**Adjusting Clinical Fee Scales: First Session Intake Fees
Moderating Couple's Total Number of Sessions Attended in
Couple's Therapy**

by

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A thesis submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Master of Science

Auburn, Alabama
December 14, 2019

Keywords: couples, poverty, therapy, intake, fee

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Abstract

Psychotherapy research has acknowledged the importance of examining attrition in therapy. However, researchers consistently neglect to look to the effect of additional fees beyond the every session fee for services on therapy attrition. Addressing this gap in the literature, the current study tested the effect that first session intake fees and income-level have on clients' total number of sessions attended through the lens of Bronfenbrenner's ecological systems model. Drawing upon measures of demographic information, intake fee paid, and total number of sessions attended, this study examined the relationship between income and total number of sessions attended, moderated by intake fee paid for clients attending Auburn University's Marriage and Family Therapy Center training clinic, while controlling for relationship quality, individual symptoms, and adverse childhood experiences at intake. Results indicate that income does not predict total number of sessions attended, and intake fee paid did not moderate the relationship between income and total number of sessions attended. Explanations of findings and future directions are provided.

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Introduction

In 2017, there were 39.7 million people, or 12.3% of the population, living in poverty in the United States (US Census Bureau, 2017). Economic hardship adversely affects individuals, couples, and families due to increased stress and decreased access to resources, resulting in a struggle to afford basic necessities such as food, shelter, clothes, transportation, childcare, and health care. Economic stress also serves as a catalyst for emotional and behavioral problems within families (Conger et al., 1994), increasing risk for unstable relationships (Fein, 2004), poorer relationship quality (Aseltine & Kessler, 1993), and more marital conflict and disruptions in skillful parenting (Conger et al., 1992). Ecosystemic theory suggests that there is competition for the limited resources of a couple and that the limited resources create conflict between micro-system interactions (Bronfenbrenner, 1979).

The multitude of environments within which couples operate (couple, family, friends, school, work, city, state, country, culture, etc.), also known as ecological systems, impact human development, mental health, and relationship functioning (Bronfenbrenner, 1979). The microsystems (i.e., the system , closest to the individual) this study will focus on are couples and therapy services, with a focus on couple's income, as multiple studies have shown that having a lower income is related to attending fewer total sessions in couple's therapy (Edlund et al., 2002; Grimes & McElwain, 2008; Knizley, 2016). Bronfenbrenner details in his Process-Person-Context-Time (PPCT) Model how different ecological systems impact and effect one another and illustrates how the relationships between systems and subsystems occur (Bronfenbrenner &

Morris, 2006). For example, while the couple relationship is part of the microsystem, it is influenced by broader contexts and systems that influence individual and relationship functioning (age, health, income, school, work, family, culture, community support, societal safe-guards, etc.). The mesosystem is the relationship between two converging microsystems. Therapeutic services, another microsystem, have proven to be an effective method for working with couples struggling with relationship quality (Fife & Weeks, 2014). The interaction between the two microsystems of the couple and the therapeutic services is an example of a mesosystemic convergence. How these two systems converge is essential to evaluate the initial interface of the couple and therapy microsystems. However, limited finances can interfere with the mesosystemic convergence impeding couple engagement due to financial worries.

Researchers have found that low-income clients are more likely to discontinue therapy treatment due to obstacles that more affluent couples do not face; like transportation, working multiple jobs or inconvenient hours, and lack of childcare (Davis et al., 2009; Grimes & McElwain, 2008; Mohr et al., 2006; Snowden & Thomas, 2000). Those income-based obstacles to attending therapy illustrate the proximal processes connecting couple income and the cost of therapeutic services in a mesosystemic convergence. Couples attending therapy presenting with financial strain often have higher levels of relational distress, more difficulties in communication, and more disagreements about finances than higher income couples in the same clinic (Aniol & Snyder, 1997). Multiple studies have found that lower income predicts clients attending fewer total sessions (Reis & Brown, 1999, Wierzbicki & Pekarik, 1993). Edlund et al. (2002) found that financial instability may influence couples attending fewer total sessions due to the simple fact that couples did not have sufficient funds to pay the therapy fees. Therefore, one pathway towards couples attending fewer total sessions includes lower income.

Community agencies and training clinics work to provide lower cost services to address the mental and relational disorders that affect client functioning. While community organizations and training clinics offer lower cost services, they also typically have limited funding, and if they do operate for profit, the agencies face pressure for sustainability. Thus, the therapy clinic initial interface with the couple microsystem is focused on a fee arrangement. Fees are necessary for sustainability, and clinics serving those who are financially disadvantaged typically offer a sliding scale of fees based on income and number of family members residing within the home (Aubry et al., 2000; Lien, 1993; Simmons & Doherty, 1995; Yates et al., 2001). This provides poorer couples the opportunity to attend therapy while also allowing the agency to provide sustainable fee structures. While many clinics use sliding scales to determine their fee rate, few clinics have evaluated how implementing a one-time intake fee at first session impacts client retention across therapy (Lien, 1993).

In this study, we will evaluate how income impacts the total number of sessions attended by couples who seek couple's therapy at a marriage and family therapy training clinic offering a sliding fee scale when moderated by the economic stressor of a first session intake fee. The first session intake fee transitioned from a flat $10.00 fee to a variable fee that affected lower income clients more than higher earners.

Review of Literature

Ecological System's Theory

American psychologist, Urie Bronfenbrenner, formulated the Ecological Systems Theory to explain how the inherent qualities of people and their environments interact to influence how they grow and develop (Bronfenbrenner, 1979). Bronfenbrenner's theory emphasizes the importance of studying people in multiple environments, also known as ecological systems, in the attempt to understand their development. According to Bronfenbrenner's Ecological Systems Theory, people typically find themselves enmeshed in various ecological systems, from the most intimate home system to the larger school/work system, and then to the most expansive system which includes society and culture. Each of these ecological systems inevitably interact with and influence each other in all aspects of a person's life. Bronfenbrenner's original ecological model organizes contexts of development into five levels of external influence: The microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (Bronfenbrenner, 1979). These levels are categorized from the most intimate level to the broadest.

The single most important difference from early theory development to later advances in the theory focus on processes of human development (Tudge et al., 2009). In some of the chapters written in the 1980s (Bronfenbrenner, 1988; Bronfenbrenner & Crouter, 1983), Bronfenbrenner referred to ''process'' as that which could explain the connection between some aspect of the context (e.g., culture, social class) or some aspect of the individual (e.g., age, race, gender) and an outcome of interest. It was only in the 1990s, however, that proximal processes

were defined as the key factor in development (Bronfenbrenner, 1994, 1995, 1999; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 1998). It was also from this time onward that he discussed the Process-Person-Context-Time model (PPCT) that has become the essence of his theory (Bronfenbrenner, 2005; Bronfenbrenner & Evans, 2000; Bronfenbrenner & Morris, 2006).

