

## **Therapeutic interaction and dropout: measuring relational communication in solution-focused therapy**

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The relational communication of sixteen dropout versus sixteen continuation sessions of solution-focused therapy was studied using two different coding schemes. On the Topic Initiation/Topic Following coding scheme (Tracey, 1986) no differences were found between dropout and continuation sessions, whereas the Family-Relational Communication Control Coding Scheme (Heatherington and Friedlander, 1987) yielded a number of significant findings. Both in 'successful' and in 'unsuccessful' dropout sessions, therapeutic interaction was found to be more conflictive than in continuation cases, with clients showing more domineering behaviour in dropout than in continuation sessions. Markovian and lag sequential analysis are used to clarify some of these findings, and their implications are discussed.

### **Introduction**

#### *Solution-focused therapy and the relational view*

One of the features which solution-focused thinking (de Shazer, 1982, 1991) shares with other systems approaches is that it takes into account the interconnections between the various elements of any system under consideration, be it a client and family, an exception and its relationship to the problem pattern, or a change by a client and the reactions of her work colleagues to it. When applied to the therapy situation, taking this view seriously implies considering therapy as a system (a linguistic system), thus allowing for the development of a rich set of descriptions of how various language games take place during therapeutic interaction (de Shazer, 1991). Within this framework, a prominent notion in solution-focused therapy is the idea that 'fit' should develop between therapist and

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client (de Shazer *et al.*, 1986). On a pragmatic level, trying to develop fit – which we like to think of as a sort of ‘necessary condition’ for solution-focused therapy – translates into several different therapeutic practices which could be summed up in two injunctions that have become popular in our field: ‘listen to your client’ and ‘use your client’s language’.

The emphasis on systemic connections and on concepts like ‘fit’ can be described as part of a broader *relational stance*, which in our opinion constitutes one of the key aspects of solution-focused thinking. We would therefore like to argue that research on solution-focused therapy should be coherent not only with specific solution-focused premises, but with this relational view also. One way of doing this is by taking into account the relational aspect of research itself, recursively opening up space for what has been described as ‘participatory research’, ‘research as therapy’ or ‘therapy as research’ (Hjerth, 1995). Another possibility is to stay within the realm of more or less ‘traditional’ psychotherapy research but to use methodological approaches that in one way or another take into account the relational view. This is the position we have taken so far in our own work (Altuna *et al.*, 1988; Beyebach, 1993; Beyebach *et al.*, 1994; Beyebach *et al.*, 1996). On the one hand, we engage in process research (Kiesler, 1975; Greenberg, 1986; Gurman *et al.*, 1986), focusing on what happens in the therapy situation itself. On the other hand, we study the process of solution-focused therapy using procedures and instruments designed to fit with a systemic and relational view (Rogers *et al.*, 1985).

In this paper we present some of the results obtained by applying this relational view to a topic which traditionally has been addressed from a monadic, non-relational perspective: dropout from therapy. Indeed, in the field of psychotherapy, dropout has generally been conceptualized as something that is basically due to certain negative features of the clients (Baekeland and Lundwall, 1975; Bischoff and Sprenkle, 1993). Dropout used to be seen, not as the product of therapeutic interaction, but as the result of having a certain ‘type’ of patient in therapy: lower class, unmotivated, drug consuming, paranoid and so on (Hiler, 1959; Scheuble *et al.*, 1987; Slipp *et al.*, 1974; Swett and Noones, 1989). We will suggest a different view, one which will privilege an interactional reading of the dropout process and hand back responsibility to therapists and clients alike. Seeing dropout as an interactional process, therapists can assume their

part of responsibility in engaging their clients in therapy (Tryon, 1989; Tryon & Tryon, 1986).

### *Dropout from solution-focused therapy*

Before we go any further, it may be worthwhile to discuss the meaning of dropout in the context of solution-focused therapy. In fact, in reading solution-focused literature, one may get the impression that for solution-focused therapists there is no such thing as a dropout, or, if there is, it is not much of a clinical problem. In our mind, this view has some serious shortcomings.

In his classical definition, Garfield suggests that 'a dropout from psychotherapy is one who has been accepted for psychotherapy, who actually has at least one session of therapy, and who discontinues treatment on his/her own initiative by failing to come for any future arranged visits with the therapist'<sup>1</sup> (Garfield, 1986). This is not such a problem for most solution-focused therapists. After all, in solution-focused therapy it is accepted that it is the client who decides when to start, but also when to stop treatment. From this perspective, dropout is not a '*premature* termination', but simply one possible way of terminating a therapy, nothing more and nothing less than the result of a client's decision not to take more therapy sessions. Due to this view, dropout is not discussed as such in the solution-focused literature, and is also not taken into account in most of the outcome research which is done: clients are simply followed up, irrespective of their ways of terminating therapy.

Although we agree that, from the client's perspective, dropping out of therapy might be the best decision to make in a given situation, we also believe that it poses a number of potential problems.

- (1) Although many clients who drop out of psychotherapy subsequently seem to do well and report improvements at follow-up (Buddeberg, 1987; Fiester and Rudestam, 1975; Persons *et al.*, 1988; Silverman and Beech, 1979; Trepka, 1986), it is not always

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<sup>1</sup> Unfortunately, in the research literature on dropout, operational definitions of the term 'dropout' are inconsistent. Garfield's is only one of the many possible definitions of dropout that have been used so far. However, there is a certain consensus that this might be the most clinically sensitive one (Bischoff and Sprenkle, 1993). For a detailed discussion of this issue, see Beyebach (1993).

the case that the clients who dropped out simply reached their goals and decided they did not need more therapy. The literature on psychotherapy suggests that a substantial proportion of clients who drop out do not improve as much as they could have if they had stayed, and that many of them still feel in need of therapy after terminating (Baekeland and Lundwall, 1975; Garfield, 1986).<sup>2</sup>

- (2) Some clients may drop out because they feel therapy is not helping them, and then seek more effective treatment elsewhere (Noel and Howard, 1989). This may be a wise decision by the client, but is also a message about the shortcomings of the previous therapy.
- (3) Even in cases when dropout is related to a good therapeutic outcome, it points to a lack of fit between therapist and client. Why did the therapist advise, and the client decline, to have another session? Why was another session scheduled, which turned out not to be necessary? Why was termination not negotiated and accepted? These questions are not only interesting in terms of what goes on between therapists and clients, but have clear pragmatic implications for therapeutic agencies in terms of the waste of time and money that unkept sessions present. Furthermore, dropout poses some additional difficulties for outcome research, as it often leads to lack of data for a sometimes high proportion of clients.

For all these reasons, we do believe it is important to do research on dropout from solution-focused therapy as for other psychotherapies. One issue that in our view should certainly be addressed is if the 'solution-focused view' of dropout holds true. How many clients of solution-focused therapy do drop out of therapy? Does dropout make any difference regarding the outcome of solution-focused therapy? Are there, at termination and at follow-up, any differences between clients who terminated by mutual agreement and those who dropped out? What kind of reasons do clients of solution-focused therapy provide for their dropping out? Large-scale outcome studies addressing these topics would probably allow us to

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<sup>2</sup> This applies to the field of psychotherapy in general, including both individual psychotherapy and marital/family therapy. We are not aware of any research on this topic within the solution-focused field, and therefore do not know if these findings do hold for solution-focused therapy.

decide, on an empirical basis, if we should consider dropout to be a significant clinical process or, alternatively, a non-issue, as the solution-focused literature seems to suggest. We are currently conducting an outcome study that will address these questions.

Another line of research is to try and identify the determinants of dropout, to find out which variables are associated with premature termination, and eventually to reduce their impact. The meagre results that previous research on dropout from psychotherapy has produced (Baekeland and Lundwall, 1975; Duehn and Proctor, 1977) suggests that certain lines of enquiry may be more fruitful than others. More specifically, most researchers and reviewers in this field agree that studying more or less static client and/or therapist variables is unlikely to yield meaningful results (Dubrin and Zastowny, 1988; Mennicke *et al.*, 1988). So far, decades of studies on demographic and diagnostic variables have only produced a few reliable findings, and these seem to have little relevance for the clinical practitioner. It is therefore suggested that research take a new direction, either by directly asking clients why they dropped out of therapy (this being very much in keeping with solution-focused ideas), or by undertaking process research on the dropout phenomenon. For instance, in their review of research on dropping out of marital and family therapy. Bischoff and Sprenkle make the following recommendation:

Studies relating process variables to premature termination are sorely needed. Very few studies to date have identified within-session therapist or client behavior (or their interaction) that is related to premature termination . . . process variables are possibly more important in determining dropouts than other variables.

