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Table of Contents

Departments

Articles

Perry C. Francis, Ed.D., Editor
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Department of Leadership & Counseling
& College of Education Clinical Suite

From the Editor

The purpose of any academic journal on the state level is, in my opinion, twofold; to add to the body of knowledge of the profession, and to offer useful, relevant, and practical information to the membership of the state association. Due to the miracle of modern technology and the foresight of the leadership of the Michigan Counseling Association, our journal is also available beyond our borders through an agreement with EBSCO, an electronic journal database. We can say with some amount of pride that our journal is available to the entire profession through our publisher. In this way, our small association is adding to the body of knowledge of the mental health profession. It is our hope and goal that we produce a quality product that is worthy of such distribution.

This edition contains three articles that offer information for school counselors, college counselors, and those professionals who work in the community providing group therapy. Each of the articles went through numerous reviews and revisions to insure the information offered was accurate, relevant, and practical. The first article seeks to offer insight on adolescent sexual behavior and its correlation to parental views of premarital sex. This is important information given the impact of teen pregnancy on the future educational and life goals of the children involved. Bryant & Nicolas, authors of our second article, review the results of their study on differences between first-generation college students and continuing-generation college students as it relates to college exploration, application, and decision-making. Finally, Hollenbaugh reviews the treatment compliance literature in group therapy and offers insights into raising compliance and improving interventions.

As always, I am indebted to my editorial review board for their willingness to read, reread, and offer direction to our authors to insure our membership and profession receives a quality journal. And finally, my thanks to the unsung hero of the journal, Christina Barbara, my editorial assistant who reads, corrects, and formats the journal for production.

Individual and Family Correlates of Adolescents' Sexual Behavior: Multiethnic Findings

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Abstract

The purpose of this study was to examine correlates of adolescent sexual activity, including age of first date, family composition, clarity of long term goals, and maternal and paternal views about premarital sex. There were 672 males and females, three races/ethnicities, both urban and suburban settings, and socioeconomic diversity. Sexual behavior was most related to parental views about premarital sex, adolescents' own values toward premarital sex, clarity of adolescents' long term goals, and the age when adolescents first learned about sexual intercourse. Important implications for sex education are discussed. Potential intervention variations by gender and race/ethnicity should be considered.

Correlates of Adolescents' Sexual Behavior: Multiethnic Findings

Adolescence is a time of exploration of one's own limits. Currently many teenagers discover their own boundaries through risky sexual behaviors. The price for early onset of sexual activity is high; each year over one million teenagers become pregnant and over four million receive the diagnosis of a sexually transmitted disease (STD) (Centers for Disease Control and Prevention, 2006). Additionally, those adolescents that have been victims of sexual abuse are at greater risk of these problems and others, including anxiety and depression (for review, see Saewyc, Pettingell, & Magee, 2003). HIV diagnosis due to sexual contact is reported as early as age 13 among teenagers in the USA, with the highest prevalence rates among ethnic minorities such as Hispanics and African Americans (Centers for Disease Control and Prevention, 2009). Only 50% of teen mothers receive their high school diploma by age 22 (Perper, Peterson, & Manlove, 2010), making pregnancy a significant contributor to high school dropout. The purpose of this study was to examine the contri-

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butions of potential individual and family correlates to risky sexual behaviors with a multiethnic sample, while considering the role of both parents separately. Specifically, the researchers looked at the relations between sexual attitudes, sexual behaviors, dating patterns, family composition, clarity of long-term goals, parental views, religious beliefs, and timing of education on sexual intercourse. For the current study, the frequency of sexual intercourse and age of first sexual intercourse were selected as the sexual behaviors of interest.

Impact of Parental Communication on Adolescents' Sexual Health Values by Race and Gender

Most adolescents report that their main sources of sex education are their parents (Lefkowitz, Sigman, & Au, 2000; Ream & Savin-Williams, 2005). Amount and quality of family discussions are positively correlated with teenagers' conservative attitudes toward sex (Fiese et al., 2002), although other studies stress the interactional nature of the relations (Coley, Drzal, & Schindler, 2009). For example, adolescents were shown to communicate about sexuality more when they had positive relationships, as well as a higher frequency of shared activities, with their parents (Muller, Frisco, & Pearson, 2006). Wyckoff et al. (2008) showed that teenagers with parents who communicated openly about sex were more likely to have fewer sex partners, use contraception, and postpone their sexual debut. Others have found very small relations between parent-adolescent sexual communication and adolescent sexual behavior (Somers & Vollmar, 2006).

Variations in communication style and the resulting values adolescents may hold about their sexual health behaviors have been found by race and gender, although the research is sparse in this specific domain and often examines mother-daughter communication only. For example, Dittus, Jaccard, and Gordon (1999) found that African-American teenagers held values similar to their mothers' views. Additionally, Somers and Fahlman (2001) found that Caucasians communicated in the least direct manner compared to other ethnic groups, while Hispanic-American parents are more direct in communicating their values to their sons and daughters (Somers & Fahlman, 2001). Wyckoff et al. (2008) indicated that both females and males communicate about sex with their mothers more than their fathers even though boys do so more with their fathers than do girls. At the same time, teens who communicated more with mothers held the most conservative values (DiIorio, Kelley, & Hockenberry-Eaton, 1999). Another study revealed that mothers' communications are more associated with daughters' than sons' outcomes (Ballard & Morris, 1998); however, other studies have found fathers to have a stronger role in teenagers' sexual activity than previously thought (Ohalete, 2007; Moore & Chase-Lansdale, 2001).

In terms of adolescent willingness to engage in sexual health communication, it has been reported that female adolescents communicate more directly with their mothers than with their fathers (Somers & Gleason, 2001). Also, the mothers' values were significantly more related to teenager's attitudes toward sexuality (Regnerus, 2005). Most notably, adolescents had a lower rate of risky sexual behaviors (this includes all sexual activity that could pose a risk to the

teenager or their partner to become pregnant and/or transmit an STD) when they understood that their maternal guardian disapproved of premarital sex (Dittus, Jaccard, & Gordon, 1999). Thus parents' attitudes do affect the adolescent's sexual choices (Moore & Rosenthal, 1991; O'Sullivan, Meyer-Bahlburg, & Watkins, 2001).