Within the PPCT Model, process refers to the progressively more complex reciprocal interactions between an active, evolving bio-psychological human organism and the persons, objects, and symbols in its immediate external environment (Bronfenbrenner & Morris, 2006). Interactions occurring on a fairly regular basis over extended periods of time in the immediate environment are referred to as proximal processes. The second "P" of the PPCT Model, person, refers to biological and genetic aspects of the person, such as age, gender, skin color, and physical appearance. Context refers to four separate systems: any environment, such as home, school/work, or peer group, in which the developing person spends a good deal of time engaging in activities and interactions (the microsystem); interactions between various aspects of the microsystem (the mesosystem); the larger social system in which the individual does not function directly, such as the neighborhood, local media, or local politics (the exosystem); a context encompassing any group whose members share value or belief systems, such as religion or culture (the macrosystem) (See Figure 1). Time refers to three elements: what is occurring during the course of some specific activity or interaction (micro-time); the extent to which activities and interactions occur with some consistency in the developing person's environment (meso-time); and the specific historical events that are occurring as the developing individuals are at one age or another (macro-time, formerly the chronosystem) (Bronfenbrenner & Morris, 2006).
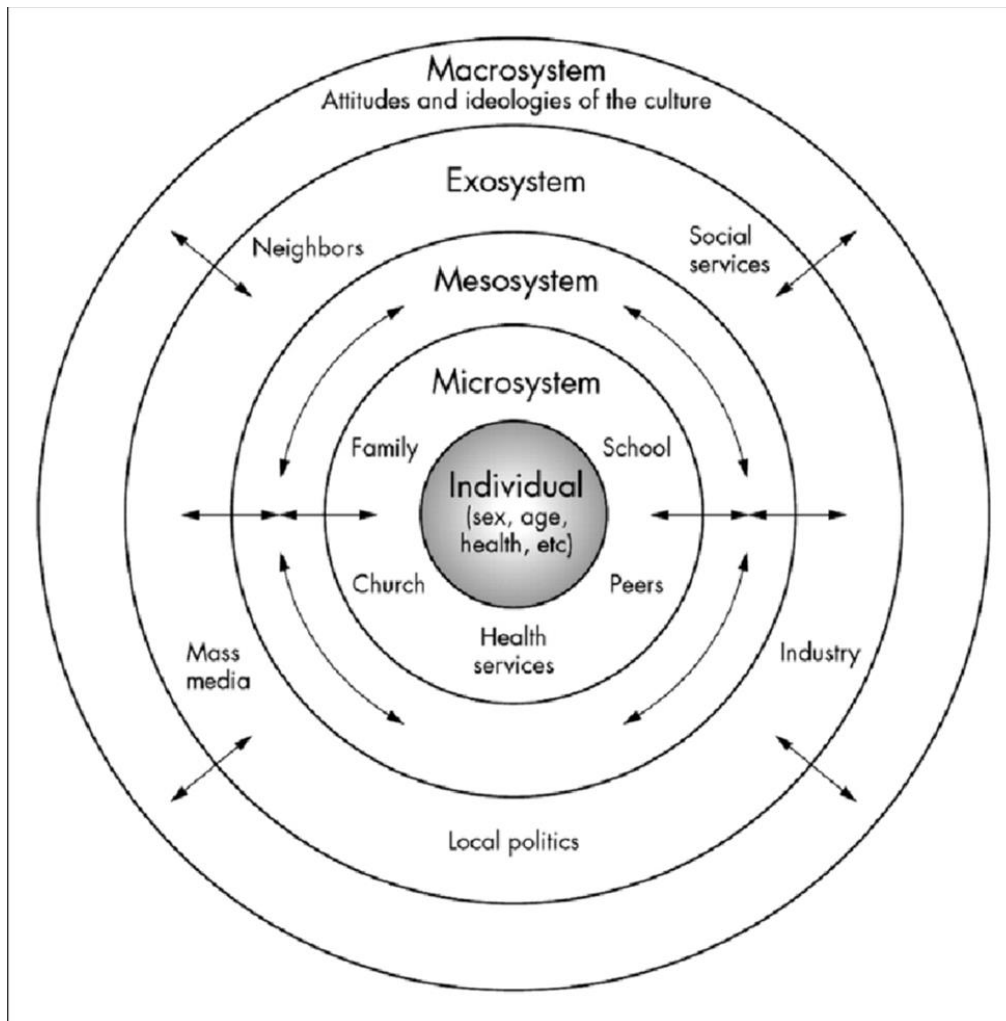
Figure 1. Bronfenbrenner's Ecological Systems Theory Model.

The couple subsystem (e.g., boyfriend/girlfriend, husband/wife) lies within the "context"

of the PPCT model (Bronfenbrenner & Morris, 2006). Within the context principle, the couple

system falls within the microsystem, which is the closest level to the self, and also includes

family, siblings, peers, work, and school (Friedman & Allen, 2011). Couples as a system consist

of two individuals who are dependent on each other; mutual influence describes that individuals

and subsystems within a family both influence and are influenced by each other's thoughts,

feelings, and behaviors (Whitchurch & Constantine, 2009). An ecological perspective offers a

way to simultaneously emphasize both individual and contextual systems and the interdependent relations between these two systems, and thus offers a variety of conceptual and methodological tools for organizing and evaluating health-promoting interventions (Eriksson, Ghazinour, & Hammarstrom, 2018).

Ecosystemic Theory, Poverty, and the Couple Microsystem

Systemic thinking is the foundation of couple and family psychology research and practice (Stanton & Welsh, 2012). Behaviors and actions within subsystems, such as the couple, influence what occurs in other subsystems, such as family and work (Whitchurch & Constantine, 2009). The macrosystem can reach and impact an individual through many pathways, such as through cultural belief systems that are generally quite supportive of marriage, childrearing, and close family relationships (Oropesa & Gorman, 2000). Elements of finance also impact individuals, and therefore couples, through all four context systems. For example, inflation and the economy exist within the macrosystem (Michałowski, 2012), which effects the costs of education and housing on the microsystem (Forrest & Hirayama, 2009), which directly impacts the individual/couple via their income (Blaauboer, 2010), though many partners can and do combine incomes (Kenney, 2004).

A study from the University of California, San Francisco examined barriers for 290 patients for attending psychotherapy. The researchers found that 46.7% of participants reported cost of psychotherapy, 13.5% reported transportation difficulties, and 10.9% reported childcare or caring for sick or disabled loved ones as barriers to attending psychotherapy (Mohr et al., 2006). Cost and lack of insurance are significant barriers to mental health service utilization among low-income groups (Snowden & Thomas, 2000). Transportation, finances, and childcare are also frequently cited barriers, which are also strongly related to income (Davis et al., 2009).

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Despite the need for care, many poor adults and couples do not receive mental health services due to financial barriers. Income-based obstacles to attending therapy illustrate the proximal processes connecting income, couple relationships, and the cost of therapeutic services in a mesosystemic convergence.

Conger et al. (1994) asserts that economic pressure because of insufficient financial resources creates stresses linked to heightened marital conflict. When measuring marital conflict, Conger et al. 1994 used a combined scale for each spouse to form an observer rating of marital conflict, and they found that marital conflict is strongly related to financial conflicts (beta = .48, fathers; beta = .50, mothers). Similarly, in a study of 748 conflict instances reported in the diaries of 100 married couples, money was the sixth most discussed topic reported by husbands, and the fifth most discussed topic reported by wives, occurring in 18.3% and 19.4% of disagreement topics, respectively (Papp et al., 2009). However, compared to non-money issues, marital conflicts about money were more pervasive, problematic, and recurrent, and remained unresolved, despite including more attempts at problem solving. Money-related marital conflicts, relative to those that did not concern money, were described by wives as lasting longer and described by husbands to more likely be a recurrent rather than a new problem. Both husbands and wives rated money conflicts in the home as having higher current and long-term importance to their relationship, relative to conflicts not concerned with money (Papp et al., 2009).

It seems that money and financial stressors are factors that impact relationship quality, but also receive an inordinate amount of attention when making value decisions about goods or services for those in poverty. Conger, Rueter, and Elder (1999) found a relationship between economic pressure (making ends meet, adding or cutting material needs) and marital functioning through marital conflict. They found, even after controlling for the initial level of marital

distress, that economic pressure was significantly related to later marital distress and marital conflict. Poverty appears to accelerate the process of marital instability (Birrell, 2004).

Low-income couple's relationships are often less stable, individuals have lower levels of education and employment, they are more likely to have children before marriage, and get married younger (Fein, 2004). Fein (2004) also found that the difficulty of staying married increases substantially with levels of economic disadvantage. The probability of splitting up in each year after marriage is consistently higher for women with less education than those with more, and for those from less affluent neighborhoods (Fein, 2004). The probability of breaking up within 10 years of marriage is nearly twice as high for women from the bottom quarter (44% break-up) as for those from the top quarter (23% break-up) of neighborhoods ranked by median family income (Fein, 2004).