(Bischoff and Sprenkle, 1993)

In any case, the heterogeneity of dropout should be taken into account: different clients drop out for different reasons, at different moments in time, with different impacts on both the clients and the therapy system (Acosta, 1980; Buddeberg, 1987; Fiester and Rudestam, 1975; Martin *et al.* 1988; Pekarik, 1983; Presley, 1987; Trepka, 1986).

#### *A study on relational communication and dropout*

The present study used a relational framework to address the issue of dropout from solution-focused therapy. Its primary objective was to investigate the differences between the communication patterns

in sessions after which the client continued in therapy and the communication patterns in sessions after which the clients dropped out. We did this from a methodological approach coherent with the perspective of the pragmatics of human communication (Watzlawick *et al.* 1967; Rogers *et al.*, 1985), using two different instruments which attempt to measure the relational control of communication taking place between therapists and clients: the Family/Relational Communication Control Coding System (F-RCCCS; see Heatherington and Friedlander, 1987) and the Topic Initiation/Topic Following coding scheme developed by Tracey (TITF; see Tracey and Ray, 1984). We see these instruments as coherent with the relational view we referred to earlier, and also as compatible with the notion of 'fit' that is so central in solution-focused therapy.

The first results of this study (presented in Beyebach *et al.*, 1996) were obtained on the RCCCS only, with all dropout treated as one group. We compared sixteen individual interviews after which the client had dropped out with a set of sixteen comparable interviews after which the client had continued in therapy. Most of the hypotheses were verified, finding a series of consistent but modest differences between the groups. We concluded that they could be described as having different relational communication patterns.

The data showed that in the interviews of the dropout group the 'question/answer pattern' (Beyebach *et al.*, 1990) occurred with greater frequency than in those after which the client continued in therapy. Additionally, in the interviews after which dropout took place, the client interrupted the therapist with much greater frequency than in the interviews of the continuation group: the clients disapproved of their therapists more, gave them less support, and received less support from their therapists. Clients who prematurely discontinued therapy insisted more on assuming a superior position in the communicative exchange than those who continued in therapy. The data suggested that the therapists from the dropout group did not respond adequately to this domineering behaviour of their clients and did not manage to avoid entering into opposition. In fact, the interviews of the dropout group showed a lower proportion of transition patterns with one-down (which would indicate a fluid exchange and mutual support), a higher frequency of competitive symmetry and a greater incidence of 'conflict triads' (Millar *et al.*, 1984). This suggested that in these interviews there was more

conflict and relational confrontation than in the sessions of the continuation group.

The results we present here were obtained in an attempt to deepen our understanding of the dropout process and to complement the results presented before. First, we reanalysed the data after differentiating between two different 'types' of dropout, in order to account for the heterogeneity of the dropout process. Second, we performed markovian and sequential lag analysis on our sample, so as to capture the interactional patterns of the conversation. Finally, we added the use of Tracey's TITF coding scheme so as to get a different description of the relational control dynamics. More specifically, we wanted to replicate the Topic Determination 'dropout thresholds' identified by Tracey in a previous study (Tracey, 1986a). Topic Determination (TD) is a variable that captures to what degree one speaker follows (accepts) the conversational topic offered by the other, and can be construed as an indicator of complementarity (Tracey, 1988). In his 1986 study, Tracey had found that clients left therapy prematurely after sessions in which either their Topic Determination values had fallen beneath  $TD = 0.30$ , or their therapists' TD values had been below  $TD = 0.40$ , and proposed these as dropout thresholds.

## **Method**

### *Sample*

The population from which our sample was taken included all the cases attending over a three-year period at a private brief psychotherapy centre ( $N = 97$ ). Outcome research (Pérez Grande, 1991) had shown that this population had been in therapy for an average of five sessions. At termination, 71% of the clients had reported the disappearance of their complaint(s) or a clear improvement. At follow-up (between six and thirty-five months after termination), 12% of the successful cases had experienced some kind of relapse, but for 38% of the clients additional positive changes had taken place.

From this population, the sample was selected following a three-step procedure:

(1) *Location of therapies with individual format.* From the overall population of solution-focused therapies, we took those where all sessions had been conducted with one client only.

(2) *Selection of cases of early dropout.* After an exhaustive review of the diverse definitions of dropout appearing in the literature (Beyebach, 1993), we decided to use an operational definition of dropout that comes very close to Garfield's (1986) recommendation:

We consider dropping out (or premature termination) as the interruption of treatment that occurs unilaterally as a decision of the client; that is, without agreement by or the knowledge of his/her therapist(s) and that may occur because the client refuses to agree on another interview (despite the counsel of the therapist); because the client fails to attend an appointment (and does not ask for another), or because s/he cancels a session and does not set up another one.

We defined dropout to be 'early' if it took place after the first, the second or the third session.<sup>3</sup> Sixteen cases were found to meet this definition.

(3) *Selection of a comparable group of interviews after which no dropout occurred.* (a) All the cases with individual format where the client had not dropped out were identified. (b) From among these, sixteen cases were selected in order to conform to the 'continuation group'. This was done by pairwise matching, controlling a series of variables to guarantee that this group would be comparable to the dropout group in a number of dimensions that the literature on relational communication identifies as relevant. As far as the therapists were concerned, the variables controlled were 'therapists's gender' (male/female) and 'professional experience' (experts/trainees). In order to also control for possible differences in the personal styles of the therapists, we tried to choose for each case of the dropout group a non-dropout case treated by the same therapist. This was possible for all therapies carried out by some of the expert therapists (ten of the sixteen cases). For the cases with trainee therapists, another case with a trainee therapist of the same sex was chosen. Finally, the 'gender of client' variable and the 'interview number' (first, second or third session) were controlled for.

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<sup>3</sup> This cut-off point was chosen based on clinical reasons, and taking into account that the average number of sessions in our population was five. The decision to differentiate between early and late dropout was taken in order to account for the heterogeneity of dropouts, as described in the literature (Acosta, 1980; Buddeberg, 1987; Fiester and Rudestam, 1975; Martin *et al.*, 1988; Pekarik, 1983; Presley, 1987; Trepka, 1986).



The final sample included thirty-two interviews corresponding to thirty-two cases of solution-focused therapy with an individual format. After the sixteen interviews of the dropout group, the client interrupted treatment unilaterally; after the sixteen interviews of the continuation group, the client continued in therapy. According to the design of the study, the dropout and continuation groups did not show differences as regards the gender and experience of the therapists, the gender of the clients and the number of the interview being studied. In addition, it was found that there were no significant differences between the two groups regarding the age of the clients, their civil status, or their occupation. Overall, the mean age was 27 years, almost one-third of the clients were college students, and half of them were unmarried. The presented problems and the basic ineffective attempted solutions (Fisch *et al.*, 1982), as rated by independent judges, were also the same across groups. Overall, clients presented a variety of complaints: marital problems (six cases); relational problems with family or peers (nine cases); depression (five cases); anxiety and psychosomatic complaints (seven cases); academic achievement problems (five cases).<sup>4</sup> As far as the clients' perception of their problems is concerned, a questionnaire administered before the first interview took place (Pérez Grande, 1991) suggested that initially there were no significant differences between the two groups, either regarding the perceived severity of the problem (continuation mean = 3.79; dropout mean = 3.61;  $t = 0.44$ ;  $p = 0.67$ ) or the perceived urgency of its resolution (continuation mean = 4.36; dropout mean = 4.38;  $t = 0.07$ ;  $p = 0.945$ ). No significant differences were found either between the number of clients who had previously been in therapy for the same problem in each of the groups. The only statistically significant difference between the two groups was, logically, length of therapy, measured on the basis of the number of sessions received. Thus, in dropout cases a mean of 1.7 sessions was held, while in the continuation group clients attended a mean of 5.6 interviews ( $t = 44$ ;  $p < 0.0001$ ).

