IMPACT OF A ROLE INDUCTION TO COUNSELING ON PREMATURE TERMINATION AND READINESS FOR CHANGE WITH CLIENTS IN A RURAL SETTING

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IMPACT OF A ROLE INDUCTION TO COUNSELING ON PREMATURE TERMINATION AND READINESS FOR CHANGE WITH CLIENTS IN A RURAL SETTING

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ABSTRACT

Research has consistently shown that therapy is effective and that clients experience positive outcomes from engaging in therapy (Orlinsky et al., 2004). However, past research has shown that many clients prematurely terminate therapy often with negative outcomes (Archer, Forbes, Metcalfe, & Winter, 2000; Carpenter, Morrow, del Gaudio, & Ritzler, 1981; Pekarick, 1985). The purpose of this study was to explore an intervention designed to reduce premature termination rates using a comprehensive, standardized role induction procedure and a more sensitive definition of premature termination. Further, the impact of the role induction as it relates to readiness for change was explored. This study also examined the impact the role induction would have on clients’ commitment to therapy. A total of 106 adult clients seeking services at a community mental health center participated in the study. Participants were randomly assigned to either the experimental or control group. Prior to the intake session, each participant viewed a video. The experimental group viewed the comprehensive role induction video and the control group viewed a video explaining the services at the counseling center. Next, all participants completed the self-report measures of commitment to therapy (i.e. EAC-B; Tinsley et al., 1980) and readiness for change (i.e. SOC; McConnaughy, Prochaska, & Velicer, 1983). The present data failed to show that a role induction to counseling significantly impacts premature termination, commitment to counseling or readiness for change among clients seeking counseling at a rural community mental health center. Overall, the data failed to support previous research.
findings that seemed to indicate a role induction to counseling could reduce the occurrence of premature termination and increase a client’s commitment to therapy (Reis & Brown, 2006; Walitzer, Dermen, & Connors, 1999).
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CHAPTER I
INTRODUCTION

Research has consistently shown that therapy is effective and that clients report positive outcomes from engaging in therapy (Orlinsky et al., 2004). However, there is a body of literature indicating that many clients fail to engage in therapy and discontinue treatment. For example, a meta-analysis identified the average rate of premature termination at 46.86% for outpatient therapy clients (Wierzbicki & Pekarik, 1993). Despite considerable research in this area, definitive causes or ways to impact rates of premature termination from therapy have not been identified. A major contributor to this lack of progress is the lack of a consensus on how best to define premature termination, limiting the ability to synthesize the literature. For example, premature termination from therapy has been defined as when the client fails to return for any scheduled session following an initial number of counseling sessions (April & Nicholas, 1997), or as a failure to return after intake (Hardin, Subich, & Holvey, 1988). Further, Renk and Dinger (2002), classified clients as prematurely terminating therapy based on therapist judgment while Hatchett and Park (2003) chose an arbitrary number of sessions to differentiate between premature terminators and mutual terminators. This lack of consistency in defining premature termination from therapy stands as a major impediment to both understanding its causes and reducing its occurrence (Hatchett & Park).
Despite the limitations in the premature termination literature, some researchers have identified constructs that may impact premature termination rates. For example, a study conducted by Reis and Brown (2006) used a pretherapy video to educate clients about therapy and compared drop out rates between those who viewed the video and those clients who did not view the video. The results indicated that the rates of premature termination were significantly lower in the group that received precounseling training than the group that did not. The researchers compared scores on a measure of therapy drop out for both groups of clients. The group that saw the video had significantly lower scores (p< .05) than those who did not view the video. The authors concluded that the pretherapy education impacted therapy dropout rates.

Similarly, Smith, Subich, and Kalodner (1995) found that clients’ readiness for change may help identify those who are at risk to prematurely drop out of therapy. These researchers found that clients who presented to therapy in the precontemplation stage of change dropped out of therapy significantly more than those clients who presented to therapy in the other stages of change. Together, these studies suggest that there may be means to identify clients who are at greater risk for premature termination as well as interventions that can be utilized to reduce rates.

Finding interventions to reduce premature termination rates is imperative due to the deleterious effects it has on clients, therapists, and available resources (Pekarik, 1985). Clients who drop out of therapy often continue to experience the symptoms they presented to counseling to ameliorate, therapists may experience lowered self efficacy and higher rates of burnout due to high premature termination rates, agencies can experience a significant loss of revenue from client cancellations and no shows (Pekarik),
and the field as a whole can be negatively affected by this phenomenon through the impact on therapy outcome research (Renk & Dinger, 2002). These are just a few of the problems that can result when clients prematurely terminate from therapy. The reasons identified above illustrate why this research is important to the field.

The purpose of this study is to explore an intervention designed to reduce premature termination from counseling using a comprehensive, standardized role induction procedure and a more sensitive definition of premature termination. Further, the role of client readiness for change as it relates to premature termination will be explored. The remainder of this chapter provides an overview of the literature on premature termination, role induction to counseling, and readiness for change to support the purpose of the proposed research.

Premature Termination From Counseling

According to a meta-analysis by Wierzbicki and Pekarik (1993), the average outpatient psychotherapy dropout rate or rate of premature termination from counseling was 46.86%. This high rate underscores the fact that premature termination is a significant issue facing therapists for a number of reasons. Pekarik (1985) suggested that premature termination may lead to negative consequences for the client and counselor, as well as being a drain on resources. For example, clients who terminate prematurely have less positive therapeutic outcomes, often return to therapy at a later time, and prior to their return to therapy, often continue to experience the negative consequences of the problem(s) they presented to therapy to ameliorate (Archer, Forbes, Metcalfe, & Winter, 2000; Carpenter, Morrow, del Gaudio, & Ritzler, 1981). Additionally, counselors may
experience premature dropout as a failure on their part and this may negatively impact their morale. Further, premature termination, which often starts with client cancellations and no shows, may result in unfilled client hours and subsequently preclude clients who require treatment from receiving it (Pekarik).

Finding a way to limit or decrease premature termination would be positive on many fronts. Clients would have a better chance to receive the treatment they need with a more positive outcome; resources, such as time and money, would not be wasted, and it might decrease the number of clients who leave and reenter therapy to address the same issue (Renk & Dinger, 2002). Further, premature termination is an issue that is going to be more important in the coming years with the growing impact of managed care. As resources continue to be difficult to acquire, identifying ways to limit waste and demonstrating therapy’s effectiveness are going to become increasingly imperative. Finally, premature termination may negatively impact therapy outcome literature and thus reduce the appearance of therapy efficacy (Renk & Dinger, 2002) leading to reductions in funding for mental health treatment. These issues illustrate the importance of studying premature termination and exploring interventions to reduce it.

However, a significant limit to the extant research on premature termination has been the failure to develop an agreed upon definition. For example, a study conducted by Hatchett and Park (2003) looked at four different definitions of premature termination used in the literature and explored the impact the definition had on the rates reported. The authors found definitions of premature termination that were based on therapist judgment or missed last appointment had a 40.8% rate of premature termination. Definitions that included failing to return for any appointment after intake led to a 17.6% premature
termination classification rate, and clients who failed to meet the median number of appointments in the entire data set led to a 53.1% rate of premature termination. This study illustrated how the definition used for premature termination greatly impacts the rates. It also showed how important it is to develop a standard definition of premature termination that can be used consistently in the literature. A definition of premature termination that can be used consistently will aid in the advancement of the literature by enabling researchers to build on each other’s research.

One potential problem with the definitions used in previous research is that they do not take into consideration the client’s perspective on therapy length (Mueller & Pekarik, 2000). That is, the definitions used in the literature are based primarily on therapists’ or researchers’ judgment that the client prematurely terminated from therapy. However, simply identifying a certain number of sessions needed to attend to be classified as either a premature or appropriate terminator is counterintuitive. Since the purpose of therapy is to help clients meet their goals and improve functioning, it would seem that clients’ perspectives would be important to include in the definition. This is one area where the literature is lacking.

Beyond definitions, some studies have explored potential causes for premature termination with differing results. For example, a study completed by Hardin et al., (1988) explored client expectancies for counseling and how these expectancies may impact premature termination. In this study, premature termination was defined as failing to return to therapy after the first session when the client agreed to do so. The findings indicated that there were no significant differences in pre-counseling expectancies for clients who returned for the next scheduled session and those clients who failed to return.
Although there were some limitations that will be addressed later, this study is a good example of researchers’ early attempts to identify reasons clients prematurely terminate from therapy.

Another study explored the relation between client readiness for change and premature termination (Smith et al., 1995). Again, the authors defined premature terminators as clients who failed to return to counseling after the first session when agreeing to do so. Results of this study indicated that premature terminators and non-premature terminators were distinguishable by the stage of change at which they entered therapy. All participants in the precontemplation stage of change terminated prematurely from therapy and all participants who entered therapy in the preparation and action stages continued after the first session. Specifically, clients who acknowledged their problems and were motivated to act on them were more likely to remain in therapy. This study illustrated that clients’ readiness for change can be related to therapy dropout and therapy continuation.

In summary, premature termination is an issue that impacts the field of counseling as well as clients and therapists. The small sampling of studies discussed above demonstrates several of the main problems with this line of research. The failure of researchers to agree upon a definition of premature termination as well as a lack of effective interventions to lower rates continues to be a problem. Specifically, expanding the research to identify interventions that may lower rates of premature termination instead of primarily focusing on ways to identify those who may prematurely terminate is a much needed shift in the research paradigm. Further, the lack of agreement on a standard definition for premature termination has limited progress in this line of research.
Advancements in this area may accrue by including clients’ perspectives in defining premature termination (Mueller & Pekarik, 2000).

Another area of need in the literature as identified above is the lack of intervention studies. The majority of studies in the literature explore constructs associated with premature termination from counseling such as client expectancies of counseling (Hardin et al., 1985) and readiness for change (Smith et al., 1995). One area of research that has shown promise in reducing premature termination, increasing clients understanding of therapy, and contributes to positive outcomes of therapy is the completion of a comprehensive role induction (Walitzer, Dermen, & Connors, 1999). The potential impact of a comprehensive role induction process coupled with an assessment of client readiness and a more sensitive definition of premature termination, may lead to a reduction in the occurrence of premature termination.

Role Induction to Counseling

Orientation to therapy is a process that typically occurs at the intake session or at the latest, the first session. This component of therapy is conceptualized as a means to educate the client about therapy (Zwick & Attkisson, 1985). When reviewing the literature, it is evident that an orientation is called many things such as *pretherapy training* (Reis & Brown, 2006), *orientation to counseling* (Zwick & Attkisson, 1985) and *informed consent to counseling* (Hass, 1991). Despite the different names used, in general, the process being discussed is the same with subtle differences. For the purposes of the current study the term role induction is used to refer to a process of educating clients regarding the expected content and process of therapy.
The role induction process should educate the client about therapy; clarify for the client what therapy entails and what therapy is not; the clients’ role in therapy, the therapist’s role in therapy; as well as provide information about confidentiality, fees, and length of sessions (Dauser, Hedstrom, & Croteau, 1995). However, role induction is an aspect of therapy that is typically approached in a cursory manner (Hass, 1991). Most therapists, when completing the initial informed consent/ role induction review only the most basic of information (Somberg, Stone, & Claiborn, 1993). This information often includes the limits of confidentiality, pay scales, and at best, a basic discussion of what the therapist’s approach to therapy might be. After this discussion, client questions are answered (Somberg et al., 1993). The underlying issue is whether or not this is enough to indoctrinate clients to therapy. More importantly, is it enough to impact the tendency toward premature termination? Some clients may present to therapy with a distorted view of what therapy is, what role they are going to play in sessions, and what the therapist actions will include (Corning, Malofeeva, & Bucchianeri, 2007). Failing to fully educate clients about therapy could have a significant impact on whether they return, and the level of investment if they do return, as well as impact the outcome of therapy. This makes role induction an important intervention point.

The completion of a comprehensive role induction may be an important mechanism to help clients make decisions regarding their readiness to enter into and increase their commitment to therapy, thus potentially reducing the occurrence of premature termination. A role induction that includes educating the client about what therapy is and is not, the importance of a mutually agreed upon initial problem focus, potential means for remediation of the problem(s), and the importance of agreeing on the
goals of therapy, may aid in increasing a client’s commitment to therapy (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Walitzer, Dermen, & Connors, 1999). Completing a role induction that includes these components may increase clients’ understanding of their role in therapy (Zwick & Attkisson, 1985), facilitate the development of the therapeutic relationship and allow clients to become invested in the process (Walitzer et al, 1999).

A study completed by Reis and Brown (2006) illustrated the importance of client education. The authors attempted to reduce premature termination rates by preparing clients for therapy through a role induction process. The results of the study indicated that education of the client about therapy did impact therapy drop out as determined by responses on the Termination Status Questionnaire (Reis & Brown) (TSQ) completed by the therapist. The TSQ was composed of 8 questions which ranged in point values from 0-8 with lower scores indicative of therapy dropout and higher scores as indicators of therapy completers. Therapy drop out scores were significantly lower for prepared clients (M=28.85) than for non-prepared clients (M=33.36) as shown by the main effect of preparation (p< .05). This study provided some evidence that educating clients about therapy potentially reduces the occurrence of premature termination.

Similarly, Zwick and Attkisson (1985) explored the effectiveness of a client pretherapy orientation video on client knowledge about therapy. The researchers randomly assigned clients to either receive orientation to counseling through a video or to a control group which received no pretherapy training. The oriented group correctly answered an average of 13.03 knowledge-based questions compared to only 9.43 in the control group and this difference was significant (p<.05). This study illustrated that a
video induction to therapy can be an effective means to educate clients about therapy. Thus, the use of a videotaped role induction may be an effective means to educate clients about therapy, under the assumption that increased knowledge will translate into reduced premature termination.

The above referenced studies demonstrate the importance of educating clients about therapy and that a role induction to therapy may be an effective means to accomplish this task. The use of a comprehensive role induction appears to have the potential to reduce premature termination rates and should be studied further in this context. Research has also linked client readiness for change with premature termination.

The Transtheoretical Model

Research conducted to date supports further exploration of client characteristics (Lampropoulos, Schneider, & Spengler, 2009) to examine their impact on premature termination. One potentially important client characteristic is a client’s readiness for change. The Transtheoretical Model is a framework through which client characteristics can be examined. The Transtheoretical model is an inclusive model which focuses on client characteristics such as readiness for change. Previous research has linked clients’ readiness for change with premature termination (Smith et al., 1995), and thus makes it a pertinent framework through which client characteristics can be explored.

The Transtheoretical Model was developed through a comparative analysis of leading theories of psychotherapy and behavioral change (Prochaska & DiClemente, 1982). From this analysis, the authors identified two core constructs, stages of change and processes of change. According to Brogan, Prochaska, and Prochaska, (1999), a client’s
status regarding readiness for change can have a significant impact on the outcome of therapy as well as on his or her commitment to therapy.

Stages of Change

Readiness for change as defined by Prochaska, DiClemente, and Norcross (1992), indicates that the client admits and accepts there is a problem and that he or she is ready to make the changes necessary to address the problem. The stages identified in the model are precontemplation, contemplation, action, and maintenance. During the precontemplation stage, the person has no intention to change, during contemplation, people are aware the problem exists and are seriously considering making changes to address the problem, but have made no commitment to take action. During the action stage, individuals modify their behavior, experiences, and/or environment to make the desired change and during the final stage, maintenance, people work to prevent relapse and consolidate the gains made during action (Prochaska & Norcross, 2003).

A study conducted by Smith et al. (1995) explored readiness for change and its relation to premature termination. The authors found some interesting results. In a college aged population, there were significant differences in readiness for change between those who prematurely terminated therapy and those who did not. The findings indicated that clients who presented to therapy in the precontemplation stage of change were more likely to prematurely terminate therapy than those clients who presented to therapy in the preparation or action stage. This study demonstrated the importance of assessing clients’ readiness for change and how it may be related to premature termination.
It is easy to see how the person’s readiness for change could have a significant impact on therapy attendance and outcome (Brogan et al., 1999). For example, a person in the precontemplation stage is not ready to admit there is a problem and consequently may not see the value in engaging in therapy. Whereas, a person who is in the action stage would be more committed to making a change and thus may be more committed to attending therapy regularly (Smith et al., 1995). A client’s readiness for change or stage of change can have a significant impact on therapy outcomes (Derisley & Reynolds, 2000) and is an important factor to consider when attempting to reduce premature termination.

Although there is support for the value of the Stages of Change model, especially in addictions treatment, it is not without its critics. Researchers have argued about the conceptualization of discrete stages of the model, the measures used to assess stage of change, what behaviors/beliefs define a stage (Derisley & Reynolds, 2002; Wilson & Schlam, 2004), as well as the value of the model outside of addiction treatment (West, 2005). Further, even though several of the stages of change have been associated with premature termination, the research is inconsistent with regard to the model’s usefulness in identifying those clients who are at risk (Brogan et al., 1999; Derisley & Reynolds, 2000). Despite the critics, the model does appear to have heuristic value especially at the start of therapy and in relation to premature termination (Smith et al.). This makes it an important factor to consider when exploring premature termination and ways to decrease this negative outcome of therapy.