The irony that marital distress due to economic hardship might lead a couple to needing therapy while at the same time a significant inhibitory factor in seeking services cannot go unnoticed. Couples may be unable to afford services without a sliding fee scale to account for the number of persons in the household living off of that income. Or the stress of the cost of therapy may impact the desire to continue therapy, when faced with intense individual or relational symptoms. This impasse is where income, relationship distress, and the cost of therapeutic fees converge within the mesosystem interface.

Cost of Services

In a study by Shipherd, Green, and Abramovitz (2010), they found that despite 95% of their sample having health insurance, the most commonly endorsed item-level barrier to accessing mental health services was the cost. Cost was the primary barrier reported in the

overall sample, and also in the sub-sample among those who were distressed but not seeking treatment. Gains have been made in making mental health services more attainable, such as with clinics that offer a sliding scale based on income (Lien, 1993). Federally funded projects that focused on enhancing the adult relationships in low-income and culturally diverse families began to emerge in 2002, such as couple relationship/marriage education programs and fatherhood programs (Brotherson & Duncan, 2004). These federally funded programs are able to provide their education courses at no cost to the participants or are sometimes funded to allow for individuals to be paid for their participation, and to provide meals and transportation reimbursement to the participants as well. Multiple studies illustrate marital therapy as providing better results for couples and their families than relational education programs alone (Cowan et al., 2005; Cowan, Cowan, & Barry, 2011; Webster-Stratton, 1994), however clinical services are rarely government funded. Community agencies and training clinics work to provide lower cost services to address mental and relational issues, but fees are necessary to keep clinics running smoothly in the absence of federal funding.

In an effort to study payment and treatment patterns, Crane and Payne (2011) compared marriage and family therapists to other mental health professions and found that patients treated by MFTs had the highest success (86.6%) and lowest recidivism rates (13.4%) compared to the other mental health professions. However, they also found that MFTs were not the most cost-effective mental health provider, which demonstrates the need for MFT clinics to attempt to increase their cost effectiveness without sacrificing their quality of care, that is, if they intend to help the poor. Many MFT clinics utilize a sliding fee scale to attempt to achieve that goal (Aubry et al., 2000; Lien, 1993; Simmons & Doherty, 1995; Yates et al., 2001).

How might a clinic decide to set its own sliding scale; to reduce/eliminate the minimum fee and/or increase the maximum fee given that these changes could affect client attendance or outcomes? McRae (1978) found that mental health center clients were less likely to terminate therapy prematurely when assessed a fee based on ability to pay than when no fee was charged. A study of free therapy provided by the Veterans' Administration (Nash & Cavenar, 1976) found that lack of a fee led to resistance and to depreciation of the value of therapy. Essentially, free therapy is more likely to be associated with perceived lower quality care, and the presence of cost indicates that therapy has both literal and metaphorical value.

Due to the proximal processes connecting income, couple relationships, and the cost of therapeutic services within the mesosystem, sliding fee scales based on income have been utilized by mental health clinics as an attempt to benefit lower income clients (Aubry et al., 2000; Lien, 1993; Simmons & Doherty, 1995; Yates et al., 2001). The practical issue typically considered involves concerns that charging fees would discourage use of the clinics. Researchers at the University of Texas (Yoken & Berman, 1984) examined the role of the fee by comparing a control, non-fee paying group, to a group paying a $10 fee. Despite having identical averages for pre-treatment problem distress, clients in the non-fee paying group had significantly lower problem distress scores after treatment (Yoken & Berman, 1984). The contradictory nature of these fee and fee scale studies indicates that the fees themselves may not be accurate predictors of client outcomes or of total number of sessions attended. Further research, such as this study, should aim to highlight more accurate predictors of client outcomes and of total number of sessions attended while also assessing the role fees play in that relationship. This study hypothesizes that first session intake fees act as a moderator rather than as a predictor of total number of sessions attended.

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Total Number of Sessions Attended

Psychotherapy research has found that low-income clients attend fewer total sessions in therapy than higher-income clients. Reis and Brown (1999) conducted a review summarizing 30 studies of total sessions attended in marriage and family therapy research, finding that low socioeconomic status was a consistent predictor of attending fewer total sessions. Wierzbicki and Pekarik (1993) ran a meta-analysis of 125 studies on therapy total sessions and found a significant effect size for income which showed that lower income clients attended fewer total sessions.

Edlund et al. (2002) found that approximately 10% of patients in both the United States and Ontario dropped out of mental health treatment by the fifth visit, 18% by the tenth visit, and 20% by the twenty-fifth visit. No significant effect of diagnosis on total sessions attended was found and no significant difference between the United States and Ontario in the effect of diagnosis in predicting total sessions attended was found. Insurance was a statistically significant predictor of client drop out, with the lowest total number of sessions attended being among those without insurance. Cost-effective interventions targeting these groups are needed to increase the proportion of patients who complete an adequate course of treatment.

Current Study

Though the above-mentioned studies have linked financial strain with total number of sessions attended in therapy, even with use of a sliding fee scale, little research has examined the role of a first session fee being charged in addition to a client's regular session fee. It is expected that the cost of therapy would be directly related to the completion of therapy, particularly as

costs that create a barrier to therapy (transportation, child care, and basic needs) would be expected to be related to other key treatment factors, such as the length of treatment.

A previous study by Laura Knizley (2016) hypothesized that clients paying a higher percentage of their income in fees would predict decreased total number of sessions attended, increased relationship distress, increased individual distress, and more adverse childhood experiences in couple's therapy clients. In analyzing the use of a sliding scale for fee payment, Knizley (2016) found that the percentage of client's income paid in therapy fees is not only unequal, but is related to fewer therapy sessions for those who are paying a larger percentage of their income than those who are paying a lower percentage of their income using the same sliding scale.

In particular, the study illustrated that those living below the poverty threshold were paying significantly higher fee percentages, and subsequently were dropping out of therapy prior to their second session. Knizley's 2016 study and the current study will utilize the same marriage and family therapy training clinic at Auburn University. Knizley's study focused on services from 2006-2011. However, starting in 2012, a flat first session $10 intake fee was imposed to increase revenue. Under pressure to increase its profit margins, the clinic changed the fee structure from a flat rate fee of $10.00 to varying additive fee that required each client to pay $50.00 at intake for all clients in 2014-2015, which for $10 clients was a 400% increase in costs for a first session despite being the least able to make up the difference. Both the flat intake fee and the additive intake fee were applied to clients, regardless of income. Given the additional intake fee, plus outside stressors to meet their financial obligations, this study questions whether the first session intake fee change from a flat $10 fee to a variable fee that required all clients to pay $50 for the first session would result in attending fewer total sessions between fee groups.

This study, intending to continue Knizley's research efforts, examined the first session intake fees, and also evaluated whether a change in fees impacted the total number of sessions attended comparing 2012-13 with 2014-15 data.

For all years within this study, 2012-2015, the maximum amount charged for a single session was $50. During 2012-2013, clients were charged an additional $10 intake fee on top of their regular session fee determined by the income-based sliding fee scale. This meant that $10 clients were charged an additional $10 at intake for a total of $20, $30 clients were charged an additional $10 for a total of $40, and $50 clients did not have an additional fee to pay at intake. Clients during 2014-2015 had their first session intake fee increased by varying amounts to reach the $50 maximum charge. This meant that $10 clients were charged an additional $40 at intake for a total of $50, $30 clients were charged an additional $20 for a total of $50, and $50 clients did not have an additional fee to pay. In this way, the "fee" at intake was $50 for all clients regardless of the sliding scale. Clients in the highest income bracket did not pay an intake fee in either grouping from 2012-2015, while clients in the lowest income bracket paid the largest fees relative to their session rate throughout 2012-2015.

