

# The Hour of Departure: Predicting Attrition in the Training Clinic From Role Expectancies

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In addition to having potentially deleterious effects on clients in distress, client attrition also thwarts efforts by trainee clinicians to develop psychotherapy competencies that are uniquely associated with providing middle- or late-stage treatment. Within the established literature, one well-replicated correlate of attrition is client expectations. Thus, the following study investigated whether client attrition within a training clinic could be prospectively predicted from pretreatment expectancies. To that end, all adult clients presenting for an intake at a training clinic completed the Psychotherapy Expectancy Inventory—Revised (PEI-R). First, normative reference ranges for the PEI-R total and factor scores were developed. Next, analyses revealed that these reference ranges had good specificity in prospectively identifying clients that subsequently prematurely terminated treatment. Moreover, the computed positive likelihood ratios revealed that an individual who obtains a total score outside of the reference range is 7 times more likely to prematurely terminate therapy in comparison with individuals obtaining scores within the normative reference range. Training clinics are therefore encouraged to routinely administer the PEI-R as a means of identifying individuals at risk for attrition and defining which role expectations may need to be modified.

*Keywords:* expectancies, expectations, training, premature termination, attrition

It has recently been reported that attrition may be highly prevalent within the training clinic setting, with some finding that over 75% of clients prematurely terminate from psychotherapy (Callahan, Aubuchon-Endsley, Borja, & Swift, in press). Recent studies on attrition demonstrate a multifaceted relationship with several variables, including abuse history (Claus & Kindleberger, 2002), interpersonal difficulty (Handelsman, Stein, & Grella, 2005; Sayre et al., 2002), comorbid psychological diagnoses (Claus & Kindleberger, 2002), personality disturbance (Ball, Carroll, Canning-Ball, & Rounsaville, 2006), cognitive dysfunction (McKellar, Kelly, Harris, & Moos, 2006), legal issues (Claus & Kindleberger, 2002; Pagnin, de Queiroz, & Saggese, 2005; Vourakis, 2005), and discord with treatment providers or programs (Ball et al., 2006; McKellar et al., 2006).

Although all of these specific variables are important, the very high rate of premature termination in the training clinic suggests that a common factor impacting a broad range of clients, rather

than specific variables, may be particularly salient to understanding the high rate of training clinic attrition. Indeed, though there has been little recent attention, the extant literature does repeatedly document a common factor as contributive to attrition: client expectations (Garfield, 1994; Joyce & Piper, 1998; Lennard & Bernstein, 1960; Lorr & McNair, 1964; Overall & Aronson, 1963; Wierzbicki & Pekarik, 1993).

## Measurement of Expectancies

Client expectations may be broadly conceptualized as predominantly reflecting role and outcome expectancies (Dew & Bickman, 2005). Role expectations reflect within-therapy expectations about what will occur, while outcome expectations can be thought of as expectations regarding psychotherapy effectiveness. Many studies have supported the relationships between role expectations with treatment outcome (Hardin, Subich, & Holvey, 1988; Nock & Kazdin, 2001; Reis & Brown, 2006; Walitzer, Dermen, & Conners, 1999) and outcome expectations with adaptive treatment processes (e.g., alliance quality) and treatment outcomes (Constantino, Arnow, Blasey, & Agras, 2005; Devilly & Borkovec, 2000; Meyer et al., 2002).

Unfortunately, at this time the literature is lacking psychometrically sound measurements of treatment outcome expectations. However, with respect to role expectations, the Psychotherapy Expectancy Inventory—Revised (PEI-R) is a psychometrically robust measure that has been used in a variety of settings, including training facilities and outpatient and inpatient facilities (Bleyen, Vertommen, Vander Steene, & Van Audenhove, 2001; Berzins, Herron, & Seidman, 1971; Rickers-Ovsiankina, Geller, & Berzins, 1971).

