The Relationship Between Number of Sessions and Client-Judged Outcome

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THE RELATIONSHIP BETWEEN NUMBER OF
SESSIONS AND CLIENT-JUDGED OUTCOME

A Thesis
Presented to
the Faculty of the Department of Psychology
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Jay Edward Athy
August 1977
THE RELATIONSHIP BETWEEN NUMBER OF SESSIONS AND CLIENT-JUDGED OUTCOME

Recommended ____________________
(Date) ____________________
Director of Thesis
Daniel A. Shul

Approved ____________________
(Date) ____________________
Dean of the Graduate College

Acknowledgements

The successful completion of this thesis has been made possible by the following people.

Dr. Clinton Layne, my thesis committee chairman and unknowing mentor, has been an ever willing resource whose tireless dedication to this project I appreciate next only to his friendship - thank you Clint. Dr. David Shiek and Dr. Lois Layne, my committee members, have also gone above and beyond what could have been expected of them to make this thesis a meaningful and relevant undertaking. I would also like to thank Dr. Hecht Lackey, Tom McGloshen, and the entire medical records staff at the Barren River Comprehensive Care Center for their kind cooperation.

My wife, Donna, deserves my deepest gratitude for her unselfish support during this very difficult period in our lives. Such good friends as Cecil Miller, Keith Politi, and Bob Hobson have been invaluable in making life enjoyable and keeping everything in its proper perspective. Finally, a special thanks to my typist, proofreader, and literary style consultant, Phyllis Fritch. No one is happier to see this thesis put to rest than she.
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Outpatient clients from a community mental health center were surveyed by questionnaire to examine the relationship between number of therapy sessions attended and client-judgments of therapeutic outcome. The results indicated that client-judgments of therapeutic benefit tended to be independent of length of therapy for specific problem areas, yet highly related to duration of therapy when the client-judgment is a global assessment of therapeutic benefit. Controls for mode of therapy, initial diagnosis, type of referral, and status of case yielded similar findings. The nature of these relationships was nonlinear with the possible existence of different zones of sessions that account for varying degrees of client-perceived success. It also appeared that clients evaluated overall therapeutic effectiveness along different criteria than they evaluated therapeutic effectiveness for specific problem areas. Implications for future research are discussed.
Introduction

A prolific area of investigation into the effectiveness of psychotherapy has been the relationship between number of sessions and outcome. This research is predicated upon the hypothesis that there is a positive relationship between case length and client improvement, i.e., the more therapy the better. Numerous studies have been reported which support this hypothesis (Bartlett, 1950; Miles, Barrabee & Finesinger, 1951; Garfield & Kurz, 1952; Seeman, 1954; Dana, 1954; Myers & Auld, 1955; Tolman & Meyer, 1957; Standal & van der Veen, 1957; Graham, 1958; Garfield & Affleck, 1959; Cabeen & Coleman, 1961; McNair, Lorr, Young, Roth & Boyd, 1964). These studies show higher success ratings for longer cases utilizing various criteria of outcome which are primarily post hoc in nature. Contrary results appear, however, in the literature showing no association between number of sessions and outcome (Pascal & Zax, 1956; Dorfman, 1958; Nichols & Beck, 1960; Rogers, 1960; Lazarus, 1963; Marks & Gelder, 1965; Heilbrunn, 1966) with at least one study manifesting a negative relationship (Cartwright & Lerner, 1963).

Another series of investigations has uncovered a curvilinear relation between the number of sessions and outcome, with the number of clients improving either leveling off or declining as the amount of therapy increases past
an apparent point of diminishing returns. Feldman, Lorr, and Russell (1958) found in a large sample drawn from Veterans Administration clinics that therapist-rated improvement of clients reached a peak at the forty-fifth session only to level off and shift to a downward trend between the fifty-fifth and sixty-fifth session. Rosenthal and Frank (1958), on the other hand, found that the percentage of clients judged improved increased only up to twenty sessions before declining in a psychoanalytically-oriented clinic. Pruitt (1963) discovered a point of diminishing returns to occur at the twenty-fourth session with a vocationally oriented group of severely disturbed clients; and Cappon (1964) found the apex of improvement to occur at the thirty-fifth session using loss of main problem as the criterion. Cappon's study also revealed no reliable difference in improvement between clients who were seen for thirty-five sessions and those seen for a greater number ranging up to 217 meetings.

A separate set of studies have also shown a curvilinear relation between number of sessions and outcome, but earmarked by a critical zone of sessions during therapy where indices of client improvement declined before they rose again. Cartwright (1955) first uncovered this zone with a university counseling center population, labeling it the "failure zone," and found it to occur between the thirteenth and twenty-first session. He suggested that this failure zone may function as a divider between two different types of therapeutic processes, one short-term, comprised of clients with situ-
tional problems, and the other long-term, comprised of clients with personality disorders. Clients who drop out during this critical period may do so as a result of a defense system which resists self-exploration of potentially threatening material. Taylor (1956) found a similar zone to exist covering approximately the same number of sessions with outpatient clients at a Veterans Administration clinic.

With another university counseling center population, Johnson (1965) discovered the failure zone to occur much earlier in two samples consisting of vocational problems. The failure zone for vocational cases appeared between the fifth and seventh meeting for one sample and the sixth and eighth for the other. A recent study by Weitz, Abramowitz, Steiger, Calabria, Conable, and Yerushalmi (1975) attempted to isolate a failure zone in college counseling clients utilizing former client's responses to a questionnaire. This mode of assessment differed from the prior studies which used either counselor ratings (Cartwright, 1955), post hoc therapist evaluations of case histories (Taylor, 1956), or academic standing (Johnson, 1965) as criteria of outcome. The respondents were to check each of five areas provided in which they felt treatment to have been productive. A failure zone, spanning the sixth to tenth session, was reported only for the area of self-respect facilitation. This finding was interpreted as support for Cartwright's (1955) hypothesis of client resistance in that certain individuals may have difficulty in dealing with the unusual amount of personal learning
that occurs during therapy thus making them hypersensitive to feedback and termination prone.