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<sup>4</sup> Given that in brief therapy diagnosis is of no clinical relevance, proper diagnostic data were not available for this sample. The categorization is based on a review of how clients described their complaints during the first therapy session (Beyebach, 1993).

### *Treatment*

The therapeutic approach used in this sample was not yet as solution-focused as our current work (Beyebach, 1996), and can be described as an integration of the brief therapy models developed at the Palo Alto Mental Research Institute (Fisch *et al.*, 1982) and at the Brief Family Therapy Center in Milwaukee (de Shazer, 1982, 1985, 1988, 1991; de Shazer *et al.*, 1986). In practice, this meant that therapists in this sample worked either to interrupt the complaint pattern or to amplify existing exceptions, or both.

In some cases, the basic therapeutic strategy was to promote an interruption of the 'unsuccessful attempted solutions', in others, it was enough to keep on amplifying exceptions. In any case, therapists would take into account both what was working from the client's perspective (exceptions, pre-treatment changes) and an appraisal of the problem-maintaining process. In other words, the relevance of exceptions was judged not only on the basis of clients' goals, but also in relation to the difference they made to the problem-maintaining pattern. The Miracle Question (de Shazer, 1988) was not yet used, but concrete, behavioural goals would routinely be negotiated in the first session. Scaling questions (de Shazer, 1988) were not used. In keeping with the brief therapy, Ericksonian tradition, a heavy emphasis was placed on using the clients' language and on joining by accepting the client's world view. Therapy sessions lasted for around 45 minutes, and, after a consultation break, the final message was delivered, including compliments and tasks. The first session formula task (de Shazer *et al.*, 1986) was used in more than one-half of the first interviews included in the sample.

### *Instruments*

(1) *Family Relational Communication Control Coding Scheme*. The F-RCCCS is the last of a series of methodological steps towards the measurement of the relational aspect of communication (Watzlawick *et al.*, 1967). As far back as 1965, Sluzki and Beavin designed a coding scheme to measure the relational dimension of verbal communication (Sluzki and Beavin, 1963). This instrument was modified by several authors in the following decades (Mark, 1971; Ericson and Rogers, 1973; Rogers and Farace, 1975; Heatherington and Friedlander, 1987), until the Relational Communication Control Coding Scheme (RCCCS) and the Family-Relational Communication Control Coding Scheme (F-RCCCS)

were developed. These were applied in different settings, including the study of marital couples, manager–subordinate dyads and therapist–client interactions (Friedlander and Heatherington, 1989; Friedlander *et al.*, 1991; Heatherington and Allen, 1984; Lichtenberg and Barké, 1981; Rogers and Bagarozzi, 1983). The Family Relational Communication Control Coding Scheme (F-RCCCS; see Heatherington and Friedlander, 1987) is an instrument specifically designed to code relational control in therapy situations involving two or more people. Sufficient data exist concerning its reliability and validity (Altuna *et al.*, 1988; Friedlander *et al.*, 1991; Gaul *et al.*, 1991; Heatherington, 1988).

Using the F-RCCCS involves three steps. In the first step each verbal intervention of the speakers (that is, each speaking turn) is coded, assigning it a three-digit code based on speaker, format and response mode. The first digit represents the speaker (1 = therapist; 2 = client), and the second the grammatical format (1 = assertion; 2 = open question; 3 = successful talkover; 4 = unsuccessful talkover; 5 = incomplete; 6 = closed question). The third digit requires greater inference for its coding and corresponds to the ‘response mode’, referring to the pragmatic function of the speaking turn in relation to the immediately preceding one. It includes the following: 1 = support; 2 = no support; 3 = extension; 4 = answer to open question; 5 = instruction; 6 = order; 7 = disconfirmation; 8 = topic change; 9 = answer to closed question. Thus, for example, code 167 indicates that the therapist asks a closed question with which she disconfirms the previous intervention by the client. A 231 code informs us that the client overlaps successfully, expressing support for the previous message of the therapist.

Once each message has been coded, the second step is taken by transforming the three-digit codes into ‘control codes’, based on a set of rationally derived rules. Each combination of second and third digit receives one of three possible control directions that reflects how the speaker defines his or her relationship to other speakers:

- *One-up messages* (domineering moves) suggest a movement toward dominance in the exchange (for example, questions that demand a specific answer; taking the floor by overlapping; orders).
- *One-down messages* (submissive moves) indicate a movement towards being controlled by seeking or accepting dominance of others (for example, providing a specific answer that was

requested; questions that seek a supportive response; obeying an order).

- *One-across messages* (neutralizing moves) are those which neither move towards control nor towards being controlled, therefore neutralizing control and having a levelling effect (for example, statements of continuance, non-committal responses to questions, filler phrases).

A 'one-up' move is not seen as more controlling than a 'one-down' or a 'one-across' message. In this context, it has to be kept in mind that relational control is conceptualized as a interpersonal process that is co-defined by the interactions (Rogers-Millar and Millar, 1979), and that is best understood in terms of constraint. From this perspective, *all* messages within an interpersonal situation constrain or limit the communicative options of other speakers. So any message by A requires B to position him or herself with respect to A and may limit the options of B, who in turn will impose a certain constriction on the next message of A, and so on. The implication of this form of understanding control is that different manoeuvres of control may be equally controlling and that a 'one-down' message may be as controlling – or even more so – as a 'one-up' message.

The transformation of the three-digit combinations in directions of control is a mechanical process. Thus, for example, a 121 (or 221) code – that is, a message of support in the form of a question – will always be assigned a 'one-down'. A code of 116 or (216) – that is, an order in assertion form – always receives a 'one-up' control direction. The prototypical example of a 'one-across' message would be a 113 code (an assertion which extends the previous message).

The third step in the use of the F-RCCCS involves moving from the monadic to the diadic level, since it creates diadic categories of control, formed by each transaction, or exchange of two interventions. This is the level of analysis to which the classic constructs of symmetry and complementarity belong (Watzlawick *et al.*, 1967). However, the combination of *three* control directions (instead of the two initially foreseen in the pragmatics of human communication) permits one to take the analysis beyond the traditional dichotomy and yields a total of up to nine combinations (Table 1): two complementary transacts, three symmetrical transacts, and four transitional transacts. Table 2 shows an example of coded interaction, including all the coding steps.

TABLE 1 *Types of transaction from the combination of the control directions of two consecutive messages*

Speaker 1 control code	Speaker 2 control code		
	one-up	one-down	one-across
one-up	up-up competitive symmetry	up-down complementarity	up-across transitory
one-down	down-up complementarity	down-down submissive symmetry	down-across transitory
one-across	across-up transitory	across-down transitory	across-across neutralized symmetry

(2) *Topic Initiation/Topic Following coding scheme (TITF)*. The TITF coding scheme (Tracey and Ray, 1984) provides an alternative means of operationally defining symmetry and complementarity (Tracey, 1988; Tracey and Miars, 1986). It was specifically designed to code verbal interaction in therapy situations, and assumes that – in therapy – the most relevant dimension on which relational control is negotiated is the determination of the conversational topic.

Each speaking turn is coded either as Topic Following (TF) or as Topic Initiation (TI), based on its relationship to the last topic in the previous speaking turn. A speaking turn is coded as Topic Initiation if the topic is different from the preceding topic in one or more of the following ways: different kind of content; different person; different time reference; different level of specificity; outright denial to pursue the previous topic while offering no other except silence; talkover. If none of the above criteria is met, a topic-following response is said to occur.

Once the speaking turns have been coded, the exchange (two contiguous speaking turns, one by each participant) can be described. A Topic Initiation/Topic Following exchange is seen as complementary, given that the second speaker accepts the new topic suggested by the first one. A Topic Following/Topic Following interaction would suggest that both participants support the interactional *status quo*, whereas a Topic Initiation/Topic Initiation would correspond to a symmetrical interaction: the second speaker does not accept the topic which the first one offered, and suggests a different one.

