Client Perception of Therapy and the Variables Implicated in Length of Stay

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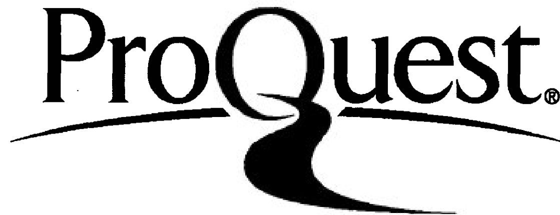

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Abstract

Consistently high rates of premature termination from counselling concern the providers and researchers of psychotherapy. In this thesis three variables were explored for a better understanding of premature termination. Social support, therapist qualities, and client demographics were hypothesized to impact on how long clients would remain in therapy. Thirty participants were placed in one of three groups, late terminators (LT), early terminators (ET) or remainers (R). Levels of perceived social support were assessed by the Social Support - Behaviors questionnaire, therapist and counsellor characteristics by the Counselor Evaluation Inventory and the Counselor Rating Form - Short. Demographics and clients' perceptions were obtained on a brief form included with the questionnaires. Social support was not found to be related to attrition rates which is in conflict with previous research. Age, sex and number of children were found to be somewhat related to termination, the results did not, however, meet the criteria for significance. Counsellor experience, attractiveness and trustworthiness were, to some extent, linked to length of stay in therapy. With regard to premature termination, some differences were noted in favour of the R group but they were not large and on some varibles the ET, LT and R groups did not differ. Further studies should make the distinction between early and late terminators as some differences do appear to exist between these two groups of premature terminators.

Clients' Perception of Therapy and the Variables Implicated in Length of Stay

INTRODUCTION

Premature termination is viewed as a serious impediment to the successful provision of psychological services. Prior to the 1950s, there was a growing awareness of this particular issue, but a dearth of research. In the early 1950s, the initial research appeared to be generated by three main beliefs about why individuals terminated and how to counter the problem. Psychotherapy research continues, but the current approaches represent a marked modification of the initial research efforts. The umbrella of knowledge has widened and has shaped present day research efforts.

The rationale behind this study was to reassess previously identified variables that impact on clients' length of stay in therapy. As well, this study was conducted to explore further the issue of whether all clients who prematurely terminate comprise a homogenous group of individuals failed by their treatment.

Identification of the Problem

The issue of premature termination is a pertinent concern to those providing psychotherapy. One standard definition of termination, and the one used for the purpose of this research, is that it involves "...persons who have unilaterally withdrawn from therapy at some point, either explicitly against the advice of the

therapist or more implicitly by canceling appointments and failing to recontact" (Cross & Warren, 1984, p. 363). When the rates of premature termination are significant in number, questions are raised about the quality of therapy and the impact therapy has had on clients. A survey of the rates being presented within the literature vary from around 20 to 57% (Baekeland & Lundwall, 1975). Wise and Rinn (1983) stated that the mental health centre they surveyed had a 75.6 % termination rate before the fourth session. A more recent investigation, where researchers examined group therapy termination, reported an overall dropout rate of 33 % (Connelly; Piper, De Carufel, & Debbane, 1986). Two-thirds of the clients receiving psychotherapy were reported to have prematurely terminated in a longitudinal study by Scogin, Belon, and Malone (1986). The numbers of individuals terminating counselling is substantial and is well-documented by psychotherapists and researchers of psychotherapy;

> It can be stated with some degree of confidence, therefore, that the finding of an unplanned and premature termination from psychotherapy on the part of a large number of clients is a reasonably reliable one (Garfield, 1971, p. 267).

The existence of premature termination as an incontrovertible occurrence within psychotherapy demands that those in the field of psychology address the problem. Those individuals rising to the challenge throughout the five decades of exploration have changed and expanded the methods of research and the theories of premature termination.

History of Premature Termination Research

The perplexing phenomenon of premature termination has elicited many different reactions from therapists and researchers. The earliest, most prevalent responses to premature termination in the literature focussed on either the client or the method of therapy as the primary contributor to the high rates (Garfield, 1971). For example, some researchers advocated that characteristics should be studied in those clients who terminate in order to be able to screen for the candidates who would remain in therapy. The high drop-out rates were deemed to be the result of 'unsuitable clients' (Garfield, 1971). Another body of researchers focussed on pre therapy training which was thought to reduce the possibility of premature termination (Garfield, 1971). Another group of researchers felt that conventional therapies should be modified to better meet the needs of clients (Garfield, 1971). This last approach appears to be tied into the therapeutic outcome studies, often viewed as the determination of most effective therapy subverted to the researcher's desire to advocate a particular method or theory. This avenue of study continues to be pursued to date, however, with a somewhat different focus because few differences were found to exist among therapy modalities.

The underlying premise of these early tenets is that termination must be indicative of a negative outcome of therapy and a poor therapeutic relationship. Out of this concern grew the movement, during the 1950s and into the 1970s, to identify relevant client and therapy variables to decrease the probability of premature termination occurring.

A few of these early studies focussing on client and therapy variables are

reviewed. For example, Rubinstein and Lorr (1956) attempted to differentiate between individuals who remained in therapy until an agreed termination point and terminators on demographic and personality variables. They found remainers to be less nomadic, less impulsive, less rigid in personal attitudes and more self-dissatisfied than those who terminated prematurely. As well, remainers differed demographically from premature terminators in that they were better educated and were of a higher socio-economic level. This seminal research led to the exploration of further client variables that played a role in remaining or terminating.

Frank, Gliedman, Imber, Nash Jr., and Stone (1957) found that client and treatment variables were implicated in the decision of whether or not to remain in therapy. The client variables correlating with remainers were the demographic variables of social class, education, occupation, and the intrapsychic variables of fluctuating illness with manifest anxiety, readiness to communicate distress and personal liabilities, suggestibility, social integrity, and perseverance. The three treatment variables identified were the relation of the treatment to the client's life situation, specific features of the treatment itself, and attributes of the therapist. Frank, et al., (1957) attempted to increase the information on premature terminators beyond the demographic information and incomplete personality variables. Although they provided more information about the group differences concerning client variables and treatment, their focus was still on those individuals who remained in therapy.

Garfield (1963) conducted a primary investigation of clients' reasons for termination based on interviews of early terminators. The result of his research was as follows:

> Six of the 11 Ts (terminators) gave as their reasons for termination some external difficulty, e.g., lack of transportation, no baby-sitter, inability to get away from work. Three felt that therapy was not helping or that they did not like the therapist. Two stated that they had improved. Thus, most of these patients gave external cause or a lack of satisfaction with therapy as their reason for termination. (Garfield, 1963, p. 38)

Based on these findings, researchers began exploring the primary reasons clients prematurely terminated their psychotherapy, widening the search to incorporate those aspects impacting on the therapeutic relationship. An influential study by Baekeland and Lundwall (1975) suggested that dropping out of therapy was the result of three main factors, not two as had been previously identified: (1) intrapsychic variables that unfavorably dispose the client toward the treatment setting (e.g., personality types); (2) therapist variables, such as positive or negative attitudes toward the type of client and type of complaint; and (3) environmental variables (e.g., family attitudes about therapy, informal help in the community and, current life-events). Since 1975 many researchers have studied these variables in detail.

Psychotherapy research into premature termination has experienced marked changes since the mid 1970s. Theories have been modified from those first uncertain tenets as a multitude of avenues have been pursued with the belief that the issue of termination can be further clarified. Several new variables have been identified as being a part of the therapeutic relationship and research techniques have been expanded and are now more sophisticated.

A contemporary movement is conducting research aimed at "... reducing the redundancy among (all therapeutic) variables and priorizing their probable importance..." (Beutler, 1991, p.230). The basis for this movement is to concisely define the variables and their impact. Pursuant to the definition and assessment of the variables, it is deemed as necessary to determine the interactional effects between potentially significant client, therapist, and therapy variables (Beutler, 1991). It is seen as improbable that a global understanding of the therapeutic relationship can exist if investigators are uncertain of the variables and their relationship to one another.

