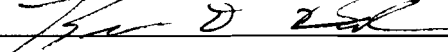


AN ABSTRACT OF THE THESIS OF

_____ Charles Glenn Herbic _____ for the _____ Master of Science _____

in _____ Psychology _____ presented on _____ March 30, 1998 _____

Title: _____ Readiness To Change As A Predictor Of Treatment Attendance _____

Abstract approved: _____  _____

Premature termination of therapy has long been recognized as a problem in the mental health field. The answers to why clients terminate therapy prematurely and how to prevent premature termination have been a source of recent debate with the advent of managed care. Results of previous studies attempting to predict premature termination have been disappointing because little information has been obtained identifying what exactly predicts premature termination. Focusing on client variables as a predictor of premature termination appears to be a likely way to examine this phenomenon. This study used the Transtheoretical Model of Change and analyzed the relationship between client readiness to change and treatment attendance and between client gender and treatment attendance. A sample of 50 non-court referred clients were drawn from a community mental health center serving a midwestern area. They were administered a questionnaire that classified them into one of four distinct stages of change. Treatment attendance was tracked for each client over a one month period. Premature termination was defined as clients who failed to attend their scheduled appointment, failed to reschedule their next appointment within a 24-hour period, or failed to inform the therapist they no longer wished to continue therapy. A chi square was performed to identify the relationship between client stage of change and treatment attendance. The results indicated that client stage of change significantly predicted treatment attendance.

These results indicate that clients' readiness for change can be used successfully to predict treatment attendance. This predictive ability could possibly help in the implementation of interventions that would effectively maximize client attendance at therapy.

READINESS TO CHANGE AS A PREDICTOR OF
TREATMENT ATTENDANCE

A Thesis

Presented to

The Division of Psychology and Special Education

EMPORIA STATE UNIVERSITY

In Partial Fulfillment

of the Requirements for the Degree

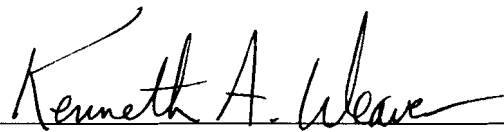
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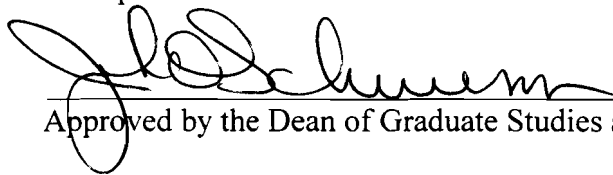
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Approved by the Chair of the Division of Psychology
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CHAPTER 1

INTRODUCTION

Third party reimbursement has recently focused greater attention on the economics of psychotherapy. Individuals' fees for treatment are often paid by insurance companies, Medicaid, or Medicare. These third parties often dictate how many treatment sessions an individual can attend. Mental health professionals and agencies utilize treatments most beneficial for the client, but also the most cost effective. Increasingly they must focus on issues that create a financial loss for themselves. Clients' premature termination of therapy has been associated with client personal loss, therapist personal loss, and financial loss (Medeiros & Prochaska, in press). Individuals referred for psychotherapy differ in the degree to which they want to change their behavior. An individual's stage of change when seeking treatment would be likely to relate to subsequent attendance at therapy. This study applied the Transtheoretical Model of Change developed by Prochaska and DiClemente (1982) to the phenomenon of premature termination. Premature termination was defined as clients who failed to attend their scheduled appointment, failed to reschedule their next appointment within a 24-hour period, or failed to inform the therapist they no longer wished to continue therapy. A client's gender was another characteristic that is indicative of premature termination. This study also looked at gender applied to premature termination. The clinical usefulness of understanding and predicting premature termination is immense. Interventions can be utilized and therapy approaches modified in order to accommodate clients who are more at risk for terminating therapy prematurely.