TABLE 2 *Example of coded interaction: three-digit code, control direction and type of transaction*

Dialogue	Message code	Control direction	Transaction
THERAPIST: What's better?	123	down	complementarity
CLIENT: Well, many things have improved. My son is really behaving, you know, that is really new.	214	up	complementarity
THERAPIST: Good for you.	111	down	complementarity
CLIENT: Well, before that let me tell you that my husband is not coming any more	218	up	competitive symmetry
THERAPIST: Did he notice these changes also?	163	up	complementarity
CLIENT: Maybe. No, not really. For him it is the same thing over and over.	219	down	

The most central variable in the TI/TF coding scheme is *Topic Determination* (TD), which is defined as the proportion of topic initiations that are subsequently followed to the total number of topic initiations. This variable reflects an interpersonal definition of control (Tracey, 1986b) and is seen to be indicative of degree of complementarity (Tracey, 1988). A high degree of Topic Determination indicates that most initiated topics are accepted by the other participant, and that there is little relationship conflict over what to discuss.

In Table 3 the same excerpt from Table 2 has been coded, this time on the TI/TF coding scheme. We also used a set of newly developed instruments for which we still do not have any reliability or validity data:

(3) *First session questionnaire*. This questionnaire was developed by Pérez Grande and her team (Pérez Grande, 1991). It is completed by the clients before the first interview and includes six Likert-type questions which attempt to reflect the client's view on (a) the seriousness of their problem; (b) the urgency they feel to resolve it; the prospects for solving it, (c) with and (d) without attending therapy;

TABLE 3 *Example of coded interaction: TI/TF*

Dialogue	Speaking turn	Exchange
THERAPIST: What's better?		
CLIENT: Well, many things have improved. My son is really behaving, you know, that is really new.	TF	TF/TF
THERAPIST: Good for you.	TF	TF/TI
CLIENT: Well, before that let me tell you that my husband is not coming any more.	TI	TI/TI
THERAPIST: Did he notice these changes also?	TI	TI/TF
CLIENT: No, not really. For him it is the same thing over and over.	TF	

(e) their willingness to participate actively in therapy and (f) the extent to which other people influenced their decision to go in to therapy. The difference between questions (c) and (d) (perceived prospects of solving the problem with and without attending therapy) is taken as an index of how useful therapy is perceived before it begins.

(4) *First session checklist*. This instrument was developed by Pérez Grande so that a set of independent judges could review videotaped first therapy sessions (Pérez Grande, 1991). It includes a number of categories referring to certain features of the complaint, the attempted ineffective solutions, goals and empathy in the therapeutic relationship. For our study, we only used the question relating to therapeutic empathy as rated by the judges.

(5) *Reasons for dropping out of therapy follow-up questionnaire*. This questionnaire was developed specifically for our study (Beyebach, 1993). It includes a number of questions about the status of the clients' complaint at follow-up, and asks if new problems have arisen or new improvements have taken place since the end of therapy. It also asks if the client has subsequently sought help from another mental health professional in relation to the problem that had initially brought him or her to therapy. Finally, an open question about the reasons for dropping out is posed, followed by a set of closed questions derived from a content analysis of previous research on

reasons for dropping out of psychotherapy (Acosta, 1980; Buddeberg, 1987; Garfield, 1963; Martin *et al.*, 1988; Pekarik, 1983; Shapiro and Budman, 1973). The client is required to respond 'yes' or 'no' to each of these questions, and is therefore able to give more than one reason for terminating therapy.

### *Procedure*

*Questionnaires.* The first session questionnaire was applied to all clients included in the sample. It is routinely applied to all incoming clients ten minutes before the first session starts. The 'reasons for dropping out' follow-up questionnaire was conducted by phone by the first author at the time the study was carried out, between one and three years after the last therapy session had taken place. The first session checklist had been used by two independent judges in a previous study (Pérez Grande, 1991). After some training in its use, they had both rated all first interviews, monitoring their rate of agreement. For the ratings of empathy (measured on a 1 to 5 scale) the correlation of the two judges was  $r = 0.71$ .

*Transcription of interviews.* The transcription of the thirty-two interviews included in the sample was carried out by the first author according to the guidelines proposed by Rogers (1979).

*Coding the transcriptions with the F-RCCCS.* Two judges (other than those who had rated the tapes) were trained using the coding manual developed by Heatherington and Friedlander (1987). Training was done on transcriptions of clinical material from previous studies, so that interviews to be included in the sample were not used in training. After an acceptable inter-rater reliability had been achieved (Cohen's kappa; see Cohen, 1960), each judge coded the thirty-two interviews included in the sample. The coders were blind to the hypothesis of the study. The fact that each session was coded by both judges allowed us to monitor inter-rater reliability throughout the process, ensuring that the 'kappa' levels stayed at acceptable values at all times (above  $k = 0.66$ , with a mean  $k$  of 0.71).

*Coding the transcriptions with the IT/CT coding scheme.* The first step for later coding the transcribed material was to train four judges, who were blind to the hypothesis of the study. These judges were not involved in the F-RCCCS coding. Training was carried out based on



the guidelines proposed by Tracey and Ray (1984), on transcriptions of clinical material from other samples. Interviews to be included in this study's sample were not used in training. After an acceptable inter-rater reliability of  $k = 0.80$  had been achieved, each coder coded one-quarter of the sample. No double coding of the sample was undertaken, due to the relative simplicity of this coding scheme and the high ' $k$ ' levels reached during training. However, blind inter-rater reliability checks were carried out at various points during the coding process, ensuring that the reliability stayed at acceptable values (for this sample, at all times above  $k = 0.76$ ).

## **Results**

### *Reasons for dropping out*

Of the sixteen cases of dropout included in our sample, we were able to contact twelve for follow-up. All of them agreed to answer the reasons for dropping out follow-up questionnaire. This high percentage of replies (75%) compares favourably with the figures reported in the literature on dropout of psychotherapy (Cross and Warren, 1984; Dubrin and Zastowny, 1988; Kolb *et al.*, 1985; Martin *et al.*, 1988; McNeill *et al.*, 1987; Pekarik, 1983a, 1983b; Presley, 1987; Ruff and Werner, 1988; Shapiro and Budman, 1973; Yalom, 1966).

As might be expected from the literature review, the dropouts in our sample gave a number of different answers in reply to the open question about their reasons for dropping out. When asked specific, closed questions, the same differences were observed. The most frequently cited reason for interrupting therapy was the clients' perception that therapy was not going to be useful any more (five clients answered 'yes' to this question; two also added 'because I could do it on my own'). Four clients reported that they felt better after the last session they had had, and four that after the session they felt they could solve the problem on their own. Two clients cited uneasiness with the videotaping as their reason for dropping out. No clients chose the option that 'the therapist did not understand their problem' or that 'therapy was not being helpful' as the reasons for terminating therapy.

Combining the data from the reasons for dropping out follow-up questionnaire with those from the first session questionnaire and the ratings done by the judges using the first session checklist, we distinguished two different dropout profiles:

- (1) The 'successful dropout' group, including five cases where a bad therapeutic experience can be excluded as the reason for dropout. These clients reported at follow-up that they dropped out because they felt better, or gave spontaneous information about a good therapeutic relationship. They also reported that at the time when the follow-up was conducted they were no longer worried about the problem, and none of them had sought professional help again after terminating therapy. The ratings on empathy for these sessions were always above three (on a five-point scale).
- (2) The 'unsuccessful dropout' group, including seven clients who either established a bad relationship with their therapist (two as reported at follow-up; two as rated on the first session checklist) or had a bad therapeutic outcome. Six of these were contacted at follow-up; all were either still worried about the problem that had brought them into therapy in the first place, or had had to consult another mental health professional after terminating therapy. For one case included in this group there were no follow-up data; it was included because empathy was rated as extremely low on the first session checklist.

Four cases were not included in either of these groups, because no clear profile could be developed from the available data. For three of these four cases there were no follow-up data. One client responded to the follow-up but the data were not consistent enough to include him in either of the groups.