Until recently individuals who dropped-out of therapy were believed to constitute treatment failures (Bergin, 1986). Further to that, Sherman and Anderson (1987) indicated that clients who leave therapy without discussing it with their therapists must not be getting the help they want or need, and that premature termination can reinforce clients' perceptions that their problems cannot be solved. Although client, therapist, and environmental variables may have an impact on length of stay in therapy, not all individuals who make a unilateral decision to terminate do so because therapy was unprofitable. Instead, there appears to exist a

group of premature terminators who experience change and satisfaction from therapy. Perkarik (1992) found that the drop-outs in his study did not consist of a homogeneous group of dissatisfied, unimproved clients. Although some clients cited that practical problems impeded access to treatment, or that they were dissatisfied with the treatment, others indicated that problems had improved (Perkarik, 1992). The outcome and satisfaction data were compatible with the clients' stated reasons for terminating. Pekarik found that the "... problem improved drop-outs showed the most improvement and satisfaction and the dissatisfied drop-outs had the least" (Perkarik, 1992, p. 97). The belief that premature terminators are failed by therapy was shaken. A new emphasis was placed on having clients express their reasons for terminating and on their post treatment adjustment. This type of qualitative analysis serves as an alternative and a mutual support to the traditional, quantitative methods (Fitz-Gibbon, 1984; Mathews & Paradise, 1988).

ANALYSES OF PREMATURE TERMINATION RESEARCH

Client Variables

A seemingly endless number of client variables have been identified and researched to date in attempts to evaluate termination and psychotherapy effectiveness; in fact, "... at least 175 categories of patient characteristics that one or another investigator has explored as potentially relevant for predicting differential responses to psycho social treatments" (Garfield & Bergin, 1986 cited in Beutler, 1991, p.227) have been described. Even with the plethora of research generated, these variables are still poorly defined and inadequately studied (Beutler, 1991). Beutler (1991) explored the literature and summarized the client variables into two major types, ordinal variables (18) and nominal variables (15). The ordinal variables identified were the clients' demographics (e.g., age, birth order, social status), personality characteristics (e.g., dogmatism, defensiveness, acuteness, dependency, introversion), and problem severity. The nominal variables identified were ethnicity, defensive style, diagnosis (100+), cognitive style, problem resolution stage, symptom type, perceptual style, sexual attitudes, life attitudes, goals, gender, interpersonal needs, expectations, and developmental level. A brief summary of a select few of the most commonly studied variables listed by Beutler (1991) is presented in the following paragraph.

The conjecture of some researchers was that individuals who prematurely terminate differ from remainers on certain personality traits (Hardin, Subich, & Holvey, 1988; Epperson, et al., 1983; Baekeland & Lundwall, 1975; Feister, 1977). The Rorschach has been used to aid in identifying those who would

terminate, but with variable results (Garfield, 1971). More recently, work with the Minnesota Multiphasic Personality Inventory has illustrated that individuals generating certain profiles have differing responses to therapy. This relationship between diagnosis and termination is complex. An individual whose primary diagnosis is severe depression is likely to drop out of treatment, "...presumably because his pessimism, low energy level, and feelings of hostility..." (Baekeland & Lundwall, 1975, 756). However, individuals suffering from low levels of anxiety and depression are also likely to prematurely terminate because these symptoms bring them into therapy and they are likely to leave shortly after the symptoms have abated (Baekeland & Lundwall, 1975). Individuals described as having personality disorders possibly terminate counselling because after their initial stress has decreased, they may feel no need to continue with counselling and address the other issues. It would appear then that the motivation to remain in therapy has to be an internal force or individuals will terminate once the symptoms of the problem have been reduced. In its totality, the evidence does not indicate that specific intrapsychic characteristics linked with premature termination can be isolated using personality tests. To summarize, "...the overall evidence for a pre therapy dropout profile is not very impressive" (Connelly, Piper, De Carufel, & Debbane, 1986, p. 147).

Researchers who have assessed the intrapsychic characteristics related to personal epistemology and cognitive styles of the clients have had more significant results. Logic supports that therapy would be of more benefit to the client when therapist and client share similarities to create a positive relationship. Fry and

Chanon (1980) found that clients reported an increase in satisfaction when their cognitive styles matched with those of the therapist. Lyddon (1989) explored the effects of personal epistemology and counselling relationships. He found that clients may be more predisposed to entering into, and continuing with, the therapeutic relationship when the counselling approach is consistent with their dominant epistemological commitment — that is, if the counselling approach is not in stark contrast to the way clients' understand the workings of the world. Another of the variables thought to impact on premature termination was client expectancies of counselling. The client expectations were viewed to be a powerful and important part of the therapeutic process (Torrey, 1986). Frank (1961) posited that "The apparent success of healing methods based on all sorts of ideologies and methods compels the conclusion that the healing power of faith resides in the patient's state of mind, not in the validity of its object" (p. 60). Some researchers have indicated that clients who have overly high expectations tend to prematurely terminate yet, expectancies must be high enough for therapy to be effective (June & Smith, 1983; Sherman & Anderson, 1987). However, other studies have shown that there were no differences in precounselling expectations for premature versus consensual termination (Hardin, Subich, & Hover, 1988; Feister, 1977). Although the results have been mixed it appears that expectancies can be an important variable in the therapeutic endeavor.

Generally, researchers have illustrated that there are demographic differences between premature terminators and remainers. The variables in this category most often researched are social class and the actuarial variables such as

income, education, age, and diagnosis or classification. Scogin, Belon and Malone (1986) found that older clients were less likely to terminate therapy prematurely. Generally, the pursuit of age as a significant variable has yielded conflicting results.

Inconsistent results have also occurred for education, although most report a positive relationship between education and length of stay. Education may not be an isolated variable; it may be associated with higher verbal ability, income, and sophistication about therapy. A definite relationship has been identified between length of stay and social class (Garfield, 1971). The higher the social class the more likely a client will not prematurely terminate.

The impact of client demographics may best be summarized by Torrey (1986): "The criterion for the best therapy candidate is well known as the YAVIS individual -- young, attractive, verbal, intelligent and successful" (p. 5). Social class and education, verbal ability and intelligence may impact on the way therapists view clients; for example, therapists are thought to be more comfortable with their upper class clients (Garfield, 1971), and this may represent a more closely shared world view which is a cornerstone of the therapeutic relationship (Torrey, 1986). Due to the sometimes conflicting results, research continues to focus on client demographics to aid in the explanation of either the success or failure of the therapeutic alliance. Perhaps with continued exploration consistent trends will be revealed.

Environmental Variables

Environmental variables have been relatively neglected as contributing factors to premature termination. However, four broad categories of environmental variables have been identified: social networks, emotional support, life events and instrumental support (material aid).

Individuals' attitudes are framed within their social networks. Consequently, the social setting may be of primary influence on their attitudes and actions, and hence, impact strongly on therapy (Gottlieb, 1983). Cross and Warren (1984) identified that remainers had access to larger social networks than did terminators. The trend that terminators generally tended to be more socially isolated had been established earlier by Frank et al., (1957) and Rubenstein and Lorr (1956). Dyck, Joyce and Azim (1984) found that clients who discuss therapy attendance with their social support system, especially family members, tended to continue with it. Further to that, without the social support necessary to help buffer the external stresses, it may be impossible for a client to withstand the demands of therapy (Bernard & Drob, 1989).

Emotional and instrumental support also influence the length of time a client is able to remain in therapy. Garfield (1963) found that clients identified lack of transportation, child care and time off from work as variables influencing their rates of termination from therapy. Cross and Warren (1984) surmised that life adjustment, external support, alternative counsel, inter current stress events and other variables consisting of availability of transportation, arranging time away

from work, home duties and satisfaction were the principle environmental factors in determining therapeutic length of stay. Although not statistically significant, they did identify trends between groups among these variables. Clearer evidence is provided by Pekarik (1992) who found that for those individuals who terminated prematurely, environmental obstacles were one of the three most cited reasons. Perhaps as the impact of environmental variables is more closely examined further, and more detailed information will be gained. An example of this is the recent move within research to study social support. For example, a number of researchers have distinguished different modes of social support. A survey of the literature indicated that researchers have been developing reliable and valid self-report measures to tap the areas of interest (Barrera, Sandler & Ramsay, 1981; Cohen & Hoberman, 1983, Vaux, Riedel, & Stewart, 1987).

Reviews of relevant works suggest that a consensus is emerging as to a set of some four to six major modes of social support (Barrera & Ainlay, 1983). The six modes of support identified are (1) material aid, (2) behavioural assistance, (3) intimate interaction, (4) guidance, (5) feedback and (6) positive social interaction (Vaux, Riedel & Stewart, 1987).

