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Help Predict Who Will Drop Out?

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Marlene Best

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*This dissertation is dedicated to my husband, Ron Chapman,
who planted the seed and tended it lovingly*

and

*to my parents, Fred and Kay Best, who always believed I could do anything I chose to,
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Table of Contents

List of Appendixes	vi
List of Tables	vii
Abstract	10
Introduction	12
Background	14
Demographic Factors	14
Personality Factors	15
Therapist Factors	16
Therapy-Specific Factors of Interest in This Study	18
Therapeutic Alliance	18
Discrepancies Between Clients' and Therapists' Expectations for Therapy	23
Expectations of Treatment Duration	23
Expectations of the Therapy Experience	25
Contextual Variables of Interest in this Study	29
Barriers to Treatment Participation	29
Moderating Effects of Pre-Therapy Motivation and Stage of Change	32
Theory of Self-Determination	32
Transtheoretical Model of Change	35
Definition of Premature Termination	39
Summary of Research to Date	42
Hypotheses	43
Method	48
Participants	48
Demographic Characteristics of Sample	49
Procedure	54
Recruitment	55
Interviews	56
Measures	61
Results	72
Preliminary Analyses	72
Testing of Hypotheses	75
Hypothesis 1:	76
Hypothesis 2	89
Hypothesis 3	97
Hypothesis 4	107

Hypothesis 5	113
Hypothesis 6	123
Summary of Results	141
Discussion	144
Summary of Findings	145
Hypothesis 1	145
Hypothesis 2	146
Hypothesis 3	146
Hypothesis 4	147
Hypothesis 5	147
Hypothesis 6	148
Discussion of Findings	149
Education and Income	149
Expectations of Treatment Duration	150
Working Alliance	154
Barriers to Treatment Participation	158
Theory of Self-Determination	160
Transtheoretical Model of Change	162
Strengths and Limitations of the Study	165
Methodological Limitations	165
Measurement Issues	167
Statistical Limitations	170
Implications for Research and Clinical Practice	171
Future Research Directions	171
Clinical Implications	176
Conclusion	181
References	182
Appendixes	200

List of Appendixes

Appendix A	
Script for Clinicians Conducting Screening Calls	200
Appendix B	
Consent for Time 1–Client	201
Appendix C	
Notice to Therapists	203
Appendix D	
Consent for Time 2–Client	204
Appendix E	
Consent for Time 2–Clinician	206
Appendix F	
Consent for Time 3–Client	208
Appendix G	
Consent for Time 3–Clinician	210
Appendix H	
Client Demographic Information	211
Appendix I	
Symptom Checklist - 10 (SCL-10)	213
Appendix J	
Working Alliance Inventory–Client Form	214
Appendix K	
Working Alliance Inventory–Clinician Form	215
Appendix L	
Client Motivation For Therapy Scale	216
Appendix M	
Stage of Change Scale	217
Appendix N	
Global Assessment of Functioning (GAF) Scale	218
Appendix O	
Client Expectations	219
Appendix P	
Clinician Expectations	220
Appendix Q	
Barriers to Treatment Participation Scale - Client	221
Appendix R	
Termination Questions for the Client.....	223
Appendix S	
Barriers to Treatment Participation Scale - Therapist	224
Appendix T	
Termination Questions for the Clinician	226
Appendix U	
Final Notice to Therapist	227

List of Tables

Table 1:	Transformations of Variables.....	74
Table 2:	Intercorrelations Between Variables from Client's Perspective.....	77
Table 3:	Hierarchical Regression of Measures of Client Perspective (Client Expectations Time 1) on Total Number of Therapy Sessions.....	79
Table 4:	Hierarchical Regression of Measures of Client Perspective (Client Expectations Time 2) on Total Number of Therapy Sessions.....	81
Table 5:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective (Client Time 1 Expectations).....	82
Table 6:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective (BTPS Subscales).....	86
Table 7:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective (Client Expectations Time 2).....	87
Table 8:	Intercorrelations Between Variables from Therapist's Perspective.....	90
Table 9:	Hierarchical Regression of Measures of Therapist Perspective on Total Number of Therapy Sessions.....	91
Table 10:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Therapist's Perspective.....	93
Table 11:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Therapist's Perspective (BTPS-Subscales).....	96
Table 12:	Intercorrelations Between Expectation and Barrier Variables from Client and Therapist Perspectives.....	98
Table 13:	Hierarchical Regression of Measures of Client and Therapist Perspectives on Total Number of Therapy Sessions - Client Time 1 Expectations for Number of Therapy Sessions.....	100
Table 14:	Hierarchical Regression of Measures of Client and Therapist Perspectives on Total Number of Therapy Sessions - Client Time 2 Expectations for Number of Therapy Sessions.....	103

Table 15:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Therapist's Perspective Over Client's Perspective.....	105
Table 16:	Hierarchical Regression of Measures of Therapist and Client Perspectives on Total Number of Therapy Sessions.....	110
Table 17:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective Over Therapist's Perspective.....	112
Table 18:	Intercorrelations Between Client and Therapist Expectations for Number of Therapy Sessions and Difference Score Variables.....	115
Table 19:	Hierarchical Regression of Measures of Client Time 1 Expectations and the Difference Between Therapist Time 2 and Client Time 1 Expectations on Total Number of Therapy Sessions.....	116
Table 20:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Differences in Client Time 1 Expectations of Number of Therapy Sessions and Therapist Time 2 Expectations for Number of Therapy Sessions-Client Perspective.....	118
Table 21:	Hierarchical Regression of Measures of Client Time 2 Expectations and the Difference Between Therapist Time 2 and Client Time 2 Expectations on Total Number of Therapy Sessions.....	120
Table 22:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Differences in Client Time 2 Expectations of Number of Therapy Sessions and Therapist Time 2 Expectations for Number of Therapy Sessions-Client Perspective.....	122
Table 23:	Intercorrelations Between Variables Used to Test Moderator Hypotheses...	124
Table 24:	Hierarchical Regression of Moderator Effect of Client Motivation for Therapy on Client Time 1 Expectations for Number of Therapy Sessions on Total Number of Therapy Sessions.....	126
Table 25:	Hierarchical Regression of Moderator Effect of Client Motivation for Therapy on Barriers to Treatment Participation- Client's Perspective on Total Number of Therapy Sessions.....	127
Table 26:	Hierarchical Regression of Moderator Effect of Client Motivation for Therapy on Working Alliance from Client's Perspective on Total Number of Therapy Sessions.....	128

Table 27:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Client Motivation for Therapy of Client Expectations for Number of Therapy Sessions.....	130
Table 28:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Client Motivation for Therapy of Barriers to Treatment Participation from Client Perspective.....	131
Table 29:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Client Motivation for Therapy of Working Alliance from Client Perspective.....	132
Table 30:	Hierarchical Regression of Moderator Effect of Stages of Change on Client Expectations of Number of Therapy Sessions at Time 1 on Total Number of Therapy Sessions.....	134
Table 31:	Hierarchical Regression of Moderator Effect of Stages of Change on Barriers to Treatment Participation- Client's Perspective on Total Number of Therapy Sessions.....	135
Table 32:	Hierarchical Regression of Moderator Effect of Stages of Change on Working Alliance - Client's Perspective on Total Number of Therapy Sessions.....	136
Table 33:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Stages of Change of Client Expectations for Number of Therapy Sessions.....	138
Table 34:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Stages of Change of Barriers to Treatment Participation from Client Perspective.....	139
Table 35:	Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Stages of Change of Working Alliance from Client Perspective.....	140
Table 36:	Summary of Results of All Analyses.....	142

Abstract

This longitudinal study was designed to refine the search for reliable predictors of premature termination from adult psychotherapy by examining therapy-specific and contextual factors that may predict clients' decisions to leave treatment early. These variables included client's stage of change prior to treatment, client's level of self-determination or motivation for therapy, client and therapist expectations and any discrepancies between them, the therapeutic alliance, and practical barriers to treatment participation. To facilitate comparison with previous research, premature termination was operationalized in two manners, duration of treatment and type of termination decision (unilateral versus mutual agreement with the therapist), although type of termination decision was considered a better measure of premature termination. These variables were examined with self-report data from 107 client/therapist dyads at a community mental health clinic. Data were collected prospectively and retrospectively from both client and therapist perspectives before therapy began, after the third treatment session, and after therapy ended.

Logistic regression analyses showed that barriers to treatment participation, measured at the end of therapy, and working alliance, measured after the third treatment session, predicted type of termination from the client perspective, and barriers predicted type of termination from the therapist's perspective. The therapist's perception of barriers to treatment added incremental predictive value to that of the client's. The client's perspective on barriers to treatment also enhanced the predictive value of the therapist's perception of barriers. The discrepancy between client and therapist expectations for therapy duration did not predict the nature of the termination decision. When a client had a low self-

determination index score, or was non self-determined, but had expectations of longer therapy, he or she tended to make a unilateral decision to end therapy. If a client, who perceived a poor working alliance, was not far along in the stage of change process (e.g., more contemplative than active), s/he was more likely to make a unilateral decision to end therapy. The strengths and limitations of the study and implication of these results for future research and clinical application are discussed. The findings support the overall contention of this study that it is therapy-specific and contextual factors, and not client or therapist factors alone, that predict the likelihood of premature termination.

Introduction

The mean number of psychotherapy clients who drop out of treatment is reported to be almost 50% (Baekland & Lundwall, 1975; Garfield, 1986; Wierzbicki & Pekarik, 1993) which undermines the proven benefits of psychological services and reduces the cost-effectiveness of these services (Garfield, 1986; Pekarik, 1985a). Those who leave treatment prematurely tend to be less satisfied with services (Lebow, 1982), and are less likely to have improved (Pekarik, 1986; Prinz & Miller, 1994). Furthermore, clients who drop out tend to be significantly more impaired and, therefore, more in need of services, than those who complete treatment (Kazdin, Mazurick, & Siegel, 1994). There are increased administration costs to handle the cancelled or missed appointments that are typical among clients who will eventually terminate early, and if the dropout process is prolonged, these clients prevent others on waiting lists from accessing needed services (Kazdin, Holland, Crowley, & Breton, 1997b). Some research evidence suggests that clients who prematurely end therapy may end up over-utilizing psychological services through repeated, incomplete attempts to resolve their problems (Baekland & Lundwall, 1975; Carpenter, Del Gaudio, & Morrow, 1979; Reis & Brown, 1999). Moreover, the experience of having clients drop out of treatment can be demoralizing for therapists and can lead to professional burn-out (Pekarik, 1985a; Piper, Ogrodniczuk, Joyce, McCallum, Rosie, O'Kelly, & Steinberg, 1999; Wierzbicki & Pekarik, 1993).

The purpose of the proposed study was to improve upon the prediction of which clients will terminate treatment prematurely. Building on the lessons learned from past research, this study was designed to refine the search for reliable predictors by examining

therapy-specific and contextual factors that may influence clients' decisions to leave treatment early. These variables include the therapeutic alliance, client and therapist expectations and any discrepancies between them, practical barriers to treatment participation, the client's stage of change prior to treatment, and the client's motivation for therapy. Improved knowledge of the reasons why clients drop out of therapy would help clinicians to develop assessment tools to more accurately identify who may be at risk of dropping out of psychotherapy, would help therapists to more effectively intervene to minimize unplanned termination, and would make a positive contribution both to improved client well-being and to more efficient mental health-care service delivery.

Over the past 30 years, researchers have attempted to empirically discriminate between clients who did or did not leave treatment prematurely. The literature, however, is replete with failures to replicate results, inconsistent or contradictory findings, and only small differences between clients who leave therapy early and those who complete treatment (Wierzbicki & Pekarik, 1993). Some researchers have attributed these inconclusive results to methodological weaknesses, including problems with the criterion used to define a client who has dropped out, and inadequate sample sizes (Pekarik, 1985a; Reis & Brown, 1999). Moreover, the common use of retrospective rather than prospective studies may lead to a hindsight bias (Mash & Hunsley, 1993). To address these concerns, the current study used multiple definitions of client drop out, ensured that the research design had adequate power to detect meaningful differences where they existed, and used measures that assessed from both prospective and retrospective perspectives.

Most research to date has explored static client or therapist factors rather than

interpersonal or therapeutic process variables. The majority of the research has focussed on specific client characteristics, such as age (Brandt, 1965), gender (Brandt, 1965; Bergin & Strupp, 1972), ethnicity (Sue, McKinney, Allen, & Hall, 1974), and psychological disorder (Hoffman, 1985; Richmond, 1992; Trepka, 1986). The following section provides an overview of this research to provide a background to the current study.

Background

Demographic Factors

The earliest research focussed on client demographic variables such as age, gender, ethnicity, income, and education. For example, some investigators hypothesized that younger, female clients from an ethnic minority group, and who had low levels of income and education, would be the most likely clients to drop out of treatment before their goals had been reached. In an early review of the literature, Brandt (1965) found no consistent predictors of early termination. Ten years later, in a comprehensive review of the literature, Baekeland and Lundwall (1975) concluded that premature termination was most strongly associated with several client variables (i.e., low socioeconomic status (SES), female gender, low levels of anxiety and/or low levels of depressive symptomology). More recently, in a meta-analysis conducted by Wierzbicki and Pekarik (1993), however, the only consistent findings identifying clients at risk of dropping out of treatment were cultural/ethnic minority status, less education, and lower income. Of these variables, low SES, a combination of low income and low level of education, was found to have the most consistent supporting evidence (Garfield, 1994; Reis & Brown, 1999). Client ethnicity has tended to be correlated with SES (Garfield, 1994), so it is not surprising that specific studies on client race have

generally shown ethnicity to have predictive value (DuBrin & Zastowny, 1988; Greenspan & Kulish, 1985; Kazdin, Stolar, & Marciano, 1995; Richmond, 1992; Sue, McKinney, & Allen, 1976). Some research, however, has found no relationship between race and premature termination (Sledge, Moras, Hartley, & Levine, 1990; Stahler & Eisenman, 1987). A recent meta-analysis conducted by Maramba and Hall (2002) concluded that ethnic match between client and therapist predicted neither retention in therapy nor an increase in use of therapy sessions. They recommended that identification of more dynamic characteristics of therapy for ethnic minority clients might help retain these clients in treatment.

Garfield (1986) suggested that underlying the relationship between SES and dropout may be discrepancies in expectations of treatment duration or the treatment experience between clients and their therapists. For example, differences in education and value systems might lead lower SES clients to seek briefer, more symptom-focussed treatment than therapists typically offer (e.g., Overall & Aronson, 1962). In support of this notion, studies that examined SES and client duration expectations found that expectations, rather than social class, were associated with treatment continuance (Pekarik, 1991; Pekarik & Stephenson, 1988; Pekarik & Wierzbicki, 1986). These findings suggest that examination of more therapy-specific factors, like expectations, may lead us to better predictors of premature termination than more static demographic variables.

Personality Factors

Efforts to identify client personality characteristics, such as psychological mindedness and defensiveness, that may be associated with treatment continuance or premature termination, respectively, have met with limited success (Baekland & Lundwall,

1975; Dubrin & Zastowny, 1988; Tasca et al., 1999). Although researchers have found some evidence to suggest that individuals with specific psychological disorders (e.g., personality disorders, severe depression) (Persons, Burns, & Perloff, 1988) or chronic problems (Tasca et al., 1999) may tend to leave therapy early, recent attempts to create measures to predict treatment dropout using the MMPI-2 have also not borne fruit (Chisolm, Crowther, Ben-Porath, 1997; Hilsenroth, Handler, Toman, & Padawer, 1995; Marshall & Roiger, 1996). Hilsenroth and colleagues (1995) concluded that reasons for premature termination are influenced by interpersonal variables rather than by psychopathology, therefore, personality assessment may not be an appropriate methodology for accessing predictive information. In an effort to pursue the interpersonal dimension, a later study by Hilsenroth, Holdwick and Castlebury (1998) examined a cluster of personality disorder symptoms that relates to a client's willingness and ability to establish a therapeutic relationship. They found that a combination of symptoms accounted for a moderate amount of variance in explaining continuance in therapy (e.g., fear of abandonment, beliefs that relationships are more intimate than they really are, inappropriate intense anger) and premature termination from therapy (e.g., excessive self-admiration, lack of remorse or indifference to having hurt others). Although promising, this vein of research still does not account for the interactional dynamics of the interpersonal relationship that are central to the experience of therapy.

Therapist Factors

In addition to examining these client characteristics, researchers have also found some evidence suggesting that therapist factors such as trustworthiness and expertiseness may contribute to a client's decision to terminate (Kokotovic & Tracy, 1987). In a study that

compared adult and child premature termination behaviour, therapist experience and referral source were found to be the most relevant variables in adult treatment dropout (Pekarik & Stephenson, 1988). In their review of the existing literature, Baekeland and Lundwall (1975) concluded that, in addition to several client variables, premature termination was most strongly associated with low levels of therapist experience. A decade later, Greenspan and Kulish (1985) found that therapists with Ph.Ds had lower rates of clients who dropped out than did therapists with MDs or MSWs, and that therapists who had had some personal therapy had lower mean premature termination rates than those who had not. In this last study, however, there may have been a SES confound because typically the services offered by Ph.D therapists are not covered by health insurance plans, therefore, their clientele may have been wealthier. Many researchers have studied the contribution of therapist variables to the premature termination of clients, however, they have concluded that studies of client or therapist characteristics alone fail to capture important interpersonal factors in the therapeutic interaction. These researchers have consistently recommended that to better understand the phenomenon of early termination, future studies should examine more complex interactional variables between the client and the therapist (Dubrin & Zastowny, 1985; Greenspan & Kulish, 1985; Hoffman, 1985; Piper et al., 1999; Reis & Brown, 1999; Richmond, 1992). Indeed, Luborsky and colleagues (1980) suggested that the key factors affecting the termination decision may not become evident until the client and the therapist begin to interact. These crucial interpersonal factors are captured in the therapeutic relationship, or therapeutic alliance.

Following the recommendations of previous researchers, this study focussed on more

dynamic variables closer to the actual therapeutic process. In addition to the therapeutic alliance, more therapy-specific factors like client expectations, motivation, and stage of change were examined. Furthermore, in recognition that therapy takes place within the larger context of a person's life, we examined contextual factors that may have a direct impact on the client's experience of therapy and influence his or her decision to end therapy. The following sections provide background on previous research in these areas.

Therapy-Specific Factors of Interest in This Study

Therapeutic Alliance

The therapeutic alliance is not just the contribution of the client or the therapist to the therapeutic process, but rather, it reflects the interpersonal dynamic between both participants (Beutler, Machado, & Neufeldt, 1994). Numerous studies have been conducted on this relationship, including its contribution to treatment outcome (Horvath & Symonds, 1991). Research that has specifically examined its role in the prediction of early termination has yielded inconsistent findings (Cochran & Stamier, 1989; Kokotovic & Tracey, 1990; Piper et al., 1999; Reder & Tyson, 1980; Samstag, Batchelder, Muran, Safran, & Winston, 1998; Steenbarger, 1994; Tracey, 1986; Tryon & Kane, 1990; Tryon & Kane, 1993; Wierzbicki & Pekarik, 1993).

A number of theoretical models have been proposed to describe the elements of the therapeutic alliance. The model that has received the most empirical attention was developed by Bordin (1979) as a pantheoretical conceptualization of the therapeutic alliance. Horvath (1981, 1982) developed the Working Alliance Inventory (WAI) to operationalize this model, and a number of outcome studies have examined the alliance from this perspective (Connors,

Carroll, DiClemente, Longabaugh, & Donovan, 1997; Kokotovic & Tracey, 1990; Raue, Goldfried, & Barkham, 1997; Safran & Waller, 1991). Bordin's (1979) model incorporates three elements (goals, tasks, and bonds) that emphasize the client's positive collaboration with the therapist against the client's pain and dysfunctional behaviours. The goals are the agreed upon targets and outcomes of therapy; the tasks involve an endorsement of relevant procedures to meet these objectives; and, the bonds are the personal attachments between client and therapist, such as trust, acceptance, and confidence. Bordin (1980) viewed a positive alliance as not therapeutic by itself, but rather as an element that "...makes it possible for the patient to accept and follow treatment faithfully" (p. 2). Bordin (1994) further clarified his model by emphasizing that the technical and process factors of therapy were interactive and each depended on the other for effective therapeutic process.

Bordin (1979) suggested that dropping out of therapy was likely a consequence of a poor alliance, and in their review of the role of the therapeutic alliance in psychotherapy outcome, Horvath and Luborsky (1993) speculated that a poor alliance at the beginning of therapy is a good prognosticator for early termination. However, research findings on the relationship between the therapeutic alliance and premature termination have been equivocal. For example, in a sample of 144 client-therapist dyads at a community counselling centre, Kokotovic and Tracey (1990) measured the working alliance using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989) and concluded that there was no significant difference in the quality of the working alliance between those who completed and those who left therapy early. These researchers rated the alliance, from the perspective of both clients and therapists, after the initial counselling session only. Premature termination

was defined as having attended fewer than four counselling sessions and failing to show up for a scheduled session.

When they measured the alliance at five different points throughout treatment, Hartley and Strupp (1983) also found that the quality of the alliance did not discriminate between clients who dropped out and those who completed short-term psychodynamic therapy. However, these researchers used a small sample of 28 clients of which only 6 terminated therapy prematurely, defined as having attended five or fewer therapy sessions of the contracted 25. The small sample size limited the power of the analysis and only trends were reported. It is interesting to note, however, that the trends revealed an increase in a combined client-therapist mean working alliance score for the group of premature terminators between their first and last session, compared to clients who remained in therapy. Hartley and Strupp reported that it was the positive scores on the therapist measure that contributed to the increase in global working alliance score, suggesting that the therapists of premature terminators may have been working harder in the last session to establish a therapeutic relationship with a client who did not appear to be engaging in treatment.

In contrast, other researchers who measured the alliance beyond the initial session found a significant relationship between the quality of the therapeutic relationship and premature termination. For example, Saltzman, Luetgert, Roth, Creaser, & Howard (1976) measured 10 dimensions of the therapeutic alliance from the perspective of the client (e.g., understanding the therapist and feeling understood, ability to express feelings and thoughts openly, perception of therapist's competence and commitment to help) and 11 dimensions of the alliance from the perspective of the therapist (e.g., understanding the client and feeling

understood, sense of concern for client and active participation in client's exploration, therapist's capacity to acknowledge and experience client's emotional reactions) after each of the first 10 therapy sessions in a sample of 91 students at a university counselling centre. The authors reported that they had "arbitrarily" defined premature termination in this study as the failure to follow through on a commitment to attend at least nine sessions of therapy, and that most clients who dropped out of therapy did so prior to the sixth session. Saltzman and colleagues found that both client and therapist assessments of the alliance after the first, third and fifth sessions differentiated between premature terminators and remainers, however, after three sessions of treatment more alliance dimensions yielded predictive value.

In two other studies, Tracey (1986) found a significant relationship between premature termination and an aspect of the working alliance he called "topic determination". Tracey argued that the proportion of topic initiations followed through by the other participant was a measure of task agreement, one of the elements in Bordin's definition of the working alliance. Using small samples of 18 and 33 client-therapist dyads at two university counselling centres, Tracey found that client-therapist dyads in which the client terminated therapy prematurely had problems agreeing on appropriate topics compared to dyads in which the client remained in therapy. Although these findings support the predictive value of one aspect of the therapeutic relationship for premature termination, Tracey used a small sample size which limits the generalizability of his findings, he did not rate the global working alliance, and he used an arbitrary definition of premature termination (attendance at less than four sessions and having outcome assessment scores from both client and therapist perspectives that were below the mean).

As we have seen, a number of factors may account for the discrepant findings in the literature regarding the relationship between the quality of the working alliance and premature termination. In some studies small sample sizes limit the generalizability of the findings or the statistical power to find significant relationships where they may exist. In each study, different measures were used to assess the working alliance, the timing of assessments differed, and in each case a different definition of premature termination was used. Kokotovic and Tracey (1990) recommended that more than one assessment of the therapeutic alliance may yield higher predictive value than a single assessment after the initial session. This is consistent with other research which has found that measurement of the alliance after the third or fourth therapy session more reliably predicts treatment outcome (Garfield, 1994). In this study, the therapeutic alliance was measured after the third session of treatment. In addition, the WAI, a psychometrically validated assessment measure, was used as a global measure of the strength of the working alliance from both client and therapist perspectives, and the sample size was large enough to ensure statistical power.

Most measures of the therapeutic alliance include self-reports from the perspectives of the therapist and the client, as well as an observer rating scale. It is interesting to note that these different perspectives have been found to be significantly divergent, particularly in the early stages of therapy. Researchers have found that these divergences, however, do not predict consistent results. For example, Horvath (1994) reported that it is the client's and observer's ratings that are more predictive of outcome than those of the therapist. Studies conducted within the client-centred approach that have used client ratings of the therapeutic relationship show more positive results than those using the observations of objective raters,

and larger correlations with outcome are more frequent between client process ratings and client self-reports of outcome (Lambert & Bergin, 1994). Tyron and Kane (1990) found that client ratings on the Penn Helping Alliance Questionnaire (Alexander & Luborsky, 1986), administered after an average of eight sessions, predicted unilateral termination from therapy. In contrast, in a later study, these same authors (Tyron & Kane, 1993) used the short version of the WAI (Tracey & Kokotovic, 1989) after the third session, and found that counsellor ratings of working alliance were positively associated with mutually agreed upon termination, and client ratings did not relate to termination type. Again, this illustrates the inconsistent and contrary results of past research.

In summary, because therapy is an interpersonal process and not the sum of two individual's characteristics, in the current study the interaction between the client and the therapist was examined as a more therapy-specific factor. Past findings have shown the importance of assessing the working alliance from the perspectives of both the client and the therapist, and the association between outcome and the quality of the therapeutic relationship after three sessions. Therefore, in this study, assessments from the perspectives of both the client and the therapist were obtained after the third therapy session. It was hoped that this early measure of the therapy-specific interaction between client and therapist would help predict the client's type of termination decision.

Discrepancies Between Clients' and Therapists' Expectations for Therapy

Expectations of Treatment Duration

In the ongoing search for predictors of premature termination that are more proximal to the therapeutic process than are simple client and therapist characteristics, other more

therapy-specific factors such as expectations for therapy have been investigated. Because the therapeutic alliance includes client and therapist collaboration on the development of therapeutic goals and tasks, the expectations that both parties bring to the therapeutic endeavour may have an impact on the quality of the alliance and the duration of treatment. More specifically, any discrepancies between the viewpoints may negatively influence the therapeutic process. To illustrate this point, researchers have found that clients generally anticipate that they will require many fewer sessions to address their problems than do their therapists (Garfield, 1986). Therapists tend to overestimate treatment length and underestimate the number of clients who will terminate prematurely (Mueller & Pekarik, 2000; Pekarik, 1992; Pekarik & Finney-Owen, 1987). For example, some studies have found that 70% of clients expected that therapy would last no more than 10 sessions, and most anticipated that they would experience improvement within five visits (Garfield & Wolpin, 1965; Pekarik & Wierzbicki, 1986). In another study, Gelso and Johnson (1983) reported that 87% of clients expected 12 or fewer sessions, with 3 as the modal expectation. Mueller and Pekarik (2000) found that clients' expectations for therapy duration was the strongest predictor of actual duration, over and above history of psychological disorder, therapist's degree, and client education. Although these authors reported that the accuracy of their prediction of the number of sessions was also related to dropout rates, the manner in which dropouts were defined was not clearly stated.

In contrast, a recent survey of 234 members of APA Division 29 (Psychotherapy) regarding their expectations of treatment duration revealed that psychologists expected that clients would require 30 to 40 sessions of individual therapy to achieve clinically significant

change (Lowry & Ross, 1997). In fact, the number of sessions that clients typically attend is between 8 and 10 (Lowry & Ross, 1997). Investigators have suggested that many therapists operate under the illusion that clients remain in therapy longer than they do because most of an experienced clinician's time is spent with clients who do remain in treatment for longer periods (Pekarik & Finney-Owen, 1987; Vessey, Howard, Lueger, Kächele, & Mergenthaler, 1994). Studies report that, in fact, it is the client's expectations of treatment duration that are the best predictor of treatment duration, accounting for approximately 8% of variance (Pekarik, 1985a; Pekarik & Wierzbicki, 1986).

Past research has documented a treatment duration expectation discrepancy between clients and therapists. Pekarik and Finney-Owen (1987) recommended that future research should investigate whether discrepant expectations are related to premature termination for particular therapist-client pairs. This study was designed to examine this question by analysing whether the discrepancy within client/therapist dyads for expectations of treatment length was predictive of client early departure from therapy.

Expectations of the Therapy Experience

In addition to clients' expectations of shorter-term therapy, researchers have concluded that there tend to be further discrepancies in the expectations that clients and therapists bring to treatment (Borghi, 1968; Pekarik, 1985a). Research has shown that any major discrepancy between a client's expectations and actual treatment content can lead to an increased risk of premature termination (Horenstein & Houston, 1976). The following studies examined the relationship between discrepant expectations and client dropout. In a sample of 147 women diagnosed with depression receiving behaviour therapy, those who

completed treatment had endorsed expectations congruent with the treatment plan significantly more than did those who left therapy prematurely (Rabin, Kaslow, & Rehm, 1985). Expectations were assessed using an experimental, 33-item, "attitudes-about-therapy" questionnaire that was developed by the authors. Premature termination was defined as the failure to attend the 10 therapy sessions that constituted the agreed-upon behavioural treatment program. In a smaller sample of clients with obsessive-compulsive disorder, where 15 treatment completers were compared to 15 premature terminators, those who left therapy early retrospectively reported more incongruent treatment expectations than completers (Hansen, Hoogduin, Schaap, & Haan, 1992). Expectations were measured with seven questions that formed a 31-item questionnaire asking the client to reflect back on his or her global experience in therapy. Premature termination was defined as the client failing to achieve the goals s/he set in therapy and ending therapy without discussion with the therapist within 10 treatment sessions. This study, however, was conducted two to seven years after the start of participants' treatment, therefore, hindsight bias is a serious limitation. In another study, Hardin, Subich and Holvey (1988), however, found different results when they compared pre-therapy expectations of clients who continued in treatment and those who terminated prematurely in a sample of 80 clients at a university counselling centre. Using a short form of the Expectations About Counseling Questionnaire (Tinsley, Workman, & Kass, 1980) that assesses expectations of personal commitment, counsellor expertise, facilitative conditions and outcome, Hardin and colleagues found no differences in pre-therapy expectations for premature versus appropriate terminations. In this study, premature termination was defined as failing to attend a second scheduled therapy session. Discrepant

findings in these studies may be attributed to different sample characteristics, different measures of expectations, the fact that some measures were administered prospectively and others retrospectively, and different, duration-based operationalizations of premature termination.

Despite the above-mentioned equivocal findings in the literature regarding the significance of discrepancies between client and therapist expectations for therapy, clients do seem to expect that the content of therapy sessions should quickly and directly address their immediate problems. In support of this notion, research has shown that a large proportion of clients expected a high level of clinician activity and more direct advice to come from their therapist, rather than participating more actively in their treatment (Hornstra, Lubin, Lewis, & Willis, 1972; Overall & Aronson, 1962). In contrast, clinicians tend to take a number of sessions to conduct thorough history-taking and assessment, pacing their treatment over 10 to 40 sessions, rather than providing a more focussed intervention that it seems many clients desire (Pekarik, 1983a). Clients seem to be more interested in rapid relief of their discomfort than in addressing underlying problematic patterns. Finally, clients and therapists have been found to differ in the amount of improvement they expect and desire from psychological services (Pekarik, 1983a). Therapists may have higher standards for improvement than do their clients, and thus expect their clients to wish to remain in treatment until greater levels of change have been realized. This may also influence therapists to underestimate how often clients end treatment because clients are satisfied with the outcome, and therefore, overestimate the number of clients who terminate prematurely (Hunsley, Aubry, Vestervelt, & Vito, 1999; Reis & Brown, 1999). This may lead to a discrepancy in perspectives on the

type of termination decision between client and therapist. For this reason, in the current study, the type of termination decision was reported from both client and therapist points of view.

