Type of counseling termination and trainee therapist–client agreement about change

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(Received 29 August 2005; final version received 3 February 2006)

Research on client–therapist agreement about change has shown mixed results within an overall pattern of limited agreement. However, relatively little research has been conducted in counseling training clinics. This archival study sheds light on this inconsistency by examining trainee therapist–client agreement on outcome in different types of counseling termination. Treatment gains were found for both counseling completers and dropouts, with findings somewhat favoring the former group. Moderate trainee therapist–client agreement about change was found. Larger agreement was obtained for clients who completed treatment ($r = .53$) compared to clients who withdrew unilaterally from treatment ($r = .30$). However, this difference was not statistically significant.

Keywords: therapist–client agreement; treatment outcome; training clinics

Limited consensus among different sources (clients, therapists, significant others, and trained judges) in evaluating the process and outcome of counseling has been observed in the literature (Hill & Lambert, 2004). Research focusing specifically on client–therapist agreement in their perceptions of treatment outcome has shown mixed results, ranging from moderate to no agreement. In their review of the literature, Weiss, Rabinowitz, and Spiro (1996) identified 18 studies that explored client–therapist agreement about some aspect of therapy outcome. Of these, 12 studies found some level of agreement. However, almost all of them reported a correlation coefficient $r < .50$, suggesting low to moderate agreement. In the remaining six studies, no statistically significant levels of agreement were reported (Weiss et al., 1996). Several studies that factor-analyzed together outcome measures from different sources have confirmed that such lack of agreement reflects the difference in perspective between the various sources that provide outcome information, and not differences in the content of the measures used (Lambert & Hill, 1994).

More recent research on client–therapist agreement reveals similar findings. Rosenblatt and Rosenblatt (2002) found only 42% agreement on client–therapist perceptions of change. Pekarik and Guidry (1999) also found moderate agreement, with therapist measures correlated less than $r = .55$ with four of the five client measures. However, Bryan, Dersch, Shumway, and Arrendodo (2004) did not report any differences in client–therapist perceptions of treatment outcome.

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It is worth noting that only three studies of therapist–client agreement have been conducted in a psychological training clinic and also found limited agreement among student therapists and their clients. Bachelor (1987) found moderate agreement (r = .34) with regard to perceived outcome among community outpatients and their clinical psychology student therapists. Garfield, Prager, and Bergin (1971) also found moderate agreement about change among clinical/counseling psychology trainee therapists and community outpatients (r = .44). However, Horenstein, Houston, and Holmes (1973) did not find significant agreement on outcome among clinical psychology trainees and their clients (r = .10, ns). Last, in a study of student therapist–client agreement in an outpatient psychiatric setting, Noel (1998) found moderate agreement (r = .43) among clinical psychology and psychiatry trainees and their clients. Similar results were found in terms of clinically significant change, where agreement was reached for 43% of client cases.

Only one study has examined agreement about change in different counseling termination types. Saltzman, Luetgert, Roth, Creaser, and Howard (1976) found a strong and statistically significant outcome agreement correlation only for the therapeutic dyads with the longest treatment duration, and great discrepancies in outcome evaluation when clients dropped out of treatment. Their results, obtained at a university student counseling center, suggest that manner of counseling termination may also influence levels of client–therapist agreement and contribute to mixed findings in the literature.

In the present investigation, the focus was on replicating the limited previous findings on outcome agreement in training clinics, and studying agreement in a training setting specific to counseling psychology and counseling trainees. Further, the role of premature termination in outcome agreement in such a training setting was investigated. Specifically, the purpose of this study was to (a) examine therapist–client agreement about outcome evaluation in a counseling training clinic and (b) examine differences in agreement depending on manner of termination from treatment. Based on existing research, it was expected that student therapists would show moderate agreement with their clients about treatment outcome. Further, it was expected that agreement about treatment outcome would be higher with clients who completed treatment compared to clients who withdrew from counseling unilaterally. Differences in perceptions of outcome and satisfaction among counseling completers and dropouts were also investigated.

Method

Setting and therapists

Data for this study were collected in a university-based training clinic located in the counseling psychology department of a Midwestern university. The clinic provides the local community with low-cost outpatient counseling. Clients who are acutely suicidal or homicidal, have predominant alcohol or substance abuse issues, or suffer from psychotic symptoms are referred out. Approximately 50 trainee therapists provide counseling services in the clinic each semester. Half of them are enrolled in a master’s degree in counseling and see clients as part of their first or second practicum. The other half hold master’s degrees in counseling or related fields and are enrolled in an APA-accredited doctoral program in counseling psychology. Mean age of trainee therapists is 28.08 (SD = 6.28, range 22–46) with a female to male ratio
Trainee therapists work within various theoretical frameworks and carry client cases for a variable number of sessions, under the supervision of a faculty psychologist.