Premature Termination

Pekarik (1985) and Greenspan and Kulish (1985) have described client personal loss as the disservice clients impose upon themselves for terminating therapy against the clinician's advice. Medeiros and Prochaska (in press) cited research that suggests therapists may interpret early termination of therapy as a personal failure as well as client rejection of the therapist. The most widely recognized cost of premature termination of therapy has been the financial loss of the associated provider. Graziano and Fink (1973) have noted that the premature termination of therapy by clients disrupts the effective provision of services. Therapists lose precious time when clients fail to show for their scheduled appointment. They could have provided service to others and generated income. The issue of premature termination of therapy has become critical. Essentially mental health centers require clinicians to be both cost effective and manage their service hours wisely. Between 20% to 57% of outpatients in general mental health centers terminate against their therapists' advice after only one session (Dodd, 1971; Overall & Aronson, 1963).

It is difficult to predict which clients are most likely to terminate therapy prematurely. A variety of research has already been conducted to identify predictors of premature termination. In a meta-analysis of 125 studies, Medeiros and Prochaska (in press) found only three client variables that significantly predicted premature termination of therapy. These variables were lower education, lower income, and ethnic and minority status. Many mental health centers operate on a sliding fee scale, attempting to accommodate clients with a lower income. Mental health centers also service a greater percentage of

clients with lower education and clients with ethnic and minority status. The issue therefore remains of how to predict premature termination in mental health centers.

Medeiros and Prochaska (in press) have identified a range of variables not significantly related to dropout rates. Therapy modality (group vs. individual), therapy setting (private clinic vs. public clinic), developmental status of clients (adult vs. children), therapist variables (gender, minority status, experience, and degree), and type of problem presented (emotional, behavioral, psychotic, and substance abuse) did not relate significantly to dropout status.

Transtheoretical Model

Beyond simple post hoc analyses of dropout rates, theoretically determining what variables predict premature termination would be useful. A theory that focuses on the interaction of client and therapist variables should be examined. Prochaska and DiClemente's (1982) Transtheoretical Model of Change provides such a framework.

Transtheoretical therapy was developed after a comparative analysis of many of the major systems of psychotherapy (Prochaska, 1979). The major systems were all considered very helpful regarding individual functioning, but few could empirically demonstrate how people respond to therapy. Further, evidence did not prove one therapy was empirically better than the next (Luborsky, Singer, & Luborsky, 1975).

Transtheoretical therapy attempted to integrate the major systems into an eclectic, empirical approach to understand human function and dysfunction. Transtheoretical therapy set out to define criteria for a new, innovative model of therapy. First, the model had to be empirical; each of the variables had to be measurable and capable of being validated. Second, it had to account for how people change without therapy as well as

within therapy. Research shows that only a minority of people with a diagnosable disorder seek professional help (Veroff, Douvan, & Kulka, 1981a, 1981b). Third, transtheoretical therapy's founders wanted a model that could account for and explain a broad range of human problems. This theory could explain health problems, such as smoking and obesity, as well as psychopathology. These criteria of the transtheoretical model would provide information on the mechanism of how people can change.

Most people seek professional help to change problems or patterns that are causing distress to themselves and/or others. They seek to improve or enhance the quality and/or the length of their lives. Transtheoretical therapy therefore attempts to discover the dimensions of change. The stages of change, processes of change, and levels of change are three dimensions that have been discovered and explained (Prochaska & DiClemente, 1982). This stages of change dimension was the focus explored in this study.

Stages of Change

The stages of change represent a temporal dimension that describes the stages a person progresses through during their lifetime (Medeiros & Prochaska, in press). The construct of stages of change in psychotherapy is a new contribution from this integrative and eclectic theory. Change is a process that unfolds over time and researchers have attempted to develop instruments that accurately measure what stage an individual is currently in. A person's stage can last for any period of time, but individuals require special efforts by the person to progress from one stage to the next. This dynamic dimension is reflective of psychological disorders and health problems in that both can last for any length of time but are open to change.

DiClemente and Prochaska (1982) identified four distinct stages in a study on smoking cessation. Precontemplation is the stage where people have no intention of changing their behavior in the foreseeable future. Precontemplators are often seen in mental health centers because someone else has referred them there. The client may be referred because a spouse threatens to leave, an employer threatens termination, or a court order threatens incarceration. Precontemplators often do not recognize the problem behavior and are resistant to the therapy process.

