THERAPEUTIC FACTORS AND PREMATURE TERMINATION IN A

UNIVERSITY-BASED COUNSELING TRAINING CLINIC

by

RASHADA NICOLE WALKER

(Under the Direction of Linda Campbell)

ABSTRACT

There is significant agreement that premature termination represents a major problem for individuals providing clinical services. There is some agreement that clients who drop out of psychotherapy do so before they are able to gain the full benefits of therapy including long-term symptom improvement. However, we are still unclear regarding how and why clients terminate from treatment prematurely. Despite years of research investigating factors that may predict premature termination, findings are variable. In psychotherapy, it is a recognized belief that there are factors common to all theories that contribute significantly to outcome. The current study explores the predictability of such factors, specifically the working alliance and expectations. A final predictive variable included was client symptom severity. Considering that most studies on premature termination were conducted in outpatient settings, the current study investigates this construct in a university-based counseling training clinic. Premature termination was defined as a participant failing to attend their last scheduled appointment. Instruments used were the Brief Symptom Inventory (BSI), Working Alliance Inventory- Long Version Form C (Client) and Form T (Therapist), and the Expectation for Counseling Success Questionnaire (ECS). Four research questions were addressed: (1) Does the strength of the working alliance as perceived by the therapist predict premature termination? (2) Does the strength of the working alliance as

perceived by the client predict premature termination? (3) Does client expectation for success predict premature termination? And (4) Does client symptom severity predict premature termination? Data was collected at Intake, Session 3, and Session 10. Participants were 48 clients receiving individual counseling services at a university-based counseling training clinic. Master's and doctoral level clinicians providing individual counseling services participated in this study as well. Binary logistic regression was used to analyze data. Results of the current investigation indicated that client's perception of the working alliance was not predictive of premature termination. Aspects of client expectations for success were predictive of premature termination as well as two symptom dimensions of the BSI. Specifically, clients who expected their lives to improve with counseling were more likely to terminate treatment prematurely. Clients endorsing high hostility at Intake and clients endorsing low levels of somatic symptoms at Session 3 were more likely to terminate treatment prematurely.

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RASHADA NICOLE WALKER

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RASHADA NICOLE WALKER

Major Professor: Linda Campbell

Committee: Gayle Spears
                     Georgia Calhoun
                     Brian Glaser

Electronic Version Approved:

Maureen Grasso
Dean of the Graduate School
The University of Georgia
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DEDICATION

I would like to dedicate this work to my entire community. Without the support of teachers, past and present, principals, ministers, church family, and neighbors, this journey would have been much, much harder. The love and support of my family is unparalleled. Thank you so much for your patience, kind words, and prayers. This is for my friends, who are so proud of me. This is also dedicated to my future better half. Words cannot express my gratitude.

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CHAPTER 1

INTRODUCTION

The field of counseling psychology has a longstanding interest and commitment to understanding the factors associated with the process and outcome of psychotherapy, beginning with Frank Robinson's research in 1938 at the Ohio State University (Hill & Corbett, 1993). Historically, counseling psychology has been devoted to determining which treatments and interventions work for which clients under which conditions. This was stated several years ago by Krumbolz (1966): "Which procedures and techniques, when used to accomplish what kinds of behavior change, are most effective with what kinds of clients when applied by what kinds of counselors?" (p. 22). Consistent with this aim, counseling psychology has emerged as a recognized leader in diversity concerns relative to other professions within the field, and has been at the forefront of the movement toward multicultural awareness (Hill & Corbett, 1993; Munley, Duncan, McDonnell, & Sauer, 2004). The extensive dedication of counseling psychology to process and outcome research coincides with the appreciation of various factors that contribute to the effective delivery of mental health services.

In an annual review of research on interventions within the field of counseling psychology, Gelso and Fassinger (1990) indicated that at the time, some of the most promising research has been in the domain of "counseling process". In relevant literature, the term process has been generally referred to as what occurs in psychotherapy (e.g. therapist behaviors, client behaviors, interaction between client and therapist) and the term outcome has been referred to as the changes that occur as a result of the psychotherapy process (Hill & Corbett, 1993). Rosenzweig, in1936, asserted the Dodo Bird verdict indicating that "everybody has won and all must have prizes". This means that of all theories of psychotherapy that have been studied in controlled clinical trials, all have equivalent clinical effectiveness; though there are common

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factors in all therapies. "The common-factors approach seeks to determine the core ingredients shared by the different therapies with the eventual goal of developing more efficacious treatments based on these components" (Grencavage & Norcross, 1990, p. 372). Since the time of Gelso and Fassinger's (1990) review, several process and outcome studies have been appeared in the counseling psychology literature, including investigations of the common-factors approach to psychotherapy. An area of significance received special attention in Gelso and Fassinger's (1990) review and in process and outcome research as a whole. For the purposes of this dissertation, this area will be referred to as premature termination.

Broadly speaking, premature termination refers to clients ending treatment prior to the time deemed appropriate by their clinician (Mennicke, Lent, & Burgoyne, 1988). Throughout the years, psychotherapy literature has utilized interchangeable terms to refer to premature termination, including client dropout, forced termination, unilateral termination, and attrition. A thorough review of the literature indicates that premature termination has been a persistent and relevant topic of interest. Consistent with the field's commitment to understanding the underlying processes and outcomes of psychotherapy, a considerable amount of attention has been paid not only to identifying what works in psychotherapy, but also what doesn't. There appears to be agreement within the field of psychology that premature termination represents a major clinical challenge for today's practicing psychologist (Ogrodniczuk, Joyce, & Piper, 2005; Swift, Callahan, & Levine, 2009) and clients receiving clinical services.

Significance of the Problem

The goal of psychotherapy has consistently been to alleviate psychological distress and create an environment where interpersonal and/or intrapersonal growth is possible. Most clients present to treatment with a desire to improve some aspect of themselves, feel better, and/or gain insight. When a requisite level of improvement or change has occurred, it is assumed that the client and therapist ultimately reach the identifiable stage of treatment deemed termination. Effective termination involves assessing client readiness for closure, consolidating learning, maximizing transfer of knowledge, and increasing self-reliance and confidence in ability to maintain change (Ward, 1984).

"Termination of therapy can be thought of as a recapitulation of the multiple preceding goodbyes of living. At the same time it is a preparation for being able to deal more adequately and openly with future goodbyes" (Maholick & Turner, 1979, p. 584). This statement epitomizes what competent, ethical psychologists hope for when a productive psychotherapy relationship ends. Research suggests that the outcome of clients who terminate prematurely within three sessions have outcomes parallel to those individuals who never began therapy (Stark, 1992). According to Cahill et al. (2003) clients who completed psychotherapy as agreed upon by their therapist demonstrated greater treatment gains from the intake session to the closing session when compared to their counterparts.

In addition to the significance of the termination process in improving treatment outcome, a large body of research suggests that a minimum number of sessions are necessary as well, offering evidence of a dose-effect relationship in psychotherapy (Anderson & Lambert, 2001; Hatchett, 2004; Howard, Kopta, Krause, & Orlinsky, 1986). Disagreement exists among researchers regarding the number of sessions necessary for improvement (Saatsi, Hardy, &

Cahill, 2007). Research utilizing stringent criteria for clinically significant change indicates that 50% of clients improved following 21 sessions (Lambert, Hansen, & Finch, 2001). Studies utilizing less stringent criteria for clinically significant change indicate that 50% of clients can improve after 7 sessions (75% in 14 sessions) (Lambert et al., 2001). Evidence-based interventions implemented at a minimum of 11-13 sessions is necessary for approximately 50%-60% of clients to experience recovery (Hansen, Lambert, & Forman, 2001). These outcomes are similar to the findings of Anderson and Lambert (2001) who estimated that within a sample of outpatients in a university training clinic, 50% of clients will demonstrate clinically significant change within as many as 11-16 sessions.

Between 65% and 85% of individuals receiving mental health treatment will terminate prior to the 10th session (Garfield, 1994). A meta-analysis of 125 studies of various forms of psychotherapy indicated that prevalence rates for premature termination averaged 47% (Wierzbicki & Pekarik, 1993). These rates appear consistent across modality, including individual, family, couples, and group therapies. In a more recent review by Ogrodniczuk, et al. (2005), prevalence rates in settings utilizing short-term therapy may be lower than long-term treatment, and even lower for manualized treatment.

Lowered rates of premature termination in settings utilizing a shorter-term therapy model raise the possibility that clients may receive their desired outcomes in fewer sessions. These clients may be satisfied with their progress; thus ending treatment accordingly. Premature terminators who are dissatisfied with progress in psychotherapy report experiencing more psychological distress (Pekarik, 1992), and ultimately more in need of services (Kazdin, Mazurick, & Siegel, 1994). Premature termination plays a role in the efficacy of treatment for the

client, who may inevitably experience poorer treatment outcomes due to lack of sufficient treatment (Swift et al., 2009; Phillips & Depalma, 1983).

Prevalence rates of premature termination demonstrate that a large number of individuals receiving mental health services may not receive the full benefits of counseling. It is imperative that psychologists continue to value process and outcome research through commitment to understanding the factors associated with premature termination. These negative consequences, particularly clients who get worse upon ending treatment prematurely, represent an essential ethical charge that psychologists must consider wisely. Counseling psychologists in particular have earned the identity of appreciating process and outcome research. Accordingly, understanding premature termination as a treatment barrier is in alignment with this identity. Premature termination has profound negative impacts on the clients seeking symptom reduction through receipt of mental health services.

There have been few investigations regarding the extent to which premature termination is a negative consequence for the therapist providing services (Ogrodniczuk et al., 2005). Psychologists aspire to establish trust and assume professional responsibility for individuals to whom they provide services (APA, Principle B, 2002). Instances where clients end treatment prematurely may leave the ethical professional wondering what their role was in this occurrence. Psychologists practicing for years post-graduation may question their competence and ability to meet the needs of their clients.

Narcissistic injury is commonly referred to as the negative impact experienced by clinicians whose self-esteem is contingent on the extent to which they help, or fail to help others (Ogrodniczuk et al., 2005). Narcissistic injury is an unpleasant phenomenon. The possible implications on the therapist's confidence may be detrimental to the clients remaining on their

caseload. "Painful reactions to losing a patient through premature termination, such as hurt, rejection, or anger, may interfere with other aspects of the therapist's professional or personal life (e.g. interfering with the therapy of another patient who may be similar to the one who prematurely terminated)" (Ogrodniczuk et al., 2005, p. 58).

In private practice or other settings that rely on consistent client contact for expenses, premature termination causes a considerable financial burden. "From an administrative perspective, financial and human resources are not used efficiently when patients prematurely terminate" (Ogrodniczuk et al., 2005, p. 58). "A single no-show can exact a significant financial burden in terms of staff salaries, overhead, and lost revenue in addition to personnel losses resulting from low morale and high staff turnover" (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008, p. 248). Clinician lowered sense of efficacy in providing services and decreased job satisfaction are additional adverse consequences to psychotherapists as clients terminate treatment prematurely (Pekarik, 1985).

Premature termination has been found to be particularly demoralizing for beginning therapists (Garfield, 1994). This could be related to the fact that, developmentally, therapists in the initial transition to applied clinical work often exhibit heightened self-preoccupation and limited self or other awareness (Bernard & Goodyear, 2008; Stoltenberg, 1998). Premature termination may be an even greater hindrance in training clinic environments where students spend a considerable amount of time contacting clients who have missed appointments.

Premature termination provokes issues associated with treatment efficacy and represents a substantial cost to mental health settings as a whole. Fiscal costs include administrative time dedicated to no-shows who are typically not charged (Pekarik, 1985). Ultimately, these time slots intended for clients who do not show up utilize appointment times that could be offered to other

clients (Rapaport, Roldolfa, & Lee, 1985). Research has demonstrated that clients who terminate prematurely experience longer delays on a waiting list before beginning therapy. (Rapaport et al.,1985). This problem reaches several facets of mental health service delivery. Not only does premature termination negatively affect the treatment outcome of the client and the self-worth of the clinician, but it can also ultimately impede the ability of the clinician to be effective with other clients. This is an even greater impetus to understand why and how premature termination of psychotherapy occurs.

Purpose of the Present Study

"What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?" (Paul, 1967, p. 111). We know that psychotherapy is by and large, far from a simple phenomenon. The complexity of this process baffles beyond the confounds of traditional therapy to other facets of the helping profession. "Healers all over the world have tried to understand whether what they are doing is helpful and whether what they do leads to change" (Hill & Corbett, 1999, p. 3). After several decades of research, we are still unclear regarding how and why clients end treatment prematurely. It appears that a common trend throughout the years in investigating this phenomenon has been through isolating factors such as client demographic variables (e.g. Garfield, 1994; Baekeland & Lundwall, 1975).

In Wierzbicki and Pekarik's (1993) meta-anaylysis, clients with lower income, lower education, and racial/ethnic minority status were identified as having higher rates of premature termination. These relatively stable characteristics that are not typically directly influenced in therapy are considered pretherapy characteristics (Hill & Corbett, 1993). Hill & Corbett (1993) stress that the primary concern for counseling psychologists is understanding how such

pretherapy characteristics influence the process and outcome of psychotherapy. Thus, investigating premature termination through utilization of static variables exclusively may fail to contribute to our understanding of why such characteristics lead to this outcome.

Considering that several processes influence the outcome in psychotherapy, understanding premature termination by isolating static variables seems insufficient at best. Swift and Callahan (2011) noted that several literature reviews (e.g Barrett et al. 2008; Reis & Brown, 1999) have found a null and poor relationship between premature termination and demographic variables. These disappointing findings and poor understanding of why clients end treatment prematurely emphasize a need to alter the way in which we investigate premature termination. According to Mennicke et al. (1988), studying these static client variables alone as predictors of premature termination has produced unhelpful findings. According to Brogan, Prochaska, and Prochaska (1999), future investigations should include dynamic variables as factors that may influence premature termination.