Pekarik (1983a) suggested that given these common discrepancies between client and therapist expectations, training programs should adjust their curriculum to teach therapeutic models that conform more closely to clients' needs, thereby helping therapists to better align their expectations to those of their clients. At the very least, however, the explicit discussion of each party's expectations for treatment duration and process may help to minimize misunderstandings regarding the course of treatment, and may reduce decisions to terminate that appear to be unplanned from the perspective of the therapist. This study examined to what degree therapy-specific factors like client expectations and therapist expectations for therapy duration and fit uniquely impact on premature termination, and whether a discrepancy in client-therapist expectations of treatment duration is predictive of clients leaving therapy early.

Summary of Therapy-Specific Factors of Interest in the Study

Considerable effort has been devoted to searching for client characteristics, therapist characteristics, and to a lesser degree, interpersonal variables in the psychotherapeutic interaction that might help predict premature termination from treatment. This research has not reliably identified any predictive factors. This study, therefore, was designed to fine-tune the search by examining more psychological variables that were specifically related to therapy. The therapy-specific psychological variables considered were the expectations that each member of the dyad brought to the therapeutic process, as well as any discrepancies

between the two viewpoints that might have accounted for termination behaviour.

Furthermore, the psychological interaction between the client and therapist in the context of the working alliance was examined in an attempt to capture any complex interpersonal factors that might contribute to the termination decision. If these variables were found to predict premature termination, assessment of expectations and monitoring of the alliance might help to prevent a breakdown in the therapeutic process and reduce unilateral decisions to end therapy before treatment goals are met. In addition to these more psychological factors, possible contextual factors were also examined, in recognition that therapy does not occur in isolation from other important parts of an individual's life.

Contextual Variables of Interest in this Study

Barriers to Treatment Participation

Despite the fact that some variables that affect unplanned termination in child and family therapy have been found to differ from those that may be instrumental for adult clients (Wierzbicki & Pekarik, 1993), research findings in the child and family domain provide insight into adult premature termination and, thus, guided this study. Because adults, unlike children, can be either self-referred or referred by others, and they have more direct power to determine whether or not to continue treatment (Pekarik & Stephenson, 1988), the most recent research has studied the two client groups separately (Kazdin & Wassell, 1998; Kazdin, Holland, & Crowley, 1997a; Pekarik & Stephenson, 1988). Child and family researchers have addressed the role of multiple influences including situational factors and more therapy-specific factors that accumulate as risk factors (Kazdin et al., 1997a). Socioeconomic disadvantage, difficult living circumstances for the parent and child, and

family stress and life events were identified as broad characteristics that could lead to dropping out for multiple reasons (Armbruster & Kazdin, 1994; Gould, Shaffer, & Kaplan, 1985).

More recently, Kazdin and colleagues have focussed on the importance of contextual factors, including more therapy-specific factors, in research that has further refined the search for salient reasons for unplanned termination using a “barriers-to-treatment” model (Kazdin, Holland, Crowley, & Breton, 1997b; Kazdin & Wassell, 1998). In this model, barriers include: practical obstacles to participation in treatment (e.g., transportation difficulties, scheduling conflicts); perceptions of treatment as demanding, unhelpful, or irrelevant to the problems experienced by the client; and, a poor working alliance with the therapist. Kazdin and colleagues (1997b) found that the contribution of these barriers to premature termination added to the contribution of previously studied client characteristics (income, ethnicity, level of education), and that these findings were consistent across both parent and therapist perspectives of the reasons for families terminating therapy early. When both the parents of children in therapy and the therapists completed similar measures, the perceived relevance of treatment was the domain which had the largest effect size ($ES = 1.10$ for parents; $ES = 1.67$ for therapists), followed by stressors ($ES = 0.72$ for parents; $ES = 1.26$ for therapists), relationship with therapist ($ES = 0.43$ for parents; $ES = 0.61$ for therapists) and finally, treatment demands ($ES = 0.12$ for parents; $ES = 0.65$ for therapists) in discriminating between clients who completed and those that left treatment prematurely. According to Cohen (1992), effect sizes, or the degree to which the null hypothesis is believed to be false, can be interpreted as .20 = small, .50 = medium, and .80 = large for independent t-test

analyses like those performed by Kazdin and colleagues (1997b). Therefore, there was a large effect size for treatment relevance from the perspective of both parents and therapists, a medium effect size for parents and a large effect size for therapists for stressors, and only small and medium effect sizes for the therapeutic relationship and treatment demands for parents and therapists, respectively. Critical events that had occurred in a client's life while they were in treatment (e.g., moving, job loss, illness, change in marital status) were not found to contribute significantly to a decision to leave treatment early (Kazdin et al., 1997b).

It seems reasonable to consider that contextual factors may influence the lives of adults in therapy as well as they do parents and children receiving psychological services. The relevance of treatment, life stressors, the relationship with the therapist and treatment demands are all factors which contribute to an adult client's experience in treatment and may play a role in his or her decision regarding the timing of termination. In fact, some research evidence suggests that practical factors, such as transportation or getting time away from work, may be implicated in the decisions of adult clients to leave therapy early (Beckam, 1992; Cross & Warren, 1984; Hynan, 1990; Pekarik, 1983). The barriers-to-treatment model has yet to be tested in an adult outpatient population, however, and given the findings of previous research that child and adult clients may differ with respect to early termination (Pekarik & Stephenson, 1988; Wierzbicki & Pekarik, 1993), without empirical investigation we cannot assume that the barriers-to-treatment model would be equally relevant for adults. It was the intent of this study, therefore, to determine whether the contextual factors found to be significant contributors to dropout in child and family therapy could also serve as useful ways to distinguish those adult clients who complete treatment from those who terminate

prematurely. If this study established that contextual factors significantly contribute to a client's decision to drop out of therapy, therapists could assess for these factors early in therapy and address the needs of at-risk clients in a preventative manner.

Moderating Effects of Pre-Therapy Motivation and Stage of Change

When considering the role that the therapeutic alliance, expectations, and practical barriers may play in a client's decision to terminate therapy early, questions were raised regarding whether motivation for change or readiness to change may moderate the relation between these predictors and a client's decision to drop out of treatment. For example, some researchers have proposed that a lack of motivation may explain why a large number of outpatient early terminators reported practical reasons for their decision to terminate early (Acosta, 1980; Garfield, 1963; Pekarik 1983). If, for example, a client is more motivated or more ready to make changes might these factors decrease the impact of obstacles encountered in the process of therapy, such as alliance ruptures, unmet expectations, or other barriers to treatment participation, and keep him or her engaged in therapy in order to circumvent these challenges. On the other hand, a client with low motivation or who was less advanced in the stages of change, might find such obstacles insurmountable and sufficient to terminate treatment. Two empirically verified theories that address the role of motivation in behaviour change (Self-Determination Theory: SCT: Deci & Ryan, 1985), and that specify the processes and stages of behaviour change (Transtheoretical Model of Change (TMC: DiClemente & Prochaska, 1982) may help to discern whether a client's initial motivation or his or her pre-therapy stage of change moderate the effects of other predictors on the decision to terminate treatment.

Theory of Self-Determination

In 1985, Deci and Ryan proposed a theory of self-determination that explains how three types of motivation regulate human behaviour. Understanding these three forms of motivation, intrinsic, extrinsic, and amotivation, may contribute to our comprehension of therapeutic effectiveness, including how treatment conditions may impede or facilitate clients' motivation to change (Pelletier, Tuson, & Haddad, 1997), and, therefore, affect clients' decisions to continue treatment or leave prematurely. Pelletier and colleagues (1997) recommended examining whether measures of client motivation might help predict attrition from therapy.

Intrinsically motivated behaviours are performed voluntarily for the pleasure and satisfaction of the act itself (Pelletier et al., 1997). They are believed to arise from the need to feel competent and self-determined (Deci & Ryan, 1985). No external rewards or pressures are required for engagement in the behaviour. In the case of therapy, an intrinsically motivated client would participate in treatment for the pleasure of greater self-understanding (Pelletier et al., 1997). In more cognitive-behaviourally oriented treatments, an intrinsically motivated individual might be seeking a sense of self-mastery.

In contrast, extrinsically motivated behaviours are performed for instrumental purposes (Pelletier et al., 1997). They are carried out in order to obtain an external reward or avoid some form of punishment (Deci, 1975). A continuum of four types of extrinsic motivation has been proposed to account for the lesser to higher degrees of self-determination that may be operating in extrinsically motivated behaviours: external regulation, introjection, identification, and integration. Externally regulated behaviours operate for the purpose of

external rewards or some kind of constraint imposed from an outside source (Deci & Ryan, 1985). When the source of external regulation has been internalized in the form of anxiety, guilt or feelings related to self-esteem, introjected regulation is operating. Identified regulation describes behaviours that are engaged in because they conform to an individual's personal values or goals (Deci & Ryan, 1985). Finally, integrated regulation is in operation when an individual carries out behaviours that are consistent with other self-schemas that make up their personal identity (Deci & Ryan, 1985).

Amotivation is the last class of motivation that has been identified. It is characterized by a perceived lack of connection between an individual's behaviours and the outcomes of those behaviours. A person typically experiences feelings of incompetence and lack of control when they act out of amotivation (Deci & Ryan, 1985).

Research on situational factors that may enhance or diminish intrinsic motivation has shown that self-determined motivation results in better learning, greater life satisfaction, persistence, and improved health (Blais et al., 1990; Deci, Vallerand, Pelletier, & Ryan, 1991; Pelletier, Vallerand, Green-Demers, Briere, & Blais, 1995; Pelletier, Fortier, et al., 1995; Ryan & Connell, 1989; Vallerand & Bissonette, 1992). The theory has also been tested in the field of therapy, and results show that client motivation may be related to participation in treatment for smoking cessation (Curry, Wagner, & Grothaus, 1991), alcohol abuse (Ryan, Plant, & O'Malley, 1995), and excessive weight loss (Williams, Grow, Freedman, Ryan, & Deci, 1996).

Self-determination research has indicated that if a client's behaviour is internally motivated it is more likely that change will occur (Pelletier et al., 1997). Furthermore,

research using the Client Motivation for Therapy Scale (CMOTS) has shown that higher levels of self-determination were positively correlated with higher perceptions of therapists as collaborative rather than controlling (Pelletier et al., 1997), providing a stronger foundation for a constructive working alliance.

Pelletier and colleagues (1997) have recently developed the CMOTS that operationalized the theory of self-determination. This 24-item scale, for which validity and reliability have been supported, consists of 6 factors that correspond to the 6 motivational types described in the model. In this study, the CMOTS was used to determine whether the level of client self-determination had a moderating influence on the relation between other predictors and a client's decision to abandon therapy.

Transtheoretical Model of Change

The transtheoretical model of change is an integrative and comprehensive model of behaviour change that has been used to describe the stages that individuals go through in a process towards changing maladaptive behaviours (Prochaska & DiClemente, 1982). The model was developed in an effort to understand the dynamics and challenges of various stages of change, and has been used to predict client self-change behaviour, persistence in treatment, treatment effectiveness, and treatment outcome (Prochaska, DiClemente, & Norcross, 1992; Smith, Subich, & Kalodner, 1999). Research has shown that at certain stages of change clients are more ready to change, and consequentially experience more positive treatment outcomes (McConaughy, Prochaska, & Velicer, 1983; Prochaska & DiClemente, 1982; Prochaska et al., 1992).

The transtheoretical model includes five stages of change: precontemplation,

contemplation, preparation, action, and maintenance (Prochaska et al., 1992). In precontemplation, the person is not aware of any need to change, nor does s/he have any desire to do things differently. In the contemplation stage, the individual has become aware that s/he may have a problem, but has not yet decided to change. In preparation, the person has determined that action is required, but s/he has not yet followed through on his/her decision. In the action stage, a process of change has been actively engaged, but the desired results have not yet been achieved. Finally, at the maintenance stage, the individual has made significant progress toward his/her goals, and attempts are made to consolidate changes and develop strategies for the prevention of relapse. It is proposed that individuals progress through this series of stages, and when difficulties are encountered at any given point, they may need to recycle through the model (Smith et al., 1999). For example, smokers have been found to cycle through the action stage an average of three or four times before reaching long-term maintenance (Schachter, 1982).

The transtheoretical model of change has also been used to predict treatment duration and outcome. For example, in a study examining a behaviour therapy program for weight control, stages of change was the second best predictor of outcome, following the actual processes of change, or covert and overt activities and experiences that individuals engage in when they attempt to modify problem behaviours. Stages of change, however, were more predictive than SES, self-efficacy, social support, proportion overweight, years overweight, goals and expectations (Prochaska et al., 1992). Moreover, the stages of change model has been used to predict early termination from treatment. For example, stage-related variables accurately predicted 93% of early terminators in a sample of 60 clients from various

psychologists and mental health clinics where the reported a drop out rate was 40% (Prochaska, 1991). Clients who left therapy prematurely had entered therapy in the precontemplation stage which is characterized by unreadiness to undertake change. Smith and colleagues (1995) reported similar findings in a study of 74 clients who received services at a counselling centre. They found significant differences in the stages of change in which premature terminators and completers entered therapy. Like previous results, the precontemplation stage was associated with clients who dropped out of therapy, the relationship between the contemplation stage and early termination was not clear, and the preparation and action stages characterized those who completed therapy.

In a recent longitudinal study of 60 client-therapist dyads, the pre-therapy stage profiles for premature terminators, appropriate terminators, and continuers were significantly predicted by stages of change, processes of change, and decision-making variables (Brogan, Prochaska, & Prochaska, 1999). Specifically, premature terminators were found to be in the precontemplation stage, more focussed on changing their environment than themselves. In contrast, appropriate terminators were in the action stage, and therapy continuers endorsed the contemplation stage. Although identification of dynamic variables such as the pre-therapy stage of change shows promise for improving the prediction of which clients are likely to terminate treatment early, the findings of this research, too, are equivocal. For example, Derisley and Reynolds (2000) failed to replicate Brogan and colleagues' (1999) findings that endorsement of the precontemplation stage would predict premature termination. Rather, they found that it was low contemplation scores (coupled with a high level of symptom severity) that most accurately distinguished clients who left therapy early. Furthermore, this

study also found that stage of change did not predict the number of therapy sessions attended.

Other researchers have raised questions about the stage of change model. Critiques in the literature suggest that there is no empirical evidence to demonstrate that change progresses in discrete stages (Littrell & Girvin, 2002; Weinstein, Rothman, & Sutton, 1998). After reviewing the existing literature on stages of change, Littrell and Girvin (2002) argued that “there are no comprehensive reviews of empirical evidence on the validity of the stages of change across problem behaviors” (p. 225). These authors raise both conceptual and psychometric concerns with the stage model. Categorizing an individual into one stage may not be appropriate because stages of change may overlap and individuals may cycle through different stages in both “backward” and “forward” directions in the process of change. Moreover, the psychometric properties of some of the stage categories are less well validated than others. For example, if an individual’s highest score were on a less psychometrically reliable subscale, he or she would be categorized at that stage of change, however, that classification might not be as reliable as classifications at other stages. A global assessment of readiness for change reported as a continuous score was used in the current study to address this concern.

The transtheoretical model of change has been operationalized using the Stage of Change Scale (SCS; McConaughy, DiClemente, Prochaska, & Velicer, 1989; McConaughy et al., 1982). In the current study, the overall score on this 32-item scale was used to assess whether a client’s readiness for change at the beginning of therapy moderated the impact of other predictors on treatment participation. If information regarding a client’s self-determination, or motivation for therapy, and stage of change can enhance our ability to

predict which clients are at a risk of dropping out of therapy, clinicians could assess for these factors prior to therapy, adjust their interventions accordingly (e.g., using motivational interviewing techniques), and by so doing, reduce the risk of client dropout.

Moderator hypotheses in this study, therefore, predicted that when motivation is less self-determined and/or a client is early in the stage of change process (precontemplation or contemplation), the impact of a poor alliance, a poor fit of client/therapist expectations, or many contextual barriers to treatment participation on premature termination would be higher; that is, premature termination would be more likely.

Definition of Premature Termination

Premature termination has been defined in different ways in past research, and these varied definitions have contributed to the difficulty in finding consistent predictors of early termination (Pekarik, 1985b; Reis & Brown 1999). Dropouts have been identified as clients who fail to attend a scheduled session, or as those who fail to complete a prescribed number of therapy sessions determined at the outset of treatment, or alternatively, as clients who make a decision to end treatment without the agreement of the therapist (Wierzbicki & Pekarik, 1993). When researchers have used the client's failure to attend a scheduled session as their criterion for defining dropout, this definition has been found to produce a lower dropout rate than other definitions because with this definition clients were considered completers if they chose not to schedule a further session at all (Wierzbicki & Pekarik, 1993). When therapy duration or the total number of treatment sessions attended is measured, usually researchers use a cut-off number of sessions, below which a client is considered to be a dropout. This definition is problematic because it assumes that all early terminators

represent treatment failures and no consideration is given as to whether the client may have met his or her therapeutic goals in a brief intervention.

In a study where two different operationalizations, treatment duration and type of termination decision, were compared, Pekarik (1985b) found that a unilateral decision on the part of the client to terminate best captured the construct of premature termination. One hundred and fifty-two outpatients at a mental health clinic were classified as dropouts or completers using two methods. Significant differences were found between dropouts and completers on 11 out of 18 client and therapist variables when clients were classified using therapist judgment regarding the type of termination. In contrast, no differences were found when the groups were classified using duration criteria. Defining premature termination according to the type of decision addressed the problem of appropriately classifying clients who meet their treatment goals with few therapy sessions as well as clients who may remain in therapy for a longer period of time, but leave before their goals have been reached. Since Pekarik's recommendations were made, most researchers have used this operationalization (e.g., Chisolm et al., 1997; Keijsers, Kampman, & Hoogduin, 2001; Richmond, 1992; Smith et al., 1995; Tryon & Kane, 1993). With this definition, there is no agreement on the part of the therapist that termination is timely, and it is the therapist's judgement that further therapy would have been of benefit to the client. Some researchers who continue to use therapy duration as a measure of premature termination, now qualify their classification with the therapist's judgment that the client left therapy before their treatment goals had been met (e.g., Piper et al., 1999).

For the purpose of this study, two operationalizations of premature termination were

used to facilitate comparison of the results with previous research: categorical (unilateral versus mutual), and continuous (number of sessions in treatment). For the first operationalization, premature termination was defined as a unilateral decision on the part of the client to end therapy (that is, the therapist did not concur that the agreed upon treatment goals had been met). The type of termination decision was reported by both the client and the therapist, which helped control for possible reporting biases, continued the theme of parallel measurement in the study, and made a unique contribution to previous methodologies used in this field of research. This definition took into account the client's view of his or her termination decision and also allowed for the flexibility of the therapist's judgment about the appropriateness of the timing of termination for the client's progress towards meeting treatment objectives (Pekarik, 1985b; Wierzbicki & Pekarik, 1993). Furthermore, treatment was considered to be prematurely terminated under the categorical definition if the client explicitly indicated that s/he no longer wished to continue, or if s/he failed to return after further direct contact to schedule appointments (Kazdin et al., 1997b). In contrast, termination was considered to be non-premature if there was mutual agreement between the client and the therapist that treatment goals had been met.

In addition to measuring the nature of termination as a categorical variable, therapy duration was also assessed as a continuous variable (number of sessions in treatment). Although this measure does not capture the construct of premature termination as well as the decision-making process, it was used in the study to allow comparison with previous studies that used treatment duration as an indication of premature termination. It is clear that to benefit from therapy a client has to attend sessions, however, a measure of the total number

of sessions is a weak proxy for the manner of leaving therapy. Consistent with Pekarik's (1985) recommendation, the measurement of treatment duration in a study on premature termination was only considered relevant when examining variables, such as client expectations, that might reduce attendance for both dropouts and completers. It was planned, therefore, that results of analyses using therapy duration would be compared to the results of analyses using the type of termination decision, and that findings using the type of termination would be weighed more heavily when interpreting and discussing the implications of the results of the study. These different measures of treatment participation were used in separate analyses because previous research has shown that they share some common variance (Kazdin et al., 1997b).

Summary of Research to Date

Wierzbicki and Pekarik (1993) noted that whereas research on clinical demographics, such as ethnicity and SES, may be the easiest form of investigation, examination of more therapy-specific variables may yield more interesting and conclusive results. Their recommendation to expand the search for predictors of premature termination from simple demographic variables to more therapy-specific variables, such as client's expectations and the interactions between client and therapist, has been echoed by other investigators (e.g., Brogan et al., 1999; Dubrin & Zastowny, 1988; Greenspan & Kulish, 1985; Hoffman, 1985; Piper et al., 1999; Richmond, 1992). Therapy is a complex process involving a sophisticated interpersonal interaction over a period of time, and if research has not yet found reliable predictors for client's leaving therapy early, the investigation must focus on factors that specifically relate to more subtle features of the therapeutic interaction. Reis and Brown

(1999) concluded that “multiple factors accounting for unplanned termination are more interactive than static, more interpersonal than intrapsychic” (p. 132). Consistent with these recommendations, this study was designed to examine the predictive value of psychological variables that are specific to therapy, including the therapeutic alliance, and the fit between client and therapist expectations for therapy. In addition, contextual factors like practical obstacles to treatment continuation were examined. Finally, these same factors were examined to see whether their effects on termination decisions are moderated by the client’s stage of change and/or motivation to change when starting therapy. It was hoped that findings of this exploratory study would indicate whether a focus on variables at therapy-specific and contextual levels of the therapeutic interaction provided more predictive value than has been found in previous research, or whether yet further strategic refinements of observations of the therapeutic process might be required to better predict premature termination from psychotherapy.

Hypotheses

The main hypotheses in this research project examined the relationship between therapy-specific and contextual variables, and premature termination. Data were collected from both client and therapist perspectives. This was a departure from most previous research on premature termination that has examined general static client or therapist variables, not necessarily specific to therapy. In addition, because some research has suggested that clients who drop out would attribute their failure to complete therapy to practical obstacles when in fact they were less motivated to continue, the study also addressed whether levels of self-determination and readiness to change might moderate the relationship

between any of the predictors and premature termination.

Hypotheses fell into four different classes: 1) those that focus on the client's perspective; 2) those that focus on the therapist's perspective; 3) those that examine the client's and therapist's perspective together; and, 4) those that predict moderating influences on the relation between predictors and premature termination from the client's perspective.

The most consistent findings in previous research on static client variables pointed to the predictive value of client income and education as factors associated with premature termination from therapy. In an effort to isolate factors that might contribute to prediction over and above these two factors, client education and income were controlled for in each of the study's hypotheses.

Client's Perspective

1. After controlling for income and education, therapy-specific factors and contextual barriers to treatment from the client's perspective, including the therapeutic alliance, treatment expectations (number of sessions and fit), and barriers to treatment participation (treatment relevance, stressors, therapeutic relationship, and treatment demands) would account for a significant proportion of variance in predicting premature termination. More specifically, expectations of shorter treatment duration, poor fit between expectations and actual experience of initial therapy sessions, poor working alliance, and more barriers to treatment participation would be associated with unilateral termination.

Therapist's Perspective

2. After controlling for income and education, therapy-specific factors and contextual barriers to treatment from the therapist's perspective, including the therapeutic alliance,

treatment expectations (number of therapy sessions and fit), and barriers to treatment participation (treatment relevance, stressors, therapeutic relationship, and treatment demands) would account for a significant proportion of variance in predicting premature termination. More specifically, expectations of longer treatment duration, poor fit between expectations and actual experience of initial therapy sessions, poor working alliance, and more barriers to treatment participation would be associated with unilateral termination.

Client's and Therapist's Perspectives

3. Consistent with previous research findings, after controlling for income and education, it was further predicted that the therapist's perspective would account for a significant proportion of variance over and above the client's perspective (Kazdin et al., 1997b), when predictors from the client's perspective that were significant in the previous analyses were entered before the same predictors from the therapist's perspective.

4. Similarly, after controlling for income and education, it was predicted that the client's perspective would account for a significant proportion of variance over and above the therapist's perspective, when predictors from the therapist's perspective that were significant in the previous analyses were entered before the same predictors from the client's perspective.

5. After controlling for income and education, and first entering the client's expectations for the number of therapy sessions, it was predicted that the discrepancy between clients' and therapists' expectations for the number of therapy sessions would be predictive of premature termination.

Moderators of the Relation Between Predictors and Premature Termination

Moderator hypotheses in this study predicted that when motivation is non self-determined and/or a client is early in the stage of change process (precontemplation or contemplation), the impact of a poor alliance, a poor fit of client/therapist expectations, and many contextual barriers to treatment participation on premature termination would be higher; that is, premature termination would be more likely.

6. The client's level of self-determination (SD) and stage of change (SOC) prior to the beginning of therapy would each act as moderators of the relation between the predictor variables [expectations (E), therapeutic alliance (TA), and barriers to treatment participation (BTP)], and premature termination (PT). Six separate analyses tested the relation between each of the two moderators and each of the three predictors. In separate hierarchical regressions, a moderator and a predictor were entered hierarchically as main effects, followed by their interaction term.

- i) The interaction between E and SD would enhance the prediction of premature termination: when SD was low (non self-determined), low E would more strongly predict premature termination, but not when SD was high (self-determined).
- ii) The interaction between BTP and SD would enhance the prediction of premature termination: when SD was low (non self-determined), high BTP (many barriers) would more strongly predict premature termination, but not when SD was high (self-determined).
- iii) The interaction between TA and SD would enhance the prediction of premature termination: when SD was low (non self-determined), low TA (poor alliance) would more strongly predict premature termination, but not when SD was high (self-determined).
- iv) The interaction between E and SOC would enhance the prediction of premature

termination: when SOC was low (precontemplation and contemplation stages), low E would more strongly predict premature termination, but not when SOC was high (action and maintenance stages).

v) The interaction between BTP and SOC would enhance the prediction of premature termination: when SOC was low (precontemplation and contemplation stages), high BTP (many barriers) would more strongly predict premature termination, but not when SOC was high (action and maintenance stages).

vi) The interaction between TA and SOC would enhance the prediction of premature termination: when SOC was low (precontemplation and contemplation stages), low TA (poor alliance) would more strongly predict premature termination, but not when SOC was high (action and maintenance stages).

Method

Participants

Hypotheses were analysed by hierarchical multiple regression and sequential logistic regression analyses. The required sample size was based on multivariate statistical requirements, power, and anticipated attrition from the study. For multiple regression, ten participants per variable is required (Tabachnick & Fidell, 2001). To estimate the required sample size, the potentially most complex statistical design was used (multiple regressions that tested Hypotheses 3 and 4). The number of variables used in these analyses could only be estimated initially because they were based on the results of the previous analyses. It was anticipated that between 9 and 11 significant predictors from previous analyses would be involved in these analyses, therefore, using an estimated number of 10 variables, a sample size of 100 participants was judged to be sufficient. In fact, as it turned out, only 6 predictors were involved in the most complex analysis, therefore, the sample size was more than adequate to detect significant differences. In terms of power, a sample size of 100 participants would yield sufficient power (.80) with $\alpha = .05$ to detect both large and medium effect sizes (Cohen, 1992). Anticipated large and medium effect sizes were consistent with previous findings for the contribution of contextual factors to the decision to terminate therapy early (Kazdin et al., 1997b). Because the object of this study was premature termination, no client participants were eliminated from the study because they failed to complete treatment, therefore, the size of the sample was not negatively affected by early termination of participants. However, in order to account for possible attrition from the study for other reasons (e.g., failure to attend the intake interview, inability to contact

participant following therapy, lack of interest or commitment to the study), an additional 55 client participants (55%) were recruited for the study, bringing the total number of participants who began the study to 155 individuals. Participants were recruited from among English-speaking adults requesting individual psychological services from the Centre for Psychological Services (CPS), an American Psychological Association (APA) and Canadian Psychological Association (CPA)-accredited training facility and a community outpatient clinic in Ottawa, that has a sliding fee scale. Of these 155 client participants, 39 completed measures while they were on the waiting list but never attended an initial interview. There were 116 participants who actually began therapy, 9 of whom did not complete measures at the end of treatment because they either could not be reached or were no longer interested in participating in the study. A total of 107 client participants completed the measures following therapy.

Therapist participants were practicum students and interns in a doctoral program in clinical psychology who were supervised by registered psychologists. Thirty-eight different therapists began the study. For the 107 clients who completed the measures at post-treatment, there were thirty-five different therapists (women = 28; men = 7), providing therapy to between 1 and 11 different client participants. Therapists for 107 client participants began the study and therapists for 106 client participants (35 different therapists) completed measures at the end of therapy.

Demographic Characteristics of Sample

The mean age of the 107 client participants was 30.6 years ($SD=9.2$), with a range from 17 to 60. There were 22 male and 85 female participants. Among the sample, 75% were

single, 25% were married or living with a partner, and 25% had children currently living in the same household. In general, participants were highly educated, with approximately 40% having some university or college education and 50% having attained at least a university undergraduate degree. Data on the employment status revealed that 34% were students, 33% were employed full-time, 20% were unemployed, 12% were employed part-time and 2% were homemakers. Participants reported their income ranging from under \$10,000 (36%), between \$10,000 and \$20,000 (26%), between \$20,000 and \$30,000 (16%), between \$30,000 and \$40,000 (13%), and over \$40,000 (8%), compared to a median income of \$29,000 for persons 15 years of age or older in the Ottawa-Hull region (Statistics Canada, 2001). Most participants reported their racial background as white (86%), however, other racial groups represented in the sample included black (4%), Asian (7%), aboriginal (1%) and other (3%), reflecting the exact ethnic diversity of the Ottawa-Hull region according to the Statistics Canada 2001 Community Profile for the Ottawa-Hull region (Statistics Canada, 2001).

Although CPS is a training facility, training centres have not been found to be different from other non-training outpatient community clinics in terms of client characteristics and intervention (Todd, Kurcias, & Gloster, 1994). Based on comparisons with the demographics of the overall population of clients who receive psychological services at CPS (CPS Annual Report, 2001-2002), the current sample is similar in terms of age, education, income and ethnicity. CPS, however, has a higher percentage of male clients (36%) compared to the study sample in which only 21% of the participants were male. The profile of a typical CPS client (CPS Annual Report, 2001-2002) is also consistent with a recent profile of consumers of psychological services in Canada (Hunsley, Lee, & Aubry, 1999) with respect to age,

gender, marital status, and education, which permits generalizability of the findings of this research.

The current sample of 107 client participants is also similar to the 48 clients who initially participated in the study, but did not complete it. On 12 different demographic measures, the only statistically significant difference between the two groups was in education, where the current sample had a slightly higher level of education ($M = 7.05$, $SD = 1.68$), characterized by some university courses, than the group who did not complete the study ($M = 6.41$, $SD = 2.09$) that was characterized by college graduation. This finding is consistent with the literature that suggests that individuals with higher education are less likely to drop out of therapy (Garfield, 1994). A comparison of these two groups on level of psychological distress prior to therapy from both client (SCL-10) and therapist (GAF) perspectives revealed no significant differences.

In the sample of 107 client participants, 42 clients (39%) reported having made a unilateral decision to terminate therapy and 65 clients (61%) indicated that their decision to end therapy was based on a mutual agreement with their therapist. Similarly, therapists reported that 43 clients (41%) made a unilateral decision to end therapy, whereas 63 clients (59%) ended therapy after mutual agreement with the therapist. Twenty-three client-therapist dyads (21%) did not agree on the type of termination decision, indicating the importance of collecting data from both perspectives. Eleven clients reported unilateral termination whereas their therapists reported mutual agreement, and 12 clients reported mutual agreement whereas their therapists reported unilateral termination. Overall, clients attended between 1 and 55 therapy sessions with an average of 16.4 sessions ($SD=12$). Unilateral terminators

attended from 1 to 36 sessions with an average of 9.7 sessions ($SD=8.1$), whereas those who terminated with the mutual agreement of their therapist attended between 1 and 55 sessions with an average of 20.8 sessions ($SD=12.2$).