The PEI-R (Berzins et al., 1971) was conceived as representing four separate role- expectation factors characterizing the client's

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expectations of the roles that he or she and the therapist will assume during treatment, including approval-seeking, advice-seeking, audience-seeking, and relationship-seeking. These pre-therapy expectations about the “rights, obligations, and “appropriate” behaviors” (Rickers-Ovsiankina et al., 1971, p. 124) of the client and therapist during treatment may represent the client’s early commitment to therapeutic change and, by extension, the therapeutic alliance. An example of an item measuring approval is “How strongly do you expect to be concerned with how you appear to your therapist,” while an example of an item measuring advice is “How strongly do you expect to get definite advice from your therapist.” Similarly, an example of an item measuring audience is “How strongly do you expect to feel like opening up without any help from your therapist,” and an example of an item measuring relationship is “How strongly do you expect to be comfortable in expressing your feelings toward the therapist” (Bleyen et al., 2001, pp. 80–81). However, more recently Bleyen et al. (2001) noted that a five-factor model that included a latent construct for impression-seeking (e.g., “How strongly do you expect to be concerned with the impression you make on your therapist”) was a significantly better fit (four-factor model, CFI 0.87; five-factor model, CFI = 0.99) upon confirmatory factor analysis than was the original four-factor model.

Internal consistency (ranging from  $\alpha = .75$  to  $\alpha = .87$ ) and test–retest reliability (ranging from  $r = 0.54$  to  $r = 0.68$  for an interval of 1 week and from  $r = .56$  to  $r = 0.76$  for an interval of 4 weeks) for each subscale have been reportedly relatively high for the four-factor model (Berzins et al., 1971; Rickers-Ovsiankina et al., 1971). Reliability of the five-factor model has also been reported to be reasonable using Gultian item analysis with  $\lambda_2$  values ranging from 0.67 to 0.89. Indeed, Arnkoff, Glass, and Shapiro (2002) concluded that the PEI–R was a unique measure of role expectations in that it demonstrated good psychometric properties, whereas most measures of expectancies have poor psychometric properties, typically being only single-item measures. Overall, the PEI–R is thought to be reliable and valid in several contexts, but most notably to the following study, it has been used within a training environment. However, as was stated previously, a reference range for normative expectancies on the PEI–R has never been computed and the measure’s practical, clinical utility has thus far been rather limited as a result.

#### Salience of Expectancies to the Training Clinic Environment

The prevalence of premature termination is widely reported to fall between 40% and 60% (e.g., Clarkin & Levy, 2003; Garfield, 1994; Wierzbicki & Pekarik, 1993), with approximately 30% of treatment attrition observed after the very first session (Garfield, 1994; Hansen, Lambert, & Forman, 2002). Unfortunately, there is some indication that premature termination may be a greater concern within training clinics with as many as 77% of clients terminating prematurely (Callahan et al., in press). Furthermore, it has been reported that approximately 11% to 14% of the variance in premature termination within a training clinic environment may be accounted for by client pretreatment expectancies (Callahan et al., in press). In that study, as well as in the present investigation, attrition was defined as a disruption in the planned course of treatment, including any unplanned termination of treatment (e.g.,

just stopped going) or termination by the client that was against the clinician’s advice. Conversely, termination initiated by the therapist or via mutual agreement was not considered attrition. One method of reducing attrition that has been well documented is to address role expectations prior to treatment (e.g., Orlinsky, Grawe, & Parks, 1994; Scamardo, Bobele, & Biever, 2004; Walitzer et al., 1999; Zwick & Attkisson, 1985). Thus, it appears that prospectively identifying training clinic clients at risk for attrition so that client expectancies can be addressed might be one method of improving psychotherapeutic services within training clinics.

#### Potential Impact on Training of Students

Aside from potentially improving psychotherapeutic services within training clinics, identifying clients at risk for attrition might also be a means of improving training. High attrition may limit a trainee’s exposure to learning opportunities that foster acquisition of skills and competencies uniquely associated with middle or late stage treatment (Spruill et al., 2004). Similarly, students might be able to build their skills and also enhance treatment retention by learning to measure expectancies with clients at intake. Furthermore, when a client demonstrates expectations that fall beyond a normative reference range, it can provide the trainee with an opportunity to learn how to discuss different types of role expectancies and also to learn how to assist clients in modifying their expectations to be more congruent with what is likely to happen in the subsequent course of treatment (Reis & Brown, 2006). In summary, prospective identification of clients at risk for attrition could allow for several unique training opportunities for students and improve the quality of care for clients seen in training clinics.

#### The Current Study

The present study sought to accomplish several goals. In addition to bridging a gap in the existing literature by examining the internal consistency of subscales according to both the four-model and five-model conceptualizations of the PEI–R, this study sought to enhance the utility of the PEI–R in the training clinic by developing a normative reference range for the PEI–R scales. This study also sought to identify whether the use of such normative reference ranges might allow the PEI–R to serve as a good prospective method for identifying new training clinic clients who are at risk for subsequent treatment attrition.

