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The Impact of Perceived Therapist Characteristics on Patients Decision to Return or Not Return for More Sessions

Raúl J. Alcázar Olán[*1], Jerry L. Deffenbacher[2], Laura Hernández Guzmán[3], Bipin Sharma[4] and María Eugenia de la Chaussée Acuña[1]

[1]*Universidad Iberoamericana Puebla* [2]*Colorado State University*

[3]*Universidad Nacional Autónoma de México* [4]*Sam Houston State University*

Abstract

The initial contact with the patient is a crucial element in determining whether he/she will return to therapy. Patients often make their first impressions of their therapists after the intake interview, and then decide if they will return (or not) for more sessions. However, the decision made by patients has not been fully explored with regard to the characteristics they perceived in their therapists. This study compared two groups of patients: Those who decided to return to sessions after the intake interview, and those who opted not to return. One hundred and seventy three patients (*Mean* age= 26.09 years, *SD*= 9.75) participated in the study. They responded to an instrument designed to assess the extent to which a patient perceives positive qualities in their therapist (e.g., expert, attractive, and trustworthy). As a result, at the end of the intake interview 141 patients decided to return (DR), and 32 decided not to return (DNR). DR patients perceived more positive qualities in their therapists and attended a greater number of sessions (*Median*= 10) compared to DNR patients, who attended less sessions (*Median*= 2). Sex of the patient was not related to the decision to return after the intake interview.

Key words: dropout, patient, perception, interview, therapy.

Resumen

El contacto inicial con el paciente es importante para determinar si regresará a terapia. Después de la entrevista inicial los pacientes ya tienen una primera impresión de su terapeuta, y entonces deciden si regresarán (o no) a más sesiones. Sin embargo, la decisión que toman los pacientes no ha sido ampliamente estudiada con respecto a las características que percibieron en sus terapeutas. Esta investigación comparó dos grupos de pacientes: los que deciden regresar versus los que deciden no regresar después de la entrevista inicial. Participaron 173 pacientes (*Media* edad= 26,09 años, *DT*= 9,75) que respondieron una escala para evaluar el grado en que percibieron a su terapeuta con características positivas (e.g., experto, atractivo y confiable). Como resultado, al final de la entrevista inicial 141 pacientes decidieron regresar (DR) y 32 decidieron no regresar (DNR). Los pacientes DR percibieron a su terapeuta con más características positivas y asistieron un mayor número de sesiones (*Mediana*= 10) en comparación con los pacientes DNR, quienes asistieron menos veces (*Mediana*= 2). El sexo del paciente no se relacionó con la decisión de regresar.

Palabras clave: abandono, paciente, percepción, entrevista, terapia.

[*] Correspondence concerning this paper should be addressed to the first author: Universidad Iberoamericana Puebla. Departmento de Ciencias del Desarrollo Humano, Blvd. del Nino Poblano 2901, Unidad Territorial Atlixcayotl. Puebla, Pue., Mexico, Z.C. 72430. Phone: 52-(222)-372-30-52. E-mail: rulet7@gmail.com, raul.alcazar@iberopuebla.edu.mx

Approximately fifty percent of the psychotherapy patients terminate by dropping out of treatment (Wierzbicki & Pekarik, 1993), and most of them stop attending after the first few sessions (Baekeland & Lundwall, 1975; Richmond, 1992; Tryon, 1986, 1990). This problem exists across all types of mental health settings (Johnson, Mellor, & Brann, 2008; Mennicke, Lent, & Burgoyne, 1988; Richmond, 1992) throughout the world, including Mexico (Jaimes, 2005; Jurado, 2002; Saucedo, Cortes, Salinas, & Berlanga, 1997). As a consequence, those who stop attending their appointments obtain less benefit from therapy (Pekarik, 1983, Seligman, 1995; Steenbarger, 1994), and the psychotherapist may feel inadequate as a practitioner (Duehn & Proctor, 1977).

There are multiple factors (and sometimes contradictory results) with regard to why patients stop attending sessions (Baekeland & Lundwall, 1975; Mennicke *et al*., 1988; Reis & Brown, 1999; Sharf, 2008; Wierzbicki & Pekarik, 1993). To date, there seems to be no single characteristic that fully explains why some patients attend more sessions than others. Actually, the reasons to attend sessions or not might vary from one person to another, and these reasons might vary from one moment to another in the same person.