A comparison of unilateral versus mutual terminators on measures of psychological distress prior to therapy from both client (SCL-10) and therapist perspectives (GAF), ethnic origin, gender, referral source, and duration of their presenting problem revealed no statistically significant differences between the two groups. The sample was comprised of clients with a range of presenting problems, 36% with symptoms of anxiety, 32% with depressive symptomology, 31% with relationship problems, 11% who had suffered sexual abuse, and 8% with anger management problems. Other identified problems included attention deficit disorder, loneliness, personality disorder, posttraumatic stress disorder, problems with sexual functioning, and shyness.

On the Symptom Checklist-10, a measure of symptoms of psychological distress, unilateral terminators reported a significant decline in distress over the course of therapy, with a mean of 16.8 ($SD=6.7$) before therapy and 9.7 ($SD=7.2$) following treatment ($t(41) = 6.6, p < .001$). A similar pattern was apparent for mutual terminators, who also reported a significant decline in distress with a mean of 14.77 ($SD=7.0$) before therapy and 6.8 ($SD=5.6$) following treatment ($t(64) = 8.8, p < .001$). At the end of therapy, mutual terminators were significantly less distressed than unilateral terminators when symptom distress scores prior to therapy were controlled for ($F(1) = 5.4, p < .05$). Therapists assessed their unilaterally terminating clients' overall psychological functioning on the Global Assessment of Functioning Scale as having significantly improved from a mean of 66.23 ($SD=11.2$) prior to

therapy to a mean of 68.9 (SD=11.8) after treatment ($t(42) = -2.3, p < .05$). Therapists assessed their mutual agreement clients' overall psychological functioning on the Global Assessment of Functioning Scale as also having significantly improved from a mean of 62.5 (SD=12.7) prior to therapy to a mean of 73.9 (SD=14.2) after treatment ($t(61) = -9.3, p < .001$). At the end of therapy, mutual terminators were significantly less distressed than unilateral terminators when therapists' assessment of symptom distress prior to therapy were controlled for ($F(1) = 21.4, p < .001$). Overall, it appears that with the current sample, even when clients left therapy prematurely, gains were made from the experience of therapy from both the client's and therapist's points of view, however, there was greater improvement if the client did not drop out of therapy. Previous research has shown that clients who terminate therapy prematurely are not a homogenous group. Some researchers have concluded that premature terminators become repeat users of psychological services because they continue to experience distress (e.g., Reis & Brown, 1999), whereas others consider that many clients who leave therapy prematurely may be satisfied with the amount of progress they have made in a short time period (Garfield, 1994). The research literature does not indicate that the discrepancy in outcome among premature terminators can be attributed to differences in client and therapist ratings.

Clients were treated by 35 different therapists who provided therapy to between 1 and 11 different participants. To determine if there was a problem of dependence in the data, 56 comparisons of independent sample means were conducted on 8 different therapist variables comparing 7 groups of therapists who had seen 1, 2, 3, 4, 5, 7, 8, and 11 different clients, respectively. On only 1 measure were 2 groups significantly different at $p < .05$, suggesting

no significant differences across study variables in therapists who provided treatment to different numbers of client participants. Different therapeutic approaches were used, including cognitive-behavioural (67%), experiential (17%) and interpersonal (16%), thereby providing greater generalizability of results. There was no statistically significant difference in the type of therapeutic approach used between participants who prematurely terminated or who completed therapy $t(107) = -1.42$, ns.

Following treatment, when measures were administered for the final time, both clients and therapists were asked whether involvement in the study had affected their experience in therapy. In response to debriefing questions asking whether participation in the study had affected what they did in therapy or how committed the client was to therapy, 94% of both clients and therapists responded “no.” Ninety-nine percent of clients and 92% of therapists indicated that participating in the study had not affected how long the client had stayed in therapy.

Procedure

Data collection for this longitudinal study took 35 months. Client participants were assessed at three different times: the first time, following a request for therapy, but prior to the intake session, to gather information regarding expectations for treatment duration, motivation for therapy, stage of change, psychological distress, and demographics; the second time, after the third therapy session, to measure the therapeutic alliance and their expectations for therapy; and, the third time, at the end of therapy, to assess retrospectively for more contextual factors which may have influenced the decision to terminate, their level of psychological distress, and their type of termination decision. In addition, the therapist's

perspective regarding the therapeutic alliance, their expectations for therapy, and the client's global level of functioning were measured at Time 2 following session 3. The therapist's perspective on any barriers to completing treatment that the client may have experienced, the client's global level of functioning, and the type of termination decision were evaluated following termination at Time 3. The measures included various assessment formats (self-report questionnaires, direct measures of participation) and informants (clients and therapists). Recruitment

When individuals call CPS to request psychological services, a 15 minute phone appointment is arranged for an intern to conduct a brief assessment of the person's presenting problem and objectives for therapy. The identification of potential participants by interns during this screening call followed the CPS protocol. It required less than one additional minute from interns during this contact to ask if the individual was interested in the study and to advise him/her that if s/he was, s/he would be contacted by a research assistant within the next week at a convenient time as indicated by the participant (see Appendix A). In this way, involvement in the study was completely divorced from the client's request for psychological services from CPS, and was designed not to cause the individual who was requesting services any additional burden or undue stress.

This research project was conducted in conjunction with another study on the process of seeking and engagement in therapy (Rumstein McKean, 1999). Measures for both studies were administered at the same times to maximize efficiency and to minimize the time required by the participant to take part in the project.

A trained research assistant administered a standard recruitment script (see Appendix B)

that provided detailed information about the study, the researchers, and measures that were taken to protect confidentiality regarding access to raw data, its storage and labelling. The second and third assessments, which were also scripted (see Appendix D and F), required 10 minutes and 20 minutes respectively of clients' time over the phone and therapists' time at their convenience.

Interviews

Time 1: Initial Interview. Interns advised the research assistant for the study about individuals interested in participating by placing a note in her mailbox at CPS. The research assistant called the individual back within a week to explain the purpose of the study, obtain informed consent, advise the client of the honoraria for participation in the study, and to administer questionnaires on client motivation (CMOTS; Pelletier et al., 1997) (see Appendix L), stage of change (SCS; McConaughy et al., 1989; McConaughy et al., 1983) (see Appendix M), psychological distress (SCL-10; Nguyen, Attkisson, & Stegner, 1983) (see Appendix I), expectations for therapy duration, and to obtain demographic information (see Appendix H). If the client preferred, an arrangement was made to call the client back at a later, more convenient time to administer the measures. Consent was requested both to access the participant's CPS clinical file in order to obtain further demographic information, and to contact the participant after his or her third therapy session and upon termination. Participants were informed that an honorarium of \$15 at Time 1, \$10 at Time 2, and \$15 at Time 3 would be paid to them for their participation. Participation in Time 1 required approximately 30 minutes.

A standard script (Appendix B), approved by the Human Research Ethics Committee of

the School of Psychology at the University of Ottawa, was used to ensure that all participants received an identical description of the study and that no details were inadvertently omitted. The research assistant then completed a brief form (see Appendix C) that was given to the receptionist to attach to the initial intake sheet when the case was assigned to a therapist to notify him or her of the client's participation in the study. For the purpose of the study, the participant was identified by his or her client identification number only.

Time 2: Post 3rd Session. All participants were eligible to participate in the second assessment phase. Because the third session of therapy had been found to be critical in the formation of the therapeutic alliance, participants were contacted by phone after session 3 to complete the measures as in Time 1. Measures examined the client's perception of the therapeutic alliance (WAI-C; Tracey & Kokotovic, 1989) (see Appendix J), and their expectations for therapy (number of sessions and fit) (see Appendix O). Participation in Time 2 took less than 10 minutes.

To ensure that data were collected from multiple perspectives, therapists were also asked to participate in the study after the third therapy session. Research assistants contacted the therapist, consent was obtained (see Appendix E), and measures of the alliance (WAI-T; Tracey & Kokotovic, 1989) (see Appendix K), a global assessment of the client's functioning (GAF scale; American Psychiatric Association, 1994) (see Appendix N), and of expectations for treatment (number of sessions and fit) (see Appendix P) were administered in a self-report questionnaire format. The completion of the measure took less than 10 minutes and was carried out at the convenience of the therapist before the fourth therapy session.

The timing of the completion of session 3 was communicated to the researchers using a

form that was attached to the inside of each participant's CPS client file (see Appendix C). So as not to place all the responsibility on therapists to notify the researchers regarding the timing of the second assessment, researchers also used a tracking sheet (see Appendix U) that was kept in each participant's file to monitor participant attendance at sessions and dates of assessment. Once the researcher was notified of the scheduling or the occurrence of session 3, she contacted the participant by phone to administer the measures or to arrange another more convenient time prior to session 4. If the client ended therapy before the third therapy session, Time 2 measures were not administered, but rather, the participant was asked to respond to Time 3 measures as soon as possible following the final session.

Time 3: Post-Termination. All participants were eligible to participate in the third assessment phase. At the end of treatment, participants were contacted by the research assistant for a structured phone interview designed to assess barriers that they may have encountered over the course of therapy (BTPS-C; Kazdin et. al., 1997b) (see Appendix Q), their level of psychological distress (SCL-10; Nguyen et al., 1983) (see Appendix I), how well treatment fit their expectations, and their type of termination decision (see Appendix R). In the case of clients who completed treatment, participants were contacted within a week of their last therapy session. In cases where termination was not planned, clients were contacted within a month of their last session to complete the same measures in the same interview format by phone. In order to limit the data collection period to within a 36 month period, one client who continued treatment beyond 20 sessions, but who had not yet terminated therapy, was asked to complete Time 3 questionnaires. The question regarding his decision to end therapy was rephrased to ask how he anticipated his treatment would end, and he

indicated that he expected that his decision to end therapy would be made with the mutual agreement of his therapist. Participants were reminded of the consent they gave to participate in the study at the beginning of their treatment and were asked if they still wished to participate. Clients were reminded of the \$15 honorarium that would be paid to them for their participation in the interview, and their mailing address was verified to ensure the cheque was sent to their current address. Therapists completed a therapist-version of the same barriers-to-treatment measure (BTPS-T; Kazdin et al., 1997) (see Appendix S), a global assessment of the client's functioning (GAF; American Psychiatric Association, 1994) (see Appendix N), as well as provided their perspective on the client's type of termination decision, and on how well therapy fit their client's expectations (see Appendix T) on paper forms which required approximately 10 minutes to complete.

The date of termination for each participant was communicated to the researcher using a form attached to the inside of each client's file (see Appendix U). The therapist was asked to complete the form when termination had been scheduled or when termination had been determined because the client was no longer attending therapy. Using the client identification number, therapists indicated the termination date of the participant on the form and placed it in the researcher's mailbox at CPS.

Administration of Measures. As indicated above, different methods were used to administer questionnaires to clients and therapists. At Time 1, the research assistant administered the questions to the client in a telephone interview. At Times 2 and 3, data were collected from the client in a telephone interview, and from the therapist using a self-report questionnaire. Telephone data collection was chosen over mailing questionnaires to improve

the response rate and reduce the amount of missing data in the study (Dillman, 1978).

Standardized administration of the measures was ensured by clear written instructions that were provided at the top of each measure. The research assistant read the instructions to the participant verbatim. Consent forms were also read to the participant and provided to the therapist, and any questions or concerns were addressed prior to administration of the measures.

Consent. At Time 1, as part of the telephone interview, the research assistant read the consent form (see Appendix B) to the potential client prior to administering questions relevant to the study that outlined the purpose of the study. The research assistant asked for their consent to answer questions over the phone, and for permission to access their CPS client file for the purpose of collecting demographic and service information data only (e.g., number of sessions, scheduling of sessions). At Times 2 and 3, participants were reminded of their previous consent to participate in the study and asked to confirm their current interest (see Appendices D and F). They also were reminded that they would receive \$15, \$10, and \$15 participation honorarium for completing each phase of the study. At Time 2, therapists were asked to sign a consent form outlining the purpose of the study and requesting their consent to participate (see Appendix E) by answering a series of questions about their perceptions of the therapeutic alliance, their client's global level of functioning, and their expectations for treatment. At Time 3, therapists' consent was requested (Appendix G), and they were asked about their view of their client's barriers to treatment participation, their client's global level of functioning, and their perspective on the client's type of termination decision.

Issues of Confidentiality. Confidentiality was ensured for all participants in this study, clients and therapists alike. Participants were assigned a client identification number and were not identified by name. Therapists did not have access to any client data obtained for the sole purpose of the study. Therapists were also assigned a therapist identification number to guarantee their anonymity. Therapists were assured that data collected would not be used for the purpose of evaluating their performance in the clinical training program. Access to CPS files was used strictly for the purposes of obtaining demographic and assessment data not already acquired directly from the participant. All information collected from participants was analysed and reported in group format so the personal identity of individual clients and therapists was protected. Both therapists and clients were offered the opportunity to receive a summary of the results of the study once it was completed. Most showed interest in receiving such a summary.

Measures

Demographic Data. With the consent of the client, information from the client's file (e.g., occupation) was obtained once the file had been created after intake. Additional demographic data such as age, gender, education level, employment status, and annual income, cultural/ethnic background and source of referral were requested at Time 1 (see Appendix H).

Definition of treatment participation/premature termination. As previously discussed, premature termination was measured in two ways, first, as unilateral termination versus mutual agreement with the therapist, and second, as the total number of treatment sessions. To determine the type of termination decision, both clients and therapists were asked whether

the decision to terminate therapy was the client's unilateral decision or whether the decision was made with the mutual agreement of the therapist (see Appendixes R and S). Decisions to end therapy based on the failure of the client to attend sessions or to schedule subsequent appointments were considered to be unilateral decisions. Decisions to refer the client to other services were considered to be mutual decisions. The total number of treatment sessions attended by the client was obtained from the client file. Based on Pekarik's (1985) recommendation, the duration-based classification was considered most relevant for analysing client expectations for treatment duration.

Symptom Checklist 10 (SCL-10). The Symptom Checklist-90 (SCL-90; Derogatis, Lipman, & Covi, 1973) is a 90-item symptom self-report inventory, rated on a 5-point scale of distress (from "not at all" = 0 and "extremely" = 4), that reflects the degree of psychological discomfort across several symptom areas. The scale is intended to reflect nine primary symptom dimensions believed to underlie the majority of symptom behaviour in an outpatient population. The subscales of the SCL-90 include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The SCL-90 is frequently used in both research and clinical practice, however, completion of the measure is often found to be time-consuming.

The SCL-10 (Nguyen et al., 1983) was derived from the SCL-90 (see Appendix I) yields a single global score that is viewed as an acceptable measure of psychological discomfort. Ten items were selected to serve as a brief, global symptom checklist. These items were chosen from the three factors that were found to be most interpretable and accounted for a large proportion of variance in the SCL-90 in an outpatient population. They

were depression (six items), somatization (two items), and phobic anxiety (two items). A sample item from the depression scale is “How much were you distressed by feeling lonely?” A sample item from the somatization scale is “How much were you distressed by feeling weak in a part of your body?” and a sample from the phobic anxiety scale is “How much were you distressed by feeling afraid in open spaces or on the street?” Nguyen et al. (1983) found a high level of internal consistency (coefficient $\alpha = .88$) for the SCL-10 and item-total correlations ranged from .48 to .70 with a median of .62, indicating that the instrument is a reliable and internally consistent measure of psychological distress. In the current study, the alpha values were .78 when the measure was administered prior to therapy and .85 when the measure was completed following treatment. This scale was used for descriptive purposes only in order to allow comparison with other samples and ensure generalizability of the research findings. Wording was adjusted so that all items were summed to arrive at a total score for psychological distress.

Global Assessment of Functioning (GAF) Scale. The Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1994) is a rating of overall psychological functioning on a scale of 0 to 100 published in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (see Appendix N). It was designed to be completed by clinicians or researchers. It was first operationalized in the Health-Sickness Rating Scale (Luborsky, 1962), was later modified as the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976), and then further modified in the DSM-III-R as the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1987). The following psychometric properties of the GAS were reported by Endicott and colleagues

(1976). The inter-rater reliability of the scale was determined in five different studies, in which the intraclass correlation coefficients ranged from $\alpha = .61$ to $.91$. Furthermore, assessments of validity of the GAS indicated that it correlated well with other independently rated measures of overall severity. It identified patients who required re-hospitalization, and it was sensitive to treatment change.

The GAF scale ranges from 1 to 100, where 1 is the most distressed and 100 is the least distressed over the period of the previous week. The scale is divided into 10 equal ten-point intervals. For example, a score of 51 to 60 indicates that the client has “moderate symptoms,” whereas a score of 61 to 70 denotes individuals with “some mild symptoms.” The assessor must evaluate whether the client’s functioning tends towards the lower level of the sub-scale or the upper level of the subscale, and the client is assigned a single score accordingly (Endicott et al., 1976). For the purpose of this study, the GAF was used for descriptive purposes of the sample only, as an overall measure of psychological distress from the therapist’s perspective.

Client Motivation for Therapy Scale. The Client Motivation for Therapy Scale (CMOTS; Pelletier et al., 1997) is a 24-item scale that measures a client’s Intrinsic Motivation, four types of regulation for Extrinsic Motivation (integrated, identified, introjected, and external regulation), and Amotivation for therapy (see Appendix L). The six subscales are located on a self-determination continuum, and each one corresponds to a different form of motivation as described by Deci and Ryan (1985). Support has been found for the 6-factor structure of the scale and the continuum of self-determination; an adequate level of internal consistency for the subscales ($\alpha = .70$ to $.92$), and the construct validity of

the scale were also reported (Pelletier et al., 1997). In the current study, the alpha levels for the subscales ranged from .45 to .81. Although the alpha levels of two subscales were below .70, this problem was not significant because only the overall score was used in all analyses using this measure.

Items on the CMOTS are rated on a 7-point Likert scale ranging from 1 (does not correspond at all) through 4 (corresponds moderately) to 7 (corresponds exactly). The following are sample items for each subscale: Intrinsic Motivation ($\alpha = .92$; current study $\alpha = .77$), "For the pleasure I experience when I feel completely absorbed in a therapy session;" Extrinsic-Integrated Regulation ($\alpha = .91$; current study $\alpha = .74$), "Because through therapy I have come to see a way that I can continue to approach different aspects of my life;" Extrinsic-Identified Regulation ($\alpha = .82$; current study $\alpha = .45$), "Because I would like to make changes to my current situation;" Extrinsic-Introjected Regulation ($\alpha = .75$; current study $\alpha = .71$), "Because I would feel guilty if I were not doing anything about my problems;" Extrinsic-External Regulation ($\alpha = .70$; current study $\alpha = .81$), "Because other people think that it's a good idea for me to be in therapy;" and, Amotivation ($\alpha = .91$; current study $\alpha = .67$), "Honestly, I really don't understand what I can get from therapy." To accommodate the administration of this measure before clients have actually begun treatment, some items (i.e., 3, 4, 8, 9, 12, 13, 17, 18, 19, 23, and 24) were modified slightly. For example, "I experience" has been changed to "I will experience." To score this measure, a relative autonomy index score was calculated for each participant using the following formula: (3 X intrinsic motivation) + (2 X integrated regulation) + (1 X identified regulation) + (-1 X introjected regulation) + (-2 X external regulation) + (-3 X amotivation) (Pelletier, 2002). This index is

a practical way to group together the different forms of motivation assessed by the CMOTS to identify the relative level of self-determined motivation.

Stages of Change Scale. The Stage of Change Scale (SCS; McConaughy et al., 1989; McConaughy et al., 1983) is a 32-item scale that measures a client's degree of readiness for change at the beginning of therapy (see Appendix M). Based on the four theoretical stages of change proposed by DiClemente and Prochaska (1982), four 8-item internally consistent subscales measure the client's endorsement of either the precontemplation, contemplation, action, or the maintenance stage of change. There is no subscale for the preparation phase. Rather, clients are considered to be in the preparation stage when they have equal high-point scores on the contemplation and action subscales (Prochaska et al., 1992). Items are scored on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). A total score from 8 to 40 is tabulated for each subscale, and the participant's stage of change can be determined by the subscale on which their score is the highest.

McConaughy, DiClemente, Prochaska, and Velicer (1989) described the stages of change and reported the following internal consistency reliability coefficients for a clinical sample for the subscales of the measure. Clients who are in the Precontemplation stage when they begin treatment do not see the value in changing themselves. Instead, they tend to want to change others or their environment, or they feel coerced into therapy by significant others or the courts. A sample item from the Precontemplation subscale ($\alpha = .79$) is: "Coming to the clinic is pretty much a waste of time for me because the problem doesn't have to do with me". In the current study, alpha was .66. In the Contemplation stage, individuals are aware that a problem exists and they are interested in finding out whether therapy can help them to

resolve it. A sample item from the Contemplation subscale ($\alpha = .84$) is "I've been thinking that I might want to change myself". In the current study, alpha was .78. Clients in the Action stage have already begun to work on making changes in their lives, and they are looking for help to implement more effective action strategies. The Action subscale ($\alpha = .84$) is characterized by this sample item: "I am really working hard to change". In the current study, alpha was .67. Finally, individuals in the Maintenance stage have already made significant changes to address their problems, and look to treatment in order to consolidate their previous achievements. A representative item from the Maintenance subscale ($\alpha = .82$) is "After all I have done to try to change my problem, every now and again it comes back to haunt me". In the current study, the alpha was .89. To facilitate the administration of the measure over the telephone prior to actually beginning therapy, slight modifications (changing "here" and "place" to "at the clinic") were made to Items 3, 5, 6, 7, 11, 12, 16, 17, 21, 24, and 27.

Little information is provided in the literature about the scoring of this measure. As previously discussed, Littell and Girvin (2002) suggested that stages of change might best be measured on a continuous scale rather than as discrete categories. Consequently, in this study, a continuous score for the full scale was obtained using the subscale scores in an equation similar to the one employed with the measure of motivation: $(-2 \times \text{precontemplation}) + (-1 \times \text{contemplation}) + (1 \times \text{action}) + (2 \times \text{maintenance})$ (Pelletier, 2002).

Working Alliance Inventory. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989) is a 36-item scale made up of three, 12-item subscales (agreement on tasks, agreement on goals, and development of a bond). Based on Bordin's (1979)

conceptualization of the working alliance, the WAI was developed to assess the strength and the dimensions of this construct (Horvath, 1994). Three versions of the WAI were developed to allow the therapeutic alliance to be assessed from the perspectives of the client, the therapist, and an observer. The measure was designed to be administered in the early stages of the development of the alliance, between the third and the fifth sessions.

For ease and speed of administration a short, 12-item version of the WAI (Tracey & Kokotovic, 1989) was used in this study. The short-form was developed using the four highest-loading items from each subscale. The factor structure and internal consistency of the short-form are similar to that of the original measure (Tracy & Kokotovic, 1989) for both the overall client score ($\alpha = .93$) and the overall therapist score ($\alpha = .87$) (Horvath & Greenberg, 1986). In the current study, the alpha values were .93 for the client and .92 for the therapist. Both a client version (WAI-C; see Appendix J) and a therapist version (WAI-T; see Appendix K) of the shortened WAI were used. The measures are rated on a 7-point scale ranging from 1 (Does not correspond at all) to 7 (Corresponds exactly). Negative items (4 and 10) were reversed, and all scores were summed to provide a rating of the general alliance.

Expectations. Two types of expectations were examined in the study: 1) expectations of duration (number of sessions) of therapy (from both clients and therapist perspectives), and 2) the extent to which therapy fit with the expectations that the client had for therapy (from both client and therapist perspectives). At Time 2, two single-item measures were used to assess these expectations for the therapeutic process. Items were worded differently for the client (see Appendix O) and the therapist (see Appendix P). The first item was “How many more times do you expect you will need to meet with the client/your therapist to resolve the

presenting/your problem or concern?”, and the anticipated number of additional sessions were noted. The second item was “To what extent has your/the therapy fit with the expectations you/the client had for therapy?” and was scored on a 7-point Likert scale ranging from “Does not fit at all” to “Fits exactly”.

Barriers to Treatment Participation Scale (BTPS) The BTPS is a relatively new measure developed in the context of outpatient treatment of children and families (Kazdin et al., 1997b). It is written in an interview format that can be administered in person or by telephone, and is phrased so that both dropouts and completers can answer the questions. Because the BTPS was designed to be completed by parents in child and family therapy, a number of the questions were not appropriate for use with adult clients in individual therapy. Eleven out of 44 items were changed (i.e., from “we” to “I”, or from “my child” to “me”). Six items were completely eliminated from an adult version (i.e., my child had other activities that made it hard to come to a session), leaving a total of 38 items. For the main analyses, only the total scale score was used, which is consistent with the recommended usage of the measure (Kazdin et al., 1997b).

There were two versions of the BTPS, one completed by the client (see Appendix Q) and the other by the therapist (see Appendix S). The modified measures consisted of 38 items that reflect perceived barriers to treatment participation and were rated on a 5-point scale (1 = never a problem, 5 = very often a problem). The items were divided into four subscales: a) stressors and obstacles that compete with treatment (16 items: e.g., conflict with a significant other about attending treatment, transportation difficulties, scheduling difficulties); b) treatment demands and issues (9 items: e.g., treatment was too long, treatment

was more work than expected); c) perceived relevance of treatment (8 items: e.g., treatment was not what was expected, treatment did not seem to be working); and, d) relationship with the therapist (5 items: e.g., did not like therapist, therapist did not seem confident treatment would work for me).

The internal consistency of items that comprise the original total barriers score (44 items) for the parent-completed BTPS was .86 for both coefficient alpha and the Spearman-Brown correlation. For the therapist-completed version, these coefficients were .93 and .89, respectively. In the current study, the alpha values were .87 for the client-completed version and .83 for the therapist-completed version. The relation between perceived barriers and measures of participation in treatment (Kazdin et al., 1997b) indicated convergent validity and construct validity of the measure. Evaluation of the scale revealed either no or low correlation and little shared variance between perceived barriers and critical events occurring while in therapy, or family, parent and child characteristics, thereby demonstrating discriminant validity.

Perceived barriers provided relevant information to help predict premature termination over and above the predictive value of family, parent and child characteristics, thereby providing evidence for incremental validity. It is interesting to note that evaluation of the scale found a moderate correlation between total barriers scores for parent and therapist, however, parent and therapist versions did contribute unique variance, indicating that information from one source cannot be assumed to fully represent the other (Kazdin et al., 1997b). Consistent with these findings, the current study ensured that data were collected from both client and therapist perspectives. As we shall see in the following results section,

in the current study there was also moderate correlation between client and therapist perspectives on barriers to treatment participation and each perspective contributed unique predictive value.

Results

Findings of the preliminary analyses are presented first. Next, the results of the analyses of each hypothesis are described. Premature termination was operationalized in two different ways, first as total number of treatment sessions attended and second, as a dichotomous distinction, from either the client's or the therapist's perspective, between clients whose decision to end therapy was either unilateral or with the mutual agreement of their therapist. Hierarchical multiple regressions (HMR) were used to predict total number of treatment sessions and sequential logistic regressions (SLR) were used to predict the categorical measurement of termination. The results of these two types of analyses are reported for each hypothesis. Finally, the overall findings of the study are summarized at the end of the section, describing the results of the two different operationalizations of premature termination separately.

Preliminary Analyses

Major analyses were performed using SPSS REGRESSION. SPSS FREQUENCIES was used in the evaluation of assumptions (SPSS, 1994; Tabachnick & Fidell, 2001). The first stage of the analysis involved screening the data for incomplete questionnaire responses and univariate outliers using SPSS FREQUENCIES. In the majority of cases, there were no missing data. Sample item means were substituted for missing values in questionnaires where missing data did not exceed 5% of the items on one measure (see Tabachnick & Fidell, 2001). However, one therapist participant who completed the Time 3 questionnaires had more than 5% of the items missing on one measure. Data from this participant were not included in analyses that included this measure (see Tabachnick & Fidell, 2001). In some

cases, clients left therapy prior to session 3 (8 clients), therefore, they did not complete Time 2 measures. In other cases, clients did not continue therapy after session 3 (5 clients), therefore they did not answer all Time 2 questions. One client was inadvertently not contacted after Session 3, therefore all his Time 2 data are missing. In summary, analyses performed with the most missing data involved client or therapist Time 2 expectations which were conducted with only 93 or 94 participants, or approximately 88% of the total sample size.

The influence of univariate outliers (scores more than three standard deviations from the sample mean) was minimized by reducing 25 values of interest to three standard deviations from the mean (see Tabachnick & Fidell, 2001). Out of the 2208 data points which made up variables used in the analyses, values that were reduced represented approximately 1% of the data set.

Analysis was performed using SPSS FREQUENCIES for evaluation of normality. Square root or logarithmic transformations were applied to reduce skewness and improve the normality of the distributions. The types of transformations applied to variables are reported in Table 1. For the analyses that will be reported, the sample includes data from 107 client and 35 therapist participants who treated 106 clients.

Pearson correlation analyses were conducted to examine associations among all the measures used in the study, including demographic education and income variables that were used as control variables in the regression analyses. These results are reported in Tables 2, 8, 12, 18 and 23, and include correlations of both transformed and untransformed data. There was moderate correlation between the two operationalizations with a coefficient alpha of .55

Table 1

Transformations of Variables

Variable	Transformation
Education	none
Income	none
Client Time 1 Expectations for Number of Therapy Sessions	logarithmic
Client Time 2 Expectations for Number of Therapy Sessions	logarithmic
Client Expectations for Therapy Fit	square root
WAI-Client	square root
BTPS-Client	logarithmic
Therapist Time 2 Expectations for Number of Therapy Sessions	square root
Therapist Expectations for Therapy Fit	square root
WAI-Therapist	none
BTPS-Therapist	none
Client Motivation for Therapy Scale	none
Stages of Change Scale	none
Total Number of Therapy Sessions	square root

Note.

WAI-Client = Working Alliance Inventory-Client. BTPS-Client = Barriers to Treatment Participation Scale-Client. WAI-Therapist = Working Alliance Inventory-Therapist. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist.

between client and therapist categorical measures (unilateral versus mutual), .45 between client categorical distinction and total number of sessions, and .42 between therapist categorical distinction and total number of sessions.

Testing of Hypotheses

All planned analyses were performed on both transformed and non-transformed variables. In each case, there were differences in the results of the analyses for raw and transformed variables, therefore, a decision was made to use and report analyses using the more statistically-sound transformed measures.

With the use of $p < .001$ criterion for Mahalanobis distance no multivariate outliers were found in any of the HMR analyses, unless otherwise indicated. Similarly, with the use of a SPSS casewise listing of residuals outside three standard deviations from the mean, no outliers were found in the SLR analyses.

No adjustments were made to control for the possibility of Type 1 error due to multiple analyses. Because past research had failed to consistently identify factors that predict premature termination, and because this study was exploratory in nature (e.g., findings in a child and family population were being tested for the first time with an adult population), it was considered appropriate to maximize the chances of finding significant therapy-specific and contextual predictors of premature termination from adult therapy by testing all hypotheses at an $\alpha = .05$ level.

All the HMR tables which summarize the statistical analyses conducted to test each hypothesis show the R^2 , adjusted R^2 , changes in R^2 , and significance for changes in R^2 for each step in the analysis. The first columns for each HMR table show the unstandardized

beta weight, the standard error of beta, and the standardized beta weight for the final equation. The order of entry of the variables was determined prior to the analysis. Education and income were entered on the first step of each analysis as control variables. Consistent with the nature of the planned hypotheses, in each HMR the specific variables of interest were entered in subsequent steps once education and income were controlled for. All HMR tables are structured in the same manner.

All the SLR tables summarizing the statistical analyses performed to test each hypothesis show the Odds ratio and Wald statistic for each variable at each step of the analysis. The first two columns of each SLR table show the beta weight and standard error of beta for each variable. The order in which variables were entered was planned prior to the analysis, including the entry of education and income as control variables in each analysis. All SLR tables are structured in the same manner.