Therapist Variables

Therapist variables have great impact on the client, and hence, the therapeutic relationship. The relationship created to foster change in the client must involve the personal aspects of the therapist. The therapist's personal qualities affect how he or she uses (or does not use) the techniques of the differing schools. There are a multitude of therapist variables identified in the literature, Beutler (1991) identified 26 potentially important therapist variables. As with the client variables, Beutler categorized the therapist variables as either ordinal or nominal types. The ordinal therapist variables are facultative skill, experience, persuasibility, credibility, religiousness, maturity, emotional well-being, previous therapy, attractiveness, authoritarianism, cognitive complexity and emotional accessibility. The nominal variables ranged from therapists' beliefs about mental health, religion, and acceptance, to their demographic variables including life stage, and finally coping styles.

Tracey (1986) examined how the failure to establish a good working relationship early in treatment can result in premature termination. The results of his study seem to indicate that it is important for therapists to monitor the relative topical harmony in the client-therapist relationship. Included in this is the ability of the therapist to identify the problem and to develop a strong working relationship. This is important as nonattendance is often cited as an indication of client resistance to the therapy (Tracey, 1986).

Consistently, therapist empathy, attractiveness, trustworthiness, listening ability and genuineness have been illustrated within the literature as important determinants of the client-therapist relationship and the continuation of therapy (Rogers, 1957; Strupp, Wallach & Wogan, 1964; Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, Stone, 1965; Dyck, Joyce & Azim, 1984; Bernard, & Drob, 1989; Beutler, L. 1991). Heppner and Heesacker (1983) found that client expectations of counsellor expertise, attractiveness, and trustworthiness are not highly correlated with the same clients' perceptions after several weeks. Subsequent conjecture by Heppner and Heesacker (1983) was that the increment or decrement in these variables over time may be related to counselling outcome.

The capacity of establish rapport is an important therapist variable. One aspect of creating rapport is the counsellor's ability to recognize the problem the client is presenting. The counsellor's ability to recognize the presenting problem increased the probability of client continuation with therapy (Epperson, et al., 1983; Shick-Tyron, 1986). Another aspect of rapport necessary to therapy is a straightforward communication of reasons for actions, as the client's perception of the therapist's motivation has bearing on length of stay (Bernard & Drob, 1989). If there is a match in the client's and therapist's epistemology, then the client is more likely to view the relationship as fulfilling and to stay in therapy (Lyddon, 1989). The therapist and client are more likely to establish a positive working relationship if each has an understanding of the other's world view or a shared world view.

Furthermore, the appropriateness of a counsellor's response appears to influence the client's overall perception of the rapport (Anderson & Anderson, 1985). The therapist's response is deemed appropriate when he or she makes self-involving statements that illustrate a present-tense, personal response to the client. It has been indicated that the self-involving counsellors are perceived as more expert, more trustworthy, and elicit more present-tense, self-referent statements (Anderson & Anderson, 1985).

The ability of the therapist to create a positive working relationship may be related to the therapist's experience or level of expertise. The higher the level of counsellor expertise, the more likely he or she has the skills and understanding of what is necessary to create a positive working relationship and how to achieve this in counselling. The research of Scogin, Belon & Malone (1986) found that more experienced therapists had lower rates of termination. Results are inconclusive in the literature as to whether counsellor experience was related to premature termination (Epperson, Bushway & Warman, 1983). Auerbach and Johnson (1977) reviewed the literature on level of experience and found that as therapists have mastered their roles and increased their confidence in their own abilities and the interventions, they become less self-preoccupied and able to display more warmth and make more comments in therapy. The increase in life experiences as therapists age also provides them with emotional experience to enhance the academic endeavors (Auerbach & Johnson, 1977).

Research has also established that premature termination may be influenced by the gender of the counsellor, as well as counsellor experience and problem recognition. Epperson, et al., (1983) illustrated that the rate of premature termination was greater for female counsellors than for male counsellors. Blier, Atkinson, and Geer (1987) found that client gender did not affect willingness to see a counsellor. They did identify that female counsellors were rated higher for personal problems and male counsellors for academic concerns. Schneider and Hayslip Jr. (1986) found that for other than the least intimate presenting problems clients anticipate greater satisfaction with older rather than younger counsellors.

RATIONALE FOR PRESENT RESEARCH

A review of the literature has illustrated that (1) environmental variables, (2) therapist variables and (3) client variables have an impact upon whether a client will prematurely terminate or remain in therapy until a time mutually agreed upon with the therapist. The purpose of this research was to assess the differences in client demographics, social support and view of therapy between those clients who prematurely terminated and those who did not . Of further interest is whether or not those clients who terminate prematurely, as identified by their therapists, constitute a homogenous group of treatment failures.

Within the body of research on termination, the primary method of identifying premature terminators has been based on the criteria of treatment duration. This method has been criticized for its limitations therefore, an alternative and prior used method was employed for this study. The counsellors were asked to divide everyone seen between the specified dates into three groups: (1) those who did not meet the criteria for the study (under 18 years); (2) those who were continuing with therapy and thus not appropriate to be used as participants and finally (3) those individuals who were no longer in therapy. Of the third group the potential participants were further divided into three groups: (1) those individuals who are no longer involved in therapy, but whose termination point was mutually agreed upon by client and therapist (Remainers, R); (2) those who made a unilateral decision to terminate in one to seven sessions without meeting their goals (Early Terminators, ET); and (3) those who terminated counselling after eight sessions but prior to mutual agreement with counsellor (Late Terminators, LT). Research

suggests that these three groups of clients may potentially differ significantly between demographics, environmental support and perception of the therapist and therapy.

Initially, it was hypothesized that those individuals falling into the ET group would terminate within one to three sessions. However, when the number of sessions of counselling was analyzed in a frequency count for the premature terminators from the outpatient counselling clinic in this study, a natural split was noted which seemed to connote that early termination is more likely to occur within one to seven sessions and late termination is more likely to occur after seven sessions, but before all identified goals had been reached. Counsellors were asked to record whether termination was mutually agreed upon and whether the clients' goals had been met. Clients were also asked to indicate whether they had met their goals during therapy.

Unfortunately discharged clients are difficult to contact for in-depth analysis. The established format for obtaining information about these individuals has been to send questionnaires through the mail. Although response rates were typically quite low, a comparison of demographic data between survey responders and those who failed to return the consent form was done to assess the similarities between the groups.

Hypotheses

1. Early and Late Terminators will evaluate their therapists more negatively than Remainers across a variety of counsellor dimensions.
2. Remainers will indicate higher perceived social support than Early or Late Terminators.
3. Demographic differences will exist between R, LT and ET groups.
4. Experienced therapists will have lower termination rates than inexperienced therapists.
5. Similarities should exist between the counsellors' and clients' perceptions of goals met during therapy.
6. Premature terminators are not a homogeneous group failed by treatment.

METHOD

Procedure

After obtaining permission from the Department of Psychology, McKellar General Hospital, and the Graduate Studies and Research Ethics Committee at Lakehead University to obtain the names and addresses of those individuals who had participated in therapy at the clinic during the previous 12 month period, an introductory letter was sent to all potential participants asking for their cooperation in completing the survey (Appendix D). This introductory letter was sent out on McKellar General Hospital stationery and was signed by both Dr. W. T. Melnyk, Department of Psychology, Lakehead University and Mr. Gene Kolisnyk, Manager, Department of Psychology, McKellar General Hospital. Confidentiality was stressed and no names were required on the questionnaires. The names of the those who responded, however, were recorded on a master list that paired a number with assigned names and addresses. This list was kept in a locked file cabinet at the Department of Psychology, McKellar General Hospital. It was further emphasized that the counsellors had no access to the clients' returned questionnaires. Clients were also notified that the raw data was stored in a locked file cabinet and would be destroyed upon the completion of this study.

The participant pool was told that the researchers were interested both in the personal factors that affect clients in treatment, and their evaluation of the therapy . Potential participants were sent a package including an introductory letter, consent form and a self-addressed stamped return envelope so no costs would be associated with their participation. All correspondence was issued on McKellar General

Hospital stationery with the exception of the questionnaires. Individuals who returned the form indicating their consent to participate in the study received the questionnaire one week later along with a covering letter (Appendix E) in which, again, confidentiality was stressed. A follow-up letter (Appendix F) requesting the return of the survey, was sent to participants two weeks after the questionnaires. Clients were also provided with names and telephone numbers in the event that they had any questions or concerns about the questionnaires.