#### Method

##### Setting

The training clinic serves as a year-round outpatient facility for members of the community as well as for students. Student clients are not afforded psychotherapy discounts, but rather, all charges are assessed on a sliding fee scale. No incentives were provided to any clients in exchange for participation in this study. Cognitive–behavioral therapy is the principal therapeutic modality within the clinic and trainees may begin providing services near the end of their first year of doctoral training. This practicum experience is contingent upon the successful completion of coursework in psychopathology, assessment, and psychotherapy and experience in conducting semistructured intake interviews. All trainee clinicians are supervised by tenure-track program faculty and are required to

meet no less than 1 hour per week for individual supervision and 2 hours per week for group supervision with other trainees. As a result, the course of treatment and case disposition results from a process in which the trainee and supervisor work collaboratively, reflected by a joint termination summary signed by both the trainee and the supervisor of the case.

### Clinicians

Although not direct participants in this study, general characterization of trainees within the training program may be useful in the interpretation of the current study. All clinicians were students enrolled in an American Psychological Association-accredited clinical psychology, scientist-practitioner doctoral program that emphasizes evidence-based practice. Previous data collected from this site indicate that the average age for a trainee in the program is 26.57 years of age ( $SD = 5.53$ ) and that they are typically female (63%), are Caucasian (70.4%), and began the program with a B.S. or B.A. degree (87.5%).

### Participants

Data were gathered from consecutively presenting adult clients ( $N = 53$ ) and ranged in age from 18 to 51 years of age ( $M = 26.49$ ,  $SD = 9.03$ ). The majority of participants were female (56.6%) and Caucasian (82.7%). Other ethnicities represented in the sample included Native American (1.9%), Hispanic American (5.8%), Asian American (5.8%), and multiracial (3.8%). The average income of this sample was \$20,576.17 annually, with a mode of \$10,000 annually. Most of the participants presented with symptoms consistent with anxiety or mood disorders, as conceptualized by the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000).

More specifically, 49.0% met diagnostic criteria for a mood disorder (e.g., major depression and bipolar disorder), 32.7% for an anxiety disorder (e.g., posttraumatic stress disorder, generalized anxiety disorder, and panic disorder), 6.1% for an impulse control or attention disorder (e.g., attention deficit/hyperactivity disorder and gambling), 2.0% for a substance-related disorder (e.g., alcohol and drugs), 2.0% for psychosis or schizophrenia, 2.0% for a health-related disorder (e.g., somatoform), and 4.1% of participants had deferred or no diagnoses. The semistructured intake interview routinely used in the clinic did not assess Axis II symptoms, and therefore the prevalence rate of personality disorders could not be determined. Additionally, only primary diagnoses were recorded, prohibiting calculation of the frequency of comorbid diagnoses. Although standardized reliability ratings were not available for assessing diagnostic reliability, each intake was supervised by a clinical faculty member within the department who provided feedback about diagnostic conceptualization after reviewing the client's intake information, discussing the case with the trainee, and/or watching the taped or live intake directly.

In addition to the semistructured diagnostic interview, self-report measures including the Beck Anxiety Inventory (BAI; Beck & Steer, 1993) and Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996) were administered at intake. The mean BAI score fell in the moderate range ( $M = 20.63$ ,  $SD = 12.29$ ), and the mean BDI-II score fell in the moderate to severe range ( $M = 22.73$ ,  $SD = 11.68$ ), consistent with normative data obtained in previous

clinical samples (Beck, Epstein, Brown, & Steer, 1988). Point biserial correlations between the scores on these measures with the categorical variable of termination status were nonsignificant.

Consistent with recent reports (Callahan et al., in press), a high rate of premature termination was observed in the training clinic ( $n = 36$ ; 67.92%). Of those, 32 clients simply stopped attending sessions without discussing termination with their clinician (mean length of treatment: 2.94 sessions; range: 1 to 10 sessions); 4 clients shared with their clinician a desire to discontinue treatment and ultimately terminated treatment against clinician advice (mean length of treatment: 4.75; range: 1 to 9 sessions). The average length of treatment for clients who terminated treatment following mutual agreement with the trainee clinician was 10.57 sessions (range: 2 to 22 sessions).