A person in the contemplation stage has recognized that there is a problem, yet has not made a commitment to take action. Contemplators typically think about changing or overcoming their problem. Individuals can remain fixed in this stage for long periods of time. In a study of 200 smokers in the contemplation stage, results showed that the typical response was to stay in this stage for two years without ever making any commitment to take action (DiClemente & Prochaska, 1985; Prochaska & DiClemente, 1984).

The action stage is where people are overtly modifying their behavior, experiences, and/or environment in order to change their problems. This stage requires a commitment of large amounts of both time and energy. Prochaska and DiClemente (1984) classified individuals in the action stage if they had successfully altered a problem behavior for a period from one day to six months. Individuals in this stage typically progress through therapy very quickly due to their motivation to change.

The final stage is the maintenance stage where clients seek therapy to prevent a relapse or improve upon gains already made in therapy. Prochaska and DiClemente (1984) classified individuals in the maintenance stage if the individual had remained free of the

problem for more than six months. It is very typical for individuals to reach the maintenance stage, relapse, and cycle back to the contemplation or action stage.

The stages of change have been identified in a variety of settings with a wide range of problems or behaviors. A 32-item Stages of Change Scale has been developed that yields stage scores (McConaughy, Prochaska, & Velicer, 1983). This questionnaire has been tested with the stage model and confirmed with outpatient psychotherapy clients (McConaughy, DiClemente, Prochaska, & Velicer, 1989), outpatient alcoholism treatment clients (DiClemente & Hughes, 1990), weight control program participants (O'Connell & Velicer, 1988), head injury rehabilitation clients (Lam, McMahon, Priddy, & Gehed-Schultz, 1988), and smoking cessation clients (Prochaska & DiClemente, 1984; 1985).

Medeiros and Prochaska (in press) successfully used the transtheoretical variables of stages and processes of change to predict the premature termination and continuation status of clients entering psychotherapy. The prediction equation used by Medeiros and Prochaska (in press) correctly discriminated premature terminators from appropriate terminators and therapy continuers. While these results are very encouraging, the applicability to mental health center populations is unclear. For example, approximately 60% of their clients in the study were seen in university based clinics. It is unknown whether the results would generalize to public mental health clinics.

Gender

Several other variables beyond stages of change have been examined as possible predictors of premature termination of therapy. Among these variables is gender of the client. The findings regarding the issue of a client's gender and relationship to premature

termination of therapy have been conflicting. Seeman (1954) reported that women were more likely to complete psychotherapy, whereas men were found to terminate psychotherapy prematurely. Mintz, Luborsky, and Auerbach's (1971) study further supported the belief that men were more likely to terminate therapy prematurely. Other researchers have found no significant difference between men and women in terms of premature termination of therapy (Affleck & Farfield, 1961; Berrigan & Garfield, 1981; Craig & Huffine, 1976).

Conclusion

The purpose of this study was to identify the client's stage of change and gender at the pretreatment period of an intake interview at a community mental health center and to predict treatment attendance. It was expected that the client's stage of change when initially seeking treatment would predict premature termination of therapy or treatment attendance. It was hypothesized that individuals in the precontemplation and contemplation stage would be more likely to terminate therapy prematurely, while individuals in the action and maintenance stage would be more likely to attend treatment. It was also hypothesized that men would be more likely than women to terminate therapy prematurely.

CHAPTER 2

METHOD

Participants

The participants involved in this study were 50 non-court referred adult clients from Wyandot Mental Health Center in Kansas City, KS. The age range of the sample was 19 to 53 with a mean of 34.70 and a standard deviation of 11.00. The sample included 24 women and 26 men. Each participant selected for the study was a new client who fits the criteria for a mental disorder using the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994).