Premature termination is an outcome of therapy that can have negative consequences for the client, the therapist and for the limited resources available (Archer,
Forbes, Metcalfe, & Winter, 2000; Carpenter, Morrow, del Gaudio, & Ritzler, 1981). Identifying interventions to minimize premature termination is needed (Barrett et al., 2008). As previously stated, one problem with this research is the definition used for premature termination. Currently there is no consensus in the literature on how to define premature termination or what constitutes premature termination from therapy. Further, most definitions fail to take the clients perspective into account which has been identified as important in numerous studies (Mueller & Pekarick, 2000; Pekarik & Wierzbicki, 1986). Identifying the number of sessions that both the client and therapist commit to at intake may make the construct of premature termination meaningful for the client and therapist. Including an idiographic component in the definition of premature termination may increase our understanding of the phenomenon and result in a more useful categorization. A recent literature review by Barrett et al., 2008, has shown that completing a thorough and educative role induction prior to the start of therapy may have positive impacts on clients’ understanding of therapy and, consequently premature termination rates. Educating clients using a thorough role induction should impact premature termination in several ways.

First, if the client is given the opportunity to make an informed choice about committing to counseling or ending therapy at intake, rates of premature termination may be reduced. This reduction might occur by differentiating between clients who make a reasoned decision to not engage in therapy from those who initially choose to enter into treatment but then discontinue prior to completion of treatment (i.e. premature termination). If the client is prepared to engage in therapy, after learning what therapy is
and is not, he or she can commit to a determined number of sessions with the therapist at this time.

Second, after the role induction, the client may have a greater knowledge about therapy and his or her role in the process and thus, may have fewer unmet expectations. As previous studies have shown, unmet expectations and failing to agree on the problem and goals of therapy are associated with premature termination (Corning, Malofeeva, & Buchhianeri, 2007). Thus this potential contributor to premature termination may be reduced by employing a comprehensive approach to role induction.

Third, a commitment by client and therapist to a specific number of sessions may enhance the development of the therapeutic alliance. The discussion about therapy length and the commitment by the therapist and client to a specified number of sessions should help the client feel connected to the therapist and enhance the therapeutic relationship. As has been shown repeatedly in the literature, a strong therapeutic alliance leads to positive outcomes in therapy (Wampold, 2001).

Fourth, educating clients through a thorough role induction may decrease the negative effect of a lack of readiness for change. A client’s readiness for change has been shown to be associated with premature termination in several studies (Brogan et al., 1999; Smith et al., 1995). Part of a client being ready to make a change is being educated about the process of therapy and understanding therapy which can occur during a role induction.
Purpose of the Study

The first purpose of this study is to explore the impact of a standardized role induction to therapy on premature termination. Role induction to therapy has been shown to be a possible means to educate clients about therapy, dispel misconceptions about therapy and be related to premature termination. A comprehensive role induction will be used in this study to educate clients about therapy and their role in therapy, as well as demonstrate in therapy behaviors.

The second purpose of the research is to explore the impact of an idiographic definition of premature termination on the occurrence of premature termination found in the study. Clients will be classified as premature terminators if they fail to attend the number of sessions they agreed to attend with the therapist. This is different than definitions often used for premature termination because it includes both the client and counselors’ perspective and agreement on number of sessions to attend. Based on this definition, premature termination rates of this study will be compared with average rates found in the literature to determine the impact of the definition.

The third purpose of the study is to explore if a comprehensive role induction will impact clients’ readiness for change. Previous research has shown that a client’s readiness for change, which is determined by the clients’ stage of change at intake, is related to premature termination. Specifically, clients who are less ready for change prematurely terminate therapy at higher rates than clients who are more prepared to make changes. This study will investigate if a client’s stage of change can be impacted by a comprehensive role induction. Exploring the impact of a comprehensive role induction on
premature termination in conjunction with stage of change will advance the literature in this area.
CHAPTER II

LITERATURE REVIEW

Introduction

Premature termination is a significant issue facing clients, therapists, and service providers. Wierzbicki and Pekarik (1993) estimated that approximately 46.8% of clients prematurely terminate counseling. The negative impacts of premature termination are experienced by most of those involved in counseling. For example, clients who drop out of therapy often continue to experience the negative effects of the presenting problem they initially entered counseling to address (Barrett et al., 2008; Pekarik, 1983) and return to therapy at a later date (Pekarik, 1985a). Counselors may experience a lowering of self-efficacy and work satisfaction when faced with high rates of premature termination and these effects may lead to higher rates of burnout (Pekarik, 1985b; Reitzel et al., 2006). Furthermore, Pekarik (1985a) has suggested that the counseling field as a whole is negatively impacted by high rates of premature termination because of the impact this can have on outcome literature and the perception of therapy efficacy. Last, the financial impacts can be felt by all those who provide clinical services. Wasted time and resources are a significant outcome of premature termination (Barrett et al.). These reasons are not an exhaustive list of the many negative impacts of premature termination; however, they do illustrate the importance of reducing the rates of premature termination.
Premature termination has been studied in a variety of settings, such as college counseling centers (McNeil, May, & Lee, 1987; Renk & Dinger, 2002), community mental health agencies (Reitzel et al. 2006; Terrell & Terrell, 1984) and private practice clinics (Mueller & Pekarik, 2000). Studies have found that premature termination is a significant issue facing service providers with rates varying across settings. For example, community mental health settings report that about 40% of clients terminate after the first or second session and private practice settings report that approximately 20% terminate within two visits and 50% by the 10th (Pekarik & Wierzbicki, 1986). These rates show that this is an issue that is pervasive and important in a variety of settings.

Many variables have been explored in an attempt to identify factors that are associated with premature termination. These have included client variables (Williams, Ketring, & Salts, 2005), definitions of premature termination (Hatchett & Park, 2003), and clients’ readiness for change (Derisley & Reynolds, 2000). However, research to this point has had limited success in identifying means to reduce premature termination for several reasons. First, the lack of consensus in the literature on a definition of premature termination is a significant limitation cited in the literature (Barrett et al., 2008; Hatchett & Park) that has negatively impacted progress. A second potentially significant issue is the exclusion of the clients’ perspective on therapy and therapy length (Mueller & Pekarik, 2000). Third, the literature is lacking intervention studies designed to reduce rates of premature termination (Barrett et al.). Although some progress has been made, an identified and empirically supported intervention to reduce premature termination has yet to be identified.
The following review focuses on the definition of premature termination from therapy, research on the construct of premature termination across settings, and research on client variables associated with premature termination. This review of the literature culminates in a rationale for the present study investigating the impact of a role induction intervention on premature termination from therapy using an idiographic definition of premature termination.

Defining Premature Termination

Research on premature termination has been severely limited by the lack of consensus on its definition (Hatchett & Park, 2003). Most research to date has defined premature termination based on an arbitrary number of sessions or has allowed therapists to identify clients as premature terminators based on their judgment (Hatchett & Park). However, these definitions indicate the lack of consensus in the literature on how to define premature termination as well as highlight the lack of clients’ perspectives in defining the construct (Mueller & Pekarik, 2000). More importantly, research has established that the rate of premature termination found in a sample is greatly impacted by the definition used (Wierzbicki & Pekarik, 1993).

A study completed by Hatchett and Park (2003) illustrated the considerable impact the definition used can have on rates of premature termination. The authors explored four often used definitions of premature termination from the literature: therapist judgment (Williams, Ketring, & Salts, 2005), failure to attend the last scheduled appointment (Terrell & Terrell, 1984), failure to return after intake (Hardin, Subich, & Holvey, 1988), and median split procedure (Pekarik, 1985b). The median split procedure
uses the median number of sessions attended by the sample as the dividing point for those
who prematurely terminated and those who did not. Hatchett and Park found large
differences in premature termination rates depending on the definition used ranging from
17.6% to 53.1%. They concluded that two of the definitions (median split procedure and
intake only definition) had little agreement with the other definitions of premature
termination while the other two (therapist judgment and failure to attend the last
scheduled appointment) had exactly the same rates in the study. The authors proposed
that different definitions of premature termination may be measuring different constructs
and should not be used interchangeably. Further, the authors recommended that a better
measure or definition of premature termination should be developed and consistently
used in the literature.

Despite the importance of the findings, the limitations need to be considered. The
sample consisted solely of college students presenting for counseling at a small university
in the southeastern United States. Due to the homogeneity of the sample, the results may
not be applicable to other clients seeking counseling services in different sections of the
country or in different counseling settings. Another limit of the study was the authors’
failure to define premature termination to the therapists in the study. The therapists were
asked if their clients prematurely terminated without a clear definition, thus, each
therapist may have had a different idea of what constituted premature termination. So,
each therapist may have been rating different behaviors and outcomes as premature
termination. Nonetheless, the study highlights the effect the definition used for premature
termination can have on rates found.
An earlier study exploring the impact of different definitions in premature termination research was conducted by Pekarik (1985b). In this study 152 outpatient clients from a private mental health clinic were classified as therapy dropouts or completers based on therapist judgment and using the median split procedure. Differences in the groups were investigated using 18 variables. These included demographic characteristics of the clients: age, sex, place of residence, race, social class, Title IX eligibility, referral source, marital status, previous therapy experience, insurance coverage, education, income, type of treatment, clients expected number of visits and four therapist variables (experience, training level, preferred length of therapy, and type of treatment typically utilized). Results indicated significant differences between premature terminators and therapy completers on 11 of the 18 client and therapist variables when the classification was made using therapist judgment. However, when the classification was made using the median split procedure, no significant differences were found between the groups on the studied variables. Comparing the methods in terms of classification efficacy, therapist classification was significantly better (chi square, p<.001) than therapy duration or median split in distinguishing premature terminators and therapy completers.

The results supported the hypothesis that the therapist classification procedure was superior to median split procedure in identifying those who prematurely terminated from therapy. Pekarik (1985b) also asserted that there are conceptual differences between clients who end therapy early and those who prematurely terminate, and that the classification criteria used are important. If classification between premature and appropriate termination is based solely on duration criteria, clients could easily be
identified inappropriately as premature terminators. One limitation of the research was that the participants used in the study were overwhelmingly white females. Men and ethnically diverse clients may have different experiences which could limit the applicability of the results to these populations. However, a significant strength of the study was that the author explored many variables, strengthening the assertion that the therapist classification procedure is a stronger method of classification than some used in the literature.

Mueller and Pekarik (2000), explored the association between client predicted treatment length and actual treatment length in a private practice setting. Two hundred and thirty clients who presented for treatment to a consortium of practices participated. At intake, clients were asked to estimate expected treatment length as well as complete measures of adjustment. The measures utilized included the Brief Symptom Inventory (BSI; Derogatis, 1982) and a six-item daily routine scale designed to assess the impact of emotional distress on several aspects of the client’s life. The clients were also asked to identify, in writing, the main presenting problem and rate problem severity using a 13-point continuum. Last, clients completed a well-being scale designed to assess general emotional adjustment and general distress.

Therapists were also asked to estimate treatment length after the intake session. The results indicated that both clients and therapists expected a greater number of sessions than were actually conducted and therapists expected longer treatment duration than clients. Client expected number of visits and therapists expected number of visits were both significantly related to the actual number of sessions attended. However, client expected number of visits was more strongly related to the actual number of visits and
was the single best predictor of the number of sessions attended ($R^2 = .10$) of the variables included in the step wise regression analysis. These results highlight the importance of talking to clients about therapy and incorporating their perspective when making judgments regarding therapy length.

A significant strength of this study was the use of the client’s perspective. This is something generally lacking in research on premature termination and the results indicated that it is an important consideration. Despite the important results, the study was not without limitations. One limitation was that participants were drawn from a private practice setting only. Clients who receive services at a private practice setting may be different than those who seek services in other settings such as community mental health and college counseling centers. Thus, research should be completed in diverse settings to determine the applicability of the results with different client populations.

Another study that explored the relation between clients’s expected and actual treatment duration was conducted by Pekarik and Wierzbicki (1986). The sample in this study included 148 clients who presented to a private, nonprofit, mental health clinic for services. The researchers found that clients expected and attended a low number of sessions. Further, increased attendance was related to clients expecting to attend a large number of sessions, higher social class, eligibility of Title IX assistance, and therapists preferring therapy aimed at personality change. However, a regression analysis found that of these variables, only clients’ expected number of visits significantly increased the prediction of actual number of sessions attended. The correlation between expected and attended visits was .28 ($p<.01$). The results indicated that client expectations about treatment length are related to treatment duration, again highlighting the importance of
including the clients’ perspective when discussing the length of therapy and subsequently, in making judgments regarding premature termination.

In summary, the literature to date has used many different definitions of premature termination. This fact has been cited in the literature as one factor that accounts for the wide range of reported rates. Specifically, researchers have utilized arbitrary numbers of sessions and therapists’ judgments as classification criteria for premature termination as well as other definitions. Additionally, definitions that have been used fail to take the clients’ perspective into account. Based on some limited research (Mueller & Pekarik, 2000) clients’ expectation about length of therapy may be an important component that should be included in any definition of premature termination.

The present study therefore, seeks to remediate several of the problems in the literature by using an idiographic definition of premature termination. In this study each client, with his or her therapist, will discuss the expected length of therapy and both will commit to a specific number of sessions to be completed. Clients who complete the agreed upon number of sessions will be classified as non-premature terminators. Clients who terminate therapy in agreement with their therapist prior to completion of the agreed upon number of sessions will also be classified as non-premature terminators. Those clients who otherwise fail to complete the number of sessions agreed upon at intake will be classified as premature terminators. This definition of premature termination takes into consideration the client’s perspective on therapy length and is hypothesized to increase the meaningfulness of the classification. The importance placed on the client’s perspective is based on research that found significant relations between clients expected
number of counseling sessions and actual number of counseling sessions attended (Mueller & Pekarick, 2000; Pekarik & Wierzbicki, 1986). Clients who at intake, decide not to continue services will not be considered premature terminators because these clients will have decided, after a discussion with the therapist, not to seek services at this time.

Research on Premature Termination Across Settings

A recent literature review on premature termination was conducted by Barrett, Chua, Crits-Cristoph, Gibbons, and Thompson (2008). The authors discussed and made recommendations about premature termination, identified problems in the research to date, provided a review of interventions designed to reduce rates, and identified future practice and research needs in this area. The authors reiterated the importance of addressing premature termination for many of the reasons discussed previously such as negative consequences for clients, agencies, service providers, and the field as a whole. The review also indicated that the lack of progress in the research is partially due to methodological problems including the range of definitions used for premature termination. Additionally they identified six broad categories of impacts on premature termination: client characteristics, enabling factors or barriers, need factors, environmental factors, perceptions of mental health and mental illness, and beliefs and assumptions about mental health treatment. Client characteristics are the factors that clients bring with them to therapy such as gender, beliefs and or expectations about counseling, and ethnicity. Enabling factors or barriers are factors that enhance or obstruct service seeking such as income level, insurance coverage, social support, time on wait
list, and difficulty finding mental health services. The third cluster relates to the client’s need for services and includes his or her diagnosis, prognosis, psychological mindedness and comorbid issues. The fourth category deals with environmental factors such as access to care, treatment setting, and type of treatment. Perceptions of mental health and mental illness constitutes the fifth category. The sixth cluster, assumptions about treatment, addresses client thoughts and beliefs about counseling services. These factors encompassed many of the client characteristics that were found to impact therapy attendance and commitment.

The authors also addressed the evidence in the literature that minority individuals, many of whom are economically disadvantaged, are at a higher risk of drop out than other clients. The authors discussed the need to educate clients about the process and goals of therapy using role induction as a means to reduce the rates of premature termination in this group. They went on to state that if therapists are to be effective they must have an appreciation and awareness, or multicultural competence, for the hardships of poverty, social class, and ethnicity.

Based on their review, Barrett et al. (2008) stated that the most empirically supported intervention was pretherapy training or role induction to counseling. A role induction to counseling can help lessen the impact of the above factors on therapy attendance and hopefully promote more positive therapeutic outcomes. The authors summarized the literature by stating that role induction to therapy is the most promising means to reduce premature termination. According to Barrett et al., future research should include exploring the impact a comprehensive role induction has on premature termination in naturalistic clinical settings.
A meta-analysis of the variables associated with psychotherapy dropout rates or premature termination was completed by Wierzbicki and Pekarik, (1993). These researchers explored a variety of variables in an attempt to delineate the reasons for therapy dropout. The authors included 125 studies, all of which met the following inclusion criteria: were published in English, reported a psychotherapy dropout rate, included actual therapy clients, and were not limited to drug and alcohol clients. The studies used were from a wide variety of treatment settings, inclusive of many different client diagnosis and treatment types. The mean drop out rate across all studies was 46.86% (95% CI 42.9-50.82). Dropout rates were explored as a function of categorical variables and it was found that premature termination rates were not significantly related to treatment mode, setting or clients. However, premature termination rates differed significantly as a function of the definition of termination used (p<.05). The definitions used were termination by failure to attend a scheduled session, therapist judgment and number of sessions attended. The authors also found that studies which defined premature termination as failure to attend a scheduled session reported lower rates than those that defined it using therapist judgment or the number of sessions attended. This result again underscores the importance of the definition used for premature termination and the significant impact the definition used can have on rates of premature termination.

In terms of the meta-analysis, only variables for which there were at least 10 effect sizes were included which limited the analysis to the following six demographic variables: sex, race, age, education, SES and marital status. Mean effect sizes for the demographic variables were calculated yielding three significant results: Race (.23), Education (.28) and SES (.37), indicating that psychotherapy dropout is significantly
related to minority racial status, low education, and low SES. The results were further summarized as indicating that premature termination is a complicated issue and that client variables are not the only factor in premature termination; however, client socioeconomic status is strongly associated with premature termination. Based on this review, a majority of the variables typically utilized in premature termination research were not strongly associated with premature termination and the authors suggested that other variables should be explored including the interaction of client and therapist variables and client expectations of therapy.

