Rorschach and MMPI–2 Indices of Early Psychotherapy Termination

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This study was an investigation of the differences between 97 patients who had prematurely terminated psychotherapy (M = 1 session) and 81 who had participated in individual psychotherapy for at least 6 months and 24 sessions (M = 18 months; 72 sessions) on selected Minnesota Multiphasic Personality Inventory–2 (MMPI-2) and Rorschach variables. None of the between-group comparisons using the MMPI–2 proved to be significant. However, a multivariate analysis of variance of 9 Rorschach variables in 3 conceptual categories—(a) interpersonal relatedness, (b) psychological resources versus resource demand, and (c) level of psychopathology—proved to be significant at \( p = .008 \). The Rorschach scores from the interpersonal–relational category proved to be the most robust in differentiating the 2 groups. The theoretical implications of interpersonal variables are discussed in relation to the termination and continuation of patients in psychotherapy.

Although a great deal of research has focused on the process and outcome of psychotherapy, far less has been written about premature termination from psychotherapy. This is surprising in view of the high dropout rates reported in the literature. For example, Garfield (1994) summarized 20 studies, mostly from the 1950s and 1960s; he reported that the median number of psychotherapy interviews for outpatient clinics clustered around six interviews. Garfield indicated that more recent studies are quite consistent with the earlier ones.

In an earlier summary (Garfield, 1986), the median number of psychotherapy sessions was between five and eight. Taube, Burns, and Kessler (1984) found similar results in a study of psychologists and psychiatrists in private practice, and Blackwell, Gutmann, and Gutmann (1988) found that the modal number of treatment sessions was a single visit for patients belonging to a health maintenance organization and for patients in a fee-for-service arrangement in a hospital-based outpatient clinic. A report by Howard, Davidson, O'Mahoney, Orflinsky, and Brown (1989) indicated that, in a national survey of the utilization of mental health services, 44% of the patients made fewer than four visits. Howard, Kopta, Krause, and Orflinsky (1986) summarized 15 studies, in which the median number of sessions reported ranged from 4 to 33 sessions, with a median of 12 for the sample. Scogin, Belon, and Malone (1986) also reported that approximately two thirds of psychotherapy patients in the clinic they sampled terminated their treatment prematurely, the majority in less than five sessions, and Phillips (1985) reported a 30% dropout rate after one session and a 50% dropout rate after two sessions.

Depending on the criteria used and the patient population studied, dropout rates as high as 80% to 90% have been reported (Burnstein, 1986; Owen & Kohutek, 1981). Pekarik (1983) found that 37% to 45% of adult outpatients terminated after the first or second session, and other studies reported that 40% of patients at community mental health centers dropped out after one or two visits (Fiester, Mahrer, Giambra, & Ormiston, 1974; Sue, McKinney, & Allen, 1976). Baekeland and Lundwall (1975) note that between 20% and 50% of the patients in general psychiatric clinics do not return for therapy after their first visit, and that 31% to 56% attend no more than four sessions. Reder and Tyson (1980) reviewed 48 published studies concerning premature termination from long-term psychotherapy. They report a median dropout rate of 43% within two to five sessions.

Even for those therapies that specify a shorter treatment interval, the estimated dropout rate can be as high as 50% (Persons, Burns, & Perloff, 1988). High attrition rates present significant problems in group therapy as well. Not only does the patient who drops out leave without completing the therapeutic experience, but he or she may disrupt the work of the remaining patients (McCallum, Piper, & Joyce, 1992).

Psychological tests, and specifically the Minnesota Multiphasic Personality Inventory (MMPI), have been used in an attempt to identify those most likely to discontinue treatment prematurely. Notably, most of this research has been in the area of alcohol and substance abuse, where the attrition rate is estimated to be between 52% and 75% (Baekeland & Lundwall, 1975). Walters, Solomon, and Walden (1982) attempted to use the Minnesota Multiphasic Personality Inventory (MMPI) to determine differences between those patients who remained in psychotherapy, compared with those who attended for less than six sessions. Their findings suggest that male outpatients who persist in psychotherapy tend to be less defensive, more aesthetically oriented, more depressed and, in general, more poorly adjusted psychologically relative to the male outpatients who leave treatment early. The correlates of persistence in female outpatients were less clear; although it does appear that persisting female outpatients were more introverted and less impulsive compared with female outpatients who demonstrated less persistence.
In a study investigating dropouts from dynamically oriented short-term group psychotherapy, Budman, Demby, and Randall (1980) reported that these patients had few close friends, were primarily involved with their family of origin, saw themselves as distant and insensitive to others, and were distrustful of the group experience. If, as Budman et al. and Walters et al. (1982) propose, there are personality characteristics that separate those who terminate from psychotherapy prematurely from those who remain in therapy, then a psychological assessment battery may serve to alert the therapist to a patient who is most likely to discontinue therapy prematurely.