A review of the demographic data available from the case files for both the remainers and terminators who responded to the questionnaire compared with those who failed to respond was completed to assess whether the participants were representative of the general clinic population. This will be further addressed in the results and discussion sections. This was completed because the response rate to mail questionnaires typically tends to be low and the study would be valid only if the sample was representative.

Participants

Clients

The subjects were individuals who had received counselling at the out-patient Department of Psychology, McKellar General Hospital between April 1990 and March 1991 and consented to participate in this study. Individuals in therapy or under 18 years of age were not contacted to participate in the study. No limitations were placed on participants' based on diagnosis, sex, marital or employment status.

The total number of clients seen between the specified dates was 230. The counsellors divided the clients into four groups for the purpose of this study. Clients identified by their counsellors as having prematurely terminated in under seven session made up 18.7% of the sample, 25.6% constituted those who terminated late, 30% were classified as having been terminated because the goals had been met and 25.6% were continuing with therapy. In sum, 44.3% of the clients dropped out prior to reaching their stated therapeutic goals and 55.7% either successfully completed or remain in counselling.

Counsellors

Thirteen therapists treated the clients. Six of the therapists had a master's degree in psychology, and the remaining seven were supervised master's student trainees. Female counsellors and female master's student trainees comprised 73.3% of the group and male full-time counsellors and master's student trainees made up the remaining 26.7%. Seventy per cent of the therapy was undertaken with experienced/full-time counsellors and 30.0% with the students.

Measures

For the research, the following criteria were used to select instruments: reliability, validity, brevity and frequency of use in similar studies . The Counsellor Evaluation Inventory (CEI), the Counsellor Rating Form - Short (CRF-S) and the Social Support-Behaviours (SS-B) were the measurement devices of choice. Verbal and written permission was sought and granted to use each of the three instruments for the purpose of the study.

Counsellor Evaluation Inventory

The CEI was developed by Linden, Stone & Shertzer in 1965 (Appendix A). It is a 21 item instrument used to explore client ratings of counsellor effectiveness. Using a 5-point Likert-style scale, scores are provided for counselling climate, counsellor comfort, and client satisfaction with a resulting total score range of 21 to 105. The lower the score, the less contented the client was with the counselling climate, satisfaction, and counsellor comfort . This instrument has acceptable levels of reliability and validity. The total test-retest reliability for the CEI was determined to be .83. For the specific scales, counselling climate = .78; counsellor comfort = .63; and client satisfaction = .74.

Counsellor Rating Form - Short

Corrigan and Schmidt developed the CRF-S in 1983. The CRF-S (Appendix B) is a brief, 12 adjective instrument that requests that the respondents rate their perceptions of the counsellor using a 7-point scale with anchors of 1 (not very) and 7 (very). Summing the items yielded three separate four-item sub scale scores: expertness, attractiveness and trustworthiness. Sub scale scores can range from 4 to 28. The overall reliability of the CRF-S is high, although there are minor variations between scales as indicated: expertness = .90; attractiveness = .91; and trustworthiness = .87. Construct validity was established through confirmatory factor analysis.

Social Support - Behaviors

The SS-B Scale (Vaux, et al., 1987) (Appendix C) is a 45 item instrument that requests respondents to rate their perceptions of family and friend support using a 5 point scale. The anchors are 1 (no one would do this) to 5 (most family members/friends would certainly do this). The self-report scale taps five modes of support: emotional, socializing, practical assistance, financial assistance, and advice/guidance. Reliability and validity for the SS-B was within acceptable ranges.

Demographic Information Sheet

In addition to the formal assessment devices mentioned above, a sheet was enclosed in the package requesting participants to record basic demographic information and their perception of the therapy (Appendix G). The demographic information obtained was the participants' sex, marital status, number of children, education (highest level and number of years) and occupation. Perception of therapy was assessed by asking subjects to indicate: (1) how satisfied they were with therapy, (2) how much benefit they felt it had, (3) how much change occurred, (4) how they were doing now, (5) how distressed they were at the onset of therapy and finally, (6) whether they had met their goals or not. They were asked to rate each question of a five-point, Likert-style scale -- one being the lowest possible score and five the highest. No information is available for either the reliability or validity of these questions. They do, however, appear to have face validity and are often utilized in service satisfaction questionnaires.

RESULTS

Description of Sample

Of the 230 individuals who had entered into counselling between April 1990 and March 1991, 25.6% were not contacted for the study because they remained in therapy and 4.7% had moved. In total, of the possible 160 participants, thirty individuals responded: sixteen of the potential 66 remainers (24.4%); seven of the 55 LT (12.72%), and seven of the 39 ET (17.94%). The overall response rate, therefore, was 18.75%. For the sake of brevity ET, LT and R participants, when combined, will be referred to as the variable length of stay in therapy. The term premature terminators is the combined group of ET and LT participants.

With regard to marital status, 34.5% of the participants were single, 44.8% were married, 13.3% were divorced, and 6.9% were separated. The majority of the participants were employed (63.3%), 10.0% were unemployed, 3.3% had retired, and 20.0% were students. Few of the sample had an elementary only level of education (3.4%); 41.4% received high school education, 31.0% had technical training and 24.1% were university educated.

The Canadian Medical Guide (CMG) was the criteria by which staff at the Department of Psychology, McKellar General Hospital, based their diagnosis. The previous CMG classification system was still in place at the time of this study, the

corresponding current CMG numbers and categories may be found in Table 1. Also illustrated in Table 1 are the numbers and percents for the ET, LT and R participants in each CMG category. The majority of the sample (43.4%) were diagnosed as primarily experiencing acute adjustment reaction (590), the next largest group (33.3%) were those individuals with depressive neuroses (591), followed by those experiencing disorders of personality and impulse control (593). The remaining participants were classified as either 596, 592 or were not found to be amenable to any of the categories (999).

Table 1

CMG Classifications: Previous and Current Numbers

Previous no.	Current no.	Description	Groups	No.	%
			ET	2	6.7
590	776	Acute adjustment reaction and disturbance	LT	2	6.7
		of psycho social functioning	R	9	30.0
			sub-total	13	43.4
			ET	2	6.7
591	777	Depressive neuroses	LT	1	3.3
			R	7	23.3
			sub-total	10	33.3
			ET	0	0.0
592	778	Unspecified neuroses	LT	1	3.3
			R	0	0.0
			sub-total	1	3.3
			ET	0	0.0
593	779	Disorders of personality and impulse	LT	2	6.7
		control	R	1	3.3
			sub-total	3	10.0
			ET	1	3.3
596	782	Child and Adolescent Disorders	LT	1	3.3
			R	0	0.0
			sub-total	2	6.7
			ET	1	3.3
999	999	No formal diagnosis	LT	0	0.0
			R	0	0.0
			sub-total	1	3.3

In attempt to control for problems generated by having a small sample size (N = 30) the alpha level was set at a stringent $p < .01$. Significance rates falling between $p < .01$ and $p < .05$ will be discussed, but only as trends approaching significance. Further, the use of multivariate procedures was limited due to the small cell sizes during analysis. *A posteriori* procedures will be used to assess differences only for those ANOVAs that have a significance level of $p < .01$. With the *a posteriori* testing the harmonic mean was calculated and used to compensate for the unequal sample sizes.

Representativeness of the Sample

Those individuals who responded were compared to those individuals who did not on a variety of demographics: age, sex, and CMG classification.

Three Small Sample T-tests were completed comparing the means of those who responded to those who did not respond from each group on the variable of age. No differences were found between the mean age for the remainers ($t = 1.29$, $p < .05$), late terminators ($t = 0.48$, $p < .05$), or early terminators ($t = 1.05$, $p < .05$) when compared to those individuals who did not respond.

Sex and CMG variables are nominal data; therefore, six chi-square tests were utilized to assess differences between R, LT, and ET responders with the corresponding group who did not respond. Those who did not respond were not

significantly different from the participant pool on the variable sex: ET ($\chi 2$ (1) = 2.40, $p > .01$); LT ($\chi 2$ (4) =1.79, $p > .01$); and R ($\chi 2$ (1) = 0.00, $p >.01$). The variable CMG did not yield significant differences between those who responded and those who did not from the R groups ($\chi 2$ (5) = 5.87, $p > .01$), the LT groups ($\chi 2$ (6) = 16.81, $p > .01$), and ET groups ($\chi 2$ (5) = 12.63, $p > .01$).