The present study seeks to examine client factors affecting total number of sessions attended in couple's therapy by examining the relationship between income, first session intake fee, and total number of sessions attended.

Research Questions. Based on this review of the literature, the following questions were developed:

Question 1. Does income predict total number of sessions attended in couple's therapy?

Question 2. Does a flat $10 first session intake fee moderate the relationship between income and total number of sessions attended?

Question 3. Does a varying first session intake fee, additive to $50, moderate the relationship between income and total number of sessions attended?

Question 4. Is there a difference between those who paid an additional $10 intake fee and those who paid a total first session fee of $50 and their resulting total number of sessions attended?

Methods

Data was collected from the Auburn University Marriage and Family Therapy Center (AUMFTC) on the campus of Auburn University in Auburn, Alabama. Auburn University is an accredited program by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), providing services to individuals, couples, and families living in the Auburn-Opelika area of East Alabama. The sample from 2012-2013 will be referred to as Flat Fee Group (FFG), and the sample from 2014-2015 will be referred to as the Variable Fee Group (VFG).

Participants

The participants consisted of married and non-married couples in heterosexual relationships who attended therapy at the Auburn University Marriage and Family Therapy Center (AUMFTC). These couples attended therapy from 2012 to 2015 for a variety of reasons related to relationship counseling. Three primary categories of treatment are communication problems, affairs, and mental health diagnoses. One hundred and forty-three couples began therapy at AUMFTC during the sampling period (see Table 1-2). Within couples, some partners attended more sessions than the other partner, so total number of sessions attended reflects the highest number of sessions attended across both partners. In the FFG, 37 couples attending couples therapy completed at least four sessions of therapy (52.9%). For the remaining couples, 18 attended only one session (25.7%), and 15 couples attended more than one but less than four sessions (21.4%). In the VFG, 39 individuals attending couples therapy completed at least four

sessions of therapy (53.4%). For the remaining couples, 11 attended only one session (15.1%), and 23 couples attended more than one but less than four sessions (31.5%).

Participants reported their race, income, and education level. In the FFG, 69.6% of males and 78.9% of females reported their race as White, 21.7% of males and 16.9% of females were African American, 1.4% of males and 4.2% of females were Hispanic, 5.8% of males indicated "other" race, and 1.4% of males provided no answer. In The VFG, 72.6% of males and 72.6% of females reported their race as White, 19.2% of males and 17.8% of females were African American, 1.4% of males and 6.8% of females were Hispanic, 1.4% of males were Asian, 1.4% of males indicated "other" race, and 4.1% of males and 2.7% of females provided no answer.

The reported annual household income for the FFG and the VFG ranged from below $5,000 to over $40,000, with a median income of over $40,000. In Group 1, 19 males (27.5%) and 13 females (18.3%) reported graduating from high school, and 17 males (24.6%) and 19 females (26.8%) reported receiving bachelor's degrees; 1 male (1.4%) and 2 females (2.8%) did not complete high school. In Group 2, 27 males (37%) and 11 females (15%) reported graduating from high school, and 15 males (20.5%) and 19 females (26%) reported receiving bachelor's degrees; 4 males (5.5%) and 2 females (2.7%) did not complete high school.

Procedure

Quantitative data was collected from case files for couples who attended couples' therapy at AUMFTC between January 2012 and December 2015. Before the first session of treatment, all clients received the same intake packet containing self-reported measures including the Demographic Questions and the Revised Dyadic Adjustment Scale (RDAS; Spanier, 1976). The questionnaires were paper-and-pen, administered by intern therapists or center staff for

clinical assessment purposes, further research, and administrative records. Master's level intern therapists treated the clients, with most sessions occurring weekly.

Measures

Demographic questions. The intake packet for all clients coming to the AUMFTC for therapy included basic demographic questions that were used in the analysis. These include questions of gender, race, employment, income, family-of-origin, current family size, and reasons for attending therapy. For the purpose of this study, the income question is of interest. For income, clients indicated a range of earning from "Under $5,000" to "Over $40,000" (with a range of $5,000 between each level) combined income with their partner as well as their past 3 pay stubs or previous year's tax return to qualify for our sliding scale, which ranges from "Under $5,000" to "Over $40,000". This study will use the median of each range of each income grouping to determine fee score, resulting in a difference of $5000 between groups.

Total number of sessions attended. Total sessions were examined by the number of sessions attended. The number of sessions attended was determined based on the client file case notes and billing sheet, where therapists recorded each session completed. The number of sessions attended in this study ranged from 1 to 29 (FFG, $M = 5$, SD = 4.91; VFG, $M = 5.44$, SD = 5.35).

First session fee. The current study evaluates first, if the first session intake fee impacted client retention measured by total number of sessions attended. Second, the current study evaluates the total number of sessions attended during the years 2012-13, in which all clients paid a flat $10.00 intake fee, compared to the total number of sessions attended for those

receiving therapy services in 2014-15, in which all clients paid a variable fee that required all clients to pay a total of $50.00 no matter their income group.

Control Variables

Relationship quality as measured by The Revised Dyadic Adjustment Scale (RDAS; Busby et al., 1995), individual symptoms as measured by the Outcome Questionnaire (OQ-45.2; Lambert et al., 1996), and adverse childhood experiences as measured by the Adverse Childhood Experiences Scale (ACES; Felitti et al., 1998) acted as the control variables in this study. The variables were chosen as control variables due to previous findings that they were related to income (Knizley, 2016; Liu & Chen, 2006).

Exclusion Criteria

This study excludes couples who were research study participants (FFG, n=12, or 8.9%), students (FFG, n= 52, or 38.5%, VFG, n=32, or 29.4%) and who were in the military (FFG n=1, or 0.7%, VFG, n=4, or 3.7%). These couples were excluded because research study participants were non-paying clients, student clients had their sessions capped at $10.00, and military clients were non-paying clients.

Results

The purpose of this study was to examine whether a first session intake fee in addition to a client's regular session fee moderates the total number of sessions attended by clients in couple's therapy. Descriptive statistics were examined to understand sample characteristics and distributions. Three models were fit in SPSS (version 24; IBM Corp, 2016) to answer the research questions. Model 1 represents the FFG, Model 2 represents the VFG, and Model 3 represents the FFG and the VFG combined into a full model. These models were conducted using hierarchical linear regression; in step one the control variables were added, in step two the main effects were added, and in step three the interaction variable was added. All results can be found in tables 8-10 of the appendix, but in text for research question one the second step main effects are reported, and thereafter the findings reported are from the third step that indicates the interaction. Missing data was handled using listwise deletion, which is the default for SPSS.

Descriptive Statistics

Descriptive statistics for each of the models were examined (see Tables 5-7). The average total number of sessions attended for all three models were approximately 5 total sessions (M1: $M = 4.93$, SD $= 4.92$; M2: $M = 5.54$, SD $= 5.44$; M3: $M = 5.26$, SD $= 5.19$). The average income bracket across all three models is the \$30,001-\$35,000 income bracket (M1: $M = 7.72$, SD $= 1.94$; M2: $M = 7.38$, SD $= 2.23$; M3: $M = 7.53$, SD $= 2.10$). The average first session intake fee for Model 1 was \$7, for Model 2 was \$10.22, and for Model 3 was \$8.72, as \$0 fees were also factored into the average.