Instruments

The Stages of Change Scale (Appendix A) was used in this study. The four subscales of the Stages of Change questionnaire (McConaughy et al., 1983) operationally define the four theoretical stages of change (Precontemplation, Contemplation, Action, and Maintenance) outlined by Prochaska and DiClemente (1982). The questionnaire assesses clients' readiness for involvement in change at the start of therapy. The four subscales have 32 total items with eight measuring each subscale. The questionnaire has a 5-point Likert format in which a score of 1 indicates strong disagreement and a score of 5 shows strong agreement. DiClemente and Prochaska (1982) place individuals into one of the four stages by subtracting the mean of the Precontemplation subscale score from the combined mean of the other three stage scores. This yields a readiness to change score which is compared to Medeiros and Prochaska's (in press) cut-off scores (Precontemplation \leq 9.2, Contemplation \leq 10.6, Action \leq 12.1, and Maintenance $>$ 12.2). McConaughy et al.'s (1983) results showed that the four subscales accounted for 58% of

the total variance in the sample. The four subscales with their respective coefficient alphas were as follows: Precontemplation, .88; Contemplation, .88; Action, .89; and Maintenance, .88.

Consent Form (Appendix B). A consent form was developed by the researcher to inform the client about methods and the confidentiality of the study. Participants were required to sign the consent form in order to participate in the study. The consent form assured participants that their responses would be seen by no one other than the researcher.

Additional Measures. Treatment notes were analyzed to identify gender and measure premature termination of therapy or therapy attendance. A “show” for treatment simply meant the individual came to the scheduled appointment. A “no show” for treatment included individuals who did not attend their scheduled appointment, failed to reschedule their next appointment within a 24-hour period, or informed the therapist they no longer wished to continue therapy.

Procedure

Individuals who sought services at Wyandot Mental Health Center first came in for a one-hour intake interview. This intake process was conducted by either a master’s level psychologist or master’s level social worker. Following the intake interview the researcher approached the client with the consent form and the Stages of Change Scale questionnaire. The researcher introduced himself to the clients and explained his reason for approaching them (see Appendix C).

If the individuals did not agree to participate, the researcher thanked them for their time and left the room. If the client agreed to participate, the packet was given to the

client, and the researcher gave further instructions (see Appendix D). The researcher then left the room, and the client began completing the packet.

Upon completion of the packet, the client returned the packet to the receptionist who put each packet in a sealed envelope for the researcher. This same procedure was repeated for every new client in a two-week period at Wyandot Mental Health Center. The researcher then scored each of the questionnaires. Following this procedure treatment logs were tracked for each of the participants to determine attendance. The number of “shows” and “no shows” were kept for each client over a four-week period. This provided ample time to determine if clients terminated therapy prematurely or continued in therapy.

CHAPTER 3

RESULTS

The variables in this study are gender, the stages of change as scored by the Stages of Change Scale, and treatment “shows” or “no shows.” The means and standard deviations for stages of change were calculated to provide descriptive statistics for this sample (see Table 1). Using Medeiros and Prochaska’s (in press) method of scoring stages of change scores (the difference between the mean Precontemplation subscale score and the combined mean of the other three stage scores), participants were categorized into one of the four stages. The Precontemplation and Contemplation scores were combined to form one group and the Action and Maintenance scores were combined to form the second group. Frequencies for the two groups (Precontemplation/Contemplation and Action/Maintenance) broken down by attendance status (show and no show) are presented in Table 2. A chi square was calculated to test the hypothesis regarding the relationship between stages of change and treatment attendance. The analysis was significant, $\chi^2(2, N = 50) = 2.17, p < .05$, indicating that there was a difference between the stages of change and treatment attendance. Examination of cell frequencies revealed that clients in the Action/Maintenance cell were more likely to attend treatment than individuals in the Precontemplation/Contemplation cell.

Table 3 displays the breakdown of gender and treatment attendance. Even though these numbers appear discrepant, there was no significant difference between men’s and women’s attendance at treatment, $\chi^2(2, N = 50) = 5.77, p > .05$, indicating that gender did not successfully predict attendance at treatment. Table 4 displays the additional information regarding stage of change related to gender and treatment attendance.