This study attempts to investigate whether or not variables that change over time influence premature termination. Considering that common factors have been deemed predictors of therapeutic outcome, two variables of interest have been included in this study. These factors are working alliance and client expectations. The aforementioned variables have been demonstrated throughout the relevant literature as being possible indicators of premature termination. "By identifying and intervening on dynamic variables that may result in premature termination, it may be possible to prevent many of the personal losses experienced by both clients and therapists when dropout occurs" (Brogan, Prochaska, & Prochaska, 1999, p. 112). Over the years, researchers have come to the consensus that premature termination can be detrimental to clients (experiencing lesser treatment outcomes)(Barrett, et al., 2008; Swift et al.,

2009) and clinicians providing services (demoralization; fiscal costs) (Ogrodniczuk et al., 2005; Swift & Callahan, 2011). There appears to be disagreement regarding the way in which the occurrence of premature termination should be operationalized (Hatchett & Park, 2003; Swift & Callahan, 2011). Barrett et al. (2008) assert that definitive conclusions of variables associated with premature termination are often obscured due to the wide variety of definitions researchers used to refer to client dropout. Moreover, research has been conducted in various settings, making it difficult to generalize results to various mental health settings.

A significant number of studies predicting premature termination exist. Several factors have been found to be predictors of premature termination including low socioeconomic status (SES), female gender, and low anxiety and/or depression (Baekeland & Lundwall, 1975). Findings are mixed and complex primarily due to methodological differences among research (Garfield, 1994; Reis & Brown, 1999; Barrett et al., 2008; Lampropoulos, Schneider, & Spengler, 2009). Thus, this study attempts to attend to process variables that occur in psychotherapy through a common factors approach.

Although several of these variables have been associated, though inconsistently, with premature termination in various settings, there is little research investigating these variables in a training clinic environment. Research supports the assertion that experienced therapists maintain their clients in treatment longer than therapists in training (Stein & Lambert, 1995). Although the reasons by which this theme occurs is unclear, speculations include inexperienced therapists' difficulty finding direction for longer term problems (Strupp & Hadley, 1979). It is the researcher's assumption that training clinic environments are unique; therefore results from other settings may not be applicable. In light of the aforementioned adverse effects of premature termination as well as the near nonexistent premature termination studies conducted in

university-based counseling training clinics (Todd, Kurcias, & Gloster, 1994), this study aims to contribute to the body of literature in this area.

Definitions

Premature Termination

The construct of premature termination has been defined in a variety of ways since the start of investigations in this area. Earlier research defined premature termination as clients failing to attend a specified number of sessions (e.g. Baekeland & Lundwall, 1975). Within this definition is the assumption that a certain number of sessions are required to bring about meaningful change (Hatchett & Park, 2003). According to Pekarik (1985), at that time, premature terminators were arbitrarily categorized by researchers; little distinction was made among early terminators who met treatment gains and those that did not. Using therapist judgment to determine premature termination is advantageous in that this method avoids erroneously "a) classifying nonsymptomatic clients who would have been terminated by therapists within a few sessions as dropouts, and b) classifying highly symptomatic clients as completers simply because they asserted their intention to (prematurely) terminate at their last session and therefore were not scheduled for further sessions" (Pekarik, 1985, p. 87).

Westmacott, Hunsley, Best, Rumstein-McKean, and Schindler (2010) assert that utilizing the definition suggested by Pekarik (1985) helps to differentiate those clients who mutually decide with their therapist to end treatment. "It also avoids the problem of defining premature termination as the failure to complete a prescribed number of sessions, because some clients achieve the necessary gains in functioning prior to the end of a set number of sessions" (Westmacott et al., 2010, p. 424).

Although Pekarik's definition has advantages, using therapist's judgment to define premature termination may fail to account for the possibility that therapists differ in their ideas about what constitutes premature termination. Pekarik (1985) found that therapist's judgment of termination status identified premature terminators on several variables when compared to classifications made by median-split procedure. This type of comparison among definitions has led researchers to continue to investigate the most effective means of defining premature termination.

Hatchett and Park (2003) compared Pekarik's (1985) definition with three additional definitions of premature termination. Participants each received four termination ratings based on each of the four autonomous definitions of premature terminations (Hatchett & Park, 2003). The four operational definitions include: 1. Participants identified as premature terminators based on therapist's judgment, 2. Participants identified as premature terminators if they did not attend their last scheduled appointment (without return), 3. Participants identified as premature terminators based on the median-split procedure, and 4. Participants identified as premature terminators if they did not return following the initial intake appointment (Hatchett & Park, 2003).

Results indicated convergence between therapist judgment and missed last appointment, suggesting that the two definitions produced significant agreement in categorizing participants as terminating prematurely (Hatchett & Park, 2003). Thus, utilizing missing last appointment to define premature termination is as efficient as therapist's judgment. Wierzbicki and Pekarick (1993) suggest that therapist judgment is the preferred definition in that it is face valid and flexible. "Yet the potential increase in validity comes at a cost of lower reliability" (Hatchett & Park, 2003, p. 230).

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For purposes of this study, premature termination will be defined as occurring when a client fails to show up for their last scheduled appointment and did not return for treatment. Hatchett and Park (2003) assert that this definition provides researchers with high reliability and some face validity. It is important to note that clients terminate therapy for a myriad of reasons including illness, unemployment, and relocation. This study was conducted in a setting where determining reasons for premature termination is unreliable and in some cases impossible. Therefore, all participants that cancelled their next scheduled appointment due to such factors were not included in this study. Participants who terminated at a time decided upon between themselves and their clinician were classified as appropriate terminators.

Working Alliance

The alliance has been a persistent topic of investigation in psychotherapy literature, linking the concept to psychotherapy outcome, for over two decades (Horvath, 2001). The concept of the alliance emerged from psychodynamic psychotherapy (e.g. Freud, 1912; Sterba, 1934; Zetzel, 1956) and was later expanded by Luborsky (1976) to include the collaborative component in all helping relationships (Horvath, Del Re, Fluckiger, & Symonds, 2011). Psychologists grew interested in understanding factors common to all therapies (Rosenzweig, 1936) "But perhaps the most potent force responsible for the sustained growth of interest in the alliance was the consistent finding of a moderate but robust relationship between the alliance and treatment outcome across a broad spectrum of treatments in a variety of clients" (Horvath et al., 2011, p. 9).

The working relationship between client and therapist has been characterized throughout the literature using various terms including the alliance, therapeutic alliance, and working alliance. For the purposes of this paper, the therapeutic relationship will be based on the

definition of the working alliance established by Bordin (1979). Researchers have varied in the way in which they define alliance, and have typically used alliance measures to operationalize this construct (Horvath et al., 2011). In keeping with this method, the current study utilizes the Working Alliance Inventory (WAI) developed by (Horvath & Greenberg, 1986). The WAI was based on Bordin's (1979) transtheoretical model.

As defined by Bordin (1979), the three aspects of the working alliance are: (a) agreement between client and therapist on the goals of therapy; (b) agreement between client and therapist that the tasks of therapy will address the presenting problem; and (c) the quality of the interpersonal bond between the client and therapist. To date, a substantial portion of research regarding reasons by which clients terminate prematurely has focused on reasons given by clients (Todd, Deane, & Bragdon, 2003). In order to gain perspective from both client and therapist, the current study investigates both client and therapist perception of the alliance.

The alliance has successfully predicted treatment outcome across modalities of treatment, measures of the alliance, and patient groups. (Horvath & Symonds, 1991). The alliance has been a strong predictor of premature termination (Barber et al., 2001; Barber et al., 1999; Constantino, Castonguay, & Schut, 2002).

According to Castonguay, Constantino, and Holtforth (2006) there is evidence to suggest that measuring alliance early in treatment is particularly predictive of premature termination. Opposing evidence suggests that high early alliance may be associated with premature termination and that unrealistic expectations may play a role in this occurrence (Horvath, 2001). Due to these mixed finding, Castonguay et al. (2006) caution against limiting assessment of alliance strength to early phase of treatment. The current study measures the alliance at various times during treatment.

Expectations for Success

Treatment expectancies are an important factor contributing to the process and outcome of psychotherapy. Recent investigations suggest that client expectations may be strongly related to premature termination (Arnkoff, Glass, & Shapiro, 2002; Aubuchon-Endsley, & Callahan, 2009; Joyce & Piper, 1998; Reiss & Brown, 1999). Clients enter treatment with preconceived notions regarding the process of psychotherapy. Evidence suggests that clients who perceived treatment as being unsuccessful were more likely to end treatment prematurely (Edlund et al., 2002). Expectations related to premature termination include, but are not limited to, duration of treatment (Mueller & Pekarik, 2000), role expectations (Dew & Bickman, 2000; Reiss & Brown, 1999), and effectiveness expectations (Garcia & Weisz, 2002). Expectations have been considered as a multidimensional factor (Tinsley, Workman, & Kass, 1980) and have been operationalized in various ways among researchers. The current study focuses specifically on expectations for treatment success. Fischer, Jome, & Atkinson (1998) assert that positive expectations about psychotherapy tend to lead to counseling success. It is possible then that expectations regarding counseling success may influence premature termination.

Research Questions

Research Question 1

Does the strength of the working alliance as perceived by the therapist predict premature termination in university-based counseling training clinics?

Research Question 2

Does the strength of the working alliance as perceived by the client predict premature termination in university-based counseling training clinics?

Research Question 3

Does client expectation for success predict premature termination in university-based counseling training clinics?

Research Question 4

Does client symptom severity predict premature termination in university-based counseling training clinics?

CHAPTER 2

REVIEW OF RELATED LITERATURE AND RESEARCH OF PREMATURE

TERMINATION

To investigate the factors associated with premature termination, it is necessary to consider prior research in several areas. Important to consider are models used to conceptualize premature termination, process and outcome research, and factors associated with premature termination including demographic variables, symptom presentation, and working alliance. An additional factor delineated in this study is client expectations for treatment success.

Conceptualizing Premature Termination

Research on premature termination is complex and often yields inconsistent findings. The lack of a systematic conceptualization incorporating both client and therapist factors as contributors to premature termination proves difficult in making comparisons among these two variables (Todd et al., 2003) In an effort to better understand this phenomenon, Barrett et al. (2008) suggest two behavior health models as a framework for conceptualizing the problem of premature termination. Developed in the 1960's, the Behavioral Model of Health Services (Andersen, 1995) uses four major categories to describe client use of health care services: (a) patient characteristics, (b) enabling factors, (c) need factors, and (d) environmental factors. Factors that describe the individual seeking services (e.g. demographic variables, expectations, beliefs) are labeled patient characteristics. Factors that impede or aid a person's utilization of health care services are considered enabling factors. Examples include level of income, cost of services, level of familial involvement, and support system. Needs factors are those that relate to need of health care services such as diagnosis, prognosis, suggested treatment length, and comorbidity. Environmental factors include accessibility of care, treatment options, and settings. "Together, these four categories help to define the scope of influence on service utilization and

offer explanations for disengagement from treatment" (Barrett et al., 2008, p. 251). A more recent model proposed by Owens et al. (2002) is similar to the model presented by Andersen (1995), but extends the category of enabling factors from more structural concepts (e.g. income level, cost for services) to include client perceptions, attitudes, and assumptions about mental health services and mental health treatment.

Each of the aforementioned factors alludes to the idea that clients may have varying reasons for terminating treatment prematurely. These factors range from barriers that can be considered practical (e.g. affordability of services) to factors that are more intrapersonal in nature (e.g. negative attitude toward mental health services). In a study conducted by Pekarik (1992), reasons for terminating psychotherapy were categorized into three broad areas: (a) problem improvement, (b) dissatisfaction with treatment, and (c) environmental obstacles. Results of the study indicated reasons for dropping out of treatment prematurely was evenly distributed within each of the three categories. According to Todd et al., (2003), although the majority of research conducted at that time included reasons for premature termination that could be logically included into those three broad areas, a few studies included more comprehensive reasons. Specifically, the more comprehensive studies have included therapist's perceptions of the reasons by which, and contributions to, clients ending treatment prematurely (Todd et al., 2003). Pekarik and Finney-Owen (1987) discovered that therapists endorsed client resistance as the primary reason for terminating prematurely. In this study examining client and therapist intake data, therapists were more likely than the client to assert that "improvement" was a reason for termination and less likely to assert "environmental constraints" and "dislike of therapy/therapy" as reasons for termination (Pekarik & Finney-Owen, 1987). These results are consistent with more recent findings indicating that therapists correctly cited more positive reasons for

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premature termination than more negative reasons for premature termination (Hunsley, Aubry, & Verstervelt, 1999). Barrett et al. (2008) suggest that therapists may have difficulty acknowledging non-positive reactions in therapy. It is clear that therapists and clients may differ in their perception regarding the process of therapy.

Although the aforementioned research study by Pekarik and Finney-Owen (1987) sheds light onto the typical reasons that therapists cite in the event that clients terminate psychotherapy prematurely, client and therapist data were not from respective therapies. Additionally, the study by Pekarik and Finney-Owen (1987) made no distinction between early and late terminators and the implications that such time intervals may have on reasons for termination.

In order to investigate differences between early and late premature terminators, Hynan (1990) conducted a research investigation that also examined differences between client experiences as they relate to early and late premature termination. In this study, participants receiving services at a university counseling center completed questionnaires in the mail following premature termination in which they checked reasons for termination that applied to them based on four categories: (a) situational constraints, (b) discomfort with services, (c) life changes, and (d) hiatus (Hynan, 1990). Early and later terminators rated their beliefs and perceptions of their therapy (e.g. respect for client, understanding of the client, agreement about the client's primary problems, warmth). Clients terminating treatment within five sessions were categorized as early terminators and clients terminating treatment after at least five sessions were categorized as late terminators. These cutoff points were used as they are consistent with the mean number of sessions reported throughout relevant literature (Hynan, 1990 as cited by Garfield, 1986).

Results of this study indicated that late terminators cited improvement associated with therapeutic gains as the reason for termination significantly more frequently than early terminators (Hynan, 1990). "However, contrary to predictions, early terminators reported that they ended treatment because of improvement not attributed to therapy no more often than did late terminators, though this comparison approached conventional levels of statistical significance ($p < .10$)" (Hynan, 1990, p. 892). More frequently than late terminators, early terminators endorsed situational constraints and discomfort with therapeutic services as the primary reasons for premature termination (Hynan, 1990). Of note, those clients who terminated treatment late reported more positive ratings of their experiences than those in the early termination category, specifically in terms of therapist respect for client, therapist warmth, and therapist competency (Hynan, 1990). Overall, this research indicates that in additional to differentiating late and early terminators, situational constraints as well as the client's experience of psychotherapy are important to consider when investigating factors associated with premature termination.