Clients' Perceptions of Therapy

One question pursued in this section of analysis was the extent to which clients' and therapists' perceptions were similar regarding goals met during the therapy. Also, correlations were completed to assess the relationship between length of stay and levels of satisfaction, benefit, change current functioning and distress at onset of therapy as indicated on their demographic information sheet (Appendix G). Pursuant to that was an assessment of the differences among the ET, LT, and R groups on perception of therapy. This was done to assess if all premature terminators were dissatisfied with therapy.

Perceptions of Goals Met

A comparable ratio was noted between endorsement of goals met, 46.7% of clients' indicated they had met their goals; 53.3% indicated they had not. The counsellors indicated that 46.7% of the clients had not met their goals and had either terminated early or late and that 53.5% of their clients had successfully met their goals. A correlation revealed a trend that clients and therapists appeared to have somewhat similar perceptions on whether their established goals had been reached ($r = .45$, $p < .05$). The majority of participants who indicated meeting their goals

were the R group (71.4%). The bulk of the individuals who did not meet their goals were, therefore, premature terminators.

Table 2

Clients' View of Therapy: Numbers and Means

	Question														
	Benefit			Change			Satisfaction			Distress at onset			Current functioning		
Ratings	ET	LT	R	ET	LT	R	ET	LT	R	ET	LT	R	ET	LT	R
1. low	0	1	0	3	1	0	0	1	2	0	0	0	0	1	0
2.	3	0	0	1	2	0	2	1	0	1	0	0	0	1	0
3.	2	3	0	1	1	2	1	1	0	1	1	1	1	2	1
4.	2	1	3	2	1	6	3	2	7	4	2	6	5	2	10
5. high	0	2	13	0	2	8	1	2	7	1	4	9	1	1	5
N =	7	7	16	7	7	16	7	7	16	7	7	16	7	7	16
mean	2.9	3.4	4.8	2.3	3.1	4.4	3.4	3.4	4.1	3.7	4.4	4.5	4.0	3.1	4.3

Perception of Benefit of Therapy

When comparing means among the three groups, the R group appeared to experience the highest level of benefit (Table 2). The results of a pearson correlation support that length of stay was strongly related to the degree of benefit the participant endorsed ($r = .78$, $p < .001$) (Table 3). In conjunction with this, the

results of an ANOVA illustrated that benefit was found to be significantly different among ET, LT and R participants ($F = 15.59$, $p < .001$). A Newman - Keuls test was completed and the results indicated that differences existed between the R and ET groups and also between the R and LT groups in rating of benefit.

Perception of Change

Participants were asked to rate how much change they felt occurred as a result of therapy. The majority of those who expressed that they had experienced a great deal of change were R participants (Table 2). The perception of change was compared with length of stay in therapy, and it seems that there was a strong positive relationship between the amount of time spent in therapy and perceived change ($r = .74$, $p < .001$) (Table 3). Also, the amount of change expressed by the ET, LT and R participants was significantly different ($F = 9.19$, $p < .001$) (Table 3). The results of a Newman - Keuls suggest that significant differences exist solely between the R and ET participants in perception of change.

Perception of Satisfaction

The vast majority of ET, LT and R participants indicated that they were either "fairly satisfied" (40.0%) or "extremely satisfied" (33.3%) with their therapy (Table 2). The results of a correlation indicate a trend that there is a positive relationship approaching significance between satisfaction and length of stay ($r = .15$, $p < .05$), however, although there is a relationship between the variables the results of an ANOVA suggest that there were no significant differences found among the three groups (Table 3).

Perception of Distress at Onset of Therapy

Participants were also asked to indicate the amount of distress they felt at the onset of therapy. The majority of the participants indicated feeling profoundly distressed (Table 2). Distress at onset of therapy did not appear to have any relationship with how long a client would stay in therapy (r = .34, p > .07). The results of an ANOVA (Table 3) however, indicate that there is a trend towards difference in the amount of distress at onset of therapy among the participants in ET, LT and R groups (F = 1.7, p > .05).

Perception of Current Functioning

A trend indicated a slight relationship seems to exist between the participants level of current functioning and their length of stay in therapy (r = .22, p < .05) (Table 3). This trend is noted also in the results of an ANOVA (F = 4.7, p < .05) which suggests that the participants in the three groups may minimally differ on how they are currently functioning. For example, all of the R and ET participants rated their current functioning from three and above, on a scale of one to five, while the LT participants primarily rated themselves either four or less.

Table 3

Clients' View of Therapy: Pearson Correlation and ANOVA results

	Question														
	Benefit			Change			Satisfaction			Distress at onset			Current functioning		
	ET	LT	R	ET	LT	R	ET	LT	R	ET	LT	R	ET	LT	R
means	2.85	3.42	4.81	2.28	3.14	4.38	3.43	3.43	4.06	3.71	4.42	4.5	4.0	3.1	4.25
r	.78***			.74***			.15*			.34			.22*		
F	15.59***			9.19***			0.87			1.71*			4.71*		

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

Client Demographics

Client demographics were examined for their impact on rates of termination from psychotherapy. Table 4 outlines participant demographic information. (Information on CMG was provided in Table 1.)

Table 4

Participants' Demographic Information

	Age	Sex		Marital status			Employment	
		F	M	M	S	Other	Y	N
ET	28.85	7	0	2	4	1	2	5
LT	35.1	6	1	5	1	1	6	1
R	40.81	11	5	6	6	4	10	6

Highly significant correlations were not identified between demographic variables and length of stay (Table 5). A trend approaching significance was the relationship between the clients' age and length of stay ($r = -.44$, $p = .04$), number of children ($r = -.39$, $p = .04$) and sex ($r = .32$, $p = .04$). ANOVAs were computed to compare client demographics among ET, LT and R groups. Of interest, although only a trend, was that the three groups differed in the number of children ($F = 3.6$, $p < .05$). The results of a chi-square test indicated that diagnosis was not significantly related to length of stay.

Table 5

Relationship Between Demographic Variables and Length of Stay in Therapy

Demographic variables	Length of stay in therapy
	r
Age	-.44*
Sex	.32*
No. of children	-.39*
Level of education	.19
Marital status	.20
Employment	.16

* $p < .05$

Impact of Counsellor Variables on Length of Stay and Perception of Therapy

The CRF-S and the CEI were utilized to assess the relationship between counsellor variables and length of stay as well as the differences among the way ET, LT and R participants viewed their counsellors. The only significant correlation was that the more the participant trusted the therapist the longer he or she would remain in therapy ($r = .60$, $p < .01$) (Table 6). A series of ANOVAs comparing differences among the three groups and the subscales of the CEI and CRF-S yielded insignificant results. Nevertheless, the results suggest that differences may exist among the three groups in their assessment of therapist trustworthiness(CRF-S, trustworthiness), ($F = 4.39$, $p = .02$).

The counsellors' level of actual and perceived experience did not impact strongly on length of stay, yet, trends were noted in the correlations and ANOVAs. A slight relationship was noted between the therapist's level of actual experience and length of stay in therapy ($r = .33$, $p < .04$). An ANOVA yielded a trend that differences exist among the groups in their perception of the therapists expertise ($F = 4.07$, $p = .05$).The vast majority of the clients seen by inexperienced counsellors were comprised or early and late terminators (66.6%) compared to experienced counsellors who had 38.3% of their clients prematurely terminate. A comparison between the counsellors' actual level of experience and the clients' perception of the level experience yielded an interesting trend that participants in this study appeared to be able to identify the actual experience of their counsellors ($r = .32$, $p = .04$).

Therapist's actual experience seemed to have minimal impact on the ability

of clients to meet goals ($r = .08$, $p > .05$). Inexperienced counsellors had 44.4% clients who met goals and 55.6% clients who reported not meeting their goals, which is comparable to experienced counsellors who had 47.6% clients met goals and 52.4% not met their goals. The trend was that the more experience the therapist was perceived to be by the client (CRF-S), the greater the ability of the client to meet goals ($F = 4.09$, $p < .05$). In general, there is only mixed support for the impact of therapist experience on the clients' length of stay.

Other interesting, but secondary, correlations were derived when the scales of the CRF-S and the CEI were compared to the questions assessing the participants' perception of therapy (Table 6). The more the client trusts the therapist the higher their rating of satisfaction ($r = .55$, $p <.01$). The subjects' belief in the therapist's expertise ($r = .69$, $p < .001$), followed by their rating of the therapist's attractiveness ($r = .61$, $p <.01$) and trust in the therapist ($r = .58$, $p <.01$) were positively correlated with the subject's perception benefit of therapy. Satisfaction with therapy, measured by the CEI, was also positively correlated with the amount of change a client experiences ($r = .56$, $p < .01$) and with benefit ($r = .63$, $p < .01$). As an interesting aside, there was no significant correlation between CEI satisfaction and satisfaction as quantified on the Demographic Information Sheet.

