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ABSTRACT

Premature termination of client counseling has primarily been studied in university counseling centers and outpatient therapy settings. Findings from studies at university centers have indicated that some personality variables may be related to premature termination, including low self-esteem, low anxiety, high tolerance for ambiguity, and impulsivity. There has been little clear information obtained about the demographic and psychological characteristics of clients who are unlikely to follow through with treatment. This study investigated premature termination of treatment at a university counselor training clinic. Client demographics (age, gender, education, marital status, family income, client urgency, prior counseling experience at the clinic, and prior counseling experience elsewhere) and psychological symptoms as measured by the Symptom Check List-90-Revised were analyzed for 417 primarily Caucasian clients. Two factors emerged as statistically significant: family income and being a former client at the clinic. Clients with higher incomes tended to continue in counseling, while those with lower incomes were more likely to prematurely terminate. Clients who had received prior treatment at the clinic were more likely to continue in counseling than those who were first-time clients. (NB)

Symptomatic and Demographic Predictors of Premature Termination

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Running Head: PREMATURE TERMINATION

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Abstract

This study investigated premature termination at a university counselor training clinic. Factors considered included client demographics (e.g., age, gender, marital status) and psychological symptoms, as measured by the SCL-90-R. The sample was predominantly Caucasian, consisting of 279 females (67%) and 138 males (33%). Two factors emerged as statistically significant: (a) family income and (b) being a former client at the clinic. Implications for counseling are delineated.

Symptomatic and Demographic Predictors of Premature Termination

Premature termination has been studied in a wide variety of settings and has been defined in several ways over the past three decades. From these studies, it has been estimated that 30%-60% of all out-patient psychotherapy clients drop out of treatment prematurely (Pekarik, 1983).

Definitions of premature termination have varied. In a broad sense, premature termination is defined as clients leaving treatment before they should (Mennicke, Lent, & Burgoyne, 1988). However, several more specific definitions have been used, including a failure to return for a certain number of counseling sessions following an intake (Betz & Shullman, 1979; Epperson, 1981; Hoffman, 1985; Rapaport, Rodolfa, & Lee, 1984). A related definition of dropouts from treatment defined these clients as those who failed to return after the initial interview, failed to return prior to a mutually agreed upon time of termination, or failed to keep their initial appointment (Miller, 1983).

Premature termination has primarily been studied in university counseling centers (Berry & Sipps, 1991; Eliot, Anderson, & Adams, 1987; Mennicke et al., 1988) and out-patient therapy settings (Baekeland & Lunwall, 1975; Hoffman, 1985). A review of research for each setting has indicated that several variables have been examined in an attempt to understand the factors which contribute to this common occurrence.

Findings from studies at university counseling centers have indicated that some personality variables may be related to premature termination. These variables included low self-esteem (Robbins, Mullison, Boggs, Riedesel, & Jacobson, 1985), low anxiety (Jenkins, Fuqua, & Blum 1986), high tolerance for ambiguity (Heilbrun, 1982), and impulsivity (Kirk & Frank, 1976). In a study of MMPI profiles, Elliot,

Anderson, and Adams (1987) noted that social isolation and depression were shown to be predictive of longer treatment. These socially isolated clients may be using therapy as a "purchase of friendship" (Schofield, 1964). The elevated depression score indicated how much discomfort the client is feeling and how likely he/she is to remain in treatment (Dahlstrom, Welsh, & Dahlstrom, 1972; Duckworth, 1979; Graham, 1977). In considering demographics, both low socioeconomic status and minority group status have also been found to be correlated with high attrition rates (Garfield, 1986).