Recently, investigators have demonstrated significant relationships between the pattern of a patient’s pretherapy interpersonal relationships and the therapeutic alliance established in the treatment (Luborsky, McLellan, Woody, O’Brien, & Auerbach, 1985; Marmar, Weiss, & Gaston, 1989; Piper et al., 1991). In addition, Orlinsky and Howard (1967) and Luborsky et al. (1988) cited numerous studies that indicate that various measures of the therapeutic bond were significantly related to a favorable outcome in psychotherapy. Piper et al. (1991) stated, “the evidence from the present study indicates that quality of object relations was a significant predictor of therapeutic alliance when considered from the perspectives of both patients and therapists” (p. 437). These findings are of great practical importance, as a negative therapeutic alliance is quite likely to result in premature termination.

The present study was strongly influenced by the aforementioned research and the use of the Rorschach in a study by Weiner and Exner (1991) concerning the measurement of progress in intensive psychotherapy, as well as other seminal research using interpersonal variables to measure change and assess treatment outcome (Alphé, Henry, & Strupp, 1990; Alphé, Perfetto, Henry, & Strupp, 1990; Blatt & Ford, 1994; Blatt, Ford, Berman, Cook, & Meyer, 1988; Exner & Andronikof-Sanglade, 1992; Luborsky, Crist-Christoph, Mintz, & Auerbach, 1988; Tuber, 1983). Using the Rorschach and the MMPI-2, we decided to examine an outpatient population to determine whether there were significant differences between those patients who dropped out of psychotherapy prematurely and those who remained in therapy.

Among the variables found to be relevant by the aforementioned authors are (a) the quality of interpersonal relationships established, (b) the patient’s available internal resources, compared with the demand on these resources, and (c) the level of psychopathology. Therefore, we decided to focus on the following three clusters of Rorschach variables: interpersonal variables (Rorschach aggressive movement [AG], Rorschach cooperative movement [COP], and Rorschach sum texture-shading [T]); (b) psychological resources versus resource demand (Rorschach Experience Actual [EA] and Rorschach Experienced Stimulation [es]); and (c) level of psychopathology (four Rorschach measures of psychopathology: the Morbid Content Score [MOR]; the Raw Number of the Six Special Scores [Sum6]; Deviant Verbalization, Incongruous Combination, Deviant Response, Fabulized Combination, Contamination, and Inappropriate Logic; the Depression Index [DEPI]; and the Schizophrenia Index [SCZI]).

Interpersonal Variables: AG, COP, and T

The first hypothesis concerned those Rorschach variables said to measure interpersonal relationships: AG, COP, and T. It is our belief that those patients who remain in therapy do so in part because they have problems expressing their needs and difficulties in their personal relationships. Correspondingly, those who drop out prematurely have lower needs for extreme closeness and intimacy, but have better overall interpersonal relationships with others. For this reason, they would probably be less dependent on the therapeutic relationship. Blatt and Ford (1994) found, in a 15-month follow-up testing at a long-term psychoanalytically oriented treatment facility, that those inpatients who made substantial clinical progress (defined as less frequent or less severe clinical symptoms and more intact social behavior) had produced more disrupted and malevolent interpersonal interactions on the Rorschach in their initial intake assessment. Their findings suggest that patients with more disturbed interpersonal relationships are more likely to enter actively into therapy and gain most from the treatment process. Therefore, we hypothesized that those people who terminate from psychodynamically oriented outpatient psychotherapy prematurely would also produce Rorschach protocols that reflect average or better interpersonal skills compared with those who remain in treatment. Those who terminate were hypothesized to have less AG, more COP, and low or average T, compared with those remaining in treatment who were predicted to have poorer interpersonal skills (i.e., more AG and less COP in their Rorschach records and more T, compared with those who terminate prematurely).

Psychological Resources Versus Resource Demand: EA and es

The EA Rorschach measure concerns the extent to which resources are organized in such a way that they are accessible to the individual. The es Rorschach variable is an estimate of the emotional demands the person is experiencing. Because these two Rorschach scores have proven useful in psychotherapy outcome studies, we felt it both necessary and timely to determine whether they might aid in understanding those patients who terminate psychotherapy prematurely or decide to continue. We hypothesized that those who dropped out of therapy prematurely would have higher EA (more available resources) and lower es (less demand on those resources) scores, compared with those who remain in treatment.

Level of Psychopathology Variables: MOR, SUM6, DEPI, SCZI

Concerning the psychopathological aspects of Rorschach responses informing treatment, Colson, Eyman, and Coyne (1994) found a significant negative correlation between patients’ scores on the Rorschach Severity of Disturbance Scale and a perceived treatment difficulty rating by their therapists. There was a significant tendency for the more psychologically disturbed women (but not the men) to be perceived as less difficult to treat.

This finding reminds us of the numerous instances in which our colleagues have puzzled over the fact that many patients whose ego resources (as judged by psychological tests) fall at the higher end of the spectrum of patients we treat engage in some of the most intensely conflictual, troublesome behavior, prolonged regressive
states of mind, and treatment impasses. (Colson et al., 1994, p. 386)

Colson et al. also found that higher Severity of Disturbance scores were associated with a positive shift in the therapeutic alliance during the first year in therapy, and a significant positive relationship between the Rorschach Aggression–Malevolence score and the therapeutic alliance evaluations by the therapists. There was a better therapeutic alliance with the therapist in patients with higher Aggression–Malevolence Rorschach scores. This finding, that patients with more serious thought disorders made better clinical improvement later in the treatment process, was also supported in the Blatt and Ford (1994) study of therapeutic change in hospitalized patients.

