TERMINATION OF PSYCHOTHERAPY: THE RELATIONSHIP BETWEEN THE TERMINATION PROCESS, JUDGEMENTS OF THE CLIENT'S NEED FOR FURTHER TREATMENT AND PSYCHOTHERAPY OUTCOME.

A Thesis Presented in fulfilment of the requirements for the degree of Master of Arts in Psychology at Massey University (Under Clause9 of the M.A. regulations).

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ABSTRACT

This study was based on the data gained from eighty one terminating clients and their therapists at a university Psychological Services Centre. The study investigated the frequency with which clients and therapists agreed about three components of the termination process and if agreement was related to client outcome. The three components of termination investigated were, the reasons therapy was terminated, the mutuality of termination and the degree of need for further therapy. Client narrative responses to the question "Why is your therapy ending?" were coded into categories of reason and mutuality of termination. Raters reliably coded the majority of narrative answers. No difference in the ability of raters to make a coding with regard to the raters experience in Clinical Psychology was found. In approximately fifty percent of cases, therapists and clients did not agree about these three components of termination. It was also found that in those cases where there was agreement, the clients had better psychological outcomes, than in cases where there was no agreement.

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CHAPTER ONE
INTRODUCTION

OVERVIEW

The introductory chapter of this thesis is set in seven sections. The first section explains the reasons why understanding termination is an important component in understanding the therapeutic relationship. The second section outlines the unique nature of each termination, leading to the third section, which outlines some of the common differences between therapist and client views of therapy. It is argued that these differences contribute to making each termination unique. It is of note that every therapeutic relationship is unique, as previous research has tended to regard the role of the therapist as constant, when the role is actually redefined in each relationship.

The forth section of the thesis examines how previous research has tended to use therapists' judgements about the therapeutic relationship, largely ignoring clients' judgements. This section also explores the reasons why the therapists' judgements may be biased. The fifth section develops the idea of appropriate termination and how it may be more appropriately defined, using both client and therapist judgements.

Having outlined some definitions of termination status, the sixth section examines previous research into the relationship between termination status and psychotherapy outcome. Leading from previous research that does indicate a relationship between termination status and outcome, the seventh section of the introduction outlines the specific questions that this study seeks to answer.

1.1. WHY IS TERMINATION OF INTEREST?

The way therapy is terminated has been linked to client outcome in a great number of studies (eg. Baekeland & Lundwall, 1975; Garfield, 1986; Pekarik & Wierzbicki, 1993). Therapy is undertaken with the goal of achieving positive outcomes, therefore it is important to research the conditions under which positive client outcomes are most likely.

Prior research examining the relationship between therapy termination and outcome has shown that clients who terminate therapy earlier than is appropriate (often termed drop-outs) are more likely to experience negative outcomes than all other clients (Pekarik, 1986). Indeed, Rubinstein and Lorr (1956) found that many clients do not attend psychotherapy long enough for the helping process to have a chance to begin, while other studies have shown that between 25 and 50% of clients fail to keep even their first appointment (Rosenberg & Raynes, 1973; Turner and Vernon, 1976).

Recently, health delivery services in New Zealand have had their infrastructures reorganised (particularly with regard to funding) to make them more accountable. In this context, the cost of broken appointments and unrecovered fees must be considered an inefficient use of limited sources (Larson, Nguyen, Green & Attkisson, 1983; Pekarik, 1985a). Clients who terminate early and break appointments are often unable to be contacted, either for the recovery of fees or to assess client outcome (Pekarik, 1985b). This is at a cost to both the service delivery agency and the client (Benjamin - Bauman, Reiss & Bailey, 1984). Pekarik (1985a) concluded that psychotherapy dropouts represent clinical, fiscal and morale problems for mental health professionals.

1.2. TERMINATIONS ARE ALL DIFFERENT

Every therapeutic relationship is formed under different circumstances, with different combinations of personalities, which results in each relationship being unique (Bernal & Kreutzer, 1976). Consequently, every termination will also be unique. However, termination of therapy has been divided into two broad types, those that occur when termination of therapy is considered appropriate, and those that occur when it is considered inappropriate (Pekarik, 1983a).

The way in which the therapy is terminated and the perceptions that both client and therapist have of the termination, may well reflect many of the issues present in the relationship (Blotcky & Friedman, 1984). Both the therapist and the client have entered into the relationship with their own expectations and goals of both the process and the results of therapy (Pekarik, 1985; Garfield, 1978; Martin & Schurtman, 1985). These different expectations are likely to lead the client and therapist to view termination differently and there is evidence that these discrepant expectations may contribute to premature termination (Pekarik & Wierzbicki, 1986).

There are divergent opinions about the importance of therapy termination to psychotherapy outcome, however, Sullivan (1954) stated that termination done badly, can seriously damage or destroy all the beneficial psychotherapeutic work previously accomplished.

1.3. THERAPIST AND CLIENT PRE-THERAPY EXPECTATIONS, GOALS AND PERCEPTIONS OF TERMINATION.

Clients entering psychotherapy have expectations of their impending involvement in a psychotherapeutic relationship. It has been found by a number of researchers (eg. Borghi, 1968; Levitt, 1966) that these expectations are not always confirmed during the therapy. Levitt (1966) called this phenomenon the "expectation-reality discrepancy" (EDR). It has been hypothesised (Levitt, 1966) that the disconfirmation of the client expectations interfers with subsequent psychotherapeutic

efforts. Researchers (eg. Overall & Aronson, 1968) have also found that the disconfirmation of client expectations can be related to premature termination.

Therapists also have expectations of the psychotherapeutic relationship (Benbenishty, 1987; Goodyear, 1981). Client and therapist expectations of therapy are different in specific areas. Clients, on average, anticipate a shorter length of therapy (number of sessions) than that expected by therapists (Pekarik & Wierzbicki, 1986; Benbenishty, 1987). When comparing the duration of therapy expected by therapists with actual therapy duration, therapists in one study expected three times more sessions than actually occurred (Pekarik & Finney-Owen, 1987).

The finding that therapists expect a far longer treatment duration (number of sessions) than clients expect, is consistent with the finding that a large proportion of clients terminate earlier than their therapists think appropriate (Pekarik & Finney-Owen, 1987). In some settings, it has been found that over a third of clients that therapists defined as dropouts, terminated treatment because those clients had met their own goals for improvement (Pekarik, 1985b). Those clients who have met their goals for therapy would probably view their termination as appropriate, often in disagreement with their therapist. This supports the hypothesis that clients and therapists will differ in the way they view termination and perceive the need of the client for further therapy.

Differences between therapist and client expectations of therapy (eg. the differing expectations of treatment duration) are also related to their different perceptions of what happens during therapy (Pekarik & Finney-Owen; 1987). These different views of the events that take place as part of the therapeutic relationship have been shown to have a relationship with the clients' outcome (Pekarik & Wierzbicki; 1986). Llewellyn (1988) found that when both therapists and clients record their views of significant events in their therapy, greater differences in perception are found in the cases where client outcome is poor. This is relevant to termination, as termination is a significant event in the course of the therapeutic relationship (Llewellyn, 1988).

Benbenishty (1987) found that there was a gap between the expectations and the perceived realities of both clients and therapists. The gap for clients is, however, different from the gap for therapists. Early in therapy, clients and therapists both expect the clients' identified problem behaviours to occur more than they actually perceive them to happen. In the first session the expectation-reality gap was larger for clients than therapists. However, over time the expectation-reality gap significantly closes for clients, but remains nearly constant for therapists. These differences between client and therapist judgements regarding the degree of symptom improvement are likely to impact upon the differences in judgement between clients and therapists as to when termination of psychotherapy is appropriate.

1.4. WHO DECIDES IF TERMINATION IS APPROPRIATE AND WHY MIGHT THERAPIST JUDGEMENTS NOT BE RELIABLE?

In Wierzbicki and Pekarik's 1993 meta-analysis of psychotherapy dropout literature, it was found that most researchers either took the therapist's judgement of the appropriateness of termination, or used an arbitrary definition, such as the client missing the last scheduled appointment, or attending less than a specified number of sessions. In studies that have included the clients judgement of the appropriateness of termination, (eg. Garfield, 1963, Pekarik, 1988), it has most often been the judgements of clients identified as terminating inappropriately (dropouts) that have been considered.

Fiester (1977) compared therapists with low client attrition rates with therapists with high client attrition rates. It was found that different therapy approaches by therapists effect changes in the rate of client attrition (inappropriate termination). Fiester found that earlier researchers had an implicit tendency to consider the influence of the therapist as uniform and therefore of little explanatory value. It has been suggested that, regarding the role of the therapist as uniform, is yet another unfounded homogeneity myth (Kiesler, 1971; Fiester, 1977).

Therapists and clients both have personal issues that they bring into the therapeutic relationship. As early as 1937, Freud postulated theories about the issues that are brought to the therapeutic relationship by therapists and how these issues influence the course taken during therapy. Freud felt that beliefs and life experience are as much an influence on the way a therapist perceives the world, as they are for the client. Differing client pre-therapy perceptions are important to the success of therapy. Indeed, in their 1986 study of client pre-therapy expectations, Filak, Abeles and Norquist found that these expectations are predictive of client outcome.

The acknowledgment of the therapist's emotional investment in the therapeutic relationship is important when considering therapist bias in their judgement of appropriate termination. DeWald (1980) wrote that therapists will experience emotions effected by unconscious personal needs, therapeutic ambitions and reactions specific to particular clients. Given that the therapist has an emotional investment in the client, that therapist will experience feelings of loss at the termination of therapy. Goodyear (1981) highlighted the loss experienced by therapists, by stating that termination of therapy with a client who has made positive progress often involves the loss of a gratifying relationship for the therapist. Part of the overall loss is the loss of professional status, as at termination the therapist ceases to be that client's therapist (Easson, 1971).

Quintana (1993) has challenged some of the existing beliefs regarding termination as loss. Quintana emphasises that terminations as loss does not mean termination as crisis, in all cases. Quintana proposes that termination as development can be a component of the termination process.

It has also been postulated that the therapist's awareness of the importance of the termination phase of therapy can cause increased levels of anxiety, even for experienced therapists (Martin & Schurtman, 1985). This increased anxiety could colour the therapists judgement about how ready the client is to terminate appropriately. All these factors suggest multiple influences on therapist judgements

regarding termination process and appropriateness. These multiple factors are potential causes of distorted and/or biased judgements.

There are good reasons for using therapist judgements regarding the appropriateness of termination. Therapists do, as participants, have intimate knowledge of the relationship and they are accessible when clients often are not (particularly in the case of "dropouts"). However, only taking account of the therapists' judgement is severely limiting, if not clearly biased, as has been argued in the measurement of therapy outcome (Luborsky, Chandler, Auerbach, Cohen & Bachrach, 1971). The practice of only regarding the therapist's judgement may be indicative of an underlying assumption that the therapist is the "expert". Given that there are many factors with the potential to distort or bias the judgements of therapists, there may be a strong case for also considering the judgements of clients.

In a study which considered both therapist and client judgements, Huber (1990) found that in only 20% of terminations at a university psychological services clinic, did both parties agree that termination was appropriate. This implies that in eighty per cent of cases either the therapist or client (and possibly both) felt that termination was inappropriate. If this is so, then the effectiveness of therapy would potentially be undermined in the 80% of terminations that are not appropriate. In order to assess the validity of both the therapist and client judgement of the appropriateness of termination, it is important to first establish a definition of appropriate termination.

1.5. DEFINITIONS OF APPROPRIATE TERMINATION.

There have been a range of definitions of termination status and appropriate termination. For example, Pekarik (1985a) described two definitions of appropriate termination. The first definition was duration of therapy; that is, clients who attended less than a specific number of sessions were defined as terminating inappropriately.

The second definition deemed those clients who missed their last scheduled appointment as having terminated inappropriately. Neither of these definitions considered the client's need for further treatment as a factor in determining who had appropriately terminated. In addition, each of these definitions defined groups which constituted different members.

Pekarik has also studied termination status by breaking inappropriate terminations into categories of reasons for termination (Pekarik, 1983b; Pekarik and Finney-Owen, 1987). Examples of reasons are "Financial", "No need for services", "Transportation problems", "Dislike of services", etc.

Reason for termination was determined by the reason the client or the therapist nominates at the time that therapy terminates (eg. cost too high, problem abatement).
Pekarik (1985b) suggested an alternative to defining termination status by reasons for termination, when he proposed that termination be defined by the nature of termination. Nature of termination was determined by whether the client or therapist initiated the termination, or the initiation of termination was mutually agreed. It was suggested appropriate termination be defined as one where termination was "mutually agreed upon by therapist and client" (Pekarik, 1985b).

By contrast, Pekarik (1983a) defined appropriate termination as "someone not in need of continued therapy beyond the last session"; this was determined by the therapist. Using this need for therapy definition, it was found that clients who appropriately terminated therapy had better outcomes than clients with any other type of termination (Pekarik, 1983a).

Huber (1991) discounted the "mutual agreement" definition of appropriate termination. He disputed the concept of mutual termination, concluding that there can be no such thing as mutually initiated termination, as one party must introduce the termination issue first. Although it is true that one party must raise the issue before the other, it does not follow that one party raising the issue of termination

first precludes the other party from (honestly) agreeing that termination is appropriate.