Two major points are made in these research findings of curvilinear relationships between number of sessions and outcome. The first is that psychotherapy is not an interminable process, and sooner or later reaches a point of diminishing returns. This point has been found to range anywhere from the fifth to sixty-fifth session, depending on the type of client and the type of therapy. The implications of being able to isolate the range and central tendency of this optimal point are profound for both the economy-minded administrator and for the therapist-client relationship where goals and expectations can be more accurately assessed. Secondly, the substantiation of a failure zone with exacting parameters would not only suggest the existence of two types of therapeutic processes, but would also provide therapists invaluable information with regard to the dynamics of premature termination.

The purpose of this research was to examine further the nature and the extent of the relationship between number of sessions and therapeutic outcome.
Literature Review

Positive Relation Between Number of Sessions and Outcome

Numerous studies have demonstrated that direct positive relations occur in varying degrees of strength between number of sessions and some criterion of outcome. Bartlett (1950) attempted to assess the effectiveness of brief therapeutic counseling in a rehabilitation clinic for veterans with emotional problems. Ratings of improvement were obtained from supervisory personnel for 498 cases. A correlation of .24 was obtained between number of sessions and rated degree of improvement with those rated much improved having 5.2 sessions, some improvement 4.0, and no improvement 2.0. Miles, Barrabee, and Finesinger (1951) evaluated the effectiveness of intramural therapy using follow-up interviews of 62 cases of anxiety neurosis from Massachusetts General Hospital. Although the follow-up period ranged from two to twelve years, comparisons were made between experimenter ratings of pre-hospital adjustment based upon hospital records and experimenter ratings of contemporary adjustment based upon interviews. A significant general trend was found in favor of more psychotherapeutic interviews related to cases rated improved as opposed to those cases rated essentially unchanged.

A study done by Garfield and Kurz (1952) evaluated the records of 142 clients at a Veterans Administration clinic
with regard to number of sessions and adjudged outcome. This sample was not considered to be representative, however, and assessment of improvement was dependent upon what appeared in the records. Nevertheless, a positive relation was shown between a higher percentage of rated improvement and increased length of treatment. Interestingly, it was discovered that 30 percent of those who improved at all did so in less than five interviews, and over half in less than ten. In conjunction with a larger study done by Rogers and Dymond, Seeman (1954) examined ratings of client-centered counselors of process, relationship, and outcome variables for 29 clients seen at the University of Chicago Counseling Center. Analysis of the data revealed longer cases having higher success ratings. Furthermore, longer case ratings displayed significantly less variability than shorter cases (p < .01). Seeman concluded that if future studies confirmed these results then there would be a "strong assurance" for a client who has been seen for at least 20 sessions to gain from counseling as judged by the counselor.

Dana (1954) studied two groups of patients at the Danville Veterans Administration Hospital who had received individual psychotherapy. One group (short term) was comprised of 44 patients who had received 6 to 19 sessions (mean 12) and the other group (long term) was comprised of 46 patients who had received 20 or more sessions (mean 51). These two groups were compared along the variable of attitudes towards authority judged from responses given to Card IV of the Rorschach.
These adjudged attitudes were labeled as either adequate, inadequate, or negative and patient improvement was determined retrospectively from case summaries. It was found that adequate responding indicated a relatively good prognosis for both short and long term psychotherapy and that inadequate responding indicated a relatively poor prognosis for both short and long term psychotherapy. Negative responding indicated a relatively poor prognosis for short term psychotherapy suggesting the more therapy the better for this class of patients. Meltzoff and Kornreich (1970) point out, however, that what may have been measured was not so much attitudes toward authority as diagnosis and severity of personality disturbance. If this is the case, then the Dana study is actually illustrating the possibility of a differential relation between number of sessions and initial severity of disturbance.

Myers and Auld (1955) investigated the relationship between the manner in which therapy is terminated and number of interviews utilizing an out-patient population treated by senior staff and resident psychiatrists at Yale University. The mode of treatment for the 126 patients in the study was expressive psychotherapy. Manner of termination was assessed by a post hoc analysis of the records based upon therapist's staff notes yielding four categories of termination: patient quit, patient unimproved, patient improved, and therapy continued. It was found that 79 percent of the patients seen fewer than 10 times either quit or were discharged unimproved while this held true for only 15 percent of those seen 20 or
more times. Furthermore, the percentage of patients discharged as improved was 0 percent for those seen 10 sessions or less as compared with 43 percent for those seen 20 sessions or more. Once again these results seemed to demonstrate clearly that the more lengthy therapy was the more successful it became. The authors cautioned, however, against over interpretation because of inadequate control over individual difference among therapists in their classifications of patients as improved or unimproved and the lack of an objective criterion. Outcome, as in earlier studies, had been operationalized based upon the therapist's definition of client improvement.

A study by Tolman and Meyer (1957) at the Los Angeles Veterans Administration Clinic provided further evidence for the seemingly increased benefits of longer therapy. Case files of 354 former patients who had been seen five or more sessions including the intake interview were examined. The results showed that the group of patients who were rated as unimproved had a much greater proportion (67%) who had been seen fewer than 15 sessions than did the slightly improved (34%) or much improved (10%) groups. The converse was true with the much improved group having a far greater proportion who had continued treatment for 25 or more sessions. Hypothesizing that the relationship between case length and therapeutic change could be demonstrated more definitively, Standal and van der Veen (1957) studied length of therapy in relation to client-centered counselor estimates of personal
integration and nine other case variables. Personal integration was the primary dependent variable and was thought most likely to be related to case length because the personality reorganization that is implied is both a gradual and long process. Seventy-three clients were seen from two to more than seventy-two sessions in a negatively skewed distribution that was logarithmically transformed for purposes of data analysis. Reliability and validity of counselor judgments were discussed at length but the assumptions for reliability could not be met and validity for only two case variables, personal integration and success, was established. Results indicated that change in level of personal integration, as well as other case variables to a lesser degree, has a positive linear relationship with log case length.