Therefore, the third cluster of variables focuses on the level of pathology. Because level of psychopathology has been found to be related to the therapeutic alliance, we felt it was timely to assess whether level of psychopathology is related to early termination as well. We predicted that those patients who dropped out of therapy would have lower levels of psychopathology, as measured by SUM6, as well as lower scores on MOR, SCZI, and DEPI responses.

**MMPI–2**

We used the MMPI–2 as a measure of psychopathology and to test the ability of a new scale, Negative Treatment Indicators (TRT), to differentiate premature terminators from those who remain in treatment. The TRT scale appears to have been designed to provide some indication of who would be likely to terminate their treatment early and who would continue in treatment. High scorers on the TRT scale are said to be individuals with negative attitudes toward physicians and mental health treatment. These individuals are said to feel uncomfortable in discussing their problems with anyone, and they doubt that they can be helped (Hathaway & McKinley, 1989). Therefore, we expected that those people scoring high on the TRT scale would be most likely to terminate their treatment prematurely. In contrast, low scorers on the TRT scale suggest individuals with generally positive attitudes toward physicians and mental health professionals. They would tend to believe that others can understand and help them. Low scorers would share their problems with others easily and persist when they encounter difficult problems (Graham, 1990).

As indicated earlier, Walters, Solomon, and Walden (1982) report that patients who remained in treatment were more poorly adjusted, compared with those who terminated prematurely. For reasons that are similar to those cited earlier concerning the Rorschach (Colson et al., 1994), we also predicted that those who elect to remain in psychodynamically oriented psychotherapy early would have higher levels of pathology, as evidenced by scores on the clinical scales of the MMPI–2. In addition, we hypothesized that those who remain in therapy would score lower on the TRT scale than those who terminate prematurely. We felt that it was important to explore the validity of the TRT scale, given that this score reportedly measures negative attitudes toward mental health treatment. We also hypothesized that those patients continuing in treatment would score lower on the Ego Strength Scale of the MMPI (Barron, 1953), compared with those patients who terminate from psychotherapy prematurely. The Ego Strength Scale has been used quite frequently in a number of psychotherapy outcome studies (Luborsky et al., 1988); therefore, we felt it warranted investigation in addressing psychotherapy termination.

**Method**

All participants \((N = 178)\) were drawn from an archival search of files at a university-based outpatient psychological clinic, accomplished by an exhaustive search of over 600 consecutive cases that were evaluated over a 5-year period. The treatment model at this clinic is that of long-term, psychodynamic, insight-oriented psychotherapy. Participants used in this study had been administered the Rorschach or the MMPI–2 (or both) as part of an intake evaluation. The administration and scoring of all test materials, as well as the therapy for all patients, were performed by advanced graduate students enrolled in an APA (American Psychological Association)–approved doctoral program in clinical psychology. All assessments and psychotherapy were supervised weekly by a psychoanalytically informed faculty member. All faculty were licensed clinical psychologists with several years of applied clinical experience.

The 97 participants who compose the Psychotherapy Dropout (PTDrop) group were those who had indicated (either in person, by phone, or by letter) after the initial evaluation procedure that they no longer desired to begin or continue with treatment, against the advice of clinic staff. Those individuals who stated that they were not entering treatment or were terminating treatment because of a medical condition, hospitalization, unexpected financial hardship, relocation (moving out of the immediate vicinity), or were seeking treatment from an alternative mental health facility or professional were not included in the study. The number of sessions attended by participants in the PTDrop group ranged from zero to eight. The limit of eight sessions was based on criteria from past research (Garfield, 1986; McCallum, Piper, & Joyce, 1992). However, this variable was highly skewed, with the mean number of sessions attended being one, the median and mode being zero sessions.

A comparison group of 81 patients was collected who had participated in psychotherapy (PT group) for a minimum of 6 months and 24 sessions. Duration of psychotherapy for this group ranged from 6 months to 4 years, 7 months. The mean number of sessions attended by the PT group was 72, with an average duration of 18 months of treatment.

Table 1 displays demographic information as well as the distribution of Axes I and II diagnoses in accordance with the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised: DSM–III–R; American Psychiatric Association, 1987). Our patient sample was broadly representative of clinically disturbed outpatients, with both Axis I and Axis II diagnoses; therefore, our results are more widely generalizable than past termination studies using only substance abusers.