In terms of racial differences and their impact on a teenager's sexual frequency and age of first sexual debut, non-Hispanic males are more likely to use condoms and initiate sexual activity later in life than are Hispanic-American males (Upchurch et al., 2001). Furthermore, Hispanic-American females are more likely to become pregnant earlier in life than any other American female (Solorio et al., 2004). Disparities in the amount of correct sexual knowledge parents held were also found for this ethnic minority (Gallegos, Villarruel, & Gomez, 2007). Clearly there is a compounded effect between minorities living in less advantaged neighborhoods, as the majority of Caucasian-Americans live in middle class households. Often individuals have a mixture of correlates, such as low academic achievement, low socioeconomic status, and poor job availability, which frequently may lead to pregnancy as the most dependable option (Coley & Chase-Lansdale, 2000).

Impact of Adolescents' Family Composition, Goal Setting, and Religious Beliefs on Sexual Health Behaviors

Family composition has been explored for its relations with sexual development. Single parent homes were related to permissive adolescent sexual behavior (Browning, Leventhal, & Brooks-Gunn, 2004). Similarly, living without both biological parents was found to be associated with an earlier onset of a teenager's sexual debut (Miller, 2002). Furthermore, other studies indeed support that adolescents raised in non-intact families were involved in more premarital sexual activity (Flewelling & Bauman, 1990; Furstenberg & Teitler, 1994; Kieman, 1992; Ellis et al., 2003). Thus, living in a single parent home or with a caretaker other than their biological parents could pose a significant risk in itself for the teenager to initiate premature sexual activity.

Adolescents' personal variables have also been explored. Of specific interest for this study was the adolescents' own clarity of long-term goals, a variable rarely addressed in former research. Research shows that adolescents with few aspirations for future goals are more likely to be drawn to deviant peer groups, which in return exposes them to high risk behaviors (DiBlasio & Blenda, 1994; Bogaert et al., 2008). In contrast, adolescents who have high personal goals and a strong desire for academic achievement tend to avoid behaviors that will interfere with their future goals (De Gaston, Weed, & Jensen, 1996; Bandura et al., 2003).

Other potential personal correlates of sexual activity include adolescents' own religious beliefs. For instance, Jones, Darroch, & Singh (2005) have shown that when religion is a significant part of teenagers' lives they are more likely to hold conservative sexual attitudes. Also, the social integration and support available through interaction with members of a religious community may serve to solidify acceptable sexual behaviors (Ellison & Levin, 1998; McMillen et al., 2011). Religiosity may therefore be related to delayed sexual debut and

more responsible sexual behaviors (Rostosky et al., 2004).

Clearly there are many variables that contribute to adolescent sexual development, and most of them have been studied in isolation or in small combinations. The purpose of this study was to simultaneously understand a variety of potential correlates of adolescents' age of first sexual intercourse and frequency of current sexual intercourse, while using a large, multiethnic sample including reports about both parents. A particular strength of this study is that it separately addressed the roles of mothers and fathers on the teenagers' sexual activity level. The specific research questions were: 1) Does age of first date correlate with age of first sexual intercourse? 2) Does age of first sexual intercourse vary by family composition (e.g., two-parent versus single-parent families)? 3) Do teenagers' clarity of long-term goals vary by their current frequency of sexual intercourse? 4) Are adolescents' sexual behaviors correlated with whether or not they know what each of their parents think about premarital sex and each parent's approval of premarital sex? 5) Can adolescents' abstinence/ sexual intercourse status, age of first sexual intercourse, and frequency of sexual behavior be predicted by a combination of key variables (clarity of long term goals, parents' values, sexual attitudes, age of first education about sexual intercourse)? 6) What role do religious beliefs play in adolescents' decisions to remain abstinent?

Method

Participants

Participants in this study came from a sample of 672 American adolescents (231 males, 413 females, 28 unreported) in the 9th (n=178), 10th (n=126), 11th (n=192), and 12th (n=151) grades (n=25 unreported). The mean age was 15.97 (SD=1.26). The ethnic breakdown was 204 African-American, 181 Caucasian, 183 Hispanic-American (primary Mexican-American), and 104 others. Most Caucasian students came from a primarily middle socioeconomic status (SES) suburban area high school, and most minority students were sampled from two urban primarily low SES area high schools of a large mid-western city. This was done in order to obtain diversity in the sample. For data analysis purposes, the urban low SES group was divided into two subgroups based upon which school they attended. One was a mixed-race public high school (primarily Hispanic and African-American) and the other was a primarily African-American public high school for pregnant and/or parenting females only. In all three subgroups (middle-SES, Caucasian, suburban; low-SES, mixed race, urban; and low-SES, African-American females, urban), the age range and dispersion were approximately even.

Measures

Questionnaires included a measure of sexual attitudes, sexual behaviors, family composition, and clarity of long-term goals, parental views, religious beliefs, dating patterns, and timing of education on sexual intercourse.

Sexual attitudes. Adolescents' sexual attitudes and goals were measured using three subscales from the Mathtech Attitude and Value Scales: Attitudes Toward Premarital Intercourse (Kirby, 1990). A five-item scale was used to assess adolescents' sexual attitudes (e.g., "Unmarried people should not have sex"). For all items, adolescents responded using the same five-point

scale (1=Strongly Disagree, 5=Strongly Agree). In Kirby's (1990) samples, Cronbach's alpha coefficients were .94 for boys and .73 for girls. The current study yielded alphas of .88 and .62, respectively.

Because the Pearson correlation coefficient shrinks artificially due to a small number of items, a correction procedure was used for the girls' personal sexual values alpha. The Spearman-Brown Prophecy formula demonstrates what the reliability of the instrument would be if additional similar quality items were added to the scale. In this case, the Spearman-Brown Prophecy Formula projected internal consistency, assuming the total number of items per subscale was 10 (a more typical number of items for subscales of this type) and yielded an alpha of .77.

Sexual behaviors. Adolescents responded on a five-point scale to reveal how frequently they have engaged in sexual intercourse in the past year (ranging from "never" to "daily"). Higher scores represented greater frequency of sexual intercourse. Age of first sexual intercourse and sexual intercourse status (abstinent vs. not abstinent) were also assessed.

Adolescents' religious beliefs. If participants stated that they were not sexually active, they were asked to check one of eight reasons for their sexual inactivity. Religious beliefs were one of the eight possibilities. From this, a dichotomous "religious beliefs" variable was created, with adolescents either checking or not checking "religious beliefs" as a reason for avoiding sexual intercourse.