Graham (1958) examined the effectiveness of psychoanalytically-oriented psychotherapy at the Long Island Consultation Center. A sample of 96 adults, who were diagnosed as either neurotic or psychotic, and the parents of 44 children seen by the center rated the effectiveness of therapy on a five point scale of improvement. It was found that adult neurotics reported a higher degree of improvement (74%) when seen for more than 38 sessions as opposed to their counterparts who were seen either 20 to 37 sessions (52%) or 4 to 19 sessions (19%). This same relationship was found for the parent ratings of children. No significant differences were found for adult psychotics, however, suggesting again the mitigating factor of initial level of disturbance in trying to determine the
success of therapy. Garfield and Affleck (1959) used therapist judgments of improvement for 135 closed cases at the Nebraska Psychiatric Institute in further studying the importance of length of therapy. Approximately half of the patients were judged improved by the ninth session and 91% who were seen more than twelve sessions were rated improved. The authors cautioned, however, that these results may be confounded by the therapist's knowledge of length of treatment and that judged improvement does not necessarily equate with an actual improvement in behavior or personality. A study by Harty and Horwitz (1976) bears upon the biased effects that may occur when a therapist's judgment is utilized as an index of client improvement. When a comparison was made between therapists, clients, and a research team's judgments of therapeutic success it was discovered that therapists overrated their successes compared to the other two groups.

An evaluation of a group therapy program with 120 sex offenders at a California state hospital showed a positive relation between therapeutic improvement and length of therapy (Cabeen & Coleman, 1961). Criteria for improvement were staff judgments made by two psychologists and six psychiatrists, test-retest protocols of the MMPI, and a follow-up evaluation ranging from six months to three years after hospitalization. Those patients who participated in the maximum amount of therapy were judged by the staff as significantly ($p < .001$) more improved than those patients who had attended fewer sessions. McNair et al. examined the persistence of psychotherapeutic
effects in a follow-up study of 81 veteran outpatients who had been seen at several clinics by a predominantly analytical staff (McNair, Lorr, Young, Roth, & Boyd, 1964). Client change was based on a research test battery and ratings of a post therapy interview in comparison to administrations of the test battery and therapist evaluations both during the course of prior therapy. Relevant results showed more gains in insight and less symptomology by those patients who had been seen a greater number of sessions.

In summary, the aforementioned studies provide a consistent block of evidence for the hypothesis that there is a direct, positive relationship between number of sessions and successful therapeutic outcome. Examination of the methods employed in these studies, however, warrant caution in making such an assumption as the more therapy the better. All the studies primarily utilized a post hoc assessment of therapeutic improvement based on either case records, therapist and/or experimenter ratings (with the exception of one study using client ratings), or follow-up interviews. Such methodologies have the inherent problems of being either dependent on what appears in the case records, relying on raters who have a vested interest in illustrating the benefits of therapy and who know the length of therapy, or trying to objectively quantify criteria for improvement. Also, adequate controls were not taken in many studies with regard to the client's initial level of disturbance and the majority of these studies were primarily designed to investigate something other
than the relationship between number of sessions and outcome. Therefore, the salient feature that emerges from these studies is a need for better controlled research whose specific function is to examine the relationship between number of sessions and outcome.

**No Relation Between Number of Sessions and Outcome**

Another group of studies have failed to illustrate any relation between number of sessions and outcome. Pascal and Zax (1956) argued that psychotherapy can be shown to be effective only along the more objective criterion of behavior change and not along such ambiguous criteria as improved or unimproved. Randomly sampling case files at a psychological clinic at the University of Tennessee, they found the prediction of behavioral changes to be a reliable barometer of "success" in psychotherapy. No differences were found, however, in the amount of behavioral changes in the predicted direction between groups of clients seen for at least 100 sessions, at least thirty sessions, and at least five sessions. Dorfman (1958) also found that gains made in client-centered child therapy showed no relationship with number of sessions. Nichols and Beck (1960) isolated six factors along which change may occur in psychotherapy from the California Psychological Inventory, a sentence completion test, and client and therapist rating scales. The sample consisted of 75 undergraduate students seen at the Purdue University Psychological Clinic and a comparable control group. While four of the factors showed mean changes representing significant improvement, only one
factor, therapist's post-therapy success rating, correlated
\( r = .29 \) with number of sessions.

In an extensive survey of 10,904 patients from fifty-
three clinics across the country, Rogers (1960) found that
there was no relation between the percentage of patients rated
improved and the average number of sessions. The validity
of these results, however, are questionable as there was con-
siderable variability in reporting length of treatment, de-
fining a therapy session, and in reporting percentages of
improvement. Lazarus (1963) examined the effectiveness of
behavior therapy techniques, primarily systematic desensitization,
in the treatment of 126 severe neurotics who had been seen
at least six sessions. It was found that the 20.6 percent
who were rated as unimproved averaged 11.3 sessions as com-
pared to the 15.9 sessions averaged by the 19 percent who were
rated completely recovered. The difference of 4.6 sessions
between unimproved and completely recovered, however, was not
significant. Marks and Gelder (1965) also found no relation-
ship between number of sessions and outcome when examining
behavioral techniques in the treatment of phobic patients.

Finally, two studies not only fail to show any reliable
positive relationship between number of sessions and outcome,
but also hint at a negative relationship. Cartwright and
Lerner (1963) examined the change that takes place during psycho-
therapy using pre- and posttest rating scales administered to
the therapist and client self-report. The sample was com-
prised of 28 clients at the University of Chicago Counseling
Center who had been seen by 16 client-centered therapists. Case length ranged from 6 to 116 interviews with a mean of 40. Clients who were rated improved averaged 37.33 sessions while those rated unimproved averaged 43.69 sessions. Heilbrun (1966) examined the possibility of differential therapeutic effects with three temporal variations of psychoanalytically-oriented therapy. Thirty-seven private patients were seen in one group for over 300 hours, fifty-four were seen for 100 to 300 hours, and seventy-five were seen for up to 100 hours. Therapist's judgment of improvement was used as the criterion of outcome and yielded the respective improvement percentages of 38 percent, 43 percent, and 45 percent. Interpretation in regard to relationship with number of sessions was confounded, however, by frequency and undefined duration.

This group of studies indicated that there was no association between number of sessions and outcome. Many of the same methodological flaws that plagued the studies which demonstrated a positive relation reappear here, however, weakening any generalizations that may have been made from the results. Similarly, the main focus of these studies was often upon some other aspect of psychotherapy.