One of the variables that has been related to why patients return (or not) is the initial session or intake interview (Reis & Brown, 1999). When the intake interview is the first time that patient and therapist meet face to face in the therapist's office to assess the patient and his/her problems (Gail, 2009), then the interview becomes crucial to engaging the patient (Tryon, 1989, 1990). Again, there might be different reasons for a patient to return or not, but the intake interview is a relevant moment because most of the patients who stop attending do so after the first few sessions (Baekeland & Lundwall, 1975; Richmond, 1992; Tryon, 1986, 1990).

The intake interview is an encounter where the patient begins to perceive the characteristics of the therapist and the therapeutic connection begins (Hilsenroth & Cromer, 2007). With the exception of some cases (Tryon, 1999; Zamostny, Corrigan, & Eggert, 1981), most of the empirical findings indicate that the more the patient perceives positive qualities in his/her therapist during the intake interview (e.g. expert, understanding, empathic) the more the sessions he/she will attend (Fiester, 1977; Hunsley, Aubry, Verstervelt, & Vito, 1999; Hynan, 1990; Kokotovic & Tracey, 1987; McNeill, May, Lee, 1987; Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Reis & Brown, 1999; Sexton, Littauer, Sexton, & Tommeras, 2005; Tryon, 1989, 1990).

However, a less investigated aspect of the intake interview is the patient in terms that he/she is the one who decides or makes the determination to return (or not) for the following sessions. And not only is the patient the one who decides, but it is quite likely that he/she will make the decision (to return or not) by the end of the intake interview (Tryon, 1999). By the moment the interview ends, the patient has already made a first impression of his/her therapist, and it is desirable that he/she has perceived positive qualities in his/her therapist (Reis & Brown, 1999; Principe, Marci, Glick, & Ablon, 2006; Shea, 2002). Assuming that the patient perceived positive qualities in his/her therapist in the intake interview, it would be likely that he/she will decide to return for more sessions.

The patients' decision is relevant because it might represent a general indicator of

the outcome of the intake interview; an indicator that could be associated with returning (or not) for more sessions. Although previous research has focused on whether patients actually return after the intake interview, the patients' decision has not been widely explored. Some evidence suggests that patients would not make a second appointment when their counseling needs have been met (Tryon, 1999). Nevertheless, the authors of this study did not find published empirical evidence which have directly addressed the differences between patients who decided to return versus not return after the intake interview, with regard to the positive qualities they perceived in their therapists.

Consequently the goal of the present study was to compare two groups of patients: Those who decide to return versus those who decide not to return after the intake interview. Comparisons were based on the positive characteristics they perceived in their therapists. According to the literature (Fiester, 1977; Kokotovic & Tracey, 1987; McNeill *et al*., 1987; Mohl *et al*., 1991; Principe *et al*., 2006; Tryon, 1990, 1999), the hypothesis predicted that patients who decided to return for more sessions perceived more positive qualities in their therapists, compared to patients who decided not to return.

Therefore, it was not the goal of this study to evaluate multiple factors that might influence the patients' decisions. However, since multiple variables might impact the patients' decision to return (or not), some of them were included and examined as confounding variables. These variables included (but are not limited to) the following: (a) Type of referral (i.e. self-referred versus person/institution referral), (b) the extent to which they thought they needed psychotherapeutic help, (c) the cost of the session, and (d) how the patient felt when he sought psychotherapy. Finally, other variables that might influence the patients' decision to return are the length of time the intake interview lasted, and how the patients felt at the end of the interview. Sex was also examined.

Method

Participants

Based on the goal of the study, the following criteria were used to contact people who had had an intake interview experience with the aim of receiving psychotherapy. The inclusion criteria were: (a) Voluntarily participation in the study; (b) prior psychological treatment for emotional concerns (depression, anxiety, stress, low self esteem, etc); (c) at least 18 years of age at the moment of seeking psychotherapy; and (d) existence of an agreement between the participant and the therapist -agreed to by the participant during the intake interview- in which date, place and time of the next meeting were established as a means of having more sessions. Participants were excluded if they had one or more of the following: (a) They received family therapy (the research focus is on individual therapy); (b) they went to therapy because of poor results, low performance, or poor academic standing, (c) they sought vocational guidance; or (d) they received drug prescriptions from the therapist.

Participants were students from a public school of psychology in Mexico City. This sample of convenience (Kazdin, 2003) was important to the goal of the study because in Mexico it is more common that people who study psychology have more

trust in psychotherapeutic services in contrast to students from other professions. This characteristic was necessary to contact the largest possible number of subjects who had attended psychotherapy. Out of 844 participants initially contacted, 259 covered the inclusion criteria. From these participants, cases were eliminated if: (a) They were still attending therapy (because it is unknown how many sessions they will attend), (b) they did not answer one or more questions (missing values), or (c) the therapist was the one who informed the patient that he/she would not have any more sessions.