Hunsley et al. (1999) found that accomplishment of psychotherapy goals was the most prominent reason for premature termination cited by clients (44%) and therapists (39%) among individuals in a psychology training clinic. These finding are consistent with the assertion that premature termination is not always indicative of treatment failure, but clients sometimes experience problem resolution and help during the time that they spent in psychotherapy (Ogrodniczuk et al., 2005). Interestingly, Hunsley et al. (1999) found that dissatisfaction items (e.g. "therapy was going nowhere") were endorsed as a primary reason for termination by a large percent of the clients, but these same items were not endorsed by the corresponding clinician.

Other studies indicate that the therapist perceives aspects of the client unrelated to dissatisfaction with services as reasons for premature termination including resistance (Lane, 1984; Pekarik & Finney-Owen, 1987) and lack of treatment motivation (Rosenbaum & Horowitz, 1983). The above research suggests that there is often inconsistency between what the client perceives and what the therapist perceives as reasons by which clients end treatment prematurely. These discrepancies has logically led to research utilizing a systematic conceptualization based on existing research to directly examine reasons provided by client-therapist pairs in terms of premature termination. Imperative to note is the idea that premature termination could be a result of treatment gains and not solely representative of dissatisfaction with services and other barriers.

Premature Termination Overview

To date, there has been a considerable amount of existing research investigating the potential factors that contribute to clients terminating treatment prematurely in various settings that provide psychological services to diverse client populations (Barrett et al., 2008; Mennicke et al., 1988; Smith, Subich, & Kalodner, 1995; Swift & Callahan, 2011). Issues with research methodology, defining premature termination, and generalizability of results has plagued such investigations since the early 60's and continues to do so in today's research on client dropout. Prior to the 1970's, "definitional inexplicitness has been the hallmark of most studies of dropping out of treatment" (Baekland & Lundwall, 1975, p. 740). This problem reigns true in today's reviews regarding research on premature investigation. The phenomenon of premature termination is operationally defined in many ways and is referred to by different names (e.g. early withdrawal, attrition) (Swift & Callahan, 2011).

Premature termination has been a vexing problem for those practicing in various fields including psychiatry, medicine, and psychology. Those within the field of psychotherapy perceived early on that premature termination was a substantial barrier to the effective delivery of counseling services. To the investigator's knowledge, such research began as early as the 1960's. The areas of focus revolved primarily around client and therapist characteristics as they contribute to premature termination.

Baekland & Lundwall (1975) conducted the first major critical review of approximately twenty years of literature (362 articles) regarding premature termination in various settings including outpatient and inpatient psychiatric settings and medical hospitals. The aim of the review was to answer four relevant questions regarding client dropout: (a). Is it possible to predict those clients who will likely drop out of treatment? (b). Why do clients leave treatment prematurely (i.e. client factors, treatment setting, clinician)? (c). What are the implications for clients who terminate treatment prematurely? (d). How do treatment providers decrease the prevalence of client dropout? (Baekland & Lundwall, 1975). At the time of the review, most studies on premature termination had differentiated dropouts and remainers (i.e. clients who do not terminate prematurely) in terms of the number of session visits, ranging from a cutoff point of anywhere between 3 and 10 visits.

Baekland & Lundwall (1975) concluded that the research conducted prior to their paper on client dropout has been lacking in the extent to which demographic data (e.g. sex, age, race, and income level) were included in the investigations. According to Baekland and Lundwall (1975) "patient populations vary widely in their clinical and demographic characteristics depending on the location of the hospital or clinic and its admission policies" (p.) Therefore, it is important that summary statistics on age, sex, race, education, and income be provided as well as

those on diagnostic categories and relevant clinical symptoms in order to evaluate the prescribed treatment" (p. 741). Despite the limited number of studies that included such data, Baekland and Lundwall (1975) found that low socioeconomic status (SES) and female gender were demographic variables most strongly associated with premature termination in individual adult outpatient psychotherapy. Since that time, research on premature termination has included client demographic variables as possible factors associated with premature termination.

Demographic Variables

A plethora of process and outcome research has indicated that client variables have been strongly correlated with treatment outcomes (Kolb, Beutler, Davis, Crago, & Shanfield, 1985). Garfield (1986) concluded that variables most consistently associated with premature termination included low socioeconomic status (SES), racial minority status, and low educational level. Although findings by both Garfield (1986) and Baekland and Lundwall (1975) consistently assert the relationship between social class variables and premature termination, Wierzbicki & Pekarik (1993) consider these reviews to be dated in that they included articles published before the more modern era of mental health service delivery characterized by federally funded mental health centers, third-party payers, and alternative treatments to psychodynamically oriented psychotherapy.

In the most recent meta-analysis on client variables associated with premature termination, Wierzbicki & Pekarik (1993) coded demographic variables used in 125 studies, conducted in settings representing a wide range of clients, treatments, and diagnosis of premature termination as follows: sex, age, race, education, socioeconomic status, and marital status. The results of this meta-analysis found that among those variables associated with premature termination were racial minority status, low educational level, and low socioeconomic status.

These findings are consistent with other major critical reviews in this area as well as individual studies (e.g. Berrigan & Garfield, 1981; Garfield, 1989). According to Garfield (1989), the inverse relationship between low socioeconomic status and premature termination could be related to the value differences between low SES clients and therapists. Some research indicates that clients from lower SES backgrounds anticipate therapy that is brief and symptom focused (e.g. Brill & Storrow, 1960; Overall & Aronson, 1962), thus higher rates of premature termination among this group could be related to treatment expectations (Wierzbicki & Pekarik, 1993). "This interpretation is supported by studies that have found that univariate relationships between low SES and dropout disappear when multivariate analyses later use both social class and client duration expectation variables; in the latter case, expectation, but not social class, has been found to be related to continuance" (Wierzbicki & Pekarik, 1993, p. 193).

There is a need for theory-driven research that attends to other mechanisms as mediators (e.g. cognitive and interpersonal factors). "More recently, researchers have begun studying the relationships between more complex psychological variables and premature termination" (Hatchett, Han, & Cooker, 2002, p. 157). Additional variables of importance include symptom presentation, working alliance, and expectations of psychotherapy.

Symptom Presentation

Hilsenroth, Handler, Toman, and Padawer (1995) investigated the differences between clients who terminated counseling after an average of one session and clients who terminated counseling after an average of eight sessions on selected Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and Rorsharch variables. Although there were no significant differences between the two groups on MMPI-2 variables, several variables in three conceptual categories of the Rorsharch were indicated as predictors to early termination, including interpersonal

relatedness, psychological resources versus resource demand, and level of psychopathology (Hilsenroth et al., 1995).

Most research investigating premature termination as predicted by personality disorders has utilized the MMPI (Minnix et al., 2005). There has been little consistency between which scales are predictive of premature termination. Craig (1984) found that elevations on the Depression scale were predictive whereas Walters, Solomon, and Walden (1982) found that elevations of the Hypomanic scale were predictive. According to Minnix et al. (2005), many MMPI studies conducted in substance abuse treatment settings have reported that substance abusers with greater levels of "general psychopathology" are more likely to prematurely terminate or respond poorly to therapy" (p. 1746).

Everson (1999) investigated client variables that may be associated with premature termination as well as the association between client scores on the Personality Assessment Inventory (PAI). Results indicated that clients with lower scores on the Anxiety and Somatic Complaints scale of the PAI were more likely to drop out of counseling. Several studies indicate that a diagnosis of a personality disorder is predictive of premature termination (e.g. Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Persons, Burns, & Perloff, 1988). Inconsistent findings exist regarding symptom severity as a predictor of premature termination. Specifically, Minnix, et al. (2005) assert that high levels of depression and anxiety have been predictive of therapy completion in some studies and predictive of premature termination in others. Arnow et al. (2007) suggest that clients with this combination of concerns are at higher risk of terminating treatment prematurely.

Investigations of symptom severity and premature termination have yielded inconsistent findings. Some studies have found that clients who enter treatment with high symptom severity

are more likely to drop out of treatment (e.g. Blackburn, Bishop, Glen, Shalley, & Christie, 1981; Elkin et al., 1989). Simons, Levine, Lustman, and Murphy (1984) did not find that clients with high symptom severity were more likely to terminate prematurely. Overall, there does not appear to be agreement regarding whether or not symptom severity plays a role in premature termination.

Working Alliance

The work of therapy is not always easy for clients, and evidently requires a relational element common to various theories of psychotherapy that helps to facilitate therapeutic gains (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977). At its inception, the concept of the alliance focused on two aspects of the helping relationship; Type I and Type II (Luborsky, 1994, in Horvath & Greenberg, 1994). Type I is representative of the aspect of the relationship dependent upon the client's experience of the therapist as helpful and supportive. This aspect is most clearly associated with the humanistic or person-centered approach to therapy (Prochaska & Norcross, 2007), but is considered a necessary factor for change common to all empirically validated theoretical approaches (Prochaska & Norcross, 2007). Initial investigations of the working alliance as an outcome factor explored the relationship across multiple contexts including various treatment types, populations, and diagnostic categories (Horvath, 2005). Of additional interest was the relationship between the working alliance and the outcome of psychotherapy from the perspective of the client, therapist, and observer, including the extent to which this relationship changes across phases of psychotherapy. (Horvath, 2005; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

The earliest measure of the alliance- The Helping Alliance Counting Signs- acknowledged six signs of the Type I session as follows: 1. The patient feels the therapist is

warm and supportive; 2. The patient feels the therapist is helping; 3. The patient feels changed by the treatment; 4. The patient feels a rapport with the therapist; 5. The patient feels the therapist respects and values the patient; 6. The patient conveys a belief in the value of the treatment process (Luborsky, 1976; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). Type II is characterized by a relationship based on a joint effort of collaboration against the client's problem (Luborsky, 1994, in Horvath & Greenberg, 1994). Four signs of a Type II session are as follows: 1. The patient experiences the relationship as working together in a joint effort; 2. The patient shares similar conceptions about the source of the problem; 3. The patient expresses belief about being increasingly able to cooperate with the therapist; 4. The patient demonstrates abilities similar to those of the therapist in terms of being able to use the tools for understanding (Luborsky, 1994, in Horvath & Greenberg, 1994).

The concept of the alliance was considered initially from the dynamic perspective (Freud, 1912; Greenson, 1967; Sterba, 1934; Zetzel, 1956), and has been expanded by Bordin (1994, 1979) as a broader pantheoretical model defined as the working alliance. Although Bordin was not the first to recognize the interplay between therapist and client as a significant dynamic and interaction, his work has been a major contributor to our understanding of outcomes in psychotherapy. The primary distinguishing aspect of the alliance as defined by Bordin in comparison to others' conceptualization is the emphasis on consensus as opposed to considering therapist and client variables exclusively (Lambert & Barley, 2002 in Norcross, 2002).

"The term itself reflects the process that both the therapist and client enter into with the hope of creating change (Hanley, 2009, p. 258); "the powerful joining of forces which energizes and supports the long, difficult, and frequently painful work of life-changing in psychotherapy" (Bugental, 1987, p. 49, as cited by Hanley, 2009, p. 259). As defined by Bordin (1979), the three

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aspects of the working alliance are: 1) agreement between client and therapist on the goals of therapy; 2) agreement between client and therapist that the tasks of therapy will address the presenting problem; and 3) the quality of the interpersonal bond between the client and therapist. From Bordin's perspective, agreement of goals and tasks involves the important negotiation between therapist and client of identifiable objectives that most strongly captures the client's struggle relative to his/her personal narrative (Bordin, 1994, in Horvath & Greenberg, 1994).

Although the therapist is the source from which the therapeutic tasks are selected, the client must understand the significant of such goals in order to embody the part of active partner (Bordin, 1994, in Horvath & Greenberg, 1994). "The therapist's contribution to the alliance includes the provision of facilitative conditions, the therapist's ability to deal with certain ruptures in the alliance, and the ability to come to a mutual agreement with the client on the goals of treatment and how those goals will be accomplished" (Lambert & Barley, 2002, p. 24). The working alliance itself is not curative, but the necessary component that allows the client to faithfully comply with treatment (Bordin, 1980). "A strong alliance refers to a condition in which a person seeking change has found that a change agent can participate in the effort to shed light and open new doors without reducing the partnership to the pairing of the leader-therapist with an assistant patient. Its strengths revolves around the experiences of new possibilities in the patient's struggle rather than faith in a charismatic therapist-magician" (Bordin, 1994 in Horvath & Greenberg, 1994, p. 15 footnote).

A significant amount of process and outcome research indicates that there is a relationship between extent to which a therapeutic alliance has been established between the therapist and client and the outcome of psychotherapy (Weerasekera, Linder, Greenberg, & Watson, 2001). The working alliance has been consistently found as positively correlating to

therapy outcome, although effect sizes exist within the small to moderate range (Horvath &
Symonds, 1991; Martin, Garske, & Davis, 2000). Moreover, measures of the working alliance
correlate more strongly to psychotherapy outcome than specific techniques or interventions
(Lambert & Barley, 2002 in Norcross, 2002). The working alliance has been hypothesized as an
antecedent to the outcome of psychotherapy, including client "success" or "improvement"
(Tryon, Blackwell, & Hammel, 2007).

It is evident that the client and therapist do not always possess convergent perspectives on
the extent to which a working alliance is established (Fitzpatrick, Iwakabe, and Stalikas, 2005).
Several studies indicate that clients appear to view the working alliance as higher than their
therapists (Bachelor & Salame, 2000; Cecero, Fenton, Nich, Frankforter, & Carroll, 2001;
Fitzpatrick et al., 2005; Hilsenroth, Peters, & Ackerman, 2004; Ogrodniczuk, Piper, Joyce, &
McCallum, 2000).