**Instruments**

The administration and scoring of the Rorschach followed the procedures articulated by Exner (1986). Three clusters of structural variables were chosen a priori, on the basis of past research and designed to assess theoretically salient aspects of psychotherapy termination (Atkinson, Quarrington, Alp, & Cyr, 1986; Cohen, 1990). These three groups of scores focused on (a) interpersonal–relational responses (AG, COP, and T); (b) psychological resources versus resource demand (EA and es); and (c) level of psychopathology (MOR, SUM6, DEPI, and SCZI).
Table 1
Demographic Information of Sample

<table>
<thead>
<tr>
<th>Demographic</th>
<th>PT (n = 81)</th>
<th>PTDrop (n = 97)</th>
<th>Total (N = 178)</th>
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<tr>
<td>Gender</td>
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<tr>
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</tr>
<tr>
<td>Female</td>
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<td>61</td>
<td>117</td>
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<tr>
<td>Mean age (and SD)</td>
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<td>14,380 (8.450)</td>
<td>15,400 (10.110)</td>
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<td>Mean no. of years of education (and SD)</td>
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<td>13.9 (2.0)</td>
<td>14.3* (2.0)</td>
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Note. PT = psychotherapy group; PTDrop = psychotherapy dropout group; PD = Personality disorder; NOS = not otherwise specified.
* p < .05. (All other group comparisons were not significant.)

AG, COP, T, EA, and es

Both AG and COP are scored for any movement response (human movement [M], animal movement [FM], or inanimate movement [m]) in which the action is clearly aggressive or positive–cooperative, respectively. COP and AG, as scored in Exner’s comprehensive system, also represent styles of interpersonal relatedness. The COP and AG scores are based on the work of Piotrowski (1957), who believed that M responses on the Rorschach typically translate into interpersonal response tendencies. The COP and AG scores are quite similar to the Rorschach Mutuality of Autonomy Scale (MOA; Urist, 1977; Urist & Schill, 1982), in which low scores are given when figures are engaged in some positive and cooperative relationship or activity, and high scores are given to malevolent or destructive interactions. The relationship between AG and aggressive interpersonal intent or action has been noted by Berg, Packer, and Nunno (1993), who found AG to be very highly correlated with high scores on the MOA scale. These high scores represented extremely disturbed object relations. Berg et al. also found a high correlation between COP scores and low scores on the MOA scale, which reflects positive object relations.

Urist (1977) found that MOA scale ratings were highly correlated with independent measures of parents’ actual behavior within relationships (ward behavior, rated by ward staff), whereas Urist and Schill (1982) found similar results; MOA scores were highly correlated with data obtained from patients’ case records, including developmental history, family history, clinical progress notes, and nursing staff notes. Other studies (Goddard & Tuber, 1989; Ryan, Avery, & Grolnick, 1985) found significant correlations between MOA scores and various ratings of interpersonal functioning. Spigelman and Spigelman (1991) found significantly fewer COP responses and more hostile interactions in children whose parents were divorced, compared with those children whose parents were not divorced. According to Exner, the AG and the COP variables are not correlated.

Exner (1987; cited in Exner, 1993) found that, in a group of female college freshmen living in a dormitory and also in a group of third-year high school students, those participants with two or more COP responses were rated as interpersonally more positive five times greater than participants with fewer COP responses in their records. Those participants with no COP scores in their records received the most nominations for generating negative interpersonal statements. Exner (1993) also reports significant differences in COP in a small group of more effective group therapy participants, compared with those participants with no COP scores in their records. Exner (1993) concludes that “COP appears to be the linchpin variable in the cluster of variables related to interpersonal perception” (p. 20).

Kazaoka, Sloane, and Exner (1978; cited in Exner, 1993) found significant differences between those inpatient participants who were low in AG and those high in AG and their scores for verbal and physical aggressiveness, whereas Exner, Kazaoka, and Morris (1979; cited in Exner, 1993) found that a sample of sixth-grade children who scored high on verbal and physical aggressiveness had significantly more AG in their records, compared with participants who were low on verbal and physical aggressiveness. Exner (1993) also reports a study in which patients...
with at least three AG scores were found to manifest significant hostility in their therapy sessions, compared with a random sample of participants obtained from the same treatment study. Significantly more of the participants with the high AG scores were also rated as markedly hostile in their attitudes toward people, compared with the randomly selected comparison group. Exner (1993) concluded as follows:

This composite of studies appears to support the notion that elevations in AG signify an increased likelihood for aggressive behaviors, either verbal or nonverbal, and that they also indicate attitudes toward others that are more negative and/or hostile than is customary... People with elevations in AG see the social environment as marked by aggressiveness. (p. 528)

Klopfer (1938) originally suggested that the texture response was related to the need for affection and dependency. Breecher (1956) found more T responses among patients who had been maternally overprotected, compared with those who had been rejected, whereas Herzt (1948) found that T responses reflected a sensitivity related to a willingness to be more open to the environment. Ainsworth and Kuehne (1959) found that hospitalized, psychotic patients with more T in their records more often based categorizations of objects on tactile features, compared with low T participants and nonpatient control participants. More recently, Marsh and Viglione (1992) found significant correlations between T and touching behavior and between T and the number of block sorts based on the tactile features of the blocks. Weber, Meloy, and Gacono (1992) found significantly less T in inpatient conduct-disordered adolescents, who are reported to be interpersonally detached, compared with a group of dysthymic adolescents; the T response was infrequently produced in the former group. Similar findings (a very low number of T responses) were reported for a group of antisocial personality-disordered individuals (Gacono & Meloy, 1991; Heaven, 1988).