### Measures

*Psychotherapy Expectancy Inventory—Revised (PEI-R)*. The PEI-R was designed to assess counseling behavior expectations among clients seen in university-based student counseling centers (Berzins et al., 1971; Rickers-Ovsiankina et al., 1971), but it has more recently been described as a measure of role expectations and found to be useful in various settings, including a Flemish inpatient sample (Bleyen et al., 2001). Clients required approximately 5–10 minutes to respond to each of the 24 expectancy items using a Likert-style scale ranging from 1 (*not at all*) to 7 (*very strongly*). As was noted at the beginning of this article, there has been a relatively recent study challenging the four-factor structure of the PEI-R, suggesting that a five-factor conceptualization may be a better fit statistically (Bleyen et al., 2001). Both the four-factor and five-factor models include the following constructs: approval seeking, advice-seeking, audience-seeking, and relationship-seeking. However, the five-factor model also includes the construct of impression-seeking. The actual composition of the scales is largely similar across the two models. In the four-factor model, the scales are composed as follows: approval seeking (items 1, 5, 7, 9, 10, and 18), advice-seeking (items 13, 14, 15, 17, 21, and 24), audience-seeking (items 6, 12, 16, 19, 22, and 23), and relationship-seeking (items 2, 3, 4, 8, 11, and 20). In the five-factor model, items 9, 10, and 18 are removed from the audience-seeking factor to create an additional factor reflecting impression-seeking. The only other difference is that in the five-factor model, item 6 loads on the relationship-seeking factor.

*Beck Anxiety Inventory (BAI)*. The BAI (Beck & Steer, 1993) is a brief self-report instrument with high internal and test-retest reliability that measures severity of anxiety, particularly those symptoms that are minimally shared with depressive disorders. The BAI demonstrates acceptably strong correlations with other established measures of general anxiety (e.g., Hamilton Anxiety Rating Scale—Revised;  $r = .51$ ) as well as measures of both state (e.g., State-Trait Anxiety Inventory, Form Y—State scale;  $r = .47$ ) and trait (e.g., State-Trait Anxiety Inventory, Form Y—Trait scale;  $r = .58$ ) anxiety (Beck & Steer, 1993).

*Beck Depression Inventory II (BDI-II)*. The BDI-II (Beck et al., 1996), a 21-item, self-report measure of common depressive symptoms, was also administered. The BDI-II is reported to have excellent internal reliability and test-retest reliability with outpatient samples according to the measure's authors. In addition, scores on the BDI-II correlate highly with other established mea-

asures of depression (e.g., Hamilton Rating Scale for Depression,  $r = .47$ ).

*Procedure*

For a period of 1 training year (12 months), all help-seeking adults presenting to the clinic for intake services were asked to complete the PEI-R, BDI-II, and BAI via paper-and-pencil prior to participating in a semistructured intake session and the initiation of a course of treatment. Participation was voluntary, included consenting specifically to this study, and receipt of clinic services was not dependent upon participation. No individuals refused participation, though one individual did discontinue participation without completing the measures. This participant was thoroughly assessed and debriefed, and the participant reported that his or her distress was a function of an increased focus on his or her decision to initiate therapy.

After the conclusion of treatment, the termination summary for each client was accessed, and the reason for termination, as provided by the trainee clinician and supervisor in the termination summary, was recorded. All participants and their data were treated in accordance with the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association, 2002) and the university's Institutional Review Board.

**Results**

*Preliminary Analyses*

The preliminary analyses focused on evaluating the basic psychometric properties of the PEI-R in the training clinic setting. This included investigation of internal consistency, examination of possible group differences as a function of client demographics (e.g., gender, age, and income), and the relationship between the PEI-R and symptom severity, as is measured by the Beck Depression Inventory (BDI-II; Beck et al., 1996) and Beck Anxiety Inventory (BAI; Beck et al., 1988).

