responses for this study. Each counselor conducted an intake session with one male and one female. No sharp distinction existed between intake interviewing and counseling at the counseling center, although the emphasis in intake was on a better understanding of the problem and the formulation of a treatment plan. The length of the sessions ranged from 16 to 66 minutes ( $M = 40:30$ ,  $SD = 15:48$ ). Judges were trained until they unanimously agreed on 80% of the categorizations. Each session was divided into thirds based on duration of the session. Counselor verbal activity (i.e. how much a counselor talks in comparison to the client) was examined by comparing the number of counselor response units per third of each session to the number of client response units. Arc sine transformations were done on all counselor verbal activity scores and helping skills percentages prior to analyses to correct for skewing of the data with proportion scores.

Results of Hill (1978) indicated that the mean percentage of counselor verbal activity per thirds were 36.92% ( $SD = 12.19$ ), 39.83% ( $SD = 5.52$ ), and 55.25% ( $SD =$

10.02). There was a statistically significant difference in counselor activity across thirds of the sessions,  $F(2, 22) = 28.82, p < .001$ . A post hoc Scheffe test found that counselor activity differed between the final third and an average of the first two thirds,  $F(2, 22) = 7.61, p < .001$ , such that counselor verbal activity increased in the final third. The changes in counselor usage of response categories were analyzed using 17 one-way repeated measures analyses of variance; 9 of the 17 categories had statistically significant results for these analyses. Table 1 reports the mean percentages for each response category for each third of the session, mean percentages of each response category in the session overall, F ratios for changes across thirds of the session, and F ratios comparing the first two thirds to the last third. Post-hoc Scheffe' tests suggested that the changes occurred during the final third, as seen in the F ratios comparing the first two thirds to the last third. Decreases occurred during the final third for minimal encourager, closed question, open question, and restatement. Increases occurred for structuring, information, direct guidance, interpretation, and friendly discussion. Thus, counselors became more active during the final third of the session – they engaged relatively more in giving information, direct guidance, interpretations, and friendly discussion, and engaged relatively less in asking closed and open questions, giving minimal encouragement, and making restatements. During the first two thirds of intake sessions, counselors on average used mostly minimal encouragers (43% in the first third compared to the other categories, 40% in the second third), closed questions (15% in first third, 14% in the second third), and restatements (8% in first third, 9% in second third); the client talked the majority of the time, on average (73% of the time in first third, 60% of the time in second third). A plausible explanation of the results is that there is a shift in the

counselor's emphasis from gathering information about the client's problems to beginning work toward resolving the problems.

Table 1

*Hill (1978) Mean Proportions and Standard Deviations of Helping Skills*

Helping Skill	Part of Intake Session				F ratios	
	1 <sup>st</sup> third <i>M (SD)</i>	2 <sup>nd</sup> third <i>M (SD)</i>	3 <sup>rd</sup> third <i>M (SD)</i>	Whole Session <i>M (SD)</i>	Changes between thirds	1 <sup>st</sup> 2 3rds vs. last 3rd
Approval-reas.	.06 (.05)	.05 (.04)	.06 (.05)	.06 (.05)	–	–
Closed Questn	.15 (.08)	.14 (.05)	.09 (.05)	.13 (.07)	6.94**	3.86**
Open Question	.07 (.04)	.05 (.03)	.02 (.02)	.05 (.04)	13.71***	5.50***
Restatement	.08 (.06)	.09 (.05)	.04 (.03)	.07 (.05)	12.50***	5.10***
Reflection	.02 (.02)	.02 (.02)	.01 (.01)	.02 (.02)	–	–
Challenge	.01 (.01)	.02 (.02)	.01 (.02)	.01 (.02)	–	–
Interpretation	.04 (.03)	.06 (.05)	.08 (.05)	.06 (.05)	5.31*	3.00*
Self-disclosure	.00 (.01)	.01 (.02)	.01 (.03)	.01 (.02)	–	–
Immediacy	<i>not used in Hill (1978)</i>					
Information <sup>a</sup>	.09 (.03)	.10 (.04)	.36 (.06)	.18 (.06)		
<i>Information</i>					14.46***	5.70***
<i>Structuring</i>					8.04**	3.86**
<i>Nonverb ref.</i>					–	–
Direct Guid.	.03 (.07)	.03 (.04)	.09 (.08)	.04 (.06)	23.53***	6.57***
Other <sup>a</sup>	.03 (.03)	.03 (.02)	.04 (.01)	.03 (.01)		
<i>Friendly disc.</i>					11.54***	4.25**
<i>Silence</i>					–	–
<i>Criticism</i>					–	–
<i>Unclassifiable</i>					–	–
Minimal Enc.	.43 (.19)	.40 (.19)	.20 (.08)	.35 (.19)	29.33***	7.75***

*Note.* – = not reported in Hill (1978). The category of Information is combined with Structuring and Nonverbal Referent. The category of Other is combined with Friendly Discussion, Silence, Criticism, and Unclassifiable.

<sup>a</sup>Percentages and standard deviations calculated based on information provided in Hill (1978).

\* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

Limitations of Hill (1978) include that the intake sessions varied so greatly in length; this variable was not analyzed for whether intake session duration affected therapist verbal activity or helpings skills used in the thirds of the sessions. Other limitations include the small sample size of 12 sessions, and that the client sample was limited to university students who were willing to have their session taped, as well as the limited number and types of therapists and clients represented.

Lonborg et al. (1991) examined counselor and client verbal response mode changes during initial counseling sessions. The study used the Classification System for Counseling Responses (CSCR; Highlen, Lonborg, Hampl, & Lassiter, 1982), a counselor response mode system very similar to the HCVRCS. For data analyses, the original 18 categories of the CSCR were collapsed into 9 categories: minimal responses, requests, approval/reassurance, information, instruction, restatement, empathy, interpretation, and confrontation. Clients were 13 volunteer undergraduate students enrolled in psychology courses (6 male, 7 female), who were offered extra credit for their participation. Counselors were 8 first year master's degree students (4 female, 4 male) enrolled in an introductory practicum course. There were three judges (1 male, 2 female; two graduate students in counseling psychology and one PhD counseling psychologist) for the CSCR. Altogether, there were 13 cases of 50-minute initial sessions analyzed. Each session was divided into thirds, and 8-minute segments were analyzed from the middle of each third. The average kappa coefficient for inter-judge agreement on the counselor response modes categories was .81. As shown in Table 2, the numbers of minimal responses, information, and confrontation increased significantly across thirds of the initial sessions. A limitation of the study is that only the middle 8 minutes of each third was analyzed, which means that 26 minutes of the 50 minute session were not analyzed – so no overall percentages of the verbal response modes for the initial sessions could be reported. Another limitation is the use of a therapist sample of beginning counselor trainees who may or may not have had prior experience receiving or providing counseling (the article did not indicate experience level of the counselors). Thus, the results may not necessarily apply with more experienced counselors. A further limitation is the client sample being



composed of volunteer undergraduate clients who were offered extra credit for their participation – this sample is unlikely to be representative of clients who seek therapy in real-life counseling agencies.

Table 2

*Lonborg et al. (1991) Means Numbers and Standard Deviations of Helping Skills*

Helping Skill	Part of Intake Session			F changes across 3 <sup>rds</sup>	p
	1 <sup>st</sup> third M (SD)	2 <sup>nd</sup> third M (SD)	3 <sup>rd</sup> third M (SD)		
Approval-Reassurance	0.09 (0.23)	0.16 (.032)	0.25 (0.69)	0.19	.83
Closed Question	<i>not in Lonborg et al. (1991) measure</i>				
Open Question	<i>not in Lonborg et al. (1991) measure</i>				
Restatement	0.52 (0.82)	0.57 (0.89)	1.01 (1.26)	1.08	.36
Reflection ( <i>Empathy</i> )	3.41 (1.91)	5.77 (2.43)	5.19 (3.97)	3.05	.07
Challenge ( <i>Confrontation</i> )	0.00 (0.00)	0.31 (0.62)	0.92 (1.23)	4.19*	.03
Interpretation	2.44 (2.25)	3.88 (3.52)	4.62 (4.42)	1.89	.17
Self-Disclosure	<i>not in Lonborg et al. (1991) measure</i>				
Immediacy	<i>not in Lonborg et al. (1991) measure</i>				
Information	1.56 (1.81)	3.55 (3.27)	6.35 (6.38)	6.32**	.01
Direct Guidance					
<i>Requests</i>	3.48 (2.30)	3.96 (2.86)	5.82 (5.40)	1.23	.31
<i>Instruction</i>	0.05 (0.19)	0.77 (1.40)	0.67 (1.63)	2.41	.11
Other	<i>not in Lonborg et al. (1991) measure</i>				
Minimal encourager					
<i>Minimal responses</i>	12.63 (6.09)	14.13 (7.32)	18.71 (7.34)	16.67***	< .001

*Note.* Italics represent the name of the category used by Lonborg et al. (1991). For all F analyses df = 2, 24  
\*p < .05. \*\*p < .01. \*\*\*p < .001

Tryon (2003) investigated what helping skills therapists used during the intake for engagers versus non-engagers. The helping skills that Tryon (2003) looked at were from an older version of the Hill (2009) Helping Skills System: the Hill Therapist Verbal Response Category System (HCVRCS; Hill, 1993). The HCVRCS (Hill, 1993) contained 12 helping skills: minimal encouragers, silence, approval, information, direct guidance, closed questions, open questions, paraphrases, interpretations, confrontations, self disclosures, and other. Participants were 1 female psychologist as the therapist and 11 clients (8 female, 3 male; 7 undergraduates, 4 graduate students; 4 were intake-only

dropouts and 7 returned for the therapy session after intake). The study was conducted in a university counseling center setting with a short-term (12-session limit) model. Results did not indicate a statistically significant difference in counselor verbal activity between engagers and non-engagers. Results showed that therapists used less information-giving and more minimal encouragers during the intake session for non-engagers than compared to engagers. The opposite was found for engagers: therapists used higher amounts of information-giving and fewer minimal encouragers during the intake session than would be expected by chance. Results also showed that client return for a scheduled appointment after intake was related to an increase in information-giving and a concurrent decrease in closed questions as the intake session progressed. Table 3 summarizes the results from this study. Tryon (2003) proposed that clients returned for therapy when their problems had been sufficiently clarified to begin working on the problems (through the therapist's providing information in the latter part of the session). Limitations of the study include: the sample of therapists was very small since only one therapist (a 38 year-old Caucasian female clinical psychologist with 5 years of post-Ph.D therapy experience, who had a psychodynamic theoretical orientation) participated in the study, the client sample consisted of only 11 university student clients (seven undergraduates, four graduate students) at a large private eastern university, the setting of the study was a short-term therapy service at the university (the results may not apply to long-term therapy settings), and the statistical methods may be confounded by differing levels of therapist verbal activity (i.e. some therapists talk more than others) since the analyses were based on raw numbers of the helping skills used rather than percentages.

Table 3

*Tryon (2003) Mean Number and Standard Deviations of Helping Skills*

Helping Skill	Part of Intake Session				Mean proportion for session
	1 <sup>st</sup> third <i>M (SD)</i>	2 <sup>nd</sup> third <i>M (SD)</i>	3 <sup>rd</sup> third <i>M (SD)</i>	Whole session <i>M (SD)</i>	
Approval-Reass.					
<i>Non-engager</i>	–	–	–	–	.07 <sup>b</sup>
<i>Engager</i>	–	–	–	–	.02 <sup>b</sup>
Closed Question					
<i>Non-engager</i>	11.0 (9.4)	25.8 (18.4)	16.3 (12.7)	53.0 (13.5) <sup>a</sup>	.25
<i>Engager</i>	39.9 (12.1)	30.1 (12.9)	19.6 (11.2)	89.6 (12.1) <sup>a</sup>	.29
Open Question					
<i>Non-engager</i>	–	–	–	–	.06 <sup>b</sup>
<i>Engager</i>	–	–	–	–	.04 <sup>b</sup>
Restatement					
<i>Non-engager</i>	–	–	–	–	.06 <sup>b</sup>
<i>Engager</i>	–	–	–	–	.06 <sup>b</sup>
Reflection	<i>not in the version of the HCVRCS used in Tryon (2003)</i>				
Challenge	<i>this category was eliminated from the analyses because expected value was &lt; 5</i>				
Interpretation					
<i>Non-engager</i>	–	–	–	–	.01 <sup>b</sup>
<i>Engager</i>	–	–	–	–	.01 <sup>b</sup>
Self-disclosure					
<i>Non-engager</i>	–	–	–	–	–
<i>Engager</i>	–	–	–	–	.01
Immediacy	<i>not used in Tryon (2003)</i>				
Information					
<i>Non-engager</i>	23.5 (14.4)	10.0 (6.1)	22.5 (10.5)	56.0 (10.3) <sup>a</sup>	.27
<i>Engager</i>	25.1 (14.4)	43.1 (33.0)	59.7 (40.1)	128.0 (29.2) <sup>a</sup>	.40
Direct Guidance					
<i>Non-engager</i>	–	–	–	–	.04 <sup>b</sup>
<i>Engager</i>	–	–	–	–	.03
Other <sup>c</sup>					
<i>Non-engager</i>	–	–	–	–	.01 <sup>b</sup>
<i>Engager</i>	–	–	–	–	.01 <sup>b</sup>
Minimal encour.					
<i>Non-engager</i>	–	–	–	–	.21
<i>Engager</i>	–	–	–	–	.14 <sup>b</sup>

*Note.* – = data not reported in Tryon (2003). Numbers of verbal responses did not differ between engagers and non-engagers,  $F(1, 10) = 1.20, ns$ . Response modes differed between engagers and non-engagers,  $\chi^2(9, N = 11) = 125.78, p < .001$ . Engager intake sessions, compared to non-engager intake sessions, had more Information and fewer Minimal Encouragers than expected by chance. Information changed across thirds for non-engagers vs. engagers,  $F(2, 18) = 3.81, p < .05$ . Closed questions changed across thirds for non-engagers vs. engagers,  $F(2, 18) = 5.60, p < .02$ . Minimal encouragers approached significance for thirds X engagement status,  $F(2, 18) = 3.21, p = .06$ .

<sup>a</sup>Calculated based on information in Tryon (2003): added raw numbers from thirds to get total, averaged S.D.s to get total S.D. <sup>b</sup>Estimated from Figure 1 in Tryon (2003) because exact numbers were not reported.

<sup>c</sup>Percentages may be obscured by the category of *silence* being eliminated from analysis (expected value of this category was less than 5).

*Summary.* In summary, all three of the reviewed studies found differences in the usage of helping skills across thirds of intake sessions (Hill, 1978; Lonborg et al., 1991; Tryon, 2003). Information increased across thirds of intake sessions for all three studies. Closed questions decreased as the intake sessions progressed for two of the studies (Hill, 1978, Tryon, 2003); the third study (Lonborg et al., 1991) did not examine closed questions. In the study that examined helping skills in relation to engagement, client return for therapy after intake was related to a decrease in the number of closed questions from the therapist as the intake session progressed and an increase in the number of information-giving statements across thirds of the intake (Tryon, 2003). In addition, client return was related to therapist giving higher amounts of information and fewer minimal encouragers during the intake session (Tryon, 2003). Limitations of the existing research on helping skills used across thirds of intake sessions include: only a few studies have examined helping skills in thirds of intake sessions, all of the reviewed studies had small samples of clients and therapists, and thus far the studies have only been conducted in university counseling centers (except Lonborg et al., 1991, in which volunteer clients were used). Limitations of the literature also include that only one study thus far has examined helping skills in relation to dropout. Furthermore, this one study that does investigate therapist verbal behavior in intake sessions has its own limitations: the sample of therapists was very small since only one therapist (a 38 year-old Caucasian female clinical psychologist with 5 years of post-Ph.D therapy experience, who had a psychodynamic theoretical orientation) participated in the study, the client sample consisted of only 11 university student clients (seven undergraduates, four graduate students) at a large private eastern university, the setting of the study was a short-term

therapy service at the university (the results may not apply to long-term therapy settings), and the statistical methods may be confounded by differing levels of therapist verbal activity (i.e. some therapists talk more than others) since the analyses were based on raw numbers of the helping skills used rather than percentages.