The studies used in the meta-analysis were from a wide range of settings, client diagnoses, and treatments and thus, the findings should generalize to many clinical contexts and clients. However, the authors cautioned that the research reviewed often lacked sufficient data to permit the calculation of effect sizes for the meta-analysis. With the exclusion of those studies, the authors suggested the results must be viewed as upper estimates of the true values strengthening their assertion that other variables impacting premature termination must be explored further. The next study explored the impact of client and therapist variables.

Corning, Malofeeva, and Bucchianeri (2007) completed a study at a university counseling center that explored the utility of predicting termination type from therapist/client discrepancy on severity of the presenting problem. A client was classified as a premature terminator if he or she discontinued therapy on his or her own, failed to attend a scheduled appointment and/or ended therapy without mutual agreement with his or her therapist. Four hundred and fifty three clients and their therapists were included in the study. Prior to intake, each client was asked to rate the severity of his or her
presenting problem. After completion of the intake session, each therapist was asked to
determine the severity of his or her client’s presenting problem.

The results of the study indicated that greater discrepancies between the client and
therapist about the severity of the presenting problem lowered the odds of mutual
termination for most presenting problems in the study. The researchers also completed
interaction tests of client-therapist discrepancies and session number in an attempt to
clarify the results. For clients whose presenting problems were family of origin issues or
symptoms of depression, the likelihood of premature termination remained stable even as
the number of sessions increased when there was a large discrepancy of problem severity
between the client and therapist. However, for clients with the same presenting problems
who had moderate or nonexistent discrepancies, the likelihood of premature termination
diminished as session number increased. The authors summarized the results by stating
that therapist and client communication and congruence on the presenting problem and its
severity is important to developing the therapeutic relationship which leads to positive
therapeutic outcomes including remaining in therapy.

A strength of the study was that the researchers included the clients’ perception of
the problem and explored the negative impact of divergent views between client and
therapist. This study highlights the importance of the client and therapist having an open
discussion about the presenting problem and agreeing on its severity. One limitation of
this study was that the clients’ perception of problem severity was assessed prior to
intake, while the therapists’ perceptions were assessed post intake. This time difference
between client and therapist assessment may have impacted the perception of the problem
and inflated the discrepancy. Another limitation was the definition of premature
termination. Therapists classified clients as either premature terminators or not. The researchers failed to include the client’s perspective on termination. Despite these limitations, the results suggested that the agreement between therapist and client on presenting problem severity is important and can enhance the relationship and potentially reduce the risk of premature termination.

Another study that explored potential causes for premature termination was completed by Reitzel et al. (2006). These researchers explored the relation between timeliness of case assignment to a therapist and client termination. Two different definitions of client termination were explored: nonattendance to therapy after initial screening but before intake and premature termination after therapy had been initiated. Timeliness of case assignment was conceptualized as the number of days the client waited between the screening appointment and assignment to a therapist for an intake appointment. The participants in the study were all adult clients who presented to an outpatient clinic affiliated with a university over a 5-year period (N=313). The authors also explored potential moderators of the relation between the timeliness of case assignment and premature termination. The moderators explored included, patient ethnicity, gender, age, personality disorder diagnosis, and symptom severity. The results of this study suggested that the length of time between the initial screening and assignment to a therapist was significantly related to nonattendance to therapy (p<.002) but not to premature termination once therapy had begun. The research also found that none of the moderators explored in the study significantly impacted the relation between case assignment and premature termination. This study showed how the definition of premature termination can greatly impact results as well as how a time delay for
receiving services can be connected to therapy drop out. The authors surmised that wait
time can impact therapy dropout prior to the start of therapy however, the impact
dissipates after therapy has begun.

One area of strength of this study was the clear definition of premature
termination. This allowed for a less ambiguous picture of potential causes of premature
termination at different times in therapy. Results of the study should, however, be
interpreted in the context of its limitations. For example, the length of time between
assignment to therapist and the first session was not taken into account, nor was the
length of time between the clients’ initial call to the clinic and the screening appointment.
Both of these issues may have impacted the results and rates of premature termination
found in the study. Despite these issues, the results highlight important findings.

Renk and Dinger (2002) explored reasons for therapy termination in a university
psychology clinic by completing a record review of closed cases. The researchers
examined 366 files and recorded reasons for termination graduate student therapists
documented in the files. Most frequently documented was that clients stopped attending
therapy with no reason given. This was documented in 35.8% of cases (131 total). Where
reasons were given, the most recorded reason was mutual agreement of termination or
client satisfaction with services which occurred in 23.5% of cases or 86 total. Client
difficulty unrelated to treatment was the reason cited for termination in 19.9% of the
cases or 73 cases. Of the remaining cases, 11.5% documented that the client sought
services elsewhere and 8.5% identified dissatisfaction with services as the reason for
terminating services. Therapists terminated services in only .8% of the cases. An
interesting finding of the study was that 15.6% of the clients failed to return after intake.
The results showed that a large number of clients failed to discuss ending therapy with their therapist prior to ending counseling. One hundred and thirty one or 35.8% of the 366 participants stopped attending therapy without discussing it first.

Limitations of the study included the following. All therapists whose files were reviewed were therapists in training. Thus, trainee experience levels may have impacted the occurrence of premature termination. Another limit of the research was that 10% of the cases reviewed were excluded because nothing was documented in the record regarding termination. This may have impacted the results in ways that can not be determined. Other studies have explored potential patterns of premature termination.

Edlund, Wang, Berglund, Katz, Lin, and Kessler (2002) conducted a study designed to examine patterns and predictors associated with premature termination. The authors interviewed individuals who had been treated for mental health problems in the preceding year. The participants were drawn from an epidemiological survey conducted in the U.S. (n=830) and Ontario, Canada (n=431). The authors defined premature termination as leaving mental health treatment for reasons other than symptom improvement. A unique aspect of the study was that the information on termination was gathered from the clients, not therapists. The authors contacted the clients and inquired why they had stopped attending therapy. Other information that was gathered from the clients included socioeconomic data, clients’ attitudes about mental health care, diagnosis, provider type and treatment type received. This information allowed the authors to explore demographic information that may have been related to therapy termination.
In this study, clients were asked to endorse reasons they dropped out of treatment from a list given to them in the survey packet. Those who failed to endorse a decrease in symptoms as the reason for stopping treatment were classified as premature terminators. Overall, the researchers found premature termination rates of 19% in the United States and 17% in Ontario. These rates were lower than most estimates found in the literature. The authors attributed these lower rates to the very conservative definition of premature termination used in the study. However, one could also attribute the lower rates to the fact that the authors included the client’s perspective on therapy and symptom improvement as the main identifier of therapy termination type.

Edlund et al. (2002) also explored client attitudes about treatment and their relation to premature termination. The independent effects of clients’ attitudes about mental health care on premature termination were explored after controlling for country, demographic variables, diagnosis, provider information, and number of visits. Results indicated that clients’ attitudes about treatment were significantly related to drop out (p<.001) in the omnibus test. Compared with clients who reported being very comfortable seeking mental health services, the relative odds of dropout were 2.4 (95% CI=1.4-4.1) among those who reported being very uncomfortable, 2.7 (95% CI=1.7-4.2) among those who reported being somewhat uncomfortable, and 1.6 (95% CI =1.1-2.2) among those who reported being somewhat comfortable. The results further indicated that clients who perceived therapy to be ineffective had relative odds of dropout of 1.6 (95% CI =1.2-2.2) compared to those in the study who believed therapy efficacy to be high. The results indicated that those who believed mental health treatment is not effective were more likely to prematurely terminate than were those who reported feeling uncomfortable in
treatment. Finally, age and insurance coverage were the only significant individual predictors of premature termination, with odds ratios of 1.64 (95% CI =1.01-2.64) and 1.54 (95% CI =1.04-2.30) respectively. This study found the highest occurrence of premature termination was among young clients and those without insurance. The authors concluded that educating clients about the efficacy of mental health treatment may positively impact premature termination rates. They further recommended working to reduce the stigma associated with engaging in mental health treatment as a potential means to reduce premature termination.

One of the strengths of the study was the large sample pool from two countries. Another strength was that the focus of the research was on the client’s perspective, providing a unique insight into reasons clients end therapy. One limit of this study was that the data were gathered retrospectively, introducing recall bias. Another limitation was the lack of therapist perspective. Therapist reasons for termination were not explored and may have provided interesting differences in the incidence of premature termination and reasons for therapy end. Despite these limitations, the study provided information that may be helpful in combating premature termination, such as the importance of client education about therapy and the value of the client’s perspective on therapy progress. A study that explored both perspectives is discussed next.

Hunsley, Aubry, Verstervelt, and Vito (1999) completed a study which explored the degree of agreement on the reasons for therapy termination given by therapists and their clients. One hundred and ninety-four client files from a psychology training clinic were reviewed to obtain the reasons for termination documented by therapists. Eighty-seven of these clients were contacted via telephone to acquire their perspective on
reasons for ending therapy. During the telephone interview, clients were asked to rate the importance of 10 possible reasons for terminating counseling. The comparison found little consistency between the therapist’s documented reasons and the client’s reasons for ending therapy. The primary reasons documented by therapists were that the client reached his or her goals (25.8%) or had no interest or time to continue services (20.6%). Only 3.1% of clients were perceived to have ended therapy due to dissatisfaction with services. Further, a large number (13.9%) terminated services without the therapists having a clear understanding of why.

In contrast, approximately 44% of clients contacted stated they terminated therapy because they had met their goals. Other reasons endorsed by clients as important were they felt therapy was going nowhere (34%), therapy did not fit their ideas about treatment (30%), they lacked confidence in the therapist (30%), they were experiencing financial difficulties (25%), or they decided to seek services elsewhere (25%). The authors summarized the findings by stating that therapists were able to identify when termination was influenced by the client meeting his or her goals. However, when the reason was one of the others discussed above, therapists were not as accurate. The general lack of correspondence between client and therapist is a significant issue in premature termination literature and appears to have a substantial effect on the occurrences reported. The authors recommended that clients and therapists discuss termination and the reasons for it to ensure both understand the reasons clients wish to end therapy. The authors also suggested that therapists should discuss potential difficulties that may be experienced in therapy in the hope that this will improve the therapeutic relationship and subsequently
reduce premature termination. One potential way to accomplish these recommendations is through the use of role induction.

Hunsley et al (1997) improved on previous research by including both client and therapist perspectives. However, the ability to draw clear conclusions is limited because the therapist data were collected from files unlike the client data which was collected from the clients themselves. That is, therapists may have been hesitant to document negative reasons for termination such as lack of progress or poor therapeutic alliance in the files whereas, they might have been more willing to talk about these reasons.

Another study explored client reasons for ending therapy (April & Nicholas, 1997). The clients contacted in the study had sought services at a college counseling center and were classified as premature terminators by their therapists. Premature termination was defined as failure to return for any subsequent scheduled session. Forty-eight clients were sent questionnaires to gather their reasons for ending therapy and twenty responded. The questions included both open and closed questions. The results indicated that of those who participated, 32% felt counseling was no longer needed and 27% stated that academic demands precluded them from continuing. Only 18% stated that counseling was a negative experience and that was the reason they terminated services. Eighty percent of those who responded stated that counseling was valuable and they would return to counseling in the future if necessary. The average attendance was 3.5 sessions and 75% of the clients attended between one and six sessions.

The strength of April and Nicholas’ (1997) research was the exploration of the client’s beliefs about counseling and reasons for ending therapy using open and closed questions. This allowed clients to express their thoughts and feelings about counseling in
their own words. However, this research was not without limitations. The study’s small sample size limits its generalizability. Another limit is the potential differences in reasons for ending therapy of those who failed to return the questionnaire versus those who did respond. This response bias likely impacted the results of the study.

Lastly, Pekarik (1985a) conducted a review of premature termination literature in an attempt to explore the scope of the problem, identify possible reasons for premature termination and explore points of intervention to decrease rates of premature termination. He summarized the literature by stating that prevalence rates of premature termination varied from 30-60% across outpatient settings and that mental health centers were reporting over 40% of those who entered therapy attended only 1-2 visits. This is in stark contrast to most therapists who believe that therapy should last from 20-40 visits or 10-20 visits in brief therapies. A main problem with the high rates identified by Pekarik was the personal and economic costs of premature termination to clients, providers, agencies and society. Clients who prematurely terminate therapy are negatively impacted because they often continue to experience the poorest of outcomes including continuing to experience the negative symptoms that brought them to counseling. Agencies are negatively impacted because of the financial costs associated with missed appointments including those associated with clerical and clinical staff time. Further, cost effectiveness is reduced when clients prematurely terminate because they often return to therapy and start the process over. Societal impacts of premature termination he identified included the perception that therapy is not effective. For example, therapy may be perceived to be ineffective due to high rates of premature termination and because clients often return to therapy more than once to address the same presenting concern. Lastly, high premature
termination rates can lead to a lowering of job satisfaction and performance of providers, which in turn can lead to increased staff turnover.

Pekarik (1985a) next attempted to identify potential causes of premature termination in his review of the literature. He stated that the literature was inconclusive in this regard and that a main reason for a lack of consensus in the literature related to premature termination was methodological problems with the research. Inconsistency in the way premature termination is defined was identified as a major obstacle here. Pekarik further asserted that client-therapist differences in expected length, content, and goals of therapy may be the largest factor impacting rates of premature termination. He recommended that researchers and therapists utilize procedures designed to increase the duration of treatment and use interventions that work for the client in a shorter time frame. Further, he suggested using pretherapy preparation or role induction as a means to educate clients about therapy, explain expectations of client behavior in therapy, the therapist’s role and behaviors in therapy, and common problems experienced in treatment. Finally, he stated that using pretherapy training might be an important approach to reducing premature termination.

The research reviewed above on premature termination across settings highlights several important considerations. Research to date has been unable to determine a clear reason for the high rates of premature termination, although, several variables have been consistently found to be linked to premature termination. These include variations in defining premature termination as well as a lack of agreement between the counselor and client on presenting problem and therapy length. For example, Renk and Dinger (2002) found that the reasons clients gave for ending therapy were significantly different that
what therapists documented in the case file. This difference highlights an important lack of attention to the clients’ perspective in therapy. Most definitions of premature termination have excluded the clients’ perspective and based on some of the research reviewed above, it appears that this is an area that needs to be addressed in future research.

Another area of focus in the premature termination literature has been on the relation between client variables and premature termination. The research reviewed next has attempted to identify potential characteristics of clients who are prone to prematurely terminate therapy.

Research With Client Variables

Williams, Ketring, and Salts (2005) conducted a study to explore how, if at all, client ethnicity interacts with client gender, therapist gender, therapist ethnicity, and client’s socioeconomic status (SES) to affect premature termination. The authors utilized three different definitions of premature termination to explore potential differences in rates and interactions as a function of the definition used. The definitions included were termination after one session, termination prior to six sessions, and premature termination based on therapist classification. The authors reviewed 527 case files from a marriage and family center affiliated with a university to gather the data. Of the 527 total participants, 93 were African American females, 27 were African American males, 307 were European American females, and 100 were European American males. Income ranged from less than $5,000 to more than $50,000. The therapists (48) were master’s students with less than 500 hours of clinical experience.
The results of chi square analyses indicated that the only demographic variables associated with premature termination were client income and therapist ethnicity. The next analyses compared premature termination, client ethnicity, and each of the demographic variables. Statistically significant results suggested that client SES was interrelated with several other variables included in the study such that the combination of client SES and ethnicity differentiated premature terminators from those who continued therapy. European American clients with higher SES and African American clients in the lowest SES category had higher rates of premature termination. Additionally, clients of African American female therapists had lower than expected premature termination rates while those of European American female therapists had higher than expected rates. However, when the definitions for premature termination of less than six sessions and therapist classification were used, counseling dyads of the same ethnicity had higher than expected rates. The results illustrated the complex nature of premature termination as well as the significant impact different demographic characteristics can have on premature termination.

The authors summarized the results by stating that premature termination is a complicated issue with no easy answer. The results indicated that many factors interact to impact whether clients remain in therapy or prematurely terminate. A limitation identified by the researchers was that couples, families and individuals seeking services across six years were pooled together into one data set which the authors felt may have limited potential information pertaining to specific therapeutic issues and its relation to premature termination. The strength in this study was the large data set that allowed for the analysis of the complex interactions.
Another study that explored the impact of client variables on premature termination was conducted by Kazdin, Stolar, and Marciano (1995). The researchers designed the study to explore factors that may predict dropping out of treatment among Black and White children and families who were seeking outpatient treatment. In the study, premature termination was defined as a unilateral decision to end treatment by the parents or family against the advice of the clinical team. Completion of treatment was defined as completing the full treatment regimen determined by the therapist. Two hundred and seventy nine children and families were included in the study. The overall rate of premature termination in the study was 48%, with Black families prematurely terminating at a significantly higher rate (59.6%) than White families (41.7%) (p< .01). White and Black families’ rates of premature termination were impacted by stress in the family, antisocial behavior of the children, parental history of antisocial behavior, and adverse child rearing practices. The results supported socioeconomic disadvantage as a predictor of premature termination for both White and Black families.