All three models showed clinically significant relationship distress, with average scores below the RDAS cutoff of 47.31 (M1: $M = 30.73$, SD = 5.07; M2: $M = 31.04$, SD = 3.72; M3: $M = 30.90$, SD = 4.39). In all three models the average OQ score for males were below the clinically significant indicator of 63 for symptom distress related to anxiety and depression, though the average male scores were barely below that cutoff score (M1: $M = 62.72$, SD = 19.09; M2: $M = 60.62$, SD = 23.03; M3: $M = 61.60$, SD = 21.23). The average OQ score for females were all above the clinically significant indicator (M1: $M = 70.53$, SD = 19.05; M2: $M = 64.90$, SD = 22.94; M3: $M = 67.52$, SD = 21.32). The average ACES score across all three models, for both males and females, was approximately 2 (M1: male $M = 2.02$, SD = 1.69; MI female $M = 2.27$, SD = 1.81; M2: male $M = 2.10$, SD = 1.68; M2 female $M = 2.30$, SD = 2.07; M3 male $M = 2.06$, SD = 1.68; M3: female $M = 2.29$, SD = 1.95).

Research Question 1: *Does income predict total number of sessions attended in couple's therapy?*

Based on regression analysis, there are no significant relationships between income and couple's total number of sessions attended in couple's therapy (M1: $b_{income} = -0.02$; $t(60) = -0.05$, $p = 0.958$; 95% CI [-0.79, 0.75]; $R^2 = 0.04$)(M2: $b_{income} = -0.21$; $t(69) = -0.55$, $p = 0.585$; 95% CI [-0.97, 0.55]; $R^2 = 0.32$) (M3: $b_{income} = -0.08$; $t(129) = -0.29$, $p = 0.772$; 95% CI [-0.61, 0.45]; $R^2 = 0.11$). For all of the models, the descriptive statistics are listed in Tables 5-7 of the appendix, and the model fit and test statistics are listed in Tables 8-10 of the appendix.

Research Question 2: *Does a flat $10 first session intake fee moderate the relationship between income and total number of sessions attended?*
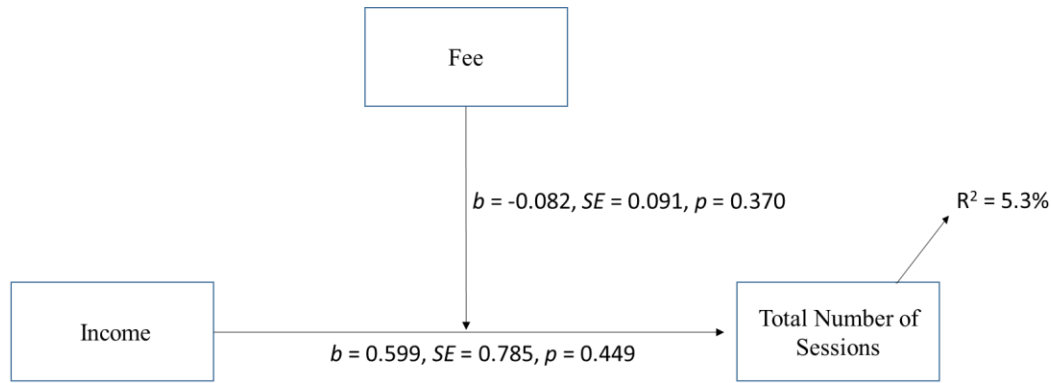
Figure 2. Model 1 (2012-2013). Note. $* = p < 0.05$. $** = p < 0.01$. $*** = p < 0.001$. Model includes control variables: RDAS ($b = 0.084$, $SE = 0.139$, $p = 0.550$), Male OQ ($b = -0.018$, $SE = 0.038$, $p = 0.636$), Female OQ ($b = -0.011$, $SE = 0.037$, $p = 0.760$), Male ACES ($b = -0.185$, $SE = 0.434$, $p = 0.672$), and Female ACES ($b = -0.251$, $SE = 0.401$, $p = 0.534$).

Based on regression analysis, Model 1 shows that the intake fee during 2012-2013 did not moderate the relationship between income and total number of sessions attended, $b_{income*fee} = -0.08$; $t(60) = -0.90$, $p = 0.370$; 95% CI [-0.27, 0.10]; $R^2 = 0.05$. The variables entered accounted for 5.3% of the variance in total number of sessions attended. For Model 1, the descriptive statistics are listed in Table 5 of the appendix, and the model fit and test statistics are listed in Table 8 of the appendix. There is no model fit due to the model being fully saturated without degrees of freedom, $\chi^2 = 0.00$, $df = 0$, RMSEA $= 0.00$, CFI $= 1.00$.

The following variables were not related to total number of sessions attended: $b_{fee} = 0.81$; $t(60) = 1.06$, $p = 0.295$; 95% CI [-0.72, 2.33]; $b_{RDAS} = 0.08$; $t(60) = 0.60$, $p = 0.550$; 95% CI [-0.20, 0.36]; $b_{maleOQ} = -0.02$; $t(60) = -0.48$, $p = 0.636$; 95% CI [-0.09, 0.06]; $b_{femaleOQ} = -0.01$; $t(60) = -0.31$, $p = 0.760$; 95% CI [-0.09, 0.06]; $b_{maleACES} = -0.19$; $t(60) = -0.43$, $p = 0.672$; 95% CI [-1.06, 0.69]; $b_{femaleACES} = -0.25$; $t(60) = -0.63$, $p = 0.534$; 95% CI [-1.06, 0.55]. R^2 for the model was 0.05.

Research Question 3: *Does a varying first session intake fee, additive to $50, moderate the relationship between income and total number of sessions attended?*
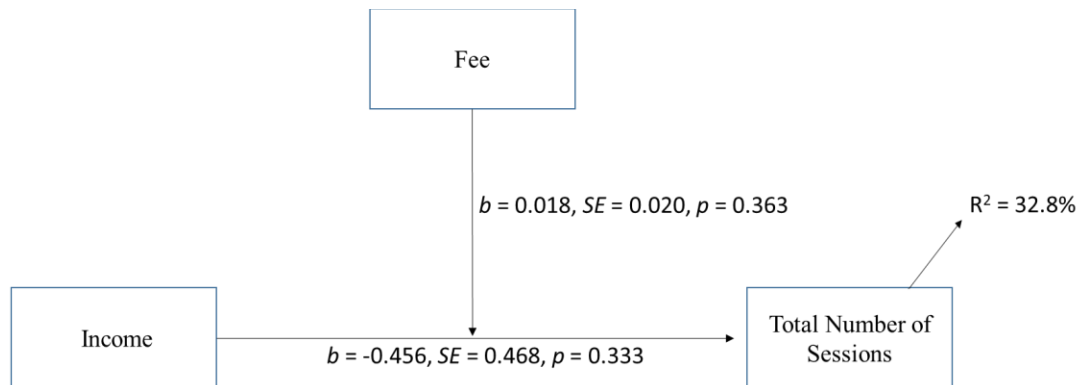
Figure 3. Model 2 (2014-2015). Note. $* = p < 0.05.$ $** = p < 0.01.$ $*** = p < 0.001.$ Model includes control variables: RDAS ($b = 0.229$, $SE = 0.166$, $p = 0.173$), Male OQ ($b = 0.108$, $SE = 0.026$, $p = 0.000***$), Female OQ ($b = 0.073$, $SE = 0.028$, $p = 0.012*$), Male ACES ($b = -0.027$, $SE = 0.384$, $p = 0.944$), and Female ACES ($b = -0.174$, $SE = 0.310$, $p = 0.576$).

Based on regression analysis, Model 2 shows that the intake fee during 2014-2015 did not moderate the relationship between income and total number of sessions attended, $b_{income*fee} = 0.02$; $t(69) = 0.92$, $p = 0.363$; 95% CI [-0.02, 0.06]; $R^2 = 0.33$. The variables entered accounted for 32.8% of the variance in total number of sessions attended. For Model 2, the descriptive statistics are listed in Table 6 of the appendix, and the model fit and test statistics are listed in Table 9 of the appendix. There is no model fit due to the model being fully saturated without degrees of freedom, $\chi2 = 0.00$, $df = 0$, RMSEA $= 0.00$, CFI $= 1.00$.