### **Adult Attachment Style: A Meta-Analysis**

In this section, I summarize a recent meta-analysis of adult pre-treatment attachment style and psychotherapy outcome conducted by Levy, Ellison, Scott, and Bernecker (2011). The definition of adult attachment categories used in Levy et al. was based on the two underlying dimensions of attachment organization: anxiety and avoidance. An anxiously attached adult tends to have fears of abandonment by important people in his/her life and tends to worry about his/her significant relationships (Brennan, Clark, & Shaver, 1998). An avoidantly attached adult tends to avoid closeness with important people in his/her life, and does not like to depend on others (Brennan et al., 1998).

Levy et al.'s meta-analysis included 19 separate therapy samples from 14 studies, with a combined *N* of 1,467. This sample included clients with a variety of diagnoses and presenting problems, including but not limited to: major depression, borderline personality disorder, marital problems, and post-traumatic stress disorder. Clients were a variety of ages (the average client age in the 14 individual studies ranged from 24.6 to 44.98 years), and included both males and females (percentages of females in individual studies ranged from 0 to 100). Therapists in the meta-analysis had various theoretical orientations, including cognitive-behavioral, psychodynamic/interpersonal, eclectic, and integrative. Therapy treatment duration ranged from 6 to 52 weeks in individual studies

used in the meta-analysis. Since various measures of attachment had been used in the 14 studies, the attachment scores in each study were coded for their degree of approximation to the two underlying dimensions of attachment avoidance and attachment anxiety. The mean effect sizes were computed as weighted averages of each samples' correlation coefficient, and weights consisted of two coefficients (one for sample size so that each sample's contribution to the overall mean would take into account the sample's size, and one for weighing samples' contributions to the overall mean based on how closely they approximated the constructs of interest; Levy et al., 2011).

Results of Levy et al. indicated that the relationship between attachment anxiety and psychotherapy outcome (various measures of outcome were used in the various studies) yielded a Cohen's weighted  $d$  of -0.460, with an 80% credibility interval of  $d = -0.320$  to  $-0.608$ . This indicates that attachment anxiety negatively affects psychotherapy outcome with a medium effect. The relationship between attachment avoidance and psychotherapy outcome yielded a Cohen's weighted  $d$  of -0.014, with an 80% credibility interval  $d = -0.165$  to  $0.275$ . This means that attachment avoidance had little, if any, effect on psychotherapy outcomes. The relationship between attachment security and outcome was  $d = 0.370$ , with an 80% credibility interval of  $d = .084$  to  $0.678$ . This means that higher attachment security predicted better psychotherapy outcomes (Levy et al., 2011).

Limitations of Levy et al. include that treatment type was not controlled for (e.g., individual and group therapy were mixed together, long-term and short-term treatments were combined in the statistical analyses, inpatient and outpatient treatments were combined), and that there was a lack of pre-treatment baseline data to compare to post-

treatment outcome (which means the results may have an alternative explanation that clients with poorer outcomes began with poorer functioning pre-therapy, which could rule out the influence of attachment on outcome). Further research with well-validated measures of attachment that converge with underlying dimensions of anxiety and avoidance, and that takes baseline measures of client functioning prior to therapy as well as post-therapy, is needed to clarify the relationship between adult attachment and psychotherapy outcome (Levy et al., 2011).

Levy et al. derived a number of implications for practice based on the attachment style literature and their meta-analysis. First, assessing the patient's attachment style, whether formally or informally, may help inform practitioners since client attachment style may influence the therapy outcome. Second, expect longer and more difficult treatment with anxiously attached patients but faster and more effective treatment with securely attached patients. Third, therapists may tailor their intervention styles to their clients' attachment styles (e.g., being more engaged with clients with a dismissing attachment style, being more explicit about the treatment frame and/or provide more structure to clients with a preoccupied attachment style, and avoiding emotional/experiential techniques that may overwhelm clients who have preoccupied attachment styles). Fourth, psychotherapists should not assume too much based on a client's attachment style (research and practice indicate that therapists tailor their interpersonal styles to not overwhelm dismissing patients as well as avoid appearing uninterested with preoccupied clients). Fifth, therapists may consider using cognitive or interpretive treatments – as opposed to interpersonally focused treatments – with dismissing individuals given preliminary evidence that such individuals seems to respond

slightly better to these in short-term treatments, and attend to the structure of the internal working models of clients who score high on both the anxiety and avoidance attachment dimensions (since research suggests that much varies in this group's functioning in therapy and outcome). Sixth, therapists may keep in mind that attachment style can be modified with treatment, even in brief treatments and for patients with severe attachment difficulties (e.g., borderline personality disorder), and that change in attachment can be considered a treatment goal. For achieving this goal, preliminary research findings suggest that focusing on the relation between therapist and client and/or using interpretations may be helpful in changing attachment style, at least for severely disturbed clients with personality disorders (Levy et al., 2006), and that a range of treatments might be useful for changing attachments styles of less disturbed patients with neurotic or Axis I disorders (Levy et al., 2011).



### **Chapter 3: Statement of the Problem**

Understanding differences between engagers and non-engagers in terms of therapist helping skills may help therapists reduce the occurrence of client non-engagement in psychotherapy. Since helping skills training is an integral part of the training of novice therapists (Hill & Lent, 2006), it may also be of interest to those training novice therapists to know what therapist helping skills are associated with client engagement in therapy. In the existing literature, however, very few researchers have examined patterns of therapist helping skills used in therapy sessions for engagers versus non-engagers. Thus, further research on therapist helping skills in relation to client engagement in therapy is an important avenue of investigation.

There is thus far only one study examining therapist helping skills in relation to engagement. Results of the Tryon (2003) study indicated that intake sessions for clients who dropped out before attending the first therapy session contained less information-giving and more minimal encouragers from the therapist than would be expected by chance compared to that of clients who returned for a subsequent session.

Tryon (2003) also found statistically significant differences regarding the timing of therapist verbal interventions. For engagers (compared to non-engagers), the number of closed questions decreased, whereas the number of information-giving statements increased as the session progressed. For non-engagers, in contrast, the amount of closed questions increased and then decreased; information-giving showed the inverse pattern (initial decrease then later increase).

Although the findings of Tryon (2003) are a valuable and stimulating starting point for investigating the relationship between client engagement in therapy and

therapist helping skills in intake sessions, further research on the topic is needed due to several considerations. First, the very small sample size of only 11 university student clients (4 non-engagers, 7 engagers) and 1 therapist in Tryon's (2003) study must be considered—further studies with larger client samples and additional therapists are needed. Second, given that only one study has been conducted on the topic, additional research is needed in all types of clinical settings, including long-term therapy settings and with clients who are not university students. Third, the Tryon study did not control for therapist verbal activity level in examining the timing of helping skills across thirds of the intake sessions—thus, additional research examining the timing of therapist verbal statements while controlling for therapist verbal activity level is needed. It is important to control for therapist verbal activity since the amount of talking a therapist does (the therapist verbal activity level) might be an extraneous variable affecting client engagement, rather than the amount of particular helping skills that were used. Fourth, since the definition of engagers in Tryon (2003) only involved clients who came back for at least one subsequent session, studies examining helping skills associated with client continuation beyond attendance of just one subsequent session are needed—it would be important to investigate what helping skills predict longer-term commitments from clients.

Thus, I seek to extend the findings of Tryon (2003) in investigating the helping skills used with non-engagers versus engagers by using: a) a larger sample size of clients, b) more therapists, c) a long-term therapy setting, d) clients who are adults seeking therapy for a low fee (rather than university students), e) statistical methods that account for therapist verbal activity in examining the timing of helping skills in relation to

engagement, and f) a definition of ‘engager’ in which clients must have attended at least 8 sessions of therapy (indicating greater “buy-in” than if they attended just one subsequent session after the intake). The most widely used content analysis system in counseling psychology research (Hill, Nutt, & Jackson, 1994), the Helping Skills System (HSS; Hill, 2009), was used in the present study to classify helping skills categories.

Since minimal empirical evidence exists on the study of helping skills and engagement, I pose research questions rather than hypotheses on the relationship between helping skills and engagement. Originally, I proposed two research questions for the present study: 1) *Do therapists use different proportions of skills in intake sessions with clients who continue versus those who drop out?*, and 2) *Does the proportion of therapist skills change over thirds of intake sessions for dropouts compared to continuers?*

However, to be more descriptive of the data, I accordingly re-formatted the original research questions into nine research questions so that each skill occurring at least 1% of the time had its own research question. In addition, to be more precise in my terminology, I use the terms ‘engager,’ and ‘non-engager,’ instead of ‘dropouts’ and ‘continuers.’

These nine research questions are presented and briefly discussed below.

*Research Question 1: Do proportions of therapist approval-reassurance differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Hill (1978) found that approval-reassurance was on average used 5 to 6% for each third of the intake; Hill found no difference in the use of approval reassurance across thirds of the intake (see Table 1 in Chapter 2). Lonborg et al. (1991) found that average

numbers of approval-reassurance did significantly differ across thirds (9% in the first third, 16% in the second third, 25% in the last third; see Table 2 in Chapter 2). Tryon (2003) found that approval-reassurance was used 7% of the time with non-engagers and 2% of the time with engagers, but no differences were reported across thirds of sessions (these percentages were estimated based on the graph presented in Tryon, 2003).

*Research Question 2: Do proportions of therapist closed questions differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Hill (1978) found that use of closed questions decreased significantly between first two thirds and the last third of intake sessions (15% for 1<sup>st</sup> third, 14% for 2<sup>nd</sup> third, and 9% for last third;  $p < .01$ ; see Table 1). Tryon (2003) found that closed questions were used on average, 53 times with non-engagers and on average, 89.6 times with engagers, a very large effect ( $d = 2.86$ ). The timing of closed questions was found to differ between engagers and non-engagers in Tryon (2003): closed questions increased at first then decreased for non-engagers (11, 26, then 16 for raw numbers of occurrences in the 1<sup>st</sup>, 2<sup>nd</sup>, and last thirds, respectively), and decreased for engagers (40, 30, then 20 in the 1<sup>st</sup>, 2<sup>nd</sup>, and last thirds, respectively), with  $p < .02$ .

*Research Question 3: Do proportions of therapist open questions about thoughts differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Currently there are no studies on whether the amount of open questions about thoughts differs across time or condition. Tryon (2003) did provide data about proportions of open questions (all subtypes) across condition – with non-engagers, open questions were used about 6% of the time in comparison with other helping skills used in

the intake session, and about 4% with engagers. However, Tryon (2003) did not specifically test whether the conditions (engagers vs. non-engagers) differed on open questions with any statistical methods.

*Research Question 4: Do proportions of therapist restatements differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Hill (1978) found that the use of restatements decreased significantly between first two thirds and the last third of intake sessions (8% for 1<sup>st</sup> third, 9% for 2<sup>nd</sup> third, and 4% for last third;  $p < .001$ ; see Table 1). Lonborg et al. (1991) did not find significant differences across thirds (9% in the first third, 16% in the second third, 25% in the last third; see Table 2).

Tryon (2003) found no significant differences between engagers versus non-engagers for therapist use of restatements (restatements were used about about 6% of the time for both engagement and non-engagement groups). No studies have examined whether the timing of restatements across thirds of intake sessions differed between engagers and non-engagers.

*Research Question 5: Do proportions of therapist reflections of feeling differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Hill (1978) and Lonborg et al. (1991) found that the use of reflections did not significantly differ across thirds (see Table 1 and Table 2). No studies have examined reflections across condition (engagers vs. non-engagers), or across the interaction of time and condition for intake sessions.

*Research Question 6: Do proportions of therapist disclosure-miscellaneous differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Currently there are no studies on whether the amount of disclosure-miscellaneous differs across time or condition in intake sessions. Tryon (2003) did provide data about proportions of self-disclosure (all subtypes) used with engagers: self-disclosure was used about 1% of the time in comparison with other helping skills used in the intake session. No studies were found that reported proportions of any type of self-disclosure for non-engagers.

*Research Question 7: Do proportions of therapist immediacy differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Currently there are no studies on whether the amount of immediacy differs across time or condition in intake sessions. Thus, the present study will be the first study examining the amount and timing (across thirds of the intake) of immediacy in relation to client engagement in psychotherapy.

*Research Question 8: Do proportions of therapist information about the process of helping differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Currently there are no studies on whether information about the process of helping differs across time or condition. The present study will be the first to investigate this research question.

*Research Question 9: Do proportions of therapist information in the form of facts, data or opinions differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Currently there are no studies on whether information-facts/data/opinions differs across time or condition. The present study will be the first to investigate this research question.

One additional research question was added to replicate the combined information category as was used by Tryon (2003). Tryon used an older 12-category version of the Helping Skills System (HCRVCR; Hill, 1993), whereas I used a newer, more differentiated version of the Helping Skills System (HSS; Hill, 2009) that had 3 subtypes of information (helping process, facts/data/opinions, and feedback about the client). The 3 subtypes were combined for comparison purposes with Tryon's category of information. Thus, the additional research question was:

*Research Question 10: Do proportions of therapist information (all subtypes combined) differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

Across time, both Hill (1978) and Lonborg et al. (1991) found that information significantly increased across thirds of the intake sessions (9%, 10%, then 36% for the Hill study, and 1.6, 3.6, and 6.4 in raw numbers for the Lonborg et al. study; see Tables 1 and 2). Across condition, Tryon (2003) found that engagement intake sessions contained statistically significantly more information than non-engagement intake sessions than expected by chance (on average, 56 compared to 128 for non-engagers and engagers, respectively), a very large effect,  $d = 3.29$ . The time X condition interaction was

investigated in Tryon (2003), which found that information increased as engagement sessions progressed, but initially decreased then increased for non-engagement sessions (see Table 3).

### **Additional Analyses**

As we conducted the data analyses, a number of additional questions arose about why there were differences between engagers and non-engagers in terms of helping skills. Fortunately, we had collected more data at the research clinic where the study was conducted. Hence, I present additional analyses of differences between engagers and non-engagers in terms of: client attachment, intake session duration, client pre-therapy self-rated need for therapy, and client pre-therapy outcome expectations.



## Chapter 4: Method

The present study examined therapist helping skills across thirds of intake sessions (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds) and across engagement condition (engager vs. non-engager). The design of the present study is a quantitative descriptive field design.

### Power Analyses

Power analyses for 2-tailed t-tests indicated that for a large effect size,  $d = 0.8$ , at an alpha level of .05, 52 participants (26 engagers, 26 non-engagers) would be needed for 80% power. With the same expected effect size,  $d = 0.8$ , and same power level of 80%, but changing the alpha level to .10, 40 clients (20 engagers, 20 non-engagers) would be needed. With the same effect size of .8 and power of 80%, but an alpha of .20, 30 clients would be needed (15 engagers, 15 non-engagers). Effect sizes from Tryon (2003) indicated very large effects for closed questions,  $d = 2.86$ , and information,  $d = 3.29$ . Using the effect size  $d = 2.86$ , and alpha = .10, 6 clients (3 engagers, 3 non-engagers) would be needed to have 80% power. Using the effect size  $d = 3.29$ , and alpha = .10, 6 clients (3 engagers, 3 non-engagers) would be needed to have 80% power. The present study, with 8 dropouts and 8 continuers, has 84.5% power to detect effects of  $d = 1.4$  at an alpha level of .10 when such effects indeed exist. Thus, the present sample size provides sufficient power for detecting very large effects ( $d = 1.4$ ) at alpha levels of .10.