Table 6

Relationship Between Counsellor Variables and Clients' Perception of Therapy

Counsellor variable	mean			Perception of therapy					
				Length of stay	Goal met	Sat.	Ben.	Change	Current function
	ET	LT	R	r	r	r	r	r	r
CRF-S trust	23.43	24.14	26.69	.60*	.24	.55*	.58*	.36	.25
CRF-S expert	20.43	20.71	24.5	.28	.53	.28	.69**	.44	.54
CRF-S attract	24.14	23.14	26.13	.53	.32	.53	.61*	.43	.44
CEI climate	29.43	27.29	26.56	.09	.50	.09	.48	.28	.37
CEI comfort	16.29	16.79	15.75	.33	.16	.33	27	.32	.06
CEI satis'n	17.86	16.14	13.56	.42	.28	.42	.63*	.56*	.38

$^{*}p < .01$ $^{**}p < .001$

CEI and CRF-S Correlations

The majority of the correlations between the subscales of the CEI and the CRF-S were positively correlated with the exceptions of the CRF-S (expert) to CEI (comfort) ($r = -.10$, $p > ,05$) and the CRF-S (attract) to the CEI (comfort) ($r = -.35$, $p > .05$). Significant correlations exist between CRF-S (trust) and CEI (satisfaction) ($r = .60$, $p < .01$), CRF-S (attract) and CEI (satisfaction) ($r = .58$, $p < .01$) and CRF-S (expert) and CEI (climate) ($r = .57$, $p < .01$).

Social Support and Termination

The scales of the SS-B were compared to all the other variables. There were no statistically significant results obtained in the area of social support although there were some correlations approaching significance, and were all negative. The results of the ANOVAs were statistically insignificant .

(2) Remainers will indicate higher perceived social support. than Early or Late Terminators.

Social support was not a significant client environmental variable in this study. This may have occurred because of the small sample size of this study. The only subscales of the SS-B that approached significance, and then negatively, were "friends' guidance," "friends' financial support", "friends' emotional support", "friends' social support", and "family financial support". These results are in contrast to the previous findings on the impact of social support.

Social support has been viewed as a significant variable since Garfield (1963) established that external difficulty impacted on the clients' ability to remain in therapy. Baekeland and Lundwell (1975) found that environmental variables such as family attitudes about therapy, informal help in the community and life-events impact on the likelihood of clients remaining in therapy. Individuals who remain in therapy tend to have larger, and be connected with, more supportive social networks than do premature terminators (Dyck, Joyce, & Azim, 1984; Cross & Warren, 1984; Frank et al., 1957; Rubenstein & Lorr, 1956). In summary, the results obtained did not support the information accumulated in other studies pursuing the impact of social support on length of stay in therapy.

(3) Demographic differences will exist between the R, LT and ET groups.

The demographic variable's age, sex, and number of children, level of education, marital status and employment were correlated to length of stay in therapy. Only three client demographics were found to be related to length of stay during therapy: (a) age; (b) sex and (c) the number of children the clients had.

DISCUSSION

Chief Findings of This Study

Six predictions were explored within the context of this research. (1) Early and Late Terminators will evaluate their counsellors more negatively than do remainers. (2) Remainers will indicate higher social support than LT or ET participants. (3) Demographic differences exist between R, LT, and ET participants. (4) Experienced counsellors will experience lower termination rates than inexperienced therapists. (5) Similarities will exist between clients' and counsellors' perceptions of goals met. (6) Premature terminators are not a homogeneous group failed by treatment. An analysis of the data provided only mixed support for the six hypotheses. The results of each question will be briefly discussed in the following pages.

(1) Early and Late Terminators will evaluate their counsellors more negatively than R participants.

With the exception of the variable trust (CRF-S), no significant differences were found to exist among the three participant groups on the other scales of the CRF-S or the CEI. The trend within this study that indicate trustworthiness has some impact on length of stay is consistent with other results using the CEI (Heppner & Heesacker, 1983). It would appear that differences were minimal among the ET, LT, and R participants in their evaluation of the counsellors' attractiveness, and their perception of the counsellor's ability to create a positive counselling climate, comfort within therapy and overall satisfaction with counselling.

These correlations, however, fell below the significance range set for the study and can thus only be viewed as trends towards significant relationships. None of the demographic variables were correlated with goals met. Education, marital status, and employment were not reliably related to length of stay in therapy . This is unusual given that the majority of the studies found positive correlations for marital status and employment, although more conflicting results were listed for level of education.

The trend in this research towards older clients being less likely to prematurely terminate is in accord with the results of other studies (Beakeland & Lundwell, 1975; Scogin, Belon, & Malone, 1986). In addition, older clients were more likely to stay until the completion of therapy and perceive benefit from it. Scogin, Belon and Malone (1986) have suggested that older clients may have greater compliance with and adherence to treatment programs. Perhaps the older clients are more focussed on their particular goals and are therefore more willing to tolerate the demands of therapy. As well, they may have the life experience to provide meaning for their change.

In contrast to other studies, the results of this research indicated a trend that individuals with children remained in therapy longer than those individuals who did not have children. Perhaps the individuals in this study were further motivated to change to enhance their family situation as they did not indicate having a great deal of social support.. It may also be that individuals with children are older than those individuals who do not have children and thus bring with them the greater compliance and adherence to this process.

(4) Experienced therapists will have lower termination rates than inexperienced therapists.

The results of a correlations yielded only a minimal relationship between the counsellors actual experience and length of stay. The trend was that the more expert clients' perceived their counsellor the more perceived benefit they endorsed. The acutal experience level of the counsellors tended to impact slightly on the amount of comfort clients' indicated in therapy. These findings are consistent with the likes of Auerback and Johnson, (1977) who found that experienced counsellors establish better relationships than non experienced counsellors. In contrast to this, however, is that no significant relationship between the therapists' experience and the clients' indication of goals met was obtained when ET, LT and R groups were compared. It would appear, then, that therapists with more expertise may have a longer counselling relationship with their clients, but not necessarily assist the clients in achieving more of their goals. Auerback and Johnson (1977) concluded that experience level has not been shown to effect better counselling outcomes in counselling research.

Clients who felt more distressed at the onset of therapy were somewhat more likely to indicate that their counsellor was experienced. It may be that if an individual is feeling out of control the therapist is more likely to be viewed as knowledgeable.

The results of this study indicate that neither the gender of the counsellor, nor the combination of sex of therapist and client, impacted on length of stay. These results are in contrast to those of Epperson, et al., (1983) who found that

male counsellors had lower attrition rates than did female counsellors.

It is also interesting to note a trend that some clients were able to identify whether or not their therapist was experienced. These findings are dissimilar to Heppener and Heesacker's (1983) findings that actual counselor experience level was not related to perceived counsellor expertness.

(5) Similarities should exist between clients' and counsellors' perceptions of goals met during therapy

Participants were asked whether they had met their goals during therapy. Therapists were asked to identify which clients had remained in therapy until they had met their goals and which clients had prematurely terminated before goals were realized. A trend was noted that clients' and therapists' perceptions of whether goals had been met during therapy were somewhat similar but not at a significant level.

(6) Premature terminators are not a homogeneous group failed by treatment.

It is often hypothesized within the literature that all those individuals who make a unilateral decision to terminate therapy constitute a treatment failure (Garfield, 1986). In this study the groups did appear to be significantly different in some of their perceptions of therapy. The R participants were significantly different from both the ET and LT participants in the amount of benefit they felt therapy had. R and LT participants do experience the same amount of change but R and ET pariticpants are different. The trend was that a greater percentage of individuals in the R group endorsed meeting their goals. Another trend was that satisfaction and current function was somewhat related to length of stay and only insignificant

differences were noted between groups. Therefore, there are some differences in favour of the remainers group but they are not large and on some of the variables measured in this research the ET, LT and R groups did not differ. Futher studies should also make the distinction between early and late terminators as some differences do appear to exist between these two groups.

Limits of the Study and Potential Confounds

Mail Questionnaires

One of the disadvantages of mailing a questionnaire is that the return rate is very low, and it lacks the advantages of face to face interviews; however, sometimes people will be more open and honest because they have more anonymity with a mail survey. A further limitation is that this survey was conducted during the summer months when people are not typically at home that may have exacerbated already low response rates.