*Relational communication and dropout: results on the TI/TF coding scheme*

The Topic Determination (TD) values for both therapist and clients in each of the coded sessions were obtained. Comparing the average values of TD of the dropout and the continuation groups, no statistically significant differences were found either for therapists (TD dropout = 0.673; TD continuation = 0.729;  $t = 1.33$ ;  $p < 0.1$ ) or for clients (TD dyad = 0.632; TD continuation = 0.643;  $t = 0.64$ ;  $p < 0.26$ ). When different types of dropout were taken into account, no differences were found either: performing separate analyses for both dropout types, the average TD values of the dropout and the continuation groups continued not to be statistically different.

As far as individual sessions are concerned, no TD value of any session of the sample fell below TD = 0.40 (therapists) or TD = 0.30

(clients), which are the dropout thresholds identified by Tracey (Tracey, 1986a). In testing other possible threshold values,  $DT = 0.60$  (therapist) emerged as the best one: in the dropout group six cases fell below  $DT = 0.60$ , whereas only one did so in the continuation group. This difference, however, turned out not to reach statistical significance (chi square = 2.925;  $p < 0.1$ ).

*Relational communication and dropout: results on the F-RCCCS coding scheme*

*Proportion of message and transaction categories.* In order to compare the relative frequencies of the types of message and the types of transaction, the Z statistic for the contrast of proportions in two independent samples (Martín Tabernero *et al.*, 1985) was used. We studied the same variables that were analysed in a previous study of the whole dropout group (Beyebach *et al.*, 1996). According to the specificities of the hypotheses researched in this previous study, some variables refer to the whole session, others to the 'information-gathering' phase only, and others to the 'intervention' phase only.<sup>5</sup> We will only discuss those findings that are statistically significant at the  $p < 0.01$  alpha level.<sup>6</sup>

Table 4 shows the results we obtained when we compared the five sessions of the 'successful dropout' group with their equivalent five continuation sessions. Table 5 summarizes our data for the seven 'unsuccessful' dropouts and their seven corresponding continuation sessions.<sup>7</sup>

For the successful dropout sessions we found that there were significantly fewer support messages, significantly more non-support

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<sup>5</sup> Labelling these different moments as 'information-gathering' and 'intervention' phase is done only as a shorthand. In fact, we consider the whole interview to be an intervention, with the final message after the break simply trying to underline certain themes or to make some suggestions explicit (tasks).

<sup>6</sup> Accepting as significant individual pairwise comparisons at  $p < 0.01$  also means that we accept a rather liberal experiment-wise alpha. However, we feel that the clinical nature of our data and our interest in *patterns* of findings (and not just individual, isolated findings) make it acceptable. The strikingly coherent pattern of results of our original study, with eleven out of sixteen comparisons being significant at the 0.01 alpha level (Beyebach, 1993) had also led us not to use adjustments like the Bonferroni correction.

<sup>7</sup> Due to the design of the study, it would not be adequate to compare the unsuccessful with the successful dropouts, given that the possible intervening variables (therapist, sex of the client, number of the sessions) would no longer be controlled for.

TABLE 4 *F-RCCCS measures: five 'successful' dropout versus five continuation sessions*

		dropout	continuation	
<i>Hypothesis H1.1 (whole session)</i>				
support (dyad)	DR<CO	0.23	0.27	$p < 0.01$
non-support (dyad)	DR>CO	0.03	0.02	$p < 0.01$
succ. talkover (dyad)	DR<CO	0.13	0.08	$p < 0.01$
<i>Hypothesis H1.3 (information gathering)</i>				
question (therapist)	DR<CO	0.22	0.23	n.s.
answer (client)	DR>CO	0.18	0.15	n.s.
one-down therapist	DR<CO	0.24	0.26	n.s.
one-up therapist	DR>CO	0.27	0.28	n.s.
one-down client	DR<CO	0.32	0.42	$p < 0.01$
one-up client	DR>CO	0.22	0.13	$p < 0.01$
<i>Hypothesis H1.5 (intervention)</i>				
one-down client	DR<CO	0.22	0.14	$p < 0.05$
one-up client	DR>CO	0.44	0.46	n.s.
<i>Hypothesis H1.2 (whole session)</i>				
one-up/one-up	DR>CO	0.06	0.04	$p < 0.01$
one-across/one-down	DR<CO	0.21	0.26	$p < 0.01$
conflict pattern	DR>CO	0.02	0.01	$p < 0.01$
<i>Hypothesis H1.4 (information gathering)</i>				
complementarity	DR>CO	0.20	0.18	n.s.
<i>Hypothesis H1.6 (intervention)</i>				
complementarity	DR<CO	0.26	0.21	n.s.

messages and significantly more successful talkovers than in continuation sessions during the entire session (Table 4). Clients who later dropped out successfully produced less one-down and more one-up messages during the information-gathering phase than did continuation clients. These differences were not evident during the intervention phase. On the transactional level, there were more symmetrical interactions and more conflict triads for the dropout than for the continuation sessions. However, transitional one-across/one-down patterns were less frequent in sessions where clients later dropped out.

As far as *unsuccessful* dropout sessions are concerned (Table 5), when compared with continuation sessions, they also showed a higher proportion of talkovers and fewer support statements. The difference in non-support messages did not reach statistical significance. During the interview or information-gathering phase, therapists tended to use more questions in the dropout cases than with

TABLE 5 *F-RCCCS measures: seven 'unsuccessful' dropout versus seven continuation sessions*

	dropout	continuation	
<i>Hypothesis H1.1 (whole session)</i>			
support (dyad)	0.25	0.28	$p < 0.01$
non-support (dyad)	0.02	0.01	n.s.
succ. talkover (dyad)	0.11	0.08	$p < 0.01$
<i>Hypothesis H1.3 (information gathering)</i>			
question (therapist)	0.24	0.20	$p < 0.01$
answer (client)	0.18	0.16	n.s.
one-down therapist	0.24	0.28	$p < 0.05$
one-up therapist	0.27	0.25	n.s.
one-down client	0.38	0.38	n.s.
one-up client	0.20	0.15	$p < 0.01$
<i>Hypothesis H1.5 (intervention)</i>			
one-down client	0.47	0.51	n.s.
one-up client	0.17	0.15	n.s.
<i>Hypothesis H1.2 (whole session)</i>			
one-up/one-up	0.06	0.04	$p < 0.05$
one-across/one-down	0.22	0.24	n.s.
conflict pattern	0.13	0.09	n.s.
<i>Hypothesis H1.4 (information gathering)</i>			
complementarity	0.20	0.17	$p < 0.05$
<i>Hypothesis H1.6 (intervention)</i>			
complementarity	0.27	0.25	n.s.

clients who later continued in therapy. They were also less often in a one-down position in relation to their clients in dropout sessions than in continuation sessions. Clients who later dropped out unsuccessfully produced significantly more one-up messages during the information-gathering phase than did the clients in the continuation group. At the transactional level, there were more symmetrical transactions in the dropout group (whole sessions), and also more complementary ones (interview phase) for the dropout group, but these differences were only significant at the  $p < 0.05$  level.

*Sequential analysis.* So far, we have been analysing the overall proportions of both monadic, dyadic and triadic data. However, in order to take into account the patterned nature of interaction, these traditional, frequency-based analyses are not enough. In this section we

will use lag sequential analysis (Bakeman and Gottman, 1986; Gottman and Roy, 1990) which most psychotherapy researchers consider to be an adequate methodological approach to study sequence and pattern in therapeutic process research (Lichtenberg and Heck, 1986).

Lag sequential analysis is based on the comparison of the unconditional probability of a behaviour and its conditional probability. In other words, if we want to know whether behaviour A (at time  $t$ ) has any effect on the likelihood of behaviour B in lag one (time  $t + 1$ ), we will compare B's unconditional probability (i.e., the probability of that behaviour in the whole sequence, irrespective of which behaviour precedes it) with its probability after A. If B is more likely after A than in unconditional terms, we will say that A has an excitatory effect on B; if B is less likely after A than in unconditional terms, we will say that A's effect on B is inhibitory. Thus, we might observe that the probability that a client makes a non-support statement during a session is u.p. = 0.05 for the overall interaction sample. However, this probability might go up to c.p. = 0.15 when the therapist's previous message is an order. If this increase is statistically significant, we would say that the 'order' messages from the therapist activate his client's non-support. To test the significance of this difference we use the Z statistic, as suggested by Allison and Liker (1982).