### Participants and Setting

**Setting.** The present study utilized data collected in the Maryland Psychotherapy Clinic and Research Lab (MPCRL), a mental health clinic providing individual psychodynamic/interpersonal psychotherapy to adults from the local community. One of the main purposes of the clinic was to collect data for psychotherapy research; thus, all

sessions were videotaped with client consent for participating in the research, and clients completed research measures prior to receiving therapy, after every session, and at post-therapy. The therapy was open-ended with no maximum number of sessions clients could attend (although there were limits on how long they could see a particular therapist, depending on therapist length of participation in the clinic). Video-recorded sessions were typically 45 to 60 minutes in length.

**Clients.** Data from 16 clients were used in this study, with two engagers and two non-engagers for each of the four therapists. Eight were non-engagers (5 female, 3 male; ages ranged from 27 to 55,  $M = 34.8$  years old,  $SD = 9.5$  years; 3 Caucasian, 2 African American, 2 Hispanic, 1 Middle Eastern); eight of the 16 were engagers (3 female, 5 male; ages 22-46,  $M = 29.1$  years old,  $SD = 8.9$  years; 5 Caucasian, 2 Hispanic, 1 African American). Client presenting problems, as reported in screening and intake interviews, included anxiety/depression ( $n = 8$ ), interpersonal relationship issues ( $n = 11$ ), and career issues ( $n = 7$ ); some clients had more than one presenting problem. None of the clients in the study were currently in psychotherapy elsewhere. None of the clients had current alcohol/drug abuse or psychosis. Any clients taking medication had been stabilized on psychotropic medication (i.e. taking it for over 2 months) prior to starting services at the MPCRL. Clients were not informed of the hypotheses of the study.

**Therapists.** Four therapists (3 female, 1 male; ages 27 to 48,  $M = 34.8$  years old,  $SD = 9.5$  years, 2 Caucasian, 2 Asian) participated in the study. All four were counseling psychology doctoral students who had completed at least two years of practicum training.

**Judges.** Five research assistants (four upper-level undergraduate research assistants, one graduate student; 2 male, 3 female; 3 Caucasian, 1 Middle Eastern, 1

Indian and Portuguese; aged 20-28,  $M = 22.8$ ,  $SD = 3.2$ ) and the primary investigator (graduate student, female, Asian American, age 24) served as judges for the Helping Skills System.

## **Measures**

**Client demographics.** A computer-administered questionnaire asked clients about their age, sex, race/ethnicity, highest educational level obtained, current job, and whether they had ever consulted a mental health practitioner for any problem.

**Therapist demographics.** A computer-administered questionnaire asked therapists about their age, sex, race/ethnicity, educational level, year in doctoral program, and number of years providing counseling.

**Judge demographics.** A computer-administered questionnaire asked helping skills judges about age, sex, race/ethnicity, educational level, and year in school.

**The Helping Skills System.** The Helping Skills System (HSS; Hill, 2009) is a revision of the Hill Counselor Verbal Response Category System (HCVRS; Hill, 1978; 1986). The HSS consists of 20 nominal, mutually exclusive categories of therapist verbal behavior: approval and reassurance, closed questions, open questions about thoughts, open questions about feelings, open question for insight, open question for action, restatements, reflection of feelings, challenge, interpretation, disclosure of feelings, disclosure of insight, disclosure of strategies, immediacy, information about the process of helping, information in the form of facts/data/opinions, information providing feedback to the client, process advisement, direct guidance, and other (Hill, 2009). For the present study, an additional category for disclosure was added since many of the therapists used disclosures for things such as the therapist's name, level of training, or

similarities to the client—we titled this category disclosure-miscellaneous. Thus, the present study utilized a 21-category version of the HSS.

The original HSS was developed by combining categories from 11 existing response modes systems and having professional therapists of differing theoretical orientations match examples to the definitions (Hill, 1978). Concurrent validity for previous versions of the HSS was established with similar categories on other response mode systems (Elliot et al., 1987). When categories in six different rating systems were compared at the same level of specificity, moderate to strong convergence was found for the six modes that were included in all six systems: question, information, advisement, reflection, interpretation, and self-disclosure (Elliot et al., 1987).

Average kappas between pairs of judges with the HCVRCS/HSS have ranged from .71 (Hill et al., 1979) to .91 (Hess et al., 2006). For the present study, average kappa between pairs of judges using the 21-category HSS was .75, ranging from .61 to .84 for individual cases. Since the present study used consensus to determine the final HSS coding for each case, the inter-rater kappas were calculated on the independent codings that were done prior to the consensus discussions.

**Client attachment style.** The Experiences in Close Relationships Scale (ECR; Brennan et al., 1998) is a 36-item self-report measure assessing adult romantic attachment style. The ECR uses a 7-point Likert scale (1 = disagree strongly, 7 = agree strongly) and is currently the most widely used paper-and-pencil measure of adult attachment style. The Avoidance subscale measures an individual's level of discomfort with emotional closeness, openness, and interdependence in romantic relationships. The Anxiety subscale measures the extent to which a person fears being rejected, neglected,

or abandoned by romantic partners. Both subscales have had high internal consistency estimates (.90 to .94 for Avoidance, .88 to .91 for Anxiety; Brennan et al., 1998; Mohr, Gelso, & Hill, 2005) and high 6-month test-retest reliabilities (.68 for anxiety and .71 for avoidance; Lopez & Gormley, 2002). In the present sample  $N = 15$  because one engager was missing ECR data. High internal consistency was found in the present sample for Avoidance ( $\alpha = .93$ ) and Anxiety ( $\alpha = .92$ ).

**Intake session duration.** Intake session duration was determined by recording the total length of each DVD recording for each of the 16 cases.

**Client pre-therapy need for therapy.** Prior to scheduling their intake session, clients were verbally asked screening questions by clinic staff to determine their appropriateness for the clinic. One of the screening questions assessed client pre-therapy need for therapy, “How much do you need to be in psychotherapy now?” and clients responded verbally on a scale of 1 (not at all) to 5 (it’s essential).

**Client pre-therapy outcome expectations.** Another question asked at the time of screening was, “How confident are you that you can eventually overcome your problems and have a satisfying life?” and clients verbally responded on a scale of 1 (not at all) to 5 (extremely confident).

## **Procedures**

**Client recruitment.** Clients were recruited from the community for the research clinic through advertisements in local newspapers, flyers on campus and in the local community, referrals from professionals in the local area, word of mouth, and the clinic’s website. Clients were screened to determine if they met the eligibility criteria. If so, they were scheduled for an intake session with one of the therapists. If not, they were given a

referral to another mental health provider. Clients were not provided with any additional compensation beyond low-fee psychotherapy (typically, \$10 to \$50 per session), because we wanted clients to be motivated for seeking therapy and thus better represent the outpatient population.

As of February 10, 2010 when the final case was collected for the present study, approximately 174 people had contacted the clinic for information, 71 were screened, 45 were scheduled for intake interviews, 42 showed up for intake interviews, 11 did not return after the intake, 8 completed between 1 to 7 sessions post-intake, and 23 completed at least 8 sessions post-intake. Of the 10 therapists who conducted intakes prior to February 10, 2010, only 4 therapists had at least 2 intake-only dropouts and at least 2 clients who continued past 8 sessions and thus were eligible for the study. Two engagers and two non-engagers were chosen from each of the 4 therapists to balance the numbers of clients in each condition, for a total of 16 cases. Data collection for these cases was completed in approximately 18 months, not including helping skills coding.

**Therapist recruitment.** Therapists for the research clinic were recruited by word of mouth and through email announcements in the counseling psychology doctoral program at the university where the study was conducted.

**Judge recruitment.** Judges were recruited from upper-level psychology classes. All judges had at least a 3.0 overall grade point average, and at least a 3.5 psychology grade point average. All judges were interviewed to determine their motivation and commitment for being judges in the present study. Out of 18 applicants, 5 were chosen to be judges for the present study.

**Intake sessions.** When clients arrived for their intake session, they first signed informed consent forms and then completed pre-therapy measures. They then met with a therapist for an approximately 60-minute-long intake session. In the intake session, therapists typically asked about the client's presenting problem(s), the nature and duration of symptoms, family history and dynamics, medical condition (overall health, medications, changes in sleep or appetite), current support systems (or lack thereof), important relationships, presentation style, and basic demographic information.

**Training for the HSS.** Judges completed 32 hours of training including bi-weekly 2 hour meetings and time spent reading and practicing coding. In the first stage of training, judges read the HSS manual [see Webform E of Hill (2009) located at <http://forms.apa.org/books/supp/hill3/index.cfm?action=students&article=3>], read and completed practice exercises, discussed the HSS, and talked about potential biases. In the second stage of training, judges practiced unitizing, coding, and discussing one full transcript. In the third stage of training, judges coded two practice videotapes of therapy sessions that were not used for the present study. Upon completion of training, the average kappa between pairs of judges exceeded .70.

**Transcripts for the HSS.** All of the therapist verbal statements in each intake session were transcribed by judges and then revised for accuracy. There was no identifying information on the transcripts to protect the anonymity of both clients and therapists. Also, to protect the anonymity of the clients, judges were given a list of names (including client names, therapist names, and other people) to see if they know any of the clients or therapists. Judges were instructed to not code sessions when they knew the client, and instructed that if they recognized a client when beginning to watch a

videotape, they should immediately stop watching. None of the judges indicated that they knew any of the clients either prior to or when watching any of the videotaped sessions.

**Unitizing for the HSS.** For each intake session, at least two judges independently unitized [i.e. divided the therapist utterances into grammatical sentences; see rules for unitization in Webform F of Hill (2009) at <http://forms.apa.org/books/supp/hill3/index.cfm?action=students&article=3>] each transcript. Judges then discussed any discrepancies and final unitization was determined by consensus of the judges assigned to the case. Average percent agreement between pairs of unitizers prior to discussion on each case was 0.88 ( $SD = 3.1$ ), ranging from 0.80 to 0.93 for individual cases. Percent agreement was assessed by dividing the number of agreed-upon units for a case by the sum of the agreed-upon and disagreed-upon units for each case. An agreed-upon unit was one that both unitizers considered a unit. Units that did not differ in meaningful content were counted as agreements—for example, if one unitizer put a unit after “dog” in the sentence “The fox jumped over the dog, / um, it was an amazing sight...” while the other unitizer put the unit after “um” in the same sentence (“The fox jumped over the dog, um, / it was an amazing sight...”), the unit was counted as an agreement. Another example would be when the word “like” in the sentence was used in such a way that units before and after the “like” would be counted as an agreement (“It was nice, / like, it was really nice” and “It was nice, like, / it was really nice” were counted as an agreed-upon unit). Disagreed-upon units were any instances in which one unitizer had a unit in a place where the other did not (except if the differences only differed by things such as “um” and “like” discussed above). Each time either



unitizer had a unit in a meaningful place where the other did not, the unit was counted as a disagreement.

**Coding using the HSS.** At least three judges independently assigned one of the 21 HSS categories to each unit in each speaking turn; these independent judgments were used to calculate inter-judge reliability. When two or more judges assigned different HSS categories for a speaking unit, the coding team discussed the coding until reaching resolution through consensus. Judges were not told of the purpose of the study, and coded the data without knowledge of which clients were engagers and which were non-engagers.

Thirds of the intake sessions were determined by dividing the total time of the session into thirds. For example, if the total time for a session was 57 minutes, 57 divided by 3 is 19, so the thirds would be 19 minutes each.

## **Chapter 5: Results**

For the main analyses, we set alpha at .10 because of the exploratory nature of the study. We were more concerned about making Type II (false negative) errors than Type I (false positive) errors, given the small sample size. For the planned comparisons, we used an alpha of .033 (i.e., .10 divided by 3) given that there were three planned comparisons for each analysis.

### **Descriptive Statistics**

Proportions for each helping skill across thirds and for the whole intake are reported for non-engagers in Table 4, for engagers in Table 5, and for engagers and non-engagers combined in Table 6. Proportions were determined by dividing the number of times each skill was used in each case by the total number of skills used in that particular case; then the proportions were averaged to determine average proportions for engagers, for non-engagers, and for engagers combined with non-engagers. Note that these proportions do not account for the nested structure of the data, and are thus not the same proportions estimated when conducting the statistical tests of the data.

Table 4

*Proportions of Helping Skills Used in Intake Sessions for Non-engagers*

Helping Skill	1 <sup>st</sup> Third		2 <sup>nd</sup> Third		3 <sup>rd</sup> Third		Overall	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Approval-Reassurance	.11	.08	.08	.05	.09	.05	.10	.05
2. Closed Question	.24	.17	.28	.19	.11	.08	.19	.11
3a. Open Question-Thoughts	.10	.05	.09	.03	.04	.04	.07	.04
3b. Open Question-Feelings	.00	.01	.02	.02	.01	.01	.01	.01
3c. Open Question-Insight	.01	.02	.00	.00	.00	.01	.00	.01
3d. Open Question-Action	.00	.00	.00	.00	.00	.00	.00	.00
4. Restatement	.19	.05	.24	.07	.13	.05	.19	.05
5. Reflection of Feelings	.03	.02	.03	.03	.03	.03	.03	.03
6. Challenge	.00	.00	.00	.01	.00	.01	.00	.00
7. Interpretation	.00	.00	.00	.01	.00	.00	.00	.00
8a. Disclosure-Feelings	.00	.01	.00	.01	.00	.01	.00	.01
8b. Disclosure-Insight	.00	.00	.00	.00	.00	.00	.00	.00
8c. Disclosure-Action	.00	.00	.00	.00	.00	.00	.00	.00
8d. Disclosure-Miscellaneous	.01	.01	.02	.05	.01	.01	.01	.02
9. Immediacy	.03	.06	.01	.02	.03	.03	.03	.03
10a. Information about Process of Helping	.24	.20	.13	.13	.42	.18	.28	.14
10b. Information-Facts/Data/Opinions	.02	.04	.10	.11	.10	.15	.07	.10
10c. Information-Feedback about the Client	.00	.01	.00	.00	.00	.01	.00	.00
11a. Process Advisement	.01	.01	.00	.00	.01	.02	.01	.01
11b. Directives	.00	.00	.00	.00	.01	.01	.01	.01
12. Other	.00	.00	.00	.00	.00	.00	.00	.00

Table 5

*Proportions of Helping Skills Used in Intake Sessions for Engagers*

Helping Skill	1 <sup>st</sup> Third		2 <sup>nd</sup> Third		3 <sup>rd</sup> Third		Overall	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Approval-Reassurance	.05	.04	.10	.05	.07	.06	.07	.03
2. Closed Question	.18	.13	.21	.14	.10	.05	.16	.08
3a. Open Question-Thoughts	.15	.08	.09	.06	.06	.03	.09	.02
3b. Open Question-Feelings	.01	.01	.01	.02	.01	.01	.01	.01
3c. Open Question-Insight	.00	.00	.00	.01	.00	.00	.00	.00
3d. Open Question-Action	.00	.00	.00	.00	.00	.00	.00	.00
4. Restatement	.26	.10	.35	.17	.12	.06	.21	.06
5. Reflection of Feelings	.05	.05	.06	.08	.01	.02	.03	.02
6. Challenge	.00	.00	.00	.00	.00	.00	.00	.00
7. Interpretation	.00	.00	.01	.02	.00	.01	.00	.00
8a. Disclosure-Feelings	.00	.00	.00	.00	.00	.00	.00	.00
8b. Disclosure-Insight	.00	.00	.00	.00	.00	.00	.00	.00
8c. Disclosure-Action	.00	.00	.00	.00	.00	.00	.00	.00
8d. Disclosure-Miscellaneous	.03	.03	.00	.00	.01	.02	.01	.02
9. Immediacy	.00	.00	.01	.03	.02	.02	.01	.02
10a. Information about Process of Helping	.26	.19	.07	.07	.50	.15	.34	.10
10b. Information-Facts/Data/Opinions	.02	.03	.08	.09	.06	.04	.06	.04
10c. Information-Feedback about the Client	.00	.00	.00	.00	.00	.00	.00	.00
11a. Process Advisement	.00	.00	.00	.00	.01	.01	.00	.00
11b. Directives	.00	.00	.00	.00	.01	.02	.01	.01
12. Other	.00	.00	.00	.00	.00	.01	.00	.00