Although Black families dropped out of treatment at a greater rate and earlier in treatment than White families in this study, both groups demonstrated high rates of premature termination. The authors summarized the results by stating that major segments of people are not getting the help they need due to premature termination from therapy for a variety of reasons. The authors acknowledged the need for providers to identify those who are at a greater risk for drop out and to develop strategies to engage these higher risk clients in treatment.

One significant limitation of the study was that the participants were all referred to treatment for the child’s disruptive behavior. Thus, the results of the study may be
more applicable for families who have children who demonstrate disruptive behaviors and may not extend to youth referred for other presenting concerns. However, the comprehensive nature of demographic variables explored allowed the results to be discussed in a more detailed manner leading to a greater understanding of the data.

A study completed by King and Canada (2004) examined the predictors of early treatment termination in adults seeking addiction treatment. Clients who failed to attend five or more therapy sessions were classified as “non-treatment engaged” or premature terminators, and clients who attended at least five sessions were classified as treatment engaged. The participants were ninety-seven individuals referred to a university affiliated substance abuse clinic. To be eligible for services, clients had to have insurance and be deemed appropriate for outpatient treatment as opposed to needing inpatient services. The researchers completed a review of the 97 files and classified those who were treatment engaged and those who were not treatment engaged based on the definition above. A logistical regression model examining the five main predictors of treatment retention (gender, ethnicity, education level, primary drug of choice, and referral source) was statistically significant (p<.0001). However, further analyses revealed that only ethnicity (p<.05) and gender (p<.05) predicted treatment drop out. Odds ratios indicated that the risk for premature termination was 5.1 times greater for African Americans than Caucasian Americans, and 3.8 times greater for females than males.

Despite the limitations in the research such as exploring a very limited number of variables and failing to use the clients’ perspective on therapy engagement, the results are pertinent. Therapists need to be cognizant of the potential impacts ethnicity and gender can have on therapy attendance and address them with clients in an attempt to increase
therapy engagement. Client education about therapy can be a means to address these factors as well as increase the client’s willingness to ask questions and express concerns about therapy (Reis & Brown, 2006). The authors asserted, based on the results, that complex and subtle socioeconomic factors, as well as role related factors, may impact engagement in therapy and thus should be a consideration when working with clients.

An early attempt to identify client variables that predicted premature termination was conducted by Hardin, Subich, and Holvey (1988). Expectancies about counseling the client held prior to beginning therapy were explored to determine their impact, if any, on premature termination from therapy. Clients were asked to complete the Expetations About Counseling (EAC; Tinsley et al., 1980) questionnaire prior to meeting with a counselor for the first time. The EAC is a 53-item self report measure that is designed to assess expectancies about client attitudes, behaviors, counselor characteristics, process characteristics and quality of therapy outcome. The participants were 80 clients who sought counseling services at a psychology training clinic, 40 of whom returned for more than one session and 40 who attended only one session. The 40 who attended only one session were classified as premature terminators. The data were analyzed with a 2 x 2 (return status X problem type) multivariate analysis of variance with EAC scales as dependent variables. Presenting problems of clients were either career or personal concerns. The results of the study indicated no significant effects for client termination type, client presenting problem type, or for the interaction of these two variables. The results implied that expectancies about counseling clients hold prior to initiating counseling had no impact on premature termination in this sample.
One limit of the research identified by the authors was the definition used for premature termination. Premature termination was defined in this study as failing to attend the session after intake. This broad definition of premature termination does not take into account clients who experienced symptom relief after the first session or clients who may have decided at intake they were not ready to make a change at that time, and thus failed to return. These issues with the definition of premature termination may have impacted the clarity of the results. Despite this, the Hardin et al (1988) study was one of the first to explore the client’s perspective on counseling which signaled an important direction in this research area.

Pekarik and Wierzbicki (1986) explored the relation between clients’ expected number of counseling sessions and the actual number of counseling sessions attended. The participants were 148 outpatient clients of a private, nonprofit mental health clinic. Clients were asked prior to their initial appointment to complete a questionnaire that asked them how many visits they believed they would attend. A second question asked them what type of counseling they preferred: brief treatment aimed at solving current problems, or longer treatment aimed at addressing personality patterns and changing long standing behavior patterns. Demographic information was also collected at this time. Only four of the client and therapist variables were significantly correlated with the client’s actual number of sessions: clients expected number of visits (r =.28, p<.01) social class (r =.17, p<.05), Title IX eligibility (r =.14, p<.05) and therapists preferred type of treatment (r =.14, p<.05). The results were summarized as indicating that increased attendance was related to clients’ expectations of attending a large number of sessions, higher social class, eligibility for assistance, and therapist preference for longer therapy.
Results of a multiple regression using all client and therapist variables to predict clients' actual number of session produced a multiple R² of .239 (F(19,98)=1.52, p<.09). A stepwise regression analysis indicated that only clients’ expected number of visits incrementally increased the predictability of the actual number of sessions attended. The results suggested that client expectation about therapy length was significantly related to the number of sessions attended. However, based on the small relation, there are clearly other factors that impact therapy attendance.

A limiting factor of the study was the homogeneity of the sample which was overwhelmingly female (67%) and White (85%). Research with male clients or ethnically diverse clients may produce different results. However, a significant strength of the study was the fact that it was completed in an actual treatment setting with clients who presented for services.

The studies reviewed above explored the relation between client variables, demographic and interpersonal, and premature termination. The results of the research indicated that client variables are related to premature termination; however the relations are often small and fail to explain fully the reasons clients prematurely terminate counseling. Despite the small associations, the importance of client demographic variables, expectations about counseling and counseling length has been supported and are important factors to consider when working to reduce premature termination and must be included in research aimed at reducing the occurrence of premature termination.

Overall, research on premature termination has explored the impact the definition used can have on the occurrence of premature termination, as well as client variables and their relation to premature termination. Research has revealed that there are significant
problems with the definitions of premature termination used in research (Hatchett & Park, 2003) and that the inclusion of the clients’ perspective on therapy termination is important (Hunsley, Aubry, Verstervelt, & Vito, 1999). Furthermore, research has shown that clients and therapists have significantly different perceptions of how long therapy should last as well as when progress has been made (Mueller & Pekarik, 2000). These studies have highlighted how important the client’s perspective is in therapy and the necessity of including client variables in research in this area.

Several client variables have been found to be associated with premature termination such as client’s readiness for change (Derisley & Reynolds, 2000), client demographic variables such as SES, age, and ethnicity (Williams et al., 2005) and client expectations about therapy (Hardin et al., 1988).

One assessment of the literature on premature termination is the lack of attention to therapist multicultural competence (Barrett et al.). Most research to date has explored client SES and ethnicity as demographic variables associated with premature termination. Current research has failed to explore other factors that may be impacting the high rates in these groups. Research has found that multicultural competence is an important factor in the success of counseling with ethnically diverse clients (Shin et al., 2005; Ward, 2005) as well as clients of lower social class (Barrett et al). The multicultural competence of therapists and the potential impact on premature termination has been largely ignored in the literature to date. Barrett et al., recommended role induction, and specifically a videotaped role induction, as a potential way to reduce the occurrence of premature termination in ethnically diverse groups and those of lower SES.
More recent research has explored strategies to reduce the occurrence of premature termination. The intervention that has shown the most promise is pretherapy education or role induction to therapy (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008; Reis & Brown, 2006). Research has shown that pretherapy role induction is an effective method to educate clients about therapy (Reis & Brown, 2006), enhance clients’ expectations about counseling (Whitaker, Phillips, & Tokar, 2004), and increase clients’ knowledge of therapy (Coleman & Caplan, 1990). Based on the literature conducted to date, videotaped role induction holds promise as a potential intervention to impact premature termination in a positive manner.

The present study attempted to follow and extend the premature termination literature in the following ways. First, this study utilized an idiographic definition of premature termination in an attempt to reduce the impact of differences in perspective on therapy length between clients and counselors. The second component of the study addresses the call for interventions designed to reduce premature termination. This will be attempted through the development and application of a thorough role induction to counseling.

Role Induction

The preceding review of the premature termination literature suggested that the use of a comprehensive role induction may be an effective means to reduce rates of premature termination. Role induction to counseling is focused on educating clients about the rationale for therapy, the process of therapy, realistic expectations for change in therapy, prognosis and outcomes of therapy, and behavioral expectations for the client
and therapist in therapy. Role induction has been completed in written format, through verbal interactions between client and therapist and through videotaped interventions all designed to familiarize the client with therapy (Walitzer, Dermen, & Connors, 1999).

Barrett et al. (2008), in a literature review stated that role induction may be an important strategy to reduce premature termination; however, it must be tested in actual therapy settings. A brief video role induction has been shown to be an effective means to educate clients about therapy (Davidshofer & Richardson, 1981), dispel misconceptions about therapy (Walitzer, Dermen, & Connors, 1999), was associated with positive outcomes of therapy (Zwick & Attkisson, 1985) and was associated with reduced rates of premature termination (Reis & Brown, 2006). Despite evidence that completing a role induction may have many positive impacts, as well as meeting ethical obligations to engage in this practice, (Hass, 1991) a comprehensive role induction is often not completed by practicing therapists (Somberg, Stone, & Claiborn, 1993). Researching a comprehensive role induction that is inclusive of all pertinent components is an important area of research.

Effects of Role Induction

Reis and Brown (2006) completed a well designed study attempting to impact premature termination using a videotaped intervention and through the inclusion of client estimation of treatment length. Participants included 125 adult clients who presented for counseling at an outpatient clinic who had not received services in the previous nine months and who presented for a variety of clinical issues. Participants in the prepared (P) group (N=59) viewed a videotape designed to inform those from diverse cultural
backgrounds about therapy. Participants in the nonprepared (NP) group watched a video about the HMO’s development. Participants were randomly assigned to two of four groups: prepared or nonprepared and estimating treatment length or not. After intake, therapists engaged in a scripted discussion with 82 of the clients which ended with the client providing an estimate of treatment length. The remaining clients engaged in the normal intake procedures which did not include estimating treatment length. The researchers stated that they placed more clients in the estimating treatment length condition to guarantee enough participants to explore the potential impact of realistic versus unrealistic treatment estimates.

Premature termination was determined according to the clients score on a brief set of questions developed for the research project (Termination Status Questionnaire, TSQ). Therapy was considered administratively terminated if the client failed to schedule a new appointment within 30 days of the last scheduled appointment. Once therapy was terminated, therapists completed the TSQ and provided a judgment on whether the client had prematurely terminated from therapy or not. Higher scores on the TSQ indicated a greater probability that the client prematurely terminated therapy. Results indicated that scores on the TSQ were significantly lower for P (M=28.85) than NP clients (M=33.36) as indicated by a main effect of preparation (p<.05). The authors summarized these results as indicating that clients who were prepared for therapy were less likely to prematurely terminate than clients who had not received a role induction to therapy. There was no main effect found for client estimate of treatment length.

The authors summarized the results by stating that pretherapy preparation or role induction to counseling seems to be an effective means to reduce premature termination.
The study’s main strength was that it was completed in a real world setting with real clients, making the results more applicable to service providers. However, one limit of the research was the definition used for premature termination. Therapists determined who prematurely terminated therapy without the client’s perspective being taken into account. Previous research has shown that clients and therapists have different perspectives on how long therapy should last, with therapists estimating longer treatment needs than clients. Although the inclusion of the clients’ perspective on therapy length is a positive direction, a change to this study that might have impacted the results would be to establish a specific number of sessions both parties commit to attend. This revision might limit the impact of the client/therapist perspective difference on therapy length and thus reduce the rate of premature termination that is caused by these differences in perspective.

A study conducted by Whitaker, Phillips, and Tokar (2004), explored the impact a videotaped intervention had on client expectations about career counseling. The participants were 168 undergraduates who received extra credit for their involvement in the research. The experimental group viewed a nine minute video that simulated a first counseling session. The control group viewed a video of a female alumna talking to a potential male student about the university. All participants completed the Expectations About Counseling (EAC) Questionnaire (H.E.A., Tinsley, 1982). The second measure used was the Attitudes Toward Career Counseling Scale (ATCCS; Rochlen et al., 1999). The ATCCS is a 16-item likert type questionnaire measuring value and stigma associated with career counseling. The participants were randomly assigned to either the experimental group or control group. In session one, all participants completed the EAC
and the ATCCS. During session two, approximately two weeks later, participants viewed the experimental video intervention or the control video and again completed the EAC and the ATCCS.

Results indicated no significant differences by group at pretest on personal commitment and counselor expertise scores, however, there were significant differences at posttest for personal commitment (p<.01) and counselor expertise (p<.025) between groups. The experimental group had higher personal commitment to therapy at posttest than the control group and lower scores on counselor expertise (indicating more appropriate expectations) than the control group. Based on the results, it appears that the intervention was able to educate the participants about therapy which may have helped reduce unmet expectations and client dissatisfaction with services and, by extension, may reduce premature termination.

A limitation of the research was the use of college students who were not actually seeking counseling as the participants. This limitation likely reduces the applicability of the findings to real clients seeking counseling services. On the other hand, the strength of the research was related to its design. The random assignment and the use of experimental and control groups increased the internal validity of the findings. The study appears to demonstrate the benefits of using a videotaped intervention to educate clients about therapy and to dispel myths clients may hold about therapy.

Walitzer, Dermen and Connors (1999) completed a review of literature that explored ways to reduce premature termination through psychotherapy preparatory techniques including role induction to therapy. Based on their review, the authors identified several factors that are consistently linked with premature termination. The
strongest trends were for higher premature termination rates to be related to lower socioeconomic status, lower education, and ethnic minority status. They also stated that there appears to be a complex relation between the identified factors and premature termination as well as many other factors that contribute to premature termination from therapy. They summarized their findings by stating that these factors make premature termination an important, but difficult, problem to solve. However, they highlighted the potential for role induction to reduce the occurrence of premature termination.

Walitzer et al., went on to discuss the manner through which they believed role induction works. First, educating the client about therapy, the rationale for therapy and instilling hope may lead to better attendance in therapy and thus better outcomes. Second, role induction may aid in aligning expectations of the client and therapist. Aligning expectations may then aid in the development of the therapeutic bond as well as reduce unmet expectations of the client and thus reduce frustration and disappointment. Third, encouraging good client behaviors in therapy such as attendance, self disclosure and openness and providing warning about potential negative aspects of treatment may enhance the treatment process and thus reduce premature termination. According to the author, one effective way to conduct role induction is through the use of vicarious therapy training such as showing the client examples of therapy sessions that include components that are likely to occur in therapy. This has the potential for positively affecting treatment attendance, process and outcome.

Walitzer et al. further discussed limits of the research they reviewed. These included small sample sizes, failure to identify the therapeutic mechanisms of the preparatory techniques and limited use of multivariate techniques. Also, research to date
has provided limited demographic information on the samples and lacked details on attrition within the samples. Despite these limits research suggests that role induction may be an effective means to reduce premature termination rates and is an area worthy of more research.

One study that explored the effects of precounseling training or role induction was completed by Davidshofer and Richardson (1981). The research was conducted in a college counseling center with 72 college students who presented to counseling for the first time. Participants were randomly assigned to either the treatment condition or control group after completing their intake session. The treatment group was invited to the center for precounseling training. The training consisted of a 30-minute videotape which included a dialogue on the basic process of counseling, explained vocational and personal counseling, described the responsibilities of a client in counseling, and showed two modeling vignettes of appropriate client behavior in counseling. The participants also were given three separate opportunities to ask questions about the video and its information. After the first session, all participants were given evaluative materials that they completed and returned to the center.

The results of the research indicated that the experimental group had significantly more knowledge about counseling (p<.001) than clients in the control group based on their scores on a measure of therapy knowledge (M=6.35; SD= 1.34 and M=4.64;SD=1.55 for the experimental and control group respectively). The researchers summarized the findings by stating that the amount of information clients’ possess about counseling can be increased by the use of a videotaped precounseling training program. Further,
based on counselor ratings, it appeared that client’s in-session behaviors were positively influenced by the videotape.

Despite the significant results, the study was not without limitations. One limitation was the time of intervention. Participants were assigned to either the control or experimental group after completion of the intake. The experimental group was then contacted to come to the center to watch the video, potentially increasing their commitment to the treatment regardless of the impact of the video intervention. Further, follow-up contacts were needed for 15 of the participants to prompt them to return the completed measures. These clients may not have been as invested in the research and not completed the measures with as much integrity as the others in the study. Despite the methodological limits, the study’s inclusion of real world counseling clients makes the results more applicable to clients who are presenting to counseling for the first time. All this considered, the study illustrated the ability of a brief video to educate clients about therapy with positive results.

Another study that explored the impact of pretherapy information on clients at a university counseling center was conducted by Dauser, Hedstrom, and Croteau (1995). These researchers investigated the impact of a comprehensive versus partial written pretherapy disclosure on the perceptions and behaviors of clients seeking services. The participants were 63 clients who, after intake, were randomly assigned to receive one of two statements in the mail. The control group participants received a statement that contained only the name of his or her therapist and the date and time of the appointment. The experimental group participants received the same information along with the following: information about his or her therapist including his or her experience, basics
about normal therapy process, typical procedures utilized in therapy, as well as expectations and anticipated results of therapy, risks, therapy alternatives, fees, identification of therapist’s supervisor if applicable, and name and phone number of the licensing board that governs the therapist’s practice. Measures used in the study were the Counselor Rating Form (CRF-S; Corrigan & Schmidt, 1983) which measured clients’ perceptions of therapists, and three multiple choice questions designed to measure attitudes and opinions of clients toward therapy. The data were collected after intake but before the first meeting with the assigned therapist.