Thus, the final sample included 173 participants (34 men and 139 women). Who from now on will be identified as "patients" because they sought psychotherapy. Their mean age was 26.09 (*SD*= 9.75). The minimum and maximum ages were 18 and 65 respectively; 147 single people and 26 married. One hundred were full-time students while 73 combined work and study. In terms of religion, 43 reported no following, 118 were Catholics, and 12 belonged to other religions (e.g. Jehovah's Witnesses or Mormons).

Design

A case-control retrospective design was used (Kazdin, 2003). To address the goal of the study two groups were formed. The patients answered to the question: "After the intake interview, did you decide to return for more sessions with the psychotherapist?" Those who answered "no" (*N*= 32) formed the case group, and those who answered "yes" (*N*= 141) the control group.

Instruments

Questionnaire on sociodemographic data. Questions included sex, age, marital status, religion, and whether the patients only studied or also worked.

Context of the intake interview. This questionnaire collected data about the moment when the intake interview was carried out. The question and answer choices were: (a) The type of referral (self-referred versus referred by other person or institution); (b) the extent to which patients thought they needed psychotherapeutic help (not at all, a little, a lot, absolutely); (c) the number of sessions they attended; (d) what the cost of the session was, and (e) how the patient felt when he sought psychotherapy (very bad, bad, good, very good.)

Scale of Patients' perception of Therapist. The scale was designed for this study to assess the extent to which the patient perceived positive qualities in his/her therapist after the intake interview. The instrument was constructed because no measures of patients' perception of therapists were found that fit the Mexican population. To build the scale, three concepts (defined by Strong, 1968) about how the patient perceives the therapist were used: (a) *Expert*, meaning it is the patient's belief that the therapist possesses the information and means to interpret information in a way that would allow the patient to obtain valid conclusions and to manage his/her problems in an effective way; (b) *Attractive*, implying the patient's positive feelings towards the therapist, his/her admiration and liking of the therapist and their desire for the therapist's approval; and (c) *Trustworthy*, or the belief that the therapist is sincere, open, and has no interest

in personal gains. These concepts have been useful in previous research for assessing the patient-therapist relationship during the intake interview (Barak & LaCrosse, 1975; Corrigan, Dell, Lewis, & Schmidt, 1980; Wachowiak & Diaz, 1987).

To obtain the content validity of the scale the following procedure was used. Seven doctoral students of psychology who attended a methodology class were asked to participate as judges. All of them were women (*Mean* age= 32.4, *SD*= 5.31; ranging from 25 to 40 years of age). The judges were given a list of adjectives that Mexican patients used in another study to describe positive characteristics in their therapists (Alcázar Olán, 2007). These adjectives fit the current Mexican sample and are congruent with the goal of the study.

The judges were given the written definitions of expert, attractive, and trustworthy as described above. Once they read them, they classified each adjective in the definitions. After the classification, a non rigorous criterion was used where at least 4 out of the 7 judges agreed to placing the adjective in the same definition. For instance, if four judges agreed that the adjective "professional" belonged to the Expert definition, then that adjective was included in the Expert subscale. A non rigorous criterion was used in order to maintain some of the adjectives because there was high disagreement and lack of consensus among the judges.

As a result of the judgment the following adjectives were selected. The Expert subscale (eight adjectives) included: (a) Intelligent, (b) professional, (c) intuitive, (d) sound counselor, (e) precise, (f) skillful, (g) clear, and (h) convincing. For the Attractive subscale five adjectives were identified: (a) Nice, (b) empathic, (c) pleasant, (d) funny, and (e) enthusiastic. Finally, there were five adjectives for the Trustworthy subscale: (a) Reliable, (b) willing, (c) honest, (d) reasonable, and (e) frank.

In the study the patients answered the question: "The therapist I consulted was…" and then they responded "yes" or "no" to each adjective. The "yes" answers had the value of two; and the "no" answers the value of one. Thus, the Expert scores (eight adjectives) ranked from 8 to 16; the Attractive ones (five adjectives) from 5 to 10; and the Trustworthy ones (5 adjectives) from 5 to 10. The higher the score, the more the patient perceived his/her therapist as expert, attractive and trustworthy. The internal consistency of the subscales (through Cronbach's alpha) with the sample studied was: .81 for Expert; .69 for Attractive; and .89 for Trustworthy. Cronbach's alpha for the full scale was .89. In summary, the scale had moderate content validity and acceptable reliability.