Table 6

*Proportions of Helping Skills Used in Intakes for Both Engagers and Non-engagers*

Helping Skill	1 <sup>st</sup> Third		2 <sup>nd</sup> Third		3 <sup>rd</sup> Third		Overall	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Approval-Reassurance	.08	.06	.09	.05	.08	.05	.08	.04
2. Closed Question	.21	.15	.24	.17	.10	.07	.17	.10
3a. Open Question-Thoughts	.12	.07	.09	.05	.05	.04	.08	.03
3b. Open Question-Feelings	.01	.01	.01	.02	.01	.01	.01	.01
3c. Open Question-Insight	.00	.02	.00	.01	.00	.01	.00	.01
3d. Open Question-Action	.00	.00	.00	.00	.00	.00	.00	.00
4. Restatement	.23	.08	.30	.14	.13	.05	.20	.06
5. Reflection of Feelings	.04	.04	.05	.06	.02	.02	.03	.02
6. Challenge	.00	.00	.00	.01	.00	.01	.00	.00
7. Interpretation	.00	.00	.00	.01	.00	.01	.00	.00
8a. Disclosure-Feelings	.00	.00	.00	.01	.00	.00	.00	.00
8b. Disclosure-Insight	.00	.00	.00	.00	.00	.00	.00	.00
8c. Disclosure-Action	.00	.00	.00	.00	.00	.00	.00	.00
8d. Disclosure-Miscellaneous	.02	.02	.01	.03	.01	.02	.01	.02
9. Immediacy	.01	.04	.01	.02	.03	.03	.02	.02
10a. Information about Process of Helping	.25	.19	.10	.10	.46	.16	.31	.12
10b. Information-Facts/Data/Opinions	.02	.03	.09	.10	.08	.11	.07	.08
10c. Information-Feedback about the Client	.00	.01	.00	.00	.00	.01	.00	.00
11a. Process Advisement	.00	.01	.00	.00	.01	.01	.00	.01
11b. Directives	.00	.00	.00	.00	.01	.02	.01	.01
12. Other	.00	.00	.00	.00	.00	.01	.00	.00

**Preliminary Analyses**

Since the data for the present study consist of helping skills nested within clients who are nested within therapists, the observations are not independent, which violates an assumption of logistic regression analyses. To address this assumption, preliminary tests of differences among therapists and among clients within therapists were conducted at the alpha = .05 level. The therapist and client effects were tested separately for each of the 10 skill categories using t-tests of covariance parameter estimates obtained using Generalized Linear Mixed Modeling (GLMM) in SAS with the PROC GLIMMIX command. Clients nested within therapists as a random factor occasionally produced statistically significant effects, so the cl(th) nesting factor was retained for all 10 categories analyzed. However, therapists as a random factor did not produce any

statistically significant effects (see Appendix A), so the random effects of therapists were excluded in the subsequent analyses. For one of the 10 categories, Open Questions-Thoughts, analyses of therapist effects could not be tested because the maximization algorithm necessary to run the analyses did not converge (i.e., the SAS software would not run the analyses).

### **Main Analyses and Planned Comparisons**

Ten doubly-nested logistic regression analyses were conducted for each of the 10 research questions via Generalized Linear Mixed Modeling in SAS with the PROC GLIMMIX command. For each analysis, we first tested the interaction of Condition X Time, while controlling for therapist verbal activity level and for cl(th) nesting. Therapist verbal activity levels were controlled for by including appropriate covariates in each model, and clients nested within therapists were controlled for by including them as random variables. If the interaction was not statistically significant, we then removed the interaction term from the model and tested a main effect model for Condition and a main effect model for Time separately, while controlling for therapist verbal activity level and clients nested within therapists for each main effects model.

Planned comparisons were conducted for any of the Condition X Time interactions or Time main effects that were statistically significant. When the interaction was statistically significant, planned comparisons tested whether dropouts and continuers differed within each third of the intake session, at an alpha level of .033. When the main effect of Time was statistically significant, planned comparisons tested whether the use of a particular skill differed from the first to the second third of the session, from the second

to the last third of the session, and from the first third to the last third of the session, at an alpha level of .033.

*Research Question 1: Do proportions of therapist approval-reassurance differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For approval-reassurance, the Condition X Time interaction was statistically significant,  $F(2, 3856) = 3.75, p = .024$ . Planned comparisons revealed that therapists used more approval-reassurance with non-engagers than they did with engagers in the first third of the sessions,  $F(1, 3856) = 4.86, p = .028$ , but did not significantly differ in their use of approval-reassurance with engagers and non-engagers in the second or last thirds of the sessions,  $F(1, 3856) = 0.17, p = .682$ , and  $F(1, 3856) = 1.31, p = .253$ , respectively. Figure 1 depicts the Condition X Time interaction for the adjusted estimated mean percentages of approval-reassurance.

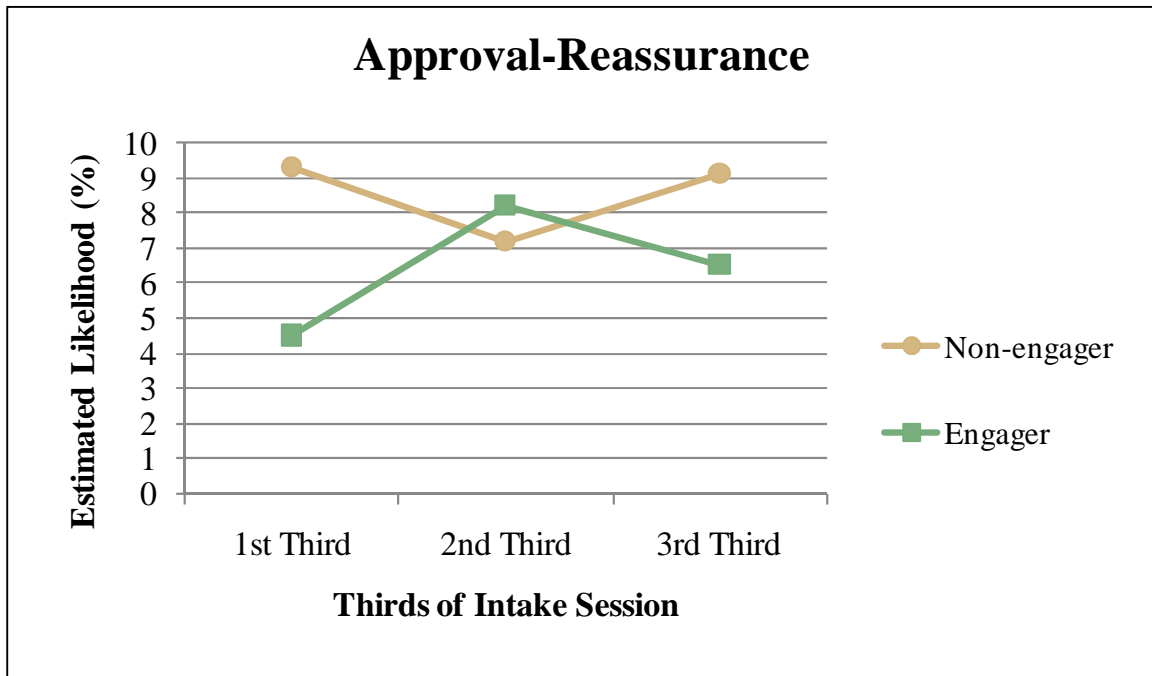


Figure 1. Adjusted estimated mean percentages of approval-reassurance for engagers and non-engagers across thirds of the intake sessions. The Condition X Time interaction was significant,  $F(2, 3856) = 3.75, p = .024$ . Therapist use of this skill differed for engagers and non-engagers in the first third of the sessions (comparing vertically),  $F(1, 3856) = 4.86, p = .028$ , but not in the second or last thirds.

*Research Question 2: Do proportions of therapist closed questions differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For closed questions, there was no statistically significant Condition X Time interaction,  $F(2, 3856) = 0.57, p = .566$ . Thus, we removed the interaction term from the model and tested the main effects models. Therapist use of closed questions did not significantly differ between engagers and non-engagers,  $F(1, 3861) = 0.03, p = .873$ . However, therapist use of closed questions differed across thirds of the intake sessions,  $F(2, 3858) = 31.48, p < .001$ . Planned comparisons revealed that the adjusted estimated mean proportions of therapist closed questions significantly increased from the first to the second third of the intake sessions,  $F(1, 3858) = 5.89, p = .015$ , decreased from the



second to last third,  $F(1, 3858) = 59.06, p < .001$ , and was significantly greater in the first compared to the last third,  $F(1, 3858) = 46.81, p < .001$ . Figure 2 illustrates the main effect of Time for the adjusted estimated mean percentages of closed questions.

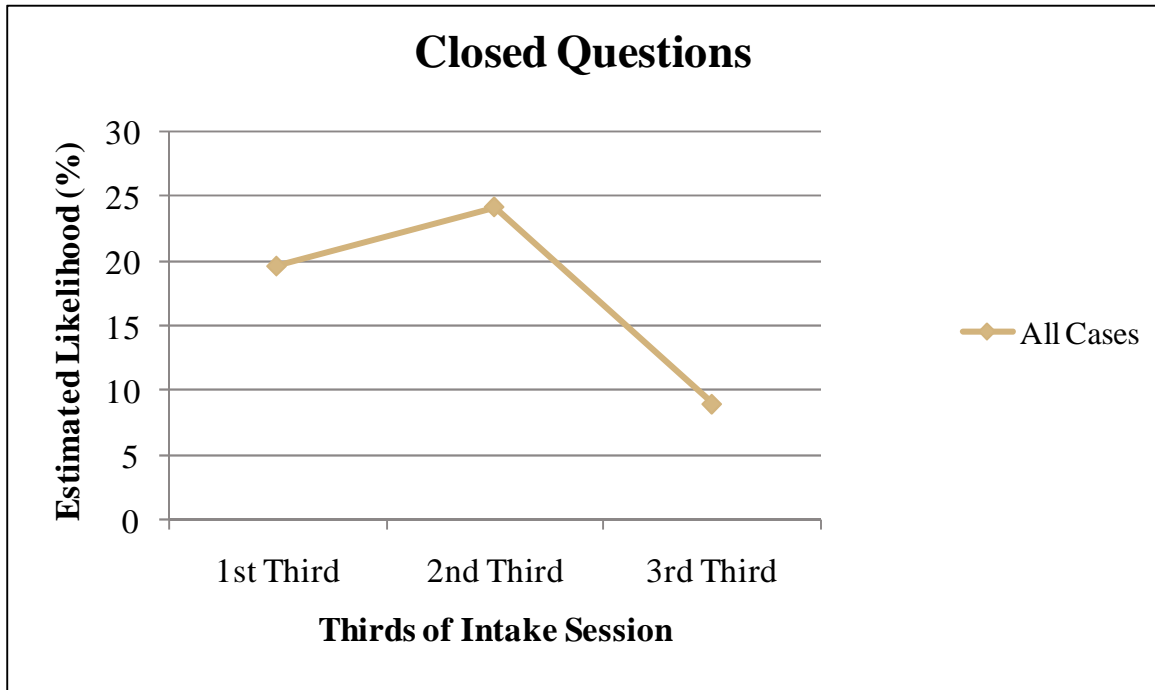


Figure 2. Adjusted estimated mean percentages of closed questions across thirds of the intake sessions when combining engagers and non-engagers. The Time main effect was statistically significant,  $F(2, 3858) = 31.48, p < .001$ . Therapist adjusted average use of closed questions changed significantly from the first to the second third,  $F(1, 3858) = 5.89, p = .015$ , from the second to the last third,  $F(1, 3858) = 59.06, p < .001$ , and from the first to the last third,  $F(1, 3858) = 46.81, p < .001$ .

*Research Question 3: Do proportions of therapist open questions about thoughts differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For open questions about thoughts, the Condition X Time interaction,  $F(2, 3856) = 0.51, p = .600$ , was not statistically significant and so we tested the main effects of condition (dropout versus continuer) and time (1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup> third of intake session)

separately. Thus, we removed the interaction term from the model and tested the main effects models. Therapist use of open questions about thoughts did not differ between engagers and non-engagers in the intake sessions,  $F(1, 3861) = 1.61, p = .205$ . However, therapist use of open questions about thoughts did differ across thirds of the intake,  $F(2, 3858) = 12.24, p < .001$ . Planned comparisons revealed that the estimated average use of open questions for thoughts significantly decreased from the first to the second third of the intake,  $F(1, 3858) = 4.91, p = .027$ , from the second to last third,  $F(1, 3858) = 6.63, p = .010$ , and from the first to last third,  $F(1, 3858) = 23.48, p < .001$ . Figure 3 illustrates the main effect of Time for the adjusted estimated mean percentages of open questions about thoughts.

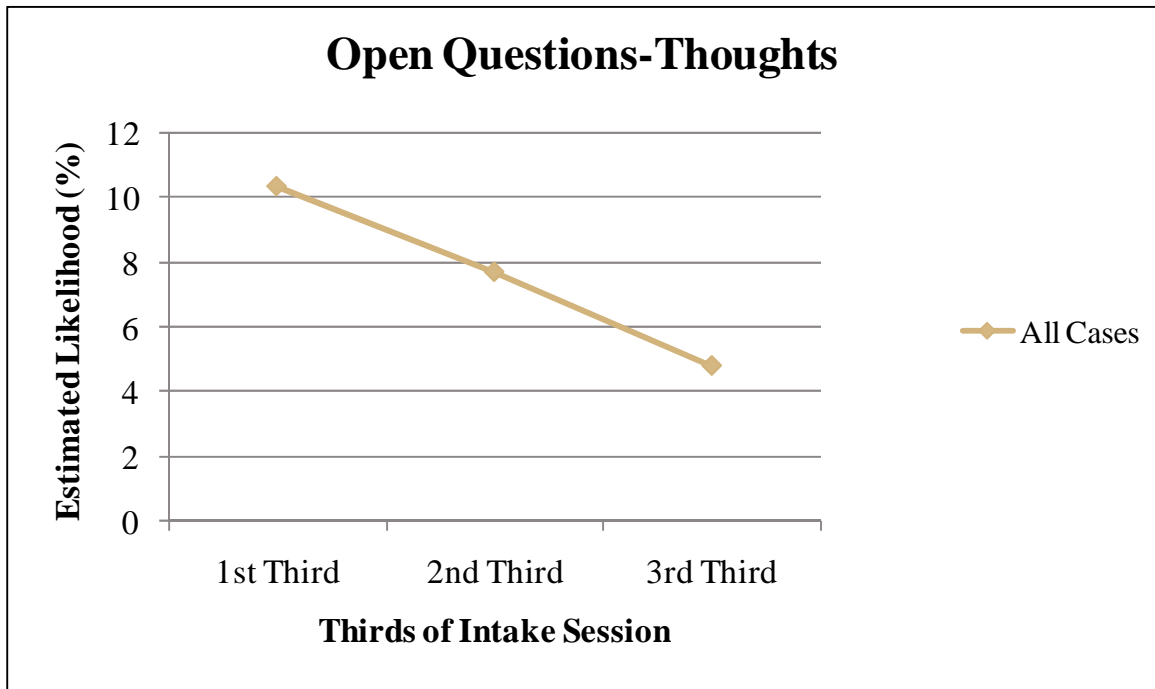


Figure 3. Adjusted estimated mean percentages of open questions-thoughts across thirds of the intake sessions when combining engagers and non-engagers. The Time main effect was statistically significant,  $F(2, 3858) = 12.24, p < .001$ . The adjusted average use of open questions about thoughts changed significantly from the first the second third,  $F(1, 3858) = 4.91, p = .027$ , from the second to last third,  $F(1, 3858) = 6.63, p = .010$ , and from the first to last third,  $F(1, 3858) = 23.48, p < .001$ .