**Client participants**

The archival files of 112 clients (59% female, and 41% male) who were seen in the clinic between 1995 and 1999 were examined. Clients’ ages ranged from 15 to 70 years ($M = 32.50, SD = 11.55$). In terms of education, approximately 15% had finished some high school, 33% were high school graduates, 22% had some college education, 22% had a bachelor’s degree, and 6% had a graduate degree. Almost half (47%) of the clients were married or cohabitating. Sixty-one percent of the clients reported an annual family income of less than $30,000. Although no data on client race or ethnicity were collected, a majority of clients seen in the clinic were Caucasian.

The most common client problems assessed by intake interviewers were depression (48%), marital problems (34%), poor self-esteem (26%), dating relationships (24%), interpersonal problems (23%), family issues (22%), intrapersonal problems (18%), guilt (13%), anxiety (16%), occupational or vocational concerns (14%), grief (13%), and decision-making issues (12%) (Percentages add up to more than 100 because interviewers recorded all client presenting problems). Clients were primarily seen in individual counseling (80%) or couples counseling (25%), with some clients being seen in both therapy formats.

**Measures**

**Therapist perception of outcome**

At the end of each counseling encounter, therapists evaluate clients’ progress by responding to a change scale consisting of the following three items: (a) “From the initial session to this point in time, rate the degree of change, overall, you perceive in this client”; (b) “From the initial session to now, rate the degree of change you perceive in this client’s self-esteem”; and (c) “From the initial session to now, rate the extent of change you perceive in this client’s sense of self-control.” Therapists record their impressions on a 5-point scale, ranging from significant negative (−2) to significant positive (+2), with a midpoint of no change (0). A change score was obtained for each client by averaging item responses ($M = 0.91; SD = 0.59$; indicating positive average change for clients as a group). Internal consistency reliability for the 3-item scale in this sample was $\alpha = .85$.

**Therapist perception of post-treatment client well-being**

At the end of each counseling encounter, therapists evaluate clients’ post-treatment well-being by responding to a 3-item scale: (a) “At this point in time, what is your estimate of this client’s level of self-esteem?” (b) “At this point in time, what is your estimate of this client’s level of perceived self-control?” and (c) “At this point in time, rate the general adjustment level of this client.” Therapists record their impressions on a 5-point scale, ranging from very low (1) to very high (5). Therapists are instructed to consider the scale midpoint of average (3) as reflecting the norm for
well-adjusted, functional individuals. A total post-treatment well-being score was obtained for each client by averaging item responses ($M = 3.22; SD = 0.78$; indicating above average mean post-treatment well-being for clients as a group). Internal consistency reliability for the 3-item post-treatment well-being scale in this sample was $\alpha = 0.85$. Both therapist measures were developed and have been used in the clinic for routine outcome evaluation.

**Client Satisfaction Survey (CSS)**

The first section of the CSS consists of 16 items that aim to capture different aspects of counseling outcome and satisfaction as perceived by clients. Clients are asked to rate 16 statements about themselves, organized under the heading “As a result of the counseling I have received, with regard to my concerns and problems:” Examples of statements include “I feel much better than before counseling,” and “I like myself more than before counseling” (see Table 1). Clients record their level of agreement with each statement on a 5-point scale, ranging from strongly disagree (1) to strongly agree (5). As part of this investigation, the CSS was subjected to an exploratory factor analysis (for data reduction purposes).

Principal component analysis and oblimin oblique rotation were used to explore the factorial structure of CSS, as the factors are expected to be correlated (Tabachnick & Fidell, 2001). Bartlett’s test of sphericity was significant ($p < .001$)