**Curvilinear Relation Between Number of Sessions and Outcome**

Several studies have shown that a curvilinear relationship exists between number of sessions and outcome with the salient feature being a decrease in therapeutic benefit past a certain point. Feldman, Lorr, and Russell (1958) surveyed 63 Veterans Administration clinics across the country to obtain
information regarding the effects and benefits of psychotherapy. The survey sample consisted of 5,367 cases of which all but 475 were classified as open and ongoing. Therapist judgments were utilized to determine the degree of improvement in nine areas of maladjustment and in one global rating of overall adjustment. Results showed, for both open and closed cases, that the mean level of adjudged improvement initially rose sharply until the forty-fifth session where it then leveled off and began to decline between the fifty-fifth and sixty-fifth session. This point of diminishing returns was interpreted by the authors, however, as indicative of more improved patients leaving therapy at this time.

At the Henry Phipps Psychiatric Clinic in Baltimore, Maryland, Rosenthal and Frank (1958) studied 384 patients who were referred for individual, psychoanalytically-oriented psychotherapy. Along with pertinent demographic information and a pretherapy motivational assessment, it was noted if the patient had dropped out of therapy or had continued on until a mutual decision had been reached with the therapist for discontinuing. Furthermore, therapist judgments of improved or unimproved were made for each case. Only 254 patients from the initial sample attended at least one therapy session and only 216 were rated as improved or unimproved. Almost half of the patients dropped out after only five sessions or less prompting the authors to infer patient disappointment and/or anxiety over this mode of treatment which precluded their continuing. The highest frequency of improved cases appeared
either between one and five or 11 and 20 sessions, with the lowest frequency occurring either between six and ten or after 20 sessions. Furthermore, of all cases judged improved, over half had less than ten sessions.

Pruitt (1963) hypothesized that there may be an optimum period for the duration of group therapy, after which any further therapeutic benefit would be minimal. A vocationally oriented group comprised of 19 emotionally disturbed and vocationally handicapped clients was studied using the completion of the Pala Alto Group Psychotherapy Scale on a bi-weekly basis by the therapist. A mean rating was obtained on each client for four session blocks as long as they remained active in the group. It was found that therapeutic benefit peaked at the end of the twenty-fourth session and then began a gradual but significant decline from the twenty-eighth session on, suggesting that additional sessions past an optimal point may have had debilitating effects on some clients in groups.

Cappon (1964) attempted to examine the degree of effectiveness he had as a therapist with 163 private patients using essentially a psychoanalytical approach. "Marked improvement" was used as the standard of change and was assessed by pre- and post measures of leading problem or symptom by both therapist and client. Results showed patient improvement to increase up to the thirty-fifth session along dimensions of therapist's rating at end of therapy and the loss of main problem at the end of therapy. There was no significant difference for those patients seen for 35 sessions and for those seen up to 217 sessions.
Furthermore, the majority of patients who would demonstrate any change at all remitted at least one symptom of the main problem by the fifteenth session.

A final set of studies also revealed a curvilinear relationship between number of sessions and outcome, but one earmarked by a critical zone in which indices of client improvement declined before they rose again. Client-centered therapists at the University of Chicago Counseling Center rated 78 clients along a nine point rating scale of success at the conclusion of therapy (Cartwright, 1955). When mean number of sessions was plotted against mean success ratings it was discovered that those clients seen between 13 and 21 sessions had significantly lower \( p < .01 \) mean success ratings than those seen less than 13 sessions or more than 21 sessions. Cartwright labeled this curvilinear phenomenon a "failure zone" and felt that it was indicative of a division between short and long term therapy. He went on to hypothesize that short term therapy would be most successful with clients experiencing situational problems and long term therapy most successful with those clients having personality disorders. Furthermore, he suggested that the clients comprising the failure zone could be illustrated as a "drastic behavioral manifestation of resistance" (p. 363), with their being unable to continue therapy because of an inability or unwillingness to deal with the revelation of threatening self-aspects. It is implied that in the future client-centered therapists should take a more directive stance in guiding their clients through
this critical zone. Some substantiation for Cartwright's hypotheses are found in a study done by Strickland and Crowne (1963) who found that client defensiveness and the desire to avoid self-criticism were major determinants in premature termination of psychotherapy. Taylor (1956) replicated Cartwright's findings of a failure zone occurring from the thirteenth to the twenty-first session in a psychoanalytically oriented Veterans Administration clinic in Denver, Colorado.

Johnson (1965) found a failure zone between the fifth and seventh sessions and between the sixth and eighth sessions, respectively, for two samples of students seen at the University of Missouri Counseling Center by an eclectic staff because of "emotional problems." It was concluded that the failure zone is probably not attributable to any specific therapeutic technique, but that it is more representative of client defensiveness and/or therapist resistance in dealing with the presenting problem. The most recent study to delineate the occurrence of a failure zone during psychotherapy is reported from another university counseling center (Weitz, Abramowitz, Calabria, Couable, Steger, & Yarus, 1975). The sample was comprised of 186 undergraduate students who had received at least two individual therapy sessions. These students responded to a questionnaire which asked them to check each of five areas in which they felt therapy to have been helpful. The five areas that may have been checked were: (a) suicidal feelings, (b) grades, (c) specific problems, (d) decision making, and (e) self-respect. A positive, linear
relationship was found for all areas except self-respect which revealed a failure zone occurring between six and ten sessions. This finding was interpreted as indicative of clients becoming termination prone as a result of perceived threat from exploring highly sensitive personal areas and, therefore, consonant with Cartwright's (1955) earlier hypothesis of the dynamics of the failure zone.

In summary, this last section of the literature review highlights a group of studies that demonstrated the occurrence of a curvilinear relationship between number of sessions and outcome. Several studies showed that the benefits to be received from therapy increased in relation to the number of sessions only up to an optimal point. Past this point, ranging anywhere from five to sixty-five sessions, the benefits to be derived from therapy began to decline with the possibility of further therapeutic contact becoming detrimental for some clients. It was also illustrated in several studies that client indices of improvement may become lower during a critical zone of sessions during therapy than either before or after this temporal period. It has been hypothesized that such a zone exists as a manifestation of client resistance to the threat of exploring highly sensitive personal areas rendering the client termination prone. Furthermore, as Meltzoff and Kornreich (1970) suggest, prior studies that have shown either positive relationships or no associations at all between number of sessions and outcome may have discovered both a point of diminishing returns and a failure zone if the data had
been analyzed with only that in mind. The verification of a curvilinear relationship between number of sessions and outcome, be it a point of diminishing returns or a failure zone, would have strong implications for the nature and practice of psychotherapy.
Statement of Problem

The research on the relationship between number of sessions and some criterion of outcome has provided three disparate points of view. One set of studies demonstrated a positive, linear relationship that implies therapeutic success to be dependent upon an increased number of sessions, i.e., the more therapy the better. Conversely, another set of studies has revealed no association between number of sessions and outcome. A final set of studies has shown a curvilinear relationship that is characterized by either a point of diminishing returns or a span of sessions during therapy where client indices of improvement decline before a later recovery. Although it has been suggested that there may be more homogeneity among the findings of these studies than first meets the eye (Meltzoff & Kornreich, 1970), the manifest picture of the relationship between number of sessions and outcome is still not clear.