Age of first education about sexual intercourse. Teenagers were asked at what age/what grade that they were in when they were first taught about sexual intercourse.

Family composition. Family Composition was explored by asking the teenagers, "With whom do you live now?" Adolescents were told to mark all people that currently lived in their household (ranging from step-father to grandmother). Teens were categorized as living with a single parent, two parents, or one parent and another caregiver.

Clarity of long-term goals. Students were asked five questions on a five point scale, which focused on the teenagers' attitudes towards their sexuality and their long-term goals. The scale ranged from "strongly disagree" to "strongly agree."

Parental attitudes about premarital sex. Adolescents' perceptions of their parents' attitudes about premarital sex were assessed. Mothers and fathers (or similar parental figures) were assessed separately. The adolescents were asked whether or not they know their mothers'/fathers' view about premarital sex, and further on filled in detailed questions of about those views. Adolescents were told to answer about a parent or a parent-figure — it did not necessarily have to be a biological parent. The options for each of their father's and their mothers' views were presented on a 4-point scale. Options ranged from "she thinks that I should definitely NOT have sex before marriage" to "she thinks that it's okay if I have sex before marriage, but she wants me to use contraception." Prior studies (Kirby, 1990) have found Cronbach's alpha=.94. Alphas for the current sample were .89 (males) and .88 (females).

Dating patterns. Adolescents were asked, "How old were you when

you went out on your first date?" Adolescents also filled in their age at first date.

Procedure

In addition to obtaining parental consent via a parental permission slip, participating adolescents signed an assent form to validate their voluntary participation. In each school, several classrooms were invited to participate. Approximately 67% of students approached at the mixed race urban school participated, and more than 95% of students approached at each of the two other schools participated This was most likely due to greater encouragement and support from teachers and their principals, as was observed by the researchers. Rates of behavior for the samples were similar to national averages. The sample is believed to be representative of the larger adolescent population, and it can be assumed that students who participated were not significantly different than those who did not participate. Surveys were completed during a single class period while supervised by the researcher and/or the teachers in the classrooms. Students were each given a packet containing all of the measures described in the above measures section at the same time. All procedures were approved by the University Institutional Review Board.

Results

Research questions 1 through 6 are addressed in separate sections below. Research question 7 has been integrated within research questions 1-6 as appropriate. For space purposes, only significant results are reported.

Question 1: Does age of first date correlate with age of first sexual intercourse?

Among those who were non-virgins (n=269), there was a low to moderate correlation between age of first date and age of first sexual intercourse overall ($r=0.346$, $p<0.01$), as well as for boys from the urban school ($r=0.353$, $p<0.01$), and girls from the pregnant/parenting school ($r(77)=0.492$, $p<0.01$).

Question 2: Does age of first sexual intercourse vary by family composition (i.e., two-parent versus single-parent families)?

An analysis of family composition revealed that 34.3% of the adolescents live in a household with only one parent, 23.1% live in a household with both parents, and 16.4% live with a parent and some other caretaker figure in the household. A significant amount (26%) of adolescents did not respond to the questions about family composition. An Analysis of Variance (ANOVA) revealed that adolescents' age of first sexual intercourse did not significantly vary by family composition ($F(2, 209)=0.806$, $p<0.05$).

Question 3: Do teenagers' clarity of long-term goals vary by their current frequency of sexual intercourse?

The respondents' clarity of long term goals, although statistically significantly correlated, were weakly associated with frequency of sexual intercourse ($r(272)=.118$, $p<0.01$). Further examination by genders and groups revealed no statistically significant relations.

Question 4: Are adolescents' sexual behaviors correlated with whether or not they know what each of their parents think about premarital sex and each parent's approval of premarital sex?

Results revealed that more liberal maternal attitudes were significantly correlated with adolescents' frequency of sexual intercourse, although the relation was weak ($r(182)=0.220$, $p<0.01$). However, maternal and paternal values

about premarital sex were moderately strongly correlated, suggesting some degree of agreement in their view on teenage premarital sex ($r(119)=0.547$, $p<0.01$). Next, results are presented for various demographic subgroups. Among females from the urban school, greater knowledge of their fathers' views about premarital sex was correlated with their fathers having more liberal attitudes toward premarital sex ($r(13)=-0.705$, $p<0.01$). Similarly, for these female adolescents, knowledge of their mothers' views about premarital sex values was inversely correlated with mothers' attitudes toward premarital sex ($r(26)=-0.512$, $p<0.01$). Males from the suburban school indicated that their mothers' and fathers' views were fairly consistent with each other ($r(38)=0.604$, $p<0.01$) and that when their mothers held more liberal views, male adolescents were engaging in more frequent sexual behaviors ($r(46)=0.334$, $p<0.01$). For females from the urban school, a strong correlation between their parents' attitudes toward premarital sex ($r(11)=0.891$, $p<0.01$) and frequency of sexual behaviors was reported.

Question 5: Can adolescents' abstinence/sexual intercourse status, age of first sexual intercourse, and frequency of sexual behavior be predicted by a combination of key variables (clarity of long term goals, parents' values, sexual attitudes, age of first education about sexual intercourse)?

Adolescent abstinence/sexual intercourse status was significantly predicted by the combination of clarity of long term goals, personal attitudes towards premarital intercourse, parental values, and age at time of first sexual education ($R^2= 0.13$, $F(8,128)=2.42$, $p<0.05$). Because the sample size was reduced significantly when only including those who have had sexual intercourse, further gender and race breakdowns were not conducted.

Question 6: What role do religious beliefs play in adolescents' decisions to remain abstinent?

Using Chi-Square analysis, results revealed no significant interaction between religious beliefs and adolescents' decisions to remain abstinent ($\chi^2(33)=0.330$, $p<0.566$). These results were similar for each gender groups and each of the schools.

Discussion

The purposes of this study were to examine a variety of potential predictors of adolescents' age of sexual debut and frequency of sexual behavior. Gender and racial variations were also explored. Adolescents' sexual attitudes, sexual behaviors, religious beliefs, age of first education about sexuality, family composition, long-term goals, parental attitudes, and age of first date were all examined. It was hypothesized that more permissive sexual behavior and earlier onset of sexual intercourse in adolescents would be correlated with parental approval of premarital sex, weak religious values, single parent homes, less clarity of long-term goals, and earlier dating. Several themes were found in the results. Each is discussed below.