<table>
<thead>
<tr>
<th>Item</th>
<th>$M$</th>
<th>$SD$</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor 1: Counseling outcome ($\alpha = 0.89$)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I like myself more than before counseling</td>
<td>3.76</td>
<td>0.97</td>
<td>.85</td>
</tr>
<tr>
<td>I feel much better than before counseling</td>
<td>4.09</td>
<td>0.81</td>
<td>.78</td>
</tr>
<tr>
<td>I’m a better person than I was before counseling</td>
<td>3.71</td>
<td>0.88</td>
<td>.73</td>
</tr>
<tr>
<td>I feel more in control of my life</td>
<td>3.93</td>
<td>0.87</td>
<td>.71</td>
</tr>
<tr>
<td>My moods are a lot better</td>
<td>3.86</td>
<td>0.81</td>
<td>.65</td>
</tr>
<tr>
<td>The future is looking much brighter for me</td>
<td>3.93</td>
<td>0.91</td>
<td>.63</td>
</tr>
<tr>
<td>I understand myself better</td>
<td>3.95</td>
<td>0.79</td>
<td>.61</td>
</tr>
<tr>
<td><strong>Factor 2: No need for additional counseling ($\alpha = 0.72$)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I still need more help (reverse scored)</td>
<td>2.67</td>
<td>1.17</td>
<td>.82</td>
</tr>
<tr>
<td>I still have the same problems as before counseling (reverse scored)</td>
<td>3.31</td>
<td>0.96</td>
<td>.66</td>
</tr>
<tr>
<td>I still don’t know what to do (reverse scored)</td>
<td>3.60</td>
<td>1.17</td>
<td>.61</td>
</tr>
<tr>
<td>I’ve solved most of my problems</td>
<td>3.10</td>
<td>1.03</td>
<td>.58</td>
</tr>
<tr>
<td><strong>Factor 3: Counseling satisfaction ($\alpha = 0.80$)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would return here for counseling again if I needed it</td>
<td>4.47</td>
<td>0.55</td>
<td>.82</td>
</tr>
<tr>
<td>I am very satisfied with my counseling experience</td>
<td>4.44</td>
<td>0.60</td>
<td>.69</td>
</tr>
<tr>
<td>I had a very good relationship with my counselor</td>
<td>4.46</td>
<td>0.60</td>
<td>.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor intercorrelations</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling outcome</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>No need for additional counseling</td>
<td>0.38</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Counseling satisfaction</td>
<td>0.37</td>
<td>0.20</td>
<td>–</td>
</tr>
</tbody>
</table>

Notes: $N=112$. 1 = I strongly disagree; 2 = I disagree; 3 = I am unsure or neutral; 4 = I agree; 5 = I strongly agree.
and the Kaiser–Meyer–Olkin Measure of Sampling Adequacy was 0.895, supporting
the factorability of the data. Based on the scree plot, eigenvalues, percentage of
variance explained, and the interpretability of the factors, a 3-factor solution was
supported. Based on an inspection of factor loadings, two items were deleted because
their highest loading was below .50. After rerunning the analysis, all cross-loading
differences were greater than .10, supporting the detection of coherent factors.
The resulting factors, item content, means and standard deviations, highest factor
loadings, and factor intercorrelations are shown in Table 1. The three factors were
labeled (a) “Counseling outcome” (seven items); (b) “No Need for additional
counseling” (four items); and (c) “Counseling satisfaction” (three items). They
collectively accounted for 65% of the total variance (46%, 10%, and 9%,
respectively). Factors scores were computed by averaging item responses on a given
factor. Mean factor scores were $M = 3.88$ ($SD = 0.67$) for Counseling outcome;
$M = 3.16$, ($SD = 0.80$) for No Need for additional counseling; and $M = 4.45$
($SD = 0.49$) for Counseling satisfaction. These results indicate that, generally, clients
reported positive changes, high satisfaction, and some need for additional
counseling. Internal consistency reliabilities for the three factors were $\alpha = 0.89$,
$\alpha = .72$, and $\alpha = .80$, respectively.

Procedure
A subsample of a larger archival dataset of counseling terminations was used in this
investigation (see Lampropoulos, Schneider, & Spengler, 2009). Of these
data ($N = 380$), only the cases for which client–therapist evaluations of outcome
were available were included in the present study ($n = 112$, or 30%). Therapists
completed their outcome evaluations at the end of the treatment. Clients completed
the CSS at the end of each semester and at the end of treatment. Only the last CSS
submitted by each client was included in the analysis (at counseling termination or
within the three-month period preceding the closing of their clinic file).