The present study was undertaken to examine further the nature of the relationship between number of sessions and therapeutic outcome. Client judgments of outcome were utilized as the criterion of success in lieu of therapist judgments which some researchers have questioned as being suspect because of vested interests (Garfield & Affleck, 1959; Harty & Horwitz, 1970). Furthermore, the subject sample employed
in this study was comprised of out-patient clients from a community mental health center which provided the opportunity for cross-validation of results from the majority of previous research whose samples were obtained from either college counseling centers, private clinics, or Veteran's Administration clinics. Data analysis was sensitive to type of referral, mode of therapy, present status of case, and initial level of disturbance which may be a significant factor in trying to determine the success of therapy. A specific attempt was made to analyze the data so as to reveal whatever relationship may exist between number of sessions and client-judged outcome.
Method

Subjects

The 93 subjects were clients who had been seen by an eclectic staff at the Barren River Comprehensive Care Center in Bowling Green, Kentucky. This is an outpatient mental health center which serves a community of approximately 46,000.

The clients included in the study were those who had started therapy at the Center during a one year period (July, 1975 to June, 1976) and who had returned a mailed questionnaire. The return rate was 48.7 percent. Not included were those who were under age 18 or those who had not attended at least one scheduled therapy session beyond the psychosocial evaluation.

Instrumentation

The questionnaire (Appendix A) utilized in the study provided three different areas of assessment for client-judged outcome. The first part of the questionnaire consisted of a 15 item checklist of common problems that clients frequently bring with them to the Center. Subjects were to check each area with regard to their contact with the Center as being either helpful, not helpful, or not a problem. The second area of assessment was a five point scale on which the subjects were to give a global rating of perceived success with
regard to the results of their contact with the Center. The final part of the questionnaire consisted of six items from the Tennessee Self Concept Scale (TSCS) which attempted to ascertain an individual's feelings of self-satisfaction with regard to his sense of personal worth. An entire subscale of the TSCS was not employed because of its prohibitive effects on response rate (Evans, Note 1). Non-quantitative features of the questionnaire included questions that asked the subjects if they would refer a friend to the Center for a similar problem and, if appropriate, reasons for termination.

Procedure

A questionnaire was mailed to 242 clients of the Comprehensive Care Center with a cover letter explaining the reason for the research. The envelope also contained a stamped, addressed envelope in which to return the questionnaire. Both the return envelope and the questionnaire were number coded to preserve client anonymity. The clients were asked to return the questionnaire within five days.

Ten days after the mailing date, for those questionnaires not returned, a phone call was made by the experimenter urging the client to send the questionnaire in as soon as possible. Those who did not respond after the phone call were sent a letter and another copy of the questionnaire. They were asked to return the questionnaire within seven days. The data collection was terminated two weeks after the last mailing date.

The therapists of the clients were told that some of
their former and present clients would be receiving questionnaires in the mail asking them to judge the outcome of therapy. Although the therapists were told the nature of the relationship to be studied and the general content of the questionnaire, they were asked to refrain from commenting on it to any former or present clients.

Relevant background data were obtained on each of the clients by reviewing the intake form in their charts located in the Center’s medical records department. The following information was included: 1) number of therapy sessions attended, 2) mode of therapy, 3) initial diagnosis, 4) type of referral, and 5) status of case.

**Scoring and Analysis**

Data for the total sample were comprised of number of therapy sessions attended, mode of therapy, initial diagnosis, type of referral, and status of case. Number of therapy sessions attended were considered in five ranges with 2 to 4 sessions being scored 1, 5 to 6 sessions scored 2, 7 to 9 sessions scored 3, 10 to 15 sessions scored 4, and 16 plus sessions scored 5. This breakdown of sessions was based upon having approximately 20% of the return sample represented within each range. Any further partitioning of sessions was prohibited by what would have been an unfairly small distribution of subjects within some of the ranges. Mode of therapy was scored 1 for primarily individual-chemotherapy, 2 for primarily group therapy, and 3 for primarily family
therapy. Initial diagnosis was scored 1 for neurosis, 2 for psychosis, 3 for personality disorder, 4 for marital maladjustment, 5 for stress reaction and situational disorder, and 6 for other diagnosis. Type of referral was scored either 1 for non-court or 2 for court. Status of case was scored either 1 for terminated or 2 for open.

For the sample returning the questionnaire, each item on the 15 item checklist was scored as either a 1 for a helpful response, a 2 for a not helpful response, or a 3 for a not a problem response. Missing values were scored as 3's and all 3 scores were excluded from the analysis. The overall success dimension had a response format of a one to five scale with a 1 being Very Unsuccessful and a 5 being Very Successful. Missing values for this dimension were excluded from the analysis. The six items from the TSCS had a response format of a one to five scale with a 1 being Completely False and a 5 being Completely True. The data obtained from these items were not analyzed.

Initially, chi square analyses were used to test the representativeness of the sample which had returned the questionnaire to the total sample surveyed along the population variables of mode of therapy, initial diagnosis, type of referral, and status of case. Chi square analyses were then performed to examine the extent of the relationship, if any, between the client-reported outcome dimensions and the number of sessions attended. Mode of therapy, initial diagnosis, type of referral, and status of case were controlled for con-
founding effects they may have had upon any association between number of sessions and outcome. Finally, the proportion of clients who responded that therapy had been helpful (helpful respondents) was also tabulated for each outcome dimension across number of sessions to assess the nature of the relationship.
Results

The total sample was comprised of 242 clients. Fifty-one clients had moved and left no forwarding address. Of the remaining 191, 48.7% or 93 clients returned the questionnaire. These 93 returns comprised the subject sample upon which data analyses were undertaken.