Interestingly, adolescents' religious beliefs were not related to their choice to remain abstinent or not. Also, family composition was not significantly related to adolescents' sexual behaviors. Hence, adolescents' sexual practices were similar regardless of whether they were living in a single parent home or in a household including two parental figures. Other parental variables were,

however, related to adolescent sexual activity outcomes. First, parental values about premarital sex were somewhat correlated with adolescents' sexual behaviors, and, most consistently, maternal attitudes were related to adolescents' sexual choices. Permissive parental attitudes appeared to be related to a higher frequency of adolescent sexual behaviors. However, this is correlational data, and causal or directional inferences should not be made. Prior research suggests that parents often do not engage in sexual communication with their children until after sexual activity in their teens has already begun (Somers & Paulson, 2000). Thus, the most likely explanation for these results here is that those parents with more liberal attitudes are more pressured to talk about what their adolescents are expressing interest in, and through that, they express values that may include messages that do not necessarily disapprove of premarital sex.

The results also demonstrated that a combination of less clarity about long term goals, more liberal parental attitudes, and earlier age of sexual education were related to higher frequency of sexual activity, lower age of first sexual intercourse, and less contraceptive use.

Adolescents' earlier age of first date was found to be related to an earlier age of onset of sexual intercourse. Although the relation was weak, it nonetheless may indicate that better sex education and heightened parental monitoring is likely to intervene in early dating leading to behaviors that set the stage for early sexual activity. This is especially important considering that early sexual debut has been linked to a variety of social, intrapersonal, and academic problems (Steinberg, 2005). Early sexual activity is also related to higher risks of STD transmission, lowered contraceptive use (Bersamin et al., 2008; Coker et al., 2000), and risk of dating violence (Coker et al., 2000). Thus, younger teens are more likely to expose themselves to higher risks and make less responsible decisions than would older adolescents.

There are limitations to this study that include the small sample sizes. Thus, some of these results should be addressed further in studies with larger and even more diverse samples. Also, variables such as individual cognitive factors were not measured. For example, prior research has indicated that individual cognitive variables (e.g., risk judgments and invulnerability) were related to sexual and other risk taking behavior and may have an impact on adolescents' decision making processes (Somers, Greenwald, & Hillman, 2008; Halpern-Felsher et al., 2001). Additionally, the role of media was not addressed.

Clearly there are many variables that likely contribute to the development of healthy sexual behaviors. The specific goal of this study was to identify multiple variables from a demographically diverse sample and their relative contributions as identified in prior literature. Interesting patterns were observed that can be used to inform future research and current interventions with children and adolescents. Most specifically, when school counselors are generating either individual or school-wide prevention efforts, it is important to understand which factors are most linked to sexual risk taking behavior in adolescents. They can tailor their education to adolescents in individual meetings and/or group talks, as well as to parents both on an individual level (e.g., if their child is having particular difficulties) or preventively through an in-service to parents (e.g., a presentation at a PTA meeting). School counselors can inform teachers

of information that will be useful to them in their interactions with students. Similarly, community counselors can utilize this information in didactic ways with their clients in order to help them to understand important key factors that should be addressed in an effort to improve children's potential outcomes. For instance, parents should be made aware that they could be talking to their children about sex before they start dating, as age of first intercourse coincides very closely with age of first date. This could maximize effectiveness of such communication. Additionally, as this research and other studies show, parents who communicate with their child about sex, but hold disapproving values about premarital sex, tend to rear adolescents that delay their sexual debut (Dittus, Jaccard, & Gordon, 1998). Several research articles pointed at the importance of starting sex education during pre-adolescence (Wyckoff et al., 2008) and helping parents to be educated themselves about the information transmitted to their children (Gallegos, Villarruel, & Gomez, 2007). Thus, parents could be taught how to educate their child about sex without seeming to encourage sexual activities and start such communication before their child's first date. Finally, family composition (single versus two-parent families) did not prove to be related to risky sexual behavior in this study. This supports the notion that universal sex education and early prevention programs are applicable to all families.

Overall, most of these research findings point to the interactional nature of risk factors instead of one single predictor for risky sexual behavior, such as a combination of living in a single parent and home, holding low SES, and holding racial or ethnic minority status (Upchurch et al., 2001). This calls for a multidimensional approach to assessment and intervention efforts by counselors, as no one factor, but rather interactional processes (e.g., kind of sex education received by parents, values parents hold about premarital sex, and goals and aspirations adolescents hold, etc.), shape the landscape of adolescent sexual risk behavior.

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Supporting and Preparing Future First-Generation College Students in the High School Environment: Implications for School Counselors

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Abstract

This study surveyed college freshmen from two different institutions in order to examine differences between First-Generation College Students and Continuing-Generation College Students. Differences between groups emerged for high school academic preparation, college exploration behaviors, college application behaviors, and college decision-making prior to matriculation. Results suggest differences between groups are relevant to professional school counseling. Suggestions for interventions, school counseling implications, and future research are discussed.

According to the American School Counselor Association (ASCA) position statement on academic and career planning (2006), "professional school counselors implement academic and career planning based on students' abilities, interests, and goals with the hope of reducing inequities based on stereotypes or special needs, and is an important step towards equal access to postsecondary opportunities" (p. 1). The ASCA National Model (2005) designated individual student planning as a component of the delivery system providing "all students an opportunity to work closely with their parents or guardian to plan, monitor, and understand their growth and development and take action on their next steps personally, educationally, and occupationally" (p.15). Professional school counselors are charged with helping all students, but information is lacking in the specific needs of students who are the first in their family to pursue higher education. This study examined distinctions between First-Generation College Students (FGCS) and Continuing-Generation College Students (CGCS) with respect to academic preparation, college exploration, and the college decision-making process in an effort to assist professional school counselors in establishing data driven interventions to academically prepare and support FGCS as they prepare for post-secondary education..

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First-Generation College Students

First-generation college students are qualitatively different with regard to their demographic and background variables compared with CGCS. Recent studies posited slightly more than a quarter of high school graduates across the country are FGCS (Owens, Lacey, Rawls & Hobert-Quince, 2010) and close to half of these FGCS came from a lower socioeconomic background (Choy, 2001). More recent studies also supported the likelihood that FGCS come from lower income families (Bui, 2002; Choy, 2001), disproportionately represent ethnic and minority groups (Engle & Tinto, 2008), and are more likely to speak a language other than English in the home (Bui, 2002). In addition, FGCS are more likely to be older, married, and have dependents when compared to CGCS (Choy, 2001; Grimes & Mehta, 2006).