Findings from out-patient counseling centers have indicated a variety of contributing factors to premature termination. Baekeland and Lundwall (1975) reviewed the literature and observed that predictors of termination included age (Brown & Kosterlitz, 1964; Gottschalk, Mayerson, & Gottlieb, 1976), sex (Brown & Kosterlitz, 1964; Cartwright, 1955; Rosenthal & Frank, 1958; Weiss & Schaie, 1958), and socioeconomic status when treatment was psychoanalytic (Bailey, Warshaw & Eichler, 1959; Winder, Ahmad, Bandura, & Rau, 1962; Yamamoto & Goin, 1965). Further psychological variables predictive of termination included low levels of anxiety and/or depression (Frank, Gliedman, Imber, Nash, & Stone, 1959; Taulbee, 1958), paranoid symptoms (Hiler, 1959), sociopathic features (Hiler, 1959; Lloyd, Katon, DuPont, & Rubenstein, 1973), and alcoholism (Straker, Devenloo, & Moll, 1967). A more recent study (Hoffman, 1985) indicated that previous psychiatric contact was indicative of longer attendance, and certain psychological variables signaled that counseling was likely to continue. Persons diagnosed as psychotic or as having a thought disorder were more apt to return. However, clients with interpersonal problems were likely to terminate prematurely. Reuter and Wallbrown (1986) found that premature termination may be correlated to personality variables (i.e.,

adventurous, impulsive, carefree, extroverted, assertive, and resourceful).

Although many studies have been undertaken in an effort to understand premature termination, there has been little clear information obtained about the demographic and psychological characteristics of clients who are unlikely to follow through with treatment. The present study is an attempt to contribute to the literature regarding research on premature termination by examining demographics and psychological variables which may predict premature client termination.

Method

Participants

Data was analyzed on 417 primarily caucasian clients who requested counseling services at a community counseling clinic during a two year period. The clinic is operated by the Counseling Psychology Department of a large Midwestern university as a training facility for masters and doctoral level counseling students. The clinic charges a nominal $30 fee per semester for weekly individual and/or family sessions.

Information extracted from the clients' data files included age, gender, education, marital status, family income, client urgency, prior counseling experience at this clinic, and prior counseling experience elsewhere. The sample consisted of 279 females (67%) and 138 males (33%) with the average age being 35 years (SD = 9.7 years). The average family income of the clients was between $15,000 and $20,000. The clients were almost exclusively Caucasian with fewer than 1.0% being from minority groups.

Instrument

SCL-90-R (The Symptom Check List) is a 90-item self-report symptom inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients (Derogatis, 1983). Each item is rated on a 5-point scale of distress (0-4),

ranging from "not-at-all" at one pole to "extremely" at the other. The inventory is scored and interpreted in terms of nine primary symptom dimensions (Somatiztion, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, Psychotism) and three global indices of distress (Global Severity Index [GSI], the Positive Symptom Distress Index [PSDI], and the Positive Symptom Total [PST]). The three global indices reflect somewhat different aspects of psychopathology (Derogatis, Yevzeroff, & Wittelsberger, 1975). The GSI represents the best single indicator of the number of symptoms and the intensity of the complaints. The PSDI indicates whether the client is augmenting or attenuating the reporting of his or her symptomatic distress. The PST is a count of the number of symptoms the client reports as having experienced.

Several studies have established satisfactory reliability and validity indications for the SCL-90-R. Test-retest reliability ranging between .80 and .90 and alpha coefficients between .77 and .90 have been reported for the nine symptom dimensions (Derogatis, 1983). A high degree of concurrent validity was found between the nine symptom dimensions and the MMPI (Derogatis, Richels, & Rock, 1976) and the Middlesex Hospital Questionnaire (Bolelouchy & Horvath, 1974). Convergent and discriminant validation of the instrument in divergent clinical settings has been established (Brown, Sweeney, & Schwartz, 1979; Kandel & Davies, 1982; Derogatis, Meyer, & Gallant,1977; and Derogatis, Meyer, & Vasquez, 1978. Evidence of the instrument's construct validation has also been cited (Derogatis & Cleary, 1977a). Alpha coefficients, ranging between .77 for Psychotism to .90 for Depression, reflect satisfactory internal consistency for the nine dimensions (Derogatis, 1983). Test-retest reliability conducted after a one week interval yielded coefficient estimates between .80 and .90 for the nine symptom scales. Demonstrations of factorial

invariance for the dimensions have also been found for social class and psychiatric diagnosis (Derogatis, Lipman, Covi, & Richels, 1971; 1972) and across gender (Derogatis & Cleary, 1977b).