Weber et al. noted that "the infrequent presence of T responses in conduct-disordered adolescents... supports the detachment observed in these individuals" (1992, p. 22). Gacono, Meloy, and Berg (1992) also found significantly less T in the Rorschach protocols of antisocial personality-disordered patients, compared with narcissistic personality-disordered patients, borderline personality-disordered patients, and nonpatients. In addition, they stated that the antisocial personality-disordered patients have a "malevolent, destructive, internalized object world characterized by intense and violent intrapsychic conflict surrounding attachment" (p. 46).

Exner (1986) has also recognized that people with elevated T responses have greater need for closeness; those with fewer texture responses tend to be more guarded or distant in their interpersonal relationships (Exner, 1993; Exner & Bryant, 1974, cited in Exner, 1993; Exner & Chu, 1981, cited in Exner, 1993; Exner, Levanto, & Mason, 1980, cited in Exner, 1993). Exner (1993) concludes that people with T elevations in their Rorschach records also "experience loneliness or stronger than usual needs to be dependent on others" (p. 385). People who have no T in their Rorschach records "appear to be more guarded and/or distant in interpersonal contacts[and]... are more concerned with issues of personal space" (p. 385). Participants with no T in their records even sit further from a collaborator in a waiting room, compared with those who have T in their records (Exner, 1978). Those with T in their records "sit as close to the collaborator as possible and frequently spoke to the collaborator, whereas T-less participants rarely spoke" (Exner, 1993, p. 385). Those with no T in their records appeared more guarded and distant in interpersonal contacts. Even more to the point, Exner (1978) found that therapists rate patients with no T in their Rorschach records as lower in motivation for treatment during the first 3 months of treatment, compared with patients who have T in their pretreatment Rorschach records.

Piotrowski and Schreiber (1952) reported that, in the long-term psychoanalytic treatment of 13 patients, both the total number of human movements (M) and the weighted sum of the color responses (WGSumC)—the two variables making up the EA score—increased significantly after treatment. Exner (1974) also reported significant increases in EA for those patients rated as improved by therapists and relatives. More recently, EA and es (because it is a factor in the D and adjusted D score) have been shown to be important variables in assessing change in both short- and long-term psychotherapy treatment (Weiner & Exner, 1991). Similar findings for support of the EA measure come from the work of Exner and Andronikof-Sanglade (1992), and from Exner, Thomas, and Mason (1985); support for the validity of the determinants that constitute the es score is reviewed in detail by Exner (1993).

The MMPI-2 was completed individually by each participant, and T scores were calculated with the aid of computer software. At this time, we are unaware of any work in which the MMPI-2 was used in the assessment of psychotherapy termination. Therefore, we have used all of the clinical and validity scales in this inquiry. In addition, we wanted to investigate any differences that these two groups might exhibit on the supplemental Ego Strength scale and the content scale TKT.

**Procedure**

Each Rorschach protocol had originally been scored, according to procedures articulated by Exner (1986), by the diagnosticians who administered the test. The advanced graduate students who administered the Rorschach protocol had two courses in personality assessment in which they were trained in the Exner Rorschach administration and scoring procedures. Exner noted that the number of T responses was compared with a group of dysthymic adolescents; the T response was one of the first 3 months of treatment, compared with patients who have T in their records (Exner, 1986). Each assessment was videotaped and viewed by the course instructors to ensure that consistently accurate administration procedures were followed. No examiner was allowed to test clinic patients until the requirements for proper administration were met. In the clinical evaluations, the examiners collected Rorschach protocols with patients under the same strict supervisory procedures. Each administration was videotaped, and each administration and scoring was reviewed by the supervisor (a clinical faculty member).

Twenty protocols, chosen at random, were rescoring (Weiner, 1991) for this study by Mark J. Hilsenroth, who was blind to the original scores and the group status, The resulting mean interrater agreement was 86% across all scoring categories. The original scoring was thus deemed sufficiently reliable to be used for this study. Thirteen participants were found to have T scores of T > 90; therefore their MMPI-2 data were excluded from the data analysis. This brought the number of participants with usable MMPI-2 data in the study to 156 (69 in the PT group and 87 in the PTDrop group).

Also, a sample of 40 files was chosen at random from the set of files searched in the study. Mark J. Hilsenroth and Karen M. Toman then independently rated group assignment and determined (a) whether a patient was excluded from the study and (b) the reason for their exclusion from the PTDrop group. Resulting interrater agreement was 100% for classification in the PT group and 98% for classification in the PTDrop group; 100% in identifying those individuals excluded from the PTDrop group; and an 100% agreement for the various reasons associated with this exclusion. These high rates are not surprising, given that detailed termination summaries are required on each case that is closed within the clinic from which this sample was drawn.

