

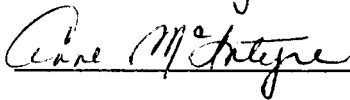
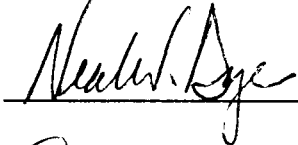
To the Graduate Council:

I am submitting herewith a dissertation written by Mary Ellen Mitchell entitled "The Relationship Between Social Network Variables, a Therapy Preparation Technique, and Therapy Attendance." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.



Robert G. Wahler, Major Professor

We have read this dissertation
and recommend its acceptance:



Accepted for the Council:



The Graduate School

THE RELATIONSHIP BETWEEN SOCIAL NETWORK VARIABLES,
A THERAPY PREPARATION TECHNIQUE,
AND THERAPY ATTENDANCE

A Dissertation
Presented for the
Doctor of Philosophy
Degree
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Mary Ellen Mitchell
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DEDICATION

I would like to dedicate this work to my Grandfather, Ingwold G. Jesness, who at the age of 96 is still teaching me the true meaning of network.

ACKNOWLEDGMENTS

It is perhaps not coincidental that I should study and write about social networks. The people in my life have offered their time, caring, and help, and I wish to express my heartfelt gratitude because they mean so much to me.

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I wish to thank all of my friends for enduring with me despite my groanings in the course of this task. Special thanks go to Bob and

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ABSTRACT

The present study was designed to examine the relationship between network variables, preparation for therapy, and therapy attendance. Clients presenting for intake at a mental health center were randomly assigned to treatment and control groups. Subjects completed an expectations questionnaire. Subjects were seen for intake and then interviewed by the author about their network. Half were given therapy preparation.

It had been hypothesized that prepared subjects would show changes in expectations; this held only for a decrease in expectation of expert advice. Analysis of change scores revealed no difference between prepared and nonprepared clients.

A multiple regression of network variables, the preparation condition, gender, and score on social desirability, against the number of sessions attended was conducted. The model could account for 14% of the variance. Low scores on social desirability, network available for the discussion of personal matters, and provision of feedback were positively associated with attendance. The index of network for fun and relaxation, and network involved in the provision of material aid, were negatively associated with attendance. A second regression of same variables against classification by attendance at one session vs. more was conducted. This yielded a significant model, accounting for 18% of the variance. Again, low score on social desirability, network available for discussion of private feelings, and network involved in

support for treatment were associated with attendance. A discriminant function was conducted. The model classified 71% of the subjects correctly.

It was hypothesized that preparation would be associated with attendance. The relationship was positive but nonsignificant. A positive relationship between attendance and network was expected. Results were mixed, but findings point to the importance of having people to provide feedback and discuss private feelings. Social desirability scores suggest a nondefensive approach is important for treatment involvement.

Analysis revealed nonsignificant findings between ratings of network need and satisfaction with attendance. Women were found to have smaller networks across all functional categories. Differences in network size were also found in association with marital status.

The findings lend credence to the predictive value of network variables and suggests need for investigation into particular functions and specific preparation techniques.

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INTRODUCTION

A concern that is voiced repeatedly by mental health professionals and by researchers of psychotherapy is the relatively high rate of clientele dropout. Estimates vary, and in their excellent and comprehensive review of the literature, Baekeland and Lundwall (1975) reported that between 20% and 57% of all patients in general psychiatric clinics fail to return after the first visit. Additionally, 31% to 56% attend four or fewer times, despite recommendations to the contrary. These numbers are significantly higher for some select populations such as the substance abuser.

Reseachers have sought to identify client variables (Borghi, 1968; Rubenstein & Lorr, 1956; Rogawski & Edmundson, 1971; Raynes & Warren, 1981; Heilbrun, 1982), therapist variables (Greenwald & Bartemeir, 1963; Moos & Schwartz, 1972; Raynes & Patch, 1971), and agency variables (Kamin & Coughlan, 1963; Moos & Schwartz, 1972; Carpenter et al., 1981) that correlate with failure to return to treatment. The bulk of the studies that investigated client characteristics focused on demographic (Brown & Kosterlitz, 1964; Goldfried, 1969) or personality (Frank et al., 1957; Allen & Dootjes, 1968) dimensions. Demographic data my be viewed as reflecting a small portion of the individual in relation to his/her environment as such data are global indices of occupational, marital, and ethnic factors. Such material represents portions of an individual's social network although the focus has been on the description of the individual and his or her

functioning rather than upon the social environment or social system per se. There has not, however, been a systematic investigation of the relationship between social network variables and psychotherapy dropout.

Network variables, as used here, refer to the individual's social, familial, occupational, and recreational system. It is the total set of people with whom the individual has contact. Studies have demonstrated the salience of network variables to the process of bereavement (Maddison & Walker, 1967), incidence of depression (Dean & Ensel, 1982; Schaffer, Coyne & Lazarus, 1981), avowed happiness (Brim, 1974), incidence of medical illness and physical symptoms (Kelly et al., 1977; Monroe, 1983), spontaneous remission (Bergin, 1971), hospital admissions (Hammer, 1963-1964), emotional disturbance (Miller & Efcourt, 1983), and help seeking behavior (McKinlay, 1973; Horowitz, 1978; Gournash, 1978). The primary focus of network research in psychology, however, appears to have been upon the delineation of various social network dimensions (Kaplan, Cassel, & Gore, 1977; Walker et al., 1977; Budson & Jolley, 1978; Horowitz, 1978; Greenblatt et al., 1982; Procidano & Heller, 1983) and on the examination of general factors which bring individuals to treatment. However, few investigators have explored the role of the social network in the process and outcome of psychotherapy. To date, the emphasis remains primarily on the individual. It is the thesis of this project however that social network variables may bear a relationship not only to help seeking but also to whether or not an individual returns and follows up on treatment recommendations.

The recognition of the high incidence of drop out has given rise to a body of research aimed at the delineation of individuals and populations who are at risk for premature termination (Cartwright, 1980a; Baekeland & Lundwall, 1975; Borghi, 1968). Researchers and practitioners have thus developed a whole host of techniques designed to decrease the rate of attrition. One method employed by several investigators (Imber et al., 1970; Sloane et al., 1970; Mosby, 1972; Jacobs, D. et al., 1972; Jacobs, M., 1976; Brosch, 1980) and which has been shown to be efficacious has been pretherapy training. This technique has been given several labels including role induction (Hoehn-Saric et al., 1964; Strupp & Bloxum, 1973), anticipatory socialization (Orne & Wender, 1968), and pretherapy preparation (e.g., Cartwright, 1976; Cartwright et al., 1980b). It involves the systematic education of clients about the process of treatment and the roles of the participants in that treatment. Pretherapy training has been conducted using a variety of media including films (Strupp & Bloxum, 1973; Cartwright, 1976), interviews, written material, video tapes (Truax & Carkuff, 1965), and dream reports (Cartwright et al., 1980a, 1980b). Repeatedly, the aim has been to decrease drop out rates, to improve treatment outcome (Hoehn-Saric et al., 1964; Heitler, 1973, 1976; Childress & Gillis, 1977; Peake, 1979; Stone et al., 1965) and to generally enhance the utilization of therapy (Eisenberg, 1980). The results of these interventions have been equivocal, and it appears that some intervening variables have yet to be determined. One possible set of factors is encompassed by social network variables. Role induction is essentially

training in the interpersonal sphere. Lennard and Bernstein (1967) make the point that orderly social process is contingent upon the consensus about respective roles of the participants. They state that it "is essential that one know who is to do what, when, and how often" (p. 1). One would think that this information would be learned within the context of the social network. Perhaps those who benefit from pretherapy training are those whose social networks are somehow limited and for whom the preparation technique is compensatory.

There is other research that suggests that the process of therapy is itself stressful and anxiety provoking. The social network may be regarded as a sort of buffer against stress (Caplan, 1974; Dean & Lin, 1977; Wilcox, 1981; Thoits, 1982; Monroe, 1983), or a source of help (Horowitz et al., 1978; Hirsch, 1980; Caldwell & Bloom, 1982) in times of stress. Hence it is possible that the social network either encourages the individual to remain in treatment or influences the patient to abandon treatment, depending upon the nature of the social network. Finally, treatment is a structure with specific rules and roles for participants much in the same way as one's social and familial network. It may be that successful navigation of one system has implications for the other. The present study is designed to examine the relationship among all three of these variables: dropout, social network factors, and a pretherapy preparation technique. Since all of these areas are large and replete with extensive research, each will be reviewed separately and in more detail below.

CHAPTER I

REVIEW OF THE LITERATURE

Dropout

The definition of dropout or premature termination is varied. In their review, Baekeland and Lundwall (1975) note that premature termination has been defined in diverse ways. These include failure to return post-intake, failure to keep the first appointment following initial telephone contact, failure to keep four consecutive appointments, termination prior to a therapist-patient mutually agreed upon date, etc. Baekeland and Lundwall (1975) state that most researchers discriminate between the terminator and the remainder at some point following three sessions. It appears that clients who continue after the initial three sessions are likely to remain for the duration and that termination after this point is highly idiosyncratic.

Not all of the dropout literature published is appropriate for the purposes of this paper. However, there are several findings that are both interesting and pertinent.

One major approach has been to explore client variables which are thought to possibly relate to premature termination. Several investigators (Rubenstein & Lorr, 1956; Heilbrun, 1961; Strickland & Crowne, 1963; Brown & Kosterlitz, 1964) sought to identify personality characteristics of clients that correlate with early patient dropout. The findings were contradictory, but there was a suggestion that

individuals with low levels of anxiety or depression or psychopathic personality features were less likely to return than others. Individuals with higher scores on measures of social desirability were also more apt to quit treatment. Social desirability scales are generally considered to assess the degree to which one is self critical and willing to acknowledge unfavorable traits. Data have indicated that individuals with isolated somatic complaints are more likely to dropout than people with other presenting problems. Other researchers have focused on the sex of the client or the therapist (Heilbrun, 1961; Betz & Shullman, 1979; Epperson, 1981), the referral source (Krauskopf et al., 1981), therapist experience level (Straker, 1968; Krauskopf et al., 1981), length of wait for therapist assignment (Carpenter et al., 1981), and length of treatment (Straker, 1968). These studies, in sum, indicated that a female client who was referred institutionally and assigned to an inexperienced male therapist and who is placed on a waiting list for long-term treatment is more likely to fail to return. It is noteworthy that data on gender factors are very equivocal and for a discussion of this, the reader is referred to Epperson (1981).

Borghi (1968) attempted to isolate dropout variables and obtained inconclusive results. Home interviews with those clients who had failed to return to treatment revealed an incongruence between their expectations and what they encountered. He cites case examples to illustrate his theory but did not statistically analyze the data. Silverman and Beech (1979) confirm that the majority of clients who dropped out expected some particular service that was not provided.

Similarly, Horenstein and Houston (1976) found a curvilinear relationship between client expectations and premature termination.