Pekarik (1983a, 1983b, 1985a) has suggested three definitions of termination, each focusing on different components of the termination process. Given that strong cases for using any of the three approaches have been made, determining termination status with a definition that combines nature of termination, reasons for termination and need for further therapy, may prove to be the most fruitful in predicting client outcome. This is because Pekariks' three definitions have shown termination to be a multidimensional process therefore a multidimenional definition is needed to be consistent and may be the most fruitful in encapsulating all that termination encompases.

Given that there are influences that may cause possible therapist bias (Easson, 1971; Goodyear, 1981), it may be useful to also consider client judgements of the mutuality of termination. Specifically, there is a need to examine the level of agreement between client and therapist views of the nature (mutuality) of termination and reasons for termination.

It has been proposed by some researchers (Brandt, 1965; Baekeland & Lundwall, 1975; Pekarik, 1985a) that different criteria for defining appropriate termination is largely responsible for the inconsistencies in the results of dropout literature. For example, in one study of the reasons for termination, the group who dropped-out because they considered themselves to be improved (but who therapists considered would benefit from further treatment) were considered to have achieved "problem abatement" (Pekarik, 1988). In another, they were described as believing they had "no need for services" (Pekarik, 1983a), while in a third they were described as having their "problem solved or improved" (Pekarik & Finney-Owen, 1987).

These terms are similar, but they are not synonymous. Clients may fit the category of "problem solved or improved" in one study, but not the similar category of "No need for services" in another study, if their problem has improved, but they are still

in need of services. This difference in the descriptive term used to label these groups makes comparisons between studies of questionable validity. Comparing client and therapist judgements regarding both reasons for, and mutuality of, termination will clarify the extent of agreement between clients and therapists on these dimensions.

1.6. TERMINATION STATUS AND PSYCHOTHERAPY OUTCOME

In order to investigate the differences in outcomes between appropriate and inappropriate terminations, researchers have studied a wide range of variables in an attempt to provide better service to clients and to assist in allocating resources more effectively (eg. Benjamin-Bauman; Reiss & Bailey, 1984).

While it is usually assumed by therapists that dropouts suffer poorer outcomes than successful completers, Garfield (1978) found that this assumption has little empirical support. The lack of empirical data needed to support or refute this assumption is in part due to the practical difficulties of locating and following-up dropouts (Pekarik, 1986).

Some of the previous research has produced apparently contradictory results. For example, Feister (1977) found that early termination does not indicate treatment failure, yet, in a meta-analysis of 125 studies of "dropouts", Wierzbicki and Pekarik (1993) found that over half the studies defined "dropouts" by termination before a set number of sessions were completed.

Fiesters' (1977) findings (that early psychotherapy termination cannot be equated with treatment failure) also seem to be at odds with the findings of Hynan (1990). Hynan (1990) split terminations into two groups. Early terminations were those that occurred after five or less sessions. Late terminations were those that occurred after more than five sessions. The findings of the study suggested that late terminators felt that therapy was of more benefit, than early terminators. Hynan also found that early terminators were more likely to stop treatment because of situational

constraints or discomfort with the service. In contrast, late terminators were more likely to stop treatment because of improvement attributed to therapy. Late terminators also reported greater levels of therapist warmth, respect from the therapist and therapist competence. This may suggest that it is more likely to be the reasons clients have for terminating therapy, than the length of time they spend in treatment, that is predictive of outcome.

Pekarik (1983a) also investigated the relationship between termination status and outcome. He found that dropouts not only had poorer outcomes than completers, but that the earlier the client dropped-out, the poorer their outcome. This finding indicates a simple relationship between termination status and psychotherapy outcome. However, this study used "Need for further treatment" to determine if termination is appropriate or not. This defines a dropout as a client still in need of further treatment after their last therapy session. A client not in need of further treatment after their last appointment is considered to have terminated appropriately. Such a definition takes no account of how "early" or "late" the termination occurred, and suggests that it is the appropriateness of the termination that is the predictor of outcome, not the timing of termination.

Both the "need for further treatment after the last session" and the "number of sessions" definitions of appropriate termination show differences in outcome, for those who terminate appropriately and those who terminate inappropriately (Fiester, 1977; Hynan 1990). Pekarik's (1983a) study suggests that the two definitions are not unrelated, as he found that clients were less likely to be in need of further therapy, the more sessions they attended. What these different studies do have in common is the finding that there is a relationship between termination status and therapeutic outcome. Their different approaches suggest that the relationship between termination status and therapeutic outcome requires further study.

1.7. THE PRESENT STUDY

The first aim of this study is to find out if it is possible, from an existing database, to determine clients' views about the reasons for and nature of termination. Therefore, **hypothesis one** of this study states that "Client narrative responses to the question "Why is your therapy ending?", can be reliably coded into mutuality (nature) of and reason for termination". The results of testing this first hypothesis lead directly to the second hypothesis. **Hypothesis two** states that " There will be no difference in the ability of different rater groups to make ratings, regardless of the rater's experience in clinical psychology."

The present study examines the match between client and therapist views of termination. Specifically the match between client and therapist ratings of the clients need for further therapy, reasons for and mutuality of therapy termination and their relationship to outcome.

Reasons for, and mutuality of, termination are examined to find the answers to several questions. The first question is addressed by **hypothesis three**, which states that "There will exist differences between client and therapists views about reasons for and mutuality of termination". If the results support hypothesis three, such a finding would be consistent with other the findings of Benbenishty (1987) who found therapists and clients have differing perceptions of other issues in therapy. In the present study, **hypothesis four** states that "More therapists than clients will rate the termination of therapy as being mutually determined". Benbenishtys' (1987) findings indicate their will be such a difference, the reason that it is hypothesised therapists are more likely to rate termination as mutual, is that therapists are likely to view the therapeutic process as one where each progressive stage is negotiated by the parties. The influence on the role of therapists in psychotherapeutic relationships by such theorists as Carl Rogers (in books like his 1961 title, "On Becoming a Person: a Therapist's view of Psychotherapy" and in lectures) has lead many therapists to approach therapy from a client-centered stance. The decision to terminate would be fully discussed by the parties involved, if at all possible, in these

therapeutic relationships, leading therapists to regard them as mutually determined terminations. Clients are generally more naive about the theories that drive therapy (than therapists) and are less likely to interpret the therapeutic relationship in terms of pre-determined paradigms.

Testing one aspect of Benbenishty's (1987) finding that therapists judge treatment improvement as less than clients rate their improvement, **hypothesis five** states that "Therapists will rate the clients' need for further therapy as being higher than clients will rate their need for further therapy". Following on from hypothesis five, the next obvious question to be raised is how accurate are the client and therapist in their judgement of need for further therapy? Pekarik (1983a) found that therapist rating of client's need for further treatment at the time of termination is highly correlated with client outcome. Pekarik (1983a) also found that therapist judgments of need for further treatment, the client giving "No further need for services" as the reason they are terminating and therapist/client agreement about significant events in therapy, are all related to positive client outcome. Given that these three variables are strongly related with positive client outcome, it is logical to ask if there exists a strong relationship between the three variables.

If a client terminates for the reason of problem abatement, they will rate their need for further therapy as being low Hypotheses six, seven and eight seek to test these ideas. **Hypothesis six** states that "Both therapist and client ratings of 'need for further therapy' will be negatively corelated to psychotherapy outcome". **Hypothesis seven** states that "Those clients who cite problem abatement as a reason for termination will rate their need for further therapy as being low. They will also be in agreement with their therapist about termination (as a significant event in therapy)." In part, hypothesis seven seeks to test the consistency of the clients answers on the Client Completed Termination Form, as a client citing problem abatement should also indicate low need for further treatment, in order to be consistent.

Hypothesis seven also seeks to support the findings of Llewellyn (1988), by establishing the relationship between client/therapist agreement about significant events in therapy and client outcome (the significant event being studied here is termination). One question raised is whether a match between therapist and client views predicts outcome. Llewellyn (1988) found that the less client and therapist views of the significant events in therapy match, the poorer the outcome. Given this, we can reasonably expect a relationship between the match in therapist and client views of termination (as a significant event) and outcome. Consequently, **hypothesis eight** states that "Clients who agree with their therapists about the reasons for and mutuality of termination will have more positive outcomes than those who do not agree with their therapists".

It may be that there are significant gaps in the data needed to answer the questions asked. A further, more general, aim of the present study will be to assess whether there is a need for more (and/or different) questions to be asked of terminating clients and their therapists. This would be in order to provide a more complete, and therefore more useful, database.

CHAPTER TWO
METHOD

2.1 SETTING

Data was obtained from the database at the Psychological Services Centre of the University of Massachusetts' (UMASS) Amherst campus (Todd, Jacobus, & Boland, 1992). The University of Massachusetts has 22,000 students enroled and is the flagship of the state higher education system. The Amherst campus is located two hours from Boston, at Amherst, a city of 35,000, that is largely white and upper middle class. The community is semi-rural with an increasing low-income and minority (eg. Hispanic, Cambodian) population. UMASS is one of five higher education institutions in the area. The Psychological Services Centre uses a diversity of theoretical approaches, therefore therapy is performed from a number of perspectives and with different patient groups (individuals, couples and families). Judgements and ratings made in the Case Summary may also reflect the theoretical approach of the therapy undertaken, the nature of the group attending therapy. The perspectives of the therapist's supervisor may also influence the judgements and ratings, as the supervisor may well review and discuss the case.

As the Psychological services centre is based on campus, students are a large part of the client population.

2.2 SUBJECTS.

The subjects were clients of the Psychological Services Centre at UMASS and the therapists who counselled them. In 1989 there were changes made in both the intent and content of the data related to termination held in the UMASS data base. Therefore, only data relating to clients whose therapy was terminated after the summer of 1989 (and before the summer of 1992) was used. There was data available for approximately thirty clients a year. Therapists who completed the forms stored in the data base were usually in training and ranged in experience from

less than one year to as much as four years. No therapist received payment for their work with clients in this clinic. However, clients did pay (on a sliding scale) a fee to the clinic for their treatment. All therapists receive individual supervision and most, but not all, were members of a treatment team.

There were eighty-one client/therapist pairs available in the database. The clients had an average age of 28.5 years, with a standard deviation of 10.62 years. The ages ranged from 7 years to 67 years. Data on age was missing for six clients. Fifty two of the clients were female, twenty nine male. Sixty six clients saw female therapists and fifteen saw male therapists.

2.3 MEASURES.

During the course of therapy, and particularly at commencement and termination of therapy, both therapists and clients complete a variety of measures. The purpose of this is to assist with determining client's current psychological state, change in the client's state, the client's satisfaction with their therapy, and possible areas for change that may improve the state of the client.

Client outcomes' were assessed on a number of measures. The Therapist Completed Termination Case Summary (Appendix 1), the Client Completed Termination Form (Appendix 2) and The Global Severity Index of the SCL-90-R (Derogatis, 1977) (Appendix 3),

Therapist Completed Case Summary.(Appendix 1).

The Case Summary is completed by the therapist at transfer or termination of a case and is used to administratively close a case. Case Summary information started to be collected prior to 1987. Information obtained includes: Duration and type of treatment, therapist orientation, disposition of the case, ratings of therapy success and the degree to which further treatment is needed. Two items were used in the present study. Item 6b asked therapists to select the most appropriate "Nature of

termination" from six alternatives. This item was used to establish therapist classification of mutuality of termination. Item 8 asked the therapist to rate the client's need for further therapy, along a seven point scale, from 1 = none through to 7 = extreme.

Client Completed Termination Form (CTF).

At the time that cases are closed, the client is asked to complete the Client Completed Termination Form (CTF, Appendix 2). Four items from the CTF were used in the present study. Using seven point Likert type scales, the clients are asked to answer three questions. Question two asks the client to rate how they were doing at the commencement of therapy. Question three asks the client to rate how they are doing "now". Question six asks the client to rate their current need for further therapy. Question seven asks the client to write a narrative response explaining why their therapy is ending. This narrative response provided the information from which the client's view of the reason for and mutuality of termination was coded.

The questions contained in both the PSC and the CTF are similar to those used in numerous questionnaires and closely resemble those developed by Strupp, Lessler and Fox (1969).

MUTUALITY (NATURE) OF TERMINATION.

The client measure of mutuality of termination is measured through the narrative "Nature of termination" item on the Client Completed Termination Form (Appendix 2). The item asks clients "Why is your therapy ending?. The therapist measure of mutuality is determined by the "Nature of termination" item of the PSC (therapist completed) form (Appendix 1). Therapists selected the most appropriate choice of six categories of nature of termination. The six categories are;

1. Mutually determined,
2. Client determined in interview,

3. Client determined by no-show some time following first session,
4. Client determined outside of interview with notification,
5. Therapist determined,
6. Other.

These six categories were collapsed, with items 2, 3, and 4 being combined, as they were all types of client determined termination. Item six was considered not able to be coded. By collapsing the categories direct comparison between the client and therapist measures of mutuality were possible.

Client measures were obtained by raters coding the client narratives into categories. The raters of the client narratives used the same three categories as for therapist judgements, with a forth category being to not make a judgement, due to insufficient information (Appendix 5).

REASONS FOR TERMINATION.

As with the client measure of mutuality of termination, the client measure of reason for termination was derived from rater codings of client narratives. There are eighteen categories of reason for termination on the form the raters of the client narratives completed (Appendix 5.) These are assessed by coding the narrative answers to question seven of the Client Completed Termination Form, which reads "Why is your therapy ending?"

MEASURES OF CLIENT OUTCOME.

Symptom Checklist-90-Revised (SCL-90-R) (Derogatis, 1977) (Appendix 3.)