According to Tryon et al. (2007), there are several factors in addition to incongruence
between the client and therapist perspectives that may affect the working alliance. One
moderating factor is severity of client disturbance (Constantino et al., 2002) which could be
related to finding that clients with severe disturbances generally possess a greater degree of
relationship problems (Hersoug, Hoglend, Monsen, & Havik, 2001; Lingiardi, Filippucci, &
Baiocco, 2005). Other moderating factors to working alliance and outcome include client
diagnosis (Tryon et al., 2007) and level of therapist experience (Hersoug et al., 2001;
Mallinckrodt & Nelson, 1991). In a meta-analysis investigating several moderating factors
including client disturbance, therapist experience, length of therapy, alliance instrument, and
treatment type, Tryon et al. (2007) found that client disturbance was a significant moderator
when there was a discrepancy between client and therapist alliance ratings. However, when the

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internal consistency of alliance measures is controlled for, clients' and therapists' alliance ratings covary in a moderately consistent, positive way regardless of client disturbance, therapist experience, therapy length, alliance measure, or type of treatment" (Tryon et al., 2007, p. 638).

Safran & Wallner (1991) used the Working Alliance Inventory (WAI) and the California Psychotherapy Alliance Scale (CPAS) in an outpatient setting providing cognitive behavioral interventions to 22 adults. Findings indicate that both measures were predictive of psychotherapy outcome, suggesting that the working alliance is an important indicator of outcome. A study conducted by the National Institute of Mental Health (NIMH) as a part of the Treatment of Depression Collaborative found that 250 clients suffering from depression receiving one of four treatments (interpersonal psychotherapy, cognitive-behavioral therapy, imipramine with case management or placebo with case management) found that "the therapeutic alliance had a significant impact on the outcome for both of the psychotherapy procedures and for the active and placebo pharmacotherapy" (Lambert & Barley, 2002 in Norcross, 2002, p.).

In a Special Issue of *Psychotherapy Research,* Horvath (2005) summarized major research trends in the investigations regarding the therapeutic relationship, and found that the correlation between the working alliance and outcome is moderate and significant (between .22 and .29). As opposed to other ratings, the client's perception of the therapeutic relationship is more predictive of outcome (Horvath, 2005). Additionally, "early alliance is as good or better predictor of outcome than assessments taken later, and the alliance as measured appears to be related but not identical to parallel therapeutic gains" (Horvath, 2005, p. 4). Similarly, it has also been found that therapist perception of the strength of the working alliance in individual therapy predicted premature termination when measured early on in the relationship (following the third session) whereas assessing following the first session did not (Kokotovic & Tracey, 1990).

Samstag, Batchelder, Muran, Safran, & Winston (1998) investigated working alliance

and interpersonal behavior between groups of clients who terminated prematurely, clients with

good outcome, and client with poor outcome utilizing the Working Alliance Inventory (WAI),

Session Evaluation Questionnaire, and the Interpersonal Adjective Scale. Results of this study

indicated that ratings of the WAI of both clients and therapists in the premature termination

group were worse than those clients in the good outcome group, but clients in the premature

termination group, and not the therapists, indicated a worse alliance than the poor outcome group

(Samstag et al., 1998). "Results of this current research suggest the case may not simply be that

patients are better subjects for rating the therapeutic relationship than therapists, but that patients

and therapists pay attention to different aspects of the treatment process" (Samstag et al., 1998,

p. 141). Incongruence between client and therapist may also be explained by the idea that

therapist rate the relationship relative to the experiences with prior clients, whereas clients

typically bring perspectives based on their experiences with other health professionals (Tryon et

al., 2007). It is also possible that clients who have few positive relationships in general may find

the therapeutic relationship as a good exception to their typical interpersonal relationships (Tryon

& Kane, 1990).

Although findings indicate that the working alliance can be a predictor of premature

termination (Saatsi et al., 2007), prior to a study conducted by Westmacott et al., (2010),

research has not investigated how client-therapist divergence in ratings of the working alliance

may differ in premature termination dyads. In the same study, it was found that client-therapist

pairs who mutually agreed on termination rated a stronger working alliance than pairs where the

client terminated prematurely (Westmacott et al., 2010). Despite divergence between client-

therapist ratings of the working alliance, client-therapist pairs where the client terminated

prematurely did not have a less similar perception of the working alliance than the client-therapist pairs who mutually agreed on termination (Westmacott et al., 2010). In both groups of pairings, clients rated the working alliance higher than their therapist. These findings are consistent with results of other investigations (e.g. Bachelor & Salame, 2000; Hilsenroth et al., 2004).

According to Al-Darmaki and Kivlighan (1993) several authors have asserted that client pretherapy characteristics, including expectations for psychotherapy, are an important factor in the development of the working alliance. The congruence between the worldview of the client and therapist with regard to treatment expectations contribute significantly to the development of the alliance (Gelso & Carter, 1985). "Recognizing the need to better inform clinicians about factors that may foster or impede alliance development, a 'second generation' of alliance research has begun focusing on multiple variables" (Greenberg, Constantino, & Bruce, 2006, p. 663). Thus, it is important to consider client expectations as a factor in the working alliance, and ultimately premature termination.

Client Expectations

Both clients and therapists enter the therapeutic relationship with expectations regarding the process of psychotherapy. These prior expectations include but are not limited to length of treatment and therapeutic tasks. In its most basic and significant form, Jerome Frank (1993), in his classic work entitled Persuasion and Healing, noted that clients come to therapy with the notion that they will be helped. Research strongly indicates that these expectations contribute significantly to the outcome of psychotherapy (Garfield, 1994; Asay & Lambert, 1999). Years of researchers have been interested in answering the question: Do client expectancies regarding the

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extent to which they will ultimately benefit from psychotherapy impact success of treatment? (Greenberg et al., 2006). "The answer to the question, both theoretically and empirically, has been a qualified 'yes' with studies focusing on both naturally occurring pre-therapy expectations and those induced in patients by giving them information designed to heighten positive expectations" (Greenberg et al., 2006, p. 658).

Lambert (1992) estimated that approximately 15% of client's improvement is related to expectancy. Thus, client expectations have been considered one of the common factors necessary for client change across major theoretical orientations (Weinberger & Eig, 1999). Despite it's proven contribution psychotherapy outcome (Rosenzweig, 1936; Wampold, 2001), client expectations has been considered one of the more neglected of the factors in that most of the earlier research failed to include it (Greenberg et al., 2006).

In a recent literature review, Noble, Douglas, & Newman (2001) found that a curvilinear relationship existed between client expectations and outcome, indicating that clients with very high or very low expectations showed lesser change than those clients with moderate improvement expectations. Both Hansson & Berglund (1987) and Sotsky et al. (1991) agree that there is at least a positive relationship between client improvement and outcome expectancies. Clients in a short-term anxiety group with higher expectations for change demonstrated better outcomes following treatment (Fromm, 2001). Although these findings are promising, concepts including credibility and faith make it difficult to determine the 'pure' association between outcome effect and client expectation (Arnkoff et al., 2002).

Drew and Bickman (2005) differentiate two types of expectations: role expectations and outcome expectations. Those behaviors that a client expects to happen in the context of therapy (e.g. whether or not there will be homework) are categorized as role expectations whereas

outcome expectations are those that are expected to occur as a result of therapy (e.g. symptom reduction, length of time necessary for change) (Swift & Callahan, 2008).

According to Greenberg et al. (2006), various types of outcome expectations exist including pretreatment outcome expectancies (i.e. beliefs of benefit of psychotherapy before actual contact with the therapist) and during treatment expectancies (i.e. beliefs of the plausibility of treatment after hearing clinician rationale). Outcome expectations, particularly length of therapy, have been helpful in predicting psychotherapy duration (Garfield, 1994). Most predictive of actual number of attended psychotherapy sessions have been client identified (Pekarik & Wierzbicki, 1986) while therapist estimates have been longer than actual duration of treatment (Pekarik & Finney-Owen, 1987).

"Consequently, clients perceived to be dropouts may actually be leaving at a time consistent with their attendance expectations and after achieving their anticipated outcomes" (Pulford, Adams, & Sheridan, 2008, p. 182). Thus, it is important to consider the way in which inconsistency between client and therapist expectations influence premature termination. According to Reis and Brown (1999), clients may end treatment prematurely as a result of failing to have expectations as well as associated frustration. These factors have been largely untapped throughout the literature (Pulford, Adams, & Sheridan, 2008). Early on, Pekarik and his colleagues identified duration of treatment as identified by the client as a more accurate predictor of duration than other variables including severity of problem and demographic variables (Pekarik, 1991; Pekarik & Wierzbicki, 1986).

Expectations have been considered as a multidimensional factor (Gladstein, 1969; Tinsley et al., 1980). Tinsley, Brown, de St. Aubin, & Lucek (1984) operationalized the dimensions of client expectations as follows: (a) Personal Commitment (client's expectations

about self-motivation, openness toward the process of psychotherapy, and responsibility in the process of psychotherapy), (b) Facilitative Conditions (client's expectations regarding acceptance, genuineness, trustworthiness, and confrontation), (c) Counselor Expertise (the client's expectations that therapist will be knowledgeable, empathetic, and directive), and (d) Nurturance (the client's expectancy that the therapist will be supportive and caring). The Expectations about Counseling (EAC) Questionnaire has become a useful instrument for assessing client expectations for counseling on these dimensions (Tinsley et al., 1980). In this measure, each item begins with I expect to or I expect the therapist to loaded on a 7-point Likert scale (Tinsley et al., 1980). Most research utilizing this scale has been on non-client samples (Mennicke et al., 1988)

Berzins (1971) identified approval-seeking, advice-seeking, audience-seeking, and relationship-seeking as important dimensions of client expectations. These categorical dimensions have been utilized in numerous studies including investigations of role expectations throughout treatment (Tracy & Dundon, 1988) and investigations of the relationship between working alliance and client-therapist expectations (Tinsley et al., 1980). Duckro, Beal, and George (1979) noted that efforts should be made to differentiate client expectations from counseling preferences. The term expectation refers to the probability that an event will occur whereas the term perception refers to information received about an event following direct observation (Tracey, Glidden, & Kokotovic, 1988). Several investigations have measured expectations by allowing respondents to rate expectations upon viewing counseling interactions in the form of videotaped sessions (Tracey et al., 1988). According to Tracey et al. (1988), in such cases, respondents may change their expectations to match their perceptions. As such,

research underscores the importance of carefully differentiating perceptions and expectations, particularly in instrumentation (Hayes and Tinsley, 1989).

Considering that treatment expectancies are an important factor contributing to the process and outcome of psychotherapy, it is not surprising that client expectations have been associated with premature termination (Garfield, 1994; Joyce & Piper, 1998; Wierzbicki & Pekarik, 1993). Despite the attention to outcome expectations, there a few psychometrically sound instruments to measure this construct (Aubuchon-Endsley, & Callahan, 2009). The Psychotherapy Expectancy Inventory-Revised (PEI-R) (Berzins, Herron, & Seidman, 1971) has been utilized in multiple settings to measure role expectations before treatment (Scamardo, Bobele, & Biever, 2004; Orlinsky, Grawe, & Parks, 1994 in Bergin & Garfield, 1994). According to Aubuchon-Endsley and Callahan (2009), the expectancies categorized in the PEI-R may indicate the client's commitment to change early in the therapeutic process and ultimately influencing the working alliance.

Linking Client Variables, Therapist Variables, Working Alliance, and Client Expectations

The way in which Bordin conceptualizes the working alliance emphasizes the idea that technical and process factors are interdependent and "positive developments in each provide a necessary facilitative base for the growth of the other" (Horvath & Luborsky, 1993, p. 563). This suggests that the outcome of psychotherapy depends on both factors together that serve as enhancements to therapeutic progress. Considering that the working alliance has been demonstrated to contribute to psychotherapy outcome as well as play a role in premature termination, it is importance to view this variable as a potential significant part of the therapeutic process. Similarly, clients have expectations regarding the process and outcome of psychotherapy. Specifically, clients may have ideas regarding the extent to which psychotherapy

is and will be successful. Such expectations may influence continuance in psychotherapy. This study attempts to investigate how common factors effect premature termination. Considering the inconclusive findings regarding symptom severity as a predictor of premature termination, the current study attempts to address the existing gap in that area.

Proposed Analysis for Research Questions

Research Question 1

Does the strength of the working alliance as perceived by the therapist predict premature termination in university-based counseling training clinics?

To investigate whether therapist's perception of the working alliance predicts the likelihood of premature termination, a binary logistic regression analysis was used. The dichotomous dependent variable for the current analysis was premature termination (yes/no). The continuous predictor variable was therapist perception of the working alliance (as measured by task, bond, and goal subscales scores and working alliance total score).

Research Question 2

Does the strength of the working alliance as perceived by the client predict premature termination in university-based counseling training clinics?

To investigate whether client's perception of the working alliance predicts the likelihood of premature termination, a binary logistic regression analysis was used. The dichotomous dependent variable for the current analysis was premature termination (yes/no). The continuous predictor variable was client perception of the working alliance (as measured by task, bond, and goal subscales scores and working alliance total score).

Research Question 3

Does client expectation for success predict premature termination in university-based counseling training clinics?

To investigate whether client's expectation of counseling success predicts the likelihood of premature termination, a binary logistic regression analysis was used. The dichotomous dependent variable for the current analysis was premature termination (yes/no). The continuous predictor variable was expectation of client success (as measured by total score and individual item response scores).

Research Question 4

Does client symptom severity predict premature termination in university-based counseling training clinics?

To investigate whether client's symptom severity predicts the likelihood of premature termination, a binary logistic regression analysis was used. The dichotomous dependent variable for the current analysis was premature termination (yes/no). The continuous predictor variable was symptoms severity (as measured by global severity score).