Hypothesis 1:

It was hypothesized that self-reports of therapy-specific factors and contextual barriers to treatment from the client's perspective, including the therapeutic alliance, treatment expectations, and barriers to treatment participation would account for a significant proportion of variance in predicting premature termination in an adult, outpatient population, beyond that accounted for by education and income. This hypothesis was tested in two ways, using either client expectations for the number of therapy sessions prior to the beginning of therapy or their expectations following the third treatment session. Pearson correlation coefficients were calculated to determine the relation between self-reported measures of the therapeutic process from the client's perspective. As shown in Table 2, the magnitude of

Table 2

Intercorrelations Between Variables from Client's Perspective

	1	2	3	4	5	6	7	<u>M</u>	<u>SD</u>
1. Education		.03	.07 (.05)	.12 (.09)	.02 (.00)	-.19 (-.21*)	-.12 (.10)	7.05	1.68
2. Income			-.07 (-.07)	-.05 (-.08)	.14 (.15)	.06 (.06)	-.05 (-.04)	4.05	2.63
3. Expc11				.47** (.57**)	-.09 (-.02)	-.10 (-.05)	-.04 (-.10)	19.78 (1.16)	16.75 (.35)
4. Expc21					.04 (.05)	-.08 (-.14)	-.10 (-.11)	15.54 (1.08)	12.07 (.32)
5. Expc25						.74** (.71**)	-.49** (-.45**)	5.27 (1.60)	1.50 (.44)
6. WAIC							-.55** (-.48**)	69.00 (3.70)	12.41 (1.52)
7. BTPSC								56.11 (1.74)	12.78 (.09)

Note.

1. Expc11 = Client Expectations for # of sessions at Time 1. Expc21 = Client Expectations for # of sessions at Time 2. Expc25 = Client Perception of Therapeutic Fit at Time 2. WAIC = Working Alliance Inventory-Client at Time 2. BTPSC = Barriers to Treatment Participation Scale-Client at Time 3.

2. Variables based on raw data are presented throughout the Table, followed by comparable values for the transformed variables in parentheses.

** $p < .01$, * $p < .05$

coefficient alphas among the variables that comprise the hypothesis of interest ranged between .02 and .71 (.04 and .74 for untransformed variables), indicating very low to high correlation. The high correlation between working alliance and expectations of therapy fit (.74 – untransformed; .71 -- transformed) suggested redundancy between these two measures. To avoid redundancy and to ensure that only separate constructs were analysed (Tabachnick & Fidell, 2001), expectations for treatment fit were dropped from the analyses. This decision was based on the fact that this single-item measure had not been psychometrically validated, whereas the measure of working alliance is a well-validated instrument.

Total Number of Treatment Sessions Using Client Time 1 Expectations for the Number of Therapy Sessions. In order to predict premature termination from therapy, as measured by the total number of treatment sessions attended, a HMR was performed to determine the amount of variance that could be accounted for by variables from the client's perspective. Education and income were entered as predictor variables on the first step, followed by the addition, as a block, of measures from the client's perspective on the second step (Time 1 expectations for the number of therapy sessions, working alliance, and barriers to treatment participation).

Table 3 shows the amount of variance in total number of therapy sessions accounted for by self-report measures from the client perspective. These variables significantly increased R^2 when entered on the second step of the regression equation once the variance from education and income demographic variables was removed. Two variables, client expectations for the number of therapy sessions and barriers to treatment participation contributed significantly to prediction of total number of therapy sessions. The hypothesis

Table 3

Hierarchical Regression of Measures of Client Perspective (Client Expectations Time 1) on Total Number of Therapy Sessions (N=105)

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0.01	
Income	0.03	0.09	0.06			
Education	0.06	0.06	0.06			
Step 2				.21***	.17***	.20***
Income	0.03	0.05	0.05			
Education	0.06	0.08	0.07			
Client Time 1 Expectations	1.1	0.39	.26**			
WAI-Client	0.15	0.11	0.15			
BTPS-Client	-4.22	1.73	-.26*			

Note.

WAI-Client = Working Alliance Inventory-Client. BTPS-Client = Barriers to Treatment Participation Scale-Client.

*** $p < .001$, ** $p < .01$, * $p < .05$

that therapy-specific factors and contextual barriers to treatment from the client's perspective would help predict premature termination was, therefore, supported when client expectations for therapy duration, measured prior to treatment, were used.

Total Number of Treatment Sessions Using Client Time Two Expectations for the Number of Therapy Sessions. To test the same hypothesis using client Time 2 expectations for the number of therapy sessions, a similar HMR was performed. After controlling for education and income, client Time 2 expectations for the number of therapy sessions, working alliance, and barriers to treatment participation were entered on step 2.

Table 4 shows the amount of variance in total number of therapy sessions accounted for by self-report measures from the client. These variables significantly increased R^2 when entered on the second step of the regression equation once the variance from education and income demographic variables was removed, however in this analysis, only one IV, client Time 2 expectations for the number of therapy sessions contributed significantly to prediction of total number of therapy sessions. The hypothesis that therapy-specific factors and contextual barriers to treatment from the client's perspective would help predict premature termination was only minimally supported when client expectations for therapy duration, measured after the third treatment session (Time 2), were used.

Unilateral Decision Versus Mutual Agreement Using Client Time 1 Expectations for Number of Therapy Sessions. In order to predict premature termination from therapy, as measured by client's self-report of whether their decision to end therapy was unilateral or with the agreement of their therapist, a SLR was performed (see Table 5). Education and income were entered as predictor variables on the first step, followed by the addition as a

Table 4

Hierarchical Regression of Measures of Client Perspective (Client Expectations Time 2) on Total Number of Therapy Sessions (N=94)

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 1				0.02	0.01	
Income	0.04	0.05	0.08			
Education	0.08	0.08	0.1			
Step 2				.14**	.09**	.12**
Income	0.04	0.05	0.08			
Education	0.04	0.09	0.04			
Client Time 2 Expectations	1.13	0.44	.27**			
WAI-Client	-0.03	0.12	-0.03			
BTPS-Client	-3.4	1.84	-0.21			

Note.

WAI-Client = Working Alliance Inventory-Client. BTPS-Client = Barriers to Treatment Participation Scale-Client.

** $p < .01$

Table 5

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective (Client Time 1 Expectations) (N=105)

Variable	B	SE	Odds ratio	Wald statistic	X ²	Δ X ²
Model at Step 1					3.38	
Income	0.09	0.08	1.1	1.27		
Education	0.17	0.12	1.18	1.88		
Model at Step 2					16.99**	4.25*
Income	0.09	0.09	1.1	1.13		
Education	0.22	0.14	1.24	2.4		
Client Time 1 Expectations	0.96	0.63	2.61	2.29		
WAI-Client	0.22	0.17	0.81	1.6		
BTPS-Client	-5.76	2.87	0	4.04*		
Model at Step 3					12.75**	9.37**
Income	0.1	0.09	1.1	1.25		
Education	0.25	0.13	1.28	3.45		
Client Time 1 Expectations	1.06	0.62	2.88	2.9		
WAI-Client	0.38	0.15	0.68	6.33**		

Note.

WAI-Client = Working Alliance Inventory-Client. BTPS-Client = Barriers to Treatment Participation Scale-Client.

** $p < .01$, * $p < .05$

block, of the same variables described above from the client's perspective on the second step. Exceptionally in this analysis, a third step involved removal of the barriers variable in order to test the model without this variable. The addition of the third step was for the purpose of compensating for weaknesses in the Wald test that is described below.

There was poor discrimination between groups on the basis of education and income alone, $\chi^2 (2, 105) = 3.38$, NS. After addition of the three predictors, however, $\chi^2 (3, 105) = 13.62$, $p < .01$, showing a statistically significant improvement in the model. A test of the full model with control variables and all three predictors against a constant-only model was statistically reliable, $\chi^2 = (5, 105) = 16.99$, Nagelkerke $\Delta R^2 = .20$, indicating that the predictors, as a set, reliably distinguished between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 68%, or moderate. Prediction success was lower than chance (41%) for unilateral decision makers and moderate (84%) for mutual agreement seekers.

Table 5 shows regression coefficients, Wald statistics, and odds ratios for each of the three predictors. According to the Wald criterion, only client perception of client barriers to treatment participation reliably predicted premature termination. Because of difficulties associated with the Wald test, a third step was added to the analysis to evaluate predictors in the model without barriers to treatment participation (Tabachnick & Fidell, 2001). A model run with barriers to treatment participation omitted was reliably different from a constant-only model and reliably different from the full model, $\chi^2 (1, 105) = 4.25$, $p < .05$. This indicates that working alliance also reliably predicted premature termination when the variance it shared with barriers was taken out of the equation. The odds ratio of .00 shows a

100% greater likelihood of unilateral termination on the basis of one unit increase in barriers to treatment and the odds ratio of .68 shows a 32% likelihood of unilateral termination on the basis of one unit increase in working alliance. The hypothesis that therapy-specific factors, such as working alliance and contextual factors, such as barriers to treatment from the client's perspective would help predict premature termination as defined by the type of termination decision-making process was, therefore, supported when client expectations for therapy duration, measured prior to treatment (Time 1), were used.

Post-hoc Analysis of Subscales of Barriers to Treatment Participation. In the previous analysis of Hypothesis 1, client barriers to treatment participation were demonstrated to significantly distinguish between clients who made a unilateral decision to end therapy and clients who terminated treatment with the mutual agreement of their therapist. The client version of the BTPS is made up of four subscales which measure different kinds of therapy-specific and contextual factors that may hinder an individual's participation in treatment. The internal consistency of the modified subscales used in the study was calculated, however, no comparison could be made with their original versions because the psychometric properties of the subscales are not reported in the literature. The following were the coefficient alpha values found for the subscales with the current sample from the client perspective: stressors = .79; treatment demands = .44; treatment relevance = .75; and, therapeutic relationship = .82. In the current study, all but the alpha value for treatment demands fell generally within the range for the subscales reported by Kazin and colleagues (1997b), .61 to .80 for the client version. Because the internal consistency of the treatment demands subscale was much lower and did not correspond with previous studies, the current sample is different from other

samples in this respect. This difference might be accounted for by dissimilarities between our adult sample and the family therapy sample from which the psychometric properties of the scale were derived. In order to determine which of these factors (stressors, treatment demands, treatment relevance, and therapeutic relationship) may have contributed to the predictive value of the BTPS-Client, an additional SLR was conducted (see Table 6).

Education and income were entered as predictor variables on the first step, followed by the addition, as a block, the BTPS subscales from the client's perspective on the second step.

There was poor discrimination between groups on the basis of education and income alone, $\chi^2(2, 107) = 3.56$, NS. After addition of the four BTPS subscales, however, $\chi^2(4, 107) = 11.29$, $p < .05$, showing a statistically significant improvement in the model. A test of the full model with control variables and all four subscales against a constant-only model was statistically reliable, $\chi^2(6, 107) = 14.85$, $p < .05$, Nagelkerke $\Delta R^2 = .18$, indicating that the predictors, as a set, reliably distinguished between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 69%, or moderate. Prediction success was lower than chance (45%) for unilateral decision makers and moderate (85%) for mutual agreement seekers.

Table 6 shows that according to the Wald criterion, none of the subscales reliably predicted premature termination. Although the overall model was significant, no one subscale within the combination of four subscales that made up the client-version of the BTPS contributed significantly unique variance. The odds ratio was not interpreted because there were no statistically significant coefficients (Tabachnick & Fidell, 2001).

Unilateral Decision Versus Mutual Agreement Using Client Time 2 Expectations for

Table 6

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective (BTPS Subscales) (N=107)

Variable	<i>B</i>	<i>SE</i>	Odds ratio	Wald statistic	X^2	ΔX^2
Model at Step 1					3.56	
Income	0.09	0.08	1.09	1.2		
Education	0.18	0.12	1.2	2.22		
Model at Step 2					14.85*	11.29*
Income	0.09	0.09	1.2	1.16		
Education	0.18	0.14	1.09	1.84		
Stressors	-3.96	2.34	0.02	2.86		
Treatment Demands	0.7	2.94	2.01	0.06		
Treatment Relevance	-0.69	0.44	0.5	2.45		
Therapeutic Relationship	-0.36	2.31	0.7	0.02		

* $p < .05$

Table 7

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective (Client Expectations Time 2) (N=94)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					6.27*	
Income	0.17	0.09	1.18	3.13		
Education	0.24	0.14	1.27	3.14		
Model at Step 2					10.25	3.98
Income	0.16	0.1	1.17	2.73		
Education	0.25	0.15	1.28	2.66		
Client Time 2 Expectations	0.45	0.76	1.57	0.35		
WAI-Client	0.11	0.2	0.9	0.28		
BTPS-Client	-4.31	3.16	0.01	1.85		

Note.

WAI-Client = Working Alliance Inventory-Client. BTPS-Client = Barriers to Treatment Participation Scale-Client.

* $p < .05$

Number of Therapy Sessions. An additional SLR was performed to test the same hypothesis using client Time 2 expectations for number of therapy sessions (see Table 7). After controlling for education and income on the first step, a block of measures from the client's perspective was added on the second step, including client Time 2 expectations for the number of therapy sessions.

Unlike the previous analysis using client Time 1 expectations, in this analysis with a smaller sample size due to missing data, there was good discrimination between groups on the basis of education and income alone, $\chi^2(2, 94) = 6.27, p < .05$. This finding will be discussed later. After addition of the three client predictors, however, $\chi^2(3, 94) = 3.98$, showing no statistically significant improvement in the model (ns). A test of the full model with control variables and all four predictors against a constant-only model was not statistically reliable, $\chi^2(5, 94) = 10.25$, ns, Nagelkerke $\Delta R^2 = .14$, indicating that the predictors, as a set, did not reliably distinguish between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 63%, or moderate. Prediction success was unimpressive (18%) for unilateral decision makers and high (85%) for mutual agreement seekers.

Table 7 shows that according to the Wald criterion, none of the client variables reliably predicted premature termination. The hypothesis that therapy-specific factors and contextual barriers to treatment from the client's perspective would help predict premature termination as defined by the nature of the termination decision-making process was, therefore, not supported when client expectations for therapy duration, measured following the third

treatment session (Time 2), were used.

Hypothesis 2:

It was hypothesized that therapy-specific factors and contextual barriers to treatment from the therapist's perspective, including the therapeutic alliance, treatment expectations, and barriers to treatment participation would account for a significant proportion of variance in predicting premature termination, beyond that accounted for by client education and income. Pearson correlation coefficients were calculated to determine the relation between self-reported measures of the therapeutic process from the therapist's perspective. As shown in Table 8, the magnitude of correlations among the variables that comprise the hypothesis of interest ranged between .02 and .62 (.05 and .60 for untransformed variables), indicating very low to high correlation. The high correlation between working alliance and expectations of therapy fit (.60 – untransformed; .62 – transformed) suggested redundancy between these two measures. To address redundancy and to ensure that only separate constructs were analysed (Tabachnick & Fidell, 2001), expectations for treatment fit was dropped from the analyses. As with analyses for Hypothesis 1, this decision was based on the fact that this single-item measure is not psychometrically validated, whereas the measure of working alliance is a well-validated instrument.

Total Number of Treatment Sessions. Education and income were entered as predictor variables on the first step, followed by the addition as a block of measures from the therapist's perspective on the second step. Table 9 shows the amount of variance in total number of therapy sessions accounted for by self-report measures from the therapist perspective (Therapist Time 2 Expectations, WAI-Therapist, BTPS-Therapist). These

Table 8

Intercorrelations Between Variables from Therapist's Perspective

	1	2	3	4	5	6	<u>M</u>	<u>SD</u>
1. Education		0.03	.01 (-.02)	.07 (.09)	0.05	-0.11	7.05	1.68
2. Income			.06 (.07)	.07 (.07)	0.19	-0.08	4.05	2.63
3. Expt21				-.17 (-.16)	-.21* (-.22*)	-.05 (-.02)	15.96 (3.92)	6.37 (.79)
4. Expt25					.60** (.62**)	-.19 (-.20*)	5.12 (1.66)	1.21 (.34)
5. WAIT						-.30*	65.46	9.9
6. BTPST							53.24	11.8

Note.

1. Expt21 = Therapist Expectations for # of sessions at Time 2. Expt25 = Therapist Perception of Therapeutic Fit at Time 2. WAIT=Working Alliance Inventory-Therapist. BTPST=Barriers to Treatment Participation Scale-Therapist.

2. Variables based on raw data are presented throughout the Table, followed by comparable values for the transformed variables in parentheses.

** $p < .01$, * $p < .05$

Table 9

Hierarchical Regression of Measures of Therapist Perspective on Total Number of Therapy Sessions (N=94)

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0	
Income	0.03	0.06	0.06			
Education	0.07	0.08	0.1			
Step 2				.27***	.22***	.25***
Income	0	0.05	0			
Education	0.07	0.07	0.09			
Therapist Time 2	0.69	0.16	0.41***			
Expectations						
WAI-Therapist	0	0.01	0.01			
BTPS-Therapist	-0.04	0.01	-.29**			

Note.

WAI-Therapist = Working Alliance Inventory-Therapist. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist.

*** $p < .001$, ** $p < .01$

variables significantly increased R^2 when entered on the second step of the regression equation once the variance from education and income demographic variables was removed. Two variables, therapist expectations for the number of therapy sessions and client barriers to treatment participation from the therapist's perspective contributed significantly to prediction of number of therapy sessions. The hypothesis that therapy-specific factors and contextual barriers to treatment from the therapist's perspective would help predict premature termination as defined by the total number of treatment sessions attended was supported.

Unilateral Decision Versus Mutual Agreement. In order to predict premature termination from therapy, as measured by therapist's self-report of whether their client's decision to end therapy was unilateral or with the agreement of the therapist, a SLR was performed using the same IVs (see Table 10). As before, education and income were entered as predictor variables on the first step, followed by the addition, as a block, of measures from the therapist's perspective on the second step.

There was a poor discrimination between groups on the basis of the demographic predictors alone, $\chi^2 (2, 94) = 2.06$, ns. After addition of the three therapist predictors, however, $\chi^2 (3, 94) = 13.28$, $p < .01$, showing reliable improvement in the model. A test of the model with the control variables and all three predictors against a constant-only model was statistically reliable, $\chi^2 (5, 94) = 15.34$, $p < .01$, Nagelkerke $\Delta R^2 = .21$, indicating that the predictors, as a set, reliably distinguished between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 69%, or moderate. Prediction success was lower than chance (41%) for unilateral decision makers and high (85%) for mutual agreement seekers.

Table 10

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Therapist's Perspective (N=94)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					2.06	
Income	.02	.09	1.02	1.98		
Education	.18	.13	1.20	.07		
Model at Step 2					3.12	1.05
Income	.01	.13	1.01	.01		
Education	.19	.09	1.21	2.02		
Therapist Time 2 Expectations	.28	.29	1.33	.92		
WAI-Therapist	-.01	.03	1.01	.31		
Model at Step 3					15.34**	12.23***
Income	-0.02	0.09	0.98	0.05		
Education	0.18	0.14	1.20	1.65		
Therapist Time 2 Expectations	0.25	0.31	1.29	0.65		
WAI-Therapist	0.01	0.03	0.99	0.06		
BTPS-Therapist	-0.08	0.02	0.92	10.53***		

Note.

WAI-Therapist = Working Alliance Inventory-Therapist. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist.

*** $p < .001$

Table 10 shows that according to the Wald criterion, only therapist perception of client barriers to treatment participation reliably predicted premature termination. A model run with barriers to treatment participation omitted was not reliably different from a constant-only model, however, this model was reliably different from the full model, $\chi^2(1, 94) = 12.23, p < .001$. This confirms that finding that client barriers to treatment participation is the only reliable predictor of premature termination among the three therapist variables. The odds ratio of .92 shows only a 8% greater likelihood of unilateral termination on the basis of one unit increase in barriers to treatment. The hypothesis that therapy-specific factors and contextual barriers to treatment from the therapist's perspective would help predict premature termination as defined by the nature of the termination decision-making process was, therefore, supported.

Post-hoc Analysis of Subscales of Barriers to Treatment Participation. In the previous analysis of Hypothesis 2, client barriers to treatment participation from the therapist's perspective were demonstrated to significantly distinguish between clients who made a unilateral decision to end therapy and clients who terminated treatment with the mutual agreement of their therapist. The therapist version of the BTPS is made up of four subscales which measure different kinds of therapy-specific and contextual factors that may hinder a client's participation in treatment. The internal consistency of the modified subscales was calculated, however, no comparison could be made with their original versions because the psychometric properties of the subscales are not reported in the literature. The following were the coefficient alpha values found for the subscales with the current sample from the therapist perspective: stressors = .73; treatment demands = .58; treatment relevance = .69;

and, therapeutic relationship = .72. In the current study, all but the alpha value for treatment demands fell generally within the range for the subscales reported by Kazin and colleagues (1997b), .76 to .87 for the therapist version. Because the internal consistency of the treatment demands subscale was much lower and did not correspond with previous studies, the current sample is different from other samples in this respect. As previously mentioned, this difference might be accounted for by dissimilarities between our adult sample and the family therapy sample from which the psychometric properties of the scale were derived. In order to determine which of these factors (stressors, treatment demands, treatment relevance, and therapeutic relationship) may have contributed to the predictive value of the BTPS-Therapist, an additional SLR was conducted (see Table 11). Education and income were entered as predictor variables on the first step, followed by the addition, as a block, of the BTPS subscales from the therapist's perspective on the second step.

There was poor discrimination between groups on the basis of education and income alone, $\chi^2(2, 106) = 1.19$, ns. After addition of the four BTPS subscales, however, $\chi^2(4, 106) = 22.21$, $p < .001$, showing a statistically significant improvement in the model. A test of the full model with control variables and all four subscales against a constant-only model was statistically reliable, $\chi^2 = (6, 106) = 23.40$, $p < .001$, Nagelkerke $\Delta R^2 = .27$, indicating that the predictors, as a set, reliably distinguished between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 76%, or moderate. Prediction success was just above chance (60%) for unilateral decision makers and high (87%) for mutual agreement seekers.

Table 11 shows that, according to the Wald criterion, therapist perception of treatment

Table 11

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Therapist's Perspective (BTPS-Subscales) (N=106)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					1.19	
Income	0.01	0.08	1.01	0		
Education	0.13	0.12	1.14	1.17		
Model at Step 2					4.81	3.62
Income	-0.01	0.08	0.99	0.02		
Education	0.13	0.12	1.14	1.12		
Demands	-0.15	0.08	0.86	3.39		
Model at Step 3					9.54*	4.74*
Income	-0.01	0.08	0.99	0.03		
Education	0.1	0.12	1.11	0.71		
Demands	-0.1	0.09	0.9	1.44		
Stressors	-0.08	0.04	0.92	4.47*		
Model at Step 4					23.40***	13.86***
Income	-0.03	0.08	0.97	0.1		
Education	0.14	0.13	1.15	1.14		
Treatment Demands	-0.13	0.12	0.88	1.06		
Stressors	-0.03	0.04	0.97	0.56		
Treatment Relevance	-0.23	0.07	0.79	10.32***		
Therapeutic Relationship	1.78	0.84	5.91	4.49*		

*** $p < .001$, * $p < .05$

relevance for the client and the therapeutic relationship reliably predicted premature termination. A model run with treatment relevance and therapeutic relationship omitted was reliably different from a constant-only model, $\chi^2 (1, 106) = 4.74, p < .05$, and reliably different from the full model, $\chi^2 (4, 106) = 9.54, p < .05$. This indicates that client stressors also reliably predicted premature termination. A model run without treatment relevance, therapeutic relationship, and stressors was not reliably different from a constant-only model $\chi^2 (1, 106) = 3.62, ns$, nor reliably different from a full model, $\chi^2 (3, 106) = 4.81, ns$, indicating that treatment demands did not provide any predictive value. The odds ratio of .79 for treatment relevance shows a 21% greater likelihood of unilateral termination on the basis of one unit decrease in treatment relevance. The odds ratio of 5.91 for therapeutic relationship shows an almost six-fold reduced likelihood of unilateral termination on the basis of one unit increase in therapeutic relationship, and the odds ratio of .97 for stressors shows a 3% greater likelihood of unilateral termination on the basis of one unit increase in stressors.

Hypothesis 3:

It was hypothesized that after controlling for education and income that the therapist's perspective would account for a significant proportion of variance over and above the client's perspective, when predictors from the client's perspective that were significant in the analysis of Hypothesis 1 were entered before the same predictors from the therapist's perspective. Pearson correlation coefficients were calculated to determine the relationship between client and therapist variables used to predict premature termination. The correlation matrix (see Table 12) indicates moderate correlation between client and therapist variables. Correlations

Table 12

Intercorrelations Between Expectation and Barrier Variables from Client and Therapist Perspectives

	1	2	3	4	5	6	7	<u>M</u>	<u>SD</u>
1. Education		.03	.07 (.05)	.12 (.09)	-.12 (.10)	.01 (-.02)	-0.11	7.05	1.68
2. Income			-.07 (-.07)	-.05 (-.08)	-.05 (-.04)	.06 (.07)	-0.1	4.05	2.63
3. Expc11				.47** (.57**)	-.04 (-.10)	.45** (.38**)	0.07	19.78 (1.16)	16.75 (.35)
4. Expc21					-.10 (-.11)	.23* (.30**)	.09 (.05)	15.54 (1.08)	12.07 (.32)
5. BTPS-C						-.09 (-.10)	.33** (.34**)	56.11 (1.74)	12.78 (.09)
6. Expt21							-.05 (-.02)	15.96 (3.92)	6.37 (.79)
7. BTPS-T								53.45	11.8

Note.

1. Expc11 = Client Expectations for # of sessions at Time 1. Expc21 = Client Expectations for # of sessions at Time 2. BTPS-C = Barriers to Treatment Participation Scale-Client. Expt21 = Therapist Expectations for # of sessions at Time 2. BTPS-T = Barriers to Treatment Participation Scale-Therapist.

2. Variables based on raw data are presented throughout the Table, followed by comparable values for the transformed variables in parentheses.

** $p < .01$, * $p < .05$

among the variables that comprise the hypothesis of interest ranged from .02 to .57 (.00 to .49 for untransformed variables), not high enough to suggest any redundancy between measures.

Total Number of Treatment Sessions Using Client Time 1 Expectations for Treatment

Duration. In the HMR to test Hypothesis 1, Time 1 client expectations for the number of treatment sessions and client barriers to treatment participation significantly predicted the total number of actual therapy sessions attended. HMR was, therefore, employed to determine if the addition of these same variables from the therapist's perspective would improve the prediction afforded by the client's perspective.

Education and income were entered as predictor variables on the first step. These were followed by the addition of significant client variables according to highest beta weight in the Hypothesis 1 analysis. Client expectations for the number of therapy sessions ($\beta = .26, p < .01$) was entered on the second step, barriers to treatment participation from the client's perspective ($\beta = -.26, p < .05$) on the third step, followed by therapist expectations for number of therapy sessions on the fourth step, and finally, barriers to treatment participation from the therapist perspective was entered on the last step.

Table 13 shows the amount of variance in total number of therapy sessions accounted for by client variables and therapist variables. In step four, when expectations for therapy duration from the therapist perspective were added to the client variables that were already in the model, R^2 increased significantly. The final addition of the therapist's view on barriers to treatment participant also contributed significantly to the model. Two variables, therapist expectations for the number of therapy sessions and barriers to treatment participation from the therapist's perspective, contributed to the prediction of number of therapy sessions over

Table 13

Hierarchical Regression of Measures of Client and Therapist Perspectives on Total Number of Therapy Sessions - Client Time 1 Expectations for Number of Therapy Sessions (N=94)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0.01	
Income	0.03	0.06	0.06			
Education	0.08	0.08	0.1			
Step 2				.12***	.09***	.11***
Income	0.04	0.05	0.08			
Education	0.07	0.08	0.09			
Client Time 1 Expectations	0.78	0.38	0.2***			
Step 3				.17*	.13*	.04*
Income	0.03	0.05	0.05			
Education	0.05	0.08	0.06			
Client Time 1 Expectations	1.2	0.38	0.31**			
BTPS-Client	-1.2	1.67	-0.07*			
Step 4				.25**	.21**	.09**
Income	0.02	0.05	0.03			
Education	0.06	0.08	0.08			
Client Time 1 Expectations	0.73	0.39	0.19			
BTPS-Client	-3.16	1.53	-.19*			
Therapist Time 2 Expectations	0.55	0.17	.33**			

Table 13 cont'd.

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 5				.30**	.26**	.05**
Income	0.01	0.05	0.01			
Education	0.06	0.07	0.07			
Client Time 1	0.78	0.38	0.20*			
Expectations						
BTPS-Client	-1.2	1.67	-0.07			
Therapist Time 2 Expectations	0.55	0.17	0.33***			
BTPS- Therapist	-0.03	0.01	-.26**			

Note.

BTPS-Client = Barriers to Treatment Participation Scale-Client. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist.

*** $p < .001$, ** $p < .01$, * $p < .05$

and above the client's perspective. The hypothesis that the therapist's perspective would add predictive value to that of the client was, therefore, supported when client expectations for treatment duration, measured prior to therapy, and BTPS were used.

Total Number of Treatment Sessions Using Client Time 2 Expectations for Treatment Duration. In the HMR to test Hypothesis 1, only client expectations for the number of treatment sessions significantly predicted the total number of actual therapy sessions attended. HMR was, therefore, employed to determine if the addition of the therapist's expectations for the number of treatment sessions improved the prediction afforded by the client's expectations. Pearson correlation coefficients were calculated to determine the relationship between client and therapist expectations for the number of treatment sessions. As shown in Table 12, the correlational analysis demonstrated that client expectations for number of treatment sessions was significantly, but only moderately, related with therapist expectations for the same ($r = .23$)

Education and income were entered as predictor variables on the first step, followed by the addition of client expectations for the number of therapy sessions on the second step, and finally, therapist expectations for the number of therapy sessions was entered on the last step. Table 14 shows the amount of variance in total number of therapy sessions accounted for both client and therapist perspectives on the expected number of therapy sessions after the third treatment session. After step 3, with therapist expectations added to the equation of total number of actual therapy sessions by client expectations there was a significant increment in R^2 . The hypothesis that the therapist's perspective would add predictive value to that of the client was, therefore, supported when client expectations for treatment duration, measured following the third therapy session, were used.

Table 14

Hierarchical Regression of Measures of Client and Therapist Perspectives on Total Number of Therapy Sessions - Client Time 2 Expectations for Number of Therapy Sessions (N=93)

Variable	<i>B</i>	<i>SE B</i>	β	<i>R</i> ²	Adj. <i>R</i> ²	ΔR^2
Step 1				0.02	0	
Income	0.04	0.05	0.07			
Education	0.09	0.08	0.11			
Step 2				.09**	.06**	.07**
Income	0.05	0.05	0.1			
Education	0.07	0.08	0.09			
Client Time 2 Expectations	1.16	0.44	0.27**			
Step 3				.20***	.16***	.11***
Income	0.03	0.05	0.06			
Education	0.08	0.08	0.1			
Client Time 2 Expectations	0.68	0.43	0.16			
Therapist Time 2 Expectations	0.59	0.17	.35***			

*** $p < .001$, ** $p < .01$

Unilateral Decision Versus Mutual Agreement. In the SLR analysis to test Hypothesis 1, client barriers to treatment participation and working alliance were found to significantly predict premature termination when client expectations for therapy duration were measured prior to treatment. In order to determine if the addition of the therapist's perception of barriers and alliance improved the prediction of unilateral decision versus mutual agreement afforded by the client's perception of these variables, a SLR was performed (see Table 15). Education and income were entered as predictor variables on the first step, barriers and alliance from the client's perspective on the second and third steps, followed by barriers and alliance from the therapist's perspective on the fourth and fifth steps.

There was a poor discrimination between groups on the basis of the demographic predictors alone, $\chi^2(2, 106) = 3.49$, ns. After addition of the client's perspective on barriers, however, there was reliable improvement in the model ($\chi^2(1, 106) = 8.39$, $p < .01$), indicating that client-perceived barriers predicted type of termination decision. Addition of the client's perspective on alliance resulted in $\chi^2(1, 106) = .87$, ns, or no improvement to the model¹ indicating that the alliance, as perceived by the client, did not add incremental value to prediction of premature termination. Further addition of the therapist's perception of barriers improved the model, $\chi^2(1, 106) = 8.19$, $p < .01$, however, adding therapist perception of alliance added no incremental value, $\chi^2(1, 106) = 2.85$, ns. A test of the model with the control variables and four predictors against a constant-only model was statistically reliable,

¹In a previous analysis, poor working alliance was a significant predictor of premature termination when variance accounted for by barriers to treatment participation was removed from the equation.