The return sample was shown to be representative of the total sample as non-significant chi square values ($p > .05$) were obtained along the population variables of mode of therapy ($\chi^2 = 2.08, df = 2$), initial diagnosis ($\chi^2 = 5.14, df = 5$), type of referral ($\chi^2 = 2.48, df = 1$), and status of case ($\chi^2 = 0, df = 1$). A significant chi square value ($p < .01$), however, was yielded for number of therapy sessions attended ($\chi^2 = 16.64, df = 4$) indicating that the distribution of subjects across number of sessions was not representative of the distribution in the total sample. Closer examination of the data revealed that this difference was exclusively attributable to fewer subjects responding within the 2 to 4 session range than would be expected from the total sample and more subjects responding within the 16 plus session range than would be expected from the total sample.

Chi square analyses were performed to assess whether therapeutic benefit as perceived by the client was dependent upon number of sessions attended. Table 1 illustrates the
obtained chi square values for each client-judged outcome dimension included in the checklist and the proportion of subjects responding in a helpful direction within each session range. Client evaluations of therapeutic benefit were shown to be independent of therapy duration with the exception of only one criterion, getting along with others (p < .05). These chi square values were a conservative estimate of the relationship in question, however, as Table 2 shows a severely skewed distribution with the majority of clients responding in a helpful direction if the outcome measure was seen as a problem area. The tabulated proportions of helpful respondents across number of therapy sessions attended revealed the nature of the relationship to be nonlinear for the majority of the checklist criteria (see Appendix B).

A chi square was also performed to test the association between the clients' overall rating of success and number of therapy sessions attended. A positive relationship was demonstrated ($\chi^2 = 36.61, df = 16$) that was statistically significant (p < .02). A nonlinear relationship also appeared for this outcome dimension when the mean success ratings for each session range were tabulated (see Figure 1). The mean success ratings were 2.84, 4.43, 3.32, 4.05, and 3.53, respectively, for each of the five session ranges.

When mode of therapy, initial diagnosis, type of referral, and status of case were individually controlled for in the above chi square analyses the obtained results were shown to be highly similar to the original findings. Finally,
Pearson product-moment correlations were performed between the client-judged outcome dimensions of the checklist and the overall success dimension. The correlations between the variables ranged from .01 to .43 indicating that these two areas of assessment for client-judged outcome were measuring different facets of treatment benefit as perceived by the client.
<table>
<thead>
<tr>
<th>Client's judgment of whether treatment was helpful in the following problem areas:</th>
<th>2-4 (n=21)</th>
<th>5-6 (n=15)</th>
<th>7-9 (n=19)</th>
<th>10-15 (n=19)</th>
<th>16-plus (n=19)</th>
<th>( \chi^2 ) value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>91.7</td>
<td>100.0</td>
<td>90.0</td>
<td>55.6</td>
<td>77.8</td>
<td>7.39</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>82.4</td>
<td>100.0</td>
<td>88.2</td>
<td>88.2</td>
<td>89.5</td>
<td>2.13</td>
</tr>
<tr>
<td>Physical</td>
<td>71.4</td>
<td>75.0</td>
<td>75.0</td>
<td>88.9</td>
<td>57.1</td>
<td>2.11</td>
</tr>
<tr>
<td>Getting along with others</td>
<td>57.1</td>
<td>100.0</td>
<td>75.0</td>
<td>100.0</td>
<td>92.9</td>
<td>9.47**</td>
</tr>
<tr>
<td>Depression</td>
<td>66.7</td>
<td>100.0</td>
<td>88.9</td>
<td>88.2</td>
<td>94.4</td>
<td>8.50</td>
</tr>
<tr>
<td>Sex</td>
<td>83.3</td>
<td>50.0</td>
<td>80.0</td>
<td>57.1</td>
<td>85.7</td>
<td>2.95</td>
</tr>
<tr>
<td>Self-respect</td>
<td>81.8</td>
<td>100.0</td>
<td>92.9</td>
<td>100.0</td>
<td>100.0</td>
<td>6.44</td>
</tr>
<tr>
<td>Anxiety</td>
<td>76.5</td>
<td>100.0</td>
<td>73.3</td>
<td>100.0</td>
<td>83.3</td>
<td>7.39</td>
</tr>
<tr>
<td>Suicide</td>
<td>83.3</td>
<td>100.0</td>
<td>80.0</td>
<td>100.0</td>
<td>100.0</td>
<td>3.56</td>
</tr>
<tr>
<td>Family</td>
<td>90.9</td>
<td>80.0</td>
<td>92.9</td>
<td>100.0</td>
<td>84.6</td>
<td>2.89</td>
</tr>
<tr>
<td>Decision-making</td>
<td>81.8</td>
<td>100.0</td>
<td>85.7</td>
<td>84.6</td>
<td>93.7</td>
<td>2.13</td>
</tr>
<tr>
<td>Phobias and fears</td>
<td>83.3</td>
<td>80.0</td>
<td>60.0</td>
<td>87.5</td>
<td>77.8</td>
<td>1.50</td>
</tr>
<tr>
<td>Work</td>
<td>75.0</td>
<td>100.0</td>
<td>100.0</td>
<td>77.8</td>
<td>71.4</td>
<td>2.54</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>100.0</td>
<td>------</td>
<td>75.0</td>
<td>100.0</td>
<td>66.7</td>
<td>1.80</td>
</tr>
<tr>
<td>Other</td>
<td>88.9</td>
<td>100.0</td>
<td>100.0</td>
<td>90.9</td>
<td>100.0</td>
<td>2.04</td>
</tr>
</tbody>
</table>

\( \ast p < .05 \)