This ninety item symptom check-list assesses the clients' current level of psychological distress. Each of the questions relates to one dimension of psychological functioning and the client rates their distress in relation to each symptom on a five point, Likert type, scale.

The ninety questions of the SCL-90-R make up a number of sub-scales and each sub-scale measures a specific area of symptom distress. However, for this study the Global Severity Index Score (total score) was used. This measures the client's overall psychological symptom distress and is defined as the mean severity rating across all items.

The validity and reliability of the SCL-90-R have been documented in a number of studies. With a sample of 209 "symptomatic volunteers", Derogatis, Rickels, and Rock (1976) found high convergent validity for the nine primary symptom scales of the SCL-90-R and a set of 30 Minnesota Multiphasic Personality Inventory scales. On eight of the nine SCL-90R sub-scales, sizeable correlations with like constructs were reported. Also, the SCL-90-R has been shown to be factor invariant, with regard to gender (Derogatis & Cleary 1977).

Although the SCL-90-R has become a widely used self-report measure (Gatchel & Baum, 1983), there has been some criticism of the ability of the SCL-90-R to be reliable across cultures. Some studies have found that some factors are not of equally good fit for different ethnic groups (Takeuchi, Kuo, Kim & Leaf, 1989). However, even in a study designed to stress the weaknesses of the SCL-90-R, Schwarzald, Weisenberg and Soloman (1991) still found it to be an accurate measure of general discomfort. Consequently, it is only this global measure of the SCL-90-R that is used in this study.

The SCL-90-R is the only multi-item outcome measure that is used in this study and is, therefore, to be given more weight than the single-item outcome measures.

Difference scores and Judgements of Outcome.

Therapists were asked to make a rating for this question -

" How helpful has therapy been?"

Clients rated a single item of how helpful they believe therapy had been to them. The clients rated this (on a seven point scale) when they completed question one of the CTF, which reads -

" How did you feel when therapy began and how do you feel now?"

The clients responded to two items. The first was question two of the CTF, which read "Please circle a number to show how well you were doing when you began this therapy". The second was Question three of the CTF, which asked the client to "Please circle a number to show how you are doing now". Both these questions were answered by marking the appropriate point on a seven point, Likert type scale. By subtracting the score for how the client was doing at termination from the score for how they were doing when therapy began, a difference score was obtained. The difference score reflects the clients view of the change in their functioning, over the time therapy was conducted.

Need for further treatment.

Both the therapists and clients independently rated the client's need for further therapy. Therapists gave their rating (on a seven point scale) when they completed question eight of the PSC case summary. Clients gave their rating (also on a seven point scale) when they completed question six of the CFT.

2.4 PROCEDURE.

Narrative responses from the CTF and the ratings from the Therapist Completed Form (PSC case summary) were coded into the four categories of mutuality (nature) of termination and the eighteen categories of reasons for termination.

Coding nature of and reasons for termination.

The three groups of raters were of differing levels of clinical experience. Group one consisted of five members, all post-graduate students with no clinical

experience, studying industrial psychology. Group two consisted of five members who had completed at least one year of a post-graduate internship leading to becoming registered clinical psychologists (and the Diploma in Clinical Psychology). Group three consisted of three members who were all registered clinical psychologists. These were the only criteria for selection into the three groups.

The raters were only divided into the three different groups to test hypothesis two (which involved a between group comparison of the codings given). For all other analyses, the raters were not divided into groups and the codings made by all thirteen raters were analysed together. When the codings of the thirteen raters were collated, only codings receiving a minimum of 69.2% agreement (9 of the 13 raters in agreement) were included for analysis . This is the first level of agreement reached that is above 65%. Sixty-five percent agreement has been considered a minimum acceptable level (Guttman et al, 1971). Using this higher level of significance strengthens the results regarding the criticism that agreement can occur by chance. Another control against agreement occurring by chance in this study, is the larger than common number of raters (Tinsley & Weiss, 1975).

The codings of reasons for termination into the eighteen categories were collapsed into the eight categories of the therapist completed termination form to allow direct comparison of the two sets of ratings. Both the codings made by the raters and by the therapists were then collapsed into the three categories described by Pekarik (1988) (See Appendix 6). This was done to allow comparison of the results from this study with the results from Pekariks' 1988 study.

A number of the narratives cite more than one reason for the termination of therapy. This occurred in sixteen cases. Where there was more than one category recorded by a rater, only those categories where nine of the thirteen raters agreed were recorded. For example; if three of the raters coded a narrative as 2 and 8, four coded it as 8 and 10 and six coded it as 4 and 8, that narrative was recorded as an 8. This is because there is over 69.2% agreement (in this example twelve of thirteen raters) that this narrative should be coded as 8, but less than 69.2% (nine of

thirteen raters) agree that it should coded as anything else. Once the client responses were coded, they were compared and contrasted with the responses of the therapists to determine the degree of agreement between the two groups.

CHAPTER THREE

RESULTS

3.1 HYPOTHESIS ONE: Client narrative responses to the question "Why is your therapy ending?", can be reliably coded into mutuality (nature) of and reason for termination.

If hypothesis one can not be supported then it would be impossible to test the hypotheses related to the match of therapist and client views of reasons for and nature of termination.

The raters were able to determine the client's view of nature of termination. Sixty of the eighty-one clients wrote an answer to the question "Why is your therapy ending?". It was these sixty written answers that were coded by the raters. Using the 69% agreement criteria, the raters agreed on a rating for nature of termination for 53 of the 60. That is, 88% of the available data could be reliably coded by multiple raters. (At a rate of agreement of 80%, the raters agreed on the rating for 41 narratives. The raters agreed about a rating for 27 clients, at a rate of agreement of 100%).

There were seven cases for which the raters did not make a coding, as there was insufficient information in the narrative to make them codable. These narratives were of one word and/or were meaningless (eg. "Cause it's over"). As these seven were not codable, they were not included in further analyses. This left fifty three agreed ratings to base further analysis on. However, of these seven, the raters agreed (at the 69% level of agreement) that there was insufficient information to make a rating in two cases. This left only five of sixty (8.3%) cases where the raters did not agree at the minimum (69%) level of agreement. If the cases where the raters agreed that there was insufficient information to make a rating were included as an agreed rating, the rate of reliable coding by the multiple raters rises to 91.7%.

The raters were also able to reliably code the client's view of the reason for termination. At a rate of agreement of 69%, the raters were able to reliably rate 83.3% of the client narratives. (At a rate of agreement of 85%, the raters agreed on ratings of the narratives of 46 clients. At a rate of agreement of 100%, the raters agreed on ratings for 24 clients' narratives).

This means that there was agreement in fifty of the sixty cases, these were the cases that were used for further analysis. There was one case where the raters agreed that there was insufficient information to make a rating. If that case was included as a case of rater agreement, then raters did not reach agreement in only nine cases (15%).

Given an accepted minimum level of agreement is 65% (Guttman et al, 1971), the raters were able to agree on the category that the majority of narratives best fit. In general there was support for hypothesis one, approximately 85% of the narratives could be reliably rated into mutuality (nature) of, and reason for termination.

3.2 HYPOTHESIS TWO: There will be no difference in the ability of different rater groups to rate accurately, regardless of the raters experience in clinical psychology. Hypothesis two was designed to determine whether greater levels of clinical knowledge influenced the ability to reliably code client's mutuality (nature) of and reasons for termination.

Table One shows how the raters coded the narratives. When the raters coded the narratives into the eighteen categories, many categories were not used, and several were used infrequently. This limited the type of analysis that could be conducted, due to low frequencies in some categories. Consequently, one step necessary in order to use Chi-square analysis was for the ratings were collapsed into Pekariks' (1988) categories. This also allowed the results of this study to be directly compared with those of Pekarik (1988).

Group ones' members consisted of post-graduate Industrial Psychology students, who had never studied clinical psychology. This means that, although they are described as the group with low experience, they had no formal experience. The members of group two had a minimum of one year's training to be Clinical Psychologists and completing a Diploma in Clinical Psychology. The membership of group three were all Registered Clinical Psychologists. This is a simple method of determining different levels of clinical experience, which takes no account of the differing years of experience the Registered Clinicians may have had. The members of all three groups were selected by practical considerations, ie. they were available and willing to participate.

Table 1. Ratings made by the three groups of raters for reason of termination.

REASONS	RATER EXPERIENCE		
	Low	Medium	High
Environmental obstacles	42	40	41
Problem abatement	9	8	7
Dislike of treatment	6	6	5

Note; 7 of the client narratives rated by the low experience group were rated as best more than one category.
6 of the client narratives rated by the medium experience group were rated as best fitting more than one category.
3 of the client narratives rated by the high experience group were rated as best fitting more than one category.

Category one, of Pekariks' (1988) three categories was Environmental obstacles to treatment. Category two was Problem abatement. Category three was Dislike of therapy, therapist, or clinic procedure. The ratings made by the raters were collapsed into the three broad categories of Pekarik (1988). The way this was done

is detailed in appendix seven. These re-codings were then analysed. Each of the three groups' ratings were compared with the both other groups ratings. This was done by conducting a chi-square analysis. In order to use chi-square analysis, only those narratives that were reliably coded by all three rater groups were included, as not to violate the assumptions of a chi-square analysis. In addition, those narratives that produced multiple ratings were excluded (multiple ratings also violate the assumptions of chi-square). There were 27 of the 50 narratives reported in Table 1, that were either given a multiple rating by one or more raters, and/or were not reliably coded by at least one rater group. These are the 27 narratives missing from Table 2, that were reported in Table 1. Table two shows the codings of the three rater groups, that were analysed by chi-square analysis. The 23 narratives that could be analysed by chi-square, were coded by all three groups into the same categories. Despite the loss of data (between Tables 1 and 2), the results reported in Table 2 are consistent with the overall pattern of Table 1. This supports Hypothesis Two.

Table 2. The Ratings made by the Three Groups of Raters for Reason for Termination (those ratings that did not Violate the Conditions of Chi-square Analysis).

REASONS	RATER EXPERIENCE		
	Low	Medium	High
Environmental obstacles	21	21	21
Problem abatement	2	2	2
Dislike of treatment	0	0	0

A chi-square analysis was also conducted on the ratings made for mutuality of termination. Again, only narratives where all three rater groups made a reliable rating were included (there were no multiple ratings of mutuality). This produced 42 cases for analysis and can be seen in Table four. As many as 52 narratives were coded for Table 3 (by the medium experience group), 10 of these ratings were lost

in Table 4, as those 10 narratives were not reliably coded by all three groups. The three groups all made the same rating in all 42 cases. This also supports Hypothesis Two.

Table 3. Ratings made by the three groups of raters for mutuality of termination.

MUTUALITY	RATER EXPERIENCE		
	Low	Medium	High
Mutual	2	1	1
Client	36	41	33
Therapist	10	8	9
Insufficient information	2	2	2

Note; No group rated any narrative as indicating more than one type of mutuality of termination. The low experience group agreed on a coding for 50 clients, the medium experience group agreed on a coding for 52 clients and the high experience group agreed on a coding for 45 clients.

Manual cross-referencing of the ratings showed that there was a high level of agreement between the three rater groups. All three groups of raters made the same rating for reason for termination in 43 of 60 cases. All three groups agreed there was insufficient information to give a coding in one other case. This is a 100% agreement, between the three groups, for 73.3% of the client narratives.

Note: Of the 16 cases where there was no agreement between the three groups, there was no case of clear disagreement. A clear disagreement is where at least one of the three groups of raters agrees on a rating different from that agreed by the members of another group. In the cases where there was no clear agreement the members of one or more of the three groups of raters did not agree on a rating.

The low experience group agreed on the mutuality of termination for forty-eight of the sixty cases. The medium experience group agreed on the mutuality of termination for fifty of the sixty cases. The high experience group agreed on the mutuality of termination for forty-three of the sixty cases. All three groups agreed that there was insufficient information to make a judgement in two other cases. As with the ratings for reason for termination, manual cross-referencing the ratings of the mutuality of termination showed a high level of between group agreement. All three groups of raters agreed on the mutuality of termination in 39 of the 60 cases. All three groups agreed that there was insufficient information to give a rating in two further cases. This is an agreement, between the three groups, for 68.3% of ratings for client narratives. In the 19 other cases, one or more groups achieved an agreement level of less than 69%. In no cases did one of the three groups agree on a rating different from that agreed on by the other groups. It could, therefore, be argued that there was no clear between group disagreement, as Table four shows.

Given that no group of raters proved any more reliable than any other in testing hypothesis two, all the ratings made were combined for all subsequent analyses (as for hypothesis one).This high rate of agreement also supports hypothesis two.

Table 4. The Ratings of the Three Rater Groups for Mutuality of Termination, that did not Violate the Conditions of Chi-square Analysis.

MUTUALITY	RATER EXPERIENCE		
	Low	Medium	High
Mutual	0	0	0
Client	33	33	33
Therapist	7	7	7
Insufficient information	2	2	2

The ratings of all 13 raters were used to test hypothesis three. The 13 raters agreed (at the minimum rate of 69%) about the mutuality of termination in 53 cases. The 13 raters agreed (at the minimum 69% rate) about the reason for termination in 50 cases.

Table 5. Client and Therapist Ratings of the Mutuality of Termination.

	Client Ratings		
Therapist Ratings	**Mutual**	**Client**	**Therapist**
Mutual	1	13	2
Client		21	
Therapist	2	3	6

3.3 HYPOTHEIS THREE: There will exist differences between client and therapist views about reason for and mutuality of termination.