Table 15

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Therapist's Perspective Over Client's Perspective (N=106)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					3.49	
Income	0.09	0.08	1.09	1.17		
Education	0.18	0.12	1.2	2.12		
Model at Step 2					11.88**	8.39**
Income	0.08	0.08	1.08	0.92		
Education	0.16	0.13	1.17	1.49		
BTPS-Client	-7.01	2.55	0	7.52**		
Model at Step 3					12.75**	0.87
Income	0.08	0.09	1.08	0.88		
Education	0.2	0.14	1.22	2.1		
BTPS-Client	-5.85	2.84	0	4.25*		
WAI-Client	0.16	0.17	0.85	0.86		
Model at Step 4					20.94***	8.19**
Income	0.06	0.09	1.07	0.52		
Education	0.19	0.14	1.2	1.7		
BTPS-Client	-2.7	3.08	0.07	0.77		
WAI-Client	0.08	0.18	0.93	0.18		
BTPS-Therapist	-0.1	0.03	0.93	7.53**		

Table 15 cont'd

Variable	<i>B</i>	<i>SE</i>	Odds ratio	Wald statistic	χ^2	$\Delta\chi^2$
Model at Step 5					23.79***	2.85
Income	0.09	0.09	1.1	1.06		
Education	0.23	0.15	1.26	2.46		
BTPS-Client	-3.29	3.19	0.04	1.06		
WAI-Client	0.23	0.21	0.8	1.21		
BTPS-Therapist	-0.1	0.03	0.93	8.07**		
WAI-Therapist	0.05	0.03	0.95	2.71		

Note.

BTPS-Client = Barriers to Treatment Participation Scale-Client. WAI-Client = Working Alliance Inventory-Client. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist. WAI-Therapist = Working Alliance Inventory-Therapist.

** $p < .01$

$\chi^2 (6, 106) = 23.79, p < .001$, Nagelkerke $\Delta R^2 = .28$, indicating that the predictors reliably distinguished between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 71%, or moderate. Prediction success was at the level of chance (50%) for unilateral decision makers and moderate (84%) for mutual agreement seekers.

According to the Wald criterion (see Table 15), therapist perceptions of client barriers to treatment participation reliably improved upon client perception of barriers to predict unilateral decision versus mutual agreement to terminate therapy. The odds ratio of .93 shows only a 6% greater likelihood of unilateral termination on the basis of one unit increase in barriers to treatment from the therapist's perspective. The hypothesis that the therapist's perspective would add predictive value to that of the client was, therefore, supported when client expectations for treatment duration, measured prior to therapy, were used.

Hypothesis 4:

It was hypothesized that after controlling for education and income that the client's perspective would account for a significant proportion of variance over and above the therapist's perspective, when predictors from the therapist's perspective that were significant in the analysis of Hypothesis 2 were entered before the same predictors from the client's perspective. Pearson correlation coefficients were calculated to determine the relationship between client and therapist perspectives on barriers to client treatment participation. As shown in Table 12, the correlational analysis demonstrated that client and therapist perceptions of barriers were significantly related in a positive direction ($r = .33$; $r = .34$ for untransformed variable), however, the relationship was only moderate, suggesting that the

two perspectives were different. HMR was employed to determine if the client's perspective could improve prediction of the total number of treatment sessions over the therapist's perspective. SLR was used to determine if the client perspective could enhance the prediction of unilateral decision versus mutual agreement with the therapist regarding treatment termination, over and above the therapist perspective. SLR analyses using both the client and therapist perception of the process of termination were conducted and showed similar results, therefore, only analyses using the client's perception of the process of termination are reported.

Total Number of Treatment Sessions. In the HMR to test Hypothesis 2, therapist expectations for the number of treatment sessions and therapist's perspective on client's barriers to treatment participation significantly predicted the total number of actual therapy sessions attended. HMR was, therefore, employed to determine if the addition of the client's expectations for the number of treatment sessions and barriers to treatment participation improved the prediction of total number of therapy sessions afforded by the therapist's perspective.

Education and income were entered as predictor variables on the first step. These were followed by the addition of significant therapist variables according to highest beta weight in the Hypothesis 2 analysis. Therapist expectations for the number of therapy sessions ($\beta = .41, p < .001$) was entered on the second step, barriers to treatment participation from the therapist's perspective ($\beta = -.29, p < .01$) on the third step, followed by client expectations for number of therapy sessions on the fourth step, and finally, client barriers to treatment participation was entered on the last step.

After step 4, with client expectations added to prediction of total number of treatment sessions by therapist expectations and therapist perceived barriers, $\Delta R^2 = .03$, ns. Addition of client expectations to the equation did not reliably improve R^2 . After step 5, with client barriers added to the equation with therapist expectations, therapist perceived barriers, and client expectations, there was no significant improvement of R^2 (see Table 16). The hypothesis that the client's perspective would add incremental predictive value for therapy duration to that of the therapist was, therefore, not supported.

Unilateral Decision Versus Mutual Agreement. In the SLR used to test Hypothesis 2, the therapist's perspective on client's barriers to treatment participation significantly predicted the membership in a group of individuals who ended therapy after making a unilateral decision versus those who came to a mutual agreement with their therapist. In order to determine if the addition of the client's perception of barriers to treatment participation improved the prediction of unilateral decision versus mutual agreement afforded by the therapist's perception of barriers to treatment, a SLR was performed (see Table 17). Education and income were entered as predictor variables on the first step, client barriers from the therapist's perspective on the second step, followed by client barriers from the client's perspective on the last step.

There was a poor discrimination between groups on the basis of the demographic predictors alone, $\chi^2 (2, 106) = 1.19$, ns. After addition of the therapist's perspective on barriers, however, there was reliable improvement in the model ($\chi^2 = 12.49, p < .001$), indicating that therapist-perceived barriers contributed predictive value to the type of termination decision. Further addition of the client's perspective on barriers provided

Table 16

Hierarchical Regression of Measures of Therapist and Client Perspectives on Total Number of Therapy Sessions (N=93)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.02	0	
Income	0.04	0.05	0.07			
Education	0.09	0.08	0.11			
Step 2				.18***	.15***	.16***
Income	0.02	0.05	0.04			
Education	0.1	0.08	0.12			
Therapist Time 2 Expectations	0.68	0.16	.40***			
Step 3				.25**	.22**	.08**
Income	0.03	0.05	0.01			
Education	0.08	0.07	0.1			
Therapist Time 2 Expectations	0.68	0.16	0.40***			
BTPS-Therapist	-0.03	0.01	-.28**			
Step 4				0.28	0.24	0.03
Income	0.01	0.05	0.03			
Education	0.06	0.07	0.08			
Therapist Time 2 Expectations	0.58	0.16	0.35***			
BTPS-Therapist	-0.04	0.01	-0.29**			
Client Time 2 Expectations	0.76	0.41	0.18			

Table 16 cont'd

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 5				0.29	0.24	0
Income	0.01	0.05	0.02			
Education	0.06	0.07	0.07			
Therapist Time 2 Expectations	0.58	0.16	0.34***			
BTPS-Therapist	-0.03	0.01	-0.26**			
Client Time 2 Expectations	0.73	0.42	0.17			
BTPS-Client	-0.99	1.7	-0.06			

Note.

BTPS-Client = Barriers to Treatment Participation Scale-Client. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist.

*** $p < .001$, ** $p < .01$

Table 17

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Client's Perspective Over Therapist's Perspective (N=106)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					1.19	
Income	0.01	0.08	1.01	0		
Education	0.13	0.12	1.14	1.17		
Model at Step 2					13.68**	12.49***
Income	-0.02	0.08	0.98	0.06		
Education	0.1	0.13	1.11	0.69		
BTPS-Therapist	-0.07	0.02	0.93	10.68***		
Model at Step 3					31.08***	17.40***
Income	0.02	0.09	0.98	0.07		
Education	0.11	0.14	1.12	0.61		
BTPS-Therapist	-0.04	0.02	0.96	3.99*		
BTPS-Client	-11.74	3.05	0	14.77***		

Note.

BTPS-Client = Barriers to Treatment Participation Scale-Client. BTPS-Therapist = Barriers to Treatment Participation Scale-Therapist.

*** $p < .001$, ** $p < .01$, * $p < .05$

incremental predictive value to that of the therapist-perceived barriers, $\chi^2 = 17.40, p < .001$.

A test of the model with the control variables and two predictors against a constant-only model was statistically reliable, $\chi^2 (4, 106) = 31.08, p < .001$, Nagelkerke $\Delta R^2 = .34$, indicating that the predictors reliably distinguished between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 77%, or moderate. Prediction success was moderate (61%) for unilateral decision makers and high (89%) for mutual agreement seekers.

According to the Wald criterion, client perceptions of client barriers to treatment participation reliably improved upon therapist perception of barriers to predict unilateral decision versus mutual agreement to terminate therapy (see Table 17). The odds ratio of .00 shows a 100% greater likelihood of unilateral termination on the basis of one unit increase in barriers to treatment from the client's perspective. The hypothesis that the client's perspective would add predictive value to that of the therapist was, therefore, supported.

Hypothesis 5:

It was hypothesized that the discrepancy between clients' and therapists' expectations for the number of therapy sessions would be predictive of premature termination. The difference between client and therapist expectations for the number of sessions in therapy was calculated, using client expectations at Time 1 and client expectations at Time 2 to create two difference scores. Difference scores are reported as number of sessions with the following valences: (0) = no discrepancy; (+) = therapist predicted more sessions than client; and, (-) = client predicted more sessions than therapist. Pearson correlation coefficients were calculated to determine the relationship between client expectations at Time 1 and Time 2

and the difference between therapist and client expectations for the number of treatment sessions. As shown in Table 18, the correlational analysis demonstrated that client expectations at both Times were significantly correlated as were the difference scores to the respective client expectations at both times of measurement. The magnitude of correlations among the variables ranged from .31 and .84 (.23 and .75 for untransformed variables). The client scores at Time 1 and Time 2 and their corresponding difference scores are understandably highly correlated.

As for previous analyses, HMR and SLR were employed to test the two definitions of premature termination. SLR analyses using both the client and therapist perception of the process of termination were conducted and showed similar results, therefore, only analyses using the client's perception of the process of termination are reported. All analyses were conducted using client expectations at Time 1 and at Time 2.

Analyses Using Client Time 1 Expectations.

Total Number of Treatment Sessions. In a HMR, education and income were entered as predictor variables on the first step. These were followed by the addition of client expectations for number of therapy sessions measured before the beginning of treatment (Time 1) on the second step. The difference score between therapist expectations for number of treatment sessions after the third therapy session (Time 2) and client expectations for number of treatment sessions at Time 1 was entered on the last step.

Table 19 shows the amount of variance in total number of therapy sessions accounted for both by client and therapist perspectives. Time 1 Client expectations significantly increased R^2 when entered on the second step of the regression equation once the variance

Table 18

Intercorrelations Between Client and Therapist Expectations for Number of Therapy Sessions and Difference Score Variables

	1	2	3	4	5	6	7	<u>M</u>	<u>SD</u>
1. Education		.03	.07 (.05)	.12 (.09)	.01 (-.02)	-.07 (-.09)	-.12 (-.13)	7.05	1.68
2. Income			-.07 (-.07)	-.05 (-.08)	.06 (.07)	.08 (.09)	.13 (.14)	4.05	2.63
3. Expc11				.47** (.57**)	.45** (.38**)	-.75** (-.84**)	-.14 (-.35**)	19.78 (1.16)	16.75 (.35)
4. Expc21					.23* (.31**)	-.30** (-.40**)	-.63** (-.81**)	15.54 (1.08)	12.07 (.32)
5. Expt21						-.02 (.20)	.35** (.29**)	15.96 (3.92)	6.37 (.79)
6. Difference Score T1							.55** (.53**)	-2.78 (.00)	15.79 (.33)
7. Difference Score T2								1.62 (.09)	14.14 (.31)

Note.

1.Expc11 = Client Expectations for # of sessions at Time 1. Expc21 = Client Expectations for # of sessions at Time 2. Expt21 = Therapist Expectations for # of sessions at Time 2. Difference Score T1 = Difference Between Therapist T2 and Client T1 Expectations for # of Therapy Sessions. Difference Score T2 = Difference Between Therapist T2 and Client T2 Expectations for # of Therapy Sessions.

2. Variables based on raw data are presented throughout the Table, followed by comparable values for the transformed variables in parentheses.

** $p < .01$, * $p < .05$

Table 19

Hierarchical Regression of Measures of Client Time 1 Expectations and the Difference Between Therapist Time 2 and Client Time 1 Expectations on Total Number of Therapy Sessions (N=94)

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0	
Income	0.03	0.06	0.06			
Education	0.08	0.08	0.1			
Step 2				.12***	.09***	.11***
Income	0.04	0.05	0.08			
Education	0.07	0.08	0.09			
Client Time 1 Expectations	1.27	0.39	.33***			
Step 3				.22**	.18**	.10**
Income	0.02	0.05	0.05			
Education	0.08	0.08	0.1			
Client Time 1 Expectations	1.4	0.37	0.37***			
Difference Between Therapist and Client Time 1 Expectations	0.63	0.19	.31**			

*** $p < .001$, ** $p < .01$

from education and income demographic variables was removed. After step 3, with the difference between therapist and client expectations added to the equation of total number of actual therapy sessions by client expectations. When the therapist expected more sessions than did the client, the client's attendance in treatment was longer. The hypothesis that the discrepancy in treatment duration expectations between client and therapist would be of predictive value for premature termination as defined by treatment duration was, therefore, supported when client expectations for the length of time of treatment, measured prior to therapy, were used.

Unilateral Decision Versus Mutual Agreement. Using SLR (see Table 20), education and income were entered as predictor variables on the first step, client expectations at Time 1 were entered on the second step, followed by the addition of the difference score between therapist and client expectations on the last step.

There was a poor discrimination between groups on the basis of the demographic predictors alone, $\chi^2(2, 94) = 5.60$, ns. After addition of client expectations, however, there was no reliable improvement in the model, $\chi^2(1, 94) = 1.49$, ns, showing that client expectations did not predict type of termination. Further addition of the difference score also showed no reliable improvement in the model ($\chi^2(1, 94) = .00$, ns), indicating that the discrepancy between client and therapist expectations did not predict type of termination. A test of the model with the control variables and two predictors against a constant-only model was not statistically reliable, $\chi^2(4, 94) = 7.10$, ns, Nagelkerke $\Delta R^2 = .08$, indicating that the predictors did not reliably distinguish between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 67%,

Table 20

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Differences in Client Time 1 Expectations of Number of Therapy Sessions and Therapist Time 2 Expectations for Number of Therapy Sessions-Client Perspective (N=94)

Variable	<i>B</i>	<i>SE</i>	Odds ratio	Wald statistic	X^2	ΔX^2
Model at Step 1					5.6	
Income	0.15	0.09	1.16	2.66		
Education	0.23	0.13	1.26	2.92		
Model at Step 2					7.1	1.49
Income	0.16	0.09	1.17	2.85		
Education	0.23	0.14	1.25	2.76		
Client Time 1 Expectations	0.8	0.66	2.21	1.46		
Model at Step 3					7.1	0
Income	0.16	0.09	1.17	2.81		
Education	0.23	0.14	1.25	2.76		
Client Time 1 Expectations	0.8	0.66	2.22	1.46		
Difference Between Therapist Time 2 and Client Time 1 Expectations	0.02	0.35	1.02	0		

or moderate. Prediction success was unimpressive (21%) for unilateral decision makers and high (93%) for mutual agreement seekers.

According to the Wald criterion, the difference between therapist and client expectations for number of treatment sessions did not reliably predict premature termination (see Table 20). The odds ratio was not interpreted because there were no statistically significant coefficients (Tabachnick & Fidell, 2001). The hypothesis that the discrepancy in treatment duration expectations between client and therapist would be of predictive value for premature termination as defined by the nature of the termination decision-making process was, therefore, not supported when client expectations for the length of time of treatment, measured prior to therapy, were used.

Analyses Using Client Time 2 Expectations.

Total Number of Treatment Sessions. Education and income were entered as predictor variables on the first step. These were, followed by the addition of client expectations for number of therapy sessions measured following the third therapy session (Time 2) on the second step. The difference score between therapist expectations for number of treatment sessions and client expectations for number of treatment sessions after the third therapy session was entered on the last step.

Table 21 shows that the variance accounted for by client expectations significantly increased R^2 when entered on the second step of the regression equation once the variance from education and income demographic variables was removed. After step 3, with the difference between therapist and client expectations added to the equation of total number of actual therapy sessions by client expectations. Addition of the difference score to the equation

Table 21

Hierarchical Regression of Measures of Client Time 2 Expectations and the Difference Between Therapist Time 2 and Client Time 2 Expectations on Total Number of Therapy Sessions (N=93)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.02	0	
Income	0.04	0.05	0.07			
Education	0.09	0.08	0.11			
Step 2				.07*	.04*	.06*
Income	0.05	0.05	0.09			
Education	0.07	0.08	0.09			
Client Time 2 Expectations	1.32	0.57	.24*			
Step 3				.19***	.15***	.18***
Income	0.03	0.05	0.05			
Education	0.08	0.08	0.1			
Client Time 2 Expectations	1.36	0.54	0.24**			
Difference Between Therapist and Client Time 2 Expectations	0.68	0.19	.35***			

*** $p < .001$, ** $p < .01$, * $p < .05$

with client expectations following the third therapy session resulted in a significant increment in R^2 , thereby supporting the hypothesis of its predictive value. When the client expected more treatment sessions than the therapist, the client stayed in therapy longer.

Unilateral Decision Versus Mutual Agreement. A SLR was performed (see Table 22) to determine whether the difference score between therapist and client expectations for the number of therapy sessions could distinguish between dichotomous groups (unilateral decision versus mutual agreement). Education and income were entered as predictor variables on the first step, client expectations at Time 2 were entered on the second step, followed by the addition of the difference score on the last step.

Unlike in the previous analysis using client Time 1 expectations, in this analysis, using a smaller sample size due to missing data, there was good discrimination between groups on the basis of the demographic predictors alone, $\chi^2(2, 93) = 6.19, p < .05$. This finding will be discussed later. After addition of client expectations, however, $\chi^2(1, 93) = .28, ns$, showing no reliable improvement in the model. Further addition of the difference score resulted in no reliable improvement in the model $\chi^2(1, 93) = .04, ns$. A test of the model with the control variables and two predictors against a constant-only model was not statistically reliable, $\chi^2(4, 93) = 6.51, ns$, Nagelkerke $\Delta R^2 = .09$, indicating that the predictors did not reliably distinguish between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 68%, or moderate. Prediction success was low (24%) for unilateral decision makers and high (92%) for mutual agreement seekers.

According to the Wald criterion, the difference between therapist and client

Table 22

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Differences in Client Time 2 Expectations of Number of Therapy Sessions and Therapist Time 2 Expectations for Number of Therapy Sessions-Client Perspective (N=93)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					6.19*	
Income	0.16	0.09	1.17	2.91		
Education	0.25	0.13	1.28	3.26		
Model at Step 2					6.47	0.28
Income	0.16	0.09	1.17	3.04		
Education	0.24	0.14	1.27	3.04		
Client Time 2 Expectations	0.52	0.97	1.68	0.28		
Model at Step 3					6.51	0.04
Income	0.16	0.09	1.18	2.92		
Education	0.24	0.14	1.27	3.07		
Client Time 2 Expectations	0.51	0.97	1.67	0.28		
Difference Between Therapist Time 2 and Client Time 2 Expectations	0.07	0.34	1.07	0.04		

* $p < .05$

expectations did not reliably predicted premature termination (see Table 22). The hypothesis that the discrepancy in treatment duration expectations between client and therapist would be of predictive value for premature termination as defined by the nature of the termination decision-making process was, therefore, not supported when client expectations for the length of time of treatment, measured following the third therapy session, were used.

Hypothesis 6:

To demonstrate that a third variable moderates a relation, an interaction between the moderator variable and the predictor variable must be demonstrated (Baron & Kenny, 1986). This hypothesis predicted that after controlling for income and education, a client's relative level of self-determination (SD as measured by the Client Motivation for Change Scale (CMOTS) and stage of change (SOC as measured by the Stages of Change Scale (SCS)) prior to the beginning of therapy would each act as moderators of the relation between the predictor variables (client expectations for the number of therapy sessions (E), client perception of the working alliance (WA), and barriers to treatment participation from the client perspective (BTP)) and premature termination (as measured by total number of treatment sessions or the dichotomous operationalization of premature termination (unilateral decision versus mutual agreement)). As shown in Table 23, the magnitude of correlational values for the each of the predictor and moderator variables ranged from .01 and .48 (.01 and .55 for transformed variables). None of the variables correlated highly enough to suggest redundancy between measures.

To test the moderator hypotheses, HMR and SLR analyses were conducted using the two different operationalizations of premature termination. SLR analyses using both the

Table 23

Intercorrelations Between Variables Used to Test Moderator Hypotheses

	1	2	3	4	5	6	7	<u>M</u>	<u>SD</u>
1. Education		0.03	0.09	0.05	.07 (.05)	-.19 (-.21*)	-.12 (.10)	7.05	1.68
2. Income			0.04	-0.06	-.07 (-.07)	.06 (.06)	-.05 (-.04)	4.05	2.63
3. CMOTS				.31**	.01 (.05)	.19 (.21*)	-.13 (-.11)	76.71	29.08
4. SCS					-.02 (-.01)	.14 (.19)	.11 (.12)	26.87	18.26
5. Expc11						-.10 (-.05)	-.04 (-.10)	19.78 (1.16)	16.75 (.35)
6. WAI-C							-.55** (-.48**)	69.00 (3.70)	12.41 (1.52)
7. BTPS-C								56.11 (1.74)	12.78 (.09)

Note.

1. CMOTS = Client Motivation for Therapy Scale. SCS = Stages of Change Scale. Expc11 = Client Expectations for # of sessions at Time 1. WAI-C = Working Alliance Inventory-Client. BTPS-C = Barriers to Treatment Participation Scale-Client.

2. Variables based on raw data are presented throughout the Table, followed by comparable values for the transformed variables in parentheses.

** $p < .01$, * $p < .05$

client and therapist perceptions of the process of termination were conducted and showed similar results, therefore, only analyses using the client's perception of the process of termination are reported. In each analysis, education and income were entered as control variables on the first step, followed by the addition of either client expectations for number of therapy sessions, working alliance or barriers to treatment participation, all from the client's perspective. The client motivation for therapy score or client stage of change score was entered on the third step, followed by the interaction term of the predictor variable and the hypothesized moderator on the last step.

Results of the HMR and SLR analyses are reported in Tables 24 through 35. In five out of the six analyses, main effects were found and they are reported below. Significant interactions were found between client expectations and client motivation for therapy, as well as between working alliance and client stages of change, when premature termination was operationalized as a categorical measurement of termination.

Hypothesis 6a-c

Total Number of Treatment Sessions. These hypotheses predicted that client motivation would moderate the relationship between client expectations of therapy duration, barriers to treatment participation, working alliance, and the total number of therapy sessions attended. In analyses that used client expectations and working alliance, three multivariate outliers were identified and removed. Tables 24, 25, and 26 show the amount of variance in total number of therapy sessions accounted for by these predictor variables, motivation and the interaction between the hypothesized predictors and moderator. In each of these three analyses the predictor variables (expectations, barriers, and working alliance) significantly increased R^2

Table 24

Hierarchical Regression of Moderator Effect of Client Motivation for Therapy on Client Time 1 Expectations for Number of Therapy Sessions on Total Number of Therapy Sessions
(*N*=104)

Variable	<i>B</i>	<i>SE B</i>	β	<i>R</i> ²	Adj. <i>R</i> ²	ΔR^2
Step 1				0.01	0	
Income	0.03	0.06	0.06			
Education	0.07	0.09	0.08			
Step 2				.10**	.07**	.09**
Income	0.05	0.06	0.09			
Education	0.05	0.09	0.05			
Client Time 1 Expectations	1.39	0.44	.31**			
Step 3				0.11	0.08	0.01
Income	0.05	0.05	0.09			
Education	0.06	0.09	0.07			
Client Time 1 Expectations	1.35	0.44	0.29**			
CMOTS	-0.01	0.01	-0.1			
Step 4				0.12	0.08	0.01
Income	0.06	0.06	0.1			
Education	0.08	0.09	0.09			
Client Time 1 Expectations	2.75	1.5	0.6			
CMOTS	0.02	0.02	0.28			
Client Time 1 Expectations X CMOTS	-0.02	0.02	-0.48			

Note.

CMOTS=Client Motivation for Therapy Scale

** $p < .01$

Table 25

Hierarchical Regression of Moderator Effect of Client Motivation for Therapy on Barriers to Treatment Participation- Client's Perspective on Total Number of Therapy Sessions (N=107)

Variable	<i>B</i>	<i>SE B</i>	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0.01	
Income	0.03	0.06	0.05			
Education	0.07	0.09	0.08			
Step 2				.14***	.12***	.14***
Income	0.02	0.05	0.04			
Education	0.04	0.08	0.04			
BTPS-Client	-6.15	1.53	-.37***			
Step 3				0.17	0.14	0.03
Income	0.02	0.05	0.04			
Education	0.05	0.08	0.06			
BTPS-Client	-6.4	1.52	-0.39***			
CMOTS	-0.01	0.01	-0.17			
Step 4				0.17	0.13	0
Income	0.02	0.05	0.04			
Education	0.05	0.08	0.06			
BTPS-Client	-6.84	3.97	-0.41			
CMOTS	-0.02	0.09	-0.37			
BTPS-Client x CMOTS	0.01	0.05	0.2			

Note.

CMOTS = Client Motivation for Treatment Scale. BTPS-C = Barriers to Treatment Participation Scale-Client

*** $p < .001$

Table 26

Hierarchical Regression of Moderator Effect of Client Motivation for Therapy on Working Alliance from Client's Perspective on Total Number of Therapy Sessions (N=102)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.03	0.01	
Income	0.07	0.06	0.12			
Education	0.12	0.09	0.13			
Step 2				0.08*	0.05*	0.05*
Income	0.05	0.06	0.09			
Education	0.15	0.09	0.17			
WAI-Client	0.22	0.1	0.22*			
Step 3				0.1	0.06	0.02
Income	0.05	0.06	0.08			
Education	0.16	0.09	0.18			
WAI-Client	0.26	0.1	0.26			
CMOTS	-0.01	0.01	-0.14			
Step 4				0.1	0.05	0
Income	0.05	0.06	0.08			
Education	0.16	0.09	0.17			
WAI-Client	0.39	0.3	0.38			
CMOTS	-0.01	0.02	-0.25			
WAI-Client x CMOTS	0	0	-0.15			

Note.

CMOTS = Client Motivation for Therapy Scale. WAI-Client = Working Alliance Inventory-Client.

* $p < .05$

when entered on the second step of the regression equation once the variance from education and income demographic variables was removed. Client motivation did not significantly increase R^2 when entered on the third step of the regression equation. As previously indicated, the interaction between expectations, barriers or working alliance, and motivation did not contribute to explained variance, therefore, the client motivation moderator hypotheses were not supported. Nonetheless, there were main effects of expectations, barriers, and working alliance.

Unilateral Decision Versus Mutual Agreement. These hypotheses also predicted a moderating influence of client motivation on the relationship between expectations, barriers to treatment, and working alliance, and the client's type of termination decision. Tables 27, 28, and 29 show the amount of variance in type of termination decision accounted for by these predictor variables, motivation and the interaction between the hypothesized predictors and moderator. There was reliable improvement in each model following the addition of each of the predictor variables. There was further improvement in the model after client motivation was added to barriers and working alliance, suggesting that motivation and these other predictors each account for unique variance. As previously indicated, only the interaction between expectations and client motivation contributed to explained variance.

For the model which analysed the interaction between client expectations and client motivation, a test of the model with the control variables, the two predictors and the interaction term against a constant-only model was statistically reliable, $\chi^2(5, 107) = 15.76, p < .01$, Nagelkerke $\Delta R^2 = .19$, indicating that the addition of the moderator did help to distinguish between unilateral decision-makers and those who ended therapy by mutual

Table 27

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Client Motivation for Therapy of Client Expectations for Number of Therapy Sessions (N=107)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					3.56	
Income	0.1	0.1	1.09	1.2		
Education	0.18	0.12	1.2	2.22		
Model at Step 2					6.18	2.62
Income	0.1	0.1	1.1	1.46		
Education	0.18	0.12	1.19	2.04		
Client Time 1 Expectations	0.96	0.6	2.61	2.53		
Model at Step 3					10.56*	4.38*
Income	0.1	0.1	1.11	1.59		
Education	0.2	0.13	1.22	2.44		
Client Time 1 Expectations	1.04	0.62	2.82	2.78		
CMOTS	0	0	0.99	4.11*		
Model at Step 4					15.76**	5.21*
Income	0.1	0.1	1.1	1.49		
Education	0.28	0.13	1.32	4.32		
Client Time 1 Expectations	4.63	1.82	102.55	6.48**		
CMOTS	0	0	1.04	2.12		
Client Expectations x CMOTS	0	0	0.95	4.64*		

Note.

CMOTS=Client Motivation for Therapy Scale

** $p < .01$, * $p < .05$

Table 28

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Client Motivation for Therapy of Barriers to Treatment Participation from Client Perspective (N=107)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					3.56	
Income	0.09	0.1	1.09	1.2		
Education	0.18	0.12	1.2	2.22		
Model at Step 2					14.46**	10.90** *
Income	0.08	0.1	1.09	1.05		
Education	0.17	0.13	1.18	1.67		
BTPS-C	-7.78	2.52	0	9.53**		
Model at Step 3					20.62***	6.17**
Income	0.1	0.1	1.1	1.25		
Education	0.2	0.13	1.22	2.19		
BTPS-C	-8.72	2.61	0	11.21		
CMOTS	0	0	0.98	5.57*		
Model at Step 4					21.04***	0.42
Income	0.1	0.1	1.11	1.35		
Education	0.2	0.13	1.22	2.24		
BTPS-C	-4.68	6.73	0.01	0.48		
CMOTS	0.08	0.16	1.09	0.27		
BTPS-C x CMOTS	-0.1	0.1	0.94	0.41		

Note.

CMOTS = Client Motivation for Treatment Scale. BTPS-C = Barriers to Treatment Participation Scale-Client

*** $p < .001$, ** $p < .01$, * $p < .05$

Table 29

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Client Motivation for Therapy of Working Alliance from Client Perspective (N=105)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					3.38	
Income	0.09	0.08	1.1	1.27		
Education	0.17	0.12	1.18	1.88		
Model at Step 2					9.73*	6.36**
Income	0.08	0.08	1.09	0.97		
Education	0.25	0.13	1.28	3.58		
WAI-C	0.36	0.15	0.7	5.90**		
Model at Step 3					16.19**	6.45**
Income	0.08	0.09	1.09	0.96		
Education	0.31	0.14	1.37	5.00*		
WAI-C	0.46	0.16	0.63	8.51**		
CMOTS	-0.02	0.01	0.98	5.75*		
Model at Step 4					16.25**	0.06
Income	0.08	0.09	1.09	0.98		
Education	0.31	0.14	1.37	5.07*		
WAI-C	0.37	0.41	0.69	0.85		
CMOTS	-0.02	0.02	0.98	0.58		
WAI-C x CMOTS	0	0	1	0.06		

Note.

CMOTS = Client Motivation for Treatment Scale. WAI-C = Working Alliance Inventory-Client

* $p < .05$

agreement with their therapist. Overall prediction success was 64%, or moderate. Prediction success was lower than chance (38%) for unilateral decision makers and moderate (82%) for mutual agreement seekers.

According to the Wald criterion, the interaction between client expectations and client motivation reliably predicted premature termination (see Table 27). The hypothesis that client motivation moderates the relationship between client expectations and the type of termination was, therefore, supported. There was no significant interaction between barriers or working alliance, and motivation, however. The client motivation moderator hypotheses, therefore, were only partly supported. Nonetheless, there were main effects of expectations, barriers, working alliance, and client motivation.