**Data Analysis**

The presence of possible confounds was investigated before the preplanned data analyses were performed. An analysis of variance (ANOVA) showed that gender, age, patient income, marital status, Axis
I diagnosis, and Axis II diagnosis were not significantly different between the PT and PTDrop groups (p > .05). Years of education completed (EDUC) was found to be significantly greater for the PT group, (p < .05) with seven of the nine Rorschach variables and serves a predominantly lower-middle-income clientele. This is not surprising, because the clinic where those participants were evaluated operates on a sliding fee scale and represents that of a lower-middle-income individual.

An ANOVA showed overall response productivity on the Rorschach to be nonsignificant (p = .17). However, using procedures recommended by Kalter and Marsden (1970) we found overall response productivity to be correlated (p < .05) with seven of the nine Rorschach variables (AG, EA, es, MOR, Sum6, DEPI, and SCZI). Therefore, the effects of overall response productivity were also covaried in analyses that used these variables. Preplanned analyses of covariance (ANCOVAs) were performed between the two groups on the variables of interest.

Results

Results of a multivariate ANCOVA (MANCOVA) failed to detect any significant differences between the two groups using the 14 MMPI-2 variables listed in Table 2, F(14, 129) = .894, p = .566. Therefore, it is not surprising that each of the individual ANCOVAs comparing the 14 MMPI-2 variables failed to find significant differences between the PT and PTDrop groups as well. Table 2 summarizes results of ANCOVAs comparing variables from the MMPI-2 between the PT and PTDrop groups and displays T score means and standard deviations for each variable, as well as the F statistic and the p values for each comparison.

Results of a MANCOVA demonstrated significant differences between the two groups using the nine Rorschach variables, F(9, 113) = 2.65, p = .008. Therefore, the results reported in Table 3 most likely reflect actual differences between the two groups, rather than the emergence of a limited number of significant comparisons by chance. Results of ANCOVAs comparing Rorschach variables from each of the three conceptual categories between the PT and PTDrop groups are displayed in Table 3. Table 3 displays means and standard deviations for each variable as well as the F statistic and the p values for each comparison.

The Rorschach scores from the interpersonal–relational category appear to be the most robust in differentiating the two groups. The PT group showed a trend to have more T (p = .07) and AG (p = .09) responses, while producing significantly fewer COP responses (p = .0004) than the PTDrop group. The PT group also exhibited a trend to score higher on the level of pathology variable Sum6 (p = .11) than the PTDrop group.

Discussion

The patients who terminated from psychodynamically oriented psychotherapy prematurely (before the eighth session) were found to have fewer texture responses, more cooperative movement responses, and fewer aggressive movement responses, compared with those patients who remained in treatment. Although there were no significant differences between those who terminated prematurely and those who stayed in treatment for the EA, es, MOR, Sum 6, DEPI, and SCZI variables, the results of the MANCOVA (p = .008) with all nine Rorschach variables indicated a significant difference between those who terminated prematurely and those who remained in treatment. Thus, the picture that emerges of the person who prematurely ends treatment is someone who is somewhat less disturbed; is less aggressive; establishes more cooperative relationships; and has less need for the close contact of the therapeutic interaction, compared with the person who remains in treatment.

Table 2

<table>
<thead>
<tr>
<th>MMPI-2 Scale (and abbreviation)</th>
<th>PT (n = 69)</th>
<th>PTDrop (n = 87)</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lie (L)</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td></td>
<td>48.8</td>
<td>10.6</td>
<td>49.7</td>
<td>12.1</td>
</tr>
<tr>
<td>Infrequency (F)</td>
<td>62.5</td>
<td>15.0</td>
<td>64.1</td>
<td>14.5</td>
</tr>
<tr>
<td>Correction (K)</td>
<td>44.4</td>
<td>9.4</td>
<td>44.9</td>
<td>9.7</td>
</tr>
<tr>
<td>Hypochondrasis (Hs)</td>
<td>54.2</td>
<td>12.6</td>
<td>56.5</td>
<td>13.9</td>
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<tr>
<td>Depression (D)</td>
<td>66.9</td>
<td>13.3</td>
<td>67.7</td>
<td>15.0</td>
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<tr>
<td>Conversion Hysteria (Hy)</td>
<td>58.5</td>
<td>13.9</td>
<td>59.0</td>
<td>12.8</td>
</tr>
<tr>
<td>Psychopathic Deviate (Pd)</td>
<td>64.9</td>
<td>12.7</td>
<td>64.4</td>
<td>12.8</td>
</tr>
<tr>
<td>Paranoia (Pa)</td>
<td>62.4</td>
<td>11.5</td>
<td>61.3</td>
<td>11.6</td>
</tr>
<tr>
<td>Psychasthenia (Pt)</td>
<td>67.9</td>
<td>13.4</td>
<td>67.3</td>
<td>14.3</td>
</tr>
<tr>
<td>Schizophrenia (Sc)</td>
<td>64.3</td>
<td>12.8</td>
<td>64.9</td>
<td>13.8</td>
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<tr>
<td>Hypomania (Ma)</td>
<td>51.5</td>
<td>9.9</td>
<td>54.3</td>
<td>10.3</td>
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<tr>
<td>Social Introversion (Si)</td>
<td>58.9</td>
<td>12.9</td>
<td>56.9</td>
<td>12.1</td>
</tr>
<tr>
<td>Ego Strength (Es)</td>
<td>38.9</td>
<td>12.1</td>
<td>39.6</td>
<td>12.9</td>
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<tr>
<td>Negative treatment indicators</td>
<td>61.2</td>
<td>13.4</td>
<td>59.4</td>
<td>13.0</td>
</tr>
</tbody>
</table>