Table 1

Means and Standard Deviations for Stages of Change Subscales (n=50)

| Stage | <u>M</u> | <u>SD</u> |
|------------------|----------|-----------|
| Precontemplation | 8.70 | .50 |
| Contemplation | 10.30 | 1.22 |
| Action | 12.00 | 1.67 |
| Maintenance | 13.30 | 1.18 |
| Composite | 11.62 | 1.08 |

Table 2

Crosstabulation of Stage Membership and Treatment Attendance Status

| | Show | No Show |
|--------------------------------|------|---------|
| Precontemplation/Contemplation | 10 | 11 |
| Action/Maintenance | 23 | 6 |

Table 3

Crosstabulation for Gender and Treatment Attendance Status

| | Show | No Show |
|-------|------|---------|
| Women | 18 | 6 |
| Men | 15 | 11 |

Table 4

Frequencies of Gender, Treatment Attendance Status, and Stage of Change

| | <u>Women</u> | |
|------------------------------------|--------------|---------|
| | Show | No Show |
| Precontemplation/ Contemplation | 4 | 3 |
| Action/ Maintenance | 14 | 3 |

| | <u>Men</u> | |
|------------------------------------|------------|---------|
| | Show | No Show |
| Precontemplation/ Contemplation | 6 | 8 |
| Action/ Maintenance | 9 | 3 |

CHAPTER 4

DISCUSSION

The purpose of this study was to examine the relationship between stages of change, as defined in the Transtheoretical Model of Change (Prochaska & DiClemente, 1982), and treatment attendance and gender and treatment attendance. Clients' responses on a stages of change questionnaire classified individuals into one of four stages (Precontemplation, Contemplation, Action, or Maintenance). Premature termination was defined as client failure to attend a scheduled appointment, failure to reschedule an appointment, or failure to inform the therapist the client no longer wished to continue therapy. Treatment notes of 50 clients who sought services at a community mental health center were analyzed to determine this relationship.

The first hypothesis stated that clients in the Precontemplation and Contemplation stages would be more likely to drop out of treatment than clients in the Action and Maintenance stages. This hypothesis was supported. Clients in the Precontemplation and Contemplation stage typically view their problems as outside of themselves. These individuals tend to minimize their problems and deflect many causes of the problem behavior. This faulty thinking process prevents them from facing their problems; therefore, they tend to drop out of therapy.

Clients who endorsed items indicative of the Action and Maintenance stages apparently entered treatment ready for action and valued the personal benefits of seeking help for their problems. These individuals tended to acknowledge their problems and their own limitations in correcting the problems. They sought help correcting the

problem by attending treatment at a mental health center which enabled them to actively work on their problem with a mental health professional.

The second hypothesis stated that client gender would predict treatment attendance, specifically that men would be more likely to drop out of treatment than women. This hypothesis was not supported. Findings regarding whether gender is a valid predictor of treatment attendance have been equivocal (Affleck & Farfield, 1961; Berrigan & Garfield, 1981; Craig & Huffine, 1976). Unfortunately, this study does not resolve the issue. Further research may clarify this issue by looking at the interaction between gender and other variables (e.g., client education, client income).

Limitations

There were several limitations to this study. This study was conducted on entirely non-court referred clients. Replications of this study could include court referred clients to assess the applicability of the stages of change model to that population. The participants drawn for this study all resided in a single, urban county located in north-east Kansas. Even if the sample represents the population from which it was drawn, it may not be representative of the population at large.

A concern could also be raised that clients' attendance was tracked for only a one month period. Clients may enter treatment, drop out of treatment for a period of time and then re-enter the treatment process. A study that tracked a longer treatment period may produce different results.

Implication

This study supported the idea that a client's stage of change is important in predicting treatment attendance. If clinicians can successfully predict the vast majority of premature

terminations, then they will have the potential to control costly drop-outs. Interventions could be utilized that are appropriate to clients' stage of change. Treating precontemplators as if they are ready to take action or to contemplate in depth the causes of their problems may lead to premature termination. A therapist with a client in the Precontemplation stage would use consciousness raising techniques and other processes of change (Prochaska & DiClemente, 1982) to move the client from one stage to the next. By intervening on variables which may result in premature termination, it may be possible to prevent many of the personal and financial losses experienced by clients, therapists, and mental health centers when drop-outs occur.

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APPENDIX A

Stages of Change Scales

Stages of Change Scale

This questionnaire is to help us improve services. Each statement describes how a person might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to “here,” that refers to Wyandot Mental Health Center.

Name: _____.