Results indicated a significant difference in the treatment versus control group’s understanding of what counseling would be like (p<.001). The treatment group felt they understood what to expect from counseling more than the control group. Otherwise there were no significant differences between in session behaviors between groups and no significant differences in “no-show appointments” for the first session. The authors summarized the findings by stating that education of the client prior to therapy yielded positive effects related to therapy knowledge and did not negatively impact clients’ perceptions of the therapist. This last result was important in that previous research had indicated that clinicians do not complete comprehensive role inductions due to fear of a negative reaction by clients (Somberg, Stone, & Claiborn, 1983). Dauser et al.’s results did not support clinicians’ fears in this area and further highlighted the positive effects of educating clients about therapy.

This study utilized data collected in a real world setting making the results more applicable to clients seeking services. Despite the value of the real world setting, having clients meet with an intake counselor prior to data collection may have impacted their
perception of counseling in ways that were not detected. For example, the personal contact with a counselor may have strongly impacted the clients’ perceptions and opinions about therapists in general so that it overshadowed any potential effects of the written information provided to them about the therapist and counseling. Also, no demographic information was collected on the participants. If racial or other social group differences impacted the outcome of pretherapy disclosure of services, this would not have been detected.

In a study comparing methods of providing counseling information to clients, Stewart and Jessell (1986) randomly assigned clients to either a written or videotaped role induction to counseling. The sample was comprised of 60 college undergraduates who presented to counseling for the first time. In the written consent condition, clients were given 12 minutes to read a three page document designed to give them an understanding of what to expect in counseling, the roles of the client and counselor, information about how counseling works and the potential for counseling to help the client make the desired changes. The document was a written transcript of a simulated first counseling session. In the videotape condition, clients watched a 12-minute video which showed actors enacting the same dialogue found in the written form.

After role induction and the first session, participants completed the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1964, 1969). The BLRI is designed to measure aspects of the client-therapist relationship. Results of the ANOVA revealed significant differences (p<.05) on the BLRI scores between the groups, with the experimental group (M=168.98; SD=29) rating the relationship better than the control group (M=149.75; SD= 21). The authors summarized the results by stating that
videotaped role induction to counseling was superior to the written format, particularly with promoting the therapeutic relationship. Further, they went on to state that client preparation should be incorporated in the training of counselors as a means to enhance the counseling process.

One strength of the research was the use of random assignment in a field experiment. This design makes the results applicable to those providing services to clients. A second strength of the research was the comparison between a videotaped intervention and a written intervention, which showed that video technology can be employed in counseling with positive results. On the other hand, the use of a college student sample limits the ability to generalize the results to clients seeking services at other types of agencies serving a non-college aged population. Despite this, the research supported the value of videotaped role induction to therapy and the positive impacts it may have on the counseling process.

The literature reviewed above illustrates the potential importance of a role induction process as an effective means to impact rates of premature termination (Reis & Brown, 2006), increase client’s knowledge about therapy (Davidshofer & Richardson, 1981), dispel misconceptions about therapy (Walitzer, Dermen, & Connors, 1999) alter client’s behavior in session (Stewart & Jessell, 1986) and impact the outcome of therapy (Zwick & Attkisson, 1985). Although this has provided evidence for the importance of completing a role induction, and highlighted the potential benefit of utilizing video in this process, extant studies have been somewhat limited in the breadth of information included in the role induction protocols. Clearly, the next logical step in this line of
research is to develop a comprehensive role induction protocol and explore its impact on premature termination.

Beyond providing accurate information about counseling, reducing unrealistic expectations, and using a more sensitive definition of premature termination, another variable that has been associated with premature termination is a clients’ readiness for change (e.g., Smith, Subich, & Kalodner, 1995). The literature on readiness for change and its relation to commitment to therapy is reviewed in the following section.

Readiness for Change

**Review of the Transtheoretical Model**

The Transtheoretical Model (TTM) was developed from a review of many systems of psychotherapy (Prochaska & DiClemente, 1982). The model was designed as an attempt to develop an integrated and comprehensive approach to therapy that included the means clients used to change, independent of therapy as well as in therapy. Through the review of the empirical literature and theoretical writings, the authors identified five stages of change as well as 10 processes of change. The focus in this review will be on the stages of change, as they pertain to the present research.

According to the theory, a client’s stage of change indicates how ready he or she is to make changes in an identified area (Prochaska & DiClemente, 1982). Each stage represents a time period and a set of tasks that need to be completed to move to the next stage. The five stages in the model include precontemplation, contemplation, preparation, action and maintenance. However, through research it was determined that the
preparation stage was not a discrete stage and it was subsequently removed (McConnaughy, Prochaska, & Velicer, 1983). Thus, only four stages will be discussed. During the precontemplation stage, clients spend little time thinking about change, are less open about the need for change, and do little to attempt to make changes. Clients are often in treatment during this stage at the insistence of others who see the problem when often the clients do not (Prochaska, DiClemente, & Norcross, 1992). During the contemplation stage, individuals begin to think more about the need to make changes, are more open to potentially making changes and think about how they feel about making changes. The authors suggest that at this stage, clients appear to know where they want to go, but are unsure how to get there. The action stage is characterized by clients’ belief in their ability to make changes and they are actively working to make those changes. A client is in the action stage if he or she has altered his or her behavior in relation to his or her goals from one day to six months. The maintenance stage focuses on working to maintain change and prevent relapse. This occurs through developing plans to cope with potential relapse and through the solidification of his or her changes.

The review that follows discusses research on the stage of change model as it relates to premature termination. Reviewed research includes studies that explored potential relations between a client’s stage of change and readiness for treatment, expectations about counseling, and most importantly premature termination. Criticisms of the model are also discussed.
Stage of Change Research

One study explored client stage of change and expectations about counseling (Satterfield, Buelow, Lyddon, & Johnson, 1995). The sample consisted of 88 clients seeking services at a university based clinic. The measures used included the University of Rhode Island Change Assessment Scale (URICA) designed to represent the stages of change (McConnaughey, Prochaska, & Velicer, 1983), and the Expectations About Counseling-Brief Form (EAC-B; Tinsley, 1982) designed to measure expectancies toward personal commitment, facilitative conditions, counselor expertise, and nurturance. All clients completed the URICA and the EAC-B prior to the intake session. A canonical correlation analysis was completed to investigate the relation between clients’ expectations about counseling and their relative commitments to the stages of change. Two roots were extracted. The canonical correlation for the first root was .64 (p<.001), and the second was .39 (p<.05). The results of the first root implied that, when compared to clients who are either contemplating change, are already engaged in the change process, or are focused on maintaining previously made changes, clients in the precontemplation stage had significantly lower expectations for counselor facilitative conditions of acceptance, genuineness, trustworthiness, and confrontation. The results of the second root were summarized as indicating that clients who entered counseling in contemplation and maintenance stages may have higher expectations for counselor responsibility in facilitating change and directing the course of therapy. The authors summarized the results by stating that different stages of change may be meaningfully related to different client expectations. Based on these results, it appears that knowing a
client’s stage of change could aid the counselor in tailoring his or her approach to counseling.

One limit to consider when reviewing the results of this study is that all the participants were college age, limiting the generalizability. Despite this limitation, the results are important because they may provide counselors with a tool to assess clients’ readiness to make changes as well as offer counselors information that can be used to alter their interventions to fit a particular client. Altering interventions based on the client’s needs may help reduce unmet expectations which in turn may reduce premature termination from therapy. Next to be discussed is the measure designed to assess clients’ readiness for change.

Derisley and Reynolds (2000) conducted a study which explored the use of the stages of change as a predictor of premature termination. Sixty clients of a mental health center completed the Stages of Change Scales (SoC; McConnaughy et al., 1983; McConnaughy, DiClemente, Prochaska, & Velicer, 1989) and the Brief Symptom Inventory (BSI; Derogatis, 1977) prior to intake. A client was classified as prematurely terminating therapy if therapy ended without the client and therapist mutually agreeing. In this sample, 65% of clients mutually terminated therapy and 35% prematurely terminated therapy. Clients who prematurely terminated therapy did not differ from mutual terminators on any demographic variables including gender, marital status, parental status, age, educational background, or employment status. A logistical regression analysis was completed to determine which variables predicted termination type using symptom severity and the four Stages of Change variables entered simultaneously. A combination of Stage of Change scores and symptom severity
significantly predicted premature termination (p<.01). Contemplation and baseline symptom severity were statistically significant independent predictors of premature termination (p<.05) while precontemplation scores did not significantly predict premature termination.

The authors summarized the results by concluding that the application of the Stages of Change model to clients who are seeking mental health services for emotional changes may be different than clients who are seeking behavioral change (i.e. alcohol and drug treatment and smoking cessation) which is to whom the model was originally applied. However, the results highlight the importance of contemplation in those seeking mental health services. Based on the results of this study, identifying clients who are low in contemplation, and using interventions to address this, may increase engagement in therapy and thus reduce the occurrence of premature termination.

A methodological strength of this study was external validity. The participants in the study were clients who presented for counseling in a true treatment setting making the results applicable to clinicians and the clients they serve. However, there were several important limitations. Many clients who were asked to participate declined and there was a high attrition rate. Additionally, to be included in the analysis, clients had to attend three sessions and many clients failed to complete this requirement. Clients who were not included in the study because of this requirement may have been influenced by variables studied in the research (such as being in the precontemplation stage of change) and thus, the results may have been skewed by the absence of these data.

Another study that explored the Stages of Change Model and its relation to premature termination was conducted by Brogan, Prochaska, and Prochaska (1999). The
participants were 60 client-therapist pairs sampled from university counseling centers (51.7%), a community mental health center (38.3%), and a doctoral training clinic (10%). Therapists in the study recruited clients with whom they had at least one but no more than two sessions. Each member of the dyad completed a packet of assessment materials no later than the beginning of the third session. Data included demographic information, symptom information, a stage of change measure, processes of change measure, information about clients’ perception of pros and cons of therapy and client perception of his or her presenting problem. Therapists also classified clients as premature terminators, appropriate terminators, or therapy continuers. Premature termination was defined as stopping therapy prior to 10 sessions and against the therapist’s recommendation.

Results of a discriminate analysis with premature terminators as one group and mutual terminators and therapy continuers grouped together was statistically significant (p<.001). The function accounted for 60.9% of the variance in termination status and classified 91.67% of the two groups correctly. When all variables were reviewed those that were found to predict premature termination included clients’ stage of change, processes of change and other variables such as gains for self in making change, environmental reevaluation, self-disapproval, and utilitarian losses of others. In contrast to previous research, demographic variables were not related significantly to premature termination. Interestingly, the variables which were found to predict premature termination were all variables that are open to professional intervention. Based on the findings of the study, the authors suggested that therapists match interventions and their approach to therapy to the clients’ stage of change as a means to reduce premature termination.
The researchers’ use of a variety of settings to gather data was a significant strength of the study and increases the applicability of the results to many providers in a variety of settings. One limit of the study was that clients and therapists were paid a nominal fee for their participation. This incentive may have impacted the participants’ investment in the study and thus, may have impacted the results in an undetected manner.

An earlier study completed by Smith, Subich, and Kalodner (1995) explored the relation between stages of change and premature termination. Participants were 74 clients seeking services at a college counseling center. Prior to their first session but after intake, clients completed the Stages of Change Scale (McConnaughy et al., 1983). Clients who returned for their second session were classified as non-premature terminators and clients who failed to attend the second appointment and did not reschedule were classified as premature terminators. Results of a chi-square analysis indicated significant differences in stage of change between clients who prematurely terminated therapy and those who did not. Premature terminators entered therapy in the precontemplation stage and non-premature terminators entered at the preparation and action stages in greater numbers than would be expected by chance. A profile analysis was also conducted to explore potential differences between premature terminators and non-premature terminators. MANOVA results indicated that the profiles for the two groups were different. It appears that premature terminators scored higher on the first two stages of change (precontemplation and contemplation) whereas the highest scores for non-premature terminators were contemplation and action.

The authors summarized the results by stating that clients who prematurely terminated therapy began therapy at a different stage of change (precontemplation -
contemplation) as compared to non-premature terminators. Smith et al. recommended developing methods to prepare clients for therapy as a means to address readiness for change and thus reduce premature termination. The limited sample size notwithstanding, the Smith et al. (1995) results support similar research conclusions recommending that efforts aimed at reducing premature termination focus on developing and testing the effectiveness of client preparation techniques as an important direction for future research.

Although the research related to the Transtheoretical Model seems promising, the model is not without critics. According to Murphy (2005), problems with the model include its failure to explain individuals who do not make changes, its lack of focus on social context and its impact on client change, and the need to address the myriad personal issues each individual brings to the change process. Other problems that have been discussed in the literature are as follows: the use of the concept of “stage” when the lines between the stages seem to be arbitrary, the model’s focus on decision making and planning and its failure to address reward and punishment issues which have been shown in the literature to be associated with change (West, 2005).

Despite the identified difficulties with the model, research has suggested that a relation exists between premature termination and a client’s readiness for change. Thus it is an important factor to be included in a study attempting to understand and reduce the occurrence of premature termination.
Summary and Rationale

The literature suggests that premature termination is a significant issue facing counseling psychology for many reasons. First, research shows that premature termination is often a negative outcome of therapy for the client. Clients who prematurely terminate therapy often continue to experience the negative symptoms they initially sought treatment for and then they often return to therapy at a later date. Second, premature termination can have negative effects for counselors by impacting their self efficacy which may lead to counselor burnout. Third, there are financial costs associated with premature termination through missed appointments and no show appointments leading to wasted time and resources. Fourth, missed appointments and no show appointments preclude those who may need treatment from receiving it. Finally, premature termination can have a negative impact on outcome studies which may lead to negative perceptions of the efficacy of therapy. For these reasons, continuing to explore ways to reduce premature termination is imperative.

The research on premature termination supports the use of role induction as one potential means to impact the rates in a positive way. A study completed by Reis and Brown (2006) illustrated the positive impact a role induction to therapy can have on premature termination. A recent literature review by Barrett et al., (2008) stated that a comprehensive role induction is the most empirically supported intervention to reduce premature termination. These results make the use of a comprehensive role induction an important piece to include when researching premature termination.

The present study will attempt to reduce the occurrence of premature termination by using a comprehensive video role induction that provides the client with information
about therapy in general, the process of therapy, the importance of agreeing on the problem and goals for therapy; and help reduce unrealistic expectations for therapy. This information will address the suggestion in the literature that clients’ unrealistic expectations for therapy (Hardin, et al., 1988), lack of agreement on goals and presenting problems between the client and therapist (Corning, et al., 2007), and clients’ general lack of understanding on the process of therapy (Edlund et al., 2002) is related to premature termination.

Further, the study will address several of the definitional problems discussed in the literature by including the clients’ perspective on therapy length in conjunction with the therapist’s. Therapists and clients will discuss and agree to a specific number of sessions both will commit to attending. If the client fails to fulfill the agreed upon number of sessions, he or she will be classified as prematurely terminating therapy. Also, clients will be given the opportunity to end therapy at intake if they decide they are not ready to engage in therapy at this time. These clients will not be classified as premature terminators. Not classifying these individuals as premature terminators is an attempt to be respectful of the clients’ feelings about making change and not label them premature terminators when they actually made a decision to not enter therapy. Finally, this study will explore the impact a role induction to counseling has on clients’ readiness for change.
Hypotheses

The present study investigates the use of a comprehensive role induction as an intervention designed to reduce the occurrence of premature termination from therapy by investigating the following hypotheses:

1. The occurrence of premature termination will be less for the comprehensive role induction condition as compared to the control condition.

2. Clients who receive the comprehensive role induction intervention will be more likely to commit to therapy in the first session as compared to clients who do not receive the role induction.

3. The comprehensive role induction group will exhibit greater levels of readiness for change as compared to the control condition.

4. The comprehensive role induction group will have higher personal commitment to counseling than those who do not receive the role induction.
CHAPTER III

METHODOLOGY

This chapter reviews participants, measures, procedures, and planned analyses. Demographic characteristics of the participants and where they were drawn from are discussed. The measures utilized in the study as well as pertinent psychometric information are reviewed. Last, procedures and the statistical analyses utilized in the study are outlined.

A power analysis based on requirements for ANOVA with two groups and one dependent variable was conducted. Hypothesizing a medium effect size at p<.05 with power of .80, 50 participants for each group is required for a total sample size of at least 100 (Stevens, 1992).

Participants

Participants included 155 adult clients who sought mental health counseling at a community mental health center. The sample was comprised of 106 total, after 1 participant was removed due to being referred to another agency and 48 were not included due to incomplete information. The sample was comprised of 46 men (43.4%) and 60 women (56.6%). Participants ranged in age from 18 to 72 (M= 32.4, SD= 10.10). The majority of the participants had sought counseling previously (67%). The sample was primarily European American (88.7%), with much smaller numbers endorsing
Native American (2.8%) and bi-racial (3.8%) ethnicity, and 4.7% not reporting race/ethnicity. Most of the participants were single (44.3%) and almost half (42.5%) of the participants indicated their highest level of education completed as High School/GED. Finally, more than half the sample (55.7%) reported their household income as less than $7,356.00/year. A summary of demographic characteristics is presented in Table 1.