Note. Effects of education were covaried out of all analyses. MMPI = Minnesota Multiphasic Personality Inventory; PT = psychotherapy group; PTDrop = psychotherapy dropout group.
Thus, on the basis of the interpretation of responses described than the mean T of 1.03 for Exner's normative sample (Exner, 1993, p. 261-262). However, those who terminated prematurely had COP scores that were somewhat less than half of the mean. The mean score of .7 for those who terminated is lower than the mean T of 1.03 for Exner's normative sample (Exner, 1993, p. 260). The mean T for those who remained in treatment (T = 1.1) is slightly higher than the normative mean. Thus, on the basis of the interpretation of T responses described earlier, it appears that those who terminated prematurely had less need for the close contact of the therapeutic interaction.

Those who terminated early had less AG and significantly more COP in their records, compared with those who remained in treatment. Both groups' AG and COP scores are lower than the scores reported in Exner's (1993) normative sample (1.18 and 2.07, respectively; pp. 261-262). However, those who terminated prematurely had COP scores that were somewhat closer to the normative scores, compared with those remained, whose COP score of .5 is somewhat less than half of the mean score for the PTDrop group. Thus, the patient who leaves therapy prematurely appears to be a person with less need for closeness (lower T) but with more cooperative relationships (higher COP), compared with the person who remains in treatment.

The person who continues in psychotherapy is probably more dependent and needy of the therapeutic relationship—someone who has rather poor interpersonal relations outside of the therapeutic setting and, therefore, has a higher need for contact with an accepting individual, here represented by the therapist. Those in the PTDrop group, on the other hand, are probably more productive in their relationships outside the therapeutic one but are much less concerned with establishing a close, dependent relationship with the therapist. The image of this person is one who establishes positive but somewhat distant relationships. In addition, the patients in the PTDrop group were somewhat less disturbed psychologically compared with those who remained in therapy. Those who continued in psychotherapy are somewhat more disturbed patients who have a more intense need for interpersonal closeness, compared with those ending treatment prematurely; the remains probably do not have an extensive or effective interpersonal support system. By remaining in treatment, they focus on the therapist to fill these needs. This study, in part, supports Blatt and Ford's (1994) findings that patients with more disturbed interpersonal experiences are likely to more fully enter into treatment and, therefore, gain from the therapeutic process. Our work also extends their findings, which used inpatients at a long-term psychoanalytically oriented treatment facility, to an outpatient facility with a similar paradigmatic approach to treatment.

Piper et al. (1991) found that the greater the disturbance between a patient and his or her partner, the better was the alliance established with the therapist. This finding is consistent with the findings in our study; those patients who were emotionally needier established longer term relationships, compared with those participants who did not seem to have such need and stopped treatment prematurely. Also, disturbance with one's partner is but one aspect of problems in interpersonal relationships, thus turning the patient more toward an important positive alliance with the therapist. Our findings are also consistent with those of Alpher, Perfetto, Henry, and Strupp (1990) who found a significant positive relationship between clinician ratings based on clinical interviews of patients' capacity to engage in short-term dynamic psychotherapy and the amount of T in their Rorschach records.

The mean score of .7 T for those who terminated is lower than the mean T of 1.03 for Exner's normative sample (Exner, 1993, p. 260). The mean T for those who remained in treatment (T = 1.1) is slightly higher than the normative mean. Thus, on the basis of the interpretation of T responses described earlier, it appears that those who terminated prematurely had less need for the close contact of the therapeutic interaction.

### Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>PT (n = 60)</th>
<th>PTDrop (n = 71)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
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<tr>
<td>Interpersonal</td>
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<tr>
<td>Aggressive move</td>
<td>.6</td>
<td>.9</td>
</tr>
<tr>
<td>Cooperative move</td>
<td>.5</td>
<td>.9</td>
</tr>
<tr>
<td>Resources vs.</td>
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<td>1.3</td>
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<tr>
<td>resource demand</td>
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<td></td>
</tr>
<tr>
<td>Experience Actual</td>
<td>7.7</td>
<td>4.3</td>
</tr>
<tr>
<td>Experienced</td>
<td>10.6</td>
<td>6.3</td>
</tr>
<tr>
<td>Stimulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychopathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morbid Content</td>
<td>1.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Score</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum6</td>
<td>4.9</td>
<td>5.8</td>
</tr>
<tr>
<td>Depression Index</td>
<td>3.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2.6</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Note. Effects of education were covaried out of all analyses, and the effects of R covaried out of analyses involving the measures of aggressive movement, Experience Actual, Experienced Stimulation, the Morbid Content Score, Sum 6, the Depression Index, and the Schizophrenia Index. PT group = psychotherapy group; PTDrop group = psychotherapy dropout group; Sum 6 = Raw Number of the Six Special Scores.
demands also has a need for an emotional relationship in the
therapeutic alliance, perhaps in part because he or she has rela-
tively few and perhaps poor interpersonal relationships outside
of the therapy setting.