There were 48 therapist/client pairs where a rating of mutuality was available for both. Therapists and clients agreed about the mutuality of termination in 28 of the 48 cases (58%), this can be seen on the diagonal from top left to bottom right of Table 5 (the shaded cells). The probability of 28 of 48 (or more) cases agreeing by chance is .0002 ($z=3.6$). There were 50 therapist/client pairs where there was a rating of reason for termination was available. The codings of the thirteen raters were recoded into the same eight categories as in the therapist completed PSC (Appendix 1). Therapists and clients agreed on the reason for termination in 26 of the 50 cases (52%), this can be seen on the shaded diagonal of Table 6. The proportion expected by chance in this case would be 12.5%. The probability of getting 26 matches (or more) is .0014. ($z = 2.99$). This indicates that therapists and clients were more likely to agree with each other than chance would predict. This does not support Hypothesis three.

Table 6. Client and Therapist Reasons for Termination.

Therapist Reason	Client Reason 1	2	3	4	5	6	7	8
1	6					4		
2		1				1		
3						2		
4								
5						1		
6					1	9	3	
7	1					10	10	
8						1		5

Category of reason.

Category 1: Problems reduced (no further need).

Category 2: Client dissatisfied with therapy

Category 3: Client felt therapy could help no more

Category 4: Therapist felt therapy could help no more

Category 5: Client unmotivated

Category 6: Client withdrawal due to external reasons

Category 7: Therapist no longer available

Category 8: Other.

Table 7. The Frequency of Agreement Between Therapists and Clients, for Both Mutuality of and Reason for Termination

	Agree	Disagree
Mutuality	28	20
Reason	26	24

3.4 HYPOTHESIS FOUR: More therapists than clients will rate the termination of therapy as being mutually determined.

There were forty eight therapist/client pairs for whom there was both a therapist rating of mutuality and an agreed (by a minimum of 69% of raters) client rating of mutuality. As can be seen in Table 5, for sixteen of these forty eight cases, therapists regarded the termination of therapy as mutual. Three clients regarded the termination as mutual. Only one of the forty eight therapist/client pairs agreed that the therapy was mutually terminated (that is only 2% of clients agreed with their therapist when the therapist rated termination of therapy as mutual, as seen at the top and right of Table 5).

Therapists rated exactly 33.3% of terminations as mutual, while clients only rated 6.25% of terminations as mutually determined. With therapists being more than five times more likely to rate termination as mutual than clients, hypothesis four is supported.

Table 8. Comparison of Client and Therapist Ratings of Mutuality of Termination.

	MUTUALITY RATING			
	Mutual	**Client**	**Therapist**	**Row total**
Client initiated	16	21	11	48
Therapist initiated	3	37	8	48
Column total	19	58	19	96

Minimum Expected Frequency = 9.50

$x^2 (2) = 2.6, p < .05$

Table eight shows a chi-square analysis, conducted on SPSS statistics program. This analysis showed that there were significant differences in the ratings made, with therapist ratings differing from client ratings. A further three chi-square analyses were done. These were 1) a comparison of those terminations rated as being mutually terminated with those rated as client initiated, 2) those terminations rated as mutually initiated with those rated as therapist initiated, 3) those terminations rated as client initiated with those rated as therapist initiated. This showed that the clients made far fewer mutual ratings than the expected cell score. Therapists made far more mutual ratings than expected. It was also shown that there was a significant difference in the number of ratings of client initiated termination. Therapists were more likely to rate a termination as being client initiated, than clients were.

3.5 HYPOTHESIS FIVE: Therapists will rate the clients' need for further therapy as being higher than clients will rate their need for further therapy.

In order to be included in this analysis, both therapist and client scores for need for further therapy had to be available. There were 73 cases where both scores were available, from the total of 81 cases.

A one-tailed t-test for independent means showed the difference between the mean ratings of need for further therapy made by therapists (mean = 4.48, sd. = 1.08) and that made by clients (mean = 3.86, sd. = 1.84) to be significant, $t(72) = 2.49$, $p < .05$. The mean rating by therapists is higher than that of clients. These results support hypothesis five.

3.6 HYPOTHESIS SIX: Both therapist and client ratings of "need for further therapy" will be negatively correlated to psychotherapy outcome (ie. the higher the client rates their need for further treatment, the less positive outcome will be).

Hypothesis six was tested by dividing the clients into two groups. The first group all rated their need for further therapy as being four or greater, on the seven point scale (high need). The second group all rated their need for further therapy lower than four (low need). The cut off point of four was chosen as it was the point closest to the mean, which was 3.75, and this cut off point produced two groups of sufficient size with data available to produce meaningful results. This cut off point also produced two groups more even in size than would have been produced by any other cut off point.

The therapist rating component of hypothesis six was also tested by dividing clients into two groups. The first group had a membership consisting of clients whose therapist had rated the clients' need for further therapy as four or greater (high need) on the seven point scale. The second group had a membership of those clients whose therapist's had rated the clients' need for further therapy as lower than four, on the seven point scale. The cut off point of four was chosen so these groups would be directly comparable with the two groups determined by the client rating of need for further therapy.

There were three measures of client outcome used. The first was the difference score obtained by subtracting the clients' SCL-90-R score at the beginning of therapy, from their SCL-90-R score at termination (SCLDIF). There were 50 cases for whom SCLDIF scores were available. Using the client rating, the high need

group (group one) had an average SCLDIF score of 5.35 (n=26, sd.=8.35). The low need group (group two) had an average SCLDIF score of 8.3 (n=24, sd.=9.64). A one-tailed t-test of independent means showed that this difference is not statistically significant, $t(48)=1.17$, $p>.05$. but the difference is in the expected direction.

Using the therapist ratings to determine group membership, group one (high need) had an average SCLDIF score of 5.2 (n=34, sd.=7.52). Group two (low need) had an average SCLDIF score of 12 (n=12, sd.=8.48). A one-tailed t-test of independent means showed that this difference is both statistically significant, $t(44)=2.13$, $p<.05$, and in the expected direction.

The second measure of client outcome used was the difference score obtained by subtracting the clients rating of how they were doing at termination from their rating of how they were doing when therapy began (HOWDIF). There were 79 cases for whom a both a HOWDIF score and a client rating of need for further therapy were available. Using the client ratings to determine group membership, group one had an average HOWDIF score of 1.47 (n=36, sd.=1.8). Group two had an average HOWDIF score of 2.7 (n=43, sd.=1.34). A one-tailed t-test of independent means showed that this difference was statistically significant, $t(77)=4.04$, $p<.05$. and in the expected direction.

Using the therapist ratings to determine group membership, those members of group one (high need) for whom HOWDIF scores were available had an average HOWDIF score of 2.31 (n=54, sd.=0.43). Group two had a membership, for whom HOWDIF scores were available, with an average HOWDIF score of 2.57 (n=16, sd.= 1.6). A one-tailed t-test of independent means showed that this difference was not statistically significant, $t(68)=1.06$, $p>.05$, but was in the expected direction.

The third measure of client outcome was the clients rating of how helpful they believed therapy to have been (HOWHELP). Using the client rating, there was a HOWHELP score available for 78 cases that had a rating of need for therapy

available. Group one had an average HOWHELP score of 5.35 (n=37, sd.=1.84). Group two had an average HOWHELP score of 5.33 (n=41, sd.=2.74). A one-tailed t-test of independent means showed that this was not a statistically significant difference, t(76)=.07, p>.05. The difference was so small that no direction is indicated.

Using the therapist ratings to determine group membership produced a group one (high need) with an average HOWHELP score of 5.54 (n=59, sd.=1.89). Group two had a membership with an average HOWHELP score of 5.55 (n=18, sd.=5.89). A one-tailed t-test of independent means showed that this is not a statistically significant difference t(75)=.09, p>.05, and the difference was again to small too indicate direction. (There was one client for whom there was a client rating of need for further therapy, but no corresponding therapist rating, which is why there were only 77 therapist rated cases but 78 client rated cases).

Table 9. Client and Therapist Determined Groups of High and Low Need for Further Therapy and Client Outcome.

	Need for Further Therapy					
	Client Rated			Therapist Rated		
	High	Low	t-value	High	Low	t-value
SCLDIF	5.35	8.3	1.17	5.2	12	2.13*
	n=26	n=24	df=50	n=34	n=12	df=44
HOWDIF	1.47	2.7	4.04*	2.31	2 .57	1.06
	n=36	n=43	df=79	n=54	n=16	df=68
HOWHELP	5.35	5.33	0.07	5.54	5.55	0.09
	n=37	n=41	df=78	n=59	n=19	df=75

* is significant at p<.05 on a one-tailed t-test

Analysing the results summarised in table six, show that the results of the client ratings and analysis of the HOWDIF scores supported the hypothesis, as the clients who rated their need for further treatment as low enjoyed better outcomes than those who rated their need as high, the SCLDIF and HOWDIF scores were not different enough to support the hypothesis. Reviewing the results of the therapist ratings, showed that the SCLDIF scores were significantly different and supported the hypothesis, but the HOWDIF and HOWHELP scores were not different enough to support the hypothesis. However, more weight should be given to the SCL-90-R results, than to the other measures of outcome. This is because the SCL-90-R is a multi-item measure and the others are single-item measures. Multi-item measures have been shown to have greater reliability than single-item measures (McKinley, 1989). Although the results do tend to show support for hypothesis six, the evidence of support is not strong.

The results do indicate that therapists are far less likely to make a low rating of need for further therapy than clients. Despite therapists making far fewer judgements of low need (which, it could be argued, is a sign that therapists are more selective in making a rating of low need) they are no more accurate than clients.

3.7 HYPOTHESIS SEVEN: Those clients who cite problem abatement (no further need for services) as a reason for termination will rate their need for further therapy as being low. They will also be in agreement with their therapist about a significant event in therapy (that event being termination, operationalised as the reason for and mutuality of termination).

The same criteria for determining what constitutes a low rating of need for further therapy, was used for hypothesis six. It was found that all 8 clients who the raters considered to have cited problem abatement as a reason for termination, also rated their need for further therapy as low. Indeed, 6 of the 8 rated their need for further therapy as 1, the lowest possible rating. Of the 8 clients who had no further need for therapy as a reason for termination, 6 were in agreement with their therapists about the reason for termination. This is an agreement in 75% of the 8 cases. This

compares to the 45% rate of agreement (about the reason for termination) for the 44 therapist/client pairs for whom the client did not cite no further need for therapy as a reason for termination.

Of these 8 clients, 4 agreed with their therapists about the mutuality of termination. This is an agreement level of 50%. This compares with a 66% agreement rate (about the mutuality of termination) for those therapist/client pairs for whom the client did not cite no need as a reason for termination.

Hypothesis seven is supported, in that all the clients coded as having no further need for therapy as a reason for termination all also rated their need for further therapy as low, when answering question seven of the CTF. There was a higher rate of agreement with therapist about the reason for termination, for those clients who cite no further need for therapy as a reason for their termination. However, there was a lower than average rate of agreement with therapist as to the mutuality of termination. These contradictory results regarding the significant event of therapy being examined (termination) make the results for the second part of hypothesis seven inconclusive. Also, the small number of therapist/client pairs in agreement (8 of 52) undermines the reliability and validity of any analysis of the data, beyond the descriptive level. This is a further reason that the results for hypothesis seven are inconclusive.

3.8 HYPOTHESIS EIGHT: Clients who agree with their therapists about the reasons for and mutuality of termination will have more positive outcomes than those who do not agree with their therapist.

There were a total of forty client/therapist pairs for which there was a code for both reason for and mutuality of termination. Seventeen client/therapist pairs agreed about the reasons for and mutuality of termination. HOWDIFF scores were used as a measure of client outcome. A one-tailed t-test showed that the average HOWDIFF score for those clients who disagreed with their therapist about the reasons for and nature of termination was 2.43 ($n=23$, $sd.=1.73$). The average HOWDIFF score

for clients who did agree with their therapists was 2.82 (n=17, sd..=1.51). This is not a statistically significant difference, t(38)=0.58, p>.05.

Table 10. CLIENT/THERAPIST PAIRS AND OUTCOME

	Client and Therapist Pairs						
	Agree			Disagree			
	mean	sd.	n	mean	sd.	n	t-value
HOWDIF	2.82	1.51	17	2.43	1.73	23	0.59 df=38
SCLDIF	9.58	10.8	12	2.48	6.05	13	1.94* df=23
HOWHELP	5.82	1.61	17	6.18	1.37	22	0.75. df=37

* is significant at p<.05 on a one-tailed t-test

SCLDIFF scores were available for fifty-one cases. Twelve of the seventeen client / therapist pairs in agreement, also had the client scores for the SCL-90-R at initiation and termination available. There were thirteen client/ therapist pairs not in agreement, with SCLDIFF scores available. A one-tailed t-test showed that the difference score for non-agreeing clients had a mean of 2.84. The agreeing clients' had a mean difference score of 9.58. This difference was statistically significant, t(25)=1.94, p< .05.

It was found that there was a positive correlation (of -.22 with the HOWDIF score and -.29 with the therapist rating for the success of therapy {SUCCESS/T}) between client outcome and the client rating of how helpful they felt treatment to have been (Todd, Deane & Kendall, 1993) (see Table 2 of Appendix 8). Given this finding, it

is expected that, in order for Hypothesis seven to be confirmed, those client/therapist pairs who are in agreement about reason for and mutuality of termination will have higher client ratings of the helpfulness of therapy than those client/therapist pairs not in agreement about these dimensions of termination.