However, before we carried out the lag sequential analysis, there were two previous questions to be addressed (Cousins and Power, 1986; Gottman and Roy, 1990). Which is the order of dependency among the behaviours in the sample? Is interaction homogeneous across interviews?. We tackled these questions by using the computer program developed by Arundale (1982), based on the analysis of markov chains.

First, we determined the order of dependency; i.e., we analysed on how many previous behaviours any given behaviour in the sample is contingent. A zero-order dependency means that the behaviours of the interactors are independent of the behaviours which precede them; that neither the therapist nor the client's response is constrained by the other or by themselves. Therefore, no pattern could be established in their interaction. First-order dependency means that any given behaviour is contingent on the previous response (antecedent at time  $t - 1$ ); second-order dependency means that the speaker's response is determined by the two preceding events: for instance, the client's behaviour is in response

to the therapist's response to the client's previous behaviour.

Second, we verified if the interaction in the therapy sessions included in our sample was homogeneous. In other words, we analysed whether the transitional probabilities were the same across different interviews. This allowed us to know which interviews could be grouped for the lag sequential analysis. These analyses were carried out on the control directions only, given that in other possible variables (response mode, grammatical format) some base-rate frequencies were not high enough.

*Markov chain analysis.* Our analysis showed that, overall, the interviews of our sample displayed first-order dependency. In no interview was the order of dependency zero, and in only a few interviews was it two. We can therefore assume that the best prediction of any behaviour is done on the basis of the previous one, and that taking more preceding behaviours into account does not increase predictability.

*Markovian homogeneity tests.* We undertook markovian homogeneity tests in a progressive way, taking decisions on the basis of the results we were getting.

First, we verified that the transition probabilities of the 'information-gathering' and 'intervention' phases were homogeneous within each session; that is, that in terms of markovian analysis the sessions showed stationarity through phases. This allowed us to treat each session as one string of interaction. We then found that the thirty-two sessions, treated as one group, were not homogeneous. The sixteen dropout interviews turned out not to be homogeneous either, as did the sixteen continuation interviews. Given that these sessions could not therefore be treated as one single group for the sequential analysis, it was decided to find out if any subgroup of interviews were homogeneous.

No homogeneous group could be found among the continuation cases on the basis of the therapist's experience ('experts only' and 'trainees only' were both heterogeneous) nor on the basis of the interview number ('only first sessions', 'only second or third sessions'). For the dropout cases, 'trainees only' was found to be a homogeneous group, but it was not so for the continuation sessions.

Taking into account the dropout type, we did find that the seven interviews of 'unsuccessful dropout' were homogeneous ( $LRX(180) = 208.18; z = 1.46$ ). The seven comparable continuation sessions were also homogeneous.

*Lag sequential analysis.* The results of the markov chains analysis described above made it advisable not carry out the lag sequential analysis on the whole sample (for instance, comparing the sequences of the dropout with the sequences of the continuation group).<sup>8</sup> The only correct grouping includes the seven cases of 'unsuccessful dropout' and their continuation counterparts. On the other hand, the finding of a first-order dependency only inclined us to restrict our analysis to first-order (lag one) dependencies. We therefore only undertook lag sequential analysis on the seven cases of 'unsuccessful dropout' and their continuation counterparts, in order to find out if there were any differences in the interactional contingencies between these two groups. The question to be answered by the lag sequential analysis was whether the effect that the behaviour of one speaker has on the behaviour of the other was different in the dropout from the continuation sessions.

The transition probabilities for the control directions of both therapist and client were analysed. The transition probabilities for the seven unsuccessful dropout and the seven continuation interviews are very similar: both in the dropout group and in the continuation group one-up moves by the therapist were found to inhibit clients' one-across moves and to activate their one-down and one-up responses. In both groups, therapists' one-across activate clients' one-across, inhibiting one-down and one-up. As far as therapists' one-down interventions are concerned, a difference across groups was found: in the unsuccessful dropout group therapists' one-downs activate one-up messages by the client, inhibiting one-down and one-across, while for the continuation group there was also an activating effect on clients' one-up and an inhibitory effect on one-down, but no inhibitory effect on one-across.

Clients' one-up messages were found to elicit therapists' one-down and to inhibit their one-across, both in the dropout and in the continuation interviews. However, for the dropout group, clients' one-up had no effect on the probabilities of therapists' one-up, while in the continuation group they did elicit the therapists' one-up.

The effect of clients' one-across and clients' one-down messages

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<sup>8</sup> Performing sequential lag analysis on aggregated heterogeneous data is not only an incorrect procedure, but may generate results that contradict those found with non-aggregated data. This effect has been described as Simpson's paradox (Gottman and Roy, 1990).



was the same for the two groups: one-across messages elicit therapists' one-across, inhibiting both one-down and one-up, while submissive manoeuvres by the client (one-down) inhibit therapists' one-across and elicit both one-down and one-up.

In summary, levelling manoeuvres (one-across) of both therapists and clients appeared to elicit more levelling behaviour, inhibiting both one-down and one-up messages. Domineering (one-up) and submissive (one-down) behaviours tended to inhibit one-across by the other speaker, activating one-down and one-up messages. The only clear difference between the unsuccessful dropout and the continuation group was found in the effect of clients' one-ups: in the continuation group they activate therapists' one-up, whereas in the unsuccessful dropout group they did not show this effect.

## **Discussion**

Before entering a discussion of the findings presented so far, it is important to highlight the limitations of this study. On the one hand, we are discussing data collected on a small sample of only thirty-two sessions. Any generalizations should be done with great care, taking into account the special characteristics of this sample (for example, private practice; the inclusion of trainees; sessions with individual format only). Also, due to the design of this study, no causal links can be established between the observed therapeutic interaction and the final outcome of the cases studied. Furthermore, the differences in communication patterns found between dropout and continuation sessions might have no relationship to the dropout process, and could be accounted for by other intervening variables. The design of our study (pairwise matching, in order to control for relevant variables) makes this unlikely, but the possibility of other unknown variables influencing the results cannot be ruled out completely. In addition, the matching procedure was not completely homogeneous: in most cases two sessions conducted by the same therapist were compared, but in some the therapist is only matched by gender and experience. Finally, it has to be emphasized that the therapy model applied in the cases included in this sample cannot be described as purely 'solution-focused therapy', as it includes aspects of problem-focused MRI practices. Therefore, the conclusions of these findings might be best understood as referring to brief therapy practices, both solution-focused and beyond. To the extent that they could be applied

to the therapeutic interaction with more than one client in the consultation room, they might also apply to the clinical practice of marriage and family therapy in conjoint sessions, but this is still an open question.

### *Dropout as a heterogeneous process*

In our study, the distinction of two dropout profiles was done mainly with the intention of deepening our analysis of the therapeutic interaction in dropout sessions. To make any claims about the final outcome of dropouts in solution-focused therapy certainly requires more than twelve cases to be studied. However, we think that some of our findings deserve some comment, as they are consistent with the literature of dropout from psychotherapy in general.

In our sample it was fairly easy to distinguish different types of dropouts: there were very different reasons for leaving therapy; the final outcomes were widely discrepant; and the rating of the interviews and the initial disposition of clients showed clear differences. In other words, our data conform to what most researchers into dropout have stated: that dropout should be constructed as a heterogeneous process (Acosta, 1980; Buddeberg, 1987; Fiester and Rudestam, 1975; Martin *et al.*, 1988; Pekarik, 1983a; Presley, 1987; Trepka, 1986). One caveat in interpreting these data is that they are partly based on recently developed instruments of unproven reliability and validity. However, the fact that several different data sources were used, and the finding that the markovian chain analysis supported the homogeneity of 'unsuccessful dropout' as a group, can be taken to provide some validity to our differentiation of dropout groups. Therefore, one implication of our study is that the heterogeneity of dropout should be taken into account in any study of this process in solution-focused therapy.