\( \ast \ast p < .07 \)
TABLE 2

Distribution of Responses for Client-Judged Outcome Criteria

<table>
<thead>
<tr>
<th>Outcome criteria comprising the checklist:</th>
<th>Response Mode</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Helpful</td>
<td>Not Helpful</td>
<td>Not a Problem</td>
</tr>
<tr>
<td>Marriage</td>
<td>39</td>
<td>8</td>
<td>46</td>
<td>83</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>72</td>
<td>9</td>
<td>12</td>
<td>74</td>
</tr>
<tr>
<td>Physical</td>
<td>23</td>
<td>9</td>
<td>62</td>
<td>85</td>
</tr>
<tr>
<td>Getting along with others</td>
<td>40</td>
<td>60</td>
<td>13</td>
<td>95</td>
</tr>
<tr>
<td>Depression</td>
<td>70</td>
<td>10</td>
<td>9</td>
<td>98</td>
</tr>
<tr>
<td>Sex</td>
<td>21</td>
<td>3</td>
<td>47</td>
<td>88</td>
</tr>
<tr>
<td>Self-respect</td>
<td>65</td>
<td>11</td>
<td>13</td>
<td>97</td>
</tr>
<tr>
<td>Anxiety</td>
<td>27</td>
<td>5</td>
<td>64</td>
<td>95</td>
</tr>
<tr>
<td>Suicide</td>
<td>52</td>
<td>7</td>
<td>32</td>
<td>92</td>
</tr>
<tr>
<td>Family</td>
<td>54</td>
<td>7</td>
<td>60</td>
<td>93</td>
</tr>
<tr>
<td>Decision-making</td>
<td>26</td>
<td>7</td>
<td>62</td>
<td>99</td>
</tr>
<tr>
<td>Phobias and fears</td>
<td>23</td>
<td>5</td>
<td>65</td>
<td>95</td>
</tr>
<tr>
<td>Work</td>
<td>10</td>
<td>2</td>
<td>81</td>
<td>95</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td>37</td>
<td>2</td>
<td>54</td>
<td>95</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1. Mean overall success ratings across number of sessions.
Discussion

The results of this study indicate that client-judgments of therapeutic benefit tend to be independent of therapy duration for specific problem areas. Of the 15 outcome criteria included in the checklist on the questionnaire, only the criterion getting along with others showed any significant relationship with number of therapy sessions attended. It appears that the successful learning and integration of new and more appropriate interpersonal strategies by the client may take a longer time in therapy than some other problems.

The relationship between some of the other client-evaluated outcome measures and number of therapy sessions may have also reached the conventional standard of statistical significance ($p \leq .05$) if the variance had not been so restricted because of the severely skewed distribution of client responses in a helpful direction. A more balanced distribution of cases would have been achieved if the many clients responding to the outcome criteria as being not a problem were included in the analysis along with the not helpful responders. This would have resulted in creating an artificial amount of variance to be accounted for by the length of therapy. The Weitz et al. (1975) study, conversely, did not provide an opportunity for their subject's to respond to the outcome criteria as being not a problem. They made the implicit
assumption in their analysis that clients not responding to specific outcome criteria did so because they felt therapy not to have been helpful instead of considering the possibility that it may not have been a problem. This dubious assumption renders their findings that therapeutic productivity is dependent upon number of therapy sessions for four out of the five outcome criteria they employed as suspect. Future research utilizing client-judged outcome dimensions for specific problem areas should, therefore, be sensitive to the fact that many clients may not perceive all the criteria being assessed as problem areas.

The nature of the relationship between many of the specific outcome criteria included in the checklist and number of therapy sessions attended is manifestly nonlinear with the possible existence of both failure zones and points of diminishing returns. Problems with anxiety, suicide, and phobias/fears show their lowest client-ratings of therapeutic benefit to occur between seven to nine sessions. Failure zones for sex and family problems are found between five to six sessions and a failure zone between ten to fifteen sessions is found for marriage problems. A point of diminishing returns occurs at the end of nine sessions for work problems and at the end of fifteen sessions for physical problems. Furthermore, all of the outcome dimensions utilized in the checklist reveal varying peaks of success and valleys of failure across number of sessions. This suggests that not only is it possible for the concept of a failure zone or a
point of diminishing returns to exist in therapy, but success zones may also be occurring where clients appear to perceive maximum benefit from therapy. The nature of therapeutic productivity across number of sessions may, therefore, be comprised of session ranges where clients receive maximum benefit from therapy (success zones), and minimal benefit from therapy (failure zones).

The manifest nonlinearity between number of therapy sessions attended and client-judged outcome may also be conceptualized as a function of clients starting therapy and continuing on at different levels of therapeutic success. Some clients may always experience a high degree of success in therapy while others may never receive more than minimal benefit from therapy. A third class of clients may fluctuate between maximal and minimal therapeutic benefit throughout therapy. The uncontrolled combination of these three classes of clients into one sample may result in misleading nonlinearity between number of sessions and therapeutic outcome. This possible confounding effect is a major flaw of this study and of previous studies that have utilized cross sectional designs.

The importance of these findings is that the nature of client-judged therapeutic benefit appears to be a varying matter with more clients rating themselves as being helped at certain times than other times. Furthermore, the nature of this relationship may be conceptualized as encompassing different zones of sessions that account for varying degrees of client-perceived success. Where therapy is perceived as
being most or least productive appears to be related only to the specific outcome criterion in question rather than dependent upon any set number of sessions attended. Furthermore, mode of therapy, initial diagnosis, type of referral, and status of case seem to have minimal moderating effects on the nature of the relationships for this client sample. Future research should continue to examine the nature of the relationship between client-judged outcomes and number of therapy sessions attended with a focus on the probability that this relationship is nonlinear and may be comprised of specific success zones, success/failure zones, and failure zones or points of diminishing returns for specific problem areas. Whenever possible the designs of these future studies should be longitudinal so as to more accurately assess the intrasubject fluctuation, or lack of it, that may be occurring across number of therapy sessions attended.

The results of this study also suggested that client judgments of overall therapeutic success are dependent upon number of therapy sessions attended. It appears that the longer a client attends therapy the more likely he is to rate his general therapy experience as being successful. This finding is in sharp contrast to the prior findings of no association occurring between client judgments of therapeutic benefit for specific problem areas and number of therapy sessions. Judging whether therapy has been either helpful or not helpful for a specific problem area is apparently different from evaluating the degree of helpfulness derived from therapy
Regardless of whether a specific problem has been helped by therapy, clients may receive other unmeasured benefits from therapeutic contact. These benefits may be related to positive feelings held by the client toward the therapeutic relationship based upon such process variables as the amount of empathy, warmth, congruence, etc., expressed by the therapist. Consistent with Garfield and Affleck's (1959) hypothesis of the possible difference between adjudged and actual change, prior research relying solely on a global measure of therapeutic improvement may be guilty of assessing only "good feelings" held by the client and/or therapist toward the therapy experience instead of actual behavior or personality change. Future research should incorporate into their designs both process and outcome dimensions of therapy and be aware of the dichotomy between adjudged change and actual change by more stringent measurement of improvement.