There were scores of how helpful therapy has been (HOWHELP) for the clients who agreed with their therapists about the reasons for and mutuality of termination. The average HOWHELP rating made by this group was 5.82 ($n=17$, sd. $=1.61$). The average HOWHELP rating made by the clients whose views of termination did not match those of their therapist 6.18 ($N=22$, sd. $=1.37$). This difference was not statistically significant, $t(39)=0.75$, $p. > .05$.

As the summary of results in Table 10 shows, the SCL-90-R difference scores show that those clients who agreed with their therapists about the reasons for and mutuality of termination experienced more improvement than when there was no such agreement. However, there was no significant difference in how much better the two groups of clients felt they were doing, or how helpful they felt therapy had been. This means hypothesis seven is only partially supported.

CHAPTER FOUR.
DISCUSSION.

An important question to answer before reviewing any of the results of this study is, "Which clients were included as the subjects for most if the analysis in this study?" The answer is that those clients who made the effort to write codable narrative answers to the question "Why is your therapy ending?" were the subjects for most of the analysis in this study. It is not unlikely that this sample of clients is not an accurate representation of all potential clients refered to the Psychological Services Center. Those clients commonly refered to as "dropouts" were probably not accurately represented, as the many of their number who terminate by "no show" are unlikely to fill in a termination form. Also, it is possible that clients dissatisfied with the therapy in any way, may be less inclined to write a codable narrative. The possibility that the subjects in this study are not representitive of the general client population should be borne in mind when considering it's results.

The subject population of this study has a high proportion of students. Previous studies (eg. Horenstein & Houston, 1976) have found that the intelligence and socio-economic class of client's has an influence on the pre-therapy expectations of clients. Horenstein and Houston (1976) considered that students at a university were an elite population, the members of which were more intelligent and from more affluent backgrounds than the general population. Greater intelligence and higher socio-economic class has been related to a lower "expectation-reality discreancy" ((Overall & Aronson, 1963). As the ERD has been shown to have a relationship with client outcome (Levitt, 1966), the high proportion of students in the subject population of this study may have influenced the results obtained.

The results of the testing of the first hypothesis were of note, in that the raters were able to code the narratives reliably in so many cases. The reliability of the raters may be seen as being even greater when the narratives that were not coded reliably are considered. Of the eleven reasons for termination not reliably coded, some of the narratives would be impossible to code. These include single word narratives,

e.g. "Because", and other meaningless statements, eg. "Cause it's over". Other narratives cited no reason for termination, but made mutuality clear, eg. "Termination by Therapist". If these narratives, which were clearly uncodable, had not been included in the sixty narratives, the results would have indicated an even greater ability of the raters to code accurately. (All client responses that were of even one word were included, as it was for the raters to judge what was codable, not for the experimenter).

The results of the testing of hypothesis one were closely related to those of hypothesis two, which show clearly that the level of experience in Clinical Psychology had no relationship with the raters ability to code client's narrative answers. This is of interest, as the finding suggests that coders did not require extensive clinical experience to be able to accurately code these narratives into reason for and mutuality of termination. This indicates that for further studies that there is no need for the codings to be made by individuals with clinical experience.

For hypothesis three, it is significant that therapists and clients were about as likely to disagree with each other as to the reason for termination as they were to agree. It is important to note that there was agreement in far more cases than is likely by chance, however, it is the type of reason that clients cited and therapists didn't, that perhaps revealed the different views the two groups have of termination.

It is clear that clients were likely to cite environmental reasons for termination. Indeed, therapists and clients most often agreed about reason when an environmental reason was indicated. However, many clients cited environmental reasons when their therapistss did not. Therapists, by contrast, were more likely than clients to cite reasons for termination related to the process of therapy (eg. "Client unmotivated"). This finding replicated several other studies (eg. Hynan, 1990). This may reflect the therapists lack of awareness of practical impediments to the client remaining in therapy and these differences may reflect the different expectations that therapist and client have when they begin therapy. Eight clients cited financial constraints as a reason for termination. Not one therapist cited this

reason. It is surprising that no therapist was aware that a major stress (financial difficulty) was present in a number of their clients lives. Perhaps therapists need to include a question "can you afford this therapy?" in any questionnaire of client satisfaction. The lack of awareness suggests that either clients may not communicate to their therapist the exact nature of their circumstances, or that therapists do not take on board the information they are given. If so, there are implications for the whole therapeutic relationship (if there is a misunderstanding about this issue, then it is likely that there are misunderstandings about other issues in the therapeutic relationship).

There were also four cases where the therapist cited problem abatement where the client felt the reason for termination to be environmental constraints. This is, again, a reflection of the different conclusions the parties to the therapeutic relationship are reaching. From these results, it can be seen why therapy has been described as a Rashomon experience, where different participants in the same event, have divergent memories of the event (Mintz et al, 1973).

One of the weaknesses of collapsing the eighteen reasons of the rater completed form into the eight categories of the CTF and the three categories of Pekarik (1988), is that information is lost. For example, Table 6 records twenty eight clients rated as citing external reasons for termination. It is known that eight of these were coded as citing financial constraints, by the raters, when rating the narratives into the 18 categories of the rater completed form (Appendix 5). However, the information that eight clients were rated as citing financial constraints was lost when the ratings were collapsed into the eight categories of the CTF.

Hypothesis three produced results that were not as expected. In the light of the findings of Benbenishty (1987), a larger difference between the views of therapists and clients might have been anticipated. That 25% of client/therapist pairs agreed on both the mutuality of and reason for termination is significant, considering that only one client agreed with their therapist that termination was mutually agreed.

It is possible that there is not a clear agreement about what constitutes a mutually agreed termination. In light of Huber's (1991) argument that termination cannot be mutually initiated (as one party must raise the issue first), it may be that a slight shift in the definition of nature of termination is required. The definition the raters for this study used held that it is not really of vital importance who first raises the issue of termination, what is of vital importance is who decides to terminate. The therapists may have held in mind a definition based on Huber's theory, when they completed their form. The weakness of Huber's theory is that it may not be uncommon for termination to be mentioned at various points of therapy, but that does not mean that termination is being initiated at that point. Blotcky and Friedman (1984) found that adolescents frequently raised the issue of termination, as a threat to the therapists power. It might create a clearer understanding of the definition of termination mutuality, if the question in the therapist (and client) completed termination form reads "Who decided to terminate therapy?"

A further contaminating factor, is that clients have not been asked outright their view of the nature of termination, (this was derived by the ratings of the client narrative answers to the question "Why is your therapy ending?). It may be useful to include question 6b from the therapist completed termination form, about the mutuality of termination, in the CTF. This would give useful information for comparison with the codings made by the raters. The strengths of using the raters to code the client narratives are that the codings are independent of potential artefacts, such as expectations and social desirability.

Hypothesis four (More therapists than clients will rate the termination of therapy as being mutually determined) builds on hypothesis three, by predicting one way in which therapists and clients will differ in their view of the mutuality of termination. The results produced were consistent with hypothesis four. It is possible that therapists consider a client to be in agreement with them if the client does not actively disagree. That therapists saw agreement where clients did not, may again be a reflection of the different expectations the two parties had for therapy and their respective roles in the therapeutic relationship.

Perhaps future research into the expectations of both therapist and client for therapy, as clients appeared more inclined to see therapy as having helped them than therapists. It is possible that clients seek an improvement in their lives through therapy, while therapists possibly set far more rigourous standards to be met for therapy to be judged a success.

Hypothesis five also predicts differences between client and therapist views, this time relating to the client's degree of need for further therapy. That the results supported hypothesis five, may be seen as consistent with therapist expectation of longer therapy duration (than clients) (Pekarik & Wierzbicki, 1986). The findings of Pekarik and Wierzbicki (1986) indicate that most therapeutic relationships are shorter than therapists believe is desirable, but are longer than most clients expect them to be. As therapists believe, on average, that therapy has ended too early, it is to be expected that they will rate client's need for further therapy higher (at the time of termination) than clients rate their need for further therapy.

It may be valuable, in a future study, to ask both therapist and client the length of therapy (number of sessions) they expect at the beginning of therapy, then ask both parties, at the termination of therapy, if therapy lasted as long as they believed it would. It is possible that the expectations of therapy duration, of the participants, change over time.

Hypothesis five leads to hypothesis six. Hypothesis five indicated that therapists gave a low rating for need for further therapy in far fewer cases than clients did. Given that therapists appeared to be much more selective in giving a low rating for further need, than clients did, it would be expected that therapists would be more accurate in rating the need for further therapy.

Hypothesis six examined the relationship between client and therapist ratings for further need for therapy and client outcome. It would be logical to assume that a low rating of further need would be reflected in a positive client outcome. Relating client outcome to ratings of need for further therapy was done to test the accuracy of

the ratings made (a validity check). The results for hypothesis six found that the ratings of further need made by therapists were no more strongly related to client outcome than those ratings made by clients, in that a significant relationship was found on only one of the three outcome measures for both therapist (SCLDIF) and clients (HOWDIF). These results are not the same as those reported by Todd et al. (1993), in Table 6 of Appendix 8. Table 6 of Appendix 8 shows therapist ratings of need for further therapy to be significantly related to outcome, as measured on three of four outcome measures. The results reported in Table 5 of Appendix 8 are the same as in Table of 8 of this study, in that a significant correlation was only found for one outcome measure (HOWDIF). The results of the present study indicated that both therapist and client ratings of further need for therapy were related to client outcome to an equal extent (significant on only one of three measures), despite therapists being more selective in making a low need rating. However, the measure that was significant for therapists was SCLDIF, which should be given more weight, as a multi-item measure of outcome, than the other outcome measures used (single-item measures). The results of Todd et al (1993) (Appendix 8) show that therapist ratings of client need for further therapy are more significantly related to oucome than client ratings. Given the inconclusive results of the present (and in light of them not replicating those of Todd et al {1993}), hypothesis six cannot be confirmed.

That therapists were not shown to be more accurate in rating the client's need for further therapy, than the clients were, sheds further doubt over the assumption of the therapist as "expert".

Hypothesis seven (Those clients who cite problem abatement as a reason for termination will rate their need for further therapy as being low. They will also be in agreement with their therapist about a significant event in therapy {termination}) sought to examine two things. Firstly, were clients consistent in the answers they give when completing the CTF. Secondly, to be consistent with the findings of Llewellyn (1988), it was expected that those clients with a low need for further

therapy would be in agreement with their therapists about significant events in therapy (in this case, termination).

The results for the first part of hypothesis seven were positive. All eight clients who were rated as having given no further need of services as a reason for termination (with six of the eight giving the lowest rating possible) also fell into the group that gave a low rating for their need for further therapy. This shows that, at least these clients, were consistent in their completion of the CTF.

In the light of the results of hypothesis six (therapist ratings of need for further therapy did not appear to be any more strongly related to outcome than the client rating of further need for therapy), the results of the second part of hypothesis seven were no surprise. Llewellyn (1986) found that agreement between therapist and client about significant events in therapy was positively related to client outcome. As the results of hypothesis six indicate that rating of further need for therapy was not an accurate indication of client outcome, it was to be expected that there would be no relationship between such ratings and agreement about a significant event.

Hypothesis eight was also formulated on the basis of Llewellyns' (1986) findings. For hypothesis eight, the relationship between agreement about a significant event in therapy and client outcome was tested. The results for hypothesis eight showed that client/therapist pairs in agreement did not enjoy greatly better outcomes than those pairs not in agreement. Indeed, only one of the three measures of client outcome (SCLDIF) showed any significant difference between the agreeing and non-agreeing therapist/client pairs. These results do not give strong support to the findings of Llewellyn. However, SCLDIF is the strongest of the outcome measures used. The single-item outcome measures used in this study have not been subjected to the scrutiny that the SCL-90-R has. Indeed, some of the critisism of the SCL-90-R has been of single items, or sub-sets of items, (eg. Takeuchi, Kuo, Kim & Leaf, 1989). The strength of the SCL-90-R global score is that the potential threat to validity and reliability that the weakness of any item (or sub-set of items) poses, is greatly reduced by the number of items in the SCL-90-R. As noted by Messick (1991)

validity is a matter of degree, not all or none. It is unlikely that a single-item measure of a multi-dimensional phenomenon (eg. psychotherapy outcome) can have the same degree of validity as a multi-item measure. Derogatis and Cleary (1977) maintained that single-items have reliability weaknesses, as the client rating of one item may not reflect their true state. The multi-item test, such as the SCL-90-R, is robust and has greater reliability and validity (Derogatis & Cleary).

It has been shown that the reliability of composites differs from the reliability of their components (eg. Hartmann, 1976). Also, the single-item outcome measures used in this study were chosen because they had been shown to be related to outcome. The validity of such measures would be questioned by Messick (1991), as the only evidence that they measure psychotherapy outcome is that they correlate to another measure of psychotherapy outcome.

It would be valuable to replicate hypothesis eight, but with other (different) significant events as the dependant variable (ie. a significant event in therapy other than termination). It may be that therapist/client match about each significant event has it's own unique effect on outcome.

Overall, the findings of this study do not support the idea of the therapist as expert and indicate that therapist bias may influence their views of the therapeutic relationship and the client. The findings that therapists rate clients as having greater need for further therapy than clients rate themselves, was consistent with the findings of Benbenishty (1987). That therapist ratings of need showed no stronger relationship with outcome, than client ratings, suggests that therapist judgements may be no more reliable than client judgements.