In their review, Baekland and Lundwall (1975) attempted to summarize the findings on premature termination. One item is particularly relevant to this project. Of nineteen studies examining social isolation in relation to dropout, all found it to be significant. This suggests that individuals who have difficulty forming relationships in the world may also have difficulty establishing a therapeutic relationship. These studies examined such factors as marital status and marital discord both of which reflect one portion of the social network. Baekeland and Lundwall (1975) also reported that in 20 out of 41 studies, social stability (that is, marital, occupational, and residential stability) was found to be inversely related to dropout. The likelihood of dropping out heightened with the decrease in level of social stability. In an examination of 1106 subjects who called to obtain an outpatient appointment, Carpenter et al. (1981) found a number of variables that were significant in the case of the no-show. These included vagueness of presenting complaint, a lack of previous psychiatric care, and non-professional (e.g., friend) referral. Carpenter and his colleagues asserted that the support of significant others may be important in enabling the individual to seek help. Brown and Kosterlitz (1964) discovered that clients with intrapersonal or interpersonal difficulties had a tendency to stay in treatment longer than those with situational or somatic complaints. Thus one might expect to find a level of interpersonal conflict present among those

who remain in treatment that is greater than among those who quit treatment. These trends suggest that social network variables, while as yet unexamined, may play a significant role in the case of the premature terminator.

Therapy Preparation

The area of therapy preparation finds its root in the research on patient role expectations. Intermingled with this work, there was a separate but related effort aimed at the exploration of treatment expectancies, or the degree to which a client thinks they will improve. Although a distinct area, prognostic variables were sometimes incorporated in studies of role expectations (Uhlenhuth & Duncan, 1968; Krause et al., 1969; Imber et al., 1970; Jacobs, Muller et al., 1972). Findings suggested that positive treatment outcomes were correlated with potentiation of favorable expectancies (Frank et al., 1959; Stone et al., 1965; Luborsky et al., 1971). Expectation for improvement was found in one study to be curvilinearly related to symptom reduction (Goldstein & Shipman, 1961). It is difficult to discriminate between various dimensions because important distinctions are frequently not made in the literature. There are client expectations about the therapist, client expectations about the treatment, client expectations about their role in the process, client expectancies of improvement, etc. All of these are lumped under the generic term of patient expectations.

Hollingshead and Redlich (1958) led the way in this area of research. Their work became hallmark in the area of patient role

expectations. They found that there were grave misconceptions among people, especially poor people, about psychological services. Their findings were replicated and expanded upon by later investigators (Nunnally, 1961; Levitt, 1966; Tinsley & Harris, 1976). Although the findings were inconsistent (Garfield & Wolpin, 1963) the consensus was that misconceptions were widespread across all SES groups (Lorion, 1974; Balch et al., 1978; Saseen, 1976) and that it warranted attention. It was evident that many individuals expected to encounter a treatment situation similar to a medical visit (Overall & Aronson, 1962; Goin et al., 1965; Levitt, 1966; Hornstra et al., 1972). The confusion was exemplified by the results obtained by Kamin and Coughlan (1963) who found that 75% of the individuals entering therapy had no clear notion of treatment. This ambiguity endured through termination of treatment. Hornstra et al. (1972) found that 30% of patients were unable to express a preference for any type of treatment despite previous treatment experience. Generally speaking, however, the findings indicated that most people expect advice, direction, explanations of the problem, and prescription for the cure. Some data suggested that this was not accurate and that clients were more psychologically sophisticated than first thought (Garfield & Wolpin, 1963; Goin et al., 1965; Williams et al., 1967; Horenstein & Houston, 1975). These results suggested that the client expected both a psychological and a medical orientation.

It was readily apparent that there existed a discrepancy between what clients anticipated and their actual experience (Clemes & D'Andrea, 1965; Lennard & Bernstein, 1967; Overall & Aronson, 1963, Levitt, 1966).

It was hypothesized that this discrepancy might preclude optimal outcomes (Goldstein, 1966; Heine & Trosman, 1960; Garfield et al., 1963; Volsky et al., 1965) and that it might contribute to such factors as premature termination (Heine & Trosman, 1960; Overall & Aronson, 1963), in-therapy anxiety (Clemes & D'Andrea, 1965), poorer patient ratings by therapists (Wallach & Strupp, 1960), and lower client satisfaction (Goin et al., 1965; Severinson, 1966; Martin et al., 1976). Findings were inconsistent (Holliday, 1978; Klepac & Page, 1974) and hindered by a lack of independent expectation measures, extremely global measures of outcomes, and poor definition of the expectation concept. There were enough significant findings to make it a topic of pursuit by many researchers, and there is an extensive body of literature on the subject. The reader is referred to Heitler (1976), Wilkins (1978), Duckro et al. (1979), and Duffin (1980) for review.

In an effort to realign patient expectations with the reality of treatment, several investigators developed interventions. The work on the explication of client/therapist roles and the systematic preparation of clients for treatment was pioneered by Orne and Wender (1968). They developed a technique which they labeled anticipatory socialization. This became the basis for almost all subsequent training methods. This was an interview method that provided a rationale for talking as a legitimate mode of treatment. It described working roles of participants and outlined the course of treatment. It clarified the negative and hostile feelings that frequently arise in the course of treatment which are generally labeled by therapists as resistance. Strupp and

Bloxum (1973) made a film that expanded upon this for patients going into group psychotherapy.

It appears that without exception, researchers who employed a preparation technique excluded patients with a history of chronic alcoholism, organic brain syndrome, mental retardation, and acute psychosis. Measures were made on a whole host of variables. Significant findings included increased attendance of prepared clients (Dibner et al., 1963; Stone et al., 1965; Hoehn-Saric et al., 1964) and reduced attrition (Warren & Rice, 1972; Cartwright et al., 1980a; Coughanour, 1975; Martin, 1975). Strupp and Bloxum (1973) and Hoyt (1980) were unable to discriminate between the treatment and control groups on the basis of attendance. Incidence of more appropriate in-therapy behavior was documented by Hoehn-Saric et al. (1964) on five out of seven measures and by Cartwright et al. (1980b) and Heitler (1973). The in-therapy measures that discriminated the prepared client from the control included: more ready involvement in treatment, increased frequency of communication (Hoehn-Saric et al., 1964; Martin, 1975), decreased latency of communication, heightened frequency of self-initiated discussion (Heitler, 1973), and greater self exploration (Truax & Carkhuff, 1965; Heitler, 1973). Using a pretherapy training technique in a novel manner, Eisenberg (1980) secured mixed but positive results. He employed the method midway through the process of treatment as a booster session. Improvement on global measures of outcome was demonstrated by Childress & Gillis (1977), Stone et al. (1965), and Strupp and Bloxum (1973). Improvement on target symptoms was found on five out of eight measures

by Hoehn-Saric et al. (1964) and Childress & Gillis (1977). Therapist ratings of improvement that were significantly greater than ratings of controls were found by Hoyt (1980) and Hoehn-Saric et al. (1964). Finally, Childress and Gillis (1977) found the prepared client fared significantly better on measures of work and school adjustment, and ease at establishing relationships.

A few studies failed to demonstrate the efficacy of therapy preparation, and they appear to be quite different in design than those mentioned previously. Imber et al. (1970) used a mock physiology test to induce prognostic expectancies and then employed a role induction technique and found no differences between treatment and control groups. Jacobs et al. (1976) used a preparation technique based on a social learning model which emphasized discrete and specific events such as labeling one's feelings in the here and now. His findings were non-significant. Fernbach (1975) sent a prepared flier to patients after having made telephone contact prior to the initial appointment but found no significant or predictable findings.

It is not exactly clear why pretherapy training is effective. Authors have speculated that it provides a method for the establishment of congruent patient-therapist expectations. Orne and Wender (1968), Frank (1973), and Childress and Gillis (1977) hypothesized that the technique served a social influence function which provided a basis for the acceptance of remarks made by the therapists. Goldstein, Sechrest, and Heller (1966) postulated that the process of training individuals to be in therapy operated as an advance organizer or

cognitive set that facilitated learning. Some have speculated that therapy preparation helps the patient to behave in a manner that is consistent with the ideal patient and thus enhances patient attractiveness (Stone et al., 1965). Another possibility is that the process represents the accomplishment of an important therapeutic task.

Lennard and Bernstein (1960) studied tapes of early therapy sessions and found that 20% of patient verbalizations and 15% of therapist communications were oriented toward disclosure of respective roles. Perhaps therapy training mitigates the need for this and thus facilitates the process of therapy. The effect of training has not, however, been shown to endure. In the only reported follow up, Liberman et al. (1972) contacted patients some five years later and could not discriminate between the prepared and unprepared clients despite the fact that they had been clearly distinguishable at the time of the project. One group of authors summed up the research in this area by remarking that there "was ample evidence to support the efficacy of psychotherapy preparation and none to suggest it is harmful" (Krause et al., 1969).

Social Networks

Previously the domain of sociologists and anthropologists, social network variables have become the target of investigation for community psychologists, systems theorists, and social learning investigators. This reflects the growing shift from the individual to the larger system as the unit of analysis. The term social network has been defined by several authors (Speck & Attneave, 1973; Caplan, 1974; Walker et al.,

1977; Brim, 1974) and reviews of the concept are contained in Shulman (1976) and Mitchell and Tricket (1980). The definitions vary according to the degree of inclusiveness and the dimensions identified. The concept has been defined globally or more molecularly depending on the needs and interests of the investigators. Tolsdorf (1976) noted, "there have been dozens of variables proposed, identified, and investigated with, each author generating variable lists that suit the research problem at hand" (p. 408). Some similarity exists among the dimensions identified but the task is made all the more difficult by what appears to be a lack of conceptual clarity; authors employ different terms for similar concepts. In general, dimensions include quantitative factors referring to the structure of the social network such as size, content (e.g., primary kin, friends, neighbors), proximity or accessibility of members, density or the amount of linkage between members, symmetry or reciprocity within the relationship, and functional aspects (e.g., support, advice, guidance, etc.). Qualitative factors are also of concern as they connote the essential meaning of the relationship. A positive relationship is quite different from a negative or obligatory one. This dimension is often reflected in studies of satisfaction (Stokes, 1983; Hirsch, 1979). Greenblatt et al. (1982) asserted that research in the area of social networks has been hindered by the multitude and complexity of variables to be measured.

There has been work that describes networks broadly with emphasis on specific network components and studies which focus on particular populations. Shulman (1976) examined the networks of a group of

individuals drawn from a randomized stratified population. He asked respondents to list people important to them and found that kin accounted for 40.8% of the individuals named. Friends comprised 44.9% and neighbors made up 14.3% of the network. This was corroborated by reports made by those named in a follow up. In a study comparing size of networks between normals, neurotics, and psychotics, Pattison et al. (1975) obtained some striking results. The networks of healthy individuals were characterized by approximately twenty to thirty people with whom relations were generally positive. There were approximately five to six members in each subgroup of family, friends, neighbors, work associates, and social contacts. The friends were the most highly valued. Among the members, a measure of density revealed a ratio of about 60:40. That is, approximately one-half to two-thirds of the individuals were interconnected to each other, not simply to the client. Neurotics reported ten to twelve members in their social networks including some who were deceased or geographically remote. They had a number of negatively charged relationships and the level of interconnectedness was only 30:70. In contrast to both of these, psychotics had only four to five intimates who were usually family. The ratings of interpersonal valence were ambivalent or indicative of nonreciprocal relations. Relative to the healthy population, the network was over connected (90:10). This appears to constitute empirical support for the concept of enmeshment. In a recent review article, Leavy (1983) noted that in ten out of ten research studies comparing a clinical and a nonclinical population, normals had more support available to them. Additionally,

his research indicated that the less support, the greater the level of pathology. Other studies reported these same findings of smaller networks (Cohen & Sokolovsky, 1978), asymmetrical relationships and dense dependent relationships among psychiatric populations (Pattison et al., 1975; Hammer, 1963-1964; Sokolovsky et al., 1978; Hirsch, 1980; Mitchell, 1982). Winefield (1979) reported similar findings among depressed women. Henderson (1981), going a step further, found a lack of satisfactory social relations to be causal in the onset of neurosis independent of the level of psychosocial stressors confronting the individual. It is thought that networks of the type described above (Hirsch, 1980; Mitchell, 1980; Birkel & Reppucci, 1983) may exert pressure on the individual to conform or maintain status quo. Some authors (Horowitz, 1978; Walker et al., 1977) contend that closely knit, familial networks provide less information both generally and specifically about professional services than does the personal friend network.