Significant differences in academic preparation of FGCS were noted in previous studies and some differences corresponded with persistence once in the college setting. First-generation college students typically have lower grade point averages (GPAs) and lower SAT scores (Prospero & Vohra-Gupta, 2007), and are less likely to take college entrance exams (Warburton, Burgarin, & Nunez, 2001). Past research suggested FGCS were less likely to take advantage of honors programs (Pascarella, Pierson, Wolniak, & Terenzini, 2004) or participate in college preparation courses (Horn & Nunez, 2000). In a longitudinal study following a sample of students with above average skills in math and reading (both FGCS and CGCS), Trusty and Niles (2004) found course-taking in high school to have the strongest effect in completion of a four-year degree. Choy (2000) reported the highest level of mathematics taken by FGCS in high school (beginning with algebra in eighth grade) exerted the strongest influence in completion of a bachelor's degree. It is also noteworthy that while a lack of academic preparation is not necessarily a barrier to entry for FGCS pursuing post-secondary education, it does correlate with success once enrolled in the college setting (Ishanti, 2003).

When it comes to college selection, FGCS demonstrate differences in choice and decisional influences compared with students who have a parent with previous post-secondary experience (Bui, 2002). Due to their own lack of experience, parents of FGCS may be less able or willing to help their student with the planning, application, and decision-making process (Gibbons & Shoffner, 2004). According to Pascarella et al. (2004), "compared to their peers with highly educated parents, first-generation students are more likely to be handicapped in accessing and understanding information and attitudes relevant to making beneficial decisions" (p. 252). Horn and Nunez (2000) discerned that the probability of enrolling in college increased for FGCS when their parents participated in college preparation activities, and when these students received additional support from their high school in navigating the college application process.

Past research focused on specific demographic variables for FGCS as well as academic preparation, cognitive abilities, retention, and transitioning. Curiously, previous studies neglected to explore specific readiness and decisional factors from the school counseling perspective, although professional school counselors are ideally situated to assist these students in a preventative

fashion prior to graduation. This inquiry surveyed freshmen from two distinct institutions in order to distinguish the disparity in college preparation behaviors between FGCS and CGCS. Results have implications for school counseling interventions expressly created to close the gap, and advocate for FGCS through their college preparation journey.

Method

Participants

The questionnaire was sent to 1,666 freshmen attending an urban university and 540 freshmen enrolled at a competitive private university for a total of 2,206 possible participants. Survey respondents were 366 college freshmen from these two Midwest institutions for a response rate of 17%. Two hundred and seventy-seven of the respondents were from an urban university with the remaining 89 coming from the private university.

Eighteen questionnaires were incomplete and removed from the study. An additional participant endorsed "unknown" when asked about parental post-secondary educational experience and was also removed. Finally, because the sample contained a wide range of ages (from 17 to 67 years), the researchers decided to eliminate outliers from the study, removing all participants who reported their age as 29 or older. Consequently, 41 additional participants were removed leaving 306 participants in the study.

The sample was comprised of 200 women (65.4%), and 106 men (34.6%) ranging in age from 17 to 28 years (M = 20.11, SD = 3.42). Seventy-five percent (n = 229) reported as White, non-Hispanic with remaining respondents reporting ethnicity as African-American (7.9%), Hispanic/Latino (5.3%), Asian/Pacific Islander (2.3%), Native American (0.7%), other (8.6%) with one failing to respond to this item. Integral to this study was the post-secondary educational background of the parents of the sample. The majority of respondents reported having one or both parents graduating from college or attending college but not graduating (72.5%, n = 222) with the remainder of the sample stating his or her parents had no college education (27.5%, n = 84).

Research Materials

The authors developed a questionnaire exclusively for this study, with additional feedback from professors who had an expertise in working with freshmen populations. Item creation was embedded in previous research on FGCS with additional focus on college decisional influences, high school preparation behaviors, college exploration behaviors, and social and familial pressures and support. The questionnaire was distributed to several faculty members and graduate students for feedback and suggested revisions.

The questionnaire consisted of six sections. Section one, Participant Information, contained demographic questions while the second section, Family Information, included questions on family background. Section three, High School Information, was comprised of questions exploring basic academic information (i.e., GPA and class ranking) in addition to academic rigor offered and taken during high school. The fourth section, College Exploration and Application, contained questions on exploration behaviors (i.e., college visits, college fairs), and the college application process, while section five, College Decision-Making, included questions on priority variables, decision-making pressures, and decisional influences. The final section, Support Systems, examined peer and family support for attending college, utilization of college support structures, and perceived pressures in the college transitional process.

Subsets of the questionnaire evidenced moderate to strong reliability. Internal consistency measures using Chronbach's alpha ranged from .61 to .70 for the subsets measuring academic rigor offered and academic rigor taken. Reliability measures for college exploration, peer influence, and college decision-making ranged from .66 to .73 with several stand-alone items also reported in this analysis.

Procedure

Upon final approval from the home Institutional Review Board of the researchers, in addition to the Institutional Review Boards for each of the sites, an email list of all freshmen was obtained from each institution. Participants were sent an invitation email orienting them to the study, the forthcoming survey invitation, and informed consent. Three days later participants received an invitation email including a link to the online survey with informed consent embedded in the survey document. Participants received follow-up email reminders at one and two weeks after the original invitation. The cover letter clarified participation in the study was voluntary and consent was indicated by completion of the online survey. Participants were notified that all information would be used in aggregate form, and while no identifying information would be gathered, transmission of responses over the Internet is not completely confidential. No incentives were offered for participation in this study.

Results

Demographics

As stated earlier, a number of age outliers were removed prior to analysis. An Analysis of Variance was performed for age differences between the two groups (i.e., FGCS and CGCS) as noted in previous studies. The analysis was significant (F (1, 276) = 11.186, p = .001). With a range of 17-28 years, FGCS were still over a year older (M = 21.13, SD = 4.08) than their CGCS counterparts (M = 19.71, SD = 2.76). Likewise, an ANOVA examining differences in the years reported since graduation from high school yielded significance (F (1, 293) = 7.201, p = .008) with FGCS reporting more time from graduation to freshman status (M = 2.75 years, SD = 2.97) than CGCS (M = 1.91 years, SD = 2.11). No significant differences were found for this sample when it came to ethnicity, SES, marital status, or family of origin structure (e.g., dual or single-parent) which is significant because these findings are inconsistent with past studies.