### Table 1

**Demographic Characteristics of the Sample**

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>24.5</td>
</tr>
<tr>
<td>25-29</td>
<td>24.6</td>
</tr>
<tr>
<td>30-39</td>
<td>26.4</td>
</tr>
<tr>
<td>≥40</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>88.7</td>
</tr>
<tr>
<td>Bi-Racial</td>
<td>3.8</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>2.8</td>
</tr>
<tr>
<td>Not reported</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Relationship Status</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>44.3</td>
</tr>
<tr>
<td>Married/living as married</td>
<td>25.5</td>
</tr>
<tr>
<td>Divorced</td>
<td>15.1</td>
</tr>
<tr>
<td>Separated</td>
<td>13.2</td>
</tr>
<tr>
<td>Widow/er</td>
<td>0.9</td>
</tr>
<tr>
<td>Not reported</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Family Income</strong></td>
<td></td>
</tr>
<tr>
<td>≤ $7,356</td>
<td>55.7</td>
</tr>
<tr>
<td>$7,357-$17,280</td>
<td>21.7</td>
</tr>
<tr>
<td>≥$17,281</td>
<td>21.7</td>
</tr>
<tr>
<td>Not reported</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Previous Use of MHS</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>67.0</td>
</tr>
<tr>
<td>No</td>
<td>33.0</td>
</tr>
</tbody>
</table>

(continued)
Table 1 (continued)

Demographic Characteristics of the Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Level</td>
<td></td>
</tr>
<tr>
<td>Some High School</td>
<td>24.5</td>
</tr>
<tr>
<td>HS Graduate/GED</td>
<td>42.5</td>
</tr>
<tr>
<td>Associate/Some College</td>
<td>27.4</td>
</tr>
<tr>
<td>College Grad/Grad Degree</td>
<td>4.7</td>
</tr>
<tr>
<td>Not reported</td>
<td>0.9</td>
</tr>
</tbody>
</table>

*Note: N = 106. MHS = Mental Health Service.*

Clients received counseling services from counselors in training (n=3), licensed counselors (n=17) or psychologists (n=2). All service providers were Caucasian/European American. The counselors consisted of 14 women and 8 men.

Measures

*Personal Commitment Form (Appendix A)*

Therapists documented the number of sessions (between 0-4) each client committed to attend. The number of sessions committed to will be used to define premature termination. Zero to four sessions was utilized as the number of sessions offered based on discussions with the counseling center staff. Therapists also documented if their client discussed the video during the intake session. This form was designed for this research.
The Stage of Change Scale (SCS) developed by McConnaughy, Prochaska, and Velicer (1983) is a 32 item instrument that measures each of the four stages of change. The four stages of change the scale was designed to measure are Precontemplation, Contemplation, Action, and Maintenance (Prochaska, 1984). The SCS was constructed by generating items based on definitions derived from Prochaska and DiClemente’s (1982) theory of stages of change. An interrater reliability of 100% was used to select 125 initial items, and principal-component analysis reduced these items to 32. On the basis of component analysis, 8 items were retained for each subscale (McConnaughy et al., 1983).

The measure was originally developed for work with individuals who were dealing with alcohol and drug issues, however; subsequent research cross-validated the SCS with other clinical populations (Derisley & Reynolds, 2002; McConnaughy, DiClemente, Prochaska, & Velicer, 1989). The principal components, internal consistency and cluster profile analyses replicated the original findings and four distinct stages emerged. The four components accounted for 45% of the total variance. The following Cronbach’s coefficient alphas were reported for the four scales: Precontemplation, .79; Contemplation, .84; Action, .84; and Maintenance, .82. The Cronbach’s Alpha coefficients for the four scales in the current study were similar to those found in previous studies: Precontemplation, .79; Contemplation, .84; Action, .80; and Maintenance, .83.

The instrument uses a Likert-type response format in which respondents are asked to rate statements designed to ascertain how they feel as the begin therapy or work to deal
with problems in life. The respondents’ options are 1 = strongly disagree, 2 = disagree, 3 = undecided, 4 = agree and 5 = strongly agree. The respondent rates each item on the above anchors leading to scores on each of the four measured stages of change. A total score (range of = 8-40) is calculated for each of the four subscales. The developers of the measure indicated that an individual who completes the measure in a forthright manner will have a score on one scale higher than his or her score on the other three, and the highest scale score denotes which stage of change the client is in (McConnaughy et al., 1983).

Determining a clients’ readiness for change based on this measure has been completed in several ways in the literature. Subscale scores have been used either categorically, based on the highest subscale score (Derisley & Reynolds, 2000; Smith, Subich, & Kalonder, 1995), or continuously (McConnaughy, et al., 1989). This study used the categorical method and classified participants into a stage of change based on their highest scale score, or in the event of a tie, subjects were placed into the more advanced stage on the continuum (Derisley & Reynolds).

*Expectations About Counseling (Appendix C)*

The Expectations about Counseling questionnaire, brief form (EAC-B; Tinsley et al., 1980) is a 53-item self report instrument that assesses one’s expectations about counseling. Responses are made on a 7-point continuum from definitely do not expect this to be true (1) to definitely do expect this to be true (7).

Early research on the measure reported a four factor solution for the EAC-B (Tinsley, Workman, & Kass, 1980). However, more recent factor analytic studies
indicated that a three-factor solution best fits the EAC-B (e.g. Hatchett & Han, 2006; Hayes & Tinsley, 1989; Tinsley, D.L., Holt, Hinson, & Tinsley, 1991). The three factors include personal commitment, counselor expertise, and facilitative conditions. In this study, only the Personal Commitment Factor (20 items) was used due to the focus of the study being commitment to and remaining in counseling. The Personal Commitment factor measures clients’ expectations related to taking responsibility for and commitment to the work of counseling and the expectations related to the use of the counseling relationship (i.e., I expect to talk about my present concerns, I expect to take responsibility for making my own choices). Clients can receive a score ranging from 0 to 120 on personal commitment with higher scores indicating a stronger personal commitment to counseling. Cronbach’s Alpha in this study for the personal commitment factor was .97.

*Videotape Role Induction/Control Video (Appendices D & E)*

Participants in the experimental group viewed the comprehensive role induction (appendix E). The video included an explanation of the importance of client and therapist agreement on goals, problem etiology and severity, and the importance of the therapeutic relationship. Also a brief explanation of therapy process and what a client should expect over the course of therapy will be highlighted. A vignette of a first session demonstrating the above information was included in the video (Walitzer et al, 1999; Zwick & Attkisson, 1985). The videotape was approximately 7 minutes long. Those in the control group viewed a video of approximately the same length, explaining services offered at the counseling center (Appendix E).
Procedure

Participants in the study included 106 adult clients who sought services at a community mental health clinic. Clients were randomly assigned to the experimental group or the control group. Clients who were assigned to the experimental group (n=53) viewed the standardized role induction video and clients in the control group (n=53) viewed a video discussing the services provided at the counseling center. Clients viewed these videos prior to their first session. After viewing the video, all clients completed the EAC-B and the SCS.

All clients at the end of their first session were asked if they were ready to commit to therapy. All clients had a brief discussion with their therapists about counseling and together determined a specific number of sessions both members of the dyad committed to attending. The assigned therapist then documented the agreed upon number of sessions on the commitment form which was placed in the clients’ chart. Clients who fulfilled this initial commitment, clients who decided at the first session they were not ready to commit to therapy, and clients who terminated therapy prior to completion of their agreed upon number of sessions in agreement with their counselor were classified as non-premature terminators (NP). Clients who failed to attend the agreed upon number of sessions were classified as premature terminators (PT) (Mueller & Pekarik, 2000; Pekarik & Wierzbicki, 1986). The number of sessions each client attended was ascertained from the counseling center’s records. All measures and forms were removed from each client’s chart by administrative staff at the counseling center and placed into a locked cabinet for use in the research.
Packets were reviewed to ensure that all measures were completed and that the commitment information was gathered by the therapists at the end of the intake. This initial review of data led to the removal of 47 packets due to incomplete data. Packets were identified as incomplete if they lacked completion of an entire measure or if the therapist had failed to document commitment to therapy. Packets that were not included in the study included 22 that were assigned to the experimental group and 25 that were assigned to the control group. Packets that were excluded from the data were compared with those included in the data analysis for potential differences. The results of the Chi Square analysis revealed no significant differences (p<.05) in previous experience in counseling ($\chi^2 = 4.92$, df = 2, p < .085), sex ($\chi^2 = 1.39$, df = 1, p < .174), age ($\chi^2 = 41.93$, df = 38, p < .304), race/ethnicity ($\chi^2 = 3.07$, df = 3, p < .380), marital status ($\chi^2 = 3.77$, df = 5, p < .582), education level ($\chi^2 = 1.427$, df = 5, p < .921), and income ($\chi^2 = 7.26$, df = 10, p < .701) between included and excluded participants.

**Hypotheses and Analysis**

The first hypothesis stated that participants who received the comprehensive role induction would prematurely terminate therapy significantly less than those who did not receive the role induction. This was tested by using a 2 x 2 Chi Square Analysis in which the premature termination rates for each group were compared.

The second hypothesis examined whether participants who received the comprehensive role induction committed to therapy at a higher rate than those who did not. This hypothesis was investigated using a 2 (role induction vs. control group) by 2 (commitment to therapy vs. not committing to therapy) chi square analysis.
The third hypothesis stated that those who received the role induction would begin counseling in contemplation and action stages of change significantly more than those in who did not receive the role induction. This hypothesis will be tested using a 2 (role induction vs. control group) by 4 (precontemplation, contemplation, action, and maintenance) chi square analysis.

The fourth hypothesis explored the impact receiving a role induction would have on expectations about counseling. Between group differences were explored using an ANOVA. The independent variable was the video intervention (experimental vs. control condition) and the dependent variable was the score on the Personal Commitment scale of the EAC-B.
CHAPTER IV
RESULTS

Introduction

This chapter discusses the preliminary analyses and results of the principal analyses. Preliminary analyses included screening of the data, analysis of outliers and normality and experimental and control group comparison for potential differences. Tests of the hypotheses are presented in terms of the Chi Square and ANOVA.

Preliminary Analyses

Data were visually screened and it was determined that less than 5% of data was missing. Further inspection of the data suggested missing data were random. For the participants who had fewer than 3 data points missing, series mean score substitution was used (Tabachnick & Fidell, 1996). One subject had substantial missing data and was not included for analysis and one subject was referred to another counseling center and thus was not included in the final data. The final data set consisted of 106 participants.

Outliers were identified through the use of box plots and histograms which identified 3 outliers (Tabachnick & Fidell). Analyses were run with and without the identified outliers and no significant differences were noted in the results, thus the outliers were retained in the sample. The experimental and control group were compared using Chi Square Analyses for potential differences in previous experience in counseling (\( \chi^2 = 3.56, \text{df}=2, \))
p<.168), sex ($\chi^2 = .038$, df = 1, p<.846), age ($\chi^2 = 29.34$, df = 34, p<.695), race/ethnicity ($\chi^2 = .533$, df = 3, p<.912), marital status ($\chi^2 = 5.25$, df = 5, p<.386), education level ($\chi^2 = 6.30$, df = 5, p<.277), and income ($\chi^2 = 13.90$, df = 10, p<.178) with no statistically significant differences identified (p<.05).

Role Induction and Premature Termination

The first hypothesis addressed the question of whether a comprehensive role induction would impact the occurrence of premature termination. This hypothesis was tested using a 2 (premature vs. non-premature termination status) by 2 (role induction vs. control group) chi square analysis. The analysis was run with a predetermined alpha level of .05. An overall Chi Square statistic of .151, (df =1, p = .698) was obtained. The number of participants who were classified as prematurely terminating or not prematurely terminating therapy by video is presented in Table 2. In the role induction condition, 49.1% of the participants were classified as prematurely terminating therapy as compared to 52.8% in the control condition. The results appear to indicate that in this sample, receiving a comprehensive role induction did not significantly impact the rate of premature termination. The occurrence of premature termination was similar for both groups. Thus, the first hypothesis was not supported.

Table 2

Rates of Premature Termination (PT) of Counseling by Experimental and Control Group

<table>
<thead>
<tr>
<th>Group</th>
<th>PT</th>
<th>Non-PT</th>
<th>$\chi^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Induction</td>
<td>26</td>
<td>27</td>
<td>.151</td>
</tr>
<tr>
<td>Control</td>
<td>28</td>
<td>25</td>
<td></td>
</tr>
</tbody>
</table>
Role Induction and Therapy Commitment

The second hypothesis explored the impact the role induction to counseling video would have on therapy commitment. It was hypothesized that clients who received the comprehensive role induction would commit to therapy at a higher rate than those who did not receive the role induction. This hypothesis was investigated using a 2 (role induction vs. control group) by 2 (commitment to therapy vs. not committing to therapy) chi square analysis. The analysis was run using a predetermined alpha level of .05. An overall Chi Square statistic .485 (df =1, p =.486) was obtained. For this analysis, the Yates correction was applied when calculating the Chi- Square statistic due to several cell sizes being low and degrees of freedom = 1. The Yates correction is utilized to correct for discontinuity in the sampling distribution for 2 X 2 tables only. This adjustment allows the sample to meet the underlying assumption that it will be a continuous, normal distribution (Gardner, 2001). The results presented in Table 3 appear to indicate that in this sample, role induction did not significantly impact the rate of commitment to therapy. Despite the nonsignificant results and the use of the Yates correction, it is important to note in interpreting these results that several of the cell sizes were extremely small (Table 3). Thus, commitment was high in this sample regardless of the role induction intervention.
Table 3

Prevalence of Commitment to Counseling by Experimental and Control Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Commitment to Counseling</th>
<th>No Commitment</th>
<th>χ²(1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Induction Video</td>
<td>47</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Control Video</td>
<td>50</td>
<td>3ᵃ</td>
<td>.486, ns</td>
</tr>
</tbody>
</table>
ᵃSmall cell size.

Table 4 shows the frequencies for commitment range across groups. A large percentage of participants committed to 4 sessions.

Table 4

Frequencies of Session Commitment Across Groups

<table>
<thead>
<tr>
<th>Number of Sessions</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>9</td>
<td>8.5</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>4.7</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>4</td>
<td>87</td>
<td>82.1</td>
</tr>
</tbody>
</table>

Role Induction and Stage of Change

The third hypothesis proposed that the comprehensive role induction group scores would place them in the contemplation and action stages to a greater extent than the control group.

This hypothesis was testing using a 2 (role induction vs. control group) by 4 (precontemplation, contemplation, action, and maintenance) chi square analysis. The Chi Square statistic was calculated to determine if receiving or not receiving a role induction to counseling impacts a client’s stage of change.
The analysis was run with a predetermined alpha level of .05. An overall Chi Square statistic of 1.750, (df =3, p=. 626) was obtained. As before, several of the cells in the frequency table were extremely small (see Table 5), therefore the results should be interpreted with this in mind. However, based on the results of the analyses, it appears that receiving a comprehensive role induction did not have a significant effect on stage of change. Thus, this hypothesis was not supported.

Table 5

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Role Induction Video</th>
<th>Control Video</th>
<th>( \chi^2 ) (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>1(^a)</td>
<td>2(^a)</td>
<td></td>
</tr>
<tr>
<td>Contemplation</td>
<td>41</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>8</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>3(^a)</td>
<td>4(^a)</td>
<td>1.750, ns</td>
</tr>
</tbody>
</table>

\(^a\)Small cell size.

Due to the low frequency in several of the cells (Table 5), the data were re-analyzed using only the contemplation and action stages to explore potential differences. Despite this, the overall Chi-Square statistic of 1.233, (df =1, p<.267) again was not significant using these stages.

Role Induction and Personal Commitment

The last hypothesis explored the impact the comprehensive role induction would have on personal commitment to counseling, stating that those who received the role induction would exhibit higher scores on personal commitment than those who did not receive the role induction. This was explored using an ANOVA. The independent
variable was the role induction (i.e., experimental vs. control group) and the dependent variable was the score on the Personal Commitment scale of the EAC-B.

Skewness and kurtosis were evaluated for the EAC scores. The results indicated that the distribution was negatively skewed (-1.189) and was extremely peaked (1.553). Data were transformed utilizing a log transformation (Mertler & Vannatta, 2005) in an attempt to meet the assumption of normality however, the transformed data became more skewed (-3.26) and peaked (15.53). Thus, the untransformed data results are reported here. Further, the data were examined for outliers and three were identified. An ANOVA was run with and without the identified outliers with no meaningful differences in results. Because the answers of the outliers appeared to be valid, they were retained in the data set. Thus, 106 participants were included for this analysis.

Results were analyzed using a one-way ANOVA, between groups design. This analysis failed to reveal a significant effect for role induction (F = .052, df =1, p<.820). The sample means were similar for expectations about counseling across the experimental (M= 94.54, SD= 25.45) and control groups (M=93.53, SD=20.14). These results fail to support hypothesis four.