Given that the existing literature posits both a four-factor model and a five-factor model of the PEI-R, internal consistency for the scales associated with each model was computed. For both models, internal consistency of the scales was found to be good, with the exception of the Approval scale. In the four-factor model, alpha coefficient values were 0.72 for Approval, 0.87 for Advice, 0.83 for Audience, and 0.86 for Relationship. In the five-factor model, the alpha coefficients were 0.25 for Approval, 0.83 for Impression, 0.87 for Advice, 0.81 for Audience, and 0.89 for Relationship. For the PEI-R total score, internal consistency was excellent ( $\alpha = .90$ ). Given the poor reliability of the Approval scale in the five-factor model, the four-factor model was used for hypothesis testing (total:  $M = 105.83$ ,  $SD = 20.47$ ; Approval,  $M = 25.94$ ,

$SD = 6.56$ ; Advice,  $M = 28.40$ ,  $SD = 7.42$ ; Audience,  $M = 22.34$ ,  $SD = 6.90$ ; and Relationship,  $M = 29.15$ ,  $SD = 6.54$ ).

Using the four-factor model independent-samples *t* tests, with Bonferroni adjustment ( $\alpha = .01$ ), revealed no significant gender differences on PEI-R scores (see Table 1). Furthermore, bivariate correlations revealed no statistically significant relationships between PEI-R scores and age, income, or symptom severity at intake, as measured by the BDI-II or BAI (see Table 2).

*Primary Analyses*

The primary analyses centered on investigating the utility of the PEI-R as a tool for predicting attrition in the training clinic environment. To that end, reference ranges depicting normative expectations on the basis of the PEI-R total and scale scores, using the four-factor model, were developed and then tested for clinical utility using Bayesian analyses.

The reference ranges were established by setting the lower and upper limits at the values falling 1 standard deviation from the mean score for each scale. Thus, the normative reference ranges for the PEI-R scores were as such: 85.36–126.30 for the total score, 19.38–32.50 for Approval, 20.98–35.82 for Advice, 15.44–29.24 for Audience, and 22.61–35.69 for Relationship. Among those obtaining scores beyond the upper limit of the normative reference range, the mean scores were as follows: total,  $M = 135.63$ ,  $SD = 7.17$ ; Approval,  $M = 35.86$ ,  $SD = 1.95$ ; Advice,  $M = 38.83$ ,  $SD = 2.23$ ; Audience,  $M = 31.60$ ,  $SD = 2.07$ ; and Relationship,  $M = 40.00$ ,  $SD = 2.28$ . Conversely, for those below the lower limit of the normative reference range, the mean scores were as follows: total,  $M = 70.88$ ,  $SD = 11.52$ ; Approval,  $M = 17.13$ ,  $SD = 2.47$ ; Advice,  $M = 14.83$ ,  $SD = 2.93$ ; Audience,  $M = 10.14$ ,  $SD = 2.54$ ; and Relationship,  $M = 16.86$ ,  $SD = 2.97$ .

Using the reference ranges we established yielded good specificity (total = 0.93, Approval = 0.80, Advice = 0.87, Audience = 0.73, and Relationship = 0.87) in identifying those clients who subsequently prematurely terminated their course of psychotherapy. Stated another way, a score outside the normative range (either above or below) on the PEI-R scales is likely to correctly identify persons with role expectations that are incongruent with those that contribute to successful completion of a course of psychotherapy. This pattern seems especially salient for the PEI-R total scores and the scales measuring Advice and Relationship expectancies.

Nevertheless, as a population measure, specificity is difficult to interpret at the individual level. This is unfortunate since the typical clinical scenario is for use at the individual level directly at the time that services are provided. As a result, likelihood ratios were computed with Bayesian analyses, which allows for use directly at the individual patient level.

Table 1  
*Comparison of Psychotherapy Expectancy Inventory—Revised Scores by Gender*

Gender	Total score		Approval		Advice		Audience		Relationship	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Female	105.00	20.43	26.10	6.40	27.30	7.65	22.50	7.20	29.10	5.67
Male	106.91	20.93	25.74	6.90	29.83	7.02	22.13	6.64	29.22	7.67

Table 2  
*Comparison of Psychotherapy Expectancy Inventory—Revised Scores to Demographic and Symptom Severity Variables*

	Total		Approval		Advice		Audience		Relationship	
	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>	<i>r</i>	<i>p</i>
Age	0.09	0.51	-0.20	0.15	-0.01	0.96	0.27	0.06	-0.20	0.15
Income	0.01	0.93	-0.06	0.67	-0.07	0.63	0.13	0.34	-0.06	0.67
BDI-II	-0.01	0.96	-0.02	0.92	0.15	0.31	-0.16	0.27	-0.002	0.99
BAI	-0.12	0.38	0.01	0.93	0.03	0.84	-0.23	0.10	-0.19	0.19

Note. BDI-II = Beck Depression Inventory II; BAI = Beck Anxiety Inventory.