Another interesting finding is that, out of twelve contacted dropout clients, only five had been able to overcome their problems without any further professional help. Although this can be taken to imply that a substantial proportion of clients who drop out from solution-focused therapy do well afterwards, it also points out that a high number have a less satisfactory outcome. In other words, in our sample the rate of successful outcomes is lower among dropout clients than among continuers, and therefore one may think these data suggest that dropping out of therapy is indeed an issue of clinical significance – even in solution-focused therapy.

*Topic Determination and dropout*

On the TI/TF coding scheme no differences were found between dropout and continuation sessions on their mean Topic Determination (TD) values. Furthermore, TD values for each session were much higher than the thresholds suggested by Tracey for dropout sessions (Tracey, 1986a). In other words, we could not replicate Tracey's finding that dropout sessions are associated with a drop of complementarity (as measured through TD) below a certain critical threshold.

The departure of the TD values in our sample from those reported by Tracey is quite remarkable. Whereas in Tracey's study TD values in dropout sessions fell systematically below TD = 0.40 (therapists) and TD = 0.30 (clients), none of the sessions in our sample fell below that value, and indeed the TD values were usually much higher. There are various possible explanations for these findings.

First, it is possible that our judges coded the sample differently from Tracey's team, thereby raising the TD values incorrectly. However, we are inclined to reject this explanation, given that the TD values for our continuation sessions are fairly similar to those established in previous studies (Tracey and Ray, 1984; Tracey, 1986a; Lichtenberg and Kobes, 1992). In all these studies, average TD values for continuation sessions are in the 0.51–0.81 range, within which our results also fall. This leads us to think that our TI/TF codings are precise, but that the TD values for our dropout group are indeed higher than in other samples.

If we assume that relational communication in the dropout sessions of our sample is indeed different from that in Tracey's sample, how can this be accounted for? It could be due to the difference in therapeutic context (private practice versus university counselling service) or in the therapy models used (brief therapy versus counselling with various theoretical orientations). In a way, the fact that brief therapists emphasize the need to achieve fit with their clients might explain in part the high values in TD even in the dropout cases. Another source of difference could lie in the operational definition of dropout, as Tracey includes only cases with a poor therapeutic outcome. However, it should be noted that we could not replicate Tracey's finding even in our subsample of unsuccessful dropouts.

Finally, given that with the F-RCCCS we did find a number of

differential characteristics of therapeutic communication in dropout versus continuation sessions, we may suspect that the TI/TF may not be a sensitive enough instrument to capture communicational features in solution-focused therapy. In any case, given that Tracey's findings have not been replicated in our sample, it seems relevant to undertake further replications in order to examine the value of Tracey's claims about 'dropout thresholds' (Tracey, 1986a).

### *F-RCCCS data and dropout*

The analysis of the therapeutic interaction of dropout versus continuation sessions as described by the F-RCCCS yielded a number of interesting results. First of all, it should be emphasized that, when the analysis was carried out taking into account the heterogeneity of the dropout process, results seem to be *less* clear-cut than when performed treating all dropouts as one group. Comparing as one group all sixteen dropout sessions with the sixteen continuation sessions, most of the predictions had previously been verified (Beyebach *et al.*, 1996, and see Table 6). Now, performing separate analyses for unsuccessful and for successful dropouts, many comparisons no longer yielded any statistically significant differences (Tables 4 and 5). In global terms, and contrary to what we had expected, it was the 'successful' dropout group that fitted better into our previous findings. The analysis of the differential results allows for some interesting findings.

There were some features shared by successful and unsuccessful dropout sessions. For both types of dropout sessions, clients defined themselves more frequently in a one-up position than continuation clients, giving less support and interrupting their therapist more often. The question-answer pattern that had previously been identified for dropout sessions (Beyebach *et al.*, 1996) did not hold for the separate analyses of the two dropout groups, although for the unsuccessful dropout group the difference between the percentage of therapist questions in dropout versus continuation cases approached statistical significance.

The successful dropout group showed some features which unsuccessful dropout sessions did not. On the one hand, successful dropout clients were less submissive than continuers (whereas for the unsuccessful dropouts this was not the case) during the interview phase. On the other hand, successful dropouts showed a clear

TABLE 6 Findings for the total sample (sixteen versus sixteen), for the 'unsuccessful dropout' (seven versus seven) and the 'successful dropout' cases (five versus five)

	16 vs. 16	7 vs. 7	5 vs. 5
<i>Whole session</i>			
support (dyad)	0.01	0.01	0.01
non-support (dyad)	0.01	n.s.	0.01
successful talkover (dyad)	0.01	0.01	0.01
<i>Interview phase</i>			
questions (therapist)	0.01	0.012	n.s.
answers (client)	0.01	n.s.	n.s.
one-down therapist	0.05	0.05	n.s.
one-up therapist	0.05	n.s.	n.s.
one-down client	0.01	n.s.	0.01
one-up client	0.01	0.01	0.01
<i>Intervention phase</i>			
one-down client	0.05	n.s.	0.05
one-up client	n.s.	n.s.	n.s.
<i>Whole session</i>			
one-up/one-up	0.01	0.05	0.01
one-across/one-down	0.01	n.s.	0.01
conflict triad	0.01	n.s.	0.01
<i>Interview phase</i>			
complementarity	0.01	0.05	n.s.
<i>Intervention phase</i>			
complementarity	n.s.	n.s.	n.s.

reduction in their proportion of one-across/one-down transition transacts, together with a higher presence of competitive symmetry and conflict triads (one-up/one-up/one-up). This indicates that for the successful dropouts, the differences with continuers were evident not only on the level of monadic messages, but also on the interactional level of transactions.

We would like to put our conclusions into the context of some methodological considerations. On the one hand, given that for almost all comparisons differences for both dropout types are still in the expected direction (but without reaching statistical significance), it seems likely that it is the reduction of statistical power which accounts for the different pattern of results that are obtained after subdividing the original sixteen-sessions dropout group. On the other hand, the differences between dropout and continuation

sessions tend to be quite modest in any case, and therefore seem to be of a more quantitative nature. Finally, the design of our study does not allow us to directly compare the relational control variables of the two dropout groups, but only to examine what differences each group shows with their comparable continuation sessions. Taking all these limitations into account, we would like to put forward a number of conclusions.

(1) The relational control features of dropout sessions seem to apply not only to cases of unsuccessful dropouts (as we would have expected), but also to successful dropouts.<sup>9</sup> In fact, they apply more to successful than to unsuccessful dropouts. Therefore, even when the dropout can be described as 'successful', the therapeutic interactions seem to be more conflictive and less harmonious than in continuation sessions, with less support and more talkovers, and with more competitive symmetry and conflict patterns in the therapeutic interaction.

(2) On the other hand, sequential lag analysis showed that the differences in the proportion of symmetry and conflict between (unsuccessful) dropout and continuation sessions is not due to a different behaviour of the therapists when confronted with their clients' domineering (one-up) behaviour. Our previous interpretation (Beyebach *et al.*, 1996), that therapists in the dropout group enter into symmetrical escalation whereas in the continuation session they manage to answer in a more complementary fashion, is not supported by the lag sequential analysis. In fact, our data seem to suggest the contrary: it is in the continuation group where clients' domineering behaviour elicits therapists' one-up, while it does not have this excitatory effect in the dropout sessions. In other words, the communicational differences between dropout and continuation sessions, at least as far as competitive symmetry is concerned, seem not so much related to how therapists' handle the

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<sup>9</sup> We would like to emphasize that the denomination 'successful dropout' does not mean that this is somehow a desirable outcome. Although clients in this group had a better therapeutic outcome than those in the unsuccessful dropout group, it is possible that they might have profited more if they had had some more sessions. In addition, their dropout posed problems for the agency and, as discussed in the introduction, points to a lack of fit with their therapists as far as the timing of termination is concerned.

domineering behaviour of their clients, but simply to how much domineering behavior clients display in the first place.