Hypothesis 6d-f

Total Number of Treatment Sessions. These hypotheses predicted that client stage of change would moderate the relationship between client expectations of therapy duration, barriers to treatment participation, working alliance, and the total number of therapy sessions attended. In analyses that used client expectations and barriers, two multivariate outliers were identified and removed. Tables 30, 31, and 32 show the amount of variance in total number of therapy sessions accounted for by these predictor variables, motivation and the interaction between the hypothesized predictors and moderator. In each of these three analyses the predictor variables (expectations, barriers and working alliance significantly increased R^2 when entered on the second step of the regression equation once the variance from education and income demographic variables was removed. Client stage of change did not significantly increase R^2 when entered on the third step of the regression equation. As

Table 30

Hierarchical Regression of Moderator Effect of Stages of Change on Client Expectations of Number of Therapy Sessions at Time 1 on Total Number of Therapy Sessions (N=105)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0	
Income	0.02	0.06	0.04			
Education	0.08	0.09	0.09			
Step 2				.08**	.05**	.07**
Income	0.04	0.06	0.07			
Education	0.06	0.09	0.06			
Client Expectations Time 1	1.24	0.45	0.27**			
Step 3				0.09	0.05	0.01
Income	0.04	0.06	0.07			
Education	0.06	0.09	0.07			
Client Expectations Time 1	1.24	0.45	0.27**			
SCS	-0.01	0.01	-0.08			
Step 4				0.09	0.04	0
Income	0.04	0.06	0.07			
Education	0.06	0.09	0.07			
Client Expectations Time 1	1.26	0.97	0.27			
SCS	-0.01	0.04	-0.07			
Client T1 Expectations x SCS	0	0.03	-0.01			

Note.

SCS = Stages of Change Scale

** $p < .01$

Table 31

Hierarchical Regression of Moderator Effect of Stages of Change on Barriers to Treatment Participation- Client's Perspective on Total Number of Therapy Sessions (N=105)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0	
Income	0.02	0.06	0.03			
Education	0.04	0.09	0.05			
Step 2				0.12***	0.09***	0.12***
Income	0.02	0.05	0.03			
Education	0.03	0.09	0.04			
BTPS-Client	-5.9	1.62	-0.34***			
Step 3				0.12	0.09	0
Income	0.02	0.06	0.03			
Education	0.03	0.09	0.04			
BTPS-Client	-5.8	1.66	-0.33***			
SCS	0	0.01	-0.05			
Step 4				0.14	0.1	0.02
Income	0.03	0.06	0.01			
Education	0.02	0.09	0.02			
BTPS-Client	-0.68	3.62	-0.04			
SCS	0.29	0.19	3.5			
BTPS-Client x SCS	-0.17	0.11	-3.62			

Note.

SCS = Stages of Change Scale. BTPS-Client = Barriers to Treatment Participation Scale-Client.

*** $p < .001$

Table 32

Hierarchical Regression of Moderator Effect of Stages of Change on Working Alliance - Client's Perspective on Total Number of Therapy Sessions (N=105)

Variable	B	SE B	β	R^2	Adj. R^2	ΔR^2
Step 1				0.01	0	
Income	0.03	0.06	0.06			
Education	0.06	0.09	0.06			
Step 2				0.08**	0.05**	0.07**
Income	0.02	0.06	0.04			
Education	0.11	0.09	0.12			
WAI-Client	0.27	0.1	.28**			
Step 3				0.09	0.06	0.01
Income	0.02	0.06	0.03			
Education	0.12	0.09	0.14			
WAI-Client	0.3	0.1	0.30**			
SCS	-0.01	0.01	-0.11			
Step 4				0.09	0.05	0
Income	0.02	0.06	0.03			
Education	0.12	0.09	0.14			
WAI-Client	0.25	0.2	0.25			
SCS	0	0.02	-0.04			
WAI-Client x SCS	0	0.01	0.08			

Note.

SCS = Stages of Change Scale. WAI-Client = Working Alliance Inventory-Client.

** $p < .01$

previously indicated, the interaction between expectations, barriers or working alliance, and stage of change did not contribute to explained variance, therefore, the client stage of change moderator hypotheses were not supported. Nonetheless, the main effects of barriers, expectations, and working alliance were significant.

Unilateral Decision Versus Mutual Agreement. These hypotheses also predicted a moderating influence of client stage of change on the relationship between expectations, barriers to treatment, and working alliance, and the client's type of termination decision. Tables 33, 34, and 35 show the amount of variance in type of termination decision accounted for by these predictor variables, stage of change and the interaction between the hypothesized predictors and moderator. There was reliable improvement in each model following the addition of barriers and working alliance, but not expectations. There was no improvement in the model after stage of change was added to barriers and working alliance. As previously indicated, the interaction between working alliance and stage of change was significant. For the model which analysed the interaction between working alliance and stage of change, a test of the model with the control variables, the two predictors and the interaction term against a constant-only model was statistically reliable, $\chi^2(5, 105) = 14.48, p < .01$, Nagelkerke $\Delta R^2 = .18$, indicating that the addition of the moderator helped to distinguish between unilateral decision-makers and those who ended therapy by mutual agreement with their therapist. Overall prediction success was 64%, or moderate. Prediction success was lower than chance (32%) for unilateral decision makers and moderate (84%) for mutual agreement seekers. According to the Wald criterion, the interaction between working alliance and stage of change reliably predicted premature termination (see Table 35). The

Table 33

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Stages of Change of Client Expectations for Number of Therapy Sessions (N=107)

Variable	B	SE	Odds ratio	Wald statistic	X ²	ΔX ²
Model at Step 1					3.56	
Income	0.09	0.08	1.09	1.2		
Education	0.18	0.12	1.2	2.22		
Model at Step 2					6.18	2.62
Income	0.1	0.08	1.1	1.46		
Education	0.18	0.12	1.19	2.04		
Client Time 1 Expectations	0.96	0.6	2.61	2.54		
Model at Step 3					6.26	0.08
Income	0.1	0.08	1.1	1.44		
Education	0.18	0.12	1.19	2.08		
Client Time 1 Expectations	0.96	0.6	2.61	2.54		
SCS	0	0.01	1	0.08		
Model at Step 4					6.66	0.4
Income	0.09	0.08	1.09	1.09		
Education	0.18	0.12	1.2	2.2		
Client Time 1 Expectations	1.58	1.18	4.84	1.8		
SCS	0.03	0.05	1.03	0.29		
Client Expectations x SCS	-0.02	0.04	0.98	0.39		

Note.

SCS = Stages of Change Scale

Table 34

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Stages of Change of Barriers to Treatment Participation from Client Perspective (N=107)

Variable	B	SE	Odds ratio	Wald statistic	X^2	ΔX^2
Model at Step 1					3.56	
Income	0.09	0.08	1.09	1.2		
Education	0.18	0.12	1.2	2.22		
Model at Step 2					14.46**	10.90***
Income	0.08	0.08	1.09	1.05		
Education	0.17	0.13	1.18	1.67		
BTPS-C	-7.78	2.52	0	9.53**		
Model at Step 3					14.48**	0.02
Income	0.09	0.08	1.09	1.06		
Education	0.17	0.13	1.18	1.65		
BTPS-C	-7.83	2.55	0	9.46**		
SCS	0	0.01	1	0.02		
Model at Step 4					14.58**	0.1
Income	0.08	0.08	1.09	0.99		
Education	0.17	0.13	1.18	1.63		
BTPS-C	-6.52	4.81	0	1.83		
SCS	0.09	0.27	1.09	0.11		
BTPS-C x SCS	-0.1	0.15	0.95	0.1		

Note.

SCS-Stages of Change Scale. BTPS-C=Barriers to Treatment Participation-Client

*** $p < .01$, ** $p < .01$

Table 35

Summary of Logistic Regression Analysis Predicting Type of Therapy Termination from Moderator Stages of Change of Working Alliance from Client Perspective (N=105)

Variable	B	SE	Odds ratio	Wald statistic	χ^2	$\Delta\chi^2$
Model at Step 1					3.38	
Income	0.09	0.08	1.1	1.27		
Education	0.17	0.12	1.18	1.88		
Model at Step 2					9.74*	6.36**
Income	0.08	0.08	1.09	0.97		
Education	0.25	0.13	1.28	3.58		
WAI-C	0.36	0.15	0.7	5.90**		
Model at Step 3					10.04*	0.3
Income	0.08	0.08	1.08	0.87		
Education	0.26	0.13	1.3	3.78*		
WAI-C	0.38	0.16	0.69	6.18**		
SCS	0	0.01	0.99	0.3		
Model at Step 4					14.48**	4.44*
Income	0.07	0.08	1.08	0.76		
Education	0.28	0.14	1.33	4.30*		
WAI-C	-0.16	0.29	0.85	0.29		
SCS	0.06	0.04	1.02	2.94		
WAI-C x SCS	0.02	0.01	0.99	4.10*		

Note.

SCS=Stages of Change Scale. WAI-C=Working Alliance Inventory-Client

** $p < .01$, * $p < .05$

hypothesis that client stage of change moderates the relationship between working alliance and the type of termination was, therefore, supported. In contrast, however, expectations or barriers, and stage of change did not contribute to explained variance. The client stage of change moderator hypotheses, therefore, were only partly supported. Nonetheless, there were main effects of barriers and working alliance.

Summary of Results

Table 36 reports a summary of the results of the analyses of all hypotheses using the two operationalizations of premature termination. This summary describes the results for these two operationalizations separately. Any significant relations among the variables to be discussed were found once variance due to client level of education and income was partialled out.

Premature Termination as Defined by Total Duration of Therapy. Overall, client and therapist expectations for therapy and barriers to treatment participation contributed to the prediction of the total number of therapy sessions attended. The therapist's perception of barriers to treatment added incremental predictive value to that of the client's but not vice versa. The discrepancy between client and therapist expectations for therapy duration also predicted the length of therapy. Neither the client's stage of change nor the client's motivation for therapy prior to treatment had any moderating effects on the relationship between other predictor variables and attendance in therapy, however there were main effects of the other predictor variables.

Premature Termination as Defined by Unilateral Termination versus Mutual Agreement with the Therapist. Overall, barriers to treatment participation and working

Table 36
Summary of Results of All Analyses

Hypothesis	DV-Total Number of Sessions	DV-Unilateral versus Mutual Agreement Termination
Hypothesis 1 - Client Perspective-Time 1	Client Time 1 Expectations Barriers-Client	Barriers-Client Alliance-Client
Hypothesis 1 - Client Perspective-Time 2	Client Time 2 Expectations	NS
Hypothesis 2 - Therapist Perspective	Therapist Expectations (# of sessions); Barriers-Therapist	Barriers-Therapist
Hypothesis 3 - Client Expectations Time 1 - Therapist Added Predictive Value to Client	Yes - Therapist Expectations (# of sessions); Barriers-Therapist	Yes - Barriers - Therapist
Hypothesis 3 - Client Expectations Time 2 - Therapist Added Predictive Value to Client	Yes- Therapist Expectations (# of sessions)	Not run because Hyp 1 NS for Client Perspective-Time 2
Hypothesis 4 - Client Added Predictive Value to Therapist?	No - NS	Yes - Barriers -Client
Hypothesis 5 - Discrepancy between Therapist Time 2 and Client Time 1 Expectations	Client T1 Expectations (# sessions); Discrepancy between Client and Therapist	NS
Hypothesis 5b- Discrepancy between Therapist Time 2 and Client Time 2 Expectations	Discrepancy between Client and Therapist; Client T2 Expectations (# sessions)	NS
Hypothesis 6a - Client Expectations x Motivation	Interaction NS Main Effect (Expectations)	Interaction, Main Effects (Expectations, Motivation)
Hypothesis 6b - Barriers-Client x Motivation	Main Effect (Barriers-Client)	Main Effects (Barriers-Client, Motivation)
Hypothesis 6c - Alliance-Client x Motivation	Main Effect (Alliance-Client)	Main Effect (Alliance-Client, Motivation)
Hypothesis 6d - Client Expectations x Stages of Change	Main Effect (Expectations)	NS
Hypothesis 6e - Barriers-Client x Stages of Change	Main Effect (Barriers-Client)	Main Effect (Barriers-Client)
Hypothesis 6f - Alliance-Client x Stages of Change	Main Effect (Alliance-Client)	Interaction, Main Effect (Alliance-Client)

alliance predicted type of termination from the client perspective, and barriers predicted type of termination from the therapist's perspective. The therapist's perception of barriers to treatment added incremental predictive value to that of the client's. The client's perspective also enhanced the predictive value of the therapist's perception of barriers. The discrepancy between client and therapist expectations for therapy duration did not predict the nature of the termination decision. There was an interaction between client motivation and client expectations for therapy duration in predicting type of termination, and main effects of motivation and the other predictor variables. There was also an interaction between client stage of change and working alliance, and type of termination, and main effects of working alliance and barriers to treatment participation.

Discussion

This study was designed to identify predictors of premature termination from treatment by adults engaged in psychotherapy. The first aim was to determine whether therapy-specific and contextual factors could help predict premature termination from therapy. Of interest was whether psychological variables related to therapy, such as client expectations and the working alliance, and contextual factors, such as perceived barriers to treatment, from either or both client and therapist perspectives, could predict early termination from therapy. The second aim was to determine whether discrepancies between client and therapist expectations for the length of therapy could predict premature termination. The third aim was to determine whether client motivation and the client's stage of change prior to therapy moderated the relationship between other predictors (expectations, working alliance or barriers to treatment participation) and premature termination.

The substantive findings of the study will be presented and discussed, followed by an examination of the features of the design that may affect the interpretations and generalizations that can be made. The final section will include a discussion of the implications of this research for future research and for clinical practice.

In order to be able to compare the results of this study to previous findings in the literature, two different operationalizations of premature termination, treatment duration and type of termination decision, were used to test these hypotheses. As described in the introductory section, the latter definition, which took into account clients' and therapists' perspectives on the type of termination decision, was considered to be a more accurate and useful operationalization of premature termination and is most commonly used in recent

research. The results using termination type, therefore, are considered more valuable for the discussion on the predictive value of the variables that were studied, hence, more attention will be given to these findings. Because the results of the analyses for the two dependent variables were overlapping, but different, for each hypothesis, they will be discussed separately first.

Summary of Findings

Hypothesis 1: Client's Perspective and Premature Termination. It was hypothesized that a poor therapeutic alliance, expectations of shorter treatment length, and numerous barriers to treatment participation (treatment relevance, stressors, therapeutic relationship, and treatment demands) would predict premature termination.

Total Number of Treatment Sessions. Overall, when termination was measured by treatment duration, this hypothesis was supported. Client expectations for therapy duration and barriers to treatment participation contributed to the prediction of the total number of therapy sessions attended. The more sessions that a client expected to attend, whether these expectations were measured before treatment began or after three sessions, the more sessions they actually attended. In addition, clients who experienced more barriers to participating in treatment stayed in therapy for a shorter period of time. Only working alliance failed to predict treatment duration.

Unilateral Termination versus Mutual Agreement with the Therapist. Barriers to treatment participation and working alliance significantly differentiated clients based on their manner of terminating. Clients who experienced more barriers to treatment were more likely to make a unilateral decision to end therapy, as were clients who reported a poorer working

alliance. Therefore, the hypothesis was supported by the data. Client expectations for treatment duration were not predictive of the manner in which the client ended therapy.

Hypothesis 2: Therapist's Perspective and Premature Termination. It was hypothesized that a poor therapeutic alliance, expectations for a longer treatment length, and numerous barriers to treatment participation (treatment relevance, stressors, therapeutic relationship, and treatment demands) from the therapist's perspective would contribute to the prediction of premature termination.

Total Number of Treatment Sessions. The hypothesis that factors from the therapist's perspective would relate to treatment duration was partially supported. The more sessions the therapist expected the client to attend, the longer the client stayed in therapy. The fewer barriers to treatment that the therapist perceived the client to be experiencing, the more sessions the client attended. Working alliance was not predictive of treatment duration.

Unilateral Termination versus Mutual Agreement with the Therapist. This hypothesis was partly supported because, from the therapist's perspective, barriers to treatment participation significantly differentiated clients based on their manner of terminating. Clients who experienced more barriers to treatment were more likely to make a unilateral decision to end therapy, from their therapist's point of view. Therapist expectations for treatment duration and therapist perceptions of the working alliance were not predictive of the manner in which the client ended therapy.

Hypothesis 3: The therapist's perspective will add to that of the client to predict premature termination. It was hypothesized that the therapist's perspective would add predictive value for premature termination over and above the client's perspective, when predictors from the

client's perspective that were significant in the previous analyses were entered before the same predictors from the therapist's perspective.

Total Number of Treatment Sessions. Therapists' expectations for treatment duration and their perception of client barriers to treatment contributed predictive value to treatment duration, over and above that of the client, therefore, the hypothesis was supported.

Unilateral Termination versus Mutual Agreement with the Therapist. The therapist's perspective augmented the client's perspective of client barriers to treatment participation to predict the termination decision, therefore, this hypothesis was supported.

Hypothesis 4: The client's perspective will add to that of the therapist to predict premature termination. It was hypothesized that the client's perspective would add predictive value for premature termination over and above the therapist's perspective, when predictors from the therapist's perspective that were significant in the previous analyses were entered before the same predictors from the client's perspective.

Total Number of Treatment Sessions. The hypothesis that the client's expectations of treatment duration or barriers to treatment would provide incremental predictive value for the length of therapy over that of the therapist was not supported by the data.

Unilateral Termination versus Mutual Agreement with the Therapist. The client's perspective on barriers to treatment participation augmented the therapist's perspective to predict the termination decision, therefore, the hypothesis was supported. In contrast, the therapist's perspective on the quality of the working alliance did not provide incremental predictive value.

Hypothesis 5: Discrepancy between client and therapist expectations for total number of

treatment sessions, and premature termination. It was hypothesized that the greater the discrepancy between clients' and therapists' expectations for the number of therapy sessions, the more likely a client would terminate therapy prematurely.

Total Number of Treatment Sessions. Once client expectations were taken into account, the discrepancy between therapist and client expectations played a significant role in predicting treatment length, thereby supporting the hypothesis. When the therapist expected more sessions than the client, it was predictive of longer therapy duration and when the therapist expected fewer sessions than the client, it was predictive of fewer total sessions.

Unilateral Termination versus Mutual Agreement with the Therapist. The discrepancy between client and therapist expectations for the number of sessions of therapy did not predict the treatment termination decision, therefore, the hypothesis was not supported.

Hypothesis 6: Client motivation and client stage of change will moderate relationship between client predictors and premature termination. It was hypothesized that client motivation for therapy and readiness for change would moderate the relationship between client expectations, working alliance and barriers to treatment participation, and premature termination.

Total Number of Treatment Sessions. The hypotheses that client motivation and readiness for change would play a moderating role, and thereby improve prediction of treatment duration by other predictor variables, were not supported. Furthermore, there were no significant direct relationships between client motivation and readiness for change prior to therapy and how long a client stayed in therapy. Only expectations of shorter treatment duration, more barriers and poorer working alliance alone reliably predicted shorter treatment

length.

Unilateral Termination versus Mutual Agreement with the Therapist. The hypotheses that client motivation and/or readiness for change would improve prediction of the termination decision by other predictor variables were partially supported. In order to predict type of termination decision using client expectations for length of therapy, client motivation must be taken into account. When a client's motivation was non self-determined, client expectations of longer therapy were more likely to lead to premature termination. Furthermore, the client's stage of change strengthens the predictive value of working alliance on the type of termination decision. When a client was less further along in the stages of change and had a poor working alliance he or she was more likely to end therapy prematurely. In addition, on its own, client non self-determination predicted a client's unilateral termination decision, as did more barriers to treatment and a poorer working alliance.

Discussion of Findings

Education and Income

It is interesting to note that when the sample size was reduced by 13 participants due to missing Time 2 data in the analyses to test predictors from the client's perspective and discrepancies between client and therapist expectations using client Time 2 expectations, education and income together differentiated clients according to the type of termination, whereas with the full sample using client Time 1 expectations they did not. Most of the participants who did not report Time 2 expectations terminated therapy before the fourth therapy session. This finding reflects previous research which has found that education and

income are sometimes predictive of premature termination, however, the effects are not large and may be sensitive to sampling factors. It appears that small variations in sample size can easily eliminate the effects of these demographic variables, confirming the fact that they are not robust predictors of premature termination. This finding, however, may also suggest that these demographic factors may be less involved in predicting clients who terminate prematurely very early in the therapeutic process (less than 4 sessions) compared to clients who leave prematurely, but later in the therapeutic process. Other researchers have suggested that premature terminators may not be a homogeneous population (Garfield, 1994). In fact, clients who leave therapy before the third therapy session might be conceptualized as having failed to engage in therapy, rather than having terminated prematurely. Research that is currently being conducted to explore engagement in therapy may help to clarify these processes (Rumstein-McKean, 1999).

Expectations of Treatment Duration

Client expectations of treatment duration predicted the total number of treatment sessions. These findings suggest that even before attending an initial interview and meeting the therapist, clients have an idea of how long they will stay in therapy. One might speculate that these notions may be based on media information, word of mouth from friends, colleagues or other health care professionals, or past experience of therapy. After three meetings with the therapist, client expectations of treatment duration continued to predict treatment length. One would assume that expectations at this point in the treatment process would also be influenced by the therapeutic experience and additional information from the therapist.

Typically, the initial therapy sessions involve an assessment of the client's problem and the collaborative development of a treatment plan, including a provisional time frame. It is not surprising then, that a client's expectations for how long therapy will last would be strongly associated with how many sessions s/he attended. It appears, therefore, that clients have expectations about how long treatment will last that are shaped by ideas that they bring into therapy and that remain following their initial experience of therapy. These expectations strongly influence their therapy attendance behaviour.

This finding is consistent with previous research that found the majority of clients stayed in therapy exactly the length of time they expected, regardless of prognosis or satisfaction with treatment (Pekarick & Wierzbicki, 1986). It also replicates Mueller and Pekarik's (2000) research conducted in private practice settings where client expectations were found to be significantly related to treatment duration, and were better predictors than 31 other client and therapist variables examined (eg. diagnosis, symptom severity, demographics, therapist characteristics). Furthermore, the finding is also consistent with earlier research by Pekarik and colleagues (Pekarik, 1991; Pekarik & Stephenson, 1988; Wierzbicki & Pekarik, 1993).

Therapist expectations of treatment duration were also predictive of the total number of treatment sessions. These findings are both similar to and different from Mueller and Pekarik's (2000) study. These authors found a significant relationship between therapist expectations and treatment duration when univariate tests were applied to all predictor variables, however, when therapist expectations were analysed with client expectations and other variables in a multiple regression, they did not predict treatment duration. In their

study, only client expectations of number of sessions, history of an eating disorder, therapist's degree, and client education combined to explain 42% of variance. Mueller and Pekarik's results are not consistent with those of the current study which found that when analysed together, therapist expectations added incremental predictive value to those of the client. The discrepancy between the findings of the current study and that of Mueller and Pekarik might be explained by the different participant samples used. Mueller and Pekarik sampled 230 clients from 10 different private practice settings. Overall, private practice therapists in their study expected considerably longer treatment than actually occurred, and significantly longer treatment duration than did their clients.

Unlike previous research, however, the current study did not find major differences between the number of sessions expected by clients and the number expected by their therapists. On average, prior to therapy, clients expected 20 sessions, and after the third treatment session, both clients and therapists expected 19 sessions. This finding may have been influenced by a treatment guideline at the Centre for Psychological Services that limits treatment length to 20 sessions. This possibility will be further discussed when limitations of the study are addressed. Notwithstanding this potential influence, these findings may also reflect a growing tendency towards briefer psychological interventions, influenced by both empirically supported treatment protocols and restrictions in insurance coverage for psychological services. Given these changes, a newer generation of therapists may be trained to anticipate and deliver shorter treatment interventions than their more seasoned counterparts in private practice who have been the source of previous research findings (Pekarik, 1983a).

The findings regarding the relationship between client expectations of therapy duration

and type of termination decision were equivocal. When expectations were examined with working alliance and barriers, they did not contribute predictive value. If clients have preconceived expectations or expectations that are formed early in therapy that influence how long they stay in therapy, and if, as Pekarik and Wierzbicki (1986) noted, they leave therapy when their "time is up" regardless of their progress in treatment, then it is not surprising that a measure of expected number of sessions would not predict the type of termination. It would be only a chance occurrence that the client's early expectations of treatment length correlated with the accomplishment of treatment goals. In contrast, when analysing for moderator effects, client expectations of shorter treatment duration, when examined alone, did predict unilateral termination. If clients anticipate that therapy will take longer, they will be more likely to remain engaged until their treatment objectives have been met. Because the results of this study regarding client expectations of treatment length and premature termination are contradictory, no conclusion can be reached. The only research to date that has reported on the relationship between expected treatment duration and termination decision (Mueller & Pekarik, 2000) was unclear about how dropping out of therapy was defined. It is, therefore, difficult to compare the results of this study with their findings.

It is interesting to note that discrepancies between therapist and client expectations for treatment length did predict the actual length of treatment. Although previous research has concluded that it is client expectations that determine how long a client stays in treatment (Pekarick & Wierzibicki, 1986), the findings of this study suggest that when therapists expect the client to stay longer, they do, and when the therapists expect clients to stay for fewer sessions, they do also. Although the range of discrepancy in the dyads was large, from the

therapist expecting 62 fewer sessions than their client to the therapist expecting 27 more sessions (when client expectations were measured pre-therapy), and from the therapist expecting 44 fewer sessions than their client to the therapist expecting 25 more sessions (when client expectations were measured after session 3), the discrepancy within each dyad was typically only plus or minus 10 sessions. It is perhaps not surprising that therapist expectations appear to exert an influence on the number of sessions as therapists are responsible for trying to wrap up therapy when goals have been reached, sometimes offering fewer sessions than the client might have wanted. Similarly, therapists sometimes encourage clients to deal more fully with their personal difficulties by keeping the client in therapy a little longer to ensure adequate internalization and/or generalization of changes.

Despite the influence of discrepant expectations on treatment duration, discrepancies between therapist and client expectations did not distinguish unilateral terminators from those who completed treatment. This is perhaps not surprising given that neither client nor therapist expectations alone provided any predictive value in this regard. The findings of this study, therefore, suggest that expectations of treatment duration from either the client or therapist perspective do not hold much promise as predictors of the client's termination decision. Although expectations predict treatment duration, they do not predict unilateral (i.e., premature) termination.

Working Alliance

Contrary to what was hypothesized, neither the client's perception nor the therapist's perception of the quality of their relationship after the third treatment session predicted how long the client stayed in treatment. Previous research has not examined the relationship

between treatment duration and working alliance, therefore, comparisons cannot be made.

The data did, however, support the hypothesis that clients' perception of their relationship with their therapist influences the manner in which they end therapy. Clients who reported poorer working alliances tended to make unilateral decisions to terminate treatment.

Previous studies have also found that those who leave therapy early describe the therapeutic relationship as poor (Piper, 1999; Samstag et al., 1998). The results of this study support Bordin's (1974) suggestion that one effect of a poor working alliance is client unilateral termination. The finding in this study replicates Tryon and Kane's (1990) research in which an association was found between client-rated working alliance, but not therapist-rated working alliance, and termination. In contrast, the results of the current study contradict the findings of the same authors' later (1993) study in which an association was found between therapist-rated alliance, but not client-rated alliance. In the earlier study, whose results concur with those of the current study, Tryon and Kane (1990) used the Penn Helping Alliance Questionnaire, whereas the short form of the Working Alliance Inventory was used in their later (1993) study. Also, in the earlier (1990) study, assessment of the alliance was conducted at one overall point in time, which meant that clients reported on the alliance after a differing number of sessions of treatment (average 8 sessions). In their later study, Tryon and Kane (1993), the authors measured the alliance consistently after the third treatment session. The results of the current study using the same measure and administered at the same time as Tryon and Kane (1993) do not replicate their findings.

Similarly, the results of this study are also consistent with Tryon and Kane's (1990) research in which no relationship was found between therapist-rating working alliance and

the way therapy ended, however, my results did not replicate the results of their later study (Tyron & Kane, 1993), which found that therapist's perception of the working alliance after session 3 did predict the type of client termination. It is, therefore, interesting to note that Tyron and Kane's study that most closely resembles the current study in terms of assessment measure used and timing of administration of the measure found diametrically opposed results. The primary differences between the current study and that of Tyron and Kane (1993) were the psychological service setting and the treatment approaches used. Tryon and Kane's study took place at a university counselling centre compared to the community mental health clinic in the current study. In addition, the predominant treatment approach in Tryon and Kane's study was psychodynamic, in contrast to the diverse approaches used in the current study (e.g., cognitive-behavioural, experiential, interpersonal). Discrepancies might, therefore, be accounted for by different sample characteristics and treatment philosophies that limit the generalizability of the findings. Nonetheless, previous research that has related the working alliance to outcome more strongly supports the findings of the current study. For example, Horvath and Symonds (1991) found that client working alliance ratings were more highly correlated with outcome measures than therapist ratings of the alliance, giving more weight to the client's point of view. Furthermore, it makes more logical sense that the client, who makes the ultimate decision about when to leave therapy, would be more sensitive to the quality of the working alliance than the therapist, and use that information to decide on whether to end treatment unilaterally (Tryon & Kane, 1990). Further research using a community sample and diverse treatment approaches is needed to see if the findings of the current study can be replicated.

It is interesting to note, however, that in the current study when therapist perceived barriers to treatment participation were examined more closely by looking at the subscales of the barriers measure, the therapeutic relationship was found to distinguish clients who left early versus those who completed treatment. This finding suggests that although the therapist's perspective of the working alliance measured early in therapy does not predict termination status, the quality of the alliance at the end of therapy can help explain the termination decision. This retrospective measurement may have been contaminated by the therapist's knowledge of the client's behaviour at the end of therapy, nonetheless, it acknowledges the fluid nature of the interpersonal therapeutic interaction and suggests that shifts and changes in the working alliance over the course of therapy may influence client termination decisions. Because so many factors come into play in the process of therapy, it may be impossible to isolate a single, reliable point of measurement of the alliance from the therapist's perspective to predict premature termination. Rather, on-going assessment of the working alliance may help keep therapy on track and minimize the likelihood of premature termination.

Treatment relevance was also a significant factor in explaining the client's termination decision, from the therapist's perspective. This raises some interesting questions regarding the relationship between client progress and the working alliance. Although in the psychotherapy literature it is commonly recognized that a strong working alliance is a prerequisite for client engagement and continuance in treatment, some researchers have argued that it is treatment relevance and client change that actual forges the alliance, and not the contrary (Feeley, DeRubeis, & Gelf, 1999). If this were true, it would not be surprising

that a client's report of a poor therapeutic alliance at the end of therapy would be consistent with a decision to terminate therapy unilaterally. Future research into the relationship between these factors merits consideration.

Barriers to Treatment Participation

Barriers to treatment participation was the only significant variable that was associated with treatment duration and was also significantly related to the client's termination decision. These findings were consistent from both client and therapist perspectives. Clients who reported fewer barriers to treatment stayed longer in therapy. Personal stressors, treatment demands, perception of treatment relevance, and perception of the therapeutic relationship combined to influence clients' therapy attendance behaviour. These results for a sample of adults in psychotherapy are consistent with findings in the child and family literature (Kazdin et al., 1997b; Kazdin & Wassell, 1998) suggesting that despite differences between these populations in other areas, when it comes to factors that influence treatment attendance, these two groups are similar.

Furthermore, client barriers to treatment participation also distinguished between unilateral and mutual agreement termination decisions. Personal stressors, treatment demands, perception of treatment relevance, and perception of the therapeutic relationship combined to influence clients' termination decisions. From the client's perspective, stressors experienced over the course of treatment (e.g., being sick on the day of an appointment, transportation or parking difficulties, appointment scheduling problems, crises at home, being too tired after work, experiencing treatment as an additional stressor) and treatment relevance (e.g., lost in interest in coming to sessions, treatment did not meet expectations, treatment

was not working) were the barriers that had the most significant impact on his or her decision to leave therapy unilaterally. From the therapist's perspective, treatment relevance (e.g., client lost interest in coming to sessions, treatment no longer seemed necessary, treatment did not fit with client's expectations, treatment did not seem as important as sessions continued, treatment did not focus on client's life and problems), the therapeutic relationship, and client stressors (e.g., difficulties scheduling appointments, sessions in conflict with another of the client's activities, other life stressors interfered with treatment, treatment added another stressor to client's life) were the barriers that influenced a client's decision to terminate prematurely.