The following variables were not related to total number of sessions attended: $b_{fee} = -0.19$; $t(69) = -1.47$, $p = 0.146$; 95% CI [-0.45, 0.07]; $b_{RDAS} = 0.23$; $t(69) = 1.38$, $p = 0.173$; 95% CI [-0.10, 0.56]; $b_{maleACES} = -0.03$; $t(69) = -0.07$, $p = 0.944$; 95% CI [-0.80, 0.74]; $b_{femaleACES} = -0.17$; $t(69) = -0.56$, $p = 0.576$; 95% CI [-0.79, 0.45]. R^2 for the model was 0.33.

However, the following variables were found to be related to total number of sessions attended: $b_{maleOQ} = 0.11$; $t(69) = 4.11$, $p = 0.000$; 95% CI [0.06, 0.16]; $b_{femaleOQ} = 0.07$; $t(69) = 2.60$, $p = 0.012$; 95% CI [0.02, 0.13]. The large increase in R^2 from Model 1 to Model 2 may be

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accounted for by the significant association between male and female OQ scores and total

number of sessions attended, which was not present in model 1.

Research Question 4: *Is there a difference between those who paid an additional $10 intake fee*

and those who paid a total first session fee of $50 and total number of sessions attended?
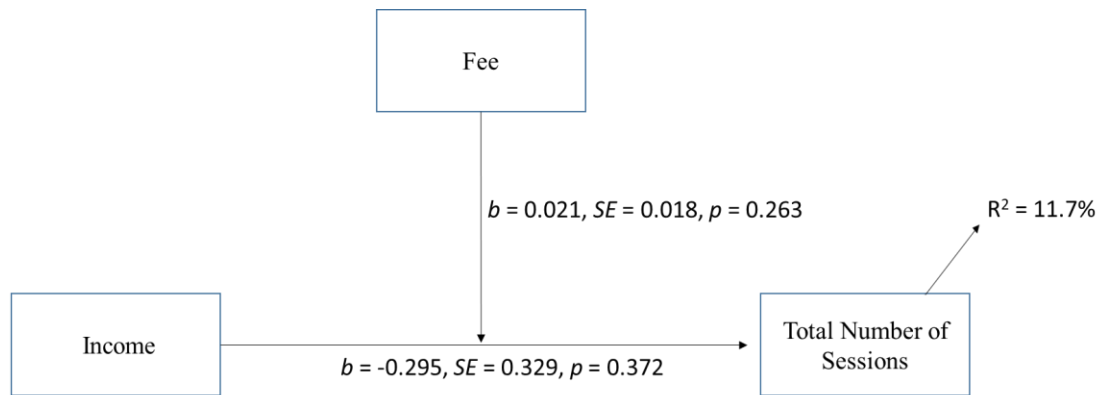
Figure 4. Model 3 (2012-2015). Note. $* = p < 0.05$. $** = p < 0.01$. $*** = p < 0.001$. Model includes control variables: RDAS ($b = 0.181$, $SE = 0.106$, $p = 0.088$), Male OQ ($b = 0.065$, $SE = 0.022$, $p = 0.004**$), Female OQ ($b = 0.035$, $SE = 0.023$, $p = 0.127$), Male ACES ($b = -0.106$, $SE = 0.279$, $p = 0.706$), and Female ACES ($b = -0.057$, $SE = 0.245$, $p = 0.817$).

Based on regression analysis, Model 3 shows that the intake fee during 2012-2015 did

not moderate the relationship between income and total number of sessions attended, $b_{income*fee} =$

0.02; $t(129) = 1.13$, $p = 0.263$; 95% CI [-0.02, 0.06]; $R^2 = 0.12$. The variables entered accounted

for 11.7% of the variance in total number of sessions attended. Model 3 was the only model that

compared the FFG and the VFG by introducing a group variable to the regression analysis.

Based on regression analysis, Model 3 shows that there are no significant differences between

the FFG and the VFG regarding their ability to predict total number of sessions attended, $b_{group} =$

1.32; $t(129) = 1.38$, $p = 0.170$; 95% CI [-0.57, 3.22]; $R^2 = 0.12$. For Model 3, the descriptive

statistics are listed in Table 7 of the appendix, and the model fit and test statistics are listed in

Table 10 of the appendix. There is no model fit due to the model being fully saturated without

degrees of freedom, $\chi2 = 0.00$, $df = 0$, RMSEA $= 0.00$, CFI $= 1.00$.

The following variables were not related to total number of sessions attended: b_{fee} = -0.16; $t(129)$ = -1.40, p = 0.165; 95% CI [-0.39, 0.07]; b_{RDAS} = 0.18; $t(129)$ = 1.72, p = 0.088; 95% CI [-0.03, 0.39]; $b_{femaleOQ}$ = 0.04; $t(129)$ = 1.54, p = 0.127; 95% CI [-0.01, 0.08]; $b_{maleACES}$ = -0.11; $t(129)$ = -0.38, p = 0.706; 95% CI [-0.66, 0.45]; $b_{femaleACES}$ = -0.06; $t(129)$ = -0.23, p = 0.817; 95% CI [-0.54, 0.43]. R^2 for the model was 0.12.

However, the following variable was found to be related to total number of sessions attended: b_{maleOQ} = 0.07; $t(129)$ = 2.97, p = 0.004; 95% CI [0.02, 0.11]. Having combined Model 1 and Model 2, male OQ scores remained statistically significant in predicting total number of sessions attended, but the probability of female OQ scores predicting total number of sessions attended became no longer significant.

Discussion

This study was initiated to examine the impact of first session intake fees to better understand the impact on attrition. Particularly, the study sought to understand whether low-income clients would be effected more greatly and therefore attend fewer total sessions in couple's therapy. Past research has shown lower income to predict fewer total sessions attended (Davis et al., 2009; Edlund et al., 2002; Mohr et al., 2006; Reis & Brown, 1999; Shipherd, Green, & Abramovitz, 2010; Snowden & Thomas, 2000; Wierzbicki and Pekarik, 1993). Additionally, previous research by Laura Knizely (2016), using data from the same MFT training clinic used in this study, found that fee as a percentage of the client's income was significantly related to total sessions attended. Though this study did not examine the fee percentage variable as Knizley (2016) did, the variable was calculated using client's income and fees paid which were variables of focus in this study. Knizley's (2016) study used data collected from 2006-2011, and therefore this study expected income and fees to have a relationship with total sessions attended through 2012-2015 as well. Given that the results of the current study found neither a relationship between income and total sessions attended, nor a relationship between intake fees and total sessions attended, it is important to discuss other factors that may have influenced how many total sessions couples attended in therapy for 2012-2015.

In the current study, the only variable found to be predictive of total number of sessions attended was OQ scores. The OQ 45.2 (Lambert et al., 1996) is a 45-item measure including three subscales: Symptom Distress (anxiety and depression), Interpersonal Relations (peers,

family, sex life), and Social Role (dissatisfaction at work/school or in leisure activities). Responses to each question are on a 5-point Likert-type scale that ranges from 0-4, with 0 indicating lower symptom distress and 4 indicating higher symptom distress. Scores above 63 indicate clinically significant distress (Beckstead et al., 2003). The OQ measure studying individual symptoms was more predictive than the relationship distress scores, despite the the sample consisting of couples attending couple's therapy. This paradox may indicate that further research will require examining what the thereaputic goals were in therapy; whether the therapy focused more on the couple relationship or individual symptoms, and whether that focus matched what the couple intended to be focusing on in therapy. It is possible that the therapist's ability to respect and address client's stated goals is predictive of client attrition.