CHAPTER 3

METHODS

Training Clinic

Data for this study was retrieved from a university-based counseling training clinic located within a counseling psychology department at a large southeastern university. This outpatient clinic provides psychological services to college students and community members on a sliding fee scale. This clinic does not accept payment from third parties (e.g. private insurance companies, Medicaid). This clinic provides treatment for a wide range of emotional, educational, interpersonal, and behavioral problems. It serves as a training facility for both masters-level and doctoral-level clinicians. Graduate students provide psychotherapy services to individuals, couples, families, and groups. These students are under direct supervision of licensed psychologists. Upon initial referral, therapists conduct intake sessions to determine appropriateness for receiving services in the clinic. Clients who have predominant alcohol or substance abuse issues are referred to other mental health service providers within the community. Clients are referred out if they have emergency service needs. Graduate student therapists are required to videotape all counseling sessions and receive appropriate supervision.

Participants

The participants in this study were 48 clients receiving individual counseling services from one of the Master's or Doctoral level therapist at the training clinic. Master's and Doctoral level therapists participated in this study as well. Clients who are cognitively impaired or court ordered were excluded from this study. Demographic information was completed by each client participant at intake. Of the 48 participants, 64.6% self-identified as female ($n = 31$) and 35.4 self-identified as male ($n = 17$). Age of participants ranged between 18 and 55 years old, with a

mean age of 22.75. 68.8% of participants self-identified as White ($n = 33$), 10.4% as African American ($n = 5$), 4.2% as Hispanic ($n = 2$), 4.2% as Middle Eastern ($n = 2$), 2.1% as African ($n = 1$), 2.1% as Asian ($n = 1$), 2.1% as Biracial ($n = 1$), 2.1% as German (n = 1), and 2.1% Irish (n = 1). Thirty-eight therapists who were completing a practicum at the clinic participated in this study.

Procedure

This study is part of ongoing systematic evaluation procedures established by the training clinic. Data was gathered at three points of treatment: (a) Intake, (b) Session 3, and (c) Session 10. At intake, each participant signed an informed consent to participate in ongoing research after receiving a thorough explanation by their clinician. Client signatures were received prior to completing any instrumentation. Authorization to collect data for research purposes was approved per client's initial informed consent.

For the purposes of this study, both the clients and their therapists completed packets of questionnaires during treatment beginning in the second week of March of 2011. Data was collected through March of 2012. Because the training clinic serves as a practicum site, therapists continued provided services at the counseling center through the duration of their practicum requirements. Only clients beginning services after the second week of March of 2011 were included in this study. Current clients (e.g. clients beginning services prior to March of 2011) were excluded from the study.

The Working Alliance Inventory- Long Version Form C (Client) and Form T (Therapist) as well as the Expectation for Counseling Success Questionnaire (ECS) contains items about the relationship between the client and their therapist. To minimize possible effects of concern regarding disclosure of potentially negative aspects of the relationship, both therapist and client

packets were sealed in separate envelopes. Clients were told that their responses would not be seen by their therapist.

Client participants were individually administered a demographic questionnaire, the BSI, and the ECS at intake. At Session 3 and Session 10, clients participants were individually administered the WAI and BSI. Therapists completed the WAI at their client's Session 3 and Session 10.

Instruments

Symptom Severity

The Brief Symptom Inventory (BSI) (Derogatis, 1993) is a measure of symptom severity developed by Leonard R. Derogatis in the late 1970's (Derogatis, 1975). The BSI is a 53-item self-report symptom inventory constructed to reflect the psychological symptom patterns of respondents. The BSI is scored and profiled in terms of nine primary symptom dimensions: Somatization (SOM), Obsessive-Compulsiveness (O-C), Interpersonal Sensitivity (I-S), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHOB), Paranoid Ideation (PAR), and Psychoticism (PSY). The BSI is comprised of three global indices of distress: the Global Severity Index (GSI), the Positive Symptom Total (PST), and the Positive Symptom Distress Index (PSDI) (Derogatis, 1993). A 4-point scale of distress is used to rate each item in which an endorsement of 0 indicates 'not at all' and an endorsement of 4 indicates 'extremely' (Derisley & Reynolds, 2000). The GSI helps quantify a patient's level of distress and provide single composite score for measuring the outcome of a treatment program based on reducing symptom severity (Derogatis, 1993). The stability coefficient of the GSI has been found to be .90 (Derogatis, 1993). Overall intensity of client symptoms is measured by the PSDI and prevalence

of self-reported symptoms is measured by the PST. Research indicates that reliability of the BSI ranges from .71 to .85.

Working Alliance

The Working Alliance Inventory-Long Version (WAI) is based on Bordin's (1979) transtheoretical conceptualization of the working alliance. The WAI is a 36-item self-report instrument comprised of three subscales: Goals, Tasks, and Bonds. (Horvath & Greenberg, 1986). The Goals subscale assesses level of agreement between the client and therapist on the objective or outcome of psychotherapy (Horvath & Greenberg, 1989). The level of agreement between the client and the therapist regarding the process of counseling (e.g. behaviors in therapy) is assessed by the Tasks subscale (Horvath & Greenberg, 1989). The Bond subscale assesses the level of agreement between the client and the therapist regarding possession of "mutual trust, acceptance, and confidence" (Horvath & Greenberg, 1989, p. 244). The subscales of the WAI are scored using a 7-point Likert scale which ranges from 1 (never) to 7(always). Scores of the subscales can be summed to acquire a total score ranging from 36-252. Individual subscale scores range from 12-84.

For purposes of this study, two of the three versions of the WAI were utilized: client version (Form C) and therapist version (Form T); the observer version was excluded. Internal consistency of the WAI subscale ranges from .85 to .92 (client version) and .68 to .87 (therapist version) and the internal consistency of the total scores are .93 (client version) and .87 (therapist version) (Horvath & Greenberg, 1989).

Expectations for Success

According to Fisher et al. (1998), clients possess expectations regarding the usefulness of counseling. Positive expectations tend to lead to counseling success (Fisher et al., 1998). Despite

acknowledgement of client expectations as a common factor to treatment effectiveness across theoretical frameworks, to the researcher's knowledge, an instrument assessing client expectations for counseling success does not exist. To measure this construct, Kim, Ng, and Ahn (2005) developed a 5-item self-report based on the definition of expectation for counseling success theorized by Fisher et al. (1998). As shown in Table 1, the ECS uses five items to measure client expectations for success. Respondents answer items utilizing a 4-point scale from 1 (Strongly Disagree) to 4 (Strongly Agree). See Table 1.

Table 1

Expectation for counseling success questionnaire items

Items	
ECS #1	I expect counseling will be helpful for me
ECS #2	I am not hopeful counseling will be beneficial for me
ECS #3	I have faith that seeing a counselor will be helpful for me
ECS #4	I believe in the helpful nature of counseling
ECS #5	I do not expect my life will get better with counseling

Note: Taken from Kim, Ng, and Ahn (2005).

CHAPTER 4

RESULTS

Participants

Participants in the study were clients and therapists at a university-based counseling training clinic on a large university campus in the southeast. A total of 51 adult client participants completed research packets upon arrival at the clinic for an intake. Clients with developmental and cognitive disabilities as well as children and adolescents were excluded from participating in this study. Of the 51 client participants, 6% (n=3) were excluded from this study leaving a total of 48 participants. Two were excluded due to missing data at intake and one was excluded due to receiving both couples and individual counseling during the same time period.

Forty-eight client participants completing data at intake, 37.5% (n=18) were categorized as premature terminators (yes=1) and 62.5% (n=30) were categorized as non-premature terminators (no=0) by the end of the study. Of the 18 total participants categorized as premature terminators, 10 dropped out of treatment after Intake and before Session 3 and eight dropped out of treatment after Session 3 and before Session 10. See Figure 1. Of the 48 participants who completed data at intake, 64.6% (n=31) completed data at Session 3 and 35.4% (n=17) did not complete data at Session 3. Of the 31 participants who completed data at Session 3, 45.2% (n=14) completed data at Session 10 and 54.8% (n=17) did not complete data at Session 10. See Figure 1 and Table 2 for additional information.

Figure 1

Number of participants characterized as premature terminators in sample
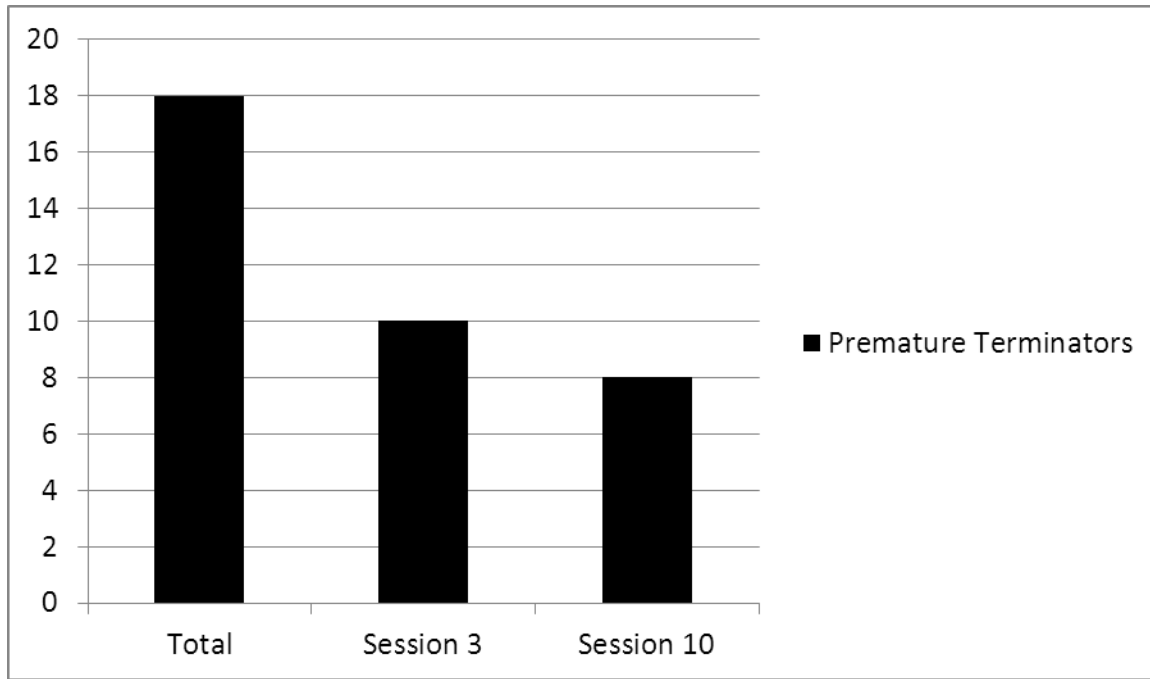
Table 2

Reasons for participants not completing data at Session 3 and Session 10

Session #	Reason	n	P
Session 3		17	35.4
	Premature Termination	10	58.8
	Data Not Returned	3	17.6
	Transferred Clinics/Moved	2	11.8
	Scheduling Conflicts	2	11.8
Session 10		17	35.4
	Premature Termination	8	47.2
	Data Not Returned	7	41.2

Completed Treatment	2	11.8

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Note: Data not returned refers to participants who had not did not attend their third or tenth session prior to the time that the study ended and data stopped being collected.

Thirty-two therapist participants completed data at Session 3. Of the 32 therapist participants, 78.1% (n = 25) of their clients were categorized as premature terminators and 21.9% (n = 7) of their clients were categorized as non-premature terminators. Statistical analyses for client participants and therapist participants were conducted separately.

Descriptive Statistics for Working Alliance

The working alliance was assessed using the Working Alliance Inventory- Long Version Form C (Client) and Form T (Therapist). Both clients' and therapists' perceptions of the working alliance were measured using a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*). Three subscale scores were derived for each participant: (1) Task, (2) Goal, and (3) Bond. One total score was derived for each participant. All participants remaining in the study completed the WAI at Session 3 and at Session 10. Total scores range from 36 to 252 and subscale scores range from 12 to 84.

The WAI does not have cut-off scores to determine high and low alliance. Thus, the current investigator established low and high alliance ranges utilizing the 7-point Likert scale as a gauge. Subscale scores and total scores ranging from never (1) to sometimes (4) were calculated for the low range category. Subscale scores and total scores ranging from often (5) to always (7) were calculated for the high range category. Task, Bond, and Goal subscales scores ranging from 12-48 were considered low alliance ratings. Subscale scores ranging from 60-84 were considered high alliance ratings. Total scores ranging from 36-144 were considered low alliance ratings and total scores ranging from 180-252 were considered high alliance ratings. Figure 2 demonstrates number of client participants in the low and high alliance ranges at

Session 3 for each subscale. At Session 10, all client participants' ratings were in the high

alliance range.

Figure 2

Number of client participants in high and low alliance ranges at Session 3
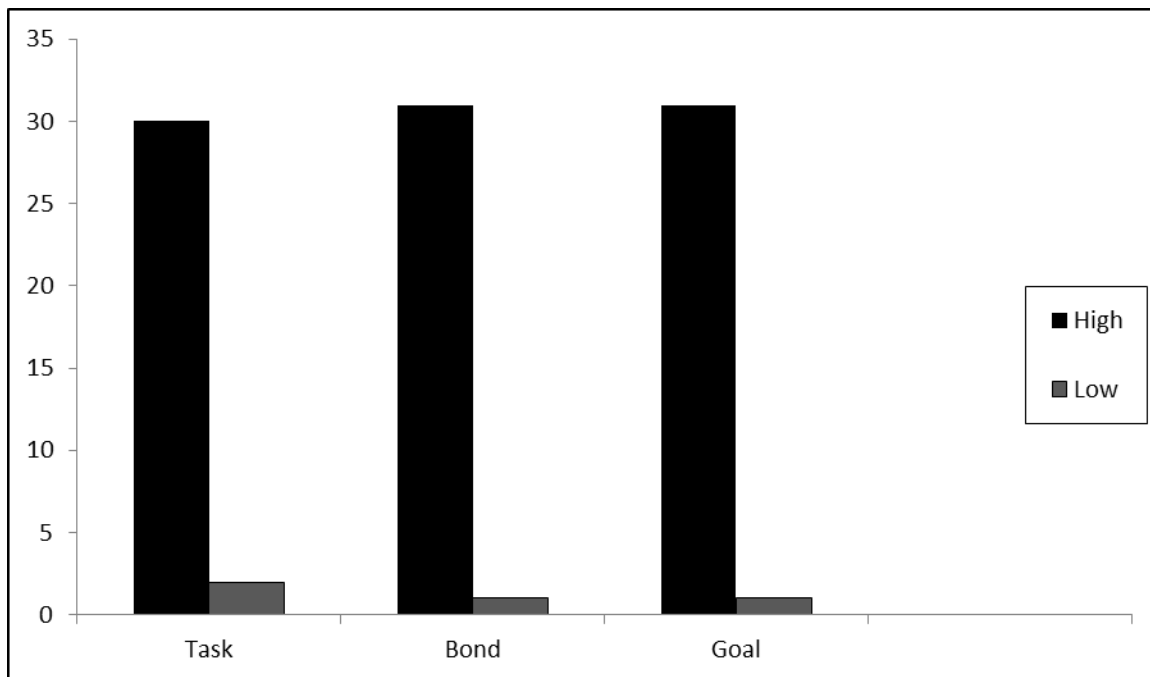
Results revealed dissimilar perceptions of working alliance at Session 3 between clients

and therapists. Specifically, at Session 3, mean scores for client participants were 71.8 for the

Task subscale, 71.8 for the Bond subscale, and 71.2 for the Goal subscale. Client's total score

mean was 214.7. Mean scores for therapists at Session 3 were 63.9 for the Task subscale, 67.9

for the Bond subscale, and 63.2 for the Goal subscale. Therapists total score mean was 194.9 (see

Figure 3).