Assessing for barriers to treatment participation brought the focus of the investigation of factors contributing to premature termination even closer to the therapeutic process. Stressors were identified by both clients and therapists as significant obstacles to participating in treatment. This highlights the importance of how contextual factors impact on therapy. Therapy is only one part of a client's life and there is an interaction between what goes on in the therapy session and the rest of the client's life, and vice versa. Although systemic therapeutic approaches attend to this reality, clinicians who use more individually-oriented treatment approaches might benefit from keeping this in mind. It is not surprising that lack of treatment relevance, identified by both clients and therapists, also proved to be a significant factor associated with early termination of therapy. If treatment does not seem to be addressing the issues that motivated the client to engage in treatment in the first place, the client is not likely to continue investing time, energy and financial resources in the process.

However, because barriers to treatment participation were assessed at the end of

treatment, they cannot legitimately be considered true predictors of premature termination. Rather, they are factors associated with how the client terminates therapy. To assess the predictive value of the barriers to treatment participation model, assessment would have to take place earlier in treatment. A.E. Kazdin (personal communication, April 2, 2003) indicated that data are currently being collected to determine whether treatment barriers, measured earlier in child and family therapy, can predict which clients will leave therapy prematurely, however, no results have been compiled to date. Although when Beckam (1992) examined anticipated practical problems, such as transportation, that might interfere with adults' treatment attendance, he did not find practical issues to be predictive of premature termination, the results of the current study suggest that studying a broader range of barriers to treatment prospectively might help identify clients at risk of premature termination from adult psychotherapy. Furthermore, because barriers to treatment may change over the course of therapy, future researchers might consider examining the impact of potential barriers using ongoing assessment throughout the treatment process.

Theory of Self-Determination

The specific hypotheses based on the Theory of Self-Determination were partially supported. Although client motivation did not improve the ability of expectations for treatment duration, working alliance or barriers to treatment participation to predict treatment duration, client motivation did improve the ability of client expectations of therapy duration to predict type of termination decision. In order to more accurately predict the client's type of termination decision using expectations of treatment duration, the client's motivation should be taken into account. The relationship between these two variables was inverse: when a

client had a lower self-determination index score, or was non self-determined, but had expectations of longer therapy, he or she tended to leave therapy prematurely. Less self-determination suggests that the client was not engaged in therapy for the satisfaction of personal change, but rather for some external purpose. If the intrinsic value placed on therapy was minimal, the expectation of longer treatment duration may have led the client to feel like therapy would take too long and he or she may have been inclined to give up. This notion is consistent with Pelletier's (2002) research on pro-environmental behaviours where individuals who were non self-determined were less likely to persevere when the activity became more difficult. Similarly, other research has found that more self-determination can predict persistence in competitive sports (Pelletier, Fortier, Vallerand, & Brière, 2001).

When a client was more self-determined and had an expectation of fewer treatment sessions, he or she tended to leave therapy prematurely (according to both client and therapist). Although at first glance this may seem counterintuitive, it is possible that some of these more self-determined clients thought they could solve their problems quickly and may have left therapy satisfied that their goals had been reached. The client's personal level of satisfaction, however, may not have corresponded with the expectations of his or her therapist for the degree of potential change that the client could make, hence the lack of mutual agreement between the two parties. Overall, the results of this study suggest that the ability of client expectations for length of therapy to predict premature termination is influenced by the level of client motivation, or self-determination. However, because the results of our analysis cannot differentiate conclusively whether motivation is influencing expectations or vice versa, further research would be required to investigate this relationship. In addition,

there were a number of other significant associations between the predictors, client motivation and type of termination decision.

There was a significant relationship between client motivation and premature termination, indicating that pre-therapy measures of self-determination contributed to the prediction of the client's type of termination. However, it is when client motivation prior to therapy is less self-determined that clients tend to leave therapy with the mutual agreement of their therapist, a finding which at first glance may be counterintuitive and contrary to what was hypothesized. We had assumed that a more self-determined client would remain in therapy until their treatment goals had been reached, whereas a less self-determined client might become discouraged or lose interest in therapy, and drop out of the process. In contrast, our findings suggest that perhaps more motivated clients may be more autonomous and tend to make decisions on their own, regardless of the opinion of their therapist. They may also have been satisfied with treatment and decided on their own to end therapy. It is also possible that therapists of non self-determined clients engaged in a discussion with their clients regarding their lack of motivation and they may have determined together that therapy was not indicated. In some cases, for example, clients may have been referred to more appropriate services. Our findings are very preliminary and further research is required to examine these relationships.

Transtheoretical Model of Change

The specific hypotheses based on the Transtheoretical Model of Change were partially supported. Although client stage of change did not improve the ability of expectations, working alliance, or barriers to treatment participation to predict treatment duration, client

stage of change did improve the ability of the client's perception of the working alliance to predict type of termination decision. If a client with a better working alliance was further along in the stages of change process (e.g., more active than contemplative), s/he was more likely to end therapy with the mutual agreement of the therapist. In order to predict unilateral termination from therapy using working alliance, the client's readiness for change should be taken into account. This suggests that the readiness for change augments the impact of a strong therapeutic relationship early in therapy. The client's own inner momentum to progress may make them even more resilient to the effects of therapist inexperience, therapeutic ruptures, or other interpersonal reactions throughout the therapeutic process, and help the client to stay engaged in treatment until his or her goals are achieved.

Similarly, these findings suggest that less change-ready clients entering therapy are more vulnerable to the effects of a poor therapeutic alliance. It would benefit the therapeutic process to assess the client's readiness for change and to then attend carefully to building a strong working alliance with clients who are less far along the continuum of change. Therapy may need to proceed more slowly with these clients and the quality of the working alliance may have to be verified at regular intervals. It may be helpful for the therapist to explicitly acknowledge, without judgement, the client's state of ambivalence, and work with him or her to develop small, achievable, and meaningful goals, and only gradually expand and extend these goals once small, observable behavioural changes or shifts in awareness can be recognized by the client.

These findings and conclusions are consistent with recommendations regarding stage of change and the therapeutic relationship made by the American Psychological Association's

Division 29 Task Force on Empirically Supported Therapeutic Relationships (Prochaska & Norcross, 2001). In the report of the Task Force, clinicians were advised to assess the client's stage of change and to tailor the therapeutic relationship and the type of intervention accordingly. Clinicians were cautioned not to treat all clients as if they are in the action stage both in terms of the interpersonal stance and the choice of therapeutic intervention. Norcross (1993) suggested that knowing where a client is on the continuum of readiness for change can help a clinician to more systematically take the appropriate relational stance over the course of therapy. For example, in keeping with Lazarus' (1993) description of a good clinician as an "authentic chameleon," who is capable of adjusting his or her relational stance, Norcross (2001) recommended that therapists adopt the role of a nurturing parent for clients who are in the precontemplative stage, a more Socratic stance in the contemplation stage, an experienced coach for clients in the preparation stage, and a consultant for individuals who are ready for action or maintenance of change. The findings of the current study suggest that attending to the relationship between stage of change and relational stance in this manner may help to strengthen the working alliance and minimize the likelihood of premature termination from therapy.

There was no direct association between client stage of change and the type of termination decision, suggesting that there is no direct predictive relationship between the client's stage of change prior to therapy and the likelihood of them leaving therapy early. The findings of this study, however, indicate that client readiness increases the impact of working alliance on premature termination. These results support the overall contention of this study that it is the interaction of client and therapist within the process of psychotherapy, and not

individual client or therapist factors, that contribute to the likelihood of premature termination. The lack of direct predictive value of the stage of change model on premature termination is consistent with recent research (Derisley & Reynolds, 2000) that failed to replicate earlier indications that readiness for change is a useful predictor (Brogan et al., 1999).

Strengths and Limitations of the Study

The present study was designed to build on the existing literature in several respects. The first strength of the present study lies in its attempt to narrow the search for predictors of premature termination by moving closer to the actual experience of therapy. Other researchers have studied static client and therapist characteristics. I tried to focus more closely on therapy-specific individual and interpersonal dynamics, such as therapy-specific and contextual factors that influence a client's participation in therapy.

Second, I observed the experience of therapy at multiple intervals and from multiple perspectives. Clients were interviewed before, during and after treatment in order to capture both prospective and retrospective perceptions of the process, and to control for the bias of one-time reporting. Both client and therapist perspectives were measured to offset the bias of self-report measures.

Third, the study was conducted in a realistic context. Participants were routine clients at a community mental health clinic and provision of therapy was in an ecologically valid setting. The use of a psychotherapy population rather than participants observed under controlled experimental conditions gives the research findings stronger clinical significance (Seligman, 1995), and greater generalizability. The clinical realism of this research project,

however, did lead to some methodological problems.

Methodological Limitations

Although the present study clearly extended previous research, there were also some limitations. This section will focus on the following issues affecting the generalizability of the findings. One potential confound in this study, that was only discovered once the study was underway, was that the clinic receptionist routinely informed potential clients that the clinic had a general policy of limiting treatment to 20 sessions. Despite the fact that clients reported a range of expected treatment length from 2 to 78 sessions, the mean and modal responses were 20 sessions, suggesting that this pre-intake information may have created a ceiling effect on client expectations of treatment duration for many clients. Nonetheless, it is important to note that 28% of clients expected more than 20 sessions of therapy before they began. The potential confound of a 20 session limit on treatment length might be even more salient after three sessions, because the service contract that clients sign at the initial interview describes the clinic's guideline for a maximum number of sessions. It is important to bear in mind, however, that client expectations ranged from 4 to 62 sessions with multiple modes of 8, 13, and 18 sessions, suggesting that client responses were not just based on externally imposed rules. Furthermore, 14% anticipated more than 20 total sessions after their third session. The same maximum 20 session treatment guideline discussed above may also have confounded therapist responses. Expected treatment duration ranged from 5 to 42 sessions, however the mean and modal responses were 19 and 20 sessions, respectively. It is important to note, however, that 34% of clients attended more than 20 sessions. Furthermore, although knowledge of the 20 session treatment guideline may have confounded participants'

responses, recommended treatment duration limitations are not uncommon in mental health clinics. In this way, client and clinician awareness of a maximum number of sessions might not have unduly limited the generalizability of our findings.

Measurement Issues

Operationalization of Premature Termination

Three measurement issues limit the findings in this study. First, the operationalization of premature termination has been a perennial difficulty for all researchers who have investigated this topic. In this study, I measured premature termination in three ways, qualifying from the beginning that a measure of treatment length was inferior to measures of the type of termination decision, from both client and therapist perspectives. Length of psychological treatment is quite variable and shorter treatment does not necessarily imply premature termination or failure, anymore than longer treatment implies completion or success. To offset the difficulties with the measurement of treatment length, the discussion of results emphasized the findings where premature termination was defined by type of termination decision from either the client's or therapist's perspectives. Client and therapist reports of unilateral termination versus termination with the mutual agreement of the therapist are superior measures of premature termination; however, they are not exact. To deal with this issue, some researchers have described their research objectives as prediction of unilateral termination from therapy. Despite the greater accuracy of this description, in focussing their studies in this manner, the behaviour of leaving therapy before treatment goals are met is limited by the operationalization of the construct. The findings of the current study

also are limited by the imperfect operationalization of premature termination.

For example, even defining type of termination as a simple dichotomous construct (unilateral versus mutual agreement) is not so simple because the two parties involved in the therapeutic interaction do not necessarily agree. In this study's sample, there was substantial disagreement (21%) between how clients and therapists perceived the manner in which therapy ended. This raises further issues about how to understand and measure premature termination. It is possible that for at least some of the 12 dyads where clients reported that they had terminated after agreement was reached with their therapist and the therapist reported that the client had terminated unilaterally, that a discussion had taken place about termination, that the therapist had respected the client's decision to end therapy, but that the therapist had different expectations for the client at that point in treatment, and therefore, reported that the client had made a unilateral decision. It is also possible that for the 12 dyads where clients reported having made a unilateral decision to end therapy and their therapists perceived that the decision was mutual, that those clients were taking personal responsibility for their decision to terminate treatment and did not consider their therapist's opinion as critical in their decision-making process, despite the fact that the therapist viewed the decision to terminate as a collaborative process.

It is inevitable that there will be differences in perceptions between individuals in any interpersonal interaction, including psychotherapy. One way of mitigating the impact of these discrepancies is through open communication between client and therapist, and ongoing assessment of each party's perception of the working alliance, at the beginning, throughout, and at the end of therapy. Rather than being viewed as intrusive to the

therapeutic process, this type of assessment may also have therapeutic benefit as it may model for the client communication skills that can be generalized to his or her interpersonal relationships. For research on premature termination, however, the existence of some degree of disagreement in perceptions must be accepted and considered as one of the challenges and limitations when conducting applied research on this phenomenon.

Retrospective Measurement of Barriers to Treatment Participation

Second, in addition to using prospective measures of therapy-specific factors that could contribute to premature termination from therapy, this study sought to determine whether contextual factors, found to be salient in child and family therapy, might also play a role in termination from adult psychotherapy. Consistent with the child and family literature, we measured these factors following treatment. Although the findings of the present study confirmed the relationship between barriers to treatment participation and premature termination, barriers were assessed retrospectively, thus they should not be considered as uncontaminated predictors of the type of termination. Participants' responses may have been distorted by the end result of therapy. The timing of the use of the barriers measure, therefore, limits the study's predictive value. To address this problem, in future studies, multiple assessments of perceived barriers to treatment early in treatment and over the course of therapy would control for possible bias and assure more predictive validity of the measure.

Scoring of Stages of Change Scale

The final possible measurement limitation was the manner in which the Stages of Change Scale was scored. The unconventional method of scoring the SOC scale may limit the validity of the findings and limit the ability to compare the findings to previous research

which typically classifies an individual into one stage of change based on the subscale with the highest score. Nonetheless, the scoring methodology used in the current study is consistent with critiques of discrete stage scoring and recognizes the continuous nature of the change process. Other researchers have created a continuous measure from the stages of change scale by reverse scoring the precontemplation items and computing the total score, and there is some empirical support for this approach (Littell & Girvin, 2002). In the present study, I chose to reverse score both precontemplation and contemplation items, in recognition of the fact that individuals who endorse items in the contemplation stage are still not ready to act on their concerns. Future research is required to psychometrically test this manner of scoring stages of change as a continuous variable.

Statistical Limitations

It is possible that the homogeneity of the sample affected the ability to statistically detect moderating effects of client motivation, given that on its own there was a main effect of client motivation on the client's type of termination decision. Holmbeck (1997) indicated that when all high and low values of the moderator and predictor are not adequately represented this problem may occur. In fact, in this sample, there was a limited range of scores on the self-determination measure. For example, only 1% of clients scored highest on each of intrinsic motivation, introjected motivation, and external motivation, leaving only two levels of motivation, integrated and identified, as the categories scored highest on by 97% of clients. Similarly, for the measure of stages of change, no clients scored highest on the precontemplation stage of change and only 5% fell into the stage of maintenance. This may be important in understanding the limited impact of stages of change as a main effect,

because previous research (Brogan et al., 1999; Smith et al., 1995) found that the precontemplation stage was a good predictor of premature termination. Overall, therefore, the restricted range of scores on some measures in this sample may have limited the ability to adequately assess for moderating effects.

Implications for Research and Clinical Practice

Future Research Directions

The results obtained from examining predictors of premature termination in this study point to interesting directions for future research. First, it is preferable that researchers obtain reports from the perspectives of both clients and therapists because each party offers unique and important information about the therapeutic process. The fact that approximately 20% of client/therapist dyads disagreed on whether or not therapy had terminated prematurely underlines the importance of including both points of view. Second, the standardized use of a dichotomous definition of premature termination would benefit this research area. Treatment duration should not be confused with unilateral (i.e., premature) termination. The type of termination decision more accurately captures the behaviour of leaving therapy early than does how long a client stays in therapy. In this way, studies could be more easily compared and research could advance more quickly. In keeping with a previous suggestion, both client and therapist perspectives should be taken into account.

Third, barriers to treatment participation merits further examination as a predictor of premature termination. This study confirmed that its explanatory powers are not only valuable for child and family therapy, but are also applicable to an adult clientele. Further research is now required to determine whether measurement of barriers throughout the

treatment process would also demonstrate their value as predictors of premature termination.

Fourth, client motivation and stages of change each interacted with other predictors of premature termination. Further research into the role client motivation plays not only as a moderator, but as a direct predictor of premature termination is warranted. The existence of moderating effects suggests that looking at more complex interactions appears to be the best way to proceed to detect predictors of premature termination.

Fifth, future research on the elements that influence the formation of client expectations for the length of therapy might elucidate the client's decision-making process when it comes to making psychological changes. What further information or intervention might be required to help clients to develop more flexible expectations that are more congruent with meeting their goals for change?

Finally, because therapy is an interpersonal interaction that takes place over time, investigation of its process would benefit from additional longitudinal research. The findings of this study demonstrated that variables measured at different times in the process yielded different results. Perspectives on therapy measured before, during and after treatment yield valuable information about clients at risk of premature termination. In keeping with the spirit of longitudinal research, future investigators may want to consider the following implications of this study. Despite the fact that the results of this study indicate that expectations of treatment duration and working alliance are useful in predicting premature termination from adult psychotherapy, some of the inconsistencies of the findings when compared with previous research must also be taken into consideration. These inconsistencies mirror previous research on premature termination. These findings suggest that premature

termination is very difficult to predict from client, therapist and therapeutic process variables assessed early in therapy.

In this study, I narrowed and refined the search for predictors of premature termination from static variables like client and therapist characteristics to an examination of variables that are closer to the therapeutic experience. Even at this closer level of scrutiny, however, our findings cannot be conclusive. The implications of these findings suggest that rather than continuing in the tradition of past endeavours to isolate predictors of dropping out of therapy, it is perhaps time to consider a new paradigm for future research endeavours in the area of premature termination from therapy. This new approach might focus on monitoring and investigating the therapeutic process at an even more micro level to identify warning signs of treatment failure at the level of on-going process, and then addressing the problems in order to reduce the likelihood of premature termination. Searching for a different approach would be consistent with a suggestion made by Keijsers, Kampman, and Hoogduin (2001). These authors proposed that factors that contribute to premature termination may be very individualistic, unique and circumstantial than has been assumed in the research to date.

A current area of promising clinical research that may guide this logical next step is being pioneered by Lambert and colleagues (Lambert, Hansen, & Finch, 2001; Lambert, Whipple, Smart, Vermeersch, Nielsen, & Hawkins, 2001; Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). Using a new paradigm, called patient-focused research, the question of whether a particular treatment process is working for a particular client is addressed (Howard, Moras, Brill, Martinovich, & Lutz, 1996). By monitoring an individual client's psychological symptoms after each treatment session, clinicians can track a client's

progress and compare this progress against a normative profile. The profile was established by Lambert and colleagues who used information about early response to treatment and the dose-response relationship to create algorithms that identify clients who may leave treatment before receiving therapeutic benefit or who are at risk of having a negative treatment outcome (Lambert, Whipple et al., 2001). Using the client's initial symptom severity score and their symptom score at a particular session of interest, the symptom change score is plotted on the normative profile. Clients who are progressing as expected can be identified, as can clients who are not responding to treatment in an expected fashion. Using a colour-coded system of feedback to clinicians, Lambert and colleagues identified clients at risk of treatment failure. Providing therapists with feedback on clients who were improving and with warnings for clients who were not progressing well improved the outcomes of all clients. Overall, as a result of this feedback system, clients who were progressing well required a shorter period of time to meet their therapeutic goals, and clients who were at risk stayed in therapy longer and showed more improvement than at-risk clients whose therapists were not given feedback. These researchers, however, did not measure unilateral termination. In a subsequent study at a university counselling centre (Whipple et al., 2003), in addition to feedback on client progress, researchers provided clinicians with clinical support tools, including a working alliance questionnaire, the stages of change scale, and a measure of perceived social support, as well as a clinical support decision-making tree to guide the usage of the tools. This study found that when clinicians receive feedback regarding their clients' progress and use the clinical support tools with at-risk clients, improvements in outcome are both statistically and clinically significant.

Lambert and colleagues' research demonstrates the successful use of frequent measurement of clinical progress. By getting extremely close to the individual client's experience of therapy on a session by session basis they were able to identify at-risk clients and help clinicians to intervene appropriately to reduce the likelihood of treatment failure. This research used psychological symptoms as the sole measure of progress. Given the results of our current study, future applied research might also administer short measures of client motivation and working alliance at regular intervals in therapy, as well as a measure of the client's type of termination decision at the end of treatment.

For example, in the current study pre-therapy motivation was found to be a predictor of the termination decision, but research on motivation recognizes that it is not a static, enduring construct. Rather, motivation changes with individual and interpersonal experience (Deci & Ryan, 1985). Self-determination may create resilience to bumps in the road in therapy, and non self-determination may place a client at risk of discouragement or disappointment that may lead to premature termination. If levels of motivation were assessed at regular intervals in the therapy process, at-risk clients could be identified and the use of motivational interviewing techniques could be used to address motivational issues. For example, Zweben and Zukoff (2002) described motivational adherence strategies and interventions to address problem adherence and treatment adherence difficulties.

The results of periodic measurement of the working alliance, overall client stressors, and the client's perception of treatment relevance might also merit further study. For example, working alliance measured after the third therapy session is not a strong enough predictor to typically recommend discontinuation of services to a client. Rather, a poor

working alliance would alert the therapist to a problem that must be addressed before treatment can continue. Once the therapist intervenes to bolster the alliance, the clinician would want to ensure that any relationship adjustments had been successful by re-assessing the alliance after the next session. The maintenance of a better alliance would also need to be monitored on an on-going basis so that no further weakness in the therapeutic relationship impeded therapeutic progress. Repeated assessment to ensure the establishment of a strong working alliance was also recommended by Kokotovic and Tracey (1990).

It is, therefore, recommended that research use the findings of this study to build on Lambert and colleagues' findings. Overall, future research on premature termination might benefit from attending to a micro-process level because client characteristics, therapist characteristics, and a single assessment of interpersonal factors do not capture the complexity and fluidity of the therapeutic process. Interventions made to address clients at risk should be assessed after several sessions to determine their effectiveness and to determine whether further adjustments are required to the treatment strategy and plan.

Clinical Implications

The intent of this study was to improve our ability to predict which clients will drop out of therapy. Clearer predictors of premature termination would help clinicians to develop screening tools to more accurately identify who may be at risk of dropping out of psychotherapy, would help therapists to more effectively intervene to minimize unplanned termination, and would make a positive contribution both to improved client well-being and to more efficient mental health-care service delivery.

Three main clinical implications emerge from the present study. First, knowledge about

client's perceptions of the working alliance, client barriers to treatment, expectations, motivation, and readiness for change is helpful in determining which clients are at risk of dropping out of therapy. Second, it is important to assess the client's perceptions of the therapeutic process because they are not always congruent with those of the therapist, and therapists should not assume they are. Furthermore, clients' perceptions of therapy provide incremental validity to the perceptions of therapists in predicting both treatment duration and premature termination. Finally, clinicians might benefit from formal on-going monitoring of client progress, including soliciting regular in-session feedback and carrying out follow-up interventions.

The first significant clinical implication of the present study points to the importance of client motivation and client expectations for treatment duration, and the quality of the working alliance as factors that influence a client's decision to terminate therapy. Furthermore, client motivation has an impact on the ability of client expectations of therapy duration to predict premature termination from therapy, as does client readiness for change on the relationship between working alliance and premature termination. In addition, barriers to treatment participation measured post-treatment are associated with the client's type of termination decision. Consistent with previous findings, the impact of these variables on premature termination suggests a need for clinicians to evaluate clients' expectations, perceptions and responses to treatment. In particular, pre-therapy assessment of therapy-specific variables like motivation for therapy, readiness for change, and expectations for therapy would prepare clinicians to better tailor their interventions to individual client needs. For example, if in the initial treatment session therapists asked clients how long they

expected therapy to last, therapeutic goals and the therapeutic intervention might be better tailored to fit the time frame that the client has in mind, and mitigate against the client leaving therapy before these goals had been met. At the very least, an open discussion about expectations of treatment duration would help both parties to take into account a more complete range of factors in the collaboratively established treatment plan. Furthermore, openly discussing other expectations like the client's role in the therapeutic work, potential obstacles to participation or to follow-through with homework assignments might prove to be useful. It is also important, however, for clinicians to remain cognizant of the fact that clients can terminate within variable time frames, as planned or not as planned by the treatment plan, therefore, therapists need to focus on fostering change within a short period of time (Renk & Dinger, 2002).

Because a client's pre-therapy level of self-determination and the interaction between self-determination (motivation) and expectations were found to be predictive of the manner in which a client terminated therapy, clinicians may benefit from implementing additional empirical evidence that has been reported in the self-determination research literature. Researchers have found that a client's feelings of autonomy, competence, and relatedness are innate psychological needs that must be satisfied to maximize an individual's natural impetus toward health (Sheldon, Williams, & Joiner, 2003). Promotion of these feelings in therapy are consistent with the formation of a strong working alliance and would help to maintain and enhance a client's level of self-determination and decrease the likelihood of premature termination. For example, the emphasis on autonomy support that self-determination theory provides encourages therapists to listen to clients, including answering clients' questions and

providing choices, to help clients get and stay in touch with their reasons for seeking treatment, and to help clients feel that they are understood and appreciated (Sheldon et al., 2003).

Second, the present study found differences in the relationship between client and therapist perceptions of the working alliance and premature termination. This finding demonstrates how important it is for therapists not to rely solely on their clinical experience and acumen, but rather, in the spirit of collaboration, to formally consult with clients regarding their perceptions of the therapeutic process. In this way, potential therapist bias might be averted. Reis and Brown (1999) noted that when a therapist is out of touch with the client's perspective, the client is more likely to disengage from therapy. Arriving at shared perspectives is not necessarily accomplished spontaneously. Rather, it is incumbent on the therapist to take the initiative to thoughtfully inquire about client perceptions of therapy (Rainer & Campbell, 2001). In the case of most clients, these inquiries might also be accomplished quite efficiently with a short post-session questionnaire.

Third, consistent with the recommendations for future research, the prospective and retrospective findings of the current study suggest that on-going assessment and monitoring client progress would provide valuable feedback to therapists. If therapists solicited client feedback on a number of key indices (e.g., working alliance, barriers), they might be alerted to problems earlier in the therapeutic process and be better positioned to address them. For example, Horvath (1995) suggested that building the working alliance probably peaks during session 3. As therapy progresses, however, the alliance must be maintained, but it is vulnerable to potential ruptures as therapists help their clients to address difficult behaviour

patterns (Rainer & Campbell, 1991). If the process of therapy stimulates conflict between the client and the therapist, these issues must be dealt with directly and resolved. The degree of rupture and its successful resolution must be assessed to ensure the client's continued engagement in treatment. Using short versions of measures to minimize the time needed for the assessment, this feedback could be gathered at the end of each session, or perhaps every 3 sessions. Clinicians would benefit from making a commitment to more frequent short assessments of their client's experience of and progress in therapy. Although the extra time might be seen as invasive or an imposition on the treatment time available, considering the negative impact of premature termination for both client well-being, therapist well-being, and cost-effectiveness of the health care system, the challenges would be well-worth the extra effort.

Related research on the impact of problems in the therapeutic relationship has already established the importance of on-going assessment and dealing with ruptures in the alliance (Safran & Muran, 1996; Safran Crocker, McMain, & Murray, 1990). Furthermore, if the alliance is solidified by the experience of therapeutic change, as Feeley and colleagues (1999) suggested, then treatment goals must be clear and "sliced thin" to help clients not only experience, but also be more consciously aware of, therapeutic progress as a staged process. To facilitate this process, both clients and therapists need regular objective feedback of on-going progress. In addition, regular assessment might also strengthen the collaborative nature of the therapeutic relationship.

In summary, reducing the number of clients who drop out of therapy may require a closer monitoring of the therapeutic process, using a strategy of risk management similar to

the one suggested by Lambert and colleagues (2003). Building on the findings of their research, a more comprehensive monitoring system might take into account the findings of this study and go beyond assessment of symptom change only, and assess a client's possible fluctuations in motivation, working alliance, and on-going or developing barriers to treatment. Being alerted to any problems in the therapeutic process, therapists would then be able to appropriately intervene to minimize unplanned termination, thereby improving the delivery of psychological services to their clients.

Conclusion

In conclusion, although there have been decades of attempts to empirically discriminate between clients who did or did not leave treatment prematurely, research is only beginning to move close enough to the therapeutic experience to isolate factors that can more reliably predict premature termination. Given the costs of a high drop-out rate to both client well-being and to the mental healthcare system, it is vital that investigators extend our understanding of factors that predict this phenomenon. In this way, measures can be taken to prevent or address problems that lead to premature termination on a client by client basis. In this study, a shift in methodology and a focus on factors specific to therapy identified variables that discriminated clients who made a unilateral decision to leave therapy. This was an important advance and suggests that with further refinement of applied research methodologies we can come even closer to identifying clients at risk and intervening to reduce the number of clients who leave therapy without meeting their treatment objectives.

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Appendixes

Appendix A

Script for Clinicians Conducting Screening Calls

Because our clinic is affiliated with the University of Ottawa, there are often research projects underway at the Centre. Currently, a study is being conducted to better understand the factors that are involved in decisions to seek, receive, and terminate psychological services. Participants will receive \$40 for their participation in all phases of the study. Participation would require, in total, about 1 hour of your time. Would you be interested in receiving a phone call from one of the researchers from this project to learn more about the study and what participation would involve?

YES NO DATE OF SCREENING CALL:

IF THE CLIENT INDICATES AN INTEREST, THEN:

What days and times would be most convenient for you?

NAME:

PHONE NUMBER:

DAYS AND TIMES:

I will pass your name and telephone number along to a research assistant and you

can expect a call at the time (or one of the times) you have indicated.

Thank you.

**PLEASE RETURN IN AN ENVELOPE TO THE CPS MAILBOX OF
MARLENE BEST OR ORLY RUMSTEIN MCKEAN. THANKS**

Appendix B

Consent for Time 1–Client

Dr. John Hunsley
School of Psychology
University of Ottawa

We are conducting a study to better understand the factors that are involved in decisions to seek and receive psychological services. This study is being conducted by Marlene Best, Orly Rumstein McKean, and Dr. John Hunsley, a professor at the School of Psychology at the University of Ottawa.

There are 3 phases to the study. In the first phase, we would like to ask you some questions about the factors that played a role in your deciding to request psychological services and about the expectations you have for therapy or counselling. As well, we will ask you for consent to access your clinical file at the Centre for Psychological Services to collect information on the nature of the services you are receiving. In the second phase, after your 3rd session at the Centre, we would like to ask you some questions about YOUR initial experiences with the services you have received. Finally, in the third phase, at the end of your treatment, we would like to ask you about your experiences with the services you received and the reasons for ending treatment. At each point, you will be asked these questions during a phone interview. Although we would appreciate your participation in each of these 3 phases, you are free to withdraw from the study at any time. If you participate in the study, we will also be interviewing your therapist to obtain some information about your therapy.

The time requirements for the study are as follows: approximately 30 minutes for phase 1, 10-15 minutes for phase 2, and 30 minutes for phase 3. You will receive an honorarium for your involvement in each phase: \$15 for phase 1, \$10 for phase 2, and \$15 for phase 3.

At this time, we would like your consent for the first phase of the study. By agreeing to answer some questions about your decision to seek and about the expectations you have for your treatment, you will be giving your consent to participate in this first phase of the study and to be contacted after your third session of therapy to request your involvement in the next phase of the study. You will receive an honorarium of \$15 for your participation in this first phase of the study. This will be mailed to you following the completion of the phase 1 questions, along with a copy of this consent form.

I consent to participate in this study. I understand that I will be required to complete an interview over the phone, or complete a mail questionnaire IF A PHONE INTERVIEW IS NOT POSSIBLE, that will involve approximately 30 minutes of my time. I have the right to refuse to

CONSENT FOR TIME 1-CLIENT

answer any question. I also consent to the use of my file AT THE CENTRE for the collection of treatment information. Finally, I can expect to be contacted at a later date and be asked to complete another set of questionnaires that will require approximately 10-15 minutes.