Procedure

Prior to the intake interview, all clients 18 years of age or older filled out the SCL-90-R questionnaire. Doctoral students in the counseling program completed the standard intake interviews which queried demographic information. Contact with clients after intake was done by the assigned counselor. Information about the nature of termination and the number of sessions was extracted from the clients' electronic data files routinely recorded by the counseling clinic office manager.

As previously discussed, the literature showed a range of definitions for premature termination. For example, Miller (1983) discussed premature termination ranging from the short and specific (not keeping the initial appointment) to longer-term and more vague (failing to return prior to a mutually agreed upon time). For the current study, "continuers" and "premature terminators" were divided into groups based partly on the previously cited literature and partly on the authors' own judgment.

Clients were assigned post-hoc to one of two groups. Clients in the first group were considered "continuing clients" if they attended three or more sessions. This group included clients in both long-term and short-term individual therapy. There were 331 clients in this group, representing 79% of the sample.

Participants in the premature termination group were placed in this category if they had attended fewer than three counseling sessions and their counselor had indicated the "client withdrew from clinic" on the termination report. There were 86 clients in this group, representing 21% of the sample.

Clients were excluded from the study if they attended fewer than three counseling

sessions and their counselor indicated on the termination report that: (a) the counselor terminated client with no referral (i.e., since these clients were counselor-terminated, they did not seem to be premature terminators; they could not be considered a continuing client either, given the brevity of their treatment), or (b) the counselor referred client to another clinician or agency (i.e., again, these clients did not fit either of the two groups).

Other clients not meeting the selection criteria were omitted if (a) the client was under age 18 years of age and did not complete the SCL-90 form; (b) the client was currently undergoing counseling and a termination report was not yet completed; or (c) the counselor failed to properly complete the termination report (e.g., the number of completed sessions was missing).

Analysis

Stepwise multiple regression at an alpha level of .05 was performed with the dependent variable being client disposition (i.e, continuing counseling and prematurely terminating). The client demographic variables (age, gender, education, marital status, family income, client urgency, being a previous client at this clinic, and prior counseling experience elsewhere) and the SCL-90-R scores were the predictive variables.

Results

Two factors emerged as statistically significant at the .05 level in the analysis. Family income ($F = 10.37$) was significant and accounted for 2.4% of the total variance. Clients with higher incomes tended to continue in counseling, while those with lower incomes were more likely to prematurely terminate. Chi-square on this variable was significant at $<.01$ ($df = 7$).

The second statistically significant variable was being a former client at the clinic

($F = 7.96$), which accounted for 1.3% of the total variance. Clients who had been a previous client at the clinic were more likely to continue in counseling than those who were first-time clients. Chi-square on this variable was significant at $<.01$ ($df = 2$).

In summary, family income and being a previous client were the only two statistically significant factors in the final equation. These factors accounted for less than 4% of the total variance of premature termination from individual counseling. No other factors emerged as significant, even with the significance level extended to .10. Results of the variables in the final regression equation are presented in Table 1.

Discussion

The results of this study indicated that family income and having had prior counseling at the same clinic were the only significant factors predicting premature termination. Consistent with indications from previous research (e.g., Baekeland & Lundwall, 1975; Brandt, 1965; Garfield, 1986) was the finding that clients with lower income were more likely to drop out from counseling than clients with higher incomes. Clients previously treated at the clinic were also less likely to terminate prematurely than new clients. This supported Hoffman's (1985) findings.

The results do not support the possibility that other salient demographics such as client age, gender, educational status, marital status, degree of urgency, or prior counseling experience outside of the clinic were significantly predictive of client attrition. Interestingly, none of the self-reported psychological symptom dimensions and global indices of stress, as measured by the SCL-90-R at the time of the intake session, was found to be related to premature withdrawal from counseling. Thus, while self-report measures of symptoms administered as part of the intake process may yield valuable clinical information about clients' presenting behavior, they may

have less predictive value than other measures such as the MMPI (Elliot, Anderson, & Adams, 1987; Reuter & Wallbrown, 1986) and the Counseling Readiness Scale (Heilbrun & Sullivan, 1962) in indicating client attrition. The finding of a client attrition rate of 21% by the third session in this study parallels the finding reported by Betz and Shullman (1979). They found that nearly 25% of clients failed to return for the scheduled first or second counseling session following intake.