In a study comparing V.A. hospital first admissions to a psychiatric unit with a group of patients admitted to a general medical unit, Tolsdorf (1976) found that psychiatric patients had what he called a negative network orientation. The psychiatric patients were reluctant to call upon members of their network for aid. They also tended to regard the members of their networks as lacking in essential expertise and as providing pity rather than help. Additionally, the psychiatric patients expressed more embarrassment about requesting help than did their medical admission counterparts. This suggests that even when the network exists, it is not exploited and may not be operable as

a source of aid. These findings should be interpreted with caution, however, because the sample was small ($N = 20$), the psychiatric patients were all schizophrenic, and probably male. It is likely that they were an homogeneous racial, age, and SES group but these data were unreported. Judging from these findings, it appears that the network of the psychiatric patient is distinctly different from that of others. The data suggest that it is limited in size, predominantly familial, and charged with negativism or ambivalence.

Other findings suggest that the network plays a dynamic role in the process of help seeking. Horowitz (1978) noted that the first response to mental illness usually occurs within the context of the community. McKinlay (1973) studied the utilization of health and welfare services and found that utilizers turned to friends and spouses more often than to mothers or others. He discovered that utilizers visited with family significantly less often than those identified as underutilizers. The underutilizers more often had relatives living at home with them, had few or no friends at work, had more family friends than personal friends, and friends were frequently not age mates. This is strikingly similar to the findings on psychiatric populations. The implication, again, is that the healthier individual has a more highly differentiated and diverse network, if one assumes that utilizers are healthier than underutilizers and distinct from nonutilizers. In this light, the data are akin to the Pattison et al. (1975) findings on the normal, neurotic, and psychotic groups.

There is literature to suggest that different parts of the network serve varying needs of the individual. Walker et al. (1977) state that there may at times be a lack of fit between the network resources and the needs of the individual. Litwak and Szelenyi (1969) indicate that kin serve to provide long-term aid, friends offer affective support, neighbors respond to emergencies, and significantly more than any other group, friends are approached for help. In addition, he regards friends as providing heterogeneity. The authors contend that while the structure and the function of the network have changed with the rise of technology and mobility, it remains paramount in the life of an individual. They state that technology has served to promote differentiation of the parts of the network but does not destroy it. Horowitz (1978) found that friends and kin are the most common source of assistance and that the marital relationship, in particular, is significant in help-seeking behavior. Barrera (1981) developed one of the few instruments that assesses social networks and which has reliability and validity data available. Drawing on theoretical work of several authors he designed a tool that indexes the size of the social network in each of five functional categories. This was founded on the notion that the network serves varying needs and that simply because the individual has a support group, one should not assume it provides for every need.

Research by Procidano and Heller (1983) lends credence to the notion of separate and valid constructs of perceived family and friend measures. These have been found to have direct implications for symptoms

of distress and pathology. Hirsch (1979) found that the network can be a source of significant support but that the greater the density, the lower the level of satisfaction associated with the network. In a later study, Hirsch (1980) found family to be a less important source of support. Using retrospective reports from patients discharged from Bellevue Hospital in New York, Hammer (1963-1964) indicated that individuals who had a central role in the family or network were hospitalized more rapidly and those with predominantly asymmetrical relationships received aid less often. In a study of 965 white married adults from rural areas, Housaini et al. (1982) found evidence for the buffering effects of social support and personal competence. Their findings found this effect to be more powerful among women. Bell et al. (1982), also using a large sample ($N = 2029$), found direct effects of social support and stressful life events on the incidence and severity of depressive symptoms. They found that individuals with the lowest level of social support had the greatest impact of stressful life events. Concomitantly, those individuals with stronger support networks showed comparatively less severe distress. Similarly, Sokolovsky, Cohen, et al. (1978) found that schizophrenics with smaller nonmultiplex networks had a higher incidence of rehospitalization than schizophrenics with larger social networks. Therefore, it appears that a variety of network factors are likely to be significant in the process and outcome of psychotherapy. For some time, the question asked by researchers was whether or not a given population had a network at all. Clearly, even the inner city chronic schizophrenic has a network, and it appears that

the quality, quantity, and diversity of the network may have serious implications and mediating effects.

In summary, there are a number of studies which indicate that the social network is important in the process of help-seeking and that different populations may be distinguished along a variety of network dimensions. It would appear that network variables may be salient with regard to an individual remaining in treatment, responding to intervention, and following treatment recommendations. Similarly, it may be that particular networks fail to provide the information and skills necessary for participation in treatment. According to Hammer (1963-1964), ". . . for a given social structure there will be appropriate ways of behaving toward persons occupying given categories. . . . For effective social interaction, the participants must share ways of executing and anticipating behavior" (p. 243). On the basis of all the findings, one might hypothesize the existence of a significant relationship between various aspects of the social network, attendance in therapy, and response to interventions such as therapy preparation.

CHAPTER II

STATEMENT OF THE PROBLEM

The previously reviewed literature indicates that there is a likelihood that a relationship exists between social network variables and therapy attrition. It appears that there is particular need to examine qualitative variables of the social network such as satisfaction, felt need, utilization, proportion of familial and non-familial membership, and function, along with quantitative measures of network size. There are grounds to hypothesize that there may also be a relationship between social network variables and response to therapy preparation. The complexity of the problem suggests need for a multiple regression model for analysis of the relative contribution of the many variables. The proposed study is designed to determine if any such relationship can be verified. The study is expected to yield broad descriptive data on the social networks of psychiatric outpatients as well.

Hypotheses

The data are expected to show the following relationships:

1. Researchers have indicated that role induction techniques serve a dual purpose: to change discrepant expectations and to educate the client about psychotherapy (Clemes & D'Andrea, 1965; Lennard & Bernstein, 1967). The need

for an independent measure of role expectations has been widely accepted. It is hypothesized that the prepared client can be distinguished from the nonprepared client on the basis of scores on each of the scales of the Client Role Expectations Inventory (CREI) (Duffin, 1980). The first analysis will examine the change scores of prepared and nonprepared clients on the posttest of the CREI. The second analysis will be on the scores of the five scale of the CREI again comparing the prepared and nonprepared client. It is hypothesized that the prepared clients will show a greater change in their scores and that their scores will show a different profile of role expectations. Median scores will be used for the comparison since the scales do not have equal numbers of items and scores are expected to cluster in such a way as to render use of high score/low score comparisons meaningless.

2. Previous research (Heilbrun, 1972; Dibner et al., 1963; Stone et al., 1965; Hoehn-Saric et al., 1964; Warren & Rice, 1972; Cartwright et al., 1980a; Coughanour, 1975; Martin, 1975) supports the notion that therapy preparation can increase therapy attendance. It is expected that clients receiving the role induction technique will attend significantly more sessions than the nonprepared clients.
3. Research (Dean & Ensel, 1982) indicates that there might be differences between males and females in their network

characteristics. Analyses will be computed to describe gender differences. It is expected that women will have a somewhat smaller network available to them and that they will utilize it more. This is expected to hold across all functional categories of the Arizona Social Support Interview Schedule (ASSIS) (Barrera, 1982).

4. A multiple regression of the primary network variables will be conducted, and it is expected to show the following relationships: the indices of network available across the five functions of private feelings, material aid, social participation, positive feedback, and treatment support will be positively correlated with the number of sessions attended. As noted (Tolsdorf, 1976) psychiatric patients are often reluctant to call upon members of their social network. Hence, it is expected that network utilization will be negatively correlated with the number of sessions attended. This is predicted on the notion that the circumstances and variables that limit the utilization of the network will also create difficulties with the utilization of treatment. The index of network against treatment is expected to be negatively correlated with attendance. The indices of negatively charged network comprised of the scales of those with whom the client is likely to have bad feelings or disagreements (CONA, CONU) are expected to be positively correlated with the number of sessions attended.

This is supported by the work of Brown and Kosterlitz (1964) in which a lower rate of dropout was found among clients with intra or interpersonal difficulties.

It is anticipated that the preparation condition will be positively correlated with the number of sessions attended and that the nonprepared condition will show no significant correlation either positive or negative with number of sessions attended. Women are likely to be over-represented in the sample (Kessler et al., 1981) and this may give rise to a slight correlation between gender and attendance. Women are not however expected to show a proportionally greater level of nonattendance simply because there is a high number of female therapists at the center. This would be congruent with the findings of Brown and Kosterlitz (1964) which suggest that assignment to a same sexed therapist increases likelihood of attendance.

The scale of social desirability (PRI) (Reynolds, 1982) will be included in the regression analysis since previous research has found such scores to be significantly correlated with dropout, and because its use will facilitate interpretation of these self-report data.

Family systems theory suggests that family members resist change. Hirsch (1980) found multidimensional friendships associated with better support and mental health. Investigators have also found that individuals who

underutilize social services (McKinlay, 1973; Walker et al., 1977) come from environments in which the network is comprised primarily of family members who live with the client. Thus, it is expected that low attendance will be associated with networks that have a high percentage of family membership.

5. The factors of network satisfaction and need will not be included in the multiple regression because they are ordinal level data and hence inappropriate for such analysis. However, a separate analysis will be conducted. A Spearman rank order correlation will be computed between the number of sessions and the ratings of satisfaction and need (ASSIS, Barrera, 1981). It is expected that high need and low satisfaction will be positively associated with therapy attendance.
6. A variety of descriptive analyses will be run on the data in order to characterize the social networks of this adult outpatient population. It is expected that the networks will be relatively small and familially oriented (Pattison et al., 1975; Shullman, 1976).

CHAPTER III

METHODS

Subjects

The subjects were selected from among those adult clients who appeared for intake at the agency. The center is a private, nonprofit, comprehensive community mental health agency with a walk-in intake procedure. All patients who presented themselves for intake were included as subjects for study and alternately assigned to experimental and control groups. Randomization was assumed on the basis of the walk-in system. Exclusion criteria included substance abuse as primary diagnosis, acute psychosis, or need for inpatient admission, mental retardation and/or organic impairment (e.g., dementia, delirium). These determinations were made by the regular intake clinicians at the agency in the course of the regular intake procedure. Subjects were drawn until $N = 150$.