Procedure

The scales were administered in group classrooms. Firstly the general objective of the questionnaire was explained, this was: To learn more about the experience of people who have attended psychotherapy. They were also informed that their participation was anonymous and voluntary.

Then, printed questions were distributed to filter the patients who actually met the inclusion criteria; those who did not were asked to leave the classroom. With the remaining students, questionnaires were distributed with the following introduction: "This

questionnaire has to do with the moment of the initial interview with your therapist. In order to make the study worthwhile it is very important that you answer all questions with the greatest care and certainty possible. All answers are confidential".

The questionnaire was divided into a six step sequence. First: the sociodemographic questions. Second: a "Read before continuing" warning appeared with this announcement "All the following questions are focused on the most recent therapist you consulted. Please respond to all the following questions having only that therapist in mind". They then answered the questionnaire about the context of the intake interview.

Third, another "Read before continuing" warning appeared saying that "It is of extreme importance to know how you felt *after* the intake interview with your therapist. All the following questions have to do with the *moment immediately following the intake interview* you had". Fourth, aiming to bring back the intake interview experience, patients were asked verbally to try to imagine the moment when they were at their initial interview with the therapist. Some of the verbal instructions were "Imagine yourself during the interview with your therapist", "After the intake interview… How did you feel? What happened?" Fifth, patients were asked to answer the perception scale. Sixth, they were asked about the time the interview lasted, whether at the end of the intake interview they decided to return or not for more sessions and why. Finally they were asked if they actually returned, and how they felt when the interview concluded.

The application of the full questionnaire took approximately 45 minutes after which they were thanked for their participation.

Results

The number of sessions that patients attended with the therapist had the minimum value of one and maximum of 99. The patients on the average attended 16.72 sessions (*SD*= 20.93); the median was 10 and the mode was to attend five sessions (*N*= 16). Kurtosis was 5.50 and the skewness 2.33, which indicates a general trend of the patients to attend few sessions. These data show that the distribution of the number of sessions that patients attended does not correspond to a normal curve. Therefore, this variable was analyzed with non-parametric statistics.

At the end of the intake interview all 173 patients had already made a decision as to whether to return or not. Of the 162 patients who actually returned, 21 had decided not to return, and 141 decided to return. On the other hand, 11 patients actually did not return; all of them had decided not to do so. Thus, the total number of patients who decided to return was 141 (control group), and the total who decided not to return was 32 (case group).

The case group attended a fewer number of times overall (*Median*= 2 sessions) compared to the control group which attended more sessions (*Median*= 10). The difference was significant (Mann Whitney *U* test= -5.32, $p < .001$).

The extent to which patients who decided to return actually did was also analyzed. The phi coefficient correlation was used with the dichotomous variables: After the intake interview did you decide to return for more sessions? (yes/no), and did you actually

return? (yes/no). As a result, the correlation was .54 (p <.001) indicating a moderate tendency of the patients to do what they decided.

The case group usually gave negative reasons for not returning (e.g. there was no rapport with the therapist, or the therapy did not help). While the control group explained they needed help (Table 1). The patients gave approximately the same number of reasons to return (*Mean*= 1.75) versus to not return (*Mean*= 1.96).

Table 1. Reasons patients frequently used to explain why they decided to return (or not return) after the intake interview.

Reasons for returning	*f*	Reasons for Not returning	*f*
I needed…		I did not like it	6
Professional help	31	There was no empathy	4
To solve my problems	22	It was too expensive	3
Treatment	20	I did not feel comfortable	2
More sessions	9	*The therapist…*	
The therapist…		Was not punctual	3
Helped me	20	Did not help	3
Was reliable	13	Did not listen	2
Seemed well-trained	13	Was not reliable	2
Listened to me	11	Minimized my problem	2
I felt good	13	Was cold	1
I liked the therapist	8	Criticized me	1

As already noted, this research had as its focus the patients' perception of therapist's characteristics and the decision to return (or not) after the intake interview. Before comparing the control group -patients who decided to return- versus the case group -deciding not to return-, with regard to their perception of positive qualities (expert, attractive, trustworthy), this variable was analyzed to observe whether it met the normal-distribution and equality of variances assumptions to run parametric tests. As a result, the patients' perception measures did not reveal a normal distribution in the control group. According to the Kolmogorov-Smirnov test, the *Zs* were between 2.65 and 5.36, and were significant with *ps* <.001 which is consistent with rejecting normal distributions. In contrast the case group had normal distributions in their perception measures; the Kolmogorov-Smirnov Zs were between 0.95 and 1.22, and were non-significant at the p >.05 level. Finally, the perception measures were not equal when comparing the variances between groups. Since all of the assumptions about normality and equality of variances were not covered, it was decided to run non-parametric tests.