Figure 3

Comparison of client and therapist mean subscale scores at Session 3 for working alliance
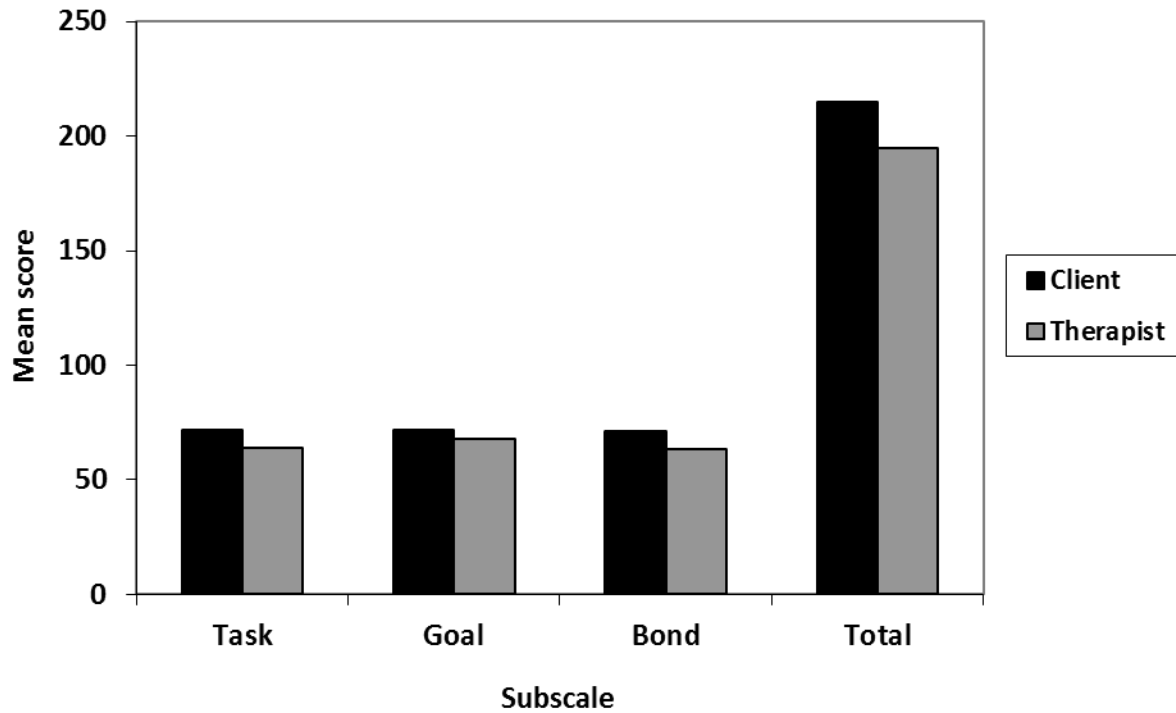
Results revealed incongruent perceptions of working alliance between clients and therapists at Session 10. Specifically, client's produced mean scores of 75.0 for the Task subscale, 73.4 for the Bond subscale, and 74.7 for the Goal subscale. The clients' total score mean was 223.1. Mean scores for therapists were 62.5 for the Task subscale, 68.1 for the Bond subscale, and 63.1 for the Goal subscale. The therapists' total score mean was 193.6, (see Figure 4).

Figure 4

Comparison of client and therapist mean subscale scores at Session 10 for working alliance
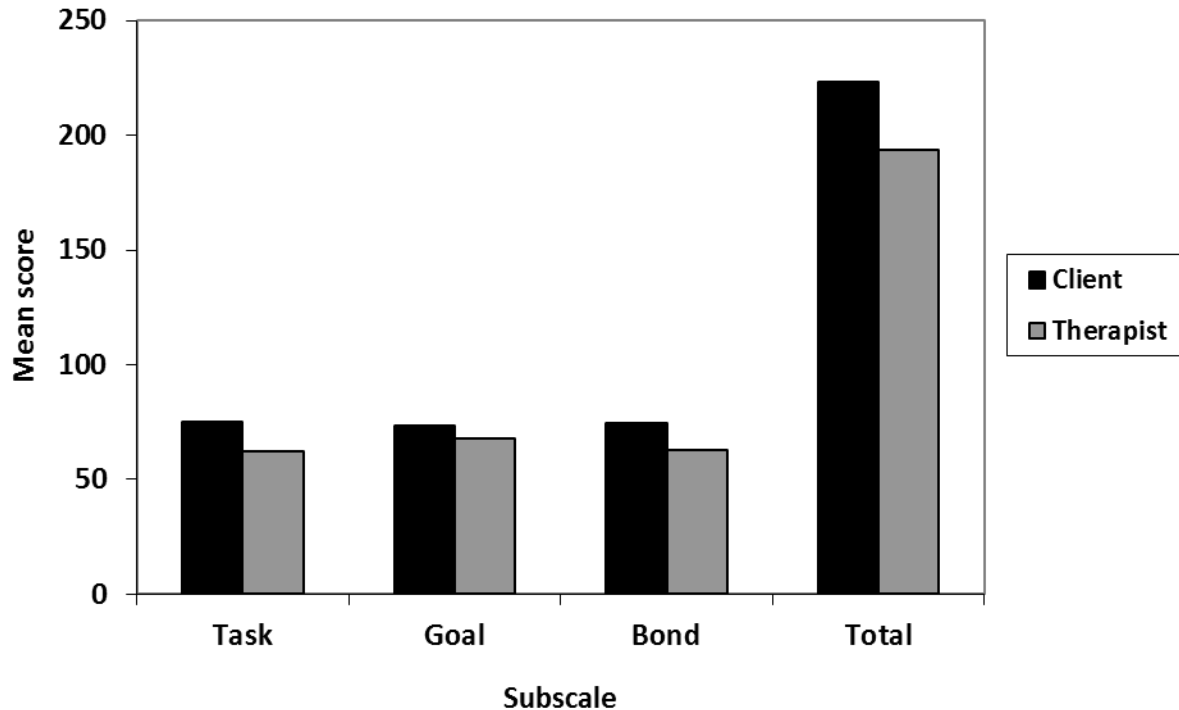

Independent-samples t-tests were conducted to compare WAI subscale scores and total scores for therapist participants and client participants at Session 3. Significant differences were found in total scores for client participants ($M = 214.73$, $SD = 27.84$) and therapist participants ($M = 194.97$, $SD = 23.16$), $t(62)=3.087$, $p=.003$. Mean differences demonstrated a large effect size (eta squared = .133).

Results indicated significant differences in Task subscales scores for client participants ($M = 71.75$, $SD = 10.59$) and therapist participants ($M = 63.90$, $SD = 8.98$), $t(62) = 3.20$, $p = .002$. A large effect size was found (eta squared=.142). Results demonstrated significant differences in Goal subscale scores for client participants ($M = 71.23$, $SD = 9.55$) and therapist

participants (M=63.19, SD=8.81), $t(62) = 3.49$, $p = .001$. Mean differences demonstrated a large

effect size (eta squared=.164). No significant differences were found in Bond subscale scores for

client participants (*M*=71.76, *SD*=9.71) and therapist participants (*M* = 67.88, *SD* = 6.95), $t(62) =$

1.84, *p* = .071.

<div align="center">

Results of Preliminary Statistical Analysis for Working Alliance

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Client Perception of Working Alliance

Binary logistic regression was conducted to determine if the working alliance as

perceived by the client is predictive of premature termination within a university-based training

clinic. Recall three subscales scores and a total score of the WAI-C measured the working

alliance for client participants. Results indicated that the WAI-C total score was not a significant

predictor of premature termination at Session 3. Omnibus Tests of Model Coefficients

demonstrated poor fit at Session 3 ($\chi2 = 15.095.$, df = 8, *p* = .305). Therefore, the hypothesis that

client's perceptions of working alliance would be predictive of premature termination was not

supported.

Binary logistical regression analysis was conducted on the three subscales of the WAI-C,

including (1) Task, (2) Goal, and (3) Bond. Again, results indicated that the model overall was

not a significant predictor. Omnibus Tests of Model Coefficients demonstrated poor fit at intake

($\chi2 = 3.035$, df = 3, *p* = .386). Working alliance, as perceived by the client, does not appear to be

significant in their deciding to prematurely terminate based on these results.

Therapist Perception of Working Alliance

Binary logistic regression was used to determine if working alliance, as perceived by

therapist, is a significant predictor premature termination of clients seeking services within a

university-based training clinic. Recall three subscales scores and a total score of the WAI-T

measured the working alliance for therapist participants. Results indicated that WAI-T total score was not a significant predictor of premature termination at Session 3. Omnibus Tests of Model Coefficients demonstrated poor fit at Session 3 ($\chi2$ = .820, df = 1, p = .365). The hypothesis was not supported.

Binary logistical regression analysis was conducted again on the three subscales of the WAI-T: (1) Task, (2) Goal, and (3) Bond. Results indicated that the model overall was not a significant predictor of premature termination. Omnibus Tests of Model Coefficients demonstrated poor fit at intake ($\chi2$ = 1.068, df = 3, p = .785). Contrary to what was expected, none of the subscales representing working alliance were effective in predicting premature termination.

Descriptive Statistics for Expectations

Client participant's mean expectation scores ranged from 2.20 to 3.40 at intake (M = 2.70, SD = 0.25). At Session 10, mean expectation scores ranged from 2.60 to 3.00 at Session 10 (M = 2.76, SD = 0.11).

Results of Preliminary Statistical Analysis for Expectations

Clients' expectations of counseling success was measured using the five items of the ECS and a total calculated score (see Table 3). A total of 47 participants scores were used for regression analysis. One participant was excluded due to missing data on one of the items of the ECS.

Table 3

Expectation for counseling success questionnaire items

Items	
ECS #1	I expect counseling will be helpful for me

ECS #2	I am not hopeful counseling will be beneficial for me
ECS #3	I have faith that seeing a counselor will be helpful for me
ECS #4	I believe in the helpful nature of counseling
ECS #5	I do not expect my life will get better with counseling

Note: Taken from Kim, Ng, and Ahn (2005).

A binary logistic regression was conducted to test the extent to which client expectations may predict premature termination within a university-based training clinic. The classification table presented in Table 4 demonstrates correct and incorrect estimates of premature termination when the predictor variable, client expectations, is included in the model. The model correctly classified 68.1 percent of observed cases overall, in comparison to the 63.8 percent of cases initially predicted. Results suggest that client expectations of the counseling process can affect premature termination.

Table 4

Results of ECS regression analysis for premature termination

Step	Overall Percentage
Step 0	63.8 (Predicted)
Step 1	68.1 (Observed)

Each of the five questions of the ECS was included in the model. See Table 5 for variables included in the equation and contribution of each variable. Omnibus Tests of Model Coefficients demonstrated goodness-of-fit ($\chi 2 = 16.392$, df = 5, p = .006). The Hosmer and Lemeshow Goodness of Fit Test indicated that the model is supported ($\chi 2 = 4.404$, df = 7, p = 0.732). The Cox and Snell R^2 and the Nagelkerke R^2 indicated that the amount of variance

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explained by the model is between 29.4 and 40.3% (Cox and Snell R^2= .294; Nagelkerke R^2 = .403).

Table 5

Binary logistic regression for premature termination and expectations

Variable	B	S.E.	Wald	df	Sig.	Exp(B)
ECS#1	-.507	1.230	.170	1	.680	.602
ECS#2	-1.948	.997	3.821	1	.051	.142
ECS#3	-1.656	1.431	1.339	1	.247	.191
ECS#4	-1.670	.892	3.501	1	.061	.188
ECS#5	2.132	.920	5.372	1	.020*	8.434

Note: * p < .05; ** p < .01; and *** p < .001.

Logistic regression analysis indicated one of the five predictors as significant. Question 5 of the ECS, "I do not expect my life to get better with counseling", was a significant predictor of premature termination (Wald = 5.372, df = 1, p = 0.02). These results indicate that a lower score on this item increases the chances of terminating prematurely. Higher client expectations (i.e., life getting better with counseling) increases the chances of clients' prematurely ending therapy approximately 8.43 times (OR = 8.434; CI.95 = 1.390, 51.177). Results indicated that the ECS total score was not a significant in predicting premature termination.

Descriptive Statistics for Symptom Severity

Symptom severity was measured using The Brief Symptom Inventory (BSI). Nine symptom dimensions were used: (1) SOM, (2) O-C, (3) I-S, (4) DEP, (5) ANX, (6) HOS, (7) PHOB, (8) PAR, and (9) PSY. The GSI was utilized as a measure of overall level of

psychological distress reported by participants. A 4-point scale of distress is used to rate each ranging from 0 (*not at all*) to 4 (*extremely*). The GSI stability coefficient is .90.