A weakness of this study was the relatively small number of subjects. It is possible that the results of testing the same hypotheses, as tested in this study, would produce more significant results with a larger subject population (nad, possibly, a population more representative of the general population). The results of the first two hypotheses are important for any future research in the area, as the ability of raters

to reliably code the client narratives for reason for and mutuality of termination, gives the researcher subjective data.

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APPENDIX 1.

PSC CASE SUMMARY.
(PSYCHOLOGICAL SERVICES CENTRE)

This form should be completed at transfer or termination. Because the form is used to administratively close a case, it must be completed for every client assigned, even if never seen.

1. Client name_____ Age_____

2. Clinician_____ Date of report_____

3. Duration of Treatment (check one)

___ Client never seen. (Do not complete rest of form.)

___ Assessment only. (Do not complete rest of form.)

___ One or more therapy sessions. Number of sessions ___

4. Type of Treatment: ___ individual ___ couple

___ family ___ group

5. Theoretical Orientation:_____

6. Disposition:

___ Transfer within PSC ___ Referral outside PSC ___ Termination

A. If referral outside PSC, name of clinician, new agency, and address:_____

B. If termination:

Nature of Termination:

1) Mutually determined

2) Client determined in interview

3) Client determined by no-show some time following first session

4) Client determined outside of interview with notification

5) Therapist determined

6) Other_____

Reason for termination:

1) Problems reduced (no further need)

2) Client dissatisfied with therapy

3) Client felt therapy could help no more

4) Therapist felt therapy could help no more

5) Client unmotivated

6) Client withdrawal due to external reasons (moving, departure from school, etc)

7) Therapist no longer available (end of team, semester, departure from school)

8) Other

7. Overall success of therapy:

Very	Moderately	Slightly		Slightly	Moderately	Very
Unsuccessful					Successful	
1	2	3	4	5	6	7

8. Degree of need for further treatment:

1) none 2) slight 3) mild 4) moderate 5) strong 6) very strong 7) extreme

APPENDIX 2.

(CLIENT COMPLETED) TERMINATION FORM.

Name:_____ Date:_____

The following information will be helpful to us in evaluating our services, and keeping our records up to date. Your therapist will only be given this information if you request it. if you would like your therapist to see your responses, please check here. _____

1. How helpful has this therapy been to you?

Extremely Unhelpful			Neither Helpful Nor Unhelpful			Extremely Helpful
1	2	3	4	5	6	7

2. Please circle a number to show how well you were doing when you began this therapy.

Extremely Poor					Extremely Well	
1	2	3	4	5	6	7

3. Please circle a number to show how you are doing now.

Extremely Poor Extremely Well
1 2 3 4 5 6 7

4. What problem or problems have you worked on in this therapy?

5. How has this therapy affected you and the problems you have addressed in therapy?

6. To what extent do you feel you need further therapy at this time?

No Need Extremely High Need
1 2 3 4 5 6 7

7. Why is your therapy ending?

8. Please list any major changes in your family over the course of this therapy: births, deaths, marriage, separation or divorce. Please include approximate dates. (Use additional sheet if needed.)

9. Are there any other important changes that have taken place in your life during this therapy (physical health, intimate relationships or friendships, job or school)

10. What, if anything, would you like to have been different about your therapy or therapist?

11. What, if any, changes would you recommend in any other aspect of the Psychological Services Centre (eg. facilities, reception, fees, etc.)?

12. Would you be willing to be contacted at some latter time your view of our services? Yes___ No___

If Yes, what might be the best way to reach you over the next few years?

We want to remind you (if you are over 16) that your case information will not be given to your family members, other mental health professionals or employers without your written permission. Confidentiality will also be protected in any use of the information for research. Thank you for taking the time to give us this information.

—

APPENDIX 3

SCL-90-R

Name:_____ Technician:_____ Ident. No._____

Location:_____ Visit No.:_____ Mode: S-R_____ Nar_____

Age:_____ Sex: M_____ F_____ Date:_____ Remarks:_____

INSTRUCTIONS

Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptors that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST_____INCLUDING TODAY. Place that number in the open block to the right of the problem. Do not skip any items, and print your number clearly. If you change your mind, erase your first number completely. Read the example below before beginning, and if you have any questions please ask the technician.

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY: Descriptors: 0 Not at all; 1 A little bit; 2 Moderately; 3 Quite a bit; 4 Extremely

Ex. Body Aches..... Ex. Answer [3]

HOW MUCH WERE YOU DISTRESSED BY: Descriptors: 0 Not at all; 1 A little bit; 2 Moderately; 3 Quite a bit; 4 Extremely

1. Headaches ☐
2. Nervousness or shakiness inside ☐
3. Repeated unpleasant thoughts that won't leave your mind ☐
4. Faintness or dizziness ☐
5. Loss of sexual interest or pleasure ☐
6. Feeling critical of others ☐
7. The idea that someone else can control your thoughts ☐
8. Feeling others are to blame for most of your troubles ☐
9. Trouble remembering things ☐
10. Worried about sloppiness or carelessness ☐
11. Feeling easily annoyed or irritated ☐
12. Pains in heart or chest ☐
13. Feeling afraid in open spaces or on the streets ☐
14. Feeling low in energy or slowed down ☐
15. Thoughts of ending your life ☐
16. Hearing voices that other people do not hear ☐
17. Trembling ☐
18. Feeling that most people cannot be trusted ☐
19. Poor appetite ☐
20. Crying easily ☐
21. Feeling shy or uneasy with the opposite sex ☐
22. Feelings of being trapped or caught ☐
23. Suddenly scared for no reason ☐
24. Temper outbursts that you could not control ☐
25. Feeling afraid to go out of your house alone ☐
26. Blaming yourself for things ☐
27. Pains in lower back ☐
28. Feeling blocked in getting things done ☐
29. Feeling lonely ☐
30. Feeling blue ☐
31. Worrying too much about things ☐
32. Feeling no interest in things ☐
33. Feeling fearful ☐
34. Your feelings being easily hurt ☐
35. Other people being aware of your private thoughts ☐
36. Feeling others do not understand you or are unsympathetic ☐
37. Feeling that people are unfriendly or dislike you ☐
38. Having to do things very slowly to insure correctness ☐
39. Heart pounding or racing ☐
40. Nausea or upset stomach ☐
41. Feeling inferior to others ☐
42. Soreness of your muscles ☐
43. Feeling that you are watched or talked about by others ☐
44. Trouble falling asleep ☐
45. Having to check and doublecheck what you do ☐
46. Difficulty making decisions ☐
47. Feeling afraid to travel on buses, subways, or trains ☐
48. Trouble getting your breath ☐
49. Hot or cold spells ☐
50. Having to avoid certain things, places, or activities because they frighten you ☐
51. Your mind going blank ☐
52. Numbness or tingling in parts of your body ☐

PLEASE CONTINUE ON THE FOLLOWING PAGE ▷

SCL-90-R

HOW MUCH WERE YOU DISTRESSED BY:	Descriptors 0 Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely
53. A lump in your throat	☐
54. Feeling hopeless about the future	☐
55. Trouble concentrating	☐
56. Feeling weak in parts of your body	☐
57. Feeling tense or keyed up	☐
58. Heavy feelings in your arms or legs	☐
59. Thoughts of death or dying	☐
60. Overeating	☐
61. Feeling uneasy when people are watching or talking about you	☐
62. Having thoughts that are not your own	☐
63. Having urges to beat, injure, or harm someone	☐
64. Awakening in the early morning	☐
65. Having to repeat the same actions such as touching, counting, washing	☐
66. Sleep that is restless or disturbed	☐
67. Having urges to break or smash things	☐
68. Having ideas or beliefs that others do not share	☐
69. Feeling very self-conscious with others	☐
70. Feeling uneasy in crowds, such as shopping or at a movie	☐

HOW MUCH WERE YOU DISTRESSED BY:	Descriptors 0 Not at all 1 A little bit 2 Moderately 3 Quite a bit 4 Extremely
71. Feeling everything is an effort	☐
72. Spells of terror or panic	☐
73. Feeling uncomfortable about eating or drinking in public	☐
74. Getting into frequent arguments	☐
75. Feeling nervous when you are left alone	☐
76. Others not giving you proper credit for your achievements	☐
77. Feeling lonely even when you are with people	☐
78. Feeling so restless you couldn't sit still	☐
79. Feelings of worthlessness	☐
80. The feeling that something bad is going to happen to you	☐
81. Shouting or throwing things	☐
82. Feeling afraid you will faint in public	☐
83. Feeling that people will take advantage of you if you let them	☐
84. Having thoughts about sex that bother you a lot	☐
85. The idea that you should be punished for your sins	☐
86. Thoughts and images of a frightening nature	☐
87. The idea that something serious is wrong with your body	☐
88. Never feeling close to another person	☐
89. Feelings of guilt	☐
90. The idea that something is wrong with your mind	☐

APPENDIX 4.

Trial of the Rater Completed Form and the Instructions of how to Code the Narratives for Mutuality and Reason for Termination.

In order to ensure that the instructions the raters of client reasons and mutuality followed were clear, a trial was conducted. The subjects used in the trial were five post-graduate psychology students with no clinical psychology experience (the same as group one, of the actual raters). The five subjects were not only asked to follow the instructions, but were also asked to state which instructions were unclear and to suggest how to make them more clear.

The five subjects in the trial rated the clients' reasons for and mutuality (nature) of termination from the narratives, with a high level of agreement. At a minimum level of agreement of 65%, they agreed on the mutuality of termination for over 88% of cases. They agreed about the reason for termination (at the minimum level of 65%) for 90% of the narratives.

Despite the high rate of agreement, the five subjects recommended more detailed instructions. This led to the following changes in the instructions given to the three groups of raters, for the actual study. The last paragraph of instructions on rating reasons for termination was changed from;-

"It is important to remember that several categories are similar, but not the same. Dislike of therapist is dislike of the person, dislike of therapy is dislike of the therapeutic treatment the client receives, and dissatisfaction with procedures occurs when it is the way the centre is run that the client is unhappy with". to read;-

"It is important to remember that several categories are similar, but not the same. Dislike of therapist is dislike of the person, dislike of therapy is dislike of the therapeutic treatment the client receives, and dissatisfaction with procedures occurs when it appears the client dislikes the way the centre is run (eg. waiting time, etc.) If you feel that the client's condition has improved, then you would categorise that as 2 (Problem reduced, solved or improved). If the client says that therapy can help

no more, but there is no indication they have improved, then you categorise this as 14 (Client felt therapy could help no more). Also, with categories 12 (Therapist no longer available) and 13 (Client withdrawal due to external reasons), it is important to decide if it is the client, the therapist or both, who are leaving".

The instructions for coding the mutuality (nature) of termination read;-

"To categorise the nature of termination you must decide if it is the client, the therapist, or a mutual agreement between the two that determines that therapy should end. When the client has determined that therapy will end, they often demonstrate this by using "I" statements (eg. I'm going home, I felt it wasn't working, etc.). When the therapist has determined that the therapy is ending, the client often shows this by beginning their statements with "Therapist" (eg. Therapist has finished her studies, My therapist is leaving town, etc.). Mutual terminations may be more difficult to recognise, but in all cases it is up to you to make your best attempt at a judgement. If you believe there is insufficient information to take even a reasonable guess, then you will categorise that as "4" on Table Two (Insufficient information)".

To these instructions this sentence was added;-"If both the client and the therapist are leaving the centre, then you categorise this as a mutual agreement".
These were the only changes that were made to make the instructions read as they did in their final form (appendix five).

APPENDIX 5.

The form the raters completed and the instructions they were given.

RATING REASONS FOR AND NATURE OF TERMINATION.

Decide which of the reasons the client gives best fits the eighteen categories of Table One. Then decide which category of Table 2 best describes the nature of the termination of therapy.

REASONS FOR TERMINATION.

If a client gives reasons that fall into more than one category, then record them both. Write the number of the category(s) that you believe best describes the reason(s) given, in the appropriate space at the end of text. (Do the same for the nature of termination). For example, a client may write;- "I don't like the way the therapist is dealing with my case and I'm going home soon anyway".

You would likely record this as two reasons, one being the 6 (Dislike of therapy), the other being 13 (Client withdrawal due to external reasons). (It also seems that it is the client who is terminating the therapy, so you would record the Nature of this termination as being 2 {Client initiated}). So at the end of the client statement you would write 6,13. in the Reason column (and 2 in the Nature of column).

If there is not enough written to attempt a judgement, then you should record this as 17 (Insufficient information). It is important to remember that several categories are similar, but not the same. Dislike of therapist is dislike of the person, dislike of therapy is dislike of the therapeutic treatment the client receives, and dissatisfaction with procedures occurs when it appears the client dislikes the way the centre is run (eg. waiting time, etc.) . If you feel that the client's condition has improved, then you would categorise that as 2 (Problem reduced, solved or improved). If the client says that therapy can help no more, but there is no indication they have improved, then you categorise this as 14 (Client felt therapy

could help no more). Also, with categories 12 (Therapist no longer available) and 13 (Client withdrawal due to external reasons), it is important to decide if it is the client, the therapist or both, who are leaving.

NATURE OF TERMINATION.

To categorise the nature of termination you must decide if it is the client, the therapist, or a mutual agreement between the two that determines that therapy should end. When the client has determined that therapy will end, they often demonstrate this by using "I" statements (eg. I'm going home, I felt it wasn't working, etc.). When the therapist has determined that the therapy is ending, the client often shows this by beginning their statements with "Therapist" (eg. Therapist has finished her studies, My therapist is leaving town, etc.). Mutual terminations may be more difficult to recognise, but in all cases it is up to you to make your best attempt at a judgement. If you believe there is insufficient information to take even a reasonable guess, then you will categorise that text as "4" (Insufficient information) on Table Two. If both the client and the therapist are leaving the centre, then you categorise this as a mutual agreement.