Sample Limitations

Only 18.85% of the population under study consented to participate in this study. Of those who participated 24.24% of those classified remainers by the therapists returned the questionnaire, 12.22% of the late terminators and 17.94 of the early terminators responded. The implication is that the data gathered from the sample may not be representative of the participant pool, and hence, the results are limited in their generalizability. However, an analysis of representativeness yielded no significant differences on sex, CMG, and age between the subjects and those in the participant pool who did not respond.

Even with the built in assessment of representativeness, certain questions are raised. The individuals used in this study were volunteers, and they as a group may differ greatly from the non responding individuals, particularly in motivation. Perhaps those individuals who replied comprised one of two extreme poles — those who were quite satisfied with therapy and those who were very dissatisfied with the therapy. Many of the clients' expressed high levels of satisfaction, benefit,

change and current functioning. These results may be due to demand characteristics. The resulting analyses, therefore, would reflect only those individuals and not the bulk of the population we were attempting to contact.

Individuals used in this study were from an out-patient psychology clinic in a general hospital. This group may differ significantly from others who seek private counselling, are in-patients, or other out-patient clinics.

These above mentioned problems greatly complicate the interpretation of these research results and their generalizability to the target population.

Small Sample Size

The sample size (n = 30) was too small to permit elaborate statistical analyses of interesting subgroups. The smaller the sample, the more likely its mean and standard deviation are not representative of the target population mean and standard deviation. The use of multiple comparisons and correlations increased the liklihood of finding significant results by change. To counter this problem the alpha level was set at $p < .01$ for interpretation of results. The correlational results may be less suspect for "in correlational research it is generally desirable to have a minimum or 30 cases (Borg & Gall, 1989, 233)," and this had been achieved in this study.

SUMMARY

When Eysenck challenged the effectiveness of psychotherapy in the early 1950's the response by researchers was overwhelming. Researchers have essentially challenged it in one of two manners; either to look at the treatment modalities or to explore the relationship of the multitude of client, therapist and therapeutic relationship variables to assess their impact on the successful provision of therapy. The successful provision of therapy being that clients did not unilaterally withdraw from therapy and were found to have experienced change due to the therapy. Within the context of this research previously identified variables were studied to identify their impact on length of stay in therapy. As well, the issue of whether all clients who prematurely terminate are failed by their treatment was investigated.

Consistent with previous studies, the current study found some relationship between the participants' age, sex and number of children to rates of termination from therapy. Counsellor experience, attractiveness and trustworthiness also impacted on the participants'length of stay in therapy . However, with regard to the impact of environmental variables, insignificant findings were obtained in this study, which is not consistent with the past research (Garfield, 1963; Baekeland & Lundwall, 1975; Gottlieb, 1983; Cross & Warren, 1984; Dyck, Joyce & Azim, 1984; Pekarik, 1992).

Premature terminations is a significant concern to those who study and provide psychotherapy. Historically it was believed that all those who terminate consistitute a failure of treatment. These findings support those of Pekarik (1992)

who suggests that the perception of all terminators as treatment failures is incorrect. Further to that, it would seem then that within the group of premature terminators there exists a subgroup that has more in common with continuers. Future exploration into the phenomenon of premature termination should have a heightened awareness of this and develop methods to separate the two seemingly different types of terminators.

The study of psychotherapy outcome is being constantly refined to concisely define the variables and their impact. A joint effort of qualitative and quantitative research should help identify the list of all possible variables implicated in outcome. At this point in time, the search for yet unknown variables and consistent findings for already identified variables continues. In future, a move to priorize the variables and an evaluation of their interaction, is paramount in gaining a global understanding of the therapeutic relationship. An alternative method of describing and studying psychotherapy may be before us.

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Appendix A

Counselor Evaluation Inventory

1 = always
2 = often
3 = sometimes
4 = rarely
5 = never

1.	I felt the counselor accepted me as an individual.	1 2 3 4 5
2.	I felt comfortable with my interviews with the counselor.	1 2 3 4 5
3.	The counselor acted as though he or she thought my concerns and problems were important to him or her.	1 2 3 4 5
4.	The counselor acted uncertain or him/herself.	1 2 3 4 5
5.	The counselor helped me to see how taking tests would be helpful for me.	1 2 3 4 5
6.	The counselor acted cold and distant.	1 2 3 4 5
7.	I felt at ease with the counselor.	1 2 3 4 5
8.	The counselor seemed restless while talking to me.	1 2 3 4 5
9.	In our talks, the counselor acted as if she/he were better than I.	1 2 3 4 5
10.	The counselor's comments helped me to see more what I need to gain my objectives in life.	1 2 3 4 5

11. I believe the counselor has a genuine desire to be of service to me. 1 2 3 4 5
12. The counselor was awkward in starting out interviews. 1 2 3 4 5
13. I felt satisfied as a result of my talks with the counselor. 1 2 3 4 5
14. The counselor was very patient. 1 2 3 4 5
15. Other people could be helped by talking with counselors. 1 2 3 4 5
16. In opening our conversations, the counselor was relaxed and at ease. 1 2 3 4 5
17. I distrusted the counselor. 1 2 3 4 5
18. The counselor's discussion of test results was helpful to me. 1 2 3 4 5
19. The counselor insisted on being right always. 1 2 3 4 5
20. The counselor gave the impression of "feeling at ease". 1 2 3 4 5
21. The counselor acted as if she/he had a job to do and didn't care how he/she accomplished it. 1 2 3 4 5

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Appendix B

CRF-S

On the following pages, each characteristic is followed by a seven-point scale that ranges from "not very" to "very". Please mark an "X" at the point on the scale that best represents how you viewed the therapist. For example,

1. Funny

not very ____ : **X**___ : ____ : ____ : ____ : ____ : ____ very

Though all of the following characteristics we ask you to rate are desirable, therapists may differ in their strengths. We are interested in knowing how you view these differences.

1. Friendly

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

2. Likable

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

3. Sociable,

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

4. Warm

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

5. Experienced

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

6. Expert

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

7. Prepared

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

8. Skillful

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

9. Honest

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

10. Reliable

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

11. Sincere

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

12. Trustworthy

not very ____ : ____ : ____ : ____ : ____ : ____ : ____ very

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Appendix C

People help each other out in a lot of different ways. Suppose you had some kind of problem (were upset about something, needed help with a practical problem, were broke or needed some advice or guidance), how likely would (a) members of you family, and (b) your friends be to help you out in the specific ways listed below. We realize you may rarely need this king of help, but if you did would family and friends help in the ways indicated. Try to base your answers on your past experience with these people. Use the scale below, and circle one number under family, and one under friends, in each row.

1. **NO ONE** would do this
2. **SOMEONE MIGHT** do this
3. **SOME** family member/friend would **PROBABLY** do this
4. **SOME** family member/friend would **CERTAINLY** do this.
5. **MOST** family members/friends would **CERTAINLY** do this.

		(a) Family	(b) Friends
1.	Would suggest doing something, just to take my mind off my problem.	1 2 3 4 5	1 2 3 4 5
2.	Would visit with me, or invite me over.	1 2 3 4 5	1 2 3 4 5
3.	Would comfort me if I was upset.	1 2 3 4 5	1 2 3 4 5
4.	Would give me a ride if I needed one.	1 2 3 4 5	1 2 3 4 5
5.	Would have lunch or dinner with me	1 2 3 4 5	1 2 3 4 5
6.	Would look after my belongings (house, pets, etc.) for a while.	1 2 3 4 5	1 2 3 4 5

7.	Would loan me a car if I needed one.	1 2 3 4 5	1 2 3 4 5
8.	Would joke around or suggest doing something to cheer me up.	1 2 3 4 5	1 2 3 4 5
9.	Would go to a movie or concert with me.	1 2 3 4 5	1 2 3 4 5
10.	Would suggest how I could find out more about a situation.	1 2 3 4 5	1 2 3 4 5
11.	Would help me out with a move or other big chore.	1 2 3 4 5	1 2 3 4 5
12.	Would listen if I needed to talk about my feelings.	1 2 3 4 5	1 2 3 4 5
13.	Would have a good time with me.	1 2 3 4 5	1 2 3 4 5
14.	Would pay for lunch if I was broke.	1 2 3 4 5	1 2 3 4 5
15.	Would suggest a way I might do something.	1 2 3 4 5	1 2 3 4 5
16.	Would give me encouragement to do something difficult.	1 2 3 4 5	1 2 3 4 5
17.	Would give me advice about what to do.	1 2 3 4 5	1 2 3 4 5
18.	Would chat with me.	1 2 3 4 5	1 2 3 4 5