Data indicates that clients' dimension scores decreased over time. GSI scores decreased over time. Figure 5 shows mean dimension scores measured at Intake, Session 3, and Session 10. Figure 6 shows mean GSI scores measured at Intake, Session 3, and Session 10. All scores were based on responses from participants at Intake ($n = 48$), Session 3 ($n = 33$), and Session 10 ($n = 14$).

Figure 5

Mean dimension scores produced by clients at Intake, Session 3, and Session 10
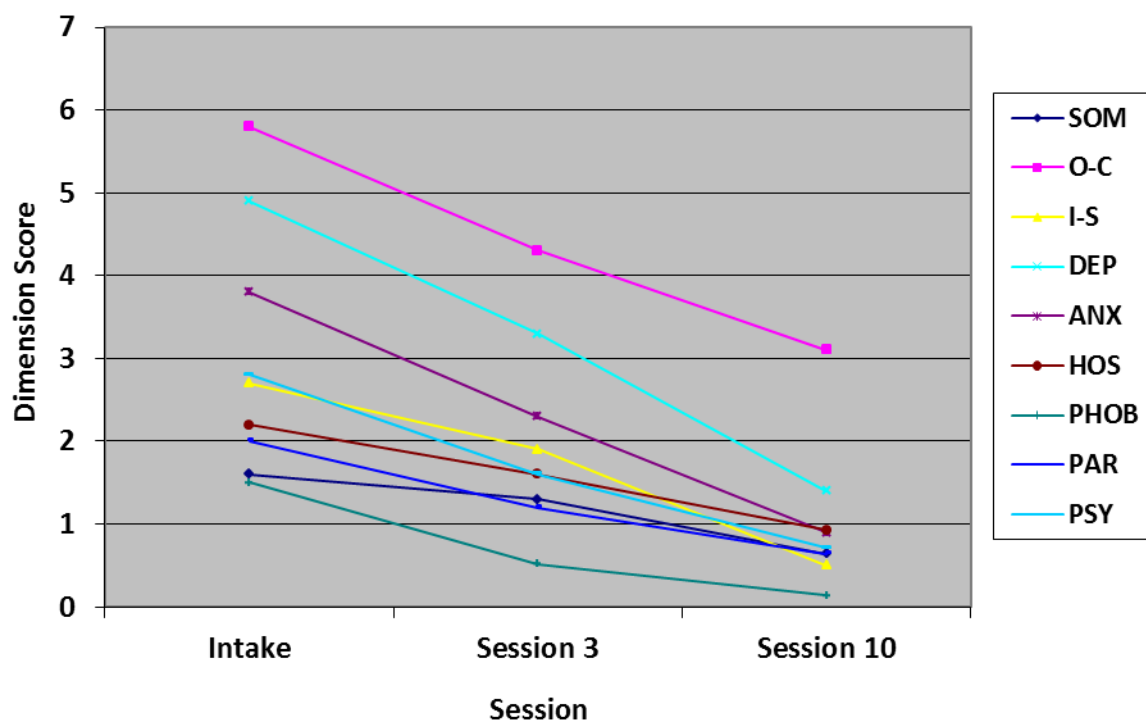
Figure 6

Mean GSI scores produced by clients at Intake, Session 3, and Session
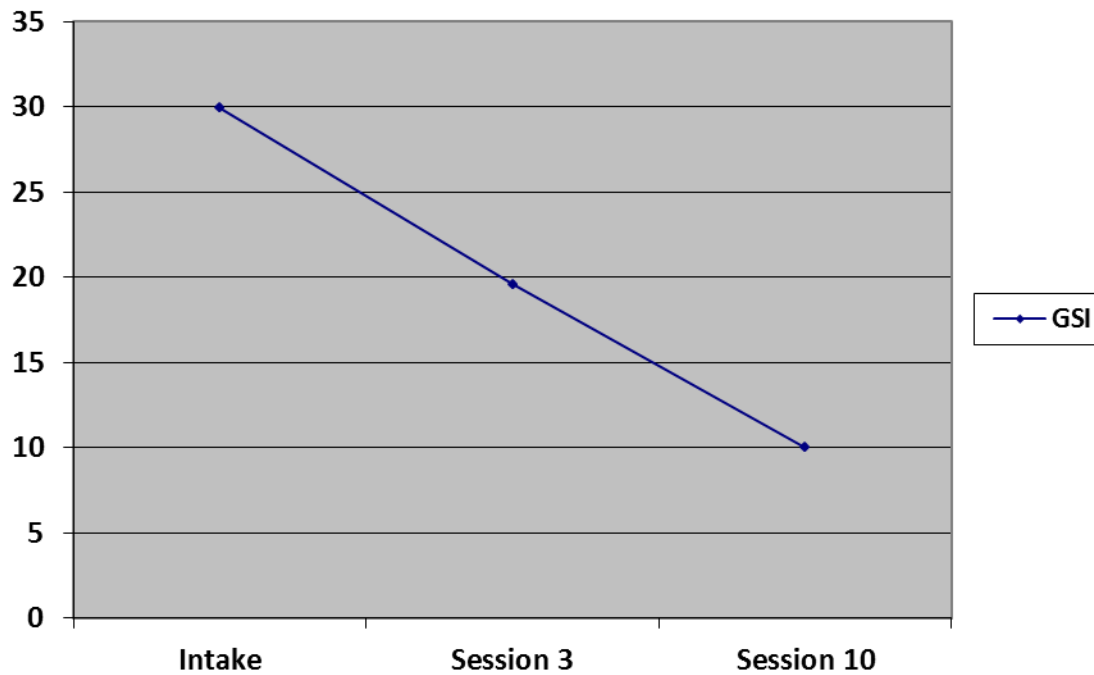
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Results of Preliminary Statistical Analysis for Symptom Severity

Symptom severity was measured using the GSI of the BSI. Reliability of the GSI is measured at .95. Results indicated that GSI score was not a significant predictor of premature termination at Intake or Session 3. Binary logistic regression was used for four factor subscales to determine predictability of each subscale of premature termination. (1) DEP, (2) ANX, (3) HOS, and (4) SOM subscales have been shown to be consistently valid in multiple factor analysis.

Results indicated that the model overall was not a significant predictor of premature termination at intake. Omnibus Tests of Model Coefficients demonstrated poor fit at intake ($\chi2 = 9.216$, df = 4, p = .056). See Table 6 for variables included in the equation and contribution of each variable.

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Table 6

Binary logistic regression for premature termination and BSI subscales at Intake

Variable	B	S.E.	Wald	df	Sig.	Exp(B)
HOS	-.479	.212	5.098	1	.024*	.619
DEP	.135	.083	2.674	1	.102	1.145
ANX	-.059	.148	.157	1	.692	.943
SOM	-.415	.505	.677	1	.411	1.205

Note: *p < .05; **p < .01; ***p < .001 .

Among the four subscales, HOS was significant at intake (Wald = 5.098, df = 1, p = .024). These results indicated that an increased score on this scale decreases the probability of terminating treatment prematurely .62 times (OR=.619; CI.95 = .409, .619). All other subscales failed to predict premature termination.

Results indicated that the model overall was a significant predictor of premature termination at Session 3. Omnibus Tests of Model Coefficients demonstrated goodness of fit (χ2 = 12.712, df = 4, p = .013). See Table 7 for variables included in the equation and contribution of each variable.

The model correctly classified 81.8 percent of cases overall, demonstrating an improvement over the 72.7 percent of cases correctly classified in Block 0. Among the four subscales, SOM was significant at intake (Wald = 4.407, df = 1, p = .036). These results indicated that a decreased score on this scale increases the probability of terminating treatment prematurely 2.89 times (OR=2.89; CI.95 = 1.073, 7.785). Stated differently, as somatic symptoms decrease, the chances of terminating treatment prematurely increases.

Table 7

Binary logistic Regression for premature termination and BSI subscales at Session 3

Variable	B	S.E.	Wald	df	Sig.	Exp(B)
SOM	1.061	.506	4.407	1	.036*	2.890
DEP	.098	.150	.423	1	.516	1.103
HOS	.415	.434	.913	1	.339	1.514
ANX	-.779	.537	2.101	1	.147	.179

Note: * p < .05; ** p < .01; and *** p < .001.

CHAPTER 5

DISCUSSION

Restatement of the Problem

Researchers are still unclear regarding how and why clients terminate from treatment prematurely. Despite interest in understanding the factors associated with premature termination, findings are mixed and inconsistent. Few studies exist that investigate this phenomenon in a university-based counseling training clinic. This study attempts to explore symptom severity, working alliance, and expectations for counseling success to contribute to field in that area.

Restatement of the Purpose

The purpose of this study was to examine select common factors to therapeutic outcome, specifically premature termination. Recognizing variables that predict this occurrence could aid therapists in treatment planning, as well as help to identify clients who may be at greater risk of terminating prematurely. Thus, therapists may be better able to help clients gain the full benefits of psychotherapy through continued treatment. Understanding factors that contribute to premature termination can be particularly useful in a training clinic environment where beginning therapists might attribute clients failing to attend therapy as their own personal and professional failure.

Restatement of the Procedure

This study was conducted as a part of ongoing systematic evaluation procedures in a university-based counseling training clinic where clients receive symptom measures at various points in treatment (e.g. Intake, Session 3, and Session 10). Clients agree to participate in research as a part of the informed consent signed at intake.

The Expectation of Counseling Success (ECS) questionnaire, Brief Symptom Inventory (BSI), and demographic questionnaire was individually administered to client participants at Intake. At Session 3 and Session 10, client participants completed the BSI and Working Alliance Inventory- Long Version (WAI-C). At their client's third session, therapist participants completed the WAI-T. Client participants were informed that their therapist would not see their responses to the questionnaires.

Description of Statistical Analysis

Binary logistic regression attempts to answer questions about predictor variables. In the current study, predictor variables include working alliance, expectations for success, and symptom severity. Each predictor variable was continuous. Binary logistic regression answers questions including "Which variables predict outcome? How do variables affect the outcome? and does a particular variable increase or decrease the probability of an outcome, or does it have no effect on outcome?" (Tabachnick & Fidell, 2007, p. 439). Binary logistic regression analysis was utilized to answer questions about the predictor variables (working alliance, expectations for success, and symptom severity) as they relate to an outcome (premature termination).

Logistic regression assesses the likelihood of a specific outcome for each case included in the study (Tabachnick & Fidell, 2007). In the current study, logistic regression examined the likelihood that a client will terminate treatment prematurely or not, given the way in which they responded to a measure (e.g. BSI, WAI-C, ECS). A model using these predictor variables can be tested to determine whether the model overall is predictive of the outcome (premature termination). Variables included in the model can be referred to as blocks. Block 0 refers to the results of the analysis without predictor variables and Block 1 is results of the analysis with the predictor variable included in the model. Goodness-of-fit tests used in this study were Omnibus

Test of Model Coefficients and the Hosmer and Lemeshow Test. Values less than .05 are considered significant in the Omnibus Test of Model Coefficients and values greater than .05 is considered significant in the Hosmer and Lemeshow Test. Goodness-of-fit provides information about how much better Block 1 (set of predictor variables) predicts premature termination as compared to Block 0 (no predictor variables). Logistic regression analysis provides information regarding the percentage that Block 0 and Block 1 correctly classified those who actually terminated prematurely. Binary logistic regression also provides information about the significance of each predictor variable individually using the Wald test. Wald values less than .05 are considered significant.

<center>**Research Questions Included in the Study**</center>

The present study investigated the predictability of the working alliance, symptoms, and expectations to premature termination in a university-based counseling training clinic.

Findings Regarding Perception of the Working Alliance and Premature Termination

Research Question 1 and Research Question 2

Results of binary logistic regression demonstrated that neither client nor therapist perception of the working alliance were significant predictors of premature termination. Recall that the Omnibus Test of Model Coefficients demonstrated that WAI-C total scores were not significant. Client's perception of the working alliance was not significant ($p=.305$). These results suggest that client perception of the working alliance did not predict premature termination.

Results of logistic regression analysis of each of the three subscales of the WAI-C and WAI-T indicated that client and therapist ratings were not predictive of premature termination. Overall, these findings are inconsistent with other studies demonstrating that the working

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alliance is predictive of premature termination. Considering that this study was conducted in a training clinic environment, it is difficult to generalize results of studies conducted in other outpatient settings.

Results of the current study indicated that over ninety percent of client's ratings were in the high alliance range. Although the WAI has been demonstrated to be a reliable measure, to the researcher's knowledge, it does not include cut-off ranges for what is considered high versus low alliance. Recall that arbitrary cut-off scores were established in the current investigation to categorize which clients were in the high and low alliance range. It is possible that the uniformly high alliance ratings found in this study may have contributed to the lack of predictability of working alliance to premature termination.

It is also possible that there were some clients within the high alliance range that may have experienced their therapeutic relationship as more negative than they admitted. Stated differently, clients may have felt that disagreement existed between themselves and their therapist regarding tasks and goals of therapy. Clients may not have disclosed the extent to which they perceive the working alliance as negative. Safran, Muran, Samstag, and Stevens (2001) suggest that clients may have difficulty recognizing or being willing to reveal disagreement or discomfort with their clinician. "Therapists should be aware that patients often have negative feelings about the therapy or the therapeutic relationship, which they are reluctant to broach for fear of the therapist's reactions" (Safran et al., 2001, p. 410).

Findings Regarding Client Expectations for Success and Premature Termination

Research Question 3

Binary logistic regression was used again to determine predictability of client expectations for success using the ECS total score and ECS individual item responses. Recall

that the model tested included each of the five items of the ECS. The model correctly classified 68.1% of clients into premature termination and non-premature termination categories. This demonstrates an improvement over the 63.8% categorized without using predictor variables. Among each of the five items of the ECS, one item was a significant contributor to the model overall. This means that the way in which clients responded to this item played a significant role in whether are not they terminated from treatment prematurely. Results demonstrated that clients with a lower score on Question 5 of the ECS ("I do not expect my life to get better with therapy) were more likely to terminate treatment prematurely. One question approached significance at the .05 level. Question 2 of the ECS ("I am not hopeful counseling will be beneficial for me") contributed to the overall predictability of the model. The Wald test indicated that ECS Question 5 as significant ($p=.020$), and Question 2 approaching significance ($p=051$).