The positive likelihood ratios for the PEI-R were found to be 7.20 (total), 2.40 (Approval), 3.00 (Advice), 1.20 (Audience), and 3.30 (Relationship), while the negative likelihood ratios were found to be 0.56 (total), 0.65 (Approval), 0.69 (Advice), 0.93 (Audience), and 0.65 (Relationship). As an example using the PEI-R total score, given a clinical range score (any score outside of the established normative reference range of 85.36–126.30) on the PEI-R, the likelihood that an individual presenting to the training clinic will prematurely terminate therapy is over seven times greater than it is for individuals who obtain scores within the normative range. This pattern was most prominent with regard to the PEI-R total score, Advice score, and Relationship score.

### Discussion

Results from this investigation reveal that the PEI-R, when administered at intake, is an excellent measure for prospectively identifying clients who are at increased risk for subsequent attrition from treatment in the training clinic. Using Bayesian analyses, it was determined that the likelihood an individual presenting to a training clinic will prematurely terminate therapy is several times greater than it is for individuals who obtain scores outside the established normative ranges on the PEI-R scales. Most notably, a client obtaining a score outside of the established normative range for the total score was seven times more likely to subsequently prematurely terminate treatment. Given the impressive performance of the PEI-R in this study, the potential benefits to be derived from routinely using this measure in training clinics appear to be quite high.

First, decreasing the rate of attrition is beneficial to clients, given that the efficacy and effectiveness of psychotherapy has been well established (e.g., Lambert & Ogles, 2004; Wampold, 2000). If clients likely to attrite are prospectively identified, strategies for enhancing the likelihood of treatment continuation can then be used. Fortunately, several ways in which a clinician might attempt to modify client expectations have already been explicated in the literature to assist trainee clinicians and their supervisors (Glass, Arnkoff, & Shapiro, 2001; Greenberg, Constantino, & Bruce, 2006; Tinsley & Bowman, 1988).

Second, if the PEI-R were used to predict non-normative expectations linked to attrition, then students could be instructed on several fundamental knowledge areas or competencies related to psychotherapy: (a) understanding the construct of expectancies, (b) understanding the relationship of expectancies to outcome, (c) learning how to measure expectancies, (d) learning how to use a normative reference range for identifying individuals at risk for

attrition, (e) learning how to discuss expectancies with clients, and (f) learning how to help clients alter their expectations to be more congruent with what can realistically be expected in therapy.

### Limitations and Suggestions for Further Research

Although this study indicates the potential for excellent PEI-R clinical and training utility, several limitations within the current study are noteworthy. First, replication is encouraged because of the preliminary nature of this investigation, the limited sample size ( $n = 53$ ), and the absence of a direct measure of unmet expectations during or following the course of treatment. Second, the clients and therapists within the study were relatively homogeneous with regard to sociodemographic variables (including ethnicity), thereby bringing into question the generalizability of the present findings. Having said this, we appreciate the possibility that training clinics might typically be homogeneous on these variables, in which case the current findings might be quite generalizable. A study characterizing training clinic clients and trainees on these variables would be a useful contribution to the literature. Third, other variables would be worthwhile to address in subsequent replications (e.g., treatment history and diagnostic comorbidity). Fourth, follow-up investigation to examine whether routine use of the PEI-R, with in-session follow-up for those clients who obtain scores outside of the normative reference range, is an effective means of reducing client attrition and enhancing trainees skills in the areas noted above would be helpful. Such a study could also shed light on whether the influence of expectations on treatment engagement may be curvilinear (i.e., too low or too high as risk factors for attrition). Fifth, analyses to examine whether client expectancies might interact with treatment variables in predicting attrition would be very helpful. Such analyses were not possible in the present study because of the vast majority of clients receiving the same treatment (i.e., cognitive-behavioral therapy) and the lack of treatment fidelity measures. More broadly, there is also a need for additional explorations of other types of expectations (e.g., effectiveness expectations) within this population.