Similary, the therapeutic alliance between therapist and client may also be predictive of client attrition (Stanton, 2012). MFT's do not only have to maintain an alliance with an individual client, but there may be varying opinions of the alliance by different people in the social unit in treatment (e.g., partners, parents, children, siblings, etc.). The assessment by women in couples therapy of their partners' therapeutic alliance with the therapist constitutes a separate outcome factor beyond their own relationship with the therapist (Knobloch-Fedders, Pinsof, & Mann, 2007). Individual low-quality family functioning in one's family of origin and the level of current interpersonal distress between partners or family members in therapy also predict the type of treatment alliance (Knobloch-Fedders, Pinsof, & Mann, 2004). Since this study found a relationship between individual distress and total sessions attended, the research by Knobloch-Fedders, Pinsof, & Mann (2004) suggests that therapeutic alliance may also predict or moderate the relationship with total sessions attended.

Another factor that was not examined in the current study is the effects of clients beliefs and stigmas related to attending therapy. Edlund et al. (2002) found that a large proportion of their respondents believed that mental health treatments are not effective. Patients who held such a belief were significantly more likely to drop out of treatment. These findings suggest that therapists should spend additional time and effort to educate their patients concerning the effectiveness of mental health treatments. In a study of mental health advocacy group members, researchers observed that receiving such education about the effectiveness of mental health treatments from providers was critically important in facilitating patients' acceptance of their treatments. Respondents who reported feeling uncomfortable in mental health care were substantially more likely to drop out than patients who reported being comfortable (Wang et al., 2000).

Limitations

Though clients in the current study were aware they were attending a clinic to receive therapy from a therapist in training, it may make clients more likely to become nervous or uncomfortable due to the presence of two-way mirrors, cameras, video and audio recordings, and the explanation of supervision. These elements of a training clinic may lead to higher attrition rates (Ward & McCollum, 2005).

Another possible limitation of this study is that the demographic questions, OQ, RDAS, and ACES are all self-report measures and therefore run the risk of additional error. Within the demographic questions, the income variable was limited by the nature of the measure itself. For income, clients indicated a range of earning from "Under $5,000" to "Over $40,000", with a range of $5,000 between each level. Due to the reported income being a multiple-choice range, with the highest report being $40,000+, there is the possibility that using exact figures could

have been provided and would have resulted in more accurate study results. As it stands, clients earning $40,000 and clients earning $80,000 are lumped into the same income category.

Clinical Implications

To address the possible issue of clients' goals not matching therapist's direction in therapy, it may be helpful for the therapist to collaborate with the client(s) when establishing a treatment plan. A therapist may write a treatment plan with the client present, or write the treatment plan and allow the client to make edits with the therapist at the next therapy session. By doing so, therapists may increase the likelihood of clients feeling like their needs are being met, that their money is being put to good use, and that they have been heard and understood, which would also serve to improve the therapeutic alliance (Norcross & Lambert, 2019).

Another way to increase therapeutic alliance is by having culturally sensitive therapists. If clients do not feel heard, understood, or like they have an adequate join with the therapist due to differing races or cultures, clients may be more likely to drop out of therapy (Norcross & Wampold, 2019). At predominantly white institutions, such as many university campuses, it is important for therapists to recognize that clients of a minority status may feel uncomfortable and on-guard before they even walk through the front doors of the therapy clinic, and minority clients might expect to not be fully understood by their White therapist (Grier-Reed & Ajayi, 2019; Patterson, 2019).

It is important for therapists to talk explicitly with clients about factors that make it harder for them to attend therapy sessions. One way to impact the processes that occur within the mesosystem, such as the processes between the couple and the therapy clinic, may be to address them directly and increase communication so that clients, who are overwhelmed already with

symptoms and stressors and with therapy fees on top of all of that, have their needs met and

continue coming to therapy sessions.

Conclusion

This study found that couple income did not predict total number of sessions attended by couples in couple's therapy. This study also found that first session intake fees, in both the FFG and the VFG, did not moderate the relationship between income and total number of sessions attended. However, this study did find that OQ scores were predictive of couple's total number of sessions attended. Further research should examine the effects of OQ on attrition, and to see if the effect is maintained across individual, couple, and family therapy samples.

An important clinical implication of this research study is the evaluation of additional factors impacting client retention and attrition, which may include but is not limited to application of the sliding-scale fees, fee structures that have continued to change since 2015, client and therapist congruency regarding treatment focus, therapeutic alliance, client's biases and education regarding the effectiveness of mental health treatment, and client's comfortability with training clinics and therapists in training. These factors may require future researchers to look at subsystems beyond those within the microsystem, and to examine subsystems within the exosystem and macrosystem as well. This study also illustrates the need for research measures to become more precise, such as when asking for income on a measure of demographic questions. More precise measures will help future psychotherapy research to continue examining the impact of barriers on low-income clients, and the factors leading to attrition in therapy, as reducing attrition is an important clinical application for the psychotherapy field (Egan, 2005).

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Table 1. *Demographic Information 2012-2013*

	Male	**Female**
Gender	69 (49.3)	71 (50.7%)
Race		
White	48 (69.6%)	56 (78.9%)
African-American	15 (21.7%)	12 (16.9%)
Hispanic	1 (1.4%)	3 (4.2%)
Asian	0	0
Other	4 (5.8%)	0
NA	1 (1.4%)	0
Education		
Elementary	0	1 (1.4%)
Middle	1 (1.4%)	1 (1.4%)
High School	19 (27.5%)	13 (18.3%)
GED	4 (5.8%)	1 (1.4%)
Some College	5 (7.2%)	11 (15.5%)
Vocational	4 (5.8%)	4 (5.6%)
Associates	7 (10.1%)	10 (14.1%)
Bachelors	17 (24.6%)	19 (26.8%)
Masters	8 (11.6%)	7 (9.9%)
Doctorate	3 (4.3%)	4 (5.6%)
NA	1 (1.4%)	0
Length of Treatment		
Completed 4+ Sessions	33 (47.8%)	37 (52.1%)
Completed 2 or 3 Sessions	18 (26.1%)	16 (22.5%)
Completed 1 Session	18 (26.1%)	18 (25.4%)

Table 2. *Demographic Information 2014-2015*

	Male	**Female**
Gender	73 (50%)	73 (50%)
Race		
White	53 (72.6%)	53 (72.6%)
African-American	14 (19.2%)	13 (17.8%)
Hispanic	1 (1.4%)	5 (6.8%)
Asian	1 (1.4%)	0
Other	1 (1.4%)	0
NA	3 (4.1%)	2 (2.7%)
Education		
Elementary	1 (1.4%)	1 (1.4%)
Middle	1 (1.4%)	0
High School	27 (37%)	11 (15%)
GED	2 (2.7%)	1 (1.4%)
Some College	4 (5.5%)	3 (4.1%)
Vocational	5 (6.8%)	7 (9.6%)
Associates	7 (9.6%)	11 (15%)
Bachelors	15 (20.5%)	19 (26%)
Masters	4 (5.5%)	12 (16.4%)
Doctorate	7 (9.6%)	7 (9.6%)
NA	0	1 (1.4%)
Length of Treatment		
Completed 4+ Sessions	38 (52.1%)	37 (50.7%)
Completed 2 or 3 Sessions	24 (32.9%)	24 (32.9%)
Completed 1 Session	11 (15%)	12 (16.4%)

Table 3. *Demographic Information 2012-2013*

	Couples
Average Household Income	
Under $5,000	0
$5,001-10,000	0
$10,001-15,000	2 (2.9%)
$15,001-20,000	7 (10%)
$20,001-25,000	2 (2.9%)
$25,001-30,000	3 (4.3%)
$30,001-35,000	1 (1.4%)
$35,001-40,000	13 (18.6%)
Over $40,000	42 (60%)
Family Size	
2 members (couple only)	25 (35.7%)
3 members	15 (21.4%)
4 members	19 (27.1%)
5 members	10 (14.3%)
6 members	1 (1.4%)