High School Experience

When high school GPA and high school class rank were compared, significant differences were minimal. Likewise, no differences emerged for time spent doing homework while in high school. While no significance emerged when asked if their school offered honors courses, differences were found in the

number of honors classes taken. Continuing-generation college students took significantly more honors courses χ^2 (3, N = 291) = 12.82, p = .005, effect size .210. Specifically, 27.6% of CGCS took six or more (16.9% of them 10 or more) compared with FGCS (12.8% taking six or more) while on the other end of the continuum 74.3% of FGCS reported taking 0-2 honors courses compared with 53.5% of CGCS.

To further examine academic rigor in high school, participants responded to several items regarding advanced placement (AP) courses offered and taken. The majority of both groups reported their high school offered AP courses (88.8% of the FGCS sample and 93.8% of the CGCS sample). However, when reporting the number of AP courses taken, group differences were found χ^2 (1, N = 300) = 13.31, p < .000, effect size .211 with only 22.8% of FGCS taking any AP courses compared with 46.3% of their CGCS counterparts. Therefore, while both groups attended schools where academic rigor was offered, FGCS did not pursue more demanding coursework or were not encouraged or allowed (i.e., didn't meet prerequisites) to do so.

Table 1—High School Experience

	FGCS	CGCS	χ^2	p	Φ
High School GPA 3.5 or Above	44.5%	44.8%	8.431	.077	.167
High School Rank Top 10%	20.9%	30.0%	4.240	.752	.119
Honors Courses Offered High School	84.1%	93.7%	9.022	.011	.173
15 Hours or More Hours of Homework Per Week	3.7%	9.5%	3.944	.227	.114
Honors Courses Taken	12.8%	27.6%	12.82	.005	.210
High School Offered AP	88.8%	93.8%			
AP Courses Taken	22.8%	46.3%	13.31	.000	.211

College Exploration, Application

Groups differed when it came to college fair attendance χ^2 (1, N = 294) = 4.90, p = .027, effect size .129 with 47.1% of CGCS reporting they had gone to one or more college fairs compared with 32.9% of FGCS. An AVOVA revealed significance for college visits (range 1 to 20), with CGCS reporting more college visits (M = 3.70 visits, SD = 3.10) than FGCS (F (1, 204) = 12.453, p < .001). Even though differences were present, when responding whether they wished they could have gone on more college visits, no differences emerged χ^2 (1, N = 330) = 1.18, p = .277. Finally, in order to explore barriers to this college exploration activity, participants were asked to respond to a list of possible reasons for attending fewer college visits. Reasons given are found in Table 2.

Table 2—Reasons for Not Going on More College Visits

	FGCS	CGCS
Couldn't Miss That Much School	50.0%	47.0%
Couldn't Afford It	34.7%	55.0%
Too Far Away	41.3%	32.0%
No Way to Get There	28.3%	37.0%
No One to Take Me	28.3%	43.0%
Other	43.5%	40.0%

Responses to the number of college applications submitted yielded significant differences as well, with CGCS submitting more applications than FGCS (F (1, 284) = 10.075, p < .002). Participants also responded to a question asking if they had had assistance in preparing college applications and differences were present χ^2 (1, N = 292) = 6.66, p = .010, effect size .151. In this sample, CGCS (63.5%) were much more likely to have received or requested help on college applications than the FGCS sample (46.9%) even though research is clear that it is FGCS who are at a disadvantage in this area.

College Decision-Making

Chi-square analysis found differences between groups χ^2 (1, N = 291) = 6.38, p = .008, effect size .154 with FGCS much more likely to consider not enrolling in college (46.9%) than CGCS (30.4%). Participants reported the number of friends considering attending college from a list of five choices ranging from *nearly all* to *none.* Chi-square analysis found significance χ^2 (4, N = 290) = 23.18, p < .000, effect size .283 with CGCS reporting most to nearly all of their friends attending college (94.7%) compared with FGCS (63.0%). Items exploring peer involvement in the decision-making process, found CGCS much more likely to discuss their college decision-making with peers than FGCS χ^2 (1, N = 277) = 8.578, p < .003, effect size .176 while FGCS felt far more peer pressure to not attend college than was reported by CGCS χ^2 (1, N = 277) = 11.65, p < .001, effect size .205.

Table 3—College Decision-Making

	FGCS	CGCS	χ^2	p	Φ
Considered Not Going to College	46.9%	30.4%	6.38	.008	.154
Friends Considering Attending College	63.0%	94.7%	23.18	.000	.238
Discussed College Decision-Making with Peers	67.9%	84.4%	8.58	.003	.176
Felt Pressure Not to Attend College	48.8%	30.8%	11.65	.001	.205

Discussion

Age-differences between FGCS and CGCS have been a consistent finding in previous studies (Choy, 2001; Grimes & Mehta, 2006). This study found FGCS are still older, but only by a little over a year. One explanation may suggest FGCS are less likely, initially, to consider post-secondary studies, but over time are willing to enroll in a college or university. Another possibility is that FGCS have an inadequate college preparation and search period during high school, and don't have the plans in place to launch directly after graduation. Future research should examine both the reasons for dismissing college as an option and the motivations and decision-making variables that lead FGCS eventually to pursue higher education.

Past studies have found differences in the level of academic rigor between FGCS and CGCS (Choy, 2000; Horn & Bobbit, 2000; Horn & Nunez, 2000; Trusty & Niles, 2004; Warburton et al., 2001). Contrary to previous research (Prospero & Vohra-Gupta, 2007), this study found no differences in reported GPA or class rank for the two groups. This discovery suggests this gap between FGCS and CGCS may be diminishing. In this sample, CGCS reported taking more honors and AP courses than FGCS. While these results are similar to previous research, this study controlled for academic rigor offered in the high school setting, and found between group differences still present. Perhaps FGCS lack relevant information regarding the academic expectations to prepare for college, or results may reflect ambivalence towards pursuing higher education

Part of the college preparation journey includes researching, applying to, as well as visiting possible post-secondary choices. In this sample, CGCS attended more college fairs held within their school, went on significantly more college visits, and requested help on their applications more often than FGCS. These results support the assertion of Gibbons and Shoffner (2004) that FGCS may be at a disadvantage in their own college preparation activities because their parents lack the experience and perhaps the self-efficacy not only to help them with their preparation, but also to advocate for support when they are unable to provide it. Results also support the proposition of Horn and Nunez (2000) that FGCS would benefit from programs in secondary schools aimed at involving parents in the college exploration, preparation, and application process.