*Research Question 4: Do proportions of therapist restatements differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For restatements, the Condition X Time interaction was statistically significant,  $F(2, 3856) = 5.66, p = .004$ . Planned comparisons indicated that therapists did not significantly differ in their use of restatements with engagers versus non-engagers in the first third of the sessions,  $F(1, 3856) = 0.75, p = .387$ , second third of the sessions,  $F(1, 3856) = 1.97, p = .161$ , or last third of the sessions, and  $F(1, 3856) = 2.46, p = .117$ , respectively. Figure 4 depicts the Condition X Time interaction for the adjusted estimated mean percentages of restatements.

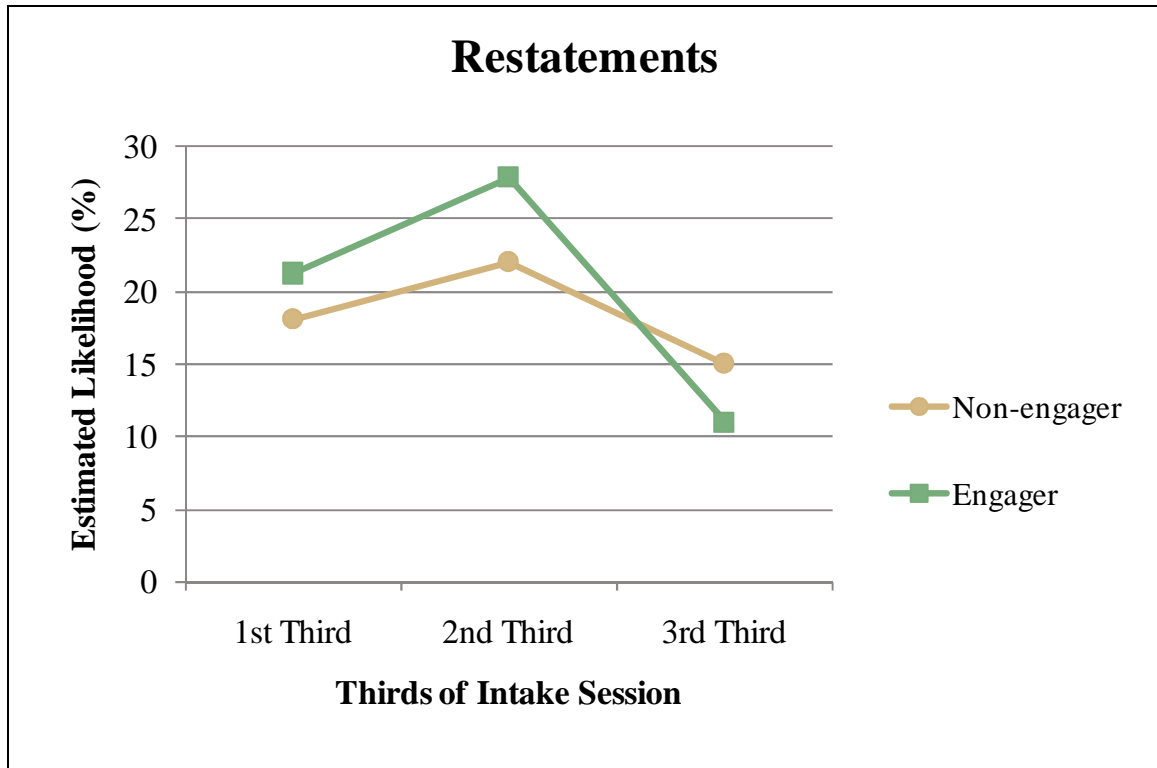


Figure 4. Adjusted estimated mean percentages of restatements for engagers and non-engagers across thirds of the intake sessions. The Condition X Time interaction was significant,  $F(2, 3856) = 5.66, p = .004$ .

Engager and non-engager groups did not significantly differ from each other (comparing vertically) within any of the thirds.

*Research Question 5: Do proportions of therapist reflections of feelings differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For reflections of feeling, the Condition X Time interaction was statistically significant,  $F(2, 3856) = 3.17, p = .042$ . Planned comparisons indicated that therapists did not significantly differ in their use of reflections of feeling with engagers versus non-engagers in the first or second third of the sessions,  $F(1, 3856) = 0.13, p = .721$ , and  $F(1, 3856) = 0.32, p = .574$ , respectively. Results for the final third were marginally

significant,  $F(1, 3856) = 3.95, p = .047$ . Figure 5 depicts the Condition X Time interaction for the adjusted estimated mean percentages of reflections of feeling.

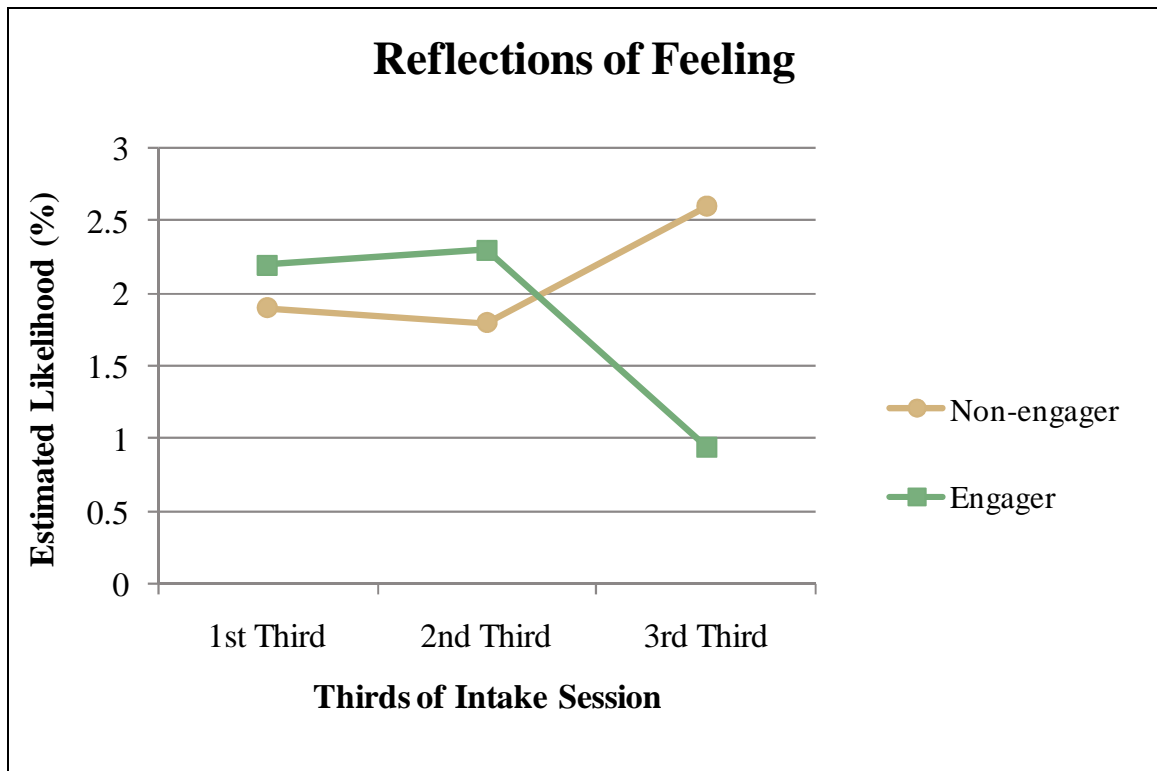


Figure 5. Adjusted estimated mean percentages of reflections of feeling for engagers and non-engagers across thirds of the intake session. The Condition X Time interaction was significant,  $F(2, 3856) = 3.17, p = .042$ . Engager and non-engager groups did not significantly differ from each other (comparing vertically) within any of the thirds.

*Research Question 6: Do proportions of therapist disclosure-miscellaneous differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For disclosure-miscellaneous, there was no statistically significant Condition X Time interaction,  $F(2, 3856) = 1.64, p = .195$ , and so we removed the interaction term from the model and tested the main effects models. Therapist use of disclosure-miscellaneous did not significantly differ between engagers and non-engagers,  $F(1, 3861)$

= 0.01,  $p = .917$ . However, therapist use of disclosure-miscellaneous differed across thirds of the intake sessions,  $F(2, 3858) = 4.16, p = .016$ . Planned comparisons revealed that the adjusted estimated mean proportions of therapist disclosure-miscellaneous significantly decreased from the first to the second third of the intake sessions,  $F(1, 3858) = 5.79, p = .016$ , but did not significantly change between the second to last third,  $F(1, 3858) = 0.47, p = .493$ , nor the first compared to the last third,  $F(1, 3858) = 3.25, p = .071$ . Figure 6 illustrates the main effect of Time for the adjusted estimated mean percentages of disclosure-miscellaneous.

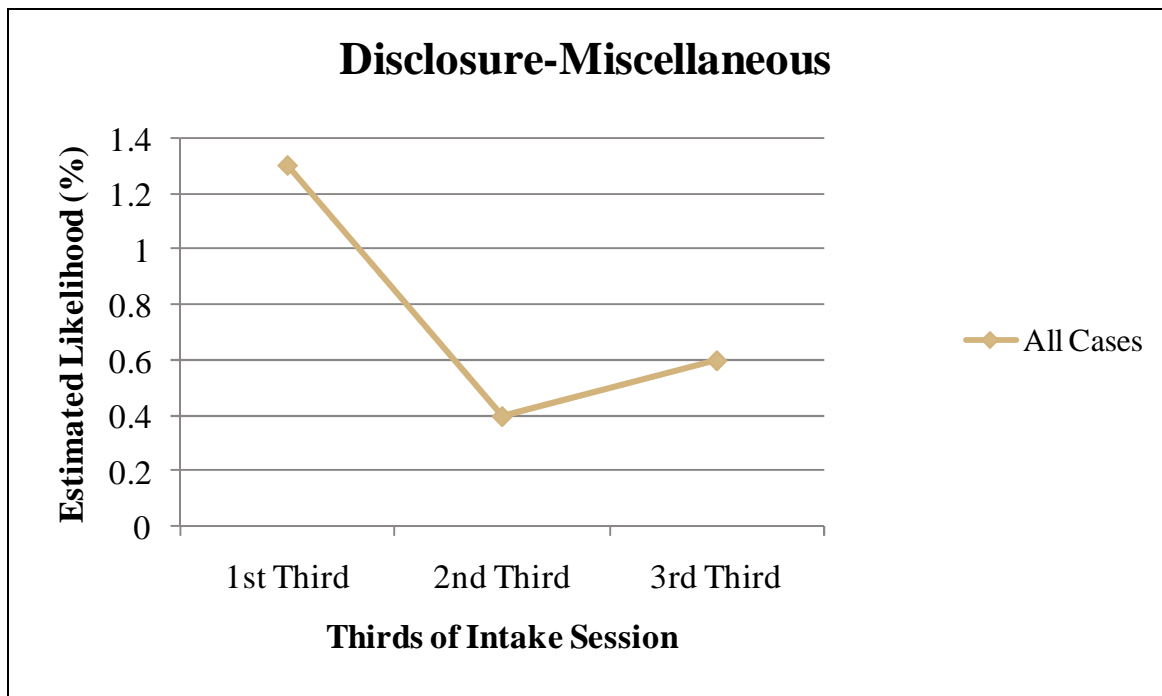


Figure 6. Adjusted estimated mean percentages of disclosure-miscellaneous across thirds of the intake session when combining engagers and non-engagers. The Time main effect was statistically significant,  $F(2, 3858) = 4.16, p = .016$ . The adjusted average use of disclosure-miscellaneous changed significantly from the first the second third,  $F(1, 3858) = 5.79, p = .016$ , but no significant differences were found from the second to the last third or from the first to the last third.

*Research Question 7: Do proportions of therapist immediacy differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For immediacy, there were no significant interactions or main effects. There was no statistically significant Condition X Time interaction,  $F(2, 3856) = 1.69, p = .185$ . Therapist use of immediacy did not significantly differ between engagers and non-engagers,  $F(1, 3861) = 1.68, p = .195$ . Therapist use of immediacy did not differ across thirds of the intake sessions,  $F(2, 3858) = 0.75, p = .472$ . Figure 7 depicts the adjusted estimated mean percentages of immediacy across thirds of the intake session for engagers and non-engagers combined.

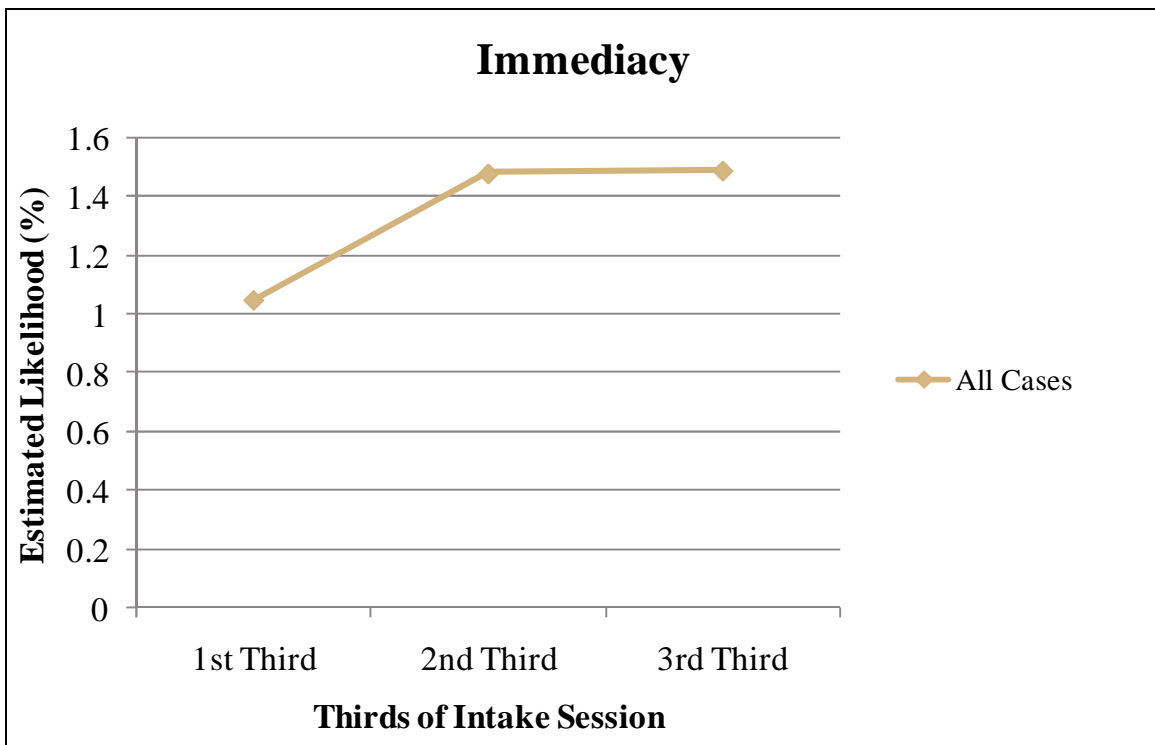


Figure 7. Adjusted estimated mean percentages of immediacy across thirds of the intake session when testing for a Time main effect. No statistically significant interaction or main effects were found.

*Research Question 8: Do proportions of therapist information about the process of helping differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For information about the process of helping, the Condition X Time interaction was statistically significant,  $F(2, 3856) = 10.86, p < .001$ . Planned comparisons indicated that therapists did not significantly differ in their use of information about the process of helping with engagers versus non-engagers in the first third of the sessions,  $F(1, 3856) = 0.42, p = .517$ , second third of the sessions,  $F(1, 3856) = 0.71, p = .398$ , or last third of the sessions, and  $F(1, 3856) = 4.05, p = .044$ . Figure 8 depicts the Condition X Time interaction for the adjusted estimated mean percentages of information about the process of helping.