It is not surprising that none of the MMPI–2 variables signif-
ificantly differentiated those who terminate from those who
remain in treatment, because the MMPI–2 is primarily a mea-
sure of psychopathology, and the difference between the two
groups is not primarily due to psychopathology. The two scales
that approached significance (Hypomania [Ma; \(p = .16\)] and
Social Introversion [Si; \(p = .16\)]) can perhaps be understood in
relation to our Rorschach data. Those who terminated prema-
turely had higher Ma scores and lower Si scores than those pa-
tients who continued in treatment. Those in the PTDrop group
were more outgoing, whereas those remaining were more intro-
verted and shy. These data tangentially support the Rorschach
findings, which suggest that those in the PTDrop group have
better interpersonal abilities and those who continue with psy-
chotherapy are more socially isolated. However, the TRT scale,
which was designed, in part, to identify premature terminators,
also did not differentiate the two groups. It appears that the use
of the TRT in the identification of patients who terminate early
from psychotherapy is unwarranted and may, in fact, be mis-
leading to clinicians. Another possible reason for the failure of
the MMPI–2 to differentiate these groups is more central than
the issue concerning psychopathology. If, as we suspect, the rea-
sons for early termination of psychotherapy are primarily
affected by interpersonal variables, which focus at least in part
on the pattern of object relations established, then the MMPI–
2 is not an instrument that is ideally suited to measure such a
variable.

It is important to attempt to understand what goes on in the
minds of those who leave therapy prematurely. Is it simply that
they come to believe that they have made a mistake and really
do not need treatment, or perhaps that their problems are not
as severe as they thought them to be, or that other cooperative
relationships are a more valuable resource in problem resolu-
tion? A more thorough investigation of the patient’s experience
in the assessment or treatment setting would be quite valuable
as the next step in understanding the premature termination
process, as would be the experience of the assessor or therapist.
The personal characteristics of the assessor and therapist must be
viewed in relation to the patient’s personality needs and desires
for relationship. Nevertheless, investigating selected Rorschach
variables is, we believe, an important step in conceptualizing
the complex issue of early and premature termination of long-
term psychotherapy.

Perhaps those patients with low T, because they need a rela-
tionship significantly less, are less accepting of an often long
assessment procedure, including an interview and a full assess-
ment battery. The possibility of falling back on relationships
outside the clinic is understandable for people with less need for
a close therapeutic alliance and, therefore, less expectation that
the eventual therapeutic connection would be a valuable one.
Another possible explanation is based on the previously cited
observation (Exner, 1978, 1986, 1993) that those patients with
no T in their records appeared more distant and less talkative
and that therapists viewed them as having less motivation for
treatment. Although it is possible that these patients do have less
motivation for treatment, it is also possible that the response of
the assessor or therapist to them was somewhat less enthusiastic
compared with their response to the patient with higher T: Beck-
ham (1992) found that an initial negative impression of the
therapist by the patient predicted early dropout from psycho-
therapy and that the patients’ first impressions of their ther-
apists may be of key importance in maintaining treatment. Al-
though Beckham considers that his data were measuring “the
patient’s ability to form a positive relationship and to view the
therapist in a positive light” (1992, p. 181), he also considers
an alternate explanation, that “the patients are able to sense
how well the therapist’s personality and approach meets their
needs” (1992, p. 181). The behavioral style of the therapist
could determine whether a patient would stay in treatment or
would terminate prematurely. It is possible that we are tapping
a stable patient variable, or, perhaps our patients, like Beck-
ham’s, were able to quickly sense that the patient–therapist
relationship would not meet their needs.

Premature termination from psychodynamically oriented
psychotherapy is undoubtedly multifactored, including ther-
apist, patient, and interaction variables. This study focuses only
on one factor, the patient’s willingness to establish a continued
relationship with the therapist. The leads provided by these
findings suggest that additional studies might focus on the abil-
ity of the Rorschach to inform a therapist about those who may
terminate their psychotherapy prematurely, to “allow the ther-
apist time to address the problem and/or adjust the technique”
(Piper et al., 1991, p. 433). Even more important, however, are
studies designed to provide a more in-depth analysis of Ror-
schach relationship variables as they are reflected in the termi-
nating patient’s behavior with the therapist. Our Rorschach
data may help the therapist to understand patients who might
end treatment prematurely and design special approaches to
deal with this problem. In conclusion, we agree with Alpher,
Henry, and Strupp (1990) who indicate that information ob-
tained from patient assessment, specifically projective tech-
niques, provides important and meaningful data to facilitate the
treatment enterprise.

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