With one exception, the Approval scale, the internal consistency values of the PEI-R subscales in the training clinic sample were relatively high and the total score internal consistency was excellent. The strikingly low internal consistency of the Approval scale in the five-factor conceptualization may suggest that a four-factor conceptualization of the PEI-R measure is superior. More specifically, the addition of the fifth factor, Impression-seeking, led to a decrease in the number of items (from six to only three) contributing to the Approval factor. The items that no longer loaded on

the Approval factor, using a five-factor conceptualization, included, "How strongly do you expect to be concerned with the impression you make on your therapist," "How strongly do you expect to please your therapist," and "How strongly do you expect to be concerned with how you appear to your therapist." With only three items remaining on the scale, reduced reliability is perhaps not surprising. Furthermore, the approval and impression constructs are so similar in content that separating them may not be conceptually beneficial. Further research may wish to reexamine the factor structure of the PEI-R.

Aside from such psychometric or theoretical explanations for the low Approval scale reliability, another possible explanation is that there may be a difference between client approval-seeking behaviors within a training environment in comparison to other environments (e.g., the inpatient setting of Bleyen et al., 2001). For example, clients presenting to a training clinic may not regard trainees as established professionals and consequently hold different expectations regarding approval from their clinician. They may, for example, possess lower expectations regarding their therapist's ability to express approval. In the present study, a very slightly lower mean approval score was observed in comparison with that in the Bleyen et al. (2001) sample ( $M_{\text{Training}} = 25.94$ ,  $M_{\text{Inpatient}} = 26.96$ ), which used professional clinicians rather than trainees.

Additionally, although small, several client variables differ between the current study and that of Bleyen and colleagues (2001), including the gender distribution (56.6% female in a training clinic and 51% female in an inpatient sample), age ( $M_{\text{Training}} = 26.49$ ,  $M_{\text{Inpatient}} = 31.97$ ), and diagnostic conceptualization (e.g., the training clinic had a greater proportion of anxiety and impulse control disorders and a lower percentage of substance-related and sexual disorders). More notably, a meaningful difference in symptom severity may be inferred from clients admitted into an inpatient facility versus those in an outpatient facility and clear cultural and regional differences based on the location of the samples (e.g., a Flemish psychiatric hospital vs. a U.S. training clinic) may contribute to differences in expectations. However, it is still highly speculative as to why approval expectations may be impacted to a greater degree by such variables than would other types of expectations. Examination of the factor structure within a training clinic setting might therefore be particularly informative. Additionally, these findings imply that further examination of cultural and sociodemographic differences in expectations could be beneficial.

There were no statistically significant relationships between scores on the PEI-R (using a four-factor conceptualization) and gender, age, income, or intake symptom severity (as measured by the BDI-II or BAI). Bleyen et al. (2001) also reported no statistically significant relationship between expectations (using a four-factor conceptualization) and age, prior experience, education level, or marital status. However, Bleyen et al. (2001) found gender differences with regard to the Audience and Relationship scales such that female participants had higher expectations than did male participants. This finding was not replicated in the current sample, and overall, it appears that the PEI-R may be used with a broad range of presenting clients. An explanation for this nonreplication may include the much smaller sample size ( $n_{\text{Training}} = 53$ ,  $n_{\text{Inpatient}} = 159$ ) or the abovementioned sample differences. An investigation of expectations within a larger and more culturally and sociodemographically diverse training clinic sample could be useful in exploring these competing hypotheses.

More broadly, an additional potential future line of inquiry might be to disentangle the relationship between different elements of the therapeutic alliance, assorted client expectations, and diverse treatment outcomes. There has been an abundance of literature documenting the strong relationship between client expectations and therapeutic alliance (Dew & Bickman, 2005) and also between the therapeutic alliance and treatment outcome (Dozier, Cue, & Barnett, 1994; Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Martin, Garske, & Davis, 2000; Tyrell, Dozier, Teague, & Fallo, 1999). More recently, studies indicate that these three variables may be interrelated with therapeutic alliance serving as a mediator between client expectancies and treatment outcome (Abouguendia, Joyce, & Piper, 2004; Gaudiano & Miller, 2006; Joyce, Ogradniczuk, Piper, & McCallum, 2003). Given the clearly salient role that client role expectations have in predicting premature termination in the training clinic, such clinics may serve as especially good settings to investigate the specific nature of the relationships among expectancies, alliance, and treatment outcome. Aside from research purposes, because of the high clinical and training utility indicated by the present findings, training clinics are encouraged to routinely administer the PEI-R as a means of identifying individuals at risk for attrition and identifying non-normative role expectations that need to be addressed at the start of treatment.

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Received February 28, 2008

Revision received September 26, 2008

Accepted October 14, 2008 ■