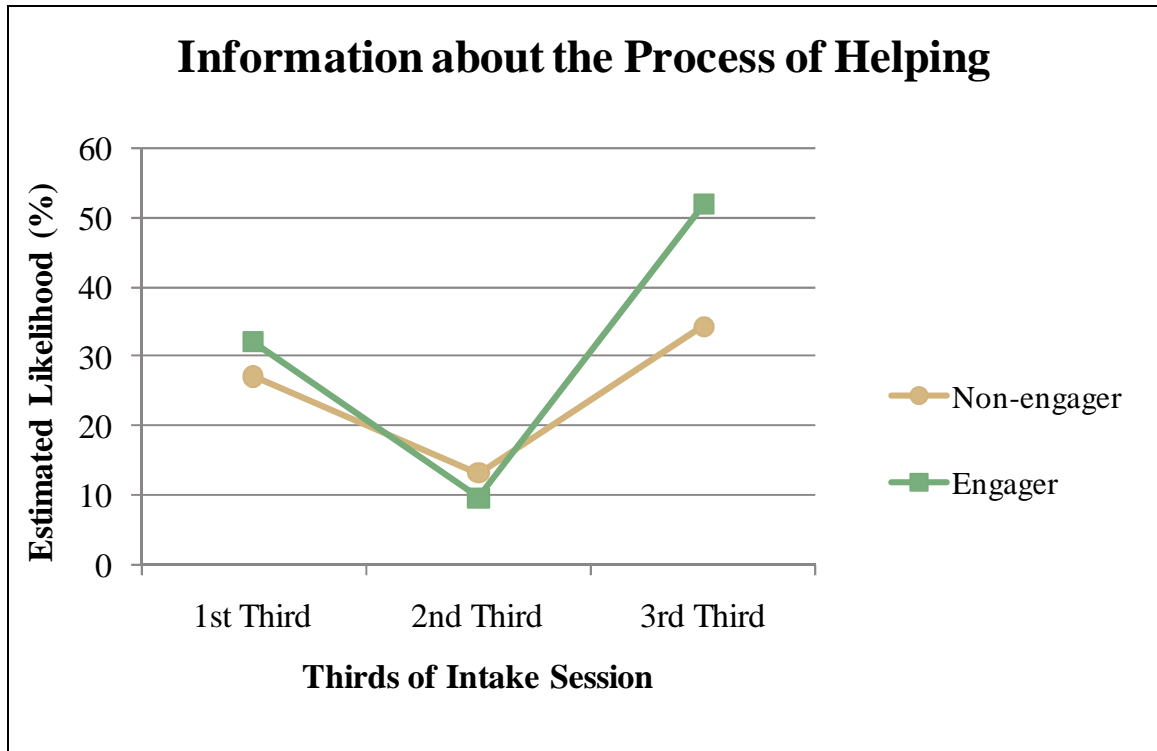


Figure 8. Adjusted estimated mean percentages of information about the process of helping for engagers and non-engagers across thirds of the intake session. The Condition X Time interaction was significant,  $F(2, 3856) = 10.86, p < .001$ . Engager and non-engager groups did not significantly differ from each other (comparing vertically) within any of the thirds.

*Research Question 9: Do proportions of therapist information in the form of facts, data or opinions differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For information in the form of facts, data or opinions, there was no statistically significant Condition X Time interaction,  $F(2, 3856) = 2.17, p = .115$ , and so we removed the interaction term from the model and tested the main effects models. Therapist use of information-facts/data/opinions did not differ between engagers and non-engagers in the intake sessions,  $F(1, 3861) = 1.36, p = .244$ . However, therapist use of information-facts/data/opinions did differ across thirds of the intake,  $F(2, 3858) = 25.57, p < .001$ .

Planned comparisons revealed that the estimated average use of information-facts/data/opinions significantly increased from the first to the second third of the intake,  $F(1, 3858) = 50.52, p < .001$ , significantly decreased from the second to last third,  $F(1, 3858) = 4.60, p = .032$ , and significantly increased from the first to last third,  $F(1, 3858) = 16.48, p < .001$ . Figure 9 illustrates the main effect of Time for the adjusted estimated percentages of information in the form of facts, data or opinions.

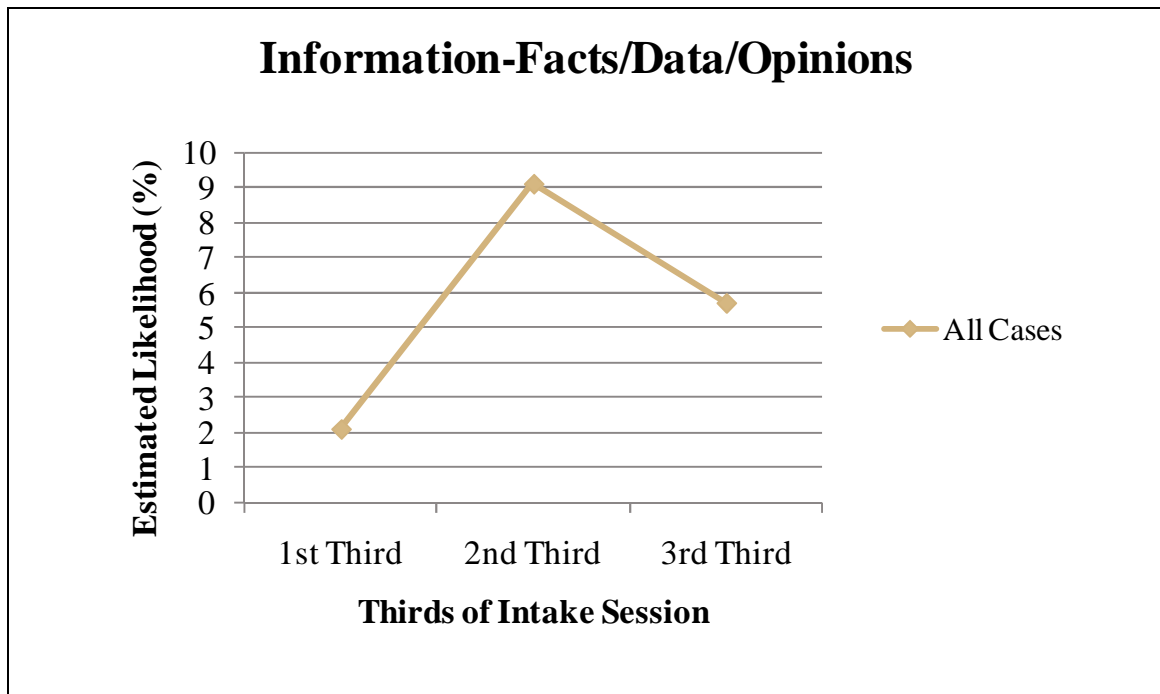


Figure 9. Adjusted estimated mean percentages of information-facts/data/opinions across thirds of the intake session when combining engagers and non-engagers. The Time main effect was statistically significant,  $F(2, 3858) = 25.57, p < .001$ . The adjusted average use of information-facts/data/opinions changed significantly from the first the second third  $F(1, 3858) = 50.52, p < .001$ , and from the second to last third,  $F(1, 3858) = 4.60, p = .032$ , and from the first to last third,  $F(1, 3858) = 16.48, p < .001$ .

*Research Question 10: Do proportions of therapist information differ across time (1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> thirds of intake sessions) and condition (engager versus non-engager)?*

For all types of information combined, the Condition X Time interaction was statistically significant,  $F(2, 3856) = 7.87, p < .001$ . Planned comparisons indicated that therapists did not significantly differ in their use of information with engagers versus non-engagers within the first third of the sessions,  $F(1, 3856) = 1.04, p = .309$ , second third of the sessions,  $F(1, 3856) = 0.49, p = .485$ , or last third of the sessions,  $F(1, 3856) = 2.37, p = .124$ . Figure 10 depicts the Condition X Time interaction for the adjusted estimated mean percentages of information (all subtypes combined).

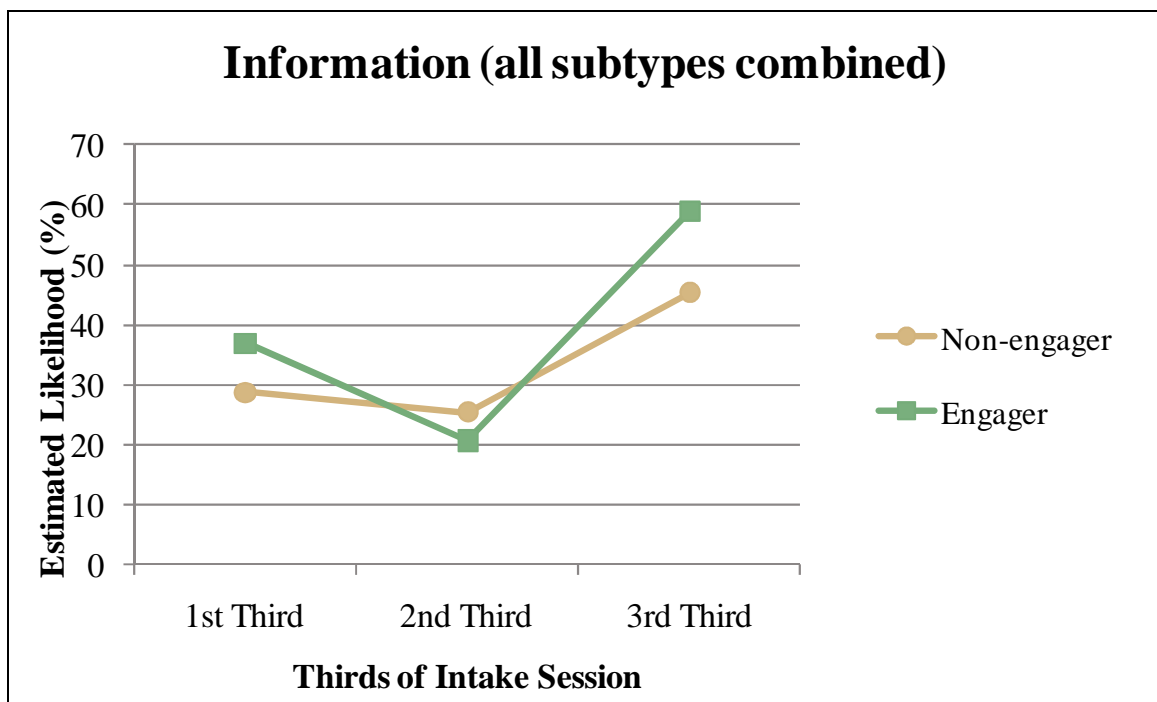


Figure 10. Adjusted estimated mean percentages of information (all subtypes) for engagers and non-engagers across thirds of the intake sessions. The Condition X Time interaction was significant,  $F(2, 3856) = 7.87, p < .001$ . Engager and non-engager groups did not significantly differ from each other (comparing vertically) within any of the thirds.

## All Nine Subtypes of Helpings Skills for Engagers and Non-engagers

All nine subtypes of helping skills for engagers versus non-engagers are shown for the intake sessions overall in Figure 11, for the first third in Figure 12, for the middle third in Figure 13, and for the last third in Figure 14.

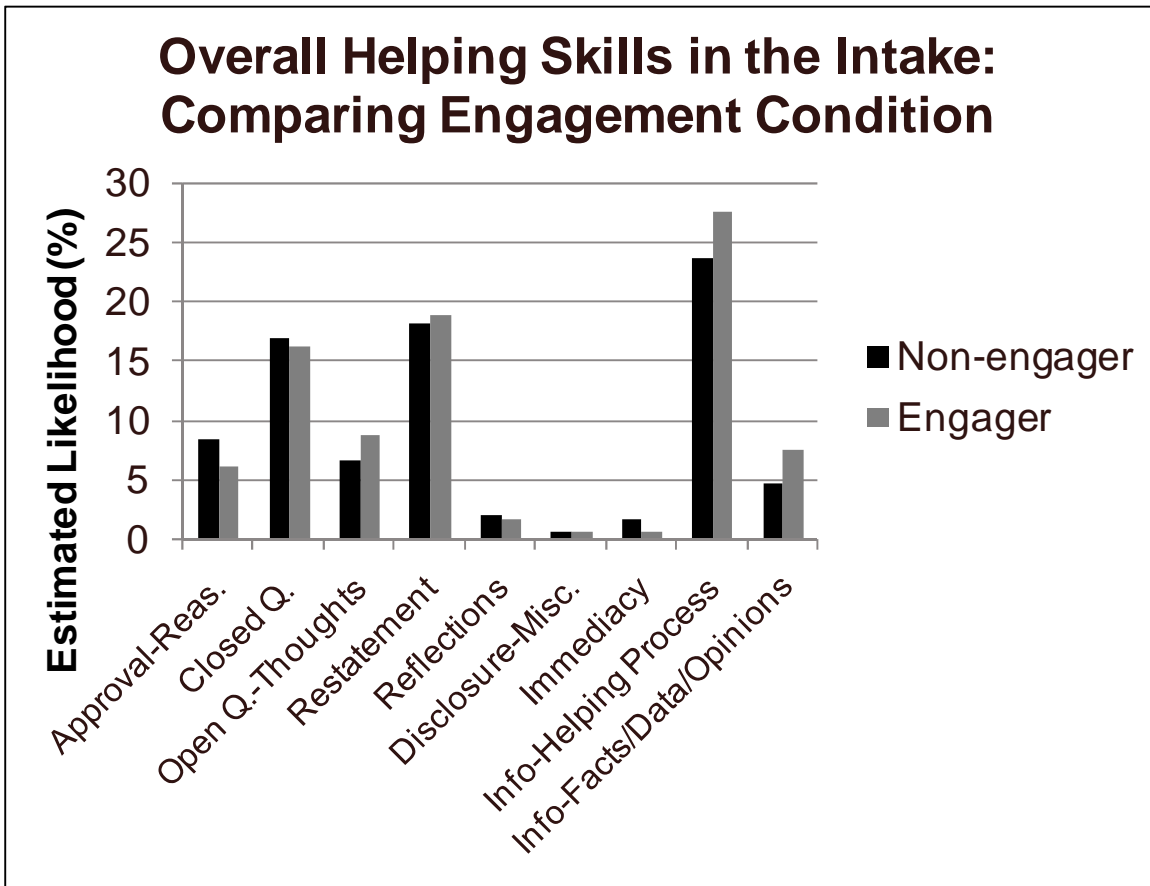


Figure 11. Adjusted estimated mean percentages of helping skills used overall in the intake session.

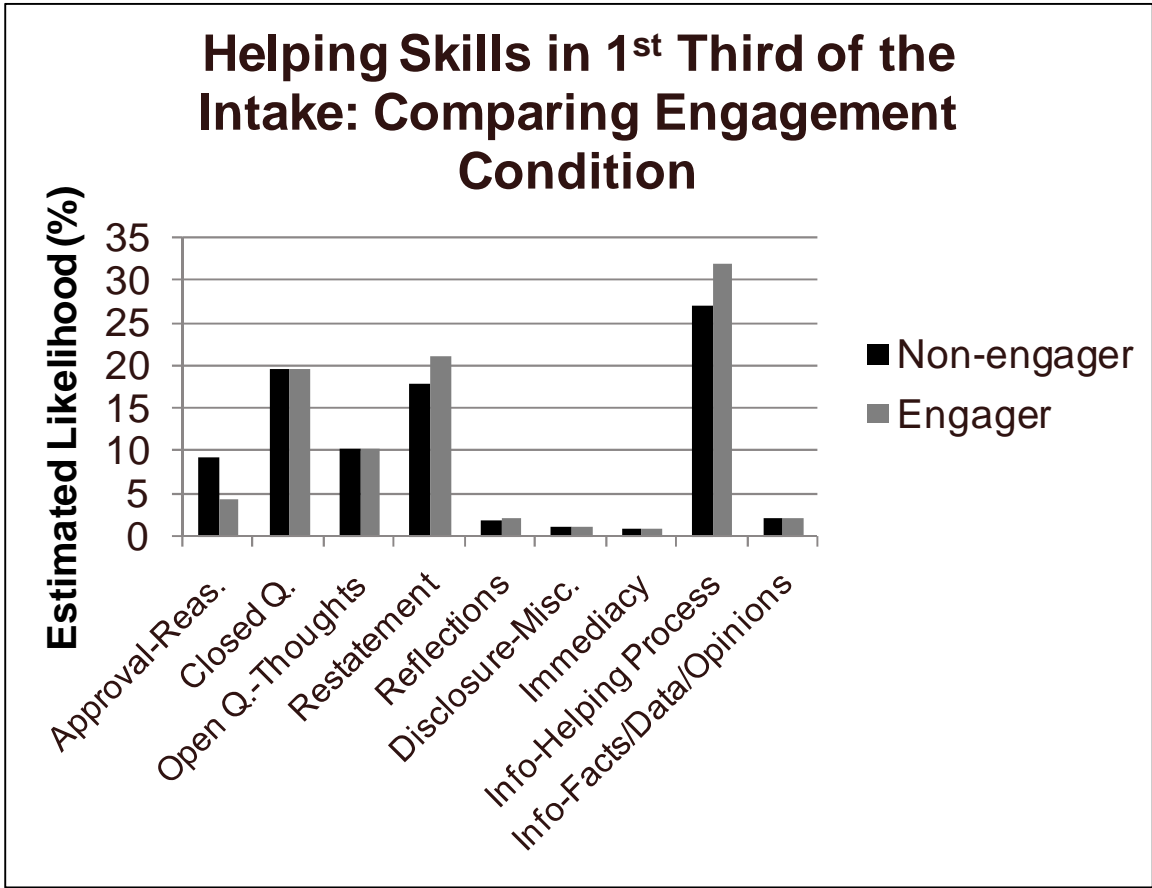


Figure 12. Adjusted estimated mean percentages of helping skills in the first third of the intake session.