19.	Would help me figure out what I wanted to do.	1 2 3 4 5	1 2 3 4 5
20.	Would show me that they understood how I was feeling.	1 2 3 4 5	1 2 3 4 5
21.	Would buy me a drink if I was short on money.	1 2 3 4 5	1 2 3 4 5
22.	Would help me decide what to do	1 2 3 4 5	1 2 3 4 5
23.	Would give me a hug, or otherwise show me I was cared about.	1 2 3 4 5	1 2 3 4 5
24.	Would call me just to see how I was doing.	1 2 3 4 5	1 2 3 4 5
25.	Would help me figure out what was going on.	1 2 3 4 5	1 2 3 4 5
26.	Would help me out with some necessary purchase.	1 2 3 4 5	1 2 3 4 5
27.	Would not pass judgment on me	1 2 3 4 5	1 2 3 4 5
28.	Would tell me who to talk to for help.	1 2 3 4 5	1 2 3 4 5
29.	Would loan me money for an indefinite period.	1 2 3 4 5	1 2 3 4 5
30.	Would be sympathetic if I was upset.	1 2 3 4 5	1 2 3 4 5
31.	Would stick by me in a crunch	1 2 3 4 5	1 2 3 4 5

32.	Would buy me clothes if I was short of money.	1 2 3 4 5	1 2 3 4 5
33.	Would tell me about the available choices and options.	1 2 3 4 5	1 2 3 4 5
34.	Would loan me tools, equipment, or appliances if I needed them.	1 2 3 4 5	1 2 3 4 5
35.	Would give me reasons why I should or should not do something.	1 2 3 4 5	1 2 3 4 5
36.	Would show affection for me.	1 2 3 4 5	1 2 3 4 5
37.	Would show me how to do something I didn't know how to do.	1 2 3 4 5	1 2 3 4 5
38.	Would bring me little presents of things I needed.	1 2 3 4 5	1 2 3 4 5
39.	Would tell me the best way to get something done.	1 2 3 4 5	1 2 3 4 5
40.	Would talk to other people, to arrange something for me.	1 2 3 4 5	1 2 3 4 5
41.	Would loan me money and want to "forget about it".	1 2 3 4 5	1 2 3 4 5
42.	Would tell me what to do.	1 2 3 4 5	1 2 3 4 5

43.	Would offer me a place to stay for a while.	1 2 3 4 5	1 2 3 4 5
44.	Would help me think about a problem.	1 2 3 4 5	1 2 3 4 5
45.	Would loan me a fairly large sum of money (say the equivalent of a month's rent or mortgage).	1 2 3 4 5	1 2 3 4 5

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Appendix D

Introductory Letter

As part of a combined project between Lakehead University and McKellar General Hospital, all individuals who have received counselling at the Department of Psychology, McKellar Hospital during the last twelve months are being contacted to ask if they would be willing to participate in a study. The researchers are interested in determining whether the counselling conducted at McKellar General Hospital was satisfactory. In order to maintain and improve the counselling service the researchers request that you complete three short surveys which will be conducted in a confidential manner and which are not related to and have no bearing on any previous counselling.

Two of the questionnaires will ask you to rate your counsellor's ability and your satisfaction with the services provided. The third questionnaire will ask you to describe any additional support you may have received apart from counselling sessions, such as, friends and family. The questionnaires will require approximately 20 minutes of your time and will provide valuable information to be used in developing our counselling services.

If you agree to participate you will not have to provide your name on the survey. You will notice a number on the top right hand side of this letter. This number will replace your name as a method of identification. This measure will make certain that the information will remain confidential. Your counsellor will not have access to your individual results and the researchers undertaking this study will not access the confidential information shared with your counsellor. The

returned questionnaires will be kept in a locked cabinet for the duration of the study, after which they will be destroyed.

If you are interested in participating in this study the following provisions apply.

1. You are a volunteer and can withdraw at any time from the study.
2. You have received explanations about the nature of the study, its purpose, and procedures.
3. There is no risk of physical or long-term psychological harm. You may feel some discomfort from having to rethink about the effectiveness of the counselling you received.
4. The data you provide will be confidential.
5. Upon request, you will receive a summary of the project, following the completion of it.
6. There will be no direct benefit to you from participating in this study. Although your participation will help to ensure a broad representation of perspectives on the counselling services at McKellar General Hospital. Any improvement that result from this study will help to ensure effective future service.

If you are willing to participate please return the addressed card enclosed in this letter. You should receive a package one week later with the survey enclosed. If we have not received your survey a follow-up letter will be sent to you in two weeks with a number to contact the researchers if you have any questions.

____
E. Kolisnyk, M. A.
Manager
Department of Psychology
McKellar General Hospital

____
Dr. W. T. Melnyk
Department of Psychology
Lakehead University
Department of Psychology
McKellar General Hospital

Appendix E

Cover Letter

Thank you for your prompt response to our request for participation in this study. We appreciate the time you took to fill out and return the consent form. As you recall from the introductory letter, this package includes a survey comprised of three short questionnaires. Two of the questionnaires invite you to rate your counsellor and your experience during counselling. The other questionnaire asks you to indicate any other assistance you may have received from friends and family during your time in counselling. As well, included is a series of questions about demographic data.

You may have had more than one counsellor at the Department of Psychology, McKellar General Hospital, if that is the case, indicate only your perceptions of the last counsellor you were with.

If you are still interested in participating in this study the following provisions apply.

1. You are a volunteer and may withdraw at any time from the study.
2. You have received explanations about the nature of the study, its purpose, and procedures.
3. There is no risk of physical or long-term psychological harm. You may, however, experience some discomfort from having to recall the effectiveness of the counselling you received.
4. Any information that is collected from you during this study will be kept confidential. If the results are published you will not be identified in any way.

5. Upon request you will receive a summary of the project, following the completion of it.
6. There will be no direct benefit to you from participating in this study. Although your participation will help to ensure a broad representation of perspectives on the counselling services at the Department of Psychology, McKellar General Hospital. Any improvements that result from this study will help ensure effective future service. As well, if you should again choose to seek services at McKellar General Hospital this will in no way affect the care that you receive.

PLEASE MAIL YOUR COMPLETED QUESTIONNAIRES AS SOON AS POSSIBLE. If we have not received your survey, a follow-up letter will be sent to you in two weeks with a number to contact the researchers if you have any questions.

Appendix F

Follow-Up Letter

This is a reminder that we have not received your completed survey. We appreciate your participation in this study and value the contribution you are making to the quality of counselling offered by the McKellar General Hospital. If you have further questions or require another survey package please contact either Dr. W. T. Melnyk or C. Long at 343-7199.

Thank you,

C. Long
Department of Psychology
Lakehead University

Dr. W. T. Melnyk
Department of Psychology
Lakehead University
Department of Psychology
McKellar General Hospital

Appendix G
Demographic Information Sheet

1. Sex: M F

2. Marital Status: Single Married Common-Law Divorced Widowed

3. Number of Children:______

4. Education (check highest level and indicate number of years)

____Elementary school ______yrs.

____High School ______yrs.

____Technical Institute ______yrs.

____Technical Institute Graduate ______________ Degree

____University ______yrs.

____University Graduate ______________Degree

5. Occupation: ______________________

Perception of Counselling

A. How satisfied were you with the results of your therapy experience?

1.____Extremely dissatisfied
2.____Fairly dissatisfied
3.____Neither satisfied nor dissatisfied
4.____Fairly satisfied
5.____Extremely satisfied

B. How much benefit do you feel the therapy had?

1.____None
2.____Very little
3.____Some
4.____A fair amount
5.____A great deal.

C. How much distress did you feel at the beginning of therapy?

1.____ Very slight.
2.____Somewhat distressed
3.____Moderate distress
4.____A great deal.
5.____Extreme amount of distress

D. How much do you feel you have changed as a result of your therapy?
1.____Not at all
2.____Very little
3.____Somewhat
4.____A fair amount
5.____A great deal.

E. How well do you feel you are getting along now?
1.____Extremely poorly
2.____Fairly well
3.____Neither well nor poorly
4.____Fairly well
5.____Extremely well.

F. Had you met all your goals when you terminated with therapy.
________Yes ________No