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

1=Strongly Disagree

2=Disagree

3=Undecided

4=Agree

5=Strongly Agree

1. As far as I'm concerned, I don't have any problems that need changing___.
2. I think I might be ready for some self-improvement___.
3. I am doing something about the problems that had been bothering me___.
4. It might be worthwhile to work on my problem___.
5. I'm not the problem one. It doesn't make much sense for me to be here___.
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help___.
7. I am finally doing some work on my problem___.
8. I've been thinking that I might want to change something about myself___.
9. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own___.
10. At times my problem is difficult, but I'm working on it___.
11. Being here is pretty much a waste of time for me because the problem doesn't have to do with me___.
12. I'm hoping this place will help me to better understand myself___.
13. I guess I have faults, but there's nothing that I really need to change___.
14. I am really working hard to change___.
15. I have a problem and I really think I should work at it___.
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem___.
17. Even though I'm not always successful in changing, I am at least working on my problem___.
18. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it___.
19. I wish I had more ideas on how to solve the problem___.
20. I have started working on my problems but I would like help___.

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

1=Strongly Disagree

2=Disagree

3=Undecided

4=Agree

5=Strongly Agree

21. Maybe this place will be able to help me___.
22. I may need a boost right now to help me maintain the changes in my problem that I've already made___.
23. I may be part of the problem, but I don't really think I am___.
24. I hope that someone here will have some good advice for me___.
25. Anyone can talk about changing; I'm actually doing something about it___.
26. All this talk about psychology is boring. Why can't people just forget about their problems___?
27. I'm here to prevent myself from having a relapse of my problem___.
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved___.
29. I have worries but so does the next guy. Why spend time thinking about them___?
30. I am actively working on my problem___.
31. I would rather cope with my faults than try to change them___.
32. After all I had done to try to change my problem, every now and again it comes back to haunt me___.

APPENDIX B

Informed Consent Form

Informed Consent Form

This study is to assess the stage of change an individual is at when they initially come to a mental health center for services. Your anonymity is assured as strict confidentiality will be used throughout the study. The only individual with access to your responses will be the researcher.

This study is not required for your treatment program. If you choose not to participate it will not impact your services at the center. If you agree to participate, you will be asked to fill out one questionnaire which will take approximately 10 to 15 minutes. If you do not wish to participate in this study, please inform the front desk and your involvement in this study will be discontinued.

This study has been reviewed and approved by the Quality Improvement Committee of Wyandot Mental Health Center Inc. and the Institutional Review Board of Emporia State University. It will neither harm any participant physically or emotionally. If you agree to participate in this study please sign the form below.

I understand that confidentiality will be used in this study, that I am not required to participate, that the Quality Improvement Committee has approved the study, that the Institutional Review Board has approved the study, and I agree to participate.

Signature of Participant

Please turn the page and begin filling out your answers to the questionnaire. When you are finished completing all 32 items, please turn in both forms to the receptionist at the front desk. Thank you for your participation.

APPENDIX C

Researcher Instructions

Researcher Instructions

“Hello. My name is Charley Herbic. I am a graduate student in clinical psychology at Emporia State University and doing my clinical internship here at Wyandot Mental Health Center. I am here today to ask for your participation in an exercise I am using as a part of my thesis. This exercise requests you to fill out one questionnaire which will take approximately 10 to 15 minutes. There is no threat to you physically or emotionally in this study. I will begin by distributing a consent form for your participation. I ask that you carefully read the form and sign it if you agree to participate. I would also like to tell you that you do not have to participate. If you do not wish to participate, tell me so now.”

APPENDIX D

Further Instructions

Further Instructions

“Please sign the consent form and read the directions for the questionnaire below. Take your time completing the form and when finished, return both forms to the receptionist at the front desk. I will have results from this study in approximately two months. If you wish to know the results of this study, please contact me at Wyandot Mental Health Center. Thank you for your participation.”

Permission to Copy Page

I, Charles Glenn Herbic, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Charles G. Herbic

Signature of Author

5/7/98

Date

Readiness To Change As A Predictor Of
Treatment Attendance

Title of Thesis

Doug Cooper

Signature of Graduate Office Staff Member

May 8, 1998

Date Received