I understand that all my answers will be kept strictly confidential, not even my therapist will have access to any information related to this study. My information will be kept in a locked filing cabinet, and only members of the research team will have access to the information. Moreover, I understand that my anonymity will be assured by never using my name or identifying information in the analysis and reporting of this study. Only a code number will be used to identify my information and all reports of this study will involve combined information from all participants. I am free to withdraw from this study at any time. Any decision to withdraw from the study will not affect my request for services.

If you have any questions or concerns about the study please feel free to contact Dr. John Hunsley. If you wish, you will be able to receive a summary of findings at the completion of the study.

ARE YOU STILL INTERESTED IN PARTICIPATING in our research?

Participant's Name: _____

Participant's Address: _____

Participant's Phone Number: _____

Signature indicating that verbal consent was obtained: _____

Date: _____

Research Assistant's signature: _____ Date: _____

I wish to receive a summary of the findings of this study upon its completion at the above address:

YES NO

Appendix C
Notice to Therapists

YOUR CLIENT IS INVOLVED IN OUR RESEARCH!

We need your cooperation in informing us of when your client has
SCHEDULED SESSION 3 with you.

Please provide us with your client's name and the date of session 3 and place it
IN A SEALED ENVELOPE in the CPS mailbox of Marlene Best or Orly
Rumstein McKean.

Thank you for your assistance!

Client's ID#: _____

Session 3 appointment: _____

Session 4 appointment if known: _____

Appendix D
Consent for Time 2–Client

Dr. John Hunsley
School of Psychology
University of Ottawa

We are conducting a study to better understand the factors that are involved in decisions to seek and receive psychological services. This study is being conducted by Marlene Best, Orly Rumstein McKean, and Dr. John Hunsley, a professor at the School of Psychology at the University of Ottawa.

You have already participated in the first phase of the study. We are now asking for your participation in the second phase. We would like to ask you some questions about initial experiences with the services you have received. This will require about 10 minutes of your time. You can complete these questions by a telephone interview or by completing a mail questionnaire. You will receive an honorarium of \$10 for your involvement in this phase of the study. This will be mailed to you following the completion of the phase 2 questions, along with a copy of this consent form. If you choose to complete the measures after your 3rd session at the clinic, you will receive the honorarium and a copy of this consent form at that time. The researcher will keep a second copy of this form. Although we would appreciate your participation in each of these 3 phases, you are free to withdraw from the study at any time. If you participate in the study, we will also be interviewing your therapist to obtain some information about your therapy.

By agreeing to answer some questions about your initial experiences with the services you are receiving, you will be giving your consent to participate in the second phase of the study and to be contacted after your final treatment session (or after 20 sessions, whichever comes first) to request your involvement in the third and final of the study.

I consent to participate in this phase of the study. I understand that I will be required to complete an interview over the phone, or complete a questionnaire after my 3rd session, that will involve approximately 10-15 minutes of my time. I have the right to refuse to answer any question. Finally, I can expect to be contacted at a later date and be asked to complete another set of questionnaires that will require approximately 30 minutes.

I understand that all my answers will be kept strictly confidential, not even my therapist will have access to any information related to this study. My information will be kept in a locked filing cabinet, and only members of the research team will have access to the information. Moreover, I understand that my anonymity will be assured by never using my name or identifying information in the analysis and reporting of this study. Only a code number will be used to identify my information and all reports of this study will involve combined information

CONSENT FOR TIME 2-CLIENT

from all participants. I am free to withdraw from this study at any time. Any decision to withdraw from the study will not affect the services I am receiving. If you have any questions or concerns about the study please feel free to contact Dr. John Hunsley

Thank you for participating in our research.

Participant's Name: _____

Participant's Address: _____

Participant's Phone Number: _____

Signature indicating that verbal consent was obtained: _____

Date: _____

Research Assistant's signature: _____ Date: _____

Appendix E
Consent for Time 2–Clinician

Dr. John Hunsley
School of Psychology
University of Ottawa

We are conducting a study to better understand the factors that are involved in decisions to seek and receive psychological services. This study is being conducted by Marlene Best, Orly Rumstein McKean, and Dr. John Hunsley, a professor at the School of Psychology at the University of Ottawa.

One of your clients is participating in the study. We have asked your client some questions about the process of seeking therapy and about their experience of treatment to date. As the therapist of Client # _____, we would like your perspective on the client's functioning and on the process of treatment to date. Participation in this study will involve answering questions in a 10 minute interview that will be scheduled according to your availability. We would also like your participation in the study following the termination of services WITH the client (or after 20 sessions, whichever comes first). However, we will seek your consent for involvement in that phase of the study at a later date.

I consent to participate in this study. I understand that I will be required to participate in a 10 minute interview scheduled at my convenience and that I will be contacted to participate in a final phase of the study following the termination of services to my client. I understand that all information that I provide for the purpose of this study is strictly confidential. None of the information collected from me or my client will be used to evaluate my clinical services at the Centre for Psychological Services. My information will be kept in a locked filing cabinet, and only members of the research team will have access to the information. Moreover, I understand that my anonymity will be assured by never using my name or identifying information in the analysis and reporting of this study. Only a code number will be used to identify my information and all reports of this study will involve combined information from all participants. Also, I am free to withdraw from this study at any time. I have the right to refuse to answer any question. Any decision to withdraw from the study will in no way influence my training or evaluation as a practicum student or intern at CPS. There are two copies of this consent form, one of which I will keep and one which the researcher will keep.

If you have any questions or concerns about the study please feel free to contact Dr. John Hunsley

CONSENT FOR TIME 2-CLINICIAN

Thank you for participating in our research.

Therapist Name: _____ Therapist's Signature: _____

Date: _____

Research Assistant's signature: _____ Date: _____

I wish to receive a summary of the findings of this study upon its completion:

YES NO

Mailing Address: _____

Appendix F
Consent for Time 3–Client

Dr. John Hunsley
School of Psychology
University of Ottawa

We are conducting a study to better understand the factors that are involved in decisions to seek and receive psychological services. This study is being conducted by Marlene Best, Orly Rumstein McKean, and Dr. John Hunsley, a professor at the School of Psychology at the University of Ottawa.

You have already participated in previous phases of the study. We are now asking for your participation in the third and final phase. We would like to ask you some questions about your experiences with the services you received and about your reasons for terminating services. This will require about 30 minutes of your time. You can complete these questions by a telephone interview or by completing a mail questionnaire. You will receive an honorarium of \$15 for your involvement in this phase of the study. This will be mailed to you following the completion of the phase 3 questions, along with a copy of this consent form. The researcher will keep a second copy of this form. You are free to withdraw from the study at any time.

By agreeing to answer some questions about your experiences with the services you received and your reasons for terminating services, you will be giving your consent to participate in the third phase of the study. If you participate in the study, we will also be interviewing your therapist to obtain some information about your therapy.

I consent to participate in this phase of the study. I understand that I will be required to complete an interview over the phone that will involve approximately 30 minutes of my time.

I understand that all my answers will be kept strictly confidential, not even my therapist will have access to any information related to this study. My information will be kept in a locked filing cabinet, and only members of the research team will have access to the information. Moreover, I understand that my anonymity will be assured by never using my name or identifying information in the analysis and reporting of this study. Only a code number will be used to identify my information and all reports of this study will involve combined information from all participants. I am free to withdraw from this study at any time. I have the right to refuse to answer any question. Any decision to withdraw from the study will not affect any future requests I might make for services at the Centre for Psychological Services.

Thank you for participating in our research.

CONSENT FOR TIME 3-CLIENT

Participant's Name: _____

Participant's Address: _____

Participant's Phone Number: _____

Signature indicating that verbal consent was obtained: _____

Date: _____

Research Assistant's signature: _____ Date: _____

Appendix G
Consent for Time 3—Clinician

Dr. John Hunsley
School of Psychology
University of Ottawa

We are conducting a study to better understand the factors that are involved in decisions to seek and receive psychological services. This study is being conducted by Marlene Best, Orly Rumstein McKean, and Dr. John Hunsley, a professor at the School of Psychology at the University of Ottawa.

One of your clients is participating in the study. We have asked your client some questions about the experience of receiving and terminating therapy. As the therapist of Client # _____, we would like your perspective on the client's functioning at termination of services and reasons for the termination of services. Participation in this phase of the study will involve answering questions in a 20 minute interview that will be scheduled according to your availability.

I consent to participate in this study. I understand that I will be required to participate in a 20 minute interview scheduled at my convenience. I understand that all information that I provide for the purpose of this study is strictly confidential. My information will be kept in a locked filing cabinet, and only members of the research team will have access to the information. Moreover, I understand that my anonymity will be assured by never using my name or identifying information in the analysis and reporting of this study. Only a code number will be used to identify my information and all reports of this study will involve combined information from all participants. None of the information collected from me or my client will be used to evaluate my clinical services at the Centre for Psychological Services. Also, I am free to withdraw from this study at any time. I have the right to refuse to answer any question. Any decision to withdraw from the study will in no way influence my training or evaluation as a practicum student or intern at CPS. There are two copies of this consent form, one of which I will keep and one which the researcher will keep.

If you have any questions or concerns about the study please feel free to contact Dr. John Hunsley

Thank you for participating in our research.

Therapist Name: _____ Therapist's Signature: _____

Date: _____

Research Assistant's signature: _____ Date: _____

Appendix H

ID Number _____

1. Gender M F 2. Age _____
3. Who referred you to the Centre? Self Other
4. Are you:
1. Single 4. Separated
2. Living with your partner 5. Divorced
3. Married 6. Widowed
5. Do you have any children? Y N If yes, how many? _____
- Living with you? Y N
6. Have you ever been in therapy before? Y N If yes, when? _____
7. Are you currently seeking psychological services elsewhere? Y N
8. What is your highest level of education?
1. Some elementary school 6. Graduated college
2. Finished elementary school 7. Some university
3. Some high school 8. Graduated university
4. Graduated high school 9. Graduate school
5. Some college 10. Professional school
9. What is your current employment status?
1. Unemployed 4. Employed part time
2. Student 5. Retired
3. Employed full time 6. Homemaker
10. What is your current annual income?
1. 0 - \$5,000 4. \$15,001 - \$20,000 7. \$30,001 - \$35,000
2. \$5,001 - \$10,000 5. \$20,001 - \$25,000 8. \$35,001 - \$40,000
3. \$10,001 - \$15,000 6. \$25,001 - \$30,000 9. \$40,001 or more

ID Number_____

11. What is your ethnic background?

- | | |
|-------------------------------------|--|
| 1. White (e.g., Europe, S. America) | 7. Native/Aboriginal People of North America |
| 2. Black | 8. South Asian (e.g., India, Uganda, Pakistan) |
| 3. Korean | 9. South East Asian (e.g., Vietnamese, Thai) |
| 4. Filipino | 10. Middle Eastern/North African (e.g., |
| 5. Japanese | Armenia, Syria, Morocco) |
| 6. Chinese | 11. Other |

Appendix I
Symptom Checklist - 10 (SCL-10)

ID Number _____

Here is a list of problems and complaints that people sometimes have. Consider each item carefully, and indicate which response best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST WEEK INCLUDING TODAY. Before we start, please write down the rating scale because it will make it easier for you to answer items.

	0 Not at all	1 A little bit	2 Moderately	3 Quite a bit	4 Extremely
1. How much were you distressed by feeling lonely?	0	1	2	3	4
2. How much were you distressed by feeling no interest in things?	0	1	2	3	4
3. How much were you distressed by feeling afraid in open spaces or on the streets?	0	1	2	3	4
4. How much were you distressed by feeling weak in part of your body?	0	1	2	3	4
5. How much were you distressed by feeling blue?	0	1	2	3	4
6. How much were you distressed by heavy feelings in your arms or legs?	0	1	2	3	4
7. How much were you distressed by feeling afraid to go out of your house alone?	0	1	2	3	4
8. How much were you distressed by feeling tense or keyed up?	0	1	2	3	4
9. How much were you distressed by feelings of worthlessness?	0	1	2	3	4
10. How much were you distressed by feeling lonely even when you are with people?	0	1	2	3	4

Appendix J
Working Alliance Inventory—Client Form

ID Number _____

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items.

	<u>Does not</u> <u>Correspond at all</u>			<u>Corresponds</u> <u>Moderately</u>		<u>Corresponds</u> <u>Exactly</u>	
	1	2	3	4	5	6	7
1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.	1	2	3	4	5	6	7
2. What I am doing in therapy gives me new ways of looking at my problem.	1	2	3	4	5	6	7
3. I believe my therapist likes me.	1	2	3	4	5	6	7
4. My therapist does not understand what I am trying to accomplish in therapy.	1	2	3	4	5	6	7
5. I am confident in my therapist's ability to help me.	1	2	3	4	5	6	7
6. My therapist and I are working towards mutually agreed upon goals.	1	2	3	4	5	6	7
7. I feel that my therapist appreciates me.	1	2	3	4	5	6	7
8. We agree on what is important for me to work on.	1	2	3	4	5	6	7
9. My therapist and I trust one another.	1	2	3	4	5	6	7
10. My therapist and I have different ideas on what my problems are.	1	2	3	4	5	6	7
11. We have established a good understanding of the kind of changes that would be good for me.	1	2	3	4	5	6	7
12. I believe the way we are working with my problem is correct.	1	2	3	4	5	6	7

Appendix K
Working Alliance Inventory—Clinician Form

ID Number _____

Below is a list of statements about your relationship with your client. Consider each item carefully and indicate your level of agreement for each of the following items.

	<u>Does not</u>	<u>Corresponds</u>	<u>Corresponds</u>
	<u>Correspond at all</u>	<u>Moderately</u>	<u>Exactly</u>
	1	2	3
	4	5	6
	7		
1. My client and I agree about the things he/she will need to do in therapy to help improve his/her situation.	1	2	3
2. What my client is doing in therapy gives him/her new ways of looking at his/her problem.	1	2	3
3. I believe my client likes me.	1	2	3
4. My client does not understand what I am trying to accomplish in therapy.	1	2	3
5. I am confident in my client's ability to help him/herself.	1	2	3
6. My client and I are working towards mutually agreed upon goals.	1	2	3
7. I feel that my client appreciates me.	1	2	3
8. We agree on what is important for my client to work on.	1	2	3
9. My client and I trust one another.	1	2	3
10. My client and I have different ideas on what his/her problems are.	1	2	3
11. We have established a good understanding of the kind of changes that would be good for him/her.	1	2	3
12. I believe the way we are working with my client's problem is correct.	1	2	3

Appendix L

Client Motivation For Therapy Scale

ID Number _____

Using the scale provided, please indicate to what extent each of the following items corresponds to the reasons why you are presently interested in seeking therapy by rating the level of correspondence with each item from 1 to 7. Please write down the rating scale because it makes it easier to answer items.

	Does not Correspond at all		Corresponds Moderately			Corresponds Exactly	
	1	2	3	4	5	6	7
1. Because other people think that it's a good idea for me to be in therapy.						1	2 3 4 5 6 7
2. Honestly, I really don't understand what I can get from therapy.						1	2 3 4 5 6 7
3. For the pleasure I will experience when I feel completely absorbed in a therapy session.						1	2 3 4 5 6 7
4. For the satisfaction I will have when I try to achieve my personal goals in the course of therapy.						1	2 3 4 5 6 7
5. Because I would feel guilty if I was not doing anything about my problem.						1	2 3 4 5 6 7
6. Because I would like to make changes to my current situation.						1	2 3 4 5 6 7
7. Because I believe that eventually it will allow me to feel better.						1	2 3 4 5 6 7
8. I wonder whether I should bother with therapy.						1	2 3 4 5 6 7
9. Because I would feel bad about myself if I didn't try therapy.						1	2 3 4 5 6 7
10. Because I should have a better understanding of myself.						1	2 3 4 5 6 7
11. Because my friends think I should be in therapy.						1	2 3 4 5 6 7
12. Because I will experience pleasure and satisfaction when I learn new things about myself that I didn't know before.						1	2 3 4 5 6 7
13. I wonder what I will do in therapy; actually, I might find it boring.						1	2 3 4 5 6 7
14. I don't know; I never really thought about it before.						1	2 3 4 5 6 7
15. Because I believe that therapy will allow me to deal with things better.						1	2 3 4 5 6 7
16. For the interest I have in understanding more about myself.						1	2 3 4 5 6 7
17. Because through therapy I will come to see a way that I can continue to approach different aspects of my life.						1	2 3 4 5 6 7
18. Because through therapy I feel that I will be able to take responsibility for making changes in my life.						1	2 3 4 5 6 7
19. Because it is important for clients to try therapy.						1	2 3 4 5 6 7
20. Because I believe it's a good thing to find solutions to my problem.						1	2 3 4 5 6 7
21. To satisfy people close to me who want me to get help for my current situation.						1	2 3 4 5 6 7
22. Because I don't want to upset people close to me who want me to be in therapy.						1	2 3 4 5 6 7
23. Because I feel that changes will take place through therapy that will become part of me.						1	2 3 4 5 6 7
24. Because I value the way therapy will allow me to make changes in my life.						1	2 3 4 5 6 7

ID Number _____

**Strongly
Disagree**

Neutral

Strongly Agree

1

2

3

4

2

- | | | | | | |
|---|---|---|---|---|---|
| 1. As far as I'm concerned, I don't have any problems that need changing. | 1 | 2 | 3 | 4 | 5 |
| 2. I think I might be ready for some self-improvement. | 1 | 2 | 3 | 4 | 5 |
| 3. I want to do something about the problems that have been bothering me. | 1 | 2 | 3 | 4 | 5 |
| 4. It might be worthwhile to work on my problem. | 1 | 2 | 3 | 4 | 5 |
| 5. I'm not the problem one. It doesn't make sense for me to come to the clinic. | 1 | 2 | 3 | 4 | 5 |
| 6. It worries me that I might slip back on a problem I have already changed,
so I am seeking help. | 1 | 2 | 3 | 4 | 5 |
| 7. I am finally going to do some work on my problems. | 1 | 2 | 3 | 4 | 5 |
| 8. I've been thinking that I might want to change something about myself. | 1 | 2 | 3 | 4 | 5 |
| 9. I have been successful in working on my problem but I'm not sure I can
keep up the effort on my own. | 1 | 2 | 3 | 4 | 5 |
| 10. At times my problem is difficult, but I'm working on it. | 1 | 2 | 3 | 4 | 5 |
| 11. Coming to the clinic is pretty much of a waste of time for me because the problem
doesn't have to do with me. | 1 | 2 | 3 | 4 | 5 |
| 12. I'm hoping this clinic will help me to better understand myself. | 1 | 2 | 3 | 4 | 5 |
| 13. I guess I have faults, but there's nothing that I really need to change. | 1 | 2 | 3 | 4 | 5 |
| 14. I am really working hard to change. | 1 | 2 | 3 | 4 | 5 |
| 15. I have a problem and I really think I should work on it. | 1 | 2 | 3 | 4 | 5 |
| 16. I'm not following through with what I have already changed as well as I
had hoped, and I'm coming to the clinic to prevent a relapse of the problem. | 1 | 2 | 3 | 4 | 5 |
| 17. Even though I'm not always successful at changing, at least I intend to work on
my problem. | 1 | 2 | 3 | 4 | 5 |
| 18. I thought once I had resolved the problem I would be free of it, but sometimes I still
find myself struggling with it. | 1 | 2 | 3 | 4 | 5 |
| 19. I wish I had more ideas on how to solve my problem. | 1 | 2 | 3 | 4 | 5 |
| 20. I have started working on my problems but I would like help. | 1 | 2 | 3 | 4 | 5 |
| 21. Maybe the clinic will be able to help me. | 1 | 2 | 3 | 4 | 5 |
| 22. I may need a boost right now to help me maintain the changes I've already made. | 1 | 2 | 3 | 4 | 5 |
| 23. I may be part of the problem, but I don't really think I am. | 1 | 2 | 3 | 4 | 5 |
| 24. I hope that someone at the clinic will have some good advice for me. | 1 | 2 | 3 | 4 | 5 |
| 25. Anyone can talk about changing; I'm actually doing something about it. | 1 | 2 | 3 | 4 | 5 |
| 26. All this talk about psychology is boring. Why can't people just forget about their
problems? | 1 | 2 | 3 | 4 | 5 |
| 27. I'm coming to the clinic to prevent myself from having a relapse of my problem. | 1 | 2 | 3 | 4 | 5 |
| 28. It is frustrating, but I feel I might be having a recurrence of a problem I thought
I had resolved. | 1 | 2 | 3 | 4 | 5 |
| 29. I have worries but so does the next person. Why spend time thinking about them? | 1 | 2 | 3 | 4 | 5 |
| 30. I am actively working on my problem. | 1 | 2 | 3 | 4 | 5 |
| 31. I would rather cope with my faults than try to change them. | 1 | 2 | 3 | 4 | 5 |
| 32. After all I had done to try to change my problem, every now and again it comes back
to haunt me. | 1 | 2 | 3 | 4 | 5 |

Appendix N

Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

- 100 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.
↓
- 91 No symptoms.
- 90 Absent or minimal symptoms (e.g., *mild anxiety before an exam*), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., *an occasional argument with family members*).
↓
- 81
- 80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., *difficulty concentrating after family argument*); no more than slight impairment in social, occupational, or school functioning (e.g., *temporarily falling behind in schoolwork*).
↓
- 71
- 70 Some mild symptoms (e.g., *depressed mood and mild insomnia*) OR some difficulty in social, occupational, or school functioning (e.g., *occasional truancy, or theft within the household*), but generally functioning pretty well, has some meaningful interpersonal relationships.
↓
- 61
- 60 Moderate symptoms (e.g., *flat affect and circumstantial speech, occasional panic attacks*) OR moderate difficulties in social, occupational, or school functioning (e.g., *few friends, conflicts with peers or co-workers*).
↓
- 51
- 50 Serious symptoms (e.g., *suicidal ideation, severe obsessional rituals, frequent shoplifting*) OR any serious impairment in social occupational, or school functioning (e.g., *no friends, unable to keep a job*).
↓
- 41
- 40 Some impairment in reality testing or communication (e.g., *speech is at times illogical, obscure, or irrelevant*) OR major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (e.g., *depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school*).
↓
- 31
- 30 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgement (e.g., *sometimes incoherent, acts grossly inappropriately, suicidal preoccupation*) OR inability to function in almost all areas (e.g., *stays in bed all day; no job, home, or friends*).
↓
- 21
- 20 Some danger of hurting self or others (e.g., *suicide attempts without clear expectation of death; frequently violent; manic excitement*) OR occasionally fails to maintain minimal personal hygiene (e.g., *smears feces*) OR gross impairment in communication (e.g., *largely incoherent or mute*).
↓
- 11
- 10 Persistent danger of severely hurting self or others (e.g., *recurrent violence*) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
↓
- 1
- 0 Inadequate information.

Appendix O
Client Expectations

ID Number _____

1. How many more times do you expect you will need to meet with your therapist to resolve your problem or concern? _____

2. To what extent has your therapy fit with the expectations you had for therapy?

1	2	3	4	5	6	7
Does not fit at all			Fits moderately well			Fits exactly

Appendix P
Clinician Expectations

ID Number _____

1. How many more times do you expect you will need to meet with the client to resolve the presenting problem or concern? _____

2. To what extent do you think that the therapy fits with the expectations the client had for therapy?

1	2	3	4	5	6	7
Does not fit at all			Fits moderately well			Fits exactly

Appendix Q
Barriers to Treatment Participation Scale - Client

ID Number _____

There can be a number of things that get in the way of someone participating fully in their treatment. Below is a list of possible barriers or obstacles you may have encountered while in therapy. Please indicate how much of a problem for you each potential barrier was.

HOW OFTEN DID THIS STRESSOR OR OBSTACLE CREATE A PROBLEM FOR YOU WHILE YOU WERE IN TREATMENT?

	1	2	3	4	5
	Never	Once in a while	Sometimes	Often	Very Often
1. Transportation (getting a ride driving, taking a bus) to the clinic for a session	1	2	3	4	5
2. Scheduling of appointment times for treatment	1	2	3	4	5
3. Treatment was in conflict with another of my activities (classes, job, friends)	1	2	3	4	5
4. During the course of treatment I experienced a lot of stress in my life	1	2	3	4	5
5. I was sick on the day when treatment was scheduled	1	2	3	4	5
6. Crises at home made it hard for me to get to a session.	1	2	3	4	5
7. Treatment added another stressor to my life.	1	2	3	4	5
8. There was bad weather and this made coming to treatment a problem	1	2	3	4	5
9. I did not have time for the assigned work	1	2	3	4	5
10. There was always someone sick in my home	1	2	3	4	5
11. Getting a baby-sitter so I could come to the sessions	1	2	3	4	5
12. Finding a place to park at the clinic	1	2	3	4	5
13. I had a disagreement with my husband/wife, boyfriend/girlfriend, partner about whether I should come to treatment at all	1	2	3	4	5
14. I was too tired after work to come to a session	1	2	3	4	5
15. My job got in the way of coming to a session	1	2	3	4	5
16. Treatment took time away from spending time with my children	1	2	3	4	5

HOW OFTEN DID THESE ISSUES CREATE A PROBLEM FOR YOU WHILE YOU WERE IN TREATMENT?

17. Treatment lasted too long (too many weeks)	1	2	3	4	5
18. I felt that treatment cost too much	1	2	3	4	5
19. I was billed for the wrong amount	1	2	3	4	5
20. Information in the session and any handouts seemed confusing	1	2	3	4	5
21. I had trouble understanding the treatment I received	1	2	3	4	5
22. I felt this treatment was more work than expected	1	2	3	4	5

23. The atmosphere at the clinic makes it uncomfortable for appointments

1 2 3 4 5

1	2	3	4	5	
Never	Once in a while	Sometimes	Often	Very Often	
24. I did not feel that I had enough to say about what goes on in treatment	1	2	3	4	5
25. The assigned work for me to do as part of this treatment was much too difficult	1	2	3	4	5

HOW OFTEN DID YOU FEEL THIS WAY ABOUT YOUR TREATMENT?

26. Treatment did not seem necessary	1	2	3	4	5
27. Treatment was not what I expected	1	2	3	4	5
28. I lost interest in coming to sessions	1	2	3	4	5
29. I felt treatment did not seem as important as the sessions continued	1	2	3	4	5
30. I feel treatment did not focus on my life and problems	1	2	3	4	5
31. I now have new or different problems	1	2	3	4	5
32. My problems seem to have improved, therefore, treatment no longer seems necessary	1	2	3	4	5
33. Treatment did not seem to be working	1	2	3	4	5

HOW OFTEN DID YOU FEEL THIS WAY ABOUT YOUR THERAPIST?

34. I did not like the therapist	1	2	3	4	5
35. I felt I had to give too much personal information to the therapist	1	2	3	4	5
36. The therapist did not seem confident that treatment would work for me	1	2	3	4	5
37. The therapist did not seem confident in my ability to make changes	1	2	3	4	5
38. I do not feel the therapist supported me or my efforts	1	2	3	4	5

Appendix R
Termination Questions for the Client

ID Number _____

1. In essence, was the decision to terminate therapy (check one only)

a) a unilateral, explicit decision on your part to end therapy? _____

b) based on your own decision not to attend sessions or to schedule subsequent appointments? _____

c) a mutual agreement between you and your therapist that treatment goals had been met? _____

d) due to a decision that you would receive services elsewhere? _____

Appendix S
Barriers to Treatment Participation Scale - Therapist

ID Number _____

There can be a number of things that get in the way of someone participating fully in their treatment. Below is a list of possible barriers or obstacles your client may have encountered while in therapy. Please indicate how much of a problem **you think** each potential barrier was **for your client**.

HOW OFTEN DID THIS STRESSOR OR OBSTACLE CREATE A PROBLEM FOR YOUR CLIENT WHILE HE/SHE WAS IN TREATMENT?

	1	2	3	4	5
	Never	Once in a while	Sometimes	Often	Very Often
1. Transportation (getting a ride driving, taking a bus) to the clinic for a session	1	2	3	4	5
2. Scheduling of appointment times for treatment	1	2	3	4	5
3. Treatment was in conflict with another of their activities (classes, job, friends)	1	2	3	4	5
4. During the course of treatment they experienced a lot of stress in their life	1	2	3	4	5
5. They were sick on the day when treatment was scheduled	1	2	3	4	5
6. Crises at home made it hard for them to get to a session.	1	2	3	4	5
7. Treatment added another stressor to their life.	1	2	3	4	5
8. There was bad weather and this made coming to treatment a problem	1	2	3	4	5
9. They did not have time for the assigned work	1	2	3	4	5
10. There was always someone sick in their home	1	2	3	4	5
11. Getting a baby-sitter so they could come to the sessions	1	2	3	4	5
12. Finding a place to park at the clinic	1	2	3	4	5
13. They had a disagreement with their husband/wife, boyfriend/girlfriend, partner about whether they should come to treatment at all	1	2	3	4	5
14. They were too tired after work to come to a session	1	2	3	4	5
15. Their job got in the way of coming to a session	1	2	3	4	5
16. Treatment took time away from spending time with their children	1	2	3	4	5

HOW OFTEN DID THESE ISSUES CREATE A PROBLEM FOR YOUR CLIENT WHILE HE/SHE WAS IN TREATMENT?

17. Treatment lasted too long (too many weeks)	1	2	3	4	5
18. They felt that treatment cost too much	1	2	3	4	5
19. They were billed for the wrong amount	1	2	3	4	5
20. Information in the session and any handouts seemed confusing	1	2	3	4	5
21. They had trouble understanding the treatment they received	1	2	3	4	5
22. They felt this treatment was more work than expected	1	2	3	4	5
23. The atmosphere at the clinic made it uncomfortable for appointments	1	2	3	4	5

	1	2	3	4	5
	Never	Once in a while	Sometimes	Often Often	Very
24. They did not feel that they had enough to say about what went on in treatment	1	2	3	4	5
25. The assigned work for them to do as part of this treatment was much too difficult	1	2	3	4	5

HOW OFTEN DO YOU THINK YOUR CLIENT FELT THIS WAY ABOUT THEIR TREATMENT?

26. Treatment did not seem necessary	1	2	3	4	5
27. Treatment was not what they expected	1	2	3	4	5
28. They lost interest in coming to sessions	1	2	3	4	5
29. They felt treatment did not seem as important as the sessions continued	1	2	3	4	5
30. They felt treatment did not focus on their life and problems	1	2	3	4	5
31. They now have new or different problems	1	2	3	4	5
32. Their problems seem to have improved, therefore, treatment no longer seems necessary	1	2	3	4	5
33. Treatment did not seem to be working	1	2	3	4	5

HOW OFTEN DO YOU THINK YOUR CLIENT FELT THIS WAY ABOUT THEIR THERAPIST?

34. They did not like the therapist	1	2	3	4	5
35. They felt they had to give too much personal information to the therapist	1	2	3	4	5
36. The therapist did not seem confident that treatment would work for them	1	2	3	4	5
37. The therapist did not seem confident in their ability to make changes	1	2	3	4	5
38. They do not feel the therapist supported them or their efforts	1	2	3	4	5

Appendix T
Termination Questions for the Clinician

ID Number _____

1. In essence, was the decision to terminate therapy (check one only)

a) a unilateral, explicit decision on the part of the client to end therapy? _____

b) based on the failure of the client to attend sessions to schedule subsequent appointments? _____

c) a mutual agreement between you and the client that treatment goals had been met? _____

d) due only to reaching the limit of 20 treatment sessions? _____

e) due to a decision for the client to receive services elsewhere? _____

Appendix U
Final Notice to Therapist

YOUR CLIENT IS STILL INVOLVED IN OUR RESEARCH!

We need your cooperation in informing us of when your client has COMPLETED THERAPY OR IS ABOUT TO COMPLETE THERAPY with you.

Please provide us with your client's name and the date of final appointment and place it IN A SEALED ENVELOPE in the CPS mailbox of Marlene Best or Orly Rumstein McKean.

Thank you for your assistance!

Client's ID #: _____

Date of final appointment: _____