Table One. TERMINATION REASONS GIVEN BY CLIENTS.

1. Time conflict.
2. Problems reduced, solved or improved. (No further need for treatment).
3. Pressure from other people to stop coming.
4. Cost too high.
5. Dislike of therapist.
6. Dislike of therapy.
7. Distance to clinic/therapist.
8. Transportation problems.
9. Dissatisfaction with procedures.
10. Sought help elsewhere.
11. Fears and anxiety about psychiatric treatment.
12. Therapist no longer available (end of team, semester, departure from school, etc).
13. Client withdrawal due to external reasons (moving, departure from school, etc.).
14. Client felt therapy could help no more.
15. Therapist felt therapy could help no more.
16. Client unmotivated.
17. Insufficient information.
18. Other (please state).

Table Two. NATURE OF TERMINATION.

1. Mutually agreed.
2. Client initiated.
3. Therapist initiated.
4. Insufficient information.

CODING FORM. pg. 1.

	REASON	NATURE
1 I'm going home.	____	____
2 My therapist is leaving PSC, and I will be leaving this area myself in September	____	____
3 I'm being abandoned by my therapist! (Sorry, I just couldn't resist I'm only kidding {therapist}) My therapist is finished with her training.	____	____
4 moving	____	____
5 I have to go away for a month and I'm moving to NYC after that.	____	____
6 I am graduating.	____	____
7 Leaving for a while - want to take stock of where I am.	____	____
8 Leaving, having a baby, feel like it's time to try my wings.	____	____
9 Finished school & sessions - {child} says she doesn't feel a need to continue	____	____
10 I had to leave town	____	____

11 The fears I was dealing with are much less and I feel any difficulties I might have will work out fine. ____ ____

12 It's become threatening to think/talk about things. Also, I'm broke. ____ ____

13 Relocating after graduation from UMASS. ____ ____

14 I choose to terminate therapy at this time. I do not feel I am consistent in keeping appointments. Going to therapy causes great anxiety and I do not attend sessions regularly enough. ____ ____

15 I have decided to end it now because it has accomplished its purpose. I do have many other available help in my congregation of Jehovah's Witnesses -especially thru our elders. They have been a support to me all through my therapy. But the therapy was a way for me to learn to use all my other help effectively. Now that I have these tools, I feel confident I can go on using them in conjuncture with the help from elders if I need it. I have a great feeling of accomplishment and satisfaction in going thru with therapy, which was very difficult at times. It was well worth all the effort to now be so well. ____ ____

16 Therapist leaving program ____ ___

17 I need to finish working on my eating disorder.

Both my therapist and I are leaving town. ____ ___

18 Therapist is moving on - want to take some

time off to absorb the process before starting

with someone new. ____ ___

19 The school year is ending and I'm leaving for

the summer._ ____ ___

20 Summer break and I will be graduating. ____ ___

21 Therapist is graduating ____ ___

22 I think cause therapist is moveing on to

other skills. Therapy is not ending moveing

on another place, probably. ____ ___

23 Therapist ending this part of her training ____ ___

24 I am leaving school - graduating this is the

only reason. ____ ___

25 {Therapist} is leaving, as her studies are finished

and I am graduating ____ ___

26 Because school is ending. ____ ____

27 Crisis seems to have passed for now. ____ ____

28 {Therapist} is moving to Los Angeles ____ ____

29 Therapist is leaving area ____ ____

30 School session ended 5/91. ____ ____

31 Moved to Blandford -- too far to travel ____ ____

32 I don't trust {therapist} to be able to help me be honest. ____ ____

33 I am moving to California. ____ ____

34 I feel that {child} needs 1:1 ____ ____

35 Because our problems are solved and our household has stabelized {stabilized}. ____ ____

36 Semester is ending ____ ____

37 My therapist is leaving. ____ ____

38 Going out of country. My son is doing fine. ____ ____

39 Going out of country. Doing very well. ____ ____

40 not getting the maximum benefits from therapy at this time -- also financial considerations ____ ____

41 The semester is ending. ____ ____

42 Your having a vacation. ____ ____

43 because its over ____ ____

44 Because. ____ ____

45 End of school year ____ ____

46 The end of school session ____ ____

47 I can't afford it, and I'm not approaching it with a completely open heart right now, so I'm not sure how much it'll really help me at this moment. ____ ____

48 Termination by therapist ____ ____

49 (time ending) ____ ____

50 end of school ____ ____

51 Because I could not afford it. ____ ____

52 -new job; relocation ____ ___

53 I feel that the issues I felt I needed to confront have been dealt w/effectively. ____ ___

54 I feel the need to take a break. I would definately return to therapy if I felt the need and I know I would recognize the feeling. ____ ___

55 Because I couldn't afford the $15.00 payment at this time. ____ ___

56 I'm moving back to Boston. I've finished school. ____ ___

57 Financial and desire to terminate. ____ ___

58 Desire to terminate and financial reasons. ____ ___

59 I moved to FLA ____ ___

60 Partner leaving to return to our home state, $ problems____ ___

APPENDIX 6.

The Tables that the rater completed form Table of reasons (Table one, Appendix 5) was compiled from.

Table 1. Termination Reasons Cited by Dropouts. (Pekarik, 1988)

1. Problem solved or improved	**	
2. Dissatisfied with procedures	***	
3. Pressure from family to terminate	*	
4. Conflict with work hours	*	
5. Cost too high		*
6. Dislike of therapist	**	
7. Dislike of type of therapy	***	
8. Distance to clinic/therapist	*	
9. Transportation problems	*	

* Category I: Environmental obstacles to treatment.
** Category II: Problem abatement.
*** Category III: Dislike of therapy, therapist, or clinic procedure.

Table 2. Why Did You Stop Coming To The Centre. (Deane,1991)

1. Lack of time
2. Problem has been solved or improved to an acceptable level
3. Pressure from other people to stop coming
4. Centre too far away
5. Dislike of type of therapy
6. Transportation problems
7. Fears and anxiety about psychiatric treatment
8. Sought help elsewhere
9. Conflict with work hours
10. Dislike of therapist
11. Other: (please specify)

Table 3. Patient Reasons for Discontinuance. (Pollak et al, 1992)

1. Need to be on one's own
2. Reached goals
3. Feeling better
4. Prefer another therapy
5. Shopping for therapist
6. Cannot afford fee
7. Does not like fee policy
8. Time conflicts
9. Fears impact of therapy
10. Moved to other city
11. Dissatisfied with therapy
12. Dissatisfied with therapist
13. Wants different type of therapy
14. No explanation
15. Other

APPENDIX 7.

Recoding the eighteen categories of the form completed by the raters of the client narratives (Appendix 5) into the eight categories of the Therapist completed termination form (Appendix 1). Recoding of both the therapist's' and raters' codings into the three categories of Pekarik (1988) (Appendix 6).

Categories the raters used to code the client narrative (Appendix 5)		Categories of the C.T.F. (Appendix 1)		Categories of Pekarik (Appendix 6)
1.	=	6.	=	1.
2.	=	1.	=	2.
3.	=	6.	=	1.
4.	=	6.	=	1.
5.	=	2.	=	3.
6.	=	2.	=	3.
7.	=	6.	=	1.
8.	=	6.	=	1.
9.	=	2.	=	3.
10.	=	Uncodable	=	3.
11.	=	Uncodable	=	3.
12.	=	7.	=	1.
13.	=	6.	=	1.
14.	=	3.	=	3.
15.	=	4.	=	3.
16.	=	5.	=	3.
17.	=	Uncodable	=	Uncodable.
18.	=	8.	=	Uncodable.

Appendix 8.

THERAPIST and CLIENT VIEWS of TERMINATION STATUS and OUTCOME in a TRAINING CLINIC:

A Preliminary Analysis.

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The present study aims to clarify the relationships between several common dimensions used in characterising termination status and outcome in psychotherapy research. Of specific interest is whether clients with different termination status have different psychotherapy outcomes. A broader aim is to determine the relative merits of various termination status dimensions included in the databases of the University of Massachusetts at Amherst and Massey University, New Zealand, psychology training clinic

At least three dimensions of termination status have been widely employed:

1. Nature of termination;
2. Reasons for termination and;
3. Need for further therapy.

Nature of termination refers to client and therapist judgements as to whether treatment was terminated by mutual agreement between client and therapist or whether termination was determined by either the client or the therapist unilaterally.

Reasons for termination refer to judgements regarding the main causes or motives for therapy ending. Need for further therapy refers to judgements made at the time of termination as to whether further treatment is needed. While this variable might well be thought of as a dimension of outcome, it is used here as an aspect of termination status related the question of whether therapy was terminated prematurely (Pekarik, 1986, 1983b).

The relative merit of using termination classification dimensions of need for therapy, nature of termination and reasons for termination have not been assessed with a single sample in relation to client outcome. Nor, to our knowledge, have these relationships been assessed outside of the dropout literature.

To date, termination classification has been weighted heavily toward therapist judgements particularly for the dimensions of "nature of termination" and "need for further therapy". Client judgements have been favoured for the "reason for

termination" dimension (Pekarik, 1983a). One study did ask therapists to select the three most common reasons that clients dropout of treatment, but did not have them designate the reasons for specific clients (Pekarik and Finney-Owen, 1987). Fifty-nine percent gave number one reason as "problem solved or improved", 11% gave "Environmental Constraints" as the number one reason, 7% indicated "Dislike of therapist/therapy" and 23% rated "Resistance" as the number one reason. The proportion of therapists who cited problem solved or improved" and environmental constraints" was similar to the proportion of public clinic clients who cited these factors as reasons for dropping out (Pekarik, 1983a). However, therapists were less likely to acknowledge client's dislike of services as a reason. The present study aims to replicate and extend some of the findings regarding termination classification criteria (Pekarik (1987). The present dataset allows us to see whether findings from community mental health settings apply to a university training clinic, and to evaluate how "therapists-in-training" make judgements in these termination dimensions. The study is exploratory, using available data from only one clinic, and an analysis has only been partially completed.

Several working hypotheses were postulated:

1. Client psychotherapy outcomes will be significantly different for different reasons for termination.
2. Client outcome will differ for categories of nature of termination.
3. Client outcome will differ for different levels of both client and therapist ratings of need for further therapy.

Method

Subjects

Data was obtained from the database at the University of Massachusetts at Amherst, Psychological Services Center (Todd, Jacobus, & Boland, 1992). The total sample after excluding child cases was 80, with a mean age of 29.84 (SD=10.41). Fifty-one (64%) were female and the total sample came predominantly from the campus student population. Approximately 73% were seen in individual therapy, 19% in family therapy and the remaining 8% in couples therapy. Only cases where the client completed termination were included, which is a relatively small percentage of clients served. A comparison of the present sample to the larger population of clients in this clinic is planned.

Procedure and Measures

Clients attending for outpatient psychotherapy at the UMass Psychological Services Center completed the SCL-90-R at the beginning and end of therapy and the Client Termination Form (CTF) at the end of treatment or at transfer. Therapists at the center o routinely complete the Therapist Case Summary (TCS) at the end of treatment or when a case is transferred. Unless noted otherwise, the primary variables for this study are taken from these forms.

Client Measures:

HELPFUL/C. Client rating of item "How helpful has this therapy been for you?" on a 7-point scale (1=Extremely Unhelpful, 7=Extremely Helpful).

HOWDIFF/C. The difference between ratings of the two following items on a 7-point scale

(1=Extremely Poor, 7=Extremely Well):

"Please circle a number to show how you were doing when you began this therapy" and

"Please circle a number to show how you are doing now."

SCLDIFF. Change in Global Severity Index of the SCL-90-R (Derogatis, 1977) from the beginning to the end of therapy (positive score indicates symptom reduction.)

NEED THERAPY/C. Client rating of item "To what extent do you feel you need further therapy at this time?" on a 7-point scale (1=No Need, 7=Extremely High Need).

Therapist Measures

TERMINATION NATURE/T. Therapists select the appropriate category(s) from the following list:

1. Mutually determined,
2. Client determined in interview,
3. Client by no-show some time following first session,
4. Client determined outside of interview with notification,
5. Therapist determined, and
6. Other.

TERMINATION REASONS/T. Therapists select the appropriate category(s) from the following list:

1. Problems reduced (no further need);
2. Client dissatisfied with therapy;
3. Client felt therapy could help no more;
4. Therapist felt therapy could help no more;
5. Client unmotivated;
6. Client withdrawal due to external reasons (moving, departure from school, etc.);
7. Therapist no longer available (end of team, semester, departure from school, etc.); and
8. Other.

SUCCESS/T. Therapists rated the item "Overall success of therapy" on the 7-point Likert-type scale

(1=Very Unsuccessful, 7= Very Successful).

NEED THERAPY/T. Therapist rating of the item "Degree of need for further treatment" on a 7-point scale (1=none, 7= extreme).

Results

Four categories of therapist codings of Reason for Termination were large enough for further analysis: problems reduced, (n=12); Client dissatisfied with therapy, (n=6); Client withdrawal due to external reasons , (n=13); Therapist no longer available n=35). These categories include 66 cases.

Therapist codings of Nature of Termination were separated into MUTUAL (n=24; (Mutually determined); CLIENT (n=26; Client determined in interview, Client by no-show some time following first session and, Client determined outside of interview with notification combined) and; THERAPIST (n=23; Therapist determined).