Table 4. *Demographic Information 2014-2015*

	Couples
Average Household Income	
Under $5,000	1 (1.4%)
$5,001-10,000	1 (1.4%)
$10,001-15,000	2 (2.7%)
$15,001-20,000	7 (9.6%)
$20,001-25,000	8 (11%)
$25,001-30,000	1 (1.4%)
$30,001-35,000	5 (6.8%)
$35,001-40,000	7 (9.6%)
Over $40,000	41 (56.1%)
Family Size	
2 members (couple only)	32 (43.8%)
3 members	17 (23.3%)
4 members	16 (21.9%)
5 members	4 (5.5%)
6 members	4 (5.5%)

Table 5. *Descriptive Statistics*

	Model 1			
	N	*M*	Range	SD
Total Sessions	60	4.93	28	4.92
Income	60	7.72	6	1.94
Fee	60	7.00	10	4.62
RDAS	60	30.73	30	5.07
Male OQ	60	62.72	82	19.09
Female OQ	60	70.53	94	19.05
Male ACES	60	2.02	6	1.69
Female ACES	60	2.27	7	1.81

Table 6. *Descriptive Statistics*

	Model 2			
	N	*M*	Range	SD
Total Sessions	69	5.54	27	5.44
Income	69	7.38	8	2.23
Fee	69	10.22	40	14.84
RDAS	69	31.04	17	3.72
Male OQ	69	60.62	113	23.03
Female OQ	69	64.90	128	22.94
Male ACES	69	2.10	6	1.68
Female ACES	69	2.30	8	2.07

Table 7. *Descriptive Statistics*

	Model 3			
	N	*M*	Range	SD
Total Sessions	129	5.26	28	5.19
Income	129	7.53	8	2.10
Fee	129	8.72	40	11.38
RDAS	129	30.90	30	4.39
Male OQ	129	61.60	113	21.23
Female OQ	129	67.52	128	21.32
Male ACES	129	2.06	6	1.68
Female ACES	129	2.29	8	1.95

Table 8. Model 1 Fit and Test Statistics

	N	b (se)	LL	UL	t b	R²	ΔR²
			95% CI for b				
Controls:							
RDAS	60	0.10(.14)	-0.18	0.37	0.71	0.02	
Male OQ	60	-0.01(.04)	-0.08	0.07	-0.20		
Female OQ	60	-0.02(.04)	-0.09	0.06	-0.46		
Male ACES	60	-0.13(.40)	-0.94	0.68	-0.32		
Female ACES	60	-0.12(.37)	-0.87	0.63	-0.32		
Main Effects:							
Income	60	-0.02(.38)	-0.79	0.75	-0.05	0.04	0.02
Fee	60	0.13(.16)	-0.18	0.45	0.85		
RDAS	60	0.09(.14)	-0.19	0.37	0.63		
Male OQ	60	-0.01(.04)	-0.08	0.06	-0.29		
Female OQ	60	-0.02(.04)	-0.09	0.06	-0.41		
Male ACES	60	-0.12(.43)	-0.98	0.74	-0.28		
Female ACES	60	-0.22(.40)	-1.02	0.58	-0.55		
Interaction:							
Income	60	0.60(.79)	-0.98	2.18	0.76	0.05	0.01
Fee	60	0.81(.76)	-0.72	2.33	1.06		
Income*Fee	60	-0.08(.09)	-0.27	0.10	-0.90		
RDAS	60	0.08(.14)	-0.20	0.36	0.60		
Male OQ	60	-0.02(.04)	-0.09	0.06	-0.48		
Female OQ	60	-0.01(.04)	-0.09	0.06	-0.31		
Male ACES	60	-0.19(.43)	-1.06	0.69	-0.43		
Female ACES	60	-0.25(.40)	-1.06	0.55	-0.63		

Note: LL = lower limit of the confidence limits. UL = Upper limit of the confidence limits. Income*Fee = Interaction term as moderator. $* = p < .05$. $** = p < .01$. $*** = p < .001$.

Table 9. Model 2 Fit and Test Statistics

	N	b (se)	LL	UL	t_{b}	R^2	ΔR^2
			95% CI for b				
Controls:							
RDAS	69	0.27(.17)	-0.06	0.60	1.62	0.29	
Male OQ	69	0.11(.03)	0.06	0.17	4.31***		
Female OQ	69	0.07(.03)	0.01	0.12	2.36*		
Male ACES	69	-0.26(.36)	-0.97	0.46	-0.71		
Female ACES	69	-0.21(.31)	-0.82	0.41	-0.66		
Main Effects:							
Income	69	-0.21(.38)	-0.97	0.55	-0.55	0.32	0.03*
Fee	69	-0.09(.06)	-0.21	0.04	-1.42		
RDAS	69	0.24(.17)	-0.09	0.57	1.45		
Male OQ	69	0.11(.03)	0.60	0.16	4.28***		
Female OQ	69	0.07(.03)	0.02	0.13	2.60*		
Male ACES	69	-0.04(.38)	-0.81	0.73	-0.11		
Female ACES	69	-0.19(.31)	-0.81	0.43	-0.61		
Interaction:							
Income	69	-0.46(.47)	-1.39	0.48	-0.98	0.33	0.01**
Fee	69	-0.19(.13)	-0.45	0.07	-1.47		
Income*Fee	69	0.02(.02)	-0.02	0.06	0.92		
RDAS	69	0.23(.17)	-0.10	0.56	1.38		
Male OQ	69	0.11(.03)	0.06	0.16	4.11***		
Female OQ	69	0.07(.03)	0.02	0.13	2.60*		
Male ACES	69	-0.03(.38)	-0.80	0.74	-0.07		
Female ACES	69	-0.17(.31)	-0.79	0.45	-0.56		

Note: LL = lower limit of the confidence limits. UL = Upper limit of the confidence limits. Income*Fee = Interaction term as moderator. * = $p < .05$. ** = $p < .01$. *** = $p < .001$.

Table 10. Model 3 Fit and Test Statistics

	N	b (se)	LL	UL	t_b	R^2	ΔR^2
			95% CI for b				
Controls:							
RDAS	129	0.19(.10)	-0.02	0.39	1.78	0.09	
Male OQ	129	0.07(.02)	0.02	0.11	3.06**		
Female OQ	129	0.03(.02)	-0.02	0.07	1.26		
Male ACES	129	-0.15(.27)	-0.69	0.39	-0.55		
Female ACES	129	-0.06(.24)	-0.54	0.42	-0.24		
Main Effects:							
Income	129	-0.08(.27)	-0.61	0.45	-0.29	0.11	0.02
Fee	129	-0.04(.05)	-0.14	0.06	-0.88		
Group	129	1.00(.92)	-0.81	2.82	1.10		
RDAS	129	0.19(.11)	-0.02	0.40	1.78		
Male OQ	129	0.07(.02)	0.02	0.11	3.09**		
Female OQ	129	0.03(.02)	-0.01	0.08	1.49		
Male ACES	129	-0.12(.28)	-0.67	0.44	-0.42		
Female ACES	129	-0.05(.25)	-0.54	0.44	-0.21		
Interaction:							
Income	129	-0.30(.33)	-0.95	0.36	-0.90	0.12	0.01
Fee	129	-0.16(.12)	-0.39	0.07	-1.40		
Group	129	1.32(.96)	-0.57	3.22	1.38		
Income*Fee	129	0.02(.02)	-0.02	0.06	1.13		
RDAS	129	0.18(.11)	-0.03	0.39	1.72		
Male OQ	129	0.07(.02)	0.02	0.11	2.97**		
Female OQ	129	0.04(.02)	-0.01	0.08	1.54		
Male ACES	129	-0.11(0.28)	-0.66	0.45	-0.38		
Female ACES	129	-0.06(.25)	-0.54	0.43	-0.23		

Note: LL = lower limit of the confidence limits. UL = Upper limit of the confidence limits. Income*Fee = Interaction term as moderator. * = $p < .05$. ** = $p < .01$. *** = $p < .001$.