The nature of the relationship between client-judgments of overall therapeutic success and number of sessions was also nonlinear. A possible success zone occurs at five to six sessions with a possible failure zone occurring at two to four sessions. The session ranges of seven to nine, ten to fifteen, and sixteen plus may be conceptualized as success/failure zones where the client receives a moderate amount of benefit from therapy.

The representativeness of the return sample to the total sample was established along all of the population values
assessed except number of therapy sessions attended. This was exclusively attributable to fewer clients responding in the two to four session range and more clients responding in the sixteen plus session range than would be expected from the total sample. This may indicate that those clients who have taken the effort to return the questionnaire are doing so because they have perceived therapy as being helpful based upon having invested more time into it. If this is the case, any generalizations made from the results of this study should take into consideration that the subject sample is possibly biased in perceiving therapy as being more productive than the total sample assessed.

In summary, the results of this study indicated that client-judgments of therapeutic benefit tended to be independent of length of therapy for specific problem areas, yet highly related to duration of therapy when the client-judgment is a global assessment of therapeutic benefit. The nature of these above relationships is nonlinear with the possible existence of different zones of sessions that account for varying degrees of client-perceived success. This manifest nonlinearity may be as a result, however, of clients starting therapy and continuing on at different levels of therapeutic success. It also appeared that clients evaluated overall therapeutic effectiveness along different criteria than they evaluated therapeutic effectiveness for specific problem areas. Any generalizations made from these results, however, should be done with caution because of what might
be a sampling bias.

Future research should be undertaken to assess the nature of the relationship between therapeutic outcome and number of therapy sessions attended. This research should incorporate designs measuring both process and outcome dimensions of therapy and be aware of the possible dichotomy between adjudged change and actual change by more stringent measurement. These studies should also be longitudinal so as to make assessments of the nature of intrasubject progress for specific outcome criteria over the course of therapy. Data analysis must be sensitive to the possibility that the nature of this relationship is nonlinear and may be comprised of different session ranges where clients experience varying degrees of therapeutic benefit. Furthermore, if client-judged outcomes are utilized for assessing specific problem areas, future researchers should be aware that many clients may not perceive all the criteria being assessed as problem areas.
Appendix A

Client-Judged Outcome Questionnaire
Below is a list of common problems that people bring with them to Comprehensive Care. We would like to know if you feel that your contact with Comprehensive Care was either helpful or not helpful in dealing with these problems. Please check the most appropriate category for each problem area.

<table>
<thead>
<tr>
<th>Helpful</th>
<th>Not Helpful</th>
<th>Not a Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Marriage problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve self-understanding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physical problems (headache, nausea, general pain, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Getting along with other people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sexual problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve self-respect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anxiety (nervousness)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suicidal feelings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve decision-making</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phobias and fears</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drugs/alcohol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other problems</td>
</tr>
</tbody>
</table>

The following set of questions are included to provide you an opportunity to give us feedback on your feelings of contact with Comprehensive Care.

1. Everything considered, how successful would you rate the
results of your contact with Comprehensive Care?  (please circle answer)

<table>
<thead>
<tr>
<th>Very unsuccessful</th>
<th>Partly successful and partly unsuccessful</th>
<th>Very successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. Would you refer a friend to Comprehensive Care who had a similar problem?
   Yes   No
   If no, why not?

3. When was the last time you came to Comprehensive Care?
   Month _____ Year _____

4. Why did you stop coming to Comprehensive Care?  (disregard if still coming)

This final set of questions is included so you may tell us how you presently feel about yourself. Please circle the most appropriate answer.

1. I am satisfied to be just what I am.

<table>
<thead>
<tr>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

2. I am just as nice as I should be.

<table>
<thead>
<tr>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
3. I despise myself.

<table>
<thead>
<tr>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

4. I am as smart as I want to be.

<table>
<thead>
<tr>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

5. I am not the person I would like to be.

<table>
<thead>
<tr>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

6. I wish I didn't give up as easily as I do.

<table>
<thead>
<tr>
<th>Completely false</th>
<th>Mostly false and partly true</th>
<th>Mostly true</th>
<th>Completely true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix B

Proportion of Clients Indicating Therapy Helped as a Function of Number of Sessions
Appendix B1: Proportion of clients indicating therapy helped as a function of number of sessions, marriage problems
Appendix B2: Proportion of clients indicating therapy helped as a function of number of sessions; improve self-understanding
Appendix B3: Proportion of clients indicating therapy helped as a function of number of sessions; physical problems
Appendix B4: Proportion of clients indicating therapy helped as a function of number of sessions; getting along with others.
Appendix B5: Proportion of clients indicating therapy helped as a function of number of sessions; depression.
Appendix B6: Proportion of clients indicating therapy
helped as a function of number of sessions; sexual problems
Appendix B7: Proportion of clients indicating therapy helped as a function of number of sessions; improve self-respect.
Appendix B8: Proportion of clients indicating therapy helped as a function of number of sessions; anxiety

![Graph showing the proportion of clients indicating therapy helped as a function of the number of sessions.]
Appendix B9: Proportion of clients indicating therapy helped as a function of number of sessions; suicidal feelings.
Appendix B10: Proportion of clients indicating therapy helped as a function of number of sessions; family problems
Appendix B11: Proportion of clients indicating therapy helped as a function of number of sessions; improve decision making
Appendix B12: Proportion of clients indicating therapy helped as a function of number of sessions; phobias and fears.
Appendix B13: Proportion of clients indicating therapy helped as a function of number of sessions: work problems
Appendix B14: Proportion of clients indicating therapy helped as a function of number of sessions: drug and alcohol problems
Appendix B15: Proportion of clients indicating therapy helped as a function of number of sessions; other problems
Reference Notes

References


Meltzoff, J., & Kornreich, M.  Research in psychotherapy.  


Nichols, R. C., & Beck, K. W.  Factors in psychotherapy change.  