Results
Of the 112 client terminations examined, 43 (38%) were categorized by their
therapists as therapy dropouts, 42 (38%) as completers, and 27 (24%) as referrals (25
within the clinic and two to an outside agency, typically because of counselors
completing their practicum, i.e., logistical terminations). A multivariate analysis of
variance revealed significant differences among these groups regarding treatment
outcomes, $F(10, 196) = 2.45$, Wilks’s lambda = 0.80, $p = .009$. Table 2 shows client
and therapist measures means and standard deviations of each termination group,
along with univariate $F$ tests and Scheffé post hoc comparisons of mean differences.
Therapists reported better counseling outcome for completers compared to the
two other groups, and higher post-treatment well-being for completers compared
to referrals. Also, referred clients acknowledged higher need for additional
counseling compared to completers.

Next, correlations between client and therapist perceptions of counseling
outcome were examined. Correlations were obtained separately for the two main
groups of interest, namely completers and dropouts (referred clients were not
included as they were considered artificial terminations). As shown in Table 3,
somewhat higher correlations were found among most of the client and therapist outcome measures for the completers compared to dropouts. The main correlation of interest was among the 3-item therapist-rated outcome scale and the 7-item client-rated outcome scale. Pearson $r$ was statistically significant and in the moderate-to-high range for the completers group ($r = .53$, $p < .001$), but in the low-to-moderate range for the dropouts group ($r = .30$, $p = .035$). Further testing of the statistical significance of the difference between correlation coefficients was performed.

Table 2. Therapist and client perceptions of outcome per counseling termination type.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Completers</th>
<th>Dropouts</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
</tr>
<tr>
<td>Tx outcome – T</td>
<td>1.19$_a$</td>
<td>0.54</td>
<td>0.78$_b$</td>
</tr>
<tr>
<td>Posttx well-being – T</td>
<td>3.53$_a$</td>
<td>0.63</td>
<td>3.19$_b$</td>
</tr>
<tr>
<td>Tx outcome – C</td>
<td>4.14</td>
<td>0.58</td>
<td>3.82</td>
</tr>
<tr>
<td>No need add. Tx – C</td>
<td>3.45$_a$</td>
<td>0.73</td>
<td>3.15</td>
</tr>
<tr>
<td>Tx satisfaction – C</td>
<td>4.58</td>
<td>0.44</td>
<td>4.38</td>
</tr>
</tbody>
</table>

Notes: For completers group, $n = 41$; for dropouts group, $n = 38$; for referrals group, $n = 26$. Means with different subscripts in the same row differ significantly from one another ($p = .05$, Scheffé post hoc comparisons); Tx outcome – T = therapist’s perception of counseling outcome; Posttx well-being – T = therapist’s perception of post-treatment client well-being; Tx outcome – C = client perception of counseling outcome; No need add. Tx – C = client perception of no need for additional counseling; Tx satisfaction – C = client perception of counseling satisfaction. ***$p = .001$; **$p < .01$; *$p < .05$.

Table 3. Correlations among client and therapist outcome measures for completers and dropouts.

<table>
<thead>
<tr>
<th>Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling completers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tx outcome – T</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Posttx well-being – T</td>
<td>0.64***</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Tx outcome – C</td>
<td>0.53***</td>
<td>0.24</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>No need add. Tx – C</td>
<td>0.36**</td>
<td>0.26</td>
<td>0.49***</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Tx satisfaction – C</td>
<td>0.34*</td>
<td>0.09</td>
<td>0.61***</td>
<td>0.24</td>
<td>–</td>
</tr>
<tr>
<td>Counseling dropouts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tx outcome – T</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Posttx well-being – T</td>
<td>0.55***</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Tx outcome – C</td>
<td>0.30*</td>
<td>0.05</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>No need add. Tx – C</td>
<td>0.08</td>
<td>0.31*</td>
<td>0.62***</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Tx satisfaction – C</td>
<td>0.35*</td>
<td>0.17</td>
<td>0.59***</td>
<td>0.58***</td>
<td>–</td>
</tr>
</tbody>
</table>

Notes: For completers group, $n = 41$; for dropouts group, $n = 38$. Tx outcome – T = therapist’s perception of counseling outcome; Posttx well-being – T = therapist’s perception of post-treatment client well-being; Tx outcome – C = client perception of counseling outcome; No need add. Tx – C = client perception of no need for additional counseling; Tx satisfaction – C = client perception of counseling satisfaction. ***$p \leq .001$; **$p < .01$; *$p < .05$ (1-tailed).
Discussion
This study explored outcome agreement among counseling and counseling psychology student therapists and their clients in a less-studied training setting. The role of type of counseling termination on levels of agreement was also explored, as were counseling outcomes among counseling completers and dropouts from both client–therapist perspectives.