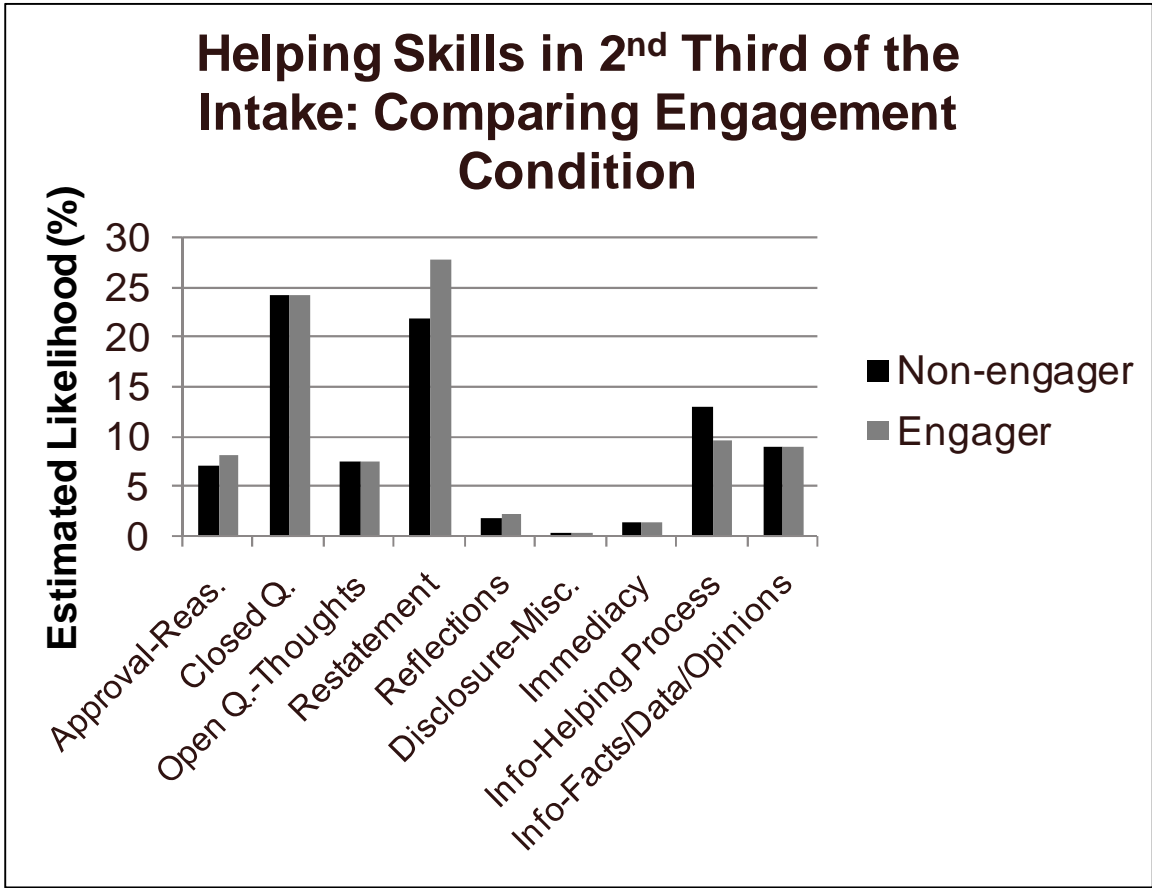


Figure 13. Adjusted estimated mean percentages of helping skills in the middle third of the intake session.

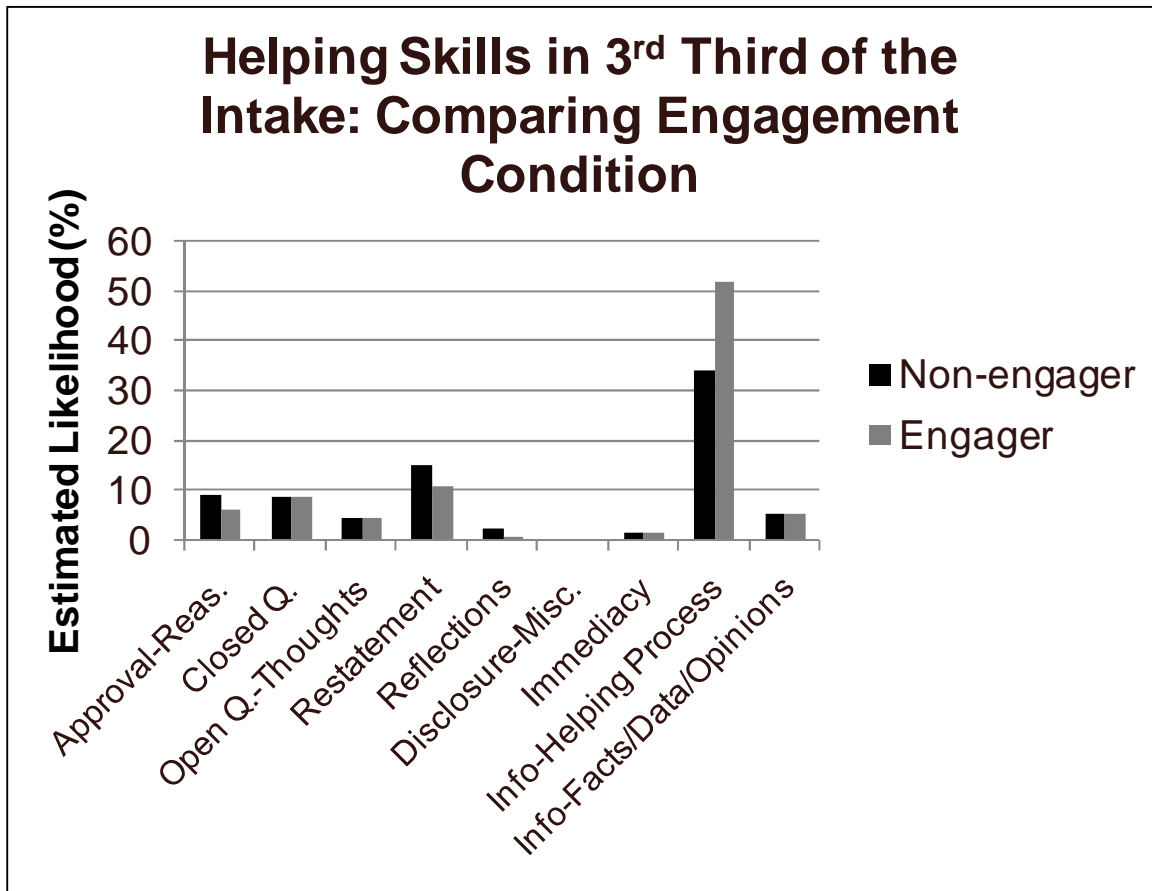


Figure 14. Adjusted estimated mean percentages of helping skills in the last third of the intake session.

#### Additional Analyses

**Client attachment style.** Attachment styles for engagers versus non-engagers were investigated. Non-engagers were more anxiously attached than engagers ( $n = 8$ ,  $M = 5.16$ ,  $SD = 1.19$  versus  $n = 7$ ;  $M = 3.93$ ,  $SD = 1.14$ , respectively; a large effect size,  $d = 1.06$ ; see Figure 15),  $t(13) = 2.05$ ,  $p = .061$  (two-tailed).

Marmarosh et al. (2009) reported that clients who dropped out after the third session but prior to a mutually-determined termination had significantly greater Anxiety subscale scores on the ECR than continuers who attended therapy beyond three sessions to a mutually-determined termination,  $F(1, 46) = 4.64$ ,  $p < .05$  (for dropouts:  $n = 17$ ,

Anxiety subscale  $M = 4.50$  [ $SD = 1.19$ ]; for engagers,  $n = 31$ , Anxiety subscale  $M = 3.67$  [ $SD = 1.34$ ]).

There was no significant difference between dropouts and engagers on the Avoidant scale (dropouts:  $n = 8$ ,  $M = 3.29$ ,  $SD = 1.40$ ; engagers:  $n = 7$ ,  $M = 3.07$ ,  $SD = 1.33$ ;  $d = 0.16$ ; see Figure 16),  $t(13) = .308$ ,  $p = .763$  (two-tailed). Marmarosh et al. (2009) found no significant differences between dropouts and engagers on self-reported attachment avoidance,  $F(1, 46) = 0.43$ ,  $p = .53$ .

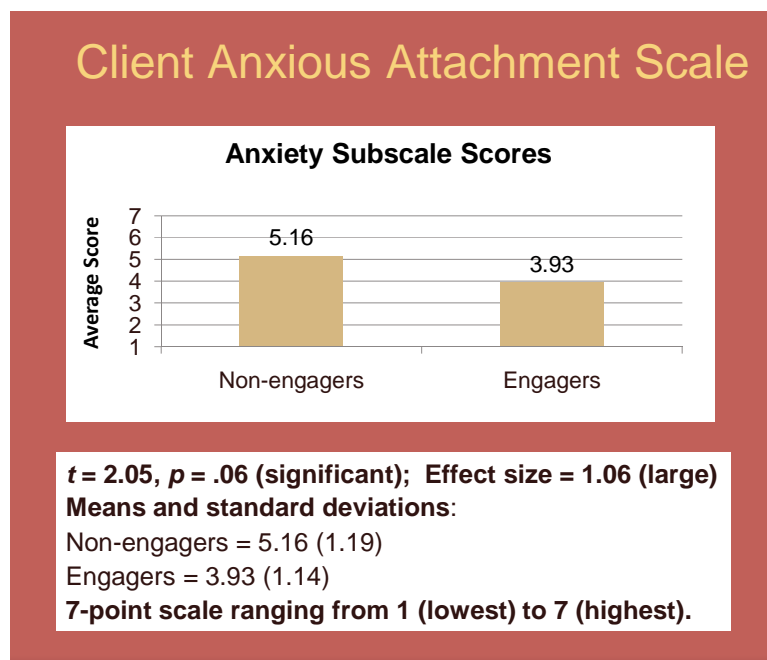
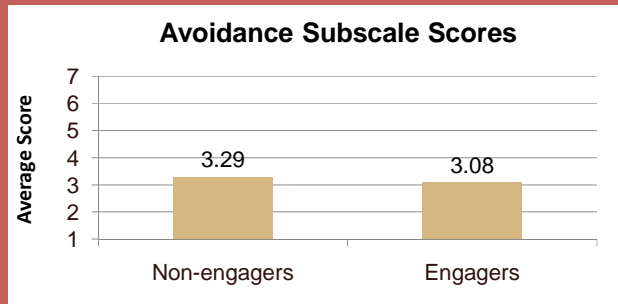


Figure 15. Engagers were more anxiously attached than non-engagers,  $t = 2.05$ ,  $p = .06$  (two-tailed).



## Client Avoidant Attachment Scale

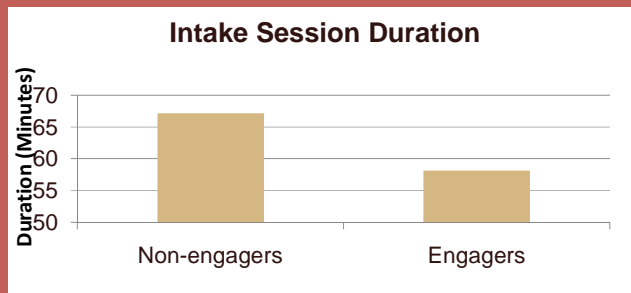


**$t = .31, p = .76$  (not significant); Effect size = .16**  
**Means and standard deviations:**  
Non-engagers = 5.16 (1.19)  
Engagers = 3.93 (1.14)  
**7-point scale ranging from 1 (lowest) to 7 (highest).**

Figure 16. Average avoidant attachment self-ratings between engagers and non-engagers did not differ.

**Intake session duration.** Intake sessions did not significantly differ in length for engagers versus non-engagers (non-engager  $n = 8, M = 67.1$  minutes,  $SD = 13.4$ ; engager  $n = 8, M = 58.1$  minutes,  $SD = 15.4$ ;  $d = 0.63$ ; see Figure 17),  $t(14) = 1.25, p = .23$  (two-tailed).

## Session Duration Results



**$t = 1.25, p = .23$  (not significant)**  
**Effect size = .67 (medium)**  
**Means and standard deviations (in minutes):**  
Non-engagers = 67.1 (12.5)  
Engagers = 58.1 (14.4)

Figure 17. Intake session duration did not significantly differ between engagers and non-engagers.

**Client pre-therapy need for therapy.** Non-engagers had higher pre-therapy self-rated need for psychotherapy than engagers (for non-engagers:  $n = 8$ ,  $M = 4.31$ ,  $SD = 0.59$ ; for engagers:  $n = 8$ ,  $M = 3.50$ ,  $SD = 1.07$ ;  $d = 0.98$ ; see Figure 18),  $t(14) = 1.88$ ,  $p = .081$  (two-tailed).

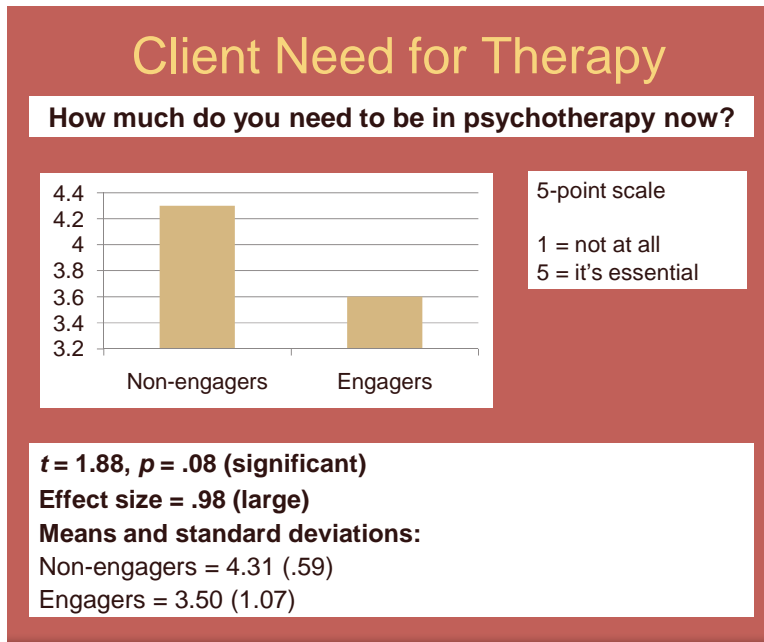
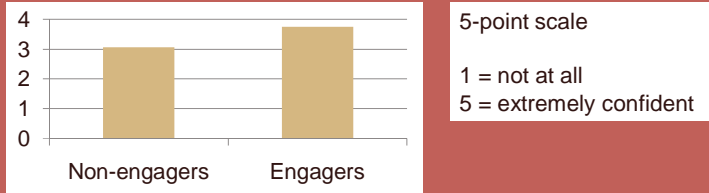


Figure 18. Engager versus non-engager pre-therapy self-rated need for psychotherapy.