The hypothesis stated that patients who decided to return perceived more positive qualities in their therapists compared to patients who decided not to return after the intake interview. As a result, Mann Whitney U tests yielded significant differences in the expected direction (Table 2). However, the score differences between the groups were small (from 1 to 3 scores).

As previously mentioned, it is possible that several variables directly or indirectly influence the patients' decision to return (or not). To examine these confounding variables, they were statistically analyzed with regard to the decision: to return (control group)

Table 2. Patients' perceptions when they decided to return versus not to return.

	At the end of the intake interview, Did the patient decide to return for more sessions?				
	Yes (n= 141)		No (n= 32)		
The patient perceived the therapist as…	Median	Sum of ranks	Median	Sum of ranks	Mann Whitney U test
Expert	15	13314.5	12	1736.5	-4.21***
Attractive	9	13050.0	8	2001.0	-3.14**
Trustworthy	10	13342.5	9	1708.5	-5.22***

Note. The higher the score, the more the patient perceived his/her therapist as expert, attractive and trustworthy.
** $p < .01$, *** $p < .001$.

or not (case group). As a result, the groups did not differ by the financial cost for the session (Mann Whitney U test= -.34, $p > .05$), the extent to which the patient considered that he/she needed psychotherapy (Mann Whitney U test= -.04, $p > .05$), how the patient felt when he/she sought psychotherapy (Mann Whitney U test= -1.15, $p > .05$), nor the length of time that the intake interview lasted (Mann Whitney U test= -.22, $p > .05$). Additionally, the groups did not differ by sex (X^2 [1]= .40, $p > .05$).

However, there was a significant correlation between deciding to return and the type of referral. Of the 141 patients who formed the control group, 124 were self-referred; and of the 32 who formed the case group, 15 were referred by other people. The phi correlation for deciding to return and being self-referred was .20 ($p < .05$).

Furthermore, on a four points scale (where 1 represents "very bad", 2 "bad", 3 "good", and 4 "very good"), patients of the case group felt very bad (*Median*= 1) at the end of the intake interview; while those in the control group felt good (*Median*= 3). Mann Whitney U test= -4.78, $p < .001$.

In summary, the confounding variables that had a significant effect on patients' decision to return were the type of referral, and how the patient felt at the end of the intake interview.

Since the perception variables (expert, attractive, trustworthy) where useful when comparing the case and control groups, it was further analyzed whether these variables increased the probability of belonging to one or the other group. In other words, it was examined whether it is possible to predict the patients' decision. To this end, a logistic regression analysis was used. This analysis is relevant to the goal of the study because it represents an additional parameter with which to evaluate the independent-predictor variables, but now in terms of the probability associated with deciding to return (or not). The significant confounding variables were also considered.

Five predictor variables were examined. The extent to which the patients perceived the therapists as: (a) Expert, (b) attractive, and (c) trustworthy; and the significant confounding variables: (d) the type of referral, and (e) how the patient felt at the end of the intake session. The dependent variable was the decision made by the patient at the end of the intake interview: To return for more sessions (controls) versus not to return (cases).

As a result, a test of the full model was found to be statistically significant (X^2 [5]= 36.58, $p < .001$), indicating that the predictors, as a set, reliably distinguished between the two groups. The Nagelkerke R^2, a comparable statistic to R^2 in linear

regression (Nagelkerke, 1991), was .30. However, only two predictors were significant (both at the .05 level). Patients were less likely to decide to return when they were referred by other person (Odds ratio [OR] and 95% confidence intervals [CI]= 0.37; 0.14-0.94), and they felt bad or very bad at the end of the intake interview (OR and 95% CI= 0.48; 0.25-0.90).

The overall percentage of cases correctly classified by the predictor variables, as a set, was 85%. The correct classification was higher to predict who would decide to return (96.5%) than to predict who would not decide to return (34.4%).