Procedure

All clients were asked to complete the Client Role Expectations Inventory (CREI) (Duffin, 1980) and a thirteen item social desirability scale known as the Personal Reaction Inventory (PRI) (Reynolds, 1982). This was done upon entry and prior to being seen by the intake clinician. The data gathered from those clients deemed inappropriate was discarded. Attached to the questionnaire there was an informed consent

form. Following the regular intake procedure, those clients fitting the criteria (above) were seen individually by the author. In the experimental condition, they were prepared for treatment in accordance with the role induction technique designed and employed by Strupp and Bloxum (1973). This procedure was of approximately one-half hour duration. Control subjects did not have this intervention. Both the experimental and control subjects were then interviewed about their social networks in a format described by Barrera (1981). The five areas from which inquiry was drawn were randomized in their order of presentation. The duration of this was somewhat variable as a function of the individual network and clarity of responsiveness of subjects. A maximum of one hour was spent with each subject. Effort was made to standardize contact time as much as possible.

All clients were asked to provide written informed consent (see Appendix 1) as noted above, and each was granted the opportunity to ask questions during the interview. Finally, at the end of the interview procedure, subjects were asked to repeat the expectations questionnaire (CREI). This provided assessment of the impact of the preparation technique on client expectations.

The agency being utilized for data collection has a relatively low level of client dropout. At the present time many clinicians perform an informal preparation to treatment. All clinicians were requested to discontinue this practice for the period of data collection in an effort to provide greater control of the study.

Basic demographic material from the following categories was collected from the clinical record: age, marital status, income level, race, diagnosis across DSM Axes I-V, employment, referral source, and whether or not medication was provided at intake. History of previous psychiatric/psychological care was also noted. This information was used later to determine whether or not the prepared and nonprepared groups were comparable.

Several authors have noted (e.g., Carpenter, Morrow, et al., 1981; Raynes & Warren, 1981; Dibner et al., 1963) that a long period of time between the client's initial contact and assignment to a therapist can increase the rate of attrition. The agency from which the sample was drawn uses a system of patient disposition that involves assignment to therapists once a week. It was felt that the time dimension was controlled by the design such that the waiting period was variable for select clients but essentially the same for the prepared and nonprepared groups.

Instruments

The Client Role Expectations Inventory (CREI)

This is a 56 item questionnaire developed by Duffin (1980) as part of a dissertation project. It is composed of items drawn from existing instruments (Berzins, 1966; Williams et al., 1967; Appfelbaum, 1958; Lorr, 1965) and from among statements generated independently from prospective clients. It has the advantage of a comprehensive item pool of 203 items which were then subjected to a factor analysis. The items

assess client role expectations rather than preferences or therapist behaviors. Items with a factor loading of .4 or greater and less than .4 on social desirability were selected for inclusion and five factors were represented. The five factors were labeled: cooperation (COOP), safe self disclosure (SSD), expert advice (EXA), facilitation (FACIL), and friendliness (FRIEND). Coefficients for internal consistencies ranged from .63 to .88. The homogeneities of the scales were judged to be acceptable. Test retest reliabilities were conducted and ranged from a low of .47 (safe self disclosure) to a high of .71 (cooperation) for the five factor scales. It was hypothesized that reliabilities were lowered by the high degree of sample homogeneity and subsequent low variance. The distribution was found to be slightly skewed.

The cooperation scale was significantly correlated to the Bem Sex Role Inventory. The friendliness scale correlated significantly with a measure of locus of control. The Assertion Inventory and Ellis Irrational Ideas test both correlated with the expert advice factor. Preliminary validation procedures have been promising.

Therapy Preparation Technique

The role induction procedure is modeled after the interview utilized in the study conducted by Strupp and Bloxum (1973). This, in turn, was developed in accordance with the original anticipatory socialization technique of Orne and Wender (1968). The preparation will follow this outline:

- I. Introduction of the interviewer.
- II. Statement of the purpose of the project, following format of the informed consent material.
- III. Description and explanation of the model that most individuals know and expect: the medical model. Differentiation of therapy from this.
- IV. Assertion that change takes time. Anticipation of client disappointment at the slowness of change.
- V. Explanation of change as:
 - a. learning how to better cope with problems
 - b. development of the potential for a more satisfactory although not problem-free life
 - c. development of the tendency to be less prone to being caught up in old problems and vicious cycles
- VI. Change as generalizable; note that change is progressive and cumulative and expected to move from one hour a week in the office to life in general.
- VII. Note that treatment is called by a variety of names and delivered by professionals with different titles, describe this.
- VIII. Indicate the distinction between internal and external problems as well as the relationship between the two with emphasis on the fact that treatment generally concerns itself with the former.
- IX. State the rule of therapy: talk.
- X. Explain why therapist might not initiate discussion.

- XI. Anticipate the development of feelings toward therapist.
- XII. Anticipate wish to terminate and/or experience of discomfort; label this as progress.
- XIII. Offer the opinion that treatment can be extremely valuable as an experience and a unique opportunity to be used.

Arizona Social Support Interview Schedule (ASSIS)

This instrument was designed to assess the adequacy of and satisfaction with eight different facets of social support. Development of the procedure was predicated on the notion that there are some specific functions served by the social network. The author based his categorizations of the work of several authors including Caplan (1974) and Hirsch (1980). The instrument is substantially different from other methods in so far as it focuses in qualitative variables and functional dimensions. The six support functions that were derived are as follows:

1. Material Aid: Providing material aid in the form of money and other physical objects.
2. Physical Assistance: Sharing of tasks.
3. Intimate Interaction: Interacting in a nondirective way such that feelings and personal concerns are expressed.
4. Guidance: Offering advice and guidance.
5. Feedback: Providing individuals with information about themselves.
6. Social Participation: Engaging in social interaction for fun, relaxation, and diversion from demanding conditions (Barrera, 1981, p. 75).

In addition to the identification of individuals who provide support, the ASSIS elicits information about sources of interpersonal conflict. Clients are asked to respond on a three-point scale of satisfaction. There is also an index of social support needed. Hence, a

number of scores are obtained including total network size, unconflicted network size (TOTA), conflicted network size (CON), satisfaction with support (S), and need scores (N). These scores may be obtained for each functional category.

Test retest reliabilities indicate that the total network size was stable; the correlation was $\underline{r} = .88$. Further analysis indicated that 73.8% of the network members named were on both assessments. The test retest reliability of the conflicted network size was understandably, somewhat lower but still significant at $\underline{r} = .54$. Test retest reliabilities for the various categories ranged from $\underline{r} = .37$ -.87. The index of satisfaction with support showed a reliability of $\underline{r} = .69$ and was found to be skewed in the direction of high satisfaction. The internal consistency was low ($\underline{r} = .33$). The measure of need of support had a good reliability ($\underline{r} = .80$) and moderate ($\underline{r} = .52$) internal consistency. A repeat of the tests of internal consistency of the satisfaction and need measures was conducted in a later study (Barrera & Ainlay, 1983) and found to be notably higher ($\underline{r} = .50, .70$, respectively). It is noteworthy that social support and social need, as assessed by the ASSIS, are negatively correlated ($\underline{r} = .55$). These indices would also be affected by fluctuations in accordance with many situational factors. One would expect these scales to be more complex and idiographic since they are subjective.

In addition to the measures already noted, an index of the total network size actually utilized may be derived. This was found to correlate with the total network size (available) at a level of $\underline{r} = .92$.

Finally, percent of familial and nonfamilial network will be computed as an addition to the instrument. Subjects will be asked to indicate who are the people to whom they are related from among those named in the course of the interview.

For the purposes of this study, the categories of Physical Assistance and Guidance were deleted. The latter was discarded on the basis of its low reliability ($r = .18$). The Physical Assistance items were considered to be so highly similar to the Material Aid items that its use seemed to constitute redundancy. In a recent factor analysis which examined the content validity of the support functions, Barrera and Ainlay (1983) found no empirical basis for distinguishing between provision of material aid and physical assistance. Similarly, the factor positive feedback was found to be closely related to guidance functions thus suggesting "surplus distinctions" (p. 141).

Finally, an additional function was developed. This addressed the availability, utilization, satisfaction, and need of individuals to support, encourage, or discourage the client from treatment. Six items within this category were developed (see Appendix 2). Test retest reliabilities were obtained for each of the six categories, all of which were found to be significant. These were as follows: Treatment Support Network available (TXSA) $r = .67$, $p < .05$; Treatment Support Network Utilized (TXSU) $r = .78$, $p < .01$; Treatment Support Network Satisfaction (TXSS) $r = .91$, $p < .01$; Treatment Support Network Needed (TXSN) $r = .86$, $p < .01$; Treatment Support Negative Actual (TXNGA) $r = .98$, $p < .01$; Treatment Support Negative Encountered (TXNGU) $r = .79$, $p < .01$. Test retest reliabilities were obtained from a random sample

of clients in treatment at the same agency that was used for data collection.

In addition to this, a measure of total network was developed which is different from the index of total network as developed by Barrera (1981). In the ASSIS, total network is derived by summing across functional categories. Thus, for example, if an individual names six people in the category of private feelings and seven in the area of material aid, and nine in social participation, the total network would be twenty two using the method established by Barrera. This method is used in the ASSIS to obtain scores of availability and utilization. However, examination of the absolute number of individuals named would reveal a lower number because some of the names would have been repeated. The total network measure here employs absolute counts to adjust for this redundancy.

A second measure of the proportion of the network represented by family was developed by taking the absolute number of family members in relation to the total network. It was felt that this would reveal whether or not the network was dominated by family. The raw scores do not show what proportion is family.

Social Desirability Scale, the Personal Reaction Inventory (PRI)

This instrument is a short form of the Marlowe-Crowne Social Desirability Scale developed by Reynolds (1982). Several short forms of social desirability have been developed and compared in terms of

internal consistency, reliability, item factor loadings, correlations with the long form of the Marlowe-Crowne, and correlations with the Edwards Social Desirability Scale. Results indicate that this thirteen item form was psychometrically the most sound. The reliability was reported to be $\underline{r} = .76$ and thus compares favorably with the standard and revised version of the Marlowe-Crowne. In relation to the Marlowe-Crowne directly, the thirteen item short form (PRI) was found to have a correlation of $\underline{r} = .93$. In short, it is a viable instrument for the assessment of socially desirable response tendencies and it has approximately one third the items.

CHAPTER IV

RESULTS

The data analyses may be divided into five parts and are reported in sections corresponding to each analysis. First are the computations that describe the sample and the similarity of the prepared and nonprepared groups. The second set of calculations examine client expectations and changes in expectations following the preparation technique. The third set of computations addresses the relationship between the social network variables and therapy attendance. The fourth group of analyses will address the relationship between scores of satisfaction and need of the social network in relation to therapy attendance. Finally, the results of a series of ancillary analyses are reported and serve to characterize the social networks of this adult outpatient population.