Overall, the results of the current study failed to support the hypotheses. In this sample and with this role induction protocol, there is no evidence of a positive impact on termination status, readiness for change, commitment to counseling, or expectations about counseling.
CHAPTER V
DISCUSSION

Research has consistently shown that therapy is effective and that clients experience positive outcomes from engaging in therapy (Orlinsky et al., 2004). However, past research has shown that many clients prematurely terminate therapy often with negative outcomes (Archer, Forbes, Metcalfe, & Winter, 2000; Carpenter, Morrow, del Gaudio, & Ritzler, 1981; Pekarick, 1985). The purpose of this study was to explore an intervention designed to reduce premature termination rates using a comprehensive, standardized role induction procedure and a more sensitive definition of premature termination. Further, the impact of the role induction as it relates to readiness for change was explored. This study also examined the impact the role induction would have on clients’ commitment to therapy. The study did this through the use of a role induction video, by utilizing the self report measures of commitment to therapy (EAC-B; Tinsley et al., 1980), and readiness for change (SOC; McConnaughy, Prochaska, & Velicer, 1983), through the client’s verbal commitment to therapy and by incorporating the client’s perspective on therapy length.

A total of 106 adult clients seeking services at a community mental health center participated in the study. Participants were randomly assigned to either the experimental or control group. Prior to the intake session, each participant viewed a video. The experimental group viewed the comprehensive role induction video and the control group
viewed a video explaining the services at the counseling center. Next, all participants completed the self-report measures of commitment to therapy (i.e. EAC-B; Tinsley et al., 1980) and readiness for change (i.e. SOC; McConnaughy, Prochaska, & Velicer, 1983).

The present data failed to show that a role induction to counseling significantly impacts premature termination, commitment to counseling or readiness for change among clients seeking counseling at a rural community mental health center. Overall, the data failed to support previous research findings that seemed to indicate a role induction to counseling could reduce the occurrence of premature termination and increase a client’s commitment to therapy (Reis & Brown, 2006; Walitzer, Dermen, & Connors, 1999).

Summary of Results

The results from the present data and analyses failed to provide support for the prediction that a comprehensive role induction would have a significant impact on the occurrence of premature termination. This suggests that although a role induction may be an important tool to impact premature termination as has been indicated in previous research (Reis & Brown, 2006; Walitzer, Dermen, & Connors, 1999), this information presented passively, as in the current study, may not be enough to have the desired effect.

Hypothesis 1 predicted that the occurrence of premature termination would be less for the comprehensive role induction group as compared to the control group. The results of the Chi Square analysis failed to support this hypothesis. This finding appears to indicate that in this sample, receiving a comprehensive role induction did not reduce the occurrence of premature termination as compared to the control group. These results are inconsistent with previous research (Reis & Brown, 2006; Walitzer, Dermen, &
Connors, 1999) and literature reviews (Barrett et al., 2008) that point to a comprehensive role induction as the most promising approach to reduce premature termination. Previously completed studies have found that the completion of a role induction to counseling is an effective means to educate clients about their role in counseling (Zwick & Attkisson, 1985), facilitate the development of the therapeutic relationship (Walitzer et al., 1999), reduce the occurrence of premature termination (Reis & Brown, 2006), and serve as an effective means to educate clients about therapy in general (Zwick & Attkisson).

The reasons that the role induction video did not significantly impact the occurrence of premature termination in this study are unclear. However, several explanations are possible. First, several demographic characteristics of the participants may help explain the results. The participants in the study reported extremely low household income with 55% of the participants having an income of less than $7,356.00 per year. Also, 24.5% reported the highest level of education complete as some high school and 42.5% reported having no more than a high school education. Previous research has found that client socioeconomic status is consistently associated with premature termination from therapy (Williams, Ketring, & Salts, 2005). A meta-analysis of variables associated with psychotherapy dropout rates was completed by Wierzbicki and Pekarik, (1993). Mean effect sizes for the demographic variables were calculated yielding significant results for education (.28) and SES (.37), indicating that psychotherapy dropout is significantly related to low education and low SES. Further, Barrett et al. (2008) stated that income level can be a major barrier to treatment attendance and commitment. For example, these clients may have a difficult time
affording child care, getting transportation to counseling or even making counseling a priority when more imminent needs arise. The negative impact of the low education level and low SES of the participants may explain the failure of the role induction to significantly reduce premature termination in this study. The results of the current study may provide further support for the importance of client SES and education on attendance in therapy; however a causal relationship cannot be inferred.

Another potential explanation for the lack of support for this hypothesis is the minimal inclusion of the therapist in the role induction to counseling. Although a videotaped role induction has been shown to be an effective method to educate clients about therapy (Reis & Brown, 2006), and better than written methods at promoting client counselor relationship (Stewart & Jessel, 1986), it may not be sufficient to have the desired impact in this sample. Few participants (18%) mentioned the video to their counselor and the counselors in the study were instructed not address the video with the client unless the client brought it up. A brief discussion about the role induction with the therapist and offering the client the opportunity to talk about the role induction or ask questions might have increased its positive impact. Research has consistently shown that the therapeutic relationship is a necessary condition for successful counseling (Wampold, 2001), and the lack of inclusion of the therapist in the role induction may have negatively impacted its potential benefit in the development of the therapeutic relationship and the client’s commitment to therapy attendance.

The inclusion of the client’s perspective in therapy length in the definition of premature termination was important based on previous research findings (Pekarik & Wierzbicki, 1986) which indicated the best indicator of therapy length is the clients
expectation of therapy length (Mueller & Pekarik, 2000). However, the failure to promote
a discussion between the client and the therapist about counseling and committing to
counseling may have negatively impacted the results of the study. Clients were asked if
they were willing to commit to counseling and were offered an option to commit to
between 0-4 sessions. An overwhelming majority of clients (82%) committed to 4
sessions. It would seem that clients may have agreed to 4 sessions even when they were
not committed to that number, which may have led to a high occurrence of premature
termination. Furthermore, the lack of range in session commitment in the current study
seems to indicate that this was not an adequate measure of this variable.

Although the inclusion of the client’s perspective has been shown to be important
in length of therapy, (Mueller & Pekarik, 2000), clients may not have had enough
information to decide at intake how many sessions they would attend. Perhaps discussing
therapy length during the first session after intake, when goals for counseling were
developed, may have made it more meaningful for the clients. Clients also would have
had time to reflect on the information shared at intake and potentially make a more
informed decision.

Hypothesis 2 predicted that participants who received the comprehensive role
induction would commit to therapy at a higher rate than those who did not receive the
role induction. The results of the Chi Square analysis failed to support this prediction.
The results appear to show that in this sample, commitment to counseling was not
significantly impacted by the role induction. This finding is inconsistent with results from
Walitzer, Dermen, and Connors, (1999) who asserted that a role induction to counseling
would increase the client’s commitment to counseling and the client’s investment in the
process of counseling. In a recent literature review, Barrett et al. (2008) stated that a role induction to counseling offers a client the expectation of success, an effective means to reduce misconceptions about therapy and leads to improved attendance in therapy. Based on the above research, the lack of significant results is perplexing.

One can hypothesize that the lack of client and therapist discussion about committing to counseling could have played a significant role in the results of this study being in conflict with previous research. In the current study, clients were given the opportunity to identify the number of sessions they could commit to attend at intake. However, the lack of a structured discussion between the counselor and therapist could have reduced the positive impact of the inclusion of the clients’ perspective. As stated earlier, very few participants (18%) discussed the video with their counselor. A brief discussion about the information in the video may have helped make the information more salient and understandable for the clients and improved its effect. Further, the participants in this study may have not have felt empowered enough to admit they were not ready to engage in counseling and thus the majority of clients indicated they would commit to counseling at intake.

Another potential explanation for the lack of significant findings is the potential impact the control video had on participants. The focus of the video on services available at the center may have enhanced the clients’ commitment to receiving services. Out of 106 total participants, only 9 failed to commit to counseling. This extremely low number indicates that an overwhelming majority of clients in this study, at intake, expressed commitment to counseling. This lack of variability in commitment appears to indicate an issue with measuring commitment to counseling. This can be explained in several ways.
One, the control video may have had similar effects as the experimental video as it relates to therapy commitment and thus an overwhelming majority of the clients were willing to commit to counseling. Second, the clients may not have felt comfortable at intake telling the counselor they were not willing to commit to counseling. Counselors are in a more powerful position than clients, especially early in therapy, and clients may not have felt they had the power to conflict with what was expected of them. Last, clients may have committed to counseling but barriers to treatment caused them to drop out of counseling before they met the agreed upon number of sessions.

Hypothesis 3 proposed that the comprehensive role induction group would be placed in the contemplation and action stages to a greater extent than the control group based on scores on the readiness to change measure. The results of the Chi Square analysis also failed to support this hypothesis. In this sample, it appears that readiness for change failed to be significantly impacted by a role induction to counseling. Previous research has found a relation between readiness for change and premature termination. For example, a study completed by Smith et al. (1995) found that premature terminators and non-premature terminators were distinguishable by the stage of change at which they entered therapy. All participants in the precontemplation stage of change prematurely terminated therapy and all subjects who entered therapy in the preparation and action stages were non-premature terminators. A client’s readiness for change can have a significant impact on therapy outcomes (Derisley & Reynolds, 2000).

One potential reason for the failure to find a relation between readiness for change and role induction was likely due to the fact that the majority of participants across experimental conditions were classified into contemplation and action stages based on
Although the topic of the two videos was different, one cannot discount the
impact the control video had on participants. The control video discussed the services
available at the center which may have had unanticipated impacts on the clients readiness
for change. Also, it is possible that the clients in both groups were ready to make changes
and thus had high scores on the self report measure of readiness for change.

Another possibility for the lack of significant results is that the Transtheoretical
Model is not applicable to those seeking mental health services (Derisley & Reynolds,
2000). This model was developed for use with those seeking addictions treatment. It is
likely that those seeking mental health services are different in many ways than those
seeking treatment for addictions and thus this model is inadequate to explain readiness
for change in this population. Although the importance of readiness for change makes
intuitive sense as it relates to remaining in therapy, in that one has to be ready to make
difficult changes, making these changes is more complicated than just being ready to
make the change. Although these clients may have been ready to make the needed
changes, there may have been other significant factors that got in the way of the change
which this model does not take into account. Derisley and Reynolds found similar results
in their study exploring the Transtheoretical model in a clinical population. They found
that premature termination from therapy was predicted by low contemplation scores not
by high precontemplation which has been supported previously in the literature. The
researchers stated that this model may not be directly generalizable to a clinical
population.

Another possible reason for the lack of significant results was the measure used to
assess readiness for change. The validity of the Transtheoretical model and SOC
questionnaire has been highly questioned in the research. Researchers have argued about the conceptualization of discrete stages of the model, the measure’s ability to assess stage of change, what behaviors/beliefs define a stage (Derisley & Reynolds, 2002; Wilson & Schlam, 2004) as well as the model’s applicability outside of addictions treatment (West, 2005). Further, there is not a consistent method utilized to classify a client into a stage of change. Subscale scores have been interpreted categorically based on the highest subscale score (Derisley & Reynolds) or continuously (McConnaughy et al., 1989). The current study used the subscales categorically. Potential problems with the measure and its ability to determine stage of change adequately may have impacted the results.

Hypothesis 4 explored the impact the comprehensive role induction would have on personal commitment to counseling, stating that those who received the role induction would exhibit higher scores on personal commitment than those who did not. The results of the ANOVA failed to support this hypothesis. The results seem to indicate that in this sample, the role induction to counseling did not significantly increase personal commitment to counseling as measured by the EAC-B. This finding is inconsistent with previous research that indicated a role induction to counseling leads to a better understanding of therapy, (Zwick & Attkisson, 1985) and subsequently to a greater commitment to therapy (Walitzer et al., 1999).

One potential explanation for this finding may be the exposure of both groups to information that is not regularly presented at intake. The experimental and control group both viewed videotapes that provided them with information about counseling. Although the topics were different, a role induction to counseling (experimental) versus services available at the center (control) may have had similar effects as it relates to commitment
to counseling. The similarity of mean scores on the EAC-B personal commitment factor for the experimental (M= 94.54, SD= 25.45) and control group (M=93.53, SD=20.14) seem to point to this as one possible explanation. Hearing about the counseling services available to them may have enhanced clients’ personal commitment to counseling in ways that were not anticipated. Both groups, based on mean scores on the EAC-B, reported a high personal commitment to counseling.

It is also possible that the role induction to counseling had no effect on personal commitment to counseling. It may be that a majority of clients, in this sample, came to counseling with high expectations and personal commitment and the video did not affect this. The similarity of mean scores for the experimental (M= 94.54, SD= 25.45) and control group (M=93.53, SD=20.14) seems to point to this as another probable explanation.

Another possible explanation for this result is the measure utilized to assess personal commitment to counseling. Although this measure has been utilized to assess clients’ expectations to counseling as it relates to personal commitment, with higher scores indicating a greater commitment, no specific scoring criteria have been determined. Cut-off scores have not been established to differentiate those who report a strong commitment to counseling and a willingness to do what it takes to be successful in counseling versus those that do not. Although the participants in the study indicated a commitment to counseling, as measured by the EAC-B, it is unclear if this translates to good therapy behaviors.
Implications for Research

The predominant recommendation found in the literature to reduce premature termination is the completion of a role induction to counseling (Barrett et al., 2008; Walitzer et al., 1999; Zwick & Attkisson, 1985). The current study seems to indicate that with low SES clients seeking counseling in a community mental health agency, a videotaped role induction to counseling alone is not sufficient to impact the occurrence of premature termination. A meta-analysis reported rates of premature termination at 46.86% for outpatient therapy clients (Wierzbicki & Pekarik, 1993). The current study’s rate of premature termination for the role induction group was 49% which is slightly higher than the average. These data indicate that the role induction alone was not enough to reduce premature termination. As stated earlier, one potential reason for the lack of significant results was the failure to include a discussion with the therapist about the role induction information.

Future research should be conducted that includes a greater role by the counselor in the role induction. A videotaped role induction could be utilized as a starting point, but the counselor should play a more active role in this process. One way this could be accomplished would be for the counselor to facilitate a discussion with the client about the information presented, ensure the client understood the information and offer the client the opportunity to ask questions or express concerns. The inclusion of a more interactive discussion about counseling may serve to enhance the benefits of the role induction. Also, this focused discussion about counseling may aid in the facilitation of the therapeutic relationship which has been consistently shown to be an important component of therapy (Wampold et al., 2001). Research should be completed using a
videotaped role induction to counseling with the addition of a brief discussion initiated by the therapist to include the points discussed above.

As discussed earlier, the lack of diversity in the sample, the counseling setting and in the race/ethnicity of the counselors limits the generalizability of the results. Future research should be conducted with more diverse clients in different counseling settings. Clients who seek counseling at community mental health centers may be different than those who seek services at other counseling settings and thus different results may be found. Further, the counselors utilized in the study were all Caucasians. Completing research with a more diverse group of counselors may impact the results as well.

One significant issue noted in the research is the lack of consensus on the definition of premature termination (Hatchett & Park, 2003). This study attempted to utilize a more meaningful definition of premature termination by including the clients’ perspective on therapy length (Mueller & Pekarik, 2000) based on research has shown that the best indicator of therapy length is clients expected length of therapy (Mueller & Pekarik). This is an area that requires more research. The inclusion of the client’s perspective on therapy length was an advancement of the literature. However, the results of this study seem to indicate that this alone is not enough. Previous definitions of premature termination have mainly been based on therapist perspective and the current study utilized the client’s perspective with similar rates of premature termination. The next step is to complete research that includes both perspectives on therapy length to explore the impact a collaborative decision would have on premature termination. Clients and counselors should have an open dialogue about counseling length and commit to a number of sessions jointly.
Implications for Practice

The value of a role induction to counseling has been shown repeatedly in the literature (Barrett et al., 2008; Reis & Brown, 2006; Walitzer et al., 1999; Zwick & Attkisson, 1985). Despite the research demonstrating the value of a role induction to counseling, most counselors approach it in a cursory manner (Haas, 1991) or only review the basic information about counseling (Somber, Stone, & Claiborn, 1993). One potential reason therapists fail to complete a thorough role induction is time. The use of the videotaped role induction may help begin to educate clients about therapy. However, the current study seems to indicate that this is not enough. Counselors should, in conjunction with a videotaped role induction, engage the client in a discussion about the information shared in the video, how the information relates to the client, ensure that the client understands the information presented and answer any questions the client may have. Further, the therapist can highlight any areas he or she feels is most salient for the client. The merging of a standardized role induction with the client therapist-discussion may help solidify the information shared as well as enhance the development of the therapeutic relationship. Also, the therapist initiating a dialogue about the information shared in the role induction will reduce the burden on the client to start the discussion.

Several demographic characteristics (i.e. low SES and low education) have consistently been linked with premature termination in the literature (Kazdin, Stolar, & Marciano, 1995; Wierzbicki & Pekarik, 1993; Williams, Ketring, & Salts, 2005). Although it is hard to draw specific conclusions about the current study due to low variability and high similarity of the participants, the results seem to mirror previous research linking low SES and education and premature termination. These demographic
characteristics, more than any others, have been identified as significant barriers to treatment (Barrett et al., 2008). The consistent link between premature termination and low SES and education, make this an important discussion point in counseling. Counselors who work in settings that serve clients with low SES and low education should address this with clients in a supportive way. Initially focusing more on these issues may help reduce premature termination in several ways.

First, discussing the impact these serious life issues are having on the client will help build the therapeutic relationship. Clients may feel understood by the counselor in a deeper way when the counselor offers support to the client. Clients may have difficulty addressing these issues in counseling or they may not fully understand the ways counseling could be affected initially. It will be important for the counselor to initiate the discussion with the client.