Discussion

This study compared two groups of patients: Those who decided to return versus those who decided not to return after the intake interview. The hypothesis predicted that patients who decided to return perceive more positive qualities in their therapists (e.g. expert, attractive, and trustworthy) compared to those who decided not to return. The results supported the hypothesis. Likewise, the patients gave negative explanations when they were asked why they decided not to return. For instance they said that there was no empathy or the therapy did not help.

Although this was a retrospective study, the results are congruent with prospective research. Patients who attend a greater number of sessions usually perceive more positive qualities in their therapists compared to patients who attend few sessions (Fiester, 1977; Kokotovic & Tracey, 1987; McNeill *et al*., 1987; Mohl *et al*., 1991; Principe *et al*., 2006; Tryon, 1990, 1999). The contribution of this research consists of its focus on the patients' decision at the end of the intake interview, and how such decisions are related to the characteristics that patients perceived in their therapists. Thus, the intake interview remains as an important moment where the therapist plays a crucial role to engage the patient (Hilsenroth & Cromer, 2007; Principe *et al*., 2006; Tryon, 1989, 1990); and, as a result, the patient might decide to return or not.

It is usually accepted that patients should feel better at the end of the intake interview (Hilsenroth & Cromer, 2007; Reis & Brown, 1999; Principe et al., 2006). This study yielded empirical evidence where patients who felt bad or very bad at the end of the intake interview were less likely to decide to return, in contrast to the patients who felt good.

The patients' decision was the studied variable. The results showed a trend where the decision to return (or not) was moderately related to actually returning (or not). Since the correlation was moderate (r= .54), then the patients' decision might not be a convenient variable to identify who will return and who will not. However, this correlation might be considered relevant within (and given) the complex research area of why patients return or not to sessions (Baekeland & Lundwall, 1975; Mennicke et al., 1988; Reis & Brown, 1999; Sharf, 2008; Wierzbicki & Pekarik, 1993). As a proof of the utility of assessing the patients' decision, those who decided to return usually attended a greater number of times (10 sessions) compared to those who decided not to return (they attended 2 sessions). Future studies should use or test in a deeper way

the utility of assessing the patients' decision to return (or not) after the intake interview.

A personal variable -the motivation to attend therapy- was also important when patients decided to return (or not) after the intake interview. The patients referred by other persons or institutions decided not to return for more sessions.

The results of this study should be considered within a frame of several limitations. Although the hypothesis was in the expected direction, the size of the differences was small, and perhaps of little practical relevance. However, this limitation is not exclusive to this study; that is, the literature reviews of why patients return or not to sessions (Baekeland & Lundwall, 1975; Mennicke *et al*., 1988; Reis & Brown, 1999; Sharf, 2008; Wierzbicki & Pekarik, 1993) barely reach consistent conclusions and sometimes the results are contradictory. Consequently, this research area is extremely challenging.

The patients first answered the perception scale, then they stated whether they had decided to return or not. Since the order of the questions was not counterbalanced, it is possible that, by responding to the perception scale, they deduced their decision. Future studies should counterbalance the order of the questions.

Another limitation comes from the retrospective design that was used. At most, in this study the patients who decided to return perceived more positive qualities in their therapists compared to those who decided not to return. However, a causal relation cannot be demonstrated and it is not clear what was first, the perception or the decision. Thus, it remains unknown in this study whether the perception of the patient made him/her to decide to return. The use of self-reports produced additional limitations. In assessing past events it is hard to trust one's memory or how the patients remember (or distort?) what actually happened. Also, the sampling biases might be responsible for the results, and not the groups (case-controls). Perhaps those who decided to return usually perceive people with more positive characteristics compared to those who decided not to return. Further research on patients' decisions should use prospective designs and additional measures (e.g. observational) to overcome these problems.

Another limitation was the dichotomous "yes-no" answer format of the perception scale. Perhaps this influenced the finding of small differences between those who decide to return versus the ones who decided not to return. Each adjective portraying positive characteristics (e.g. professional, intelligent, skillful) might be better evaluated on a continuous scale. A format with more answer choices could more precisely reflect the perception of the patient. Moreover, although the adjectives used in the perception scale fit the Mexican sample of the study, the negligible agreement among the judges reduces the validity of the results.

Finally, in the logistic regression analysis, the independent variables as a set (perception, type of referral, how the patient felt) were more useful to predict who would decide to return than to predict who would decide not to return. This suggests a greater difficulty in finding answers to why patients decide not to return.

In summary, the results of the study should be considered with caution and only as suggestive for the current sample. Patients who decided to return perceived more positive qualities in their therapists compared to those who decided not to return.

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