Sample

The demographic characteristics of the sample may be found in Table 1. Overall, the sample may be characterized as predominantly female, unemployed, white, self or professionally referred, with an average of eleven years education, and a modal diagnosis of character disorder, frequently in conjunction with a major (DSM Axis I) psychiatric disorder. Diagnostic information is contained in Appendix 3. Statistical tests of comparison between the prepared and nonprepared groups were conducted and the groups were found to differ with respect

TABLE 1
Demographic Information on Sample

Variable	Prepared	Nonprepared	Total
Sex	75	75	150
M = 44	21	23	
F = 106	54	52	
Age			
Mean	33.3	34.18	33.74
Median	30	30	30
Marital Status			
Single	18	21	39
Married	31	21	52
Divorced	14	16	30
Widowed	2	7	9
Separated	8	9	17
Multiple Marriages	2	1	3
Employment			
Yes	24	23	47
No	49	51	100
Part-time	2	1	3
Race			
White	72	64	136
Black	3	11	14
Referral Source			
Self	35	23	58
Family/Friend	14	12	26
Professional	22	34	56
Coercive*	4	6	10
Medication Given			
Yes	21	33	54
No	54	42	96
Prior Inpt. Tx.			
Yes	11	21	32
No	64	54	118

TABLE 1 (Continued)

Variable	Prepared	Nonprepared	Total
Prior Outpt. Tx.			
Yes	44	39	83
No	31	36	67
Educ. Level			
Mean	11.75	10.6	11.17

* e.g., court.

to their history of inpatient hospitalization, $\chi^2(1) = 3.97$, $p < .05$. This involved a total of thirty-two subjects; eleven in the prepared group and twenty-one in the nonprepared group. A correlation was conducted between this variable and number of sessions attended, and it was not significant; $r = -.095$, $p > .25$. The data on two subjects who had been assigned to the prepared condition was discarded because the clinician to whom the patients had been assigned failed to have any documented contact with the subjects in the course of six weeks, and it was felt that the accuracy of the data could not be relied upon.

Expectations

It was hypothesized that the prepared client could be distinguished from the nonprepared client on the basis of scores on the CREI. Chi square analyses were conducted on each of the five scales first using pretest measures to insure they were not initially different, and then using posttest measures to demonstrate changed expectations as a function of the preparation technique. Pretest measures showed no significant difference in expectations between the prepared and nonprepared clients. Posttest measures showed significant change on only the scale of expert advice ($EXA \chi^2 = 6.145$, $p < .01$), in the direction of a decrease in expectation of advice from the therapist. A table of the chi square analyses is listed in Appendix 4.

A t-test for independent samples was conducted using the change scores for the prepared and nonprepared groups. No significant changes

in expectations were found. The t scores for each analysis are listed in Appendix 5.

Social Network Variables

An initial correlation matrix between all the social network variables was computed to examine redundancy of measures because measures of utilization (U) are derived as subsets of the measures of network available (A), and it was felt that overlap would introduce duplication and therefore error into the regression model. Thus, utilization variables (U) that had a $r > .70$ with the corresponding network available (A) score were excluded from the regression model. This included private feelings (U) $r = .80$, treatment support (U) $r = .74$, social participation (U) $r = .71$, and conflicted network (U) $r = .73$. Each of the scores of availability correlated with scores of utilization. The utilization scores were chosen to be discarded on the basis of the work of Thoits (1982) which suggested that the index of network perceived to be available was more important than the actual number of people who may have had contact with the client during any given time period. It is noteworthy that the measures of availability and utilization for the variables material aid, positive feedback, and network against treatment had intercorrelations of only $r = .15$, $r = .63$, and $r = .31$ respectively.

Thus, there were ten main network variables deemed appropriate for entry into the regression model. They were as follows: private feelings (A), social participation (A), treatment support (A), network

against treatment (A & U), conflicted network (A), positive feedback (A & U), and material aid (A & U).

In addition to these, the two derived network variables (see methods) were entered; the total network and the proportion of the network comprised of family members. These were developed because the research of McKinlay (1973) suggests that the proportion of family members may bear a relationship to the utilization of health care services. The ASSIS (Barrera, 1981) was designed to provide only the raw count of family members in the network, but it was felt that an index of the relative proportion might be more telling.

In addition to the twelve network variables, the conditions of preparation, gender, and score on the PRI were entered into a stepwise multiple regression model against the number of sessions attended. A second regression was conducted against the dichotomous classification of attendance one session only, or more than one session. Each of the regression procedures will be described separately.

Multiple Regression Against the Number of Sessions

The first regression function of the fifteen variables against the dependent variable of the number of sessions attended was significant up until the thirteenth step ($F(12,135) = 1.79, p < .05$). The first four variables entered were PRI, private feelings (A), sex, and feedback (U). The variables not entered into the model were conflicted network (A), network against treatment (U), and material aid (A). This model accounted for 14% of the variance ($R^2 = .137$). The F to enter

and probability at each step may be found in Table 2. The stepwise correlational data for the fifteen variable models may be found in Table 3.

Examination of the regression analysis indicates that increases in variance accounted for were negligible after the eighth step. The model at the eighth step was highly significant: ($F(8,139) = 2.64$, $p < .01$). Beta weights and F values for this model may be found in Table 4. Among the variables entered, number of people available with whom to discuss private matters, number of people who actually provide positive feedback, and being female were all positively related to attending a greater number of sessions. Preparation for treatment loaded positively with returning two, three, or four times and having a high score on the PRI scale of social desirability was negatively loaded in the function suggesting a negative correlation with staying in treatment. The remainder of the variables, which were all network variables, loaded negatively into the function.

It had been hypothesized that therapy preparation would be found significant in relation to the number of sessions attended. This was not strongly supported. Since the preparation condition and the variable gender are dichotomized variables and would result in underestimations of the variance in a regression model, separate chi squares were computed, and results for all were nonsignificant. These may be found in Appendix 6. It was expected that the network variables in all of the five functional categories would be positively correlated with the number of sessions attended. The regression function suggests

TABLE 2

Stepwise Regression Across Number of Sessions Attended
Beta Weights, F Values, and Probabilities

Variable*	Beta	<u>F</u> to enter	<u>p</u> > <u>F</u>
Intercept	2.89		
PRI	-.044	5.84	.017
Private Feelings (A)	.104	5.58	.005
Sex/Female	.442	5.25	.002
Feedback (U)	.051	4.35	.002
Social Participation	-.040	4.02	.002
Material Aid (U)	-.063	3.42	.004
Proportion Family	-.210	2.97	.006
Against Treatment (A)	-.016	2.64	.010
Preparation	.098	2.36	.017
Positive Feedback (A)**	-.022	2.14	.026
Total Network	.018	2.15	.025
Treatment Support (A)	-.001	1.79	.054
Conflicted Network (A)	-.008	1.65	.080
Against Treatment (U)	-.029	1.52	.113
Material Aid (A)	-.000	1.42	.153

* Variables appear in order entered.

** Began process of replacement of earlier variables.

TABLE 3

Stepwise Regression Against Number of Sessions Attended Full Fifteen
Variable Model; Beta Weights, R^2 , F Values, and Probabilities

	Beta Weights	R^2	F	$p > F$
Intercept	2.513			
PRI	-.060	.038	9.18	.003
Private Feelings	.142	.071	6.10	.015
Sex: Female	.410	.099	3.04	.083
Feedback (U)	.084	.018	2.26	.136
Social Participation (A)	-.044	.124	1.27	.261
Material Aid (U)	-.068	.127	.48	.491
Proportion Family	-.199	.129	.28	.597
Against Treatment (A)	-.030	.132	.47	.496
Preparation	.087	.133	.19	.667
Feedback (A)	-.027	.135	.35	.554
Total Network	.020	.135	.28	.596
Treatment Support	-.012	.137	.08	.779
Conflicted	-.009	.138	.04	.842
Against Treatment (U)	.008	.138	.01	.915
Material Aid (A)	-.000	.138	.00	.993

Variables appear in order entered.

Values accurate for fifteenth step.

TABLE 4

Stepwise Multiple Regression Against Number of Sessions
Beta Weights, F Values, and Probabilities
Eight Variable Model

	Beta Weights	<u>F</u>	<u>p</u> > <u>F</u>
Intercept	2.627		
PRI	-.057	9.58	.002
Private Feelings (A)	.136	6.99	.009
Sex: Female	.375	2.91	.090
Feedback (U)	.067	2.57	.111
Social Participation (A)	-.040	2.51	.116
Material Aid (U)	-.067	.54	.463
Proportion Family	-.227	.43	.513
Against Treatment (A)	-.016	.37	.545
Overall Model		2.64	.010

Variables appear in the order entered.

this is not so with some network variables loading positively and some negatively. Beta weights and F values may be found in Table 4. The variables, proportion of family network, material aid (A), conflicted network (A), treatment participation (A), positive feedback (A), social support (A), material aid (U), and network against treatment (A) all loaded negatively with the number of sessions. Only private feelings (A), positive feedback (U), network against treatment (U), and total network had positive loadings, and the second two entered into the model late. It had been hypothesized that the index of negatively charged interactions (conflicted network A) would be positively correlated with the number of sessions attended. This was not supported by the regression analysis. As predicted, there was no significant relationship between gender and attendance ($F(15,132) = 2.91, p < .09$). The index of social desirability was significantly associated with the number of sessions ($F(15,132) = 9.58, p < .002$). This factor accounted for more variance than any other single variable, roughly 4%, and entered the model first with an $F(1,46) = 5.84, p < .02$.

A stepwise discriminant function was computed to assess the ability of the fifteen variable model against the number of sessions to classify an individual's membership into groups of those attending one, two, three, or four sessions. The model was found significant. Wilks lambda converts to an $F(45) = 1.59, p < .01$. Standardized canonical coefficients may be found in Table 5. This model was significant for every variable entered. This model was able to classify with an accuracy of 54% (see Table 6). The discriminant function indicates

TABLE 5
Network Variables by Sessions Attended
Standardized Canonical Coefficients

	Func 1	Func 2	Func 2
Treatment Support (A)	.580	.170	.345
PRI	.471	-.613	.253
Feedback (U)	-.516	.456	.105
Against Treatment (A)	.371	.106	.810
Total Network	-.552	.011	-.541
Social Participation (A)	-.503	-.318	.152
Private Feelings (A)	.312	.623	-.606
Material Aid (U)	-.101	-.036	.503
Sex: Female	-.001	.457	-.118
Against Treatment (U)	.317	.156	.139
Material Aid (A)	-.370	.020	.312
Proportion Family	.222	-.159	-.181
Preparation	-.240	.014	.125
Feedback (A)	.132	-.105	.364
Conflicted Network (A)	-.025	-.053	.065
Canonical Coefficients	.477	.378	.301
p <	.01	.09	.43

Variables appear in order entered.

TABLE 6
 Classification Results from Discriminant Analysis
 Network Variables in Relation to the Number
 of Sessions Attended

Predicted	1	2	3	4	Total
Actual					
1 n	18	4	11	6	39
(%)	46.2	10.3	28.3	15.4	
2 n	8	16	3	2	29
(%)	27.6	55.2	10.3	6.9	
3 n	5	5	22	2	34
(%)	14.7	14.7	64.7	5.9	
4 n	5	6	11	24	46
(%)	10.9	13	23.9	52.2	

Percent of grouped cases correctly classified: 54.05%.

that there is a lot of overlap between groups such that no single variable or combination of variables is definitive.