First, clients and therapists seemed to report positive counseling outcomes, satisfaction, and post-treatment client well-being, as well as some need for additional help in a counseling training clinic. These were reported for all three termination groups, suggesting that counseling dropouts also experienced significant benefits. This is consistent with results from other types of clinical settings that suggest considerable gains for clients who do not complete treatment, but who attend some sessions (Cahill et al., 2003; Klein, Stone, Hicks, & Pritchard, 2003; Pekarik, 1983, 1992a, 1992b).

Further, some differences were found showing better outcomes for treatment completers from the perspective of the therapist. Interestingly, no differences were found in therapist-rated client post-treatment well-being, or in client-rated counseling outcome (although it approached significance) and satisfaction between counseling completers and dropouts. This finding is consistent with research that shows that many clients who terminate treatment unilaterally may do so because of having achieved significant gains, and not because of dissatisfaction with treatment (Pekarik, 1992a). Taken together, these results showed positive gains for all termination groups, and perhaps some additional benefits for those who end treatment in agreement with their counselor. However, these findings are limited by the fact that the present investigation was based on a smaller, self-selected sample of clients seen in the clinic at that period (i.e., those who completed the CSS; 30% of terminations). That is, it is possible that clients who did not complete the CSS may have had less positive counseling outcomes and satisfaction.

Second, consistent with the majority of prior research, moderate client–therapist agreement on outcome in a counseling training clinic was found. Although agreement correlations were larger for completers, they did not appear to be statistically different from those obtained for dropouts. Thus, this study failed to clearly support previous findings by Saltzman et al. (1976) that client–therapist agreement about change might vary as a function of manner of termination. However, similarly to the Saltzman et al.’s results, therapists seemed to hold a more unfavorable view of outcome for clients who drop out of treatment. It seems possible that clients who drop out of treatment may overestimate their improvement and/or their therapists may underestimate their gains from treatment, potentially limiting agreement about outcome in this group.

In any case, it is suggested that it is beneficial to train therapists to communicate with their clients in assessing counseling process and outcome on a regular basis (Lambert et al., 2003; Lampropoulos & Spengler, 2002). It may be particularly
beneficial for trainee therapists to learn how to routinely use client feedback regarding the process and outcome of therapy, because trainees have limited clinical experience to which to base their comparisons. A variety of excellent counseling measures can be used for that purpose and are discussed in Ogles, Lambert, and Masters (1996), Cone (2001), Heppner, Kivlighan, and Wampold (1999), and Strupp, Horowitz, and Lambert (1997). Although novice therapists may be more sensitive to client feedback, such feedback early in treatment could help reduce treatment dropouts or identify early terminations due to improvement, both very clinically useful and educational types of information.

Overall, client–therapist outcome agreement in training settings seems to be moderate at best, and no different from the generally limited agreement pattern found in other clinical contexts (Hill & Lambert, 2004; Weiss et al., 1996). Thus, it is recommended that clinicians in all settings make an effort to include multiple sources of evaluation (client, therapist, and third parties) to ensure a more comprehensive and effective approach to outcome assessment. Repeated pre-post administrations of standardized outcome measures are also preferred to post-therapy estimates of change, although the latter are often more practical to use in routine clinical evaluation (Hill & Lambert, 2004). Descriptions of systematic and comprehensive models and methods of process and outcome assessment in clinical practice can be found in Ogles et al. (1996), Cone (2001), and Lampropoulos and Spengler (2002).

In summary, this study contributes to the literature by replicating existing client–therapist outcome agreement findings in psychological training clinics, and investigating such agreement separately for different types of counseling termination in these settings. Study limitations include the archival nature of this study (e.g., use of sample and measures of convenience). In order to advance research and improve clinical practice, it is recommended that counseling process and outcome be systematically monitored from both client and therapist perspectives, using well-developed instruments (Lambert et al., 2003; Lampropoulos et al., 2002; Strupp et al., 1997). Systematic evaluation and communication between client and therapist regarding client progress can potentially facilitate client retention and treatment planning and improve counseling outcome.

Acknowledgements
The writing of this article was supported in part by a Summer Research Fellowship from the Ball State University Lyell Bussell Memorial Fund, and a Scholarship from the “Alexander S. Onassis” Public Benefit Foundation, Athens, Greece. The author is thankful to Dr. Paul Spengler for his comments and to Tammy Montgomery for her assistance in accessing archival clinic data.

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