The results of this study have several implications for counselors and counseling centers. First, clients who are first-time consumers of counseling services may be more vulnerable to premature termination than those who had previous experience at the clinic. Their anxiety about their presenting issues may be exacerbated by their tentativeness about seeking counseling, apprehension about the cost of therapy, uncertainty about the counseling process, and their unrealistic notions of therapy outcome or therapist role. Such factors may contribute to clients' increased vulnerability and may require the expertise of a more experienced counselor or more specialized training for beginning counselors.

Second, lower income clients might have different expectations of the pace and nature of the counseling process than the therapist. The literature pertaining to counseling clients from lower SES backgrounds indicates that not all clients may want insight therapy (Goin, Yamamoto, & Silverman, 1965). Lower income clients may be overwhelmed with reality concerns such as unemployment and be better served by directive interventions that initially focus on their basic needs and stressors (Marthura & Baer, 1990).

There is evidence that therapists who have more clinical experience have lower dropout rates with lower class clients (Baum, Felzer, D'Zmura, & Schumaker, 1966). It has also been suggested that therapists originally from lower class backgrounds may

be more able to understand lower class clients than therapists from middle and upper class backgrounds (Mathura & Baer, 1990).

Counseling centers may also want to consider alternate arrangements for clients not able to afford the standard fee. It is important that parameters such as fees and payment schedules be agreed upon initially and reflect the client's ability to pay. Counselors and counseling centers may need to be better equipped in terms of knowledge, broader treatment modalities, programs, and services to better serve clients from all socioeconomic levels (Hoffman, 1985).

Many clients may benefit from education regarding the conditions, characteristics, procedures, and boundaries of the counseling process (Day & Sparacio, 1980; Mennicke, et al., 1988). Such structuring may facilitate early identification and resolution of client and counselor difference in assumptions and expectations.

That measures of the clients' self-reported symptoms and indices of distress did not yield any significant indicators, needs to be seen in perspective since the time that elapsed between intake and the first session could not be controlled. In some cases the first session occurred within a week of the intake. In other cases, intakes done towards the end of the semester were not assigned for several weeks. It is therefore difficult to determine whether early withdrawal from counseling was due to symptomatic relief or other reasons.

The results of this study need to be treated with caution because of constraints inherent in using an existing data base and the small effect size. Although two factors emerged as significant, there appear to be other factors not investigated in the current study. While most studies of premature termination attempt to identify the salient factors in a predictive fashion, we may learn much more about this phenomenon by directly surveying the responses of clients deemed to have withdrawn from counseling

prematurely by whatever definition.

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Table 1

Premature Termination Factors using Stepwise Regression

Variable	R	R^2	p
Demographic Factors			
Family Income	.156*	.024	<. 01
Previous Client	.114*	.013	<.02
Age	.060	.004	. 22
Gender	.023	.001	.64
Education	.075	.006	.12
Marital Status	.044	.002	.37
Client Urgency	.050	.003	.31
Prior Counseling Experience	.058	.003	.24
SCL-90-R Scores (Individual Scales)			
Somatization	.002	< .001	.97
Obsessive-compulsive	.021	< .001	.67
Interpersonal Sensitivity	.027	.001	.58
Depression	.002	< .001	.97
Anxiety	.029	.001	.56
Hostility	.017	< .001	.72
Phobic Anxiety	.051	.003	.30
Paranoid Ideation	.021	< .001	.66
Psychoticism	.011	< .001	.82
Global Rating Scores			
General Severity Index	.002	< .001	.97
Positive Symptom Distress Index	.050	.003	.30
Positive symptom Total	.001	< .001	.99

*p < .05