Multiple Regression of One Session vs. More Than One

The stepwise model examining the clients who attended one session only in relation to those who came two or more times was conducted utilizing the same variables as above. For the most part, results were similar to the analysis by sessions but with some striking differences. The full fifteen variable model was significant $F(15,132) = 1.97$, $p < .02$, and accounted for 18% of the variance. The variables PRI, positive feedback (U), treatment support (A), and preparation entered first. The variables conflicted network (A) and material aid (U) entered last. Again, an eight variable model was found to be highly significant ($F(8,139) = 3.34$, $p < .001$) and accounted for 16% of the variance. The variables contained in this model were as follows: social support (A), treatment support (A), network against treatment (U), positive feedback (U), material aid (A), PREP, PRI, and proportion of family. F to enter and probabilities for each step may be found in Table 7. Beta weights, R^2 values and F values for each variable are presented in Table 8. The two variables (PRI and positive feedback U) which entered first and second and yielded highly significant F values: $F = 9.06$, $p < .003$, and $F = 11.15$, $p < .001$, respectively. Only the variables positive feedback, preparation and material aid had positive loadings.

A stepwise discriminant function was computed to assess the ability of this model to predict an individual's attendance. The model

TABLE 7

Stepwise Regression Against Attendance at One Session vs.
Two or More; Beta Weights, F Values, and
Probabilities at Each Step

Variable*	Beta Weight	<u>F</u> to Enter	<u>p</u> > <u>F</u>
Intercept	.868		
PRI	-.019	8.15	.005
Feedback (U)	.032	6.64	.002
Treatment Support (A)	-.002	5.68	.001
Preparation	.097	4.76	.001
Proportion Family**	-.170	4.19	.002
Social Participation (A)	-.017	4.25	.001
Material Aid (A)	.013	4.43	.001
Against Treatment (A)	-.011	3.34	.002

* Variables appear in order entered.

** Began process of replacement of earlier variables in combination with other variables.

TABLE 8

Stepwise Regression Against Attendance One Session
vs. Two or More; F Values, Beta Weights, R^2
Values, and Probabilities; Eighth Step

	Beta Values	R^2	F	$p > F$
Intercept	.962			
PRI	-.022	.084	11.15	.0011
Feedback (U)	.046	.106	9.06	.0031
Treatment Support (A)	-.019	.117	2.15	.1447
Preparation	.081	.129	1.31	.2550
Proportion Family	-.174	.135	1.91	.1688
Social Participation (A)	-.021	.146	3.67	.0575
Material Aid	.014	.154	2.80	.0964
Against Treatment (A)	-.011	.161	1.28	.2602
Overall Model			3.34	.002

was found to be significant with Wilks λ converting to an $F(45) = 1.97$, $p < .02$. Standardized canonical coefficients are contained in Table 9. The coefficients indicate that PRI, feedback (U), and social participation had the largest relative contributions. This model was able to classify 71% of the subjects accurately (see Table 10).

Satisfaction and Need Ratings

A series of Spearman rank order correlations were conducted between the number of sessions attended and the satisfaction (S) and need (N) ratings for the five functional categories, private feelings (N), private feelings (S), social participation (S), social participation (N), positive feedback (S), positive feedback (N), material aid (S), material aid (N), treatment support (S), and treatment support (N). It was hypothesized that satisfaction would correlate negatively, and need would correlate positively with number of sessions. This was not supported; there were no significant correlations. The coefficients calculated are contained in Appendix 6.

A post hoc analysis of satisfaction and need ratings in relation to gender was conducted. There were no significant findings.

Descriptive Material

A series of descriptive tests were conducted across the social network variables. In this sample, the mean number of people available in the network was 12.15 people. Subjects reported an average of 2.5 people with whom they could discuss personal and private feelings. The

TABLE 9

Standardized Canonical Discriminant Function Coefficients
of One Session vs. Two or More

Variable	Coefficient
PRI: Social Desirability	.772
FDBKU: Positive Feedback Utilized	-.652
TXSA: Therapy Support	.439
PREP: Preparation	-.225
PFAM: Percent Family	.233
SOCPA: Social Participation	.609
MAIDA: Material Aid	-.243
TXNGA: Against Therapy	.396
Sex Female	-.289
TOTNW: Total Network	-.552
PVTA: Private Feelings	-.238
TXNGU: Against Treatment	.191
FDBKA: Positive Feedback	.236
MAIDU: Material Aid Utilized	.040
CONA: Conflicted Network	.023

Variables appear in order entered.

TABLE 10

Classification Results from Discriminant Analysis Network Variables Against One Session vs. More

Predicted	1 Session	2+ Sessions
Actual		
1 Session 39	29 74.4%	10 25.6%
2+ Sessions 109	33 30.3%	76 69.7%

Correct Classification 70.95%.

mean number they utilized for this purpose was 1.81. There were 4.78 people who were perceived as possibly providing positive feedback (FDBKA) and only 2.29, on the average, actually did so. There were 5 people with whom the subjects felt they could have fun or relax but in the past month they reported having spent time with 3.3 people (social participation A). There were 3.6 individuals who were expected to support the client's choice to be in treatment (treatment support A), and it was expected that all of these people would actually do so. Subjects reported having 4.83 people who would provide material assistance (A), and they reported having gotten assistance (U) from .89 people on the average. Subjects reported feeling in conflict with 3.06 individuals. In contrast to this, subjects reported the actual number of people with whom they were in conflict to be 1.81. Finally, subjects reported feeling that on the average there were 2.08 people in their network who were against treatment but only .54 who actually made negative remarks to them about therapy. Summing across categories, on the average, clients reported having 17.16 people upon whom they could rely for something (total available, containing some redundancy) and felt as if 8.27 people had actually given to them.

It was hypothesized that the social network of women might be somewhat smaller than that of the men. A series of t-tests were computed and significant sex differences were found. The actual values are contained in Table 11. There were significant differences in the total network, $t(148) = 3.23$, $p < .002$; private feelings (A), $t(148) = -2.76$, $p < .007$; material aid (A), $t(148) = -2.38$, $p < .005$; same sex,

TABLE 11
Average Size of Network Across Categories
Comparison of Men and Women

Variable	Male	Female	Total
TOTNW	14.6	11.11	12.15 [*]
PVTA	3.2	2.2	2.49 [*]
PVTU	2.05	1.7	1.81, ns
FDBKA	5.32	2.33	4.78, ns
SAMESEX	8.84	6.3	7.57 [*]
SOCPU	3.39	3.25	3.29, ns
FDBKU	2.18	2.33	2.29, ns
TOTA	21.47	15.3	17.16 [*]
SOCPU	6.31	4.53	5.05 ^{**}
TXSA	3.82	3.51	3.60, ns
TXSU	3.02	2.42	3.60, ns
TOTU	8.75	8.07	8.27, ns
MAIDA	6.64	4.08	4.83 [*]
MAIDU	1.14	.78	.89, ns
Prof			
Yes	12.00	38.00	50.00, ns
No	32.00	68.00	100.00, ns
CONA	3.23	2.99	3.06, ns
CONU	1.43	1.97	1.81, ns
TXNGA	2.3	1.99	2.08, ns
TXNGU	.14	.71	.54 ^{**}

^{*} $p < .01$, actual t values in text.

^{**} $p < .05$, actual t values in text.

or the absolute number of same sexed intimates $\underline{t}(148) = -3.39$, $\underline{p} < .0009$, total available $\underline{t}(148) = 02.96$, $\underline{p} < .004$, social support (A) $\underline{t}(148) = -2.43$, $\underline{p} < .02$, and network against treatment (U) $\underline{t}(148) = 2.12$, $\underline{p} < .04$. These findings are indicative of smaller networks for women in every category except those against treatment (U).

A post hoc analysis of the social network in relation to one's marital status was conducted because scrutiny of the data suggested there might be some major differences. The most striking finding was in the area of proportion of family. A one-way analysis of variance showed highly significant differences $\underline{F}(4,145) = 7.27$, $\underline{p} < .0001$. This was the only category which showed differences for all five categories of marital status. A summary of network size across marital status categories is contained in Table 12.

TABLE 12
Average Social Network Size Accord-
ing to Marital Status

	S	M	D	W	P
Private Feelings (A)	2.97	2.63	2.17	1.44	2.17
Private Feelings (U)	2.03	1.94	1.67	1.11	1.64
Positive Feedback (A)	5.15	4.90	4.00	6.00	4.59
Positive Feedback (U)	2.74	2.17	1.97	1.78	2.47
Social Participation (A)	5.44	5.63	3.60	5.11	5.06
Social Participation (U)	3.44	3.67	2.50	2.11	3.59
Material Aid (A)	4.26	6.17	3.90	3.78	4.65
Material Aid (U)	1.05	.75	.93	.67	1.00
Treatment Support (A)	3.46	3.83	3.37	5.44	2.88
Treatment Support (U)	2.41	2.71	2.50	3.33	2.47
Against Treatment (A)	3.33	2.00	1.37	.33	1.76
Against Treatment (U)	.28	.77	.30	.22	.82
Conflicted Network (A)	3.64	3.44	2.27	1.56	3.00
Conflicted Network (U)	2.08	2.02	1.17	1.22	2.06
Proportion of Family	.37	.65	.46	.55	.53
Total	39	52	30	9	17

Multiple marriages deleted because $n = 3$.

S = single.

M = married.

D = divorced.

W = widowed.

P = separated.

CHAPTER V

DISCUSSION

The discussion of the findings will be divided into three sections. The first will address the component of the project that focused on client expectations and preparation for treatment. The second part will be on the findings pertinent to the impact of social network variables on treatment attendance. Finally, there will be some remarks about the descriptive findings. Limitations of the present study and recommendations for future research will be contained within each section.

Expectations and Therapy Preparation

Previous researchers found support for the notion that client expectations were often not congruent with what the clients encountered. Further, it was felt that a therapy preparation technique might realign those expectations as well as contribute to improved outcome. The initial analysis of client expectations showed that there was no difference between the control and prepared group on role expectations. Overall, as reflected by the CREI, the clients expected a high level of cooperation and friendliness as well as an arena for safe self disclosure. Scores on level of expert advice (EXA) and facilitation (FACIL) were about midrange. Following the preparation technique there was no significant difference between the prepared and nonprepared groups on

the basis of expectations utilizing change scores in the analysis. Using a chi square analysis, comparison of median scores for each of the five scales revealed a difference between the prepared and nonprepared groups; the latter having lowered their expectation of expert advice. Other scales showed no difference. Clearly, the preparation had some impact, however small. It may be that the preparation technique was too generic. More specific intervention focusing on particular areas covered by the CREI may have yielded more significant results. For example, the preparation could have been tailored to describe in some detail the difference between a friend and a therapist rather than to focus simply on the reasons why the therapist might not initiate discussion, and this might have affected change on the friendliness scale.

However, the concern about changing someone's scores on the CREI was secondary to the major hypothesis which was that the provision of information about treatment might increase utilization of services as reflected by the number of sessions attended. Analysis of attendance in relation to the prepared and nonprepared conditions showed a small positive effect but was not statistically significant. This may be a result of several factors. The efficacy of a preparation technique to increase attendance has not been fully substantiated and results reported in test of such a technique have been equivocal (Strupp & Bloxum, 1973; Hoyt, 1980). Thus, the training effect may be minimal or indirect. Secondly, preparation of clients may serve to possibly motivate potential dropouts to do so sooner while encouraging others to stay. Such an effect would not be reflected by the present research measures.