Descriptive statistics on the remaining variables are listed in Table 1 and Table 2 contains a correlation matrix for these variables. We plan to do a more systematic analysis of the relationship between the various measures of outcome and need for further treatment, but our analysis to this point has focused only on selected issues.

In order to determine whether there were differences in outcome for the different Reasons for Termination assigned by therapists, a between groups one-way analysis of variance (ANOVA) was conducted with Reasons as the independent variable and the various outcome measures as dependent variables. These findings are summarised in Table 3.

There were significant differences in outcome for all but the pre- post therapy difference scores on the SCL-90-R. It is unlikely that these differences in outcome were a function of the amount of therapy that subjects in each group received since there are no significant differences in the mean number of sessions for each group ($M=26.71$, $n=66$, $p > .05$).

Independent t-tests were conducted to determine between which groups the differences occurred, due to the large number of comparisons more conservative 2-tailed tests were conducted in order to reduce the probability of type-I error. For the HELPFUL/ outcome there were differences between the Client Dissatisfied group and the other 3 groups [Problems Improved, $t(16)=4.53$, $p<.001$; Client Withdrawal, $t(17)=2.25$, $p<.04$, and; Therapist Unavailable, $t(39)=3.00$, $p<.005$]. No other differences were found.

For the HOWDIF/C outcome the pattern of results were similar except that there was no significant difference between the Client Dissatisfied and Client Withdrawal groups and in addition there was a significant difference between Problems Reduced and Therapist Unavailable $t(45)=2.04$, $p<.05$.

In order to determine whether there were differences in outcome for the different Nature of Termination, a between groups one-way ANOVA was conducted with Nature as the independent variable and the various outcome measures as dependent variables. These findings are summarised in Table 4. The results indicate a significant difference between mutual, client and therapist determined termination only for therapist ratings of treatment success. Independent t-tests indicate that there were significant differences between those who mutually terminated and client determined terminations, $t(45)=4.25$, $p<.005$ (2-tailed), with those in the client determined termination group having poorer therapist ratings of treatment success. Similarly, there was a significant difference between client and therapist determined termination, $t(45)=2.34$, p.05 (2-tailed).

The simple correlation coefficients between client ratings of need for therapy and outcome measures (Table 2) were only significant for change scores on the SCL-90-R (SCLDIFF) and client ratings of change (HOWDIFF/C). Both coefficients were in the expected direction but of only moderate strength. As ratings of improvement increased perceived need for therapy decreased.

Therapist ratings of this variable were correlated with all outcome measures except for HELPFUL/C (Table 2). All findings were in the expected direction with moderate negative correlations between the need ratings and outcome variables. This suggests t as therapist ratings of need increase outcome effects decrease.

In order to begin to explore the relationship between concurrent therapist and client ratings, a dependent t-test was conducted for client and therapist ratings of "need for further therapy". There was a significant difference between therapist and client ratings, $t(72)=2.67$, p .009 (2-tailed). The simple correlation between client and therapist ratings of "Need for further therapy" was $r = .34$, $p < .005$, $n=73$.

Discussion

All termination status dimensions appeared to show some relationship to at least one of the outcome variables. Hypothesis one was confirmed with psychotherapy outcome being significantly different for different therapist determined codings of Reason for Termination. The clearest result appeared to be that when therapists felt that a client had terminated because they were dissatisfied with therapy, clients in this category had the poorest outcomes. Client change ratings on the HOWDIFF/C variable, indicated that those clients in the "Problems Reduced" category had significantly better outcomes 3than those in the "Therapist Unavailable" category. These findings support the treatment satisfaction research suggesting that clients who are less satisfied with therapy have poorer psychotherapy outcomes (Deane, 1993). They are also consistent with Pekarik's (1983a) finding that dropouts who gave their reason for termination as "Dislike of services" had poorer outcomes than other

reason categories. Of note in this instance is that it is therapist ratings of perceived dissatisfaction as opposed to client ratings which appear related to outcome.

The process by which therapists make this judgement is unclear at this juncture. Given the small sample size in the Client Dissatisfied" category some insight into this process could be gained by examining client and therapist case narratives available n the Therapist Case Summary and Client Termination Forms. Certainly, whether there is explicit discussion of this issue may have important implications for a client's future treatment seeking and therapy .

It was also interesting to find that for no outcome variable were there differences between the Client Withdrawal and Therapist Unavailable categories. In only one instance was there any difference between the Problems Reduced category and Client Withdraw al or Therapist Unavailable. This suggests similar levels of improvement in these groups despite different reasons for termination. It is possible that the "forced" termination due to environmental constraints of client or therapist leaving merely speed up the termination process, when much of the therapeutic gain has already been made in early sessions (Howard, Kopta, Krause, & Orlinsky, 1986). The process and progress in therapy may have been artificially accelerated as client and therapist work to a specified termination date. In this instance these were usually determined by the end of the semester. Some caution regarding this set of results is needed given the small sample size in some of the reason for termination categories.

The differences in outcome for the Nature of Termination variable is less clear. For client ratings of outcome there appears to be no difference in improvement when mutual, client or therapist determined termination occurs. Only for therapist ratings of success does improvement appear to be related to the nature of termination. The results indicate that when therapists perceive that termination is client determined, they also rate the success of treatment significantly lower than for mutual or therapist determined termination.

This finding may reflect therapist bias regarding the termination process. If therapists view mutual termination as preferable, this may bias therapist outcome ratings. Similarly, therapist determined termination might be considered preferable to client determined termination. If this bias hypothesis is correct, it raises some questions regarding the objectivity and utility of the Nature of Termination dimension in termination classification.

Alternatively, the difference between client and therapist outcome ratings for the nature of termination variable may reflect differences in perception of the termination process. Huber (1990) has already commented on the complexity in judgements regarding the mutuality of termination. Differences in client and therapist perceptions of events in psychotherapy are well documented (Benbenishty, 1987; Kaschak, 1978; Llewelyn, 1988) and include events related to termination and outcome. Large discrepancies between client and therapist expectancies of the length of therapy have been found (Benbenishty, 1987; Pekarik & Finney-Owen, 1987). When therapists and clients record their views of significant events in therapy, greater differences in these perception were found when psychotherapy outcome is poor (Llewellyn, 1988). These differences in perception make it possible for client judgements of the Nature of Termination to be quite different from therapist judgements. The criteria for judging mutuality may vary considerably between judges even within client and therapist groups. Until such time that this process is more fully investigated we must assume that therapist and client judgements may have quite different relationships to psychotherapy outcome.

The assessment of "need for further therapy" provides additional insights into differences between client and therapist ratings of termination classification dimensions. The results indicated that client ratings of "need for further therapy" were related to psychotherapy outcome. As outcome improved, need for therapy was rated lower. As with the Nature of Termination" variable these relationships appeared to be rater specific. Client ratings of need for further therapy were only related to client ratings of outcomes and not therapist ratings. Although this was not assessed, it is possible that raters may moderate the relationship between some

termination dimensions and psychotherapy outcome. Also of note was the strength of the correlations between outcome need. At best these are of moderate strength and although measurement error probably accounts for much of the remaining variance, this also suggests that clients perceived need for therapy is not purely dependent on how well they have done in therapy where environmental factors such as access to other support systems and life events probably influence perceived need for therapy. We would argue that these factors are at least partially picked up by the Reason for Termination dimension and further suggest that combining Reason for Termination and "need for further therapy" dimensions would significantly improve the prediction of outcome.

Therapist ratings of "need for further therapy" produced a slightly different picture. These ratings were significantly correlated with both therapist and client outcome ratings.

There was a moderately positive correlation between client and therapist ratings of "need for further therapy" ($r=.30$). However, there were significant differences between client and therapist's ratings of need, with therapists on average perceiving higher need than clients. This further confirms the differences in therapist and client perceptions of psychotherapy with the direction of the difference also consistent with prior research (Benbenishty, 1987). Slight method variance may have contributed an underestimate in the relationship between client and therapist ratings of need for further therapy. Despite this caution, the present study provides confirmation that there are discrepancies between client and therapist perceptions of aspects of termination. It is possible that by matching client and therapist ratings on the various dimensions we will be able to produce a clearer picture of likely outcome.

It is our intention to explore the utility of matching client and therapist judgements on the various termination dimensions to determine whether these can improve the relationship with psychotherapy outcome. Pekarik (1986) has suggested that various termination status and treatment duration patterns can be used as simple procedures for estimating clinical improvement when resources for formal outcome research are

unavailable. We believe that the utility of such measures can be improved even further combining various termination dimensions and information sources. Further, we suspect that these processes and judgements may have utility in effecting psychotherapy outcome. Assessing various termination status variables may sensitise therapists and clients to termination issues which become more explicit in the psychotherapy process. It is possible this could have direct beneficial effects on psychotherapy outcome.

TABLE 1. DESCRIPTIVE STATISTICS FOR OUTCOME AND NEED FOR FURTHER THERAPY VARIABLES.

Variable	Mean	Std Dev	Min	Max	N
HELPFUL/C	5.60	1.62	1	7	80
HOWDIFF/C	2.19	1.63	-4.0	6.0	79
SCLDIFF	6.49	1.63	-4.0	34.0	51
SUCCESS/T	5.46	1.32	2.0	7.0	71
NEED THERAPY/C	3.89	1.83	1.0	7.0	78
NEED THERAPY/T	4.49	1.33	1.0	7.0	75

TABLE 2. CORRELATIONS BETWEEN THERAPIST AND CLIENT MEASURES OF OUTCOME AND NEED FOR FURTHER TREATMENT[1]

	HELPFUL/C	HOWDIFF/C	SCLDIFF	*SUCCESS/T*	*NEED/C*	*NEED/T*
HELPFUL/C	--------	.22*	.03	.29**	-.01	-.18
HOWDIFF/C	.22*	--------	.52***	.31**	-.34**	-.27**
SCLDIFF	.03	.52***	--------	.24	-.23	-.31*
SUCCESS/T	.29**	.31**	.24	--------	-.11	-.35**
NEED/C	-.01	-.34**	-.23	-.11	--------	.34**
NEED/T	-.18	-.27**	-.31*	-.35**	.34**	--------

[1]n=69 for all variables except SCLDIFF which was run separately separately with an n of 43. Therapist measures are labeled in italics

TABLE 3: MEAN OUTCOME RATINGS FOR DIFFERENT THERAPIST DETERMINED REASONS FOR TERMINATION

OUTCOME MEASURES	REASONS FOR TERMINATION				
	Problems Reduced	Client Dissatisfied	Client Withdrawal	Therapist Unavailable	F
HELPFUL/C (1-7)	6.33 (n=12)	3.86 (n=6)	5.69 (n=13)	5.86 (n=35)	4.14**
HOWDIFF/C (1-7)	3.17 (n=12)	0.67 (n=6)	2.15 (n=13)	2.29 (n=35)	3.35*
SCLDIFF	11.83 (n=6)	3.20 (n=5)	3.36 (n=11)	6.42 (n=19)	1.32
SUCCESS/T	5.82 (n=11)	3.33 (n=6)	5.77 (n=13)	5.80 (n=33)	9.37**

* $p < .025$ ** $p < .01$

TABLE 4: MEAN OUTCOME RATINGS FOR DIFFERENT THERAPIST DETERMINED NATURE OF TERMINATION

OUTCOME MEASURES	NATURE OF TERMINATION			
	Mutual	Client	Therapist	F
HELPFUL/C (1-7)	5.92 (n=24)	5.04 (n=26)	6.00 (n=23)	2.98
HOWDIFF/C (1-7)	2.08 (n=24)	1.88 (n=25)	2.52 (n=23)	0.97
SCLDIFF	6.70 (n=11)	7.61 (n=18)	6.29 (n=17)	0.09
SUCCESS/T (1-7)	6.05 (n=22)	4.68 (n=25)	5.66 (n=22)	8.09*

* $p < .001$

TABLE 5: MEAN OUTCOME RATINGS FOR DIFFERENT LEVELS OF CLIENT NEED FOR FURTHER THERAPY

OUTCOME MEASURES	NEED FOR FURTHER THERAPY-CLIENT RATED				
	Low	Medium	High	F	r
HELPFUL/C	5.52 (n=21)	5.63 (n=41)	5.69 (n=16)	0.05	-.01
HOWDIFF/C	2.95 (n=21)	2.20 (n=41)	1.31 (n=16)	5.13**	-.34**
SCLDIFF	10.25 (n=12)	6.24 (n=25)	4.38 (n=13)	1.39	-.23
SUCCESS/T	5.58 (n=19)	5.40 (n=35)	5.50 (n=15)	0.11	-.11

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

TABLE 6: MEAN OUTCOME RATINGS FOR HIGH AND LOW THERAPIST RATINGS OF NEED FOR FURTHER THERAPY

OUTCOME MEASURES	NEED FOR FURTHER THERAPY-THERAPIST RATED			
	Low	High	t-Value	r
HELPFUL/C	6.00 (n=33)	5.41 (n=42)	1.64* (df=73)	-.18
HOWDIFF/C	2.85 (n=33)	1.71 (n=41)	3.20*** (df=72)	-.27**
SCLDIFF	9.11 (n=18)	5.17 (n=29)	1.42 (df=45)	-.31*
SUCCESS/T	6.05 (n=31)	5.00 (n=40)	3.58*** (df=69)	-.35**

(1-tailed) * $p < .05$ ** $p < .01$ *** $p < .005$

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