To better examine the post-secondary decision-making process, participants responded to several questions exploring college choice. First, we looked at the most basic choice (i.e., whether or not to go to college) and for this sample FGCS were more likely to admit they considered not attending college. While this may not be surprising, it does suggest that we have yet to understand the social, familial, or personal influences for FGCS contributing to an early foreclosure decision with regard to their college. Our exploration of peer influence found CGCS discussed college plans with friends more often and not surprisingly had more friends with plans to pursue higher education. Conversely, FGCS reported they felt far more pressure *not* to attend college, raising the question of social influence and support for FGCS who are considering attending college after graduation. Such results suggest possible ambivalence for FGCS and may explain why students who are not sure they can go or are not sure they want to go to college would not pursue the academic rigor and college preparation behaviors found in students who had always planned on attending college after graduation. Findings support the notion that earlier intervention in college counseling will afford students the ability to create realistic plans for their future that may influence their academic and college preparation choices.

Implications for Professional School Counselors

According to ASCA (2009), "professional school counselors promote equity and access to rigorous educational experiences for all students" (p. 1). The Education Trust, in the New Vision for School Counseling (2009), advocates that school counselors "foster educational equity, access, and academic success in a rigorous curriculum to ensure that all students graduate from high school ready to succeed in college and careers" (p. 1). School counselors may wish to specifically identify FGCS and implement a monitoring program exclusively for this population. Psychoeducational programs at the large or small group level would also be appropriate for service delivery.

Parents are integral to the college preparation journey, and parents who did not attend college, or who come from a family with few college graduates are at a disadvantage in assisting and supporting their student. School counselors should begin in middle school identifying and meeting with these parents. Furthermore, school counselors should address not only basic college information (e.g., college entrance exams, financial aid, college applications), but also the familial variables noted in the literature. If students are ambivalent about attending college, school counselors could explore possible parental influences for this ambivalence. Professional school counselors may find it most appropriate to address these concerns in group settings with parents as a group format offers additional therapeutic factors which may increase the efficacy of the intervention.

Ultimately, FGCS need extra attention and assistance when it comes to college exploration. Professional school counselors, as part of their monitoring process and/or individual planning, could include attendance at college fairs or meetings with visiting college admission representatives as a component of the plan. Mentoring FGCS on the college application process is vital, and creation of a program to do so would assist in closing this gap in opportunity between groups. These students may also need help in planning and pursuing more college visits. Since FGCS in this study attended few college visits prior to their freshman year, and since research also suggests that these students struggle with the cultural transition to college life, taking advantage of additional college visits may help.

Limitations

Several limitations to this study are worth noting. First, both institutions were located in the Midwest. Therefore, it is possible that this sample may not be representative although institutions were dissimilar in a number of factors improving generalizability. The questionnaire used for this study was a self-developed inventory, and as such may contain some fundamental bias in construction, and a lack of reliability and validity data. The data for this study were self-reported, and consequently responses may have been influenced by social desirability. Likewise, questions asked participants to recall their high school

experience, and there may have been error in participants' recollections. The low response rate also may suggest some possible nonresponse bias. With regard to the data analysis, some respondents were removed due to age (i.e., outliers) so while this decision may be helpful for the purpose of the research questions, the participants removed did indeed represent the current freshmen population in our country at the present time. In addition, the majority of participants in this study were White, even though the largest institution sampled for this study came from an ethnically, racially, and religiously diverse student population. This fact may also limit generalizability.

Conclusion

With a recent national focus on increasing college graduation rates in addition to the current economic challenges, a college education is more essential than ever before. In past decades, research has focused on the unique differences of FGCS, and their specific challenges in pursuing higher education. Predicated on the vision of the ASCA National Model (2005) and The Educational Trusts' New Vision for School Counseling (2009), professional school counselors are exceptionally qualified and uniquely positioned to address the distinct needs of FGCS. The needs identified in this study merge seamlessly with the vision, the delivery systems, and the themes articulated in the ASCA Model. The implications from this study suggest measurable outcomes emerging from some of the interventions specifically proposed (e.g., tracking higher level courses taken, GPAs, college visits, college exploration activities, career counseling, collaboration with parents, graduation rates, college admission rates, and retention rates in both high school and college). The journey towards higher education for FGCS can successfully advance with support from professional school counselors.

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Treatment Compliance in Group Therapy: Issues and Interventions

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Abstract

In this manuscript, research on treatment compliance and dropout in group therapy is reviewed. A number of variables found to be related to the compliance and dropout are identified including client characteristics, treatment characteristics, and therapist perceptions and behavior. Implications of these results for increasing treatment compliance are discussed.

Treatment Compliance in Group Therapy

Treatment compliance has consistently been an issue in mental health treatment, and it can have very specific implications for group treatment. Premature loss of group members can result in lack of group cohesion, reduced client outcomes, disillusionment of the therapist, and other client dropouts (Rice, 1996; Joyce, Piper, Ogrodniczuk, & Klein, 2007; Roth, 1990). This problem is extremely wide in scope, and therefore it is difficult to narrow down statistics on the frequency of its occurrence. Further, level of compliance varies based on the type of treatment offered and clients' specific characteristics. Though there are no general statistics regarding treatment non-compliance in mental health treatment as a whole, Wierzbicki and Pekarik (1993) conducted a meta-analysis of research studies throughout various types of treatment and found an overall dropout rate of 47%. Other studies support this dropout rate specifically in group treatment settings (Klein & Carroll, 1986). In a study of increasing compliance in group therapy, researchers found a 30% dropout rate even after extensive screening and preparing clients for treatment (Lothstein, 1978). Regardless, dropout is a significant problem that clinicians and researchers alike have been working to address for several decades.