For example, if those wishing expert advice were disillusioned when, in the course of the preparation it was revealed that this expectation would not be met, they may have decided on the basis of one visit that therapy was not for them and might have subsequently quit. Thus, the preparation could have increased or hastened termination for some clients. Similarly, some clients anxious about the ambiguity of treatment may have felt reassured about the structure of therapy and may have continued because of clarification of treatment parameters in the course of the preparation. Thirdly, the effect may have been somewhat greater than it appears but offset by the fact that the nonprepared subjects had a history of significantly more hospitalizations. Carpenter et al. (1981) noted that previous history of treatment was associated with returning. However, separate correlations between history of inpatient treatment and sessions attended showed a slight negative correlation with attendance ($r = -.095$, $p > .25$). In any case, it is not clear how a preparation such as this impacts on the client, and it is likely that the impact is not uniform across patients. Use of in-therapy measures would appear indicated to evaluate the impact of training. It might be useful to employ specific behavioral measures designed to measure the occurrence of behaviors indicated by the topics covered in the course of preparation. This would demand that more specific preparation techniques be devised to fit the many therapies, therapists, and settings. The preparation used here may have had limited practical utility because it was not able to specifically address complex variations which influence the course of psychotherapy.

The variety and diversity of clinical styles and theoretical approaches employed by therapists have yet to be incorporated in studies such as this.

Further, there is a need to evaluate the impact of education on patient expectations about treatment and how expectations change across time with the implementation of community mental health programs and the increased portrayal of therapy in the popular media. Patients may be bringing different expectations to therapy than were common five or ten years ago. In fact, one area of investigation is the potential utilization of the media for education about the process of treatment. It seems particularly important for the profession to consider taking responsibility for the ways in which the profession is presented to the public and provide more accurate and helpful portrayals.

Within the context of this study, it appears that preparation has little effect on staying in treatment. It had been hypothesized that a preparation technique might serve a compensatory function and provide information to the client in the absence of an information providing social network. In retrospect, it would appear more efficacious to test this notion by screening clients according to network size and then comparing four groups: those with larger networks and those with small networks, with each group having a prepared and non-prepared condition. Then, the relationship between preparation and social network size, or the interaction of the two, might be more clearly illuminated.

It is noteworthy that examination of the data in terms of those attending the first session only and those attending four or more times (the two extremes) indicated the preparation condition to be a more important variable in influencing return for more than one session than if one looks at the relative number of sessions attended. It may be that in this type of research, the important dimension is the increase of return at all, rather than attendance at a given number of sessions. The finding that most people drop out during the first four sessions may be leading us to concentrate on these sessions to improve return and to overlook other important information. For example, most therapists would hold that little change if any can take place in less than ten visits. Yet, there are clients dropping out all along the course of treatment and the variables involved are both numerous and complex. Examination of more clearly differentiated groups may improve both measurement and prediction.

Social Network

The stepwise regression yielded significant models but failed to account for much variance; less than 18%. The first analysis examined the social network in relation to the number of sessions attended. An eight variable model was found to be significant at $p < .01$, and models were significant for up to twelve variables at $p < .05$. Being female, being the recipient of positive feedback, and having people with whom to speak about personal and private feelings were all positively associated with the number of sessions attended. Having a large proportion

of family members in the social network, a relatively large number of people with whom to have fun and relax, a fair number of people felt to be against treatment, and a group of individuals willing to provide material aid were all negatively related to sessions attended. Additionally, high scores on the PRI scale of social desirability were associated with lower attendance rates. These findings suggest several important things. First, as noted by Hirsch (1980), Mitchell (1980), and Birkel and Reppucci (1983) and as suggested by family systems theory, a familial network can be an obstacle or impediment to treatment, by the promotion of conformity and avoidance of change. Similarly, having someone in one's network who is overtly against treatment would seem likely to increase dropout. These findings may indicate a greater need for family intervention and for addressing the patient's concerns within the context of the family functioning with particular attention to the issues of differentiation and autonomy.

An unexpected finding was that having a group with whom to have fun and relax was negatively associated with attendance to treatment. While it is impossible to know with any certainty why this is so, there are several possibilities. It may be that the individual who retains a network with whom to enjoy life is in less distress than those without. This is supported by the findings of Bell et al. (1982) which suggest that the social network may diminish significantly with the onset of depression and possibly other forms of pathology. The implication is that the pathology decreases the network size rather than the viewpoint that the small network results in pathology. A

second explanation is supported by the findings of Baekland and Lundwall's review (1975) in which it was noted that individuals with lower levels of distress (anxiety and depression in particular) had higher rates of dropout. Perhaps the subjects in this study were relatively less distressed. However, post hoc analysis of Axis IV diagnostic ratings of the present sample does not show a relationship between this and number of sessions attended. A third explanation is that those able to engage in light social intercourse and who are able to have fun and relax are psychologically well defended and therefore less interested in psychotherapy or less able to engage in the process of self exploration. Since the PRI and other scales of social desirability are considered by some to be an index of defensiveness and since the PRI was also highly correlated with dropping out (attending one session only) then perhaps there is some merit to this line of thought. It is also possible that those individuals who report a relatively large group of people with whom to have fun and relax are action oriented rather than verbally oriented, and thus the process of engaging in treatment is more difficult for them.

The present study revealed a negative correlation between score on the PRI, the proportion of family network, the network involved in social activity, and therapy attendance. The consistent prominence of the PRI score in the predictive models warrants special comment. If the PRI is, in fact, an index of defensiveness suggestive of a strong system of denial, and if the large proportion of family membership in the network is indicative of enmeshment, then one might speculate about

the type of family structure and process from which the subjects arise. It is possible that the family system holds certain values, beliefs, and practices despite exigencies of the outside world. The system could be coercive with restrictions on both behavior and loyalty. Taken in the extreme, the family may actively resist information feedback which might otherwise be corrective of the family myths. Thus, it would foster perpetuation of self and family images that were inaccurate while harboring an intolerance of the individual who may have an emotional problem and be in need of therapy. On the contrary, the family may engage in active denial and distortion both about the individual within the system and about the world. This would call into question the supportive role of the family network and indicate need for research into the family function. It appears all too easy to conclude that because the network is not in conflict per se that it is, by default, supportive. It is quite possible that the network in general and the family in particular might be engaged in quiet control in which the conflict is covert and hence all the more difficult for the client and therapist to address.

On an individual level, it is possible that high scores on the PRI are indicative of a response set in which the client is motivated to present themselves in a socially favorable light. If this is so, it calls into question these self reports about the social network. It may be that the subjects were presenting themselves as having friends with whom to have fun and people willing to help them out when they in fact did not. This might imply more serious interpersonal difficulty

than the client in willing to admit. In particular, it may suggest facility with general social skills but serious difficulty with intimacy. The ability to score high on a social desirability scale suggests that one is well aware of convention and in combination with a relatively low score on the scale of private feelings it may indicate superficiality and naivete. It might also be indicative of serious difficulty with introspection and being honest with one's self, or with others. This suggests a need to develop interventions which do not demand introspection and which are short term and problem oriented. This would demand development of preparation techniques and therapeutic interventions which fit the individual rather than vice versa.

There is yet another way to interpret these results. According to Litwak and Szelenyi (1969) friends are a primary source of affective support whereas family members supply long-term aid. If this is so, it is possible that an individual with a network that was family dominated might score relatively high on the scales of material aid and social participation but low on feedback and private feelings since the latter involve affective exchanges. Thus, it may be that the configuration of the present findings reflects the composition of the network. In other words, the correlation between being able to speak about private feelings and being the recipient of positive feedback may be a function of having more friends, rather than a particular orientation or trait. Examination of the intercorrelation of the variables, however, does not indicate a strong relationship but shows a weak negative correlation between the network involved in social activities and the proportion of family membership.

The finding of a negative loading on the scale of material aid (A) and sessions attended appears straight forward. A network that provides material aid may provide a kind of concrete support or resiliency against stress that renders involvement with professionals either unnecessary or unlikely.

The association between sessions and PVTA and FDBKU were anticipated. The ability to speak with another about personal and private feelings and receive feedback represent a certain level of verbal facility. In addition, it bespeaks of an emotional accessibility and ability to communicate internal events as well as have some perspective or distance on one's self and the world. One might wonder whether or not these scales parallel what has been called psychological mindedness.

It appears that the level of conflict is less important than the level of support. One might want to explore this aspect further on the premis that having even one person with whom the client can talk about personal matters may serve to offset other negative interactions, and bolster the client's ability to engage in the therapeutic process. The design of the present study does not allow for this measurement.

It is noteworthy that throughout all of the analyses, the index of total network had little predictive value. This would suggest that qualitative aspects and functional dimensions are much more important than quantity. In relation to the process of psychotherapy this appears crucial.

It must be born in mind that there is little previous research on social networks of an adult outpatient population. The instrument used in this study is fairly new. As such, its psychometric properties are just beginning to be defined. The measures are all self report and the accuracy is unclear. In the absence of empirical data, one must make interpretations cautiously. It is not entirely clear at this time what the instrument assesses in terms of social network vs. social support and there may be overlap between the scales. In fact, it may assess how clients are willing to present themselves and their social milieu to a therapist rather than veridical information about their life situation.

The analysis of the data focusing on the clients who attended one session only in comparison to those who came two or more times yielded quite similar results but with some subtle and important differences. Overall, the model could account for a larger percent of the variance. The impact of the preparation technique was greater suggesting that it had some effect on whether or not clients returned at all post intake. Having people with whom to speak about private matters, as well as gender, had a weaker relationship to attendance than in the case of examination by sessions attended. Having people against treatment, not getting positive feedback, having a large proportion of family members in the network and a high score on the PRI all grew in importance. All were associated with lower levels of attendance. The eight variable model accounted for 15% of the variance, and the fifteen variable model could account for 18% of the variance.

This represented a slight improvement over the analysis by sessions attended.

It appears that the utility of a multiple regression with these data may be limited. Examination of the scales used for the assessment of the network indicates a consistent bias in the form of positive skewing of the distribution of scores. According to Hays (1963) variations in the distribution away from normality may function to limit the range of the coefficient to some unknown degree. This results in coefficients that underestimate the contribution of variables. This may shed light on the contrast between a model that accounts for a relatively small percent of the variance but which appears to have accuracy for classification of subjects. In addition, little is known about the population parameters of the instrument thus rendering corrective measures impossible. In the context of this study it would appear that the discriminant function represents a more useful statistical tool.

Despite the large proportion of the variance unexplained by the model, it does predict fairly well. In particular, it is able to predict attendance one time only with an accuracy of 74.4%. It could correctly classify individuals in all categories 70.95% of the time. This suggests that the reported network differences have important implications for what has been called therapy dropout. Indeed, if one again looks only at the extremes (one session vs. four or more) the effect of the preparation, proportion of family members, PRI, positive feedback (U), private feelings (A), treatment support (A), and material

aid (A) all increase in importance. This should be interpreted cautiously however because the number of subjects was reduced to 84 by this categorization.

It is difficult to identify with certainty any combination of variables which are definitive of attending treatment once, twice, three or four times because the discriminant function yielded three separate functions of equal predictive value in which the combinations of variables change. Thus, the canonical coefficients vary depending upon which function one employs and the relative contribution of any given variable is neither fixed nor constant. However, as the canonical coefficients indicated, social participation (A), positive feedback(U), and PRI appear to have had a powerful effect but conflicted network (A) and material aid (U) were relatively weak, especially if one examines the data in terms of attendance at one session only. This indicates that the part of the network involved in the function of relaxation and the provision of positive feedback have the greatest implications for therapy attendance. This would indicate a need for further research on these specific functions.