It appears that clients who came into therapy with the expectation that therapy would change their lives were more likely to terminate treatment prematurely. It is possible that these high expectations were incongruent with what actually occurred in therapy. Stated differently, clients may have determined that their idea about extent to which therapy would change their lives was not accurate. Perhaps they ended treatment once this became a realization. This finding is not consistent with those of Nock & Kazdin (2001) who found that clients with either extremely high or extremely low expectations for therapy were more likely to terminate treatment prematurely.

Remember that client responses to Question 5 were the only significant contributing predictor of premature termination. Although each question of the ECS purports to measure client's expectations of success, the argument could be made that Question 5 targets a different aspect of expectations than the other four questions of the measure. It is possible that Question 5

addresses a more global concept of the client's life. This aspect of expectancies addresses a concept that is external in nature; a concept that may or may not be within the client's control. One could hypothesize that such an expectation is over aspirational; thus provoking the client to terminate treatment when their life does not change drastically with therapy. Remember that 10 of the 18 clients who terminated treatment did so prior to the third session. Outcome literature suggests that at least 11 sessions are necessary for the majority of clients to experience recovery (Hansen et al., 2002).

Findings Regarding Symptoms Severity and Premature Termination

Research Question 4

Results of binary logistic regression demonstrated that symptom severity as measured by the GSI of the BSI did not predict premature termination. Results of the analysis suggest that client's overall level of distress at Intake or Session 3 were not predictive of premature termination. This means the level of distress that clients reported were not a factor in determining whether or not they continued treatment. We would expect that clients who experienced a significant amount of distress would want to continue treatment to feel better.

These results are difficult to compare to results of previous research on symptom severity and premature termination. This limitation is in part due to the limited availability of research in this area. Of the studies conducted on symptom severity related to premature termination, most research utilizes the MMPI as a symptom measure. Even a widely used, reliable instrument like the MMPI has failed to yield consistent findings overall regarding personality dimensions, symptom severity, and disorders that predict premature termination. To the researcher's knowledge, there are currently no recent investigations of premature termination using the BSI as

a measure of symptoms severity in clients. Thus, it is not surprising that the current study did not yield findings suggesting that symptom severity overall predicts premature termination.

Regarding the four symptom dimensions assessed at Intake, clients who reported a high level of hostility at intake were less likely to terminate treatment prematurely. There are three categories of the hostility dimension of the BSI: (1) thoughts, (2) feelings, and (3) actions. People who endorse items on this dimension are experiencing irritability, annoyance, and impulse to break objects (Derogatis & Melisaratos, 1983). This finding is surprising, and counterintuitive. It seems feasible to assume that clients who demonstrate hostile behaviors might also have more difficult interpersonal relationships. These relationships include not only argumentative, hostile relationship with their family and friends, but also a more negative interpersonal relationship with their therapist. However, the majority of clients in the study reported positive therapeutic relationships between themselves and their clinician. It is possible that a caring, supportive relationship contributed to a positive outcome, even among clients who may be more difficult to work with due to hostility. Recall that hostility dimension scores, like all other dimensions of the BSI, decreased after intake.

Another possibility could be that clients who report greater levels of hostility could also be getting more external pressure to continue treatment. We could assume that clients demonstrating irritability among their family might be encouraged to continue treatment by their loved ones. Other clients demonstrating hostile behavior on the job may be receiving pressure from their boss or supervisor to seek treatment. Consequences of a hostile behavior may be an additional motivator to continue treatment, even if the client would rather not. It is important to note that the interpersonal sensitivity dimension (I-S) of the BSI measures discomfort during social interactions as well as a low sense of self-worth (Derogatis & Melisaratos, 1983). The I-S

does not provide information regarding the extent to which clients believe that they have conflictual interpersonal relationships.

Results of binary logistic regression assessing the four dimension scales at Session 3 suggested that this model was predictive of premature termination. The four dimension scores together correctly categorized 81.8% of clients as premature terminators and non-premature terminators. When none of the variables were included in the equation, only 72.7% were correctly classified. This represents an improvement. The SOM dimension was the variable that contributed significantly to the model. This indicates that this dimension scale is highly predictive of premature termination. Clients with a lowered score on this dimension had an increased likelihood of terminating treatment prematurely. The SOM dimension measures physiological symptoms, including body aches and discomfort of psychological distress Derogatis & Melisaratos, 1983). These results make intuitive sense. As client's somatic symptoms decrease, they may feel that they have achieved the requisite level of therapeutic improvement.

Discussion of Additional Findings

The current study produced several important findings that are not directly related to the above research questions. Of note is the lowered rate of premature termination rate demonstrated in the study. Research suggests that prevalence rates for premature termination in outpatient settings range from 65-85% (Garfield, 1994). Average prevalence rates have been found at around 47% (Wierzbicki & Pekarik, 1993). In the current study, 37.5% of clients terminated treatment prematurely. A retention rate of 62.5% was demonstrated. These percentages are a dramatic reduction from the range typically seen in outpatient settings. Although premature termination was not predicted by working alliance, results demonstrated that significance was

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approached. As previously mentioned, overall, clients reported high levels of the working alliance. This indicated that they perceived a collaborative, caring relationship with their therapist. Years of psychotherapy research demonstrate the significance of an established working alliance to the successful outcome of psychotherapy.

Results of the current study suggested that clients perceived the working alliance as stronger than their therapists. These results are consistent with other findings that disagreement exists between therapist and client perceptions of the working alliance (e.g. Fitzpatrick et al., 2005). Research indicates that clients tend to rate the working alliance as higher than their therapist (Bachelor & Salame, 2000; Cecero et al., 2001). In comparing measures of the working alliance, Tichenor & Hill (1989) found that the therapist perception and client perception of the working alliance did not converge. It is possible that therapists and clients differ in the way in which they view the alliance. Howard, Turner, Olkin, and Mohr (2006) suggest that this discrepancy could be related to the idea that alliance measures may not assess similar constructs for therapists and clients.

Recall that each dimension subscale score of the BSI decreased over time. This means that client's symptoms improved from Intake to Session 3 and from Session 3 to Session 10. This demonstrates the effectiveness of psychotherapy to outcome. Despite more than 50 years of research confirming the overall effectiveness of psychotherapy, little research has adequately examined the relationship between training programs and therapy outcome.

Limitations

This study was conducted utilizing a small sample at a university-based counseling training clinic. Accruing a larger sample size in a setting such as a training clinic can be difficult for several reasons. First, this clinic referred out clients with significant substance use problems

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and severity that exceed the scope of practice that can be provided by therapists in training. This limited the number of clients that can be seen and therefore participate in the study. Secondly, it is impossible to predict how many clients will drop-out of treatment. Considering that there is near non-existent prevalence studies for premature termination in training clinic environments (Callahan, Aubuchon-Endsley, Borja, & Swift., 2009), projecting sample size is difficult. The findings of the current study should be interpreted with caution, and generalized to similar settings conservatively. This study should be replicated using a larger sample size.

A major limitation in the current study and the literature in general, is the definition of premature termination. Premature termination is a construct that is challenging to measure and "researchers interested in investigating premature termination are faced with the formidable task of selecting an operational definition for measuring this convoluted phenomenon"(Hatchett & Park, 2003). Considering that rates of premature termination changed depending on the operationalization of the term (Wierzbicki & Pekarik, 1993 as cited by Hatchett & Park, 2003), results of the current investigation may have been affected by this variation as well. The present study defined premature termination as a client failing to return to therapy after their last appointment and did not return for treatment. In their study Hatchett & Park (2003) indicated preference for this definition. However, it may be too simplistic and may not fully capture the construct of premature termination. In the current study, it may not be accurate to assume that all clients classified as premature terminators by this definition are similar. According to Hatchett and Park (2003) this definition may actually be assessing a different construct, like "lack of conscientiousness or avoidance of termination issues" (p. 230). Although clients who informed their clinician of extenuating circumstances that preclude continuing with counseling (e.g.

moving to another city), this study did not gather follow-up information regarding other reasons clients may have ended treatment.

The current study did not examine the extent to which experience level of therapist affected premature termination. To date, the effects of training levels on premature termination have yielded variable findings. Atkins and Christensen (2007) examined methodological issues inherent within these studies which make interpretation of findings difficult. According to Atkins and Christensen (2007) one major issue is regarding supervision. Most studies examining the relationship between degree of clinical experience and client dropout fail to indicate the extent to which, and if, trainees received supervision and/or consultation during the study (Atkins & Christensen, 2007).

The current study assesses client expectation for success using the ECS. Given that this measure has only been used in one study prior to the current study, it is not clear the extent to which this measure is reliable and valid. The current study addressed client expectations for counseling success at intake, prior to meeting with their therapist. Expectations, like other therapeutic factors, are not static (Dew & Bickman, 2005). It is possible that client expectations changed over time in either direction. Thus, making it difficult to determine how changing expectations may interact with other variables (e.g. symptom improvement, working alliance). However, Dew and Bickman (2005) assert that assessing expectancies prior to clients attending therapy sessions is most suitable, given expectancies are anticipatory in nature. Dew & Bickman (2005) note that "another problem in the measurement of expectancies deals with the measures themselves" (p. 25).

The current study is limited in that statistical analyses were not conducted to determine whether demographic variables play a role in predicting premature termination, specifically in

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this sample. This was largely due to the limited range of demographic variables available. Specifically, the majority of participants in this study were female clients identifying as White. Participants did not identify themselves as being from a range of racial/ethnic groups. Additionally, other demographic variables such as age and socio-economic status were not considered as possible predictors of premature termination. Future studies should investigate these factors in a larger, more diverse sample.

Implications and Future Directions

"Psychotherapy is a multimodal, complex dynamic interpersonal process that interacts with an array of in-treatment and external influences which contribute to a range of current and delayed effects" (Miller, 1998, p. 78). Thus, answering the question of what factors contribute to premature termination inherently lends itself to further complexity. Results of this study demonstrate that understanding which factors are predictive of premature termination prove valuable. It is imperative to consider multiple therapeutic factors and premature termination in context. Determining which strategies are the best are as complicated as the therapeutic process itself. "Patients' decisions to terminate therapy, like their decisions to begin it, depend on multiple influences. The more of these factors that we can take into account, and the better our understanding of the mechanisms that underlie the phenomenon of patient-initiated premature termination, the better we should be able to develop and employ interventions that reduce the number and frequency of such terminations" (Ogrodniczuk et al., 2005, p. 68).

The current study has profound implications for those practicing as therapists, particularly in a training clinic environment. The current study demonstrates that there are some factors for therapists to consider both during and throughout the course of treatment. Client expectancies about therapy play a role in the whether or not clients terminate treatment

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prematurely. Considering that clients form opinions about how therapy works long before their first encounter with their therapist, these expectations should be addressed early on in treatment. To reduce the occurrence of premature termination, Ogrodniczuk et al. (2005) assert that "Prior to the commencement of therapy, implement procedures that teach the patient about the rationale for psychotherapy, role expectations, how treatment evolves, common misconceptions about psychotherapy, and possible difficulties one may experience in therapy" (p. 60). According to Ogrodniczuk et al. (2005), preparing clients for therapy has been the most frequently suggested strategy for decreasing premature termination.

There is less likelihood that clients who terminate treatment prematurely will demonstrate the psychological benefits of those clients who continue treatment (Coatsworth, Santisteban, McBride, & Szapocznik, 2001; Stanton & Shadish, 1997). To maximize clinical gains for all clients, it is necessary for psychologists to note factors that may make clients more at risk for premature termination. The current study suggests that it is important for therapists to notice levels of hostility as reported by clients on symptom measures. In the current study, clients with high levels of hostility were less likely to terminate treatment prematurely.

Research indicates that clients are typically ready to end treatment sooner than their therapists believe is appropriate. Clients expect a shorter length of treatment than their therapists expect (Mueller & Pekarik, 2000). The current study suggests that clients with lower levels of somatic symptoms after the third session are more likely to terminate treatment. It is possible that clients who experience a significant amount of somatic distress at intake, and experience decreased somatic decrease over a few sessions, may feel that they no longer need treatment. For clients, this may be a desired level of change. Therapists should begin to talk with their client

about symptom improvement and collaborate with clients regarding direction of therapy, even if that means appropriate termination.

Exploring the ways in which these variables, together, predict premature termination would be helpful in making further inferences regarding how and why clients terminate treatment prematurely. The current study attempted to predict premature termination by examining predictor variables separately (working alliance, symptom severity, and expectations). This was by and large a function of the small sample size of the current study. When conducting logistic regression analysis, large parameter estimates and standard errors can occur when there are more predictor variables relative to number of cases included in the sample (Tabachnick & Fidell, 2007). We know that therapy is a complicated process that involves several factors simultaneously. Research indicates that a positive working alliance helps clients to endure the painful processes that can occur in psychotherapy. It would be interesting to investigate how the working alliance moderated the relationship between client's reported distress and premature termination. Assuming that these processes occur separately limits the extent to which we can understand the phenomenon of premature termination.

Considering that research consistently emphasizes client perspective as predictive of outcome, more so than therapist perspective (See Horvath & Symonds, 1991 for review), it is important to attend to the client's perspective of the working alliance in a treatment context. Given that clients may have more difficulty disclosing negative reactions to the therapy relationship, it is even more important for therapists to recognize and attend to signs of a weakened alliance. Safran et al. (2001) encourage therapists to take responsibility for exploring, with clients, what is occurring in the therapeutic relationship. "It appears important for patients to have the experience of expressing negative feelings about the therapy to the therapist, should

they emerge, or to assert their perspective on what has transpired when it differs from the therapist's perspective" (Safran et al., 2001, p. 411).

Again, the current study is limited in that there were no follow-up measures for determining whether or not clients who terminated treatment were satisfied. According to Mueller and Pekarik (2000) research suggests that symptom improvement and dissatisfaction with treatment can co-exist. Essentially, clients can be unhappy with the course of therapy despite improvement. Future research should consider including a follow-up component to gain the client's perspective regarding reasons for premature termination once therapy has ended.

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