(3) The finding that therapists' handling of their clients' domineering behaviour seems not to be the clue to the differences in symmetrical patterns underscores the potential relevance of levelling, one-across manoeuvres (Beyebach *et al.*, 1996). Lag sequential analysis shows that in our sample one-across messages elicit levelling sequences, sequences that various studies seem to have identified as an adaptive pattern of communication (Beyebach *et al.*, 1990; Bailin, 1995; Rogers and Bagarozzi, 1983).

(4) On the basis of our current analyses, the negative effect of what had been termed 'question-answer pattern' is not as clear as it previously appeared (Altuna *et al.*, 1988; Beyebach *et al.*, 1990, 1996). This is consistent with a recent sequential lag analysis conducted on a larger sample of brief therapy sessions (Rodríguez-Arias, 1996), and suggests that the possible negative effect of having a high percentage of question-answer exchanges had probably been overestimated (Beyebach *et al.*, 1996).

### *Implications*

As we have stated above, one implication of our study is that it supports the notion that dropout should be thought of as a heterogeneous phenomenon, and that therapists should not see dropouts necessarily as therapeutic failures – but also not necessarily as successes. Both would be too simplistic a view of a complex process. The only way to determine the ultimate outcome for clients who drop out of therapy is by including them in our follow-ups and finding out what happened after termination. This would have far-reaching research and clinical implications and, in our view, is likely to hold for all types of therapy, including marital and family therapy (Bischoff and Sprenkle, 1993).

Our study also lends some empirical support to the conceptualization of psychotherapy dropout as a *relational* phenomenon, which seems to be associated with a particular configuration of therapeutic communication. The differences between dropout and continuation sessions are probably not as clear-cut as Tracey's (1986a) research suggested, but are however evident on a number of relational communication features. This, in turn, emphasizes the

responsibility of therapists in the continuation of their clients in therapy. Our data give some support to the idea that brief therapists (and probably family therapists in general) should see the promotion of a supportive, harmonious and non-conflictual conversation as one of their main goals in conducting a therapeutic interview.

The finding of only a first-order dependency in our data may be taken to suggest that the development of a viable therapeutic relationship is basically related to the fit of the therapist's responses *with the last speech turn of his or her client*, instead of with some longer communication patterns. This interpretation, which in a way may seem to contradict the classical systemic emphasis on longer chains of communicative behaviour, is however coherent with the solution-focused interview style of 'simply' following the client's lead, of *listening* (de Shazer, 1991) more than *strategizing* (Tomm, 1987).

One clinical implication of our data is that therapists could detect the risk of dropout if they focus on the relational form – and not only on the content – of their ongoing interactions with their clients. A decrease in support messages and an increase of non-support, together with more talkovers and (in some cases) a higher number of competitive symmetric transacts and of conflict triads may be a clear sign of a deteriorating therapeutic relationship. But how should therapists handle the situation for example, their client's one-up moves, especially if they happen in a context of increasing symmetrical escalation and even verbal conflict?

One possibility, which previous research had pointed out as probably the most effective (Beyebach *et al.*, 1996), would be for the therapist to reply to the client's one-ups with one-down responses, for instance, by agreeing with her client's criticisms. Expressing it in the terms advanced by Watzlawick *et al.* (1967), this means introducing complementarity in a situation of symmetry. However, our current data suggest that this interpretation is not as sound as we first thought. Although the effect of using one-down responses to avoid symmetrical escalation merits further study, the findings of our sequential analysis suggest that the use of levelling one-across messages may be a more effective way of avoiding symmetrical escalation. In our view, our new data give additional support to an interpretation that was put forward in Beyebach *et al.*'s (1996) previous study:

We believe that the relevance of one-across messages in some way points to the importance of what is apparently secondary in the psychotherapeutic



process: neutral comments, 'non-events', 'non-therapy'. In our opinion, the value of 'one-across' comments is still an indication that sometimes what is important in therapy is precisely what tends to be overlooked; the moments in which the therapist does not attempt to dominate nor allows him/herself to be dominated, in which no attempts to introduce change are made, in which no present technique is being used.

(Beyebach *et al.*, 1996).

Our emphasis on the usefulness of one-across messages does not preclude the utilization of specific interventions designed to re-establish a useful therapeutic relationship, for instance, metacommunication on the therapeutic interaction itself. However, this possibility needs further research, as we will discuss in the next section.

### *Future research*

There are various lines along which our research could be pursued. As we have just discussed, it would be useful to re-examine the effect of competitive symmetry in therapeutic conversations, as well as the therapist's role in promoting or avoiding it. In this respect, one possibility that seems promising is to differentiate between regulative one-up moves (instructions, orders, and topic changes) and non-supportive one-up moves (non-support, disconfirmation), and to find out what difference this distinction makes.

Another issue that should be tackled is that of establishing thresholds for relational control variables. After all, we have so far described modest quantitative differences between dropout and continuation sessions, which do not tell us 'how much (of any given message or transact type) is too much'. Although this seems a difficult endeavour, it would be helpful in providing clinicians with more specific guidelines to assess the ongoing therapeutic relationship at any moment in time. Studying not only the last session before dropout, but also the previous ones, is likely to provide some additional clues about premature termination and its relationship to the unfolding of the therapeutic interaction over time.

Another direction for research is to complement the formal, process-level analysis we have carried out with a more content-based analysis. For instance, it might be useful to study relational patterns in the context of the topics that are being discussed in therapy, as well as in relation to broader therapeutic issues: When does symmetrical escalation occur? When are clients more likely to give

non-support messages? Is its effect the same in different moments of the interview? Are relational patterns different in 'problem talk' and 'solution talk' (de Shazer, 1994)? Other methodological approaches, like event analysis (Rice and Greenberg, 1984) would allow for an even more precise delimitation of the effects of particular communication patterns in particular moments of the session. Another step in this direction would be to design studies that were able to look at therapists' interventions for example, (reframing or complimenting the client), establishing causal links between them and the immediate and final outcomes of the therapeutic interaction.

It also looks promising to combine observational data, as those on which the F-RCCCS and the TI/TF coding scheme are based, with self-report measures on the therapeutic relationship. In order to get a better understanding of the dropout process, these data could be collected not only for the last session before termination, but also for the previous ones. Other useful information could be provided by the therapists; for instance, their evaluation of the therapeutic relationship in terms of 'customer', 'complainant' and 'visitor' (de Shazer, 1988). Alternatively, relational control patterns could be studied in combination with nonverbal aspects of therapeutic interaction. The interaction of control and nonverbal affect variables has yielded interesting results in the study of communication in couples (Escudero *et al.*, in press), and, in our view, also holds great promise for the research on therapeutic communication.

Finally, there are a number of possible research projects that would help to clarify the relevance of our findings for conjoint family therapy sessions. The F-RCCCS could be used to analyse dropout sessions with more than one client, allowing researchers to identify triadic moves (Hetherington and Friedlander, 1987) and to take into account the possibility of split alliances among therapists and different family members (Pinsof and Catherall, 1986). Although findings are likely to be more complex, they would also have the potential to address some of the unique features that arise in the interaction of therapists with more than one client: What happens if the therapist engages in negative communication patterns with one family member, but manages to keep a good interaction with another? How do continuation and dropout relate to the creation of different relational patterns with different family members?

We hope that replications of our study, as well as new studies including some of these suggestions, will shed more light on the process of dropout from solution-focused and family therapy.

## Conclusions

In this study we have presented a series of process analyses carried out on a sample of thirty-two sessions of brief, solution-oriented therapy. After documenting the heterogeneity of the dropout cases, we have studied the differences in the relational communication that unfolds in dropout versus continuation cases. Although we were not able to replicate the findings of a previous study undertaken with the TI/TF coding scheme (Tracey, 1986), we could find a number of differential characteristics in terms of the variables measured by the F-RCCCS coding scheme (Heatherington and Friedlander, 1987). In our view, these results highlight the prospects that process-oriented research offers in the study of the therapeutic interaction, and more specifically the possibilities that the F-RCCCS offers for research that is coherent with the systemic, relational premises of solution-focused therapy.

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