The ratings of satisfaction and need had originally been hypothesized to correlate negatively with the number of sessions attended. This was not supported. These data did not indicate any relationship of consequence between these network variables and attendance.

Description of Network

It is noteworthy that there was a predominance of character disorder diagnoses among the subjects. The average total network size

reported was 12.15. Pattison et al. (1975) reported that on the average neurotics reported 10-12 individuals in their network. It is unclear whether or not his label of neurotic corresponds to DSM III Axis II, whether character disorder diagnoses were over utilized by the intake clinicians in this study, or other influences. For this reason, it is difficult to compare the present findings with past work. The averages for any given functional category were quite low, ranging from a high of 5 to a low of .89 (social participation A, material aid U). This may explain the differences between earlier findings and the current study. The design of the social network instrument used in this study included measures that have some redundancy and may yield inflated indices of total network. If one were to account for this one might find that the numbers fit very neatly with Pattison et al.'s findings (1975) in which those with the diagnosis of character disorder fall in between the neurotic and psychotic. The subjects reported low levels of conflict (conflicted network A + those against treatment A). Subjects reported three people with whom they might have disagreements and 1.8 people who had actually made them angry or upset. On the average, subjects reported having 2 people who were probably against treatment but less than .5 who had actually expressed disapproval.

Post hoc analyses for sex differences indicated striking and significant results. On all network measures, women had significantly smaller networks, except with respect to the number of people against treatment. This may shed light on why it is that women are over represented, as others have noted (Kessler et al., 1981), among patient

populations at community mental health centers. It may be that in this society women who do not work are quite isolated and seek help from professionals when they might otherwise receive it from friends were they to have them. This sample was weighted heavily with unemployed white females. They comprised almost 55% of the sample. This fact limits the generalizeability of the present findings. As can be seen from the data, the differences in network size are pervasive and not solely in one functional area. Despite this, ratings of satisfaction and need were not significantly different for men and women. Thus, it may be that the women are not dissatisfied or needy per se, but as noted by Walker et al. (1977) the network may not always provide for the particular needs of the individual. It is possible that the networks of married, unemployed women do not provide for the needed diversity of contacts which is available to most men in the context of the work place. Alternatively, this finding may reflect a more general difference between men and women in their system of labeling. Kessler et al. (1981) found support for the notion that women interpret nonspecific feelings of distress as problems much more readily than men. The implication is that women are more likely to seek help because they are more likely to view various discomforts as problematic. In conjunction with this, Vanfossen (1981) found that depression may arise from the perception of unsupportive relationships with intimate others and unemployed wives are particularly susceptible to depression in association with nonaffirming spouses. In the context of the present research this suggests that the finding of smaller

networks among women and their overrepresentation in the sample may in part be a product of cognitive labeling, marital dissatisfaction, and insularity from the larger community. The failure to find differences in overall ratings of satisfaction and need may be a function of the global nature of the rating and the lack of focus on the marital or primary relationship in particular.

Researchers of the impact of divorce, separation, or the never married status may be interested to note that there were trends which indicate marked differences in the size and composition of the network depending on one's marital status. These findings, while only clear and significant with regard to the proportion of family members in the network, suggest need for further research in this area.

In summary, this project found little support for the notion that therapy preparation improves attendance. There are indications that the social network may be an important predictor in therapy involvement. In particular, it appears that individuals able to speak with someone about their private feelings are more readily involved in the treatment process. Secondly, being the recipient of positive feedback is associated with therapy attendance. It is perhaps, as Carpenter et al. (1981) suggested, important for an individual to have a modicum of positive support to stay with therapy. Thirdly, the unwillingness to admit to one's faults and foibles, having people who provide concrete support in the form of material aid, and being socially active are all negatively associated with treatment attendance. These findings indicate that a verbal, perhaps less active orientation appears positively

correlated with being involved in psychotherapy. These findings suggest that the profile, if you will, of the individual who is likely to stay in therapy is of a female, who discusses her private feelings, receives positive feedback, has people who support her to be in treatment, scores low on social desirability, was prepared for treatment, and has friends. Conversely, the individual likely to come for one session only is more likely male, has people with whom to have fun and relax and who are willing to give or loan things, scores high on social desirability, feels that others are against their being in treatment, and has a network with a large proportion of family members. Finally, this research has implications for therapy training insofar as it would suggest a need to focus on the development of social skills in general and the development of verbal facility and the ability to disclose private feelings in particular, because of the indications in the data that these interpersonal processes are somehow related to being involved in psychotherapy. It would be interesting to develop a therapy preparation technique that was specifically designed to address the social interchanges contained in the functions, developed by Barrera (1981), of private feelings and positive feedback, and to then assess its impact on therapy attendance, process, and outcome. Furthermore, one might wonder whether or not these functions might be somehow incorporated into family interventions since a high proportion of family membership in the network was found to be associated with dropout.

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APPENDIXES

APPENDIX 1

CONSENT TO PARTICIPATE IN RESEARCH

Project: The purpose of this project is to learn something about the expectations people have about treatment in a mental health center. This will be done by asking each individual to answer a questionnaire.

In addition to this, the project focuses on learning something about the support systems of family, friends, and neighbors that each participant has and how this does or does not help in their involvement in treatment.

Finally, this project attempts to help people to more fully understand the treatment they are given.

I have read the above summary of the research project and I have had the opportunity to ask any questions I might have.

I understand that all material is confidential and that my identity will be protected.

Furthermore, I understand that participation is voluntary and that I will not incur any negative consequences if I choose not to participate. I also understand that I may withdraw my consent at any time.

Thank you

Ms. Mitchell

Dr. Dye

Helen Ross McNabb
637-9711

name

date

witness

APPENDIX 2

THERAPY SUPPORT

1. Who are the people you can tell about your treatment and from whom you might expect to get some support to work on your problems? These could be new names or people that you mentioned before.

Probe: Anyone else?

2. Who do you think you will actually tell or talk to for some support and encouragement for therapy?

Probe: Anyone else?

3. During the time you expect to be in treatment, will you want support and encouragement to work on your problems:

1 = alot more

2 = a little more

3 = or do you expect that the amount you will get will be about right?

4. During your treatment how much do you think you will need people to support or encourage you to work on your problems?

5. Who are the people you absolutely would not tell about your treatment because they would disapprove or be discouraging about your efforts to change?

Probe: Anyone else?

6. Who are the people who have already actually said something to discourage you from treatment or who expressed some disapproval of your coming in to work on your problems?

Probe: Anyone else?

Ask about those mentioned in 5 above.

APPENDIX 3

TABLE 3-1
Primary Diagnosis of Subjects

	Prepared	Nonprepared	Male	Female	Total
Psychosis	7	4	5	9	9
Affective	15	19	10	24	34
Anxiety	4	2	2	4	6
Adjustment	7	10	9	8	17
Other/No Axis I	3	3	3	3	6
DSM Axis II	12	10	8	14	22
DSM Axis I & II	32	24	8	48	56

TABLE 3-2
DSM Axis III Diagnosis (Presence
of Medical Problem)

	Prepared	Nonprepared	Male	Female	Total
Yes	55	54	39	70	109
No	20	21	5	36	41

TABLE 3-3
DSM Axis IV (Level of Psycho-
social Stressor)

	Prepared	Nonprepared	Male	Female	Total
Unspecified	1	5	3	2	6
None	1	3	0	4	4
Minimal	0	3	0	3	3
Mild	8	9	3	14	17
Moderate	27	22	20	29	49
Severe	35	29	17	47	64
Extreme	3	4	1	6	7

TABLE 3-4
Dx 4* (Index of
Impairment)

	Prepared	Nonprepared	Male	Female	Total
Good	5	1	0	0	6
Fair	32	35	22	45	67
Poor	26	31	15	42	57
Very Poor	12	8	7	13	20

*Dx 4 constitutes a modification of DSM Axis V from highest level of functioning in the past year to level of current impairment.

APPENDIX 4

TABLE 4-1

χ^2 Comparing Prepared and Nonprepared Groups
Client Role Expectations (CREI Scores)

	Pretest	Posttest
Cooperation	1.30, ns	2.67, ns
Safe Self Disclosure	2.45, ns	0.0, ns
Expert Advice	0.42, ns	6.15, ns
Facilitation	ns*	ns*
Friendliness	.42, ns	.24, ns

*Inadequate cell size for χ^2 , df = 74.

APPENDIX 5

TABLE 5-1

t-Test Values Using Change Scores Prepared
vs. Nonprepared Conditions

Variable	<u>t</u>	<u>p</u>
Cooperation	1.31	ns
Safe Self Disclosure	-.98	ns
Expert Advice	1.39	ns
Facilitation	1.13	ns
Friendliness	-.16	ns

df = 148.

APPENDIX 6

TABLE 6-1

χ^2 Comparing Prepared and Nonprepared Groups
According to Attendance at 1-4 Sessions

Session	1	2	3	4	Total
Prepared					
Frequency	21	12	17	23	73
Percent	14.19	8.11	11.49	15.54	49.32
Nonprepared					
Frequency	18	17	17	23	75
Percent	12.16	11.49	11.49	15.54	50.68
Total					
Frequency	39	29	34	46	
Percent	26.35	19.59	22.97	31.08	

$$\chi^2(4) = 2.09, p > .71.$$

APPENDIX 7

TABLE 7-1

Ratings of Satisfaction and Need Cor-
related to Sessions Attended

Satisfaction		Need	
PVTS	$\frac{r}{p} = .048$ $\frac{p}{p} < .56$	PVTN	$\frac{r}{p} = .012$ $\frac{p}{p} < .88$
FDBKS	$\frac{r}{p} = -.015$ $\frac{p}{p} < .86$	FDBKN	$\frac{r}{p} = -.076$ $\frac{p}{p} < .36$
SOCPS	$\frac{r}{p} = -.075$ $\frac{p}{p} < .63$	SOC PN	$\frac{r}{p} = -.012$ $\frac{p}{p} < .89$
MAIDS	$\frac{r}{p} = .015$ $\frac{p}{p} < .86$	MAIDN	$\frac{r}{p} = -.088$ $\frac{p}{p} < .32$
TXSS	$\frac{r}{p} = -.025$ $\frac{p}{p} < .77$	TXSN	$\frac{r}{p} = -.082$ $\frac{p}{p} < .32$

VITA

Mary Ellen Mitchell was born April 6, 1953, to William H. and Mary J. Mitchell in Dover, New Jersey. The third of four children, she attended the Randolph Township public schools and graduated in 1971. She began undergraduate training at Antioch College, transferred, and completed her Bachelor's degree in psychology at Kirkland/Hamilton College, Clinton, New York. She accepted a departmental assistantship in the fall of 1976 at Fairleigh Dickinson University, Madison, New Jersey. She completed her Master's degree in clinical psychology June 1978. She began doctoral study in clinical psychology at The University of Tennessee, Knoxville, in fall of 1978 and was granted her Ph.D. in December 1983.

Throughout the course of her education, she worked in a variety of institutions and agencies. She completed an APA approved clinical internship at the Yale School of Medicine in July 1982. She has a variety of interests including therapy research, social networks, adult development, and organizational concerns.