**Client pre-therapy outcome expectations.** Engagers and non-engagers did not significantly differ on pre-therapy confidence that they could eventually overcome their problems and have satisfying lives (for non-engagers:  $n = 8$ ,  $M = 3.06$ ,  $SD = 1.52$ ; for engagers:  $n = 8$ ,  $M = 3.75$ ,  $SD = 1.04$ ;  $d = 0.54$ ; see Figure 19),  $t(14) = -1.06$ ,  $p = .309$ .

## Client Outcome Expectations

How confident are you that you can eventually overcome your problems and have a satisfying life?



$t = -1.06, p = .31$  (not significant)

Effect size = .54 (medium)

Means and standard deviations:

Non-engagers = 3.06 (1.52)

Engagers = 3.75 (1.04)

Figure 19. Engager versus non-engager pre-therapy outcome expectations.

## **Chapter 6: Discussion**

The present study examined therapist helping skills associated with psychotherapy engagement. Specifically, overall proportions of helping skills used in intake sessions, as well as proportions of helping skills used across thirds of intake sessions, were analyzed. In addition, a number of other variables were examined to help to explicate the results.

### **Overall Helping Skills and Psychotherapy Engagement**

Descriptively, of the 21 skills, the most frequently used skills in the intake sessions overall were: information about the helping process (28% of all skills used), restatements (19%), and closed questions (19%). Moderately-used skills in the intake included approval-reassurance (10%), open questions about thoughts (7%), and information-facts/data/opinions (7%). Less frequently used skills in the intake included reflections of feeling (3%), immediacy (3%), and disclosure-miscellaneous (1%). Rarely-used skills in the intake (less than 1%) included open questions about feelings, directives, open questions about insight, process advisement, challenge, interpretation, disclosure of feelings, information providing feedback about the client and statements not relevant to the helping situation (i.e. skills falling into the Other category). Never-used or skills in the intake were open questions about action, disclosure of insight, and disclosure of action.

Therapists did not significantly differ in their use of the helping skills with engagers versus non-engagers. This null finding contrasts to Tryon's (2003) findings that therapists used statistically significantly more information and fewer minimal encouragers with engagers than with non-engagers (the present study did not include

minimal encouragers since the 2009 version of the HSS was used). This divergence of results regarding therapist use of information could be due to a number of factors. First, the present study controlled for therapist verbal activity level whereas the Tryon (2003) study used raw numbers of skills, so it could be that the effect that Tryon (2003) found might not have turned out to be statistically significant had those analyses included more stringent controls for therapist verbal activity level. Second, perhaps the Tryon (2003) results applied to the particular therapist who participated in that study, since the Tryon (2003) study only had one therapist—the present study included four therapists. Third, the clients from Tryon’s study compared to the clients in the present study were different in terms of demographics and presenting concerns, which may have elicited differing patterns of therapist helping skills.

### **First Third of the Intake: Helping Skills and Psychotherapy Engagement**

Descriptively, the most-used helping skills in the beginning third of the intake were information about the helping process (25%), restatement (23%), and closed questions (21%). These results suggest that therapists were primarily trying to provide structure and elicit information from clients during this early stage.

In terms of differences between engagers and non-engagers, therapists provided significantly more approval-reassurance in the beginning third of the intake. Perhaps they provided more approval-reassurance because non-engagers were higher than engagers on self-reported pre-therapy anxious attachment style and rated themselves as more in need of therapy than engagers. Perhaps the non-engagers appeared more anxious and desperate for help compared to engagers, which elicited more approval-reassurance from the therapists at the beginning of the session.

### **Middle Third of the Intake: Helping Skills and Psychotherapy Engagement**

Descriptively, the middle third of the intake consisted primarily of restatements (30%) and closed questions (24%). Thus, skills related to exploring the client's issues were used the most in the middle part of the intake.

In terms of differences between engagers and non-engagers, therapists did not significantly differ in their use of helping skills in the middle third of the session. Perhaps therapists were equally able to focus on exploring client history and presenting issues mid-session with engagers and non-engagers, and perhaps client attachment style and need for therapy did not influence therapist helping skills mid-session as much as at the beginning and end of the session.

### **Last Third of the Intake: Helping Skills and Psychotherapy Engagement**

Descriptively, information about the helping process was the most-used skill (46%) by therapists in the last third of the intake. Restatements (13%), closed questions (10%), approval-reassurance (8%), and information-facts/data/opinions (8%) were moderately used. These skills suggest that therapists were wrapping up the session and doing treatment planning.

In terms of differences between engagers and non-engagers, reflections of feeling were used marginally more in the last third of the intake. Perhaps therapists noticed that the anxiously-attached non-engagers showed greater verbal and nonverbal signs of anxiety about the impending end of the session, which prompted them to use more reflections of feelings in order to discuss the negative emotions that the therapist was observing.

In contrast, information about the helping process was marginally greater with continuers than with non-engagers in the last third of the intake. One explanation, consistent with the attachment style findings, is that the therapists could focus on wrapping up the session, moving on, and talking about the next steps of the therapy process with the less anxiously-attached, less desperate-for-help engagers. Another explanation is that the more anxiously attached non-engagers may have experienced more anxiety about forming a new therapeutic relationship and may have been more ambivalent about continuing therapy. Such non-engagers may have given less clear indications about their intentions to continue with therapy, whereas engagers who planned to come back for a therapy session may have asked more questions about the therapy logistics and may have seemed more interested in hearing about how the therapy process would work. It is also possible that therapists had poorer session management with non-engagers compared to engagers, and failed to provide adequate information about the therapy logistics and the helping process at the end of the intake session.

### **Additional Analyses**

**Anxious attachment.** Non-engagers, on average, were more anxiously attached than engagers. This is similar to Marmarosh et al.'s (2009) finding that clients who dropped out after the third session of therapy had significantly higher self-reported attachment anxiety than did clients who had at least five sessions and a mutually agreed upon termination. In essence, there is initial evidence that attachment anxiety may predict premature termination, especially very early on in therapy (i.e. before the third session). In attachment theory, anxiously attached adults tend to be anxious about abandonment and worry about their relationships more than avoidantly or securely attached adults

(Brennan et al., 1998). Thus, perhaps the anxiously-attached non-engagers worried more about the therapist's ability to meet their relational needs and as a result had greater difficulty getting 'hooked in' to the therapy endeavor. Alternatively, possibly the anxiously-attached non-engagers worried that their therapists would later abandon them and pre-emptively abandoned the therapeutic relationship.

In contrast, Sauer, Lopez and Gormley (2003) did not find significant differences between engagers and non-engagers in terms of attachment anxiety, and Goldman and Anderson (2007) found no significant relationship between security of attachment and dropout. However, these two studies used other measures of attachment style, which may measure slightly different constructs (see Daniel, 2006). Further research is needed to determine whether the finding that outpatient dropouts are higher in anxious attachment is robust.

**Avoidant attachment.** No notable differences between engagers and non-engagers were found on the Avoidance scale of the attachment measure. These findings are similar to previous findings in the literature that avoidant attachment is unrelated to psychotherapy dropout (Marmarosh et al., 2009; Sauer, Lopez, & Gormley, 2003). These findings are also consistent with Goldman and Anderson's (2007) finding that attachment security was unrelated to dropout. In attachment theory, avoidantly-attached adults tend to avoid closeness with others (Brennan et al., 1998), and perhaps the tasks of an intake session were such that avoidantly-attached clients did not experience anxiety about the formation of a new therapeutic relationship as much as the more anxiously-attached non-engagers.

**Intake duration.** Engagers and non-engagers did not differ on intake session



duration. This null finding diverges from previous findings in the literature that non-engagement was associated with shorter intake sessions (Tryon, 1989a, 1989b, 1990). Perhaps the present study lacked statistical power to detect significant differences between engagers and non-engagers. Perhaps the therapist in Tryon (2003) allowed longer sessions for clients with whom the therapist had better rapport, whereas the therapists in the present study may not have differed as much for dropouts versus continuers in how long they allowed sessions to continue.

**Client pre-therapy need for therapy.** Non-engagers rated themselves as more in need of therapy prior to the intake session compared to continuers. This finding fits with greater therapist approval-reassurance at the beginning of the session with non-engagers as opposed to engagers as therapists may have tried harder to encourage the more desperate-for-help non-engagers. This finding also fits with greater therapist reflections of feeling at the end of the intakes as therapists may have continued exploration of the presenting issues of the non-engagers at the end of the session to help the more anxiously-attached, desperate-for-help non-engagers than the relatively less anxiously-attached, less desperate engagers. This finding also makes sense in light of the finding that therapists provided less information about the helping process at the end of the intakes with non-engagers than with engagers, as the more anxiously-attached non-engagers may have been showing more signs of anxiety about the end of the session and were more desperate for help from their therapists, so it may have been more difficult for therapists to wind down exploration of client concerns and move on to treatment planning.

**Client pre-therapy outcome expectations.** Engagers and non-engagers did not

differ in their confidence about overcoming their problems and have satisfying lives prior to the intake session. Although, on average, non-engagers were less hopeful than engagers, the differences at a medium effect size did not reach statistical significance. With a larger sample size and greater statistical power, this effect may have reached statistical significance.

## **Conclusions**

Overall, the patterns of helping skills (more approval-reassurance with non-engagers than engagers at the beginning of sessions, somewhat more reflections of feeling but somewhat less information about the process of helping with non-engagers than engagers at the end of sessions), the finding that non-engagers were higher in anxious attachment style than engagers, and the finding that non-engagers reported a higher need for therapy prior to therapy, provide evidence that intake sessions differ with engagers compared to non-engagers. The non-engagers may have elicited more approval-reassurance from their therapists at the beginning of the session due to verbal or nonverbal signs of anxiety about forming a new therapeutic relationship, and/or signs that they are desperate for help. Such non-engagers may have been more focused on obtaining immediate help from their therapists at the end of the session than the less-anxiously-attached, less-desperate continuers, and thus elicited somewhat more reflections of feeling and somewhat less information about the helping process at the end of the session. Strikingly, the attachment style findings were similar to that of Marmarosh et al. (2009), in which dropouts were also more anxiously attached than engagers.

## **Limitations**

Although the present study provides interesting findings about therapist helping skills, client attachment style, and client self-rated need for therapy with regard to psychotherapy engagement, the findings must be considered within the limitations of the study. One salient consideration is the low statistical power and limited generalizability due to the small sample size. Since the sample size is so small, the power to detect a significant effect when it actually exists is greatly reduced. In addition, the findings have limited generalizability since the significant findings from the study could be artifacts of the specific sample used and may not reflect the nature of outpatient psychodynamically-oriented individual adult psychotherapy. However, though the sample size is small, this is the largest study to-date looking at helping skills used in thirds of intake sessions, and Marmarosh et al. (2009) had similar attachment style findings with 31 engagers and 17 post-third-therapy-session dropouts. In addition, having therapists who worked with both engagers and non-engagers allowed for some control over therapist variables.

Another consideration to keep in mind is that the study utilized graduate student therapists rather than more experienced, licensed psychotherapists. It is possible that since the therapists for the study were graduate students in training, they were more easily de-railed from typical beginning, middle, and end-of-session tasks with the dropouts. However, the current study utilized equal numbers of engagers and non-engagers for each therapist, and controlled for therapist effects. Marmarosh et al. (2009) reported similar findings regarding anxious attachment and dropout in a study including 6 licensed therapists and 15 trainees, which suggests that similar results on attachment may

also apply to licensed therapists. It is also possible that the results may not reflect how more experienced and licensed psychotherapists would have conducted intake sessions.

A third consideration is that although helping skills were coded in a similar manner as has been done in the past, it is important to note that such coding is messy and not always clear-cut. Some of the therapist statements coded for the present study resided in ‘gray areas’ where it was debatable whether a particular sentence fell into one helping skills category versus another. Though the judges in the present study developed rules for coding ‘gray area’ sentences with high reliability, caution should be used in comparing helping skills results in this study versus other studies, given that different teams of judges may interpret the Helping Skills System manual differently and code ‘gray area’ sentences differently.

A fourth consideration is that the analysis for one of the skills, open questions about thoughts, was conducted without controlling for therapist effects due to limitations of the statistical software for this dataset. Thus, results from this particular analysis should be taken with the caution that differences in therapist use of open questions about thoughts may be affected by therapist differences.

A fifth consideration is that the measures of client pre-therapy need for therapy and outcome expectations were created for screening purposes for the clinic utilized in the study and no psychometric data had been collected prior to this study. Thus, though terms such as ‘need for therapy’ and ‘outcome expectations’ are used to describe the findings, it is advisable to keep in mind the original questions asked of the clients as they were screened for the clinic (i.e. “How much do you need to be in psychotherapy now?”

for need for therapy and “How confident are you that you can eventually overcome your problems and have a satisfying life?” for outcome expectations).

### **Implications for Practice and Research**

Given the findings about engagement in relation to client attachment and client pre-therapy self-rated need for therapy, providing therapists with feedback about client attachment style and client perceived need for therapy, when such information is available, might assist therapists in preparing strategically for their intake sessions with anxiously-attached, desperate-for-help clients. Therapists might want to try focusing on developing secure attachment relationships early on with such clients to avoid client non-engagement. Also, therapists might also try to stay focused on treatment planning at the end of the session with clients whom they believe could be anxiously attached and desperate for help. Furthermore, therapists might want to set aside time near the end of the session to process the therapeutic relationship and how the session was for the client. Processing the therapeutic relationship may avert or resolve ruptures in the therapy relationship (Hill & Knox, 2009), which in turn may help prevent or avert client dropout.

Implications for training are similar to the above. Counselors-in-training and therapists-in-training might be educated as to the research on dropout, including the patterns of helping skills associated with client engagement in therapy, and provided with feedback about client attachment style and client self-rated need for therapy. In particular, training programs might focus on what helping skills and session management techniques therapists-in-training might use to retain anxiously-attached clients, as well as desperate-for-help clients.

Further research is needed with larger-scale studies of helping skills, attachment style, intake duration, client need for therapy, client outcome expectations, and psychotherapy engagement to determine if the present study's findings are robust. Investigating interventions designed to work more effectively with anxiously attached clients, as well as clients who are desperate for help, would be clinically beneficial and possibly increase engagement in therapy of such clients. Future research is needed to determine the most effective skills and interventions for engaging anxiously-attached clients, as well as clients who are desperate for help.

### Appendix A: Preliminary Tests of Therapist Effects

Helping Skill Code & Name	Covariance Parameter Estimates		T score	Significant?*
	Estimate	Standard Error		
<b>1. Approval-Reassurance</b>	0.2350	0.2066	1.14	No
<b>2. Closed Question</b>	0.2226	0.1910	1.17	No
<b>3a. Open Question-Thoughts</b>	Did not converge.			
<b>4. Restatement</b>	0.07364	0.06632	1.11	No
<b>5. Reflection of Feelings</b>	0.3481	0.3200	1.09	No
<b>8d. Disclosure-Miscellaneous</b>	0.9872	0.8801	1.12	No
<b>9. Immediacy</b>	0.3970	0.3829	1.04	No
<b>10a. Info-Helping Process</b>	0.1627	0.1365	1.19	No
<b>10b. Info-Facts/Data/Opinions</b>	0.8682	0.7304	1.19	No
<b>10. Information (all subtypes combined)</b>	0.2602	0.2163	1.20	No

\*Note:  $t_{crit} = 1.96$  at an alpha level of .05

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