Second, counselors working with clients experiencing financial problems should focus time in counseling on helping them procure services they need. Offering the client concrete ways to address their specific needs (i.e. food, clothing, shelter, etc.) will reduce the negative impact these issues have on the client, and subsequently on therapy. Again, receiving help with these basic life needs will demonstrate the counselor’s commitment to the client and potentially serve to enhance the therapeutic relationship.

Last, social class has been regarded as one of the three most important cultural cornerstones of multicultural theory and research, but also the most misunderstood (Liu, Ali, Soleck, Hopps, Dunston, & Pickett, 2004). Therapists working with low income clients should receive training to improve cultural awareness and competence around social class (Smith, 2005). Therapists, like with other cultural groups, should examine
their attitudes towards the poor and work to increase their knowledge, awareness, and skills to better treat those of low social class. An increased competence in this area may help reduce the negative impact SES has on remaining in treatment.

Strengths and Limitations

The current study exhibited several strengths. First, the study was conducted in a community mental health center with real clients seeking counseling services. This makes the results applicable to real world clients seeking counseling services. Second, the random assignment, experimental design allowed for comparisons between those who received the role induction intervention and those in the control group who did not. A large amount of previously completed research has been non-experimental. Third, the current study tested an intervention to reduce premature termination with real clients seeking counseling. Research on methods to reduce premature termination has been called for in the literature (Barrett et al., 2008). Despite the identified strengths, the current study was not without limitations.

First, the results of the study should not be generalized to all adult clients seeking counseling. The participants in this study were mostly single, Caucasians with a high school education and a household income below $7356.00. It is possible these clients differ in important ways from clients seeking services in diverse settings or those with more education or higher SES. Although the real world setting of the study is a significant strength, this leads to limitations as well. The lack of experimental control could have impacted the results. Numerous counselors participated in the study with varying levels of training. Counselors may have approached the question of commitment
to counseling in different ways which could have impacted the clients understanding of the question and their subsequent response.

Second, although a manipulation check was included, the level of understanding of the information presented in the videos was not determined. Although a majority of participants were able to state the basic idea of the video (92%), it is unknown how deeply they understood the information presented. The clients in the experimental group may not have fully understood the importance of committing to counseling, regular attendance, and their role in counseling. Clients may have been uncomfortable broaching the topic of their specific barriers to treatment so early in counseling. Clients may also have felt powerless to express concerns or dissatisfaction with counseling in the first 4 sessions.

Despite these limitations, the present study advanced the literature in several ways. First, the current study empirically tested an intervention to reduce premature termination. The lack of significant results provides further support that premature termination is a complex issue that requires further study. Second, the study was conducted in a real world setting with real clients. The results of the study seem to indicate that with real clients in a community mental health setting, a videotaped role induction alone it not enough to reduce the occurrence of premature termination. Third, this study explored the impact an idiographic definition of premature termination would have on the occurrence of premature termination. The results of the current study seem to indicate that the inclusion of the client’s perspective on therapy length is not the sole determinant of therapy length.
REFERENCES


APPENDICES
APPENDIX A

DEMOGRAPHIC INFORMATION GATHERED

1. Age: ____________________
2. Sex
3. Have you been in counseling previously?  Y or N
4. What is your ethnicity/race?
   a. African American/Black/African Origin
   b. Asian American/Asian Origin/Pacific Islander
   c. Latino-a/Hispanic
   d. American Indian/Alaska Native/Aboriginal Canadian
   e. European Origin/White
   f. Bi-racial/Multiracial
   g. Other (specify) ______________
5. What is your current family income
6. Marital Status
7. What is the highest education level attained?
   a. Some high school
   b. High School Graduate
   c. Some college
   d. College Graduate
   e. Professional Degree
APPENDIX B

COMMITMENT INFORMATION SHEET

Client #: __________

(Therapists: complete #1 and 2 during Intake)

1. Did the client talk about the Video in your session □ Yes □ No

2. Explain: ‘Your therapy might take anywhere from ‘x’ number to ‘x’ number of sessions. How many # Session commitment:

   ________ sessions would you commit to attending
   (between 0 – 4) during this initial period?’

   ...........................................................................................................................................................................................
   ............

3. Did client attend number of sessions committed? □ Yes □ No
APPENDIX C

STAGES OF CHANGE SCALE

Each statement describes how a person might feel when starting counseling or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your “problem”, answer in terms of the problem you are seeking counseling to address. “Here” refers to the place of treatment.

There are FIVE possible responses to each of the items in the questionnaire:

1  2  3  4  5
Strongly Disagree Undecided Agree Strongly Disagree Agree

1. As far as I’m concerned, I don’t have any problems that need changing. _____
2. I think I might be ready for some self-improvement. _____
3. I am doing something about the problems that had been bothering me. _____
4. It might be worthwhile to work on my problem. _____
5. I’m not the problem one. It doesn’t make much sense for me to be here. _____
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help. _____
7. I am finally doing some work on my problem.

8. I’ve been thinking that I might want to change something about myself.

9. I have been successful in working on my problem but I’m not sure I can keep up the effort on my own.

10. At times my problem is difficult, but I’m working on it.

11. Being here is pretty much a waste of time for me because the problem doesn’t have to do with me.

12. I’m hoping this place will help me to better understand myself.

13. I guess I have faults, but there’s nothing that I really need to change.

14. I am really working hard to change.

15. I have a problem and I really think I should work at it.

16. I’m not following through with what I had already changed as well as I had hoped, and I’m here to prevent a relapse of the problem.

17. Even though I’m not always successful in changing, I am at least working on my problem.

18. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.

19. I wish I had more ideas on how to solve the problem.

20. I have started working on my problems but I would like help.

21. Maybe this place will be able to help me.

22. I may need a boost right now to help me maintain the changes I’ve already made.

23. I may be part of the problem, but I don’t really think I am.
24. I hope that someone here will have some good advice for me.

25. Anyone can talk about changing; I am actually doing something about it.

26. All this talk about psychology is boring.
   Why can’t people just forget about their problems?

27. I’m here to prevent myself from having a relapse of my problem.

28. It is frustrating, but I feel I might be having a recurrence
   of a problem I thought I had resolved.

29. I have worries but so does the next guy.
   Why spend time thinking about them?

30. I am actively working on my problem.

31. I would rather cope with my faults than try to change them.

32. After all I had done to try to change my problem,
   every now and again it comes back to haunt me.
APPENDIX D

EXPECTATIONS ABOUT COUNSELING QUESTIONNAIRE

Directions

We would like to know just what you think counseling will be like. On the following pages are statements about counseling. In each instance you are to indicate what you expect counseling to be like. For each statement, circle the number that most accurately reflects your expectation. When you are ready to begin, answer each question as quickly and as accurately as possible. Finish each page before going to the next.

Not  Slightly  Somewhat  Fairly  Quite  Very  Definitely
True  True  True  True  True  True  True

I EXPECT TO.....

1. Like the counselor.

2. Gain some experience in new ways of solving problems within the counseling process.
3. Openly express my emotions regarding myself and my problems.

4. Take responsibility for making my own choices.

5. Talk about my present concerns.

6. Get practice in relating openly and honestly to another person within the counseling relationship.

7. Enjoy my interviews with the counselor.

8. Practice some of the things I need to learn in the counseling relationship.

9. Get a better understanding of myself and others.

10. Stay in counseling for at least a few weeks, even if at first I am not sure it will help.

11. See the counselor for more than three interviews.

12. Enjoy being with the counselor.

13. Stay in counseling even thought it may be painful or unpleasant at times.
14. Contribute as much as I can in terms of expressing my feelings and discussing them.

1   2   3   4   5   6   7

15. Find that the counseling relationship will help the counselor and me identify problems on which I need to work.

1   2   3   4   5   6   7

16. Become better able to help myself in the future.

1   2   3   4   5   6   7

17. Feel safe enough with the counselor to really say how I feel.

1   2   3   4   5   6   7

18. Improve my relationship with others.

1   2   3   4   5   6   7

19. Ask the counselor to explain what he or she means whenever I do not understand something that is said.

1   2   3   4   5   6   7

20. Work on my concerns outside the counseling interviews.

1   2   3   4   5   6   7
APPENDIX E

ROLE INDUCTION VIDEO TRANSCRIPT

Introduction:

Hello. This short video has been designed to explain the process of counseling and your role in it. What you are about to see is a mock first counseling session where the “counselor” is talking to the “client” about counseling, what to expect in counseling, the process of counseling, and how you as the client fits into the process of counseling. Please pay close attention to what is happening in the session because this video has been designed to help you get the most benefit from your time in counseling.

Counselor: Hello Sue, my name is Kim, welcome. What I want to do first is talk to you about counseling, my approach to counseling, and the process of counseling. Do you have any questions before we get started?

Client: Not right now.

Counselor: Ok, please feel free to stop me and ask as we go if you think of any.

Client: Ok

Counselor: First, I want to talk about therapy in general. Therapy works best when we work collaboratively. By that I mean we work together to help you meet your goals. You and I will talk about what it is you are having trouble with and we will figure out what your goals are for therapy. I am not here to tell you what to do nor do I have all the answers, we will work together to figure that out.

Client: So, we work together to figure things out?

Counselor: That’s right, you know yourself better than I do, so we will work together to help you meet your goals. It will be very important for you to be open and honest with me and talk to me about how you are feeling, what you are thinking, etc. because that is the only way I will be able to learn how it is for you. I will do the same for you. I will be as open and honest as I can. Do you think you can do that?

Client: It may be hard but I will try.
Counselor: Great. Next I want to talk about the process of therapy. Therapy works best when the counselor and client have a good relationship. This goes back to us being open and honest with each other. Part of that includes you talking about what is working in counseling and if things are not working talking about that as well. So, what I am going to ask is that if you find yourself feeling like counseling is not working, tell me.

Client: You want me to tell you if I feel like things are not getting better?

Counselor: That is right. Often times clients feel like things are not getting better and they stop coming to counseling without talking about it first. This is understandable; however, if we can talk about these issues that we can work to resolve them. Ok? Often, if one of us feels like things are not moving along and we talk about it, we can resolve the problem and get things back on track.

A big part of this will include you showing up for your sessions. It is really important that you attend your appointments regularly. Often when clients become frustrated in therapy or don’t feel like it is going anywhere they stop showing up. However, often, things get worse before they get better so committing to therapy will go a long way to successfully meeting your goals. Counseling is effective but to be effective you have to show up. Does that make sense?

Client: I think. So, what you are saying is that if I feel like counseling is not helping or that we are not working well together, I should talk to you about that. That might be difficult but I will try. Also, I need to be good about keeping my appointments.

Counselor: I know talking about it would be hard, but we both are responsible for you meeting your goals. I want to help you the best I can and to do that we both have to be honest with each other. If I feel like things are not going well or we are not making progress I will bring it up to you as well.

Client: Ok. I think I can do that. I do have a question though.

Counselor: Great -What’s that?

Client: How long will counseling last?

Counselor: That is a great question. There is no set number of sessions that work for everyone. You and I will talk periodically about how counseling is going and we will decide together when we think it is time to end. If you feel like your goals are met or that you are near meeting your goals let me know and we can talk about ending therapy. And, if I feel like we have made progress toward your goals and we are getting near termination I will bring it up to you. When to end therapy is a decision that you and I will make together.

Client: So, you and I should talk about this and decide together?
Counselor: Yes. We are a team and we should talk about this together and decide when it is the right time to end.

Client: That sounds good.

Counselor: You are a very important component of this relationship so it is important you feel safe and comfortable in counseling. Also, please feel free to ask questions at any time throughout therapy. If you wonder what I am thinking, or how I feel things are going, please ask. I will be as honest and open as I can with you just as I hope you will be with me.

Client: That sounds good.

Summary:

What you just saw illustrates a first session of counseling and highlights some very important things.

First, the counselor and client need to develop a positive relationship, one built on trust and honesty. Both of you need to be invested in counseling and working towards meet your goals. You are a very important part of counseling and it is imperative that you be open and honest with your counselor. If you have questions at any time throughout your time in counseling, you should talk to your counselor. He or she will be happy to talk to you about any questions or concerns you have.

Second, you and your counselor will talk about your problem and set goals you are working toward. A counseling goal is what you want to get out of counseling. Then periodically, you two will talk about the goals, if you are making progress, and if not, talk about what is going wrong so that changes can be made in therapy so you can meet your goals. Again, being open and honest with your counselor about how you feel things are going will be very important.

Third, it is very vital that you attend therapy regularly. If you can’t make your appointment you should call and let your counselor know and reschedule. For counseling to be effective you need to be there. Also, you and your counselor will decide together when it is time to terminate.

Last, counseling is effective and can help you deal with what is bothering you. Sometimes counseling goes more smoothly than others and change does not happen overnight. It is important you stick with it and talk to your counselor about what you are feeling.

Thanks for watching and I hope this has been helpful for you as you start counseling.
Introduction:

Hello. This short video has been designed to explain the counseling services that are available to you at the counseling center. What you are about to see is a mock first counseling session where the “counselor” is talking to the “client” about the counseling services that are available to clients of the counselor center. Please pay close attention to what is being talked about in the mock session because this video has been designed to help you learn about all the services available to you so you can get the most benefit from your time at the counseling center.

Counselor: Hello Sue, my name is Kim, welcome. Since this is your first session I want to take a few minutes to talk to you about the services available to you as a client of the clinic. Ok? Do you have any questions before we get started?

Client: Not right now.

Counselor: Ok, please feel free to stop me and ask as we go if you think of any.

Client: ok.

Counselor: All right. First I will talk about the counseling services. All counseling services are provided to you at a minimal cost. We conduct individual, couples, family, and group counseling here at the counseling center.

Client: I didn’t know you did group and couples counseling. What types of things do people come to counseling to talk about?

Counselor: Individual counseling can focus on a number of topics. Personal issues such as depression, anxiety, or relationship concerns can be the focus of your counseling. Let’s say you are having trouble making an important decision, you can talk to your counselor about this issue and work on finding ways to deal with the situation. Also, if you feel like you are sad, overwhelmed, or even not coping as well as you would like with life, you can talk to your counselor about these issues.

Client: What if I am having trouble at work?
**Counselor:** Counseling can focus on work issues and how to cope with difficult situations like a demanding boss, trouble with co-workers, or worries about losing your job. You can also talk about making a decision about changing careers or looking for a new job.

Client: That is nice. I didn’t know people talked about all this issues in counseling. What about the couples counseling you mentioned.

**Counselor:** We also offer couples counseling at the center. Let’s say you and your partner are having trouble getting along, you can come into the center together and talk to someone who is trained to help. The counselor can help you find better ways to communicate, talk about the problems you are having and make the relationship better.

Client: That is cool. What other services do you provide at the center.

**Counselor:** We also offer group counseling that focus on a variety of issues. We offer many groups at the center which allow you the opportunity to work with other individuals that are experiencing the same issue you are. Group counseling offers you the opportunity to get feedback and help from many people who are dealing with the same issues that you are.

Client: Group counseling sounds really interesting and like it can be helpful.

**Counselor:** It is and it can be really useful to many people.

**Counselor:** Counseling can focus on a variety of problems and concerns. Counseling is for you so whatever you need help with can be the focus of your sessions. We also offer family counseling as well as counseling for children. We have counselors who are trained specifically to work with kids and families.

Client: You also work with kids and families? I didn’t know you guys did that here.

**Counselor:** Yes, often when families or children are having problems it helps to meet with the entire family together and help the family work better together.

Client: That is great information. Thanks for talking to me about all the services you offer. I didn’t know about many of the opportunities available here.

**Summary:**

What you just saw illustrates a counseling session which highlighted some of the services that are available to you at the counseling center.

As you can see, there are many services available to you here at the center. We offer counseling for many issues including personal concerns such as depression, anxiety, and interpersonal issues. People seek counseling for a variety of issues.
Next the counselor talked about couples counseling. These services are designed to help you deal with issues you may have in your romantic relationship. Relationships are difficult and learning skills that you and your partner can use to enhance your relationship can be invaluable.

Group counseling is also available. Group counseling gives you the opportunity to get feedback from a variety of people which can be very helpful. Most people find group counseling immensely beneficial.

The last type of counseling the counselor talked about was kids and family counseling. The center has counselors who are trained specifically to help children and families when they are having difficulties.

I hope you learned something about the services available to you at the clinic and feel free to ask your counselor if you have any questions about what you saw in the video.

Thanks for watching and I hope this has been helpful for you as you start counseling.
Ms. Hendrickson:
Your IRB protocol entitled "Impact of Role Induction on Premature Termination and Stage of Change" (#20090709-2) has been approved and the approval letter is in the mail to you.*

THE APPROVAL WILL EXPIRE AUGUST 28, 2010!
If at that time you intend to renew the project, an application for continuing review must be in our office and approved by the expiration date. There is no grace period.

• If changes are made to the protocol before the expiration date, you must submit an application for continuing review for IRB approval of the modifications. (Present only the form which is in current use. * Old forms will not be accepted.)

• When the project is completed, you must submit a final report form to complete the IRB file. (Present only the form which is current use. Old forms will not be accepted.)

*Please see:
http://www.uakron.edu/research/orssp/compliance/IRBAppForms.php

* (So that we may maintain contact with you, forward change of mailing address, phone number or e-mail address to this office.)

Please call if you have questions. Thank you.