The definitions of "treatment compliance" and "treatment dropout" in group treatment vary, as different programs and theoretical approaches may have a different conceptualization of what these terms mean (Joyce et al., 2007). *Treatment compliance* can include finishing a prescribed course of group treatment, completing homework assignments or objectives to meet treatment goals, or simply following through with treatment until both the client and therapist agree that the treatment goals have been fulfilled (Stone & Rutan, 1984). Conversely, Rice (1996) defines *treatment dropout* as "someone who

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chooses not to, or is unable to, make a commitment to the group and will most likely leave within 6 months of joining the group" (p. 10). However, these definitions can change with modalities as other researchers have specific time restrictions that define when a client has officially dropped out (McMurran, Huband, & Overton, 2010). When clients drop out of therapy, they are less likely to experience improvement in mental health symptoms, and this can lead to further mental health problems down the road (Davis and Addis, 2002).

Some research suggests that non-compliance is related to the value our society places on mental health treatment. Clients seem to under value mental health treatment, and are less likely to be compliant and maintain mental health appointments in comparison with medical appointments (Carter, Turovsky, Sbrocco, Meadows, & Barlow, 1995). This creates a problem for mental health providers. How do we deliver quality care and treatment to clients when they refuse to comply with treatment, or terminate early? Evidence shows that there are characteristics of clients as well as characteristics of treatment that are correlated with group treatment non-compliance. Knowledge of these variables can help counselors and administrators prevent treatment drop-out and increase positive outcomes.

Client Characteristics

Demographics

The demographics found to be correlated with treatment compliance in group treatment include age, race, socioeconomic status, and education level. These findings have been consistent through several studies and literature reviews on the topic (Berrigan & Garfield, 1981; Baekland & Lundwall, 1975; Wierzbicki & Pekarik, 1993).

Age. Research suggests that the younger the client, the more likely he or she is to be non-compliant with group treatment. We may even be more specific in terms of age. In a study of alcohol-dependent patients, dropout rates were higher for patients who were 35 years old or younger, and a similar study found that clients aged 34 and younger were more likely to drop out (Hird, Williams, & Markham, 1997; Monras & Gaul, 2000).

Education & Socioeconomic Status. Level of education is a risk factor for treatment drop out. In one study comparing those who completed group therapy to those that did not, 68% of dropouts did not complete high school, as opposed to only 41% of completers (Fisher, Winne, & Ley, 1993). Often correlated with level of education, socioeconomic status is also a factor in treatment compliance, as research shows that lower levels of income are associated with higher levels of treatment dropout (Rabin, Kaslow, & Rehm, 1985). In fact, in a study of process groups for domestic violence offenders, the only predictor of drop out was low income (Chang & Saunders, 2002).

Minority Status. Consistently, minority clients are less compliant with group treatment than their non-minority counterparts (Wierzbicki & Pekarik, 1993; Lothstein, 1978). Chang and Saunders (2002) found that clients enrolled in a domestic violence treatment program were more likely to drop out before treatment even began if they were a minority. Historically, research conducted

in the field of group counseling has been applied to Caucasians, which leaves much to be desired with regard to interventions specifically designed for racial and cultural minorities (Bemak & Chung, 2004).Clinicians may not be multiculturally competent which creates barriers for minority clients that other clients do not face, and puts them at higher risk for treatment dropout (Williams, 1994).

Diagnosis. There are a few diagnoses that continue to present themselves in the literature as predictors of dropout in group treatment: substance dependence, anti-social and borderline personality disorders.

Drug and Alcohol Dependence. AoD (Alcohol or Drug) dependence is one of the major predictors of dropout in group treatment. Addictions can be difficult to overcome, and relapse occurs frequently. Unfortunately, relapse is quite common with patients diagnosed with AoD dependence, and with relapse comes therapy drop-out (Daley & Zuckoff, 1999). Many studies on predictors of dropout in group therapy found that regardless of dependence, those who reported past or current AoD use were more likely to be non-compliant with treatment (Gilbert, Fine, & Haley, 1994). There is a significant amount of research available on reducing dropout in addictions treatment in comparison with other mental health diagnoses due to the high dropout rates (Carroll, 1997; Daley & Zuckoff, 1999).

Antisocial Personality Disorder. Of all the personality disorders, antisocial personality disorder has the highest rate of group treatment dropout (Chang & Saunders, 2002). Domestic violence and sex offender programs have high percentages of clients diagnosed with antisocial personality disorder, and also have a high dropout rate. In a study of sex offenders, clients with higher levels of personality disorder traits were less likely to complete the program, possibly due to the fact that they were less likely to report empathy for the victim (Chaffin, 1992). In a similar study of dropout in domestic offender treatment, 62% of the original sample dropped out of treatment prematurely, and antisocial personality disorder was a significant predictor of attrition (Chang & Saunders, 2002).

Borderline Personality Disorder. Clients diagnosed with borderline personality disorder (BPD) can be difficult to engage in treatment on a long term basis, and can be extremely non-compliant (Harper, 2004; McMurran, Huband, & Overton, 2010). While percentages of dropout in this population vary by study, Stiwne (1994) found that as many as 60% of participants with BPD dropped out of a long term group treatment program by the end of 20 months. In a qualitative exploration of clients diagnosed with BPD, researchers found that non-compliant clients engaged in higher rates of impulsive, manipulative, and aggressive behaviors than other clients, and higher symptom severity is correlated with non-compliance in treatment for clients with BPD (Gunderson et al., 2006; Tanesi, Yazigi, DeMattos, & doNascimento, 2007).

Treatment Attitude and Expectations. Client attitude (how one feels about treatment) and treatment expectations (beliefs about the therapy experience) have a significant relationship with group treatment compliance. Research has found that even though these two aspects are different, treatment expectations mediate client attitudes toward treatment (Vogel & Wester, 2003). A positive attitude toward treatment not only increases treatment compliance,

but increases positive outcomes in therapy (Connelly, Piper, de Carufel, & Debbane, 1986; Wenzel, Jeglic, Levy-Mack, Beck, & Brown, 2008; Buchanan, 1996). Clients with expectations of treatment that are similar to that of the treatment rationale are more likely to comply with treatment (Davis & Addis, 2002). This can include satisfaction with treatment modality and rationale, and an expectation of positive outcomes (Carter et al., 1995; Favret, 1991; Kuusisto, Knuuttila, & Saarnio, 2011).

Previous Treatment. Individuals that have been in therapy before are more likely to comply with treatment. In a study of college students, MacNair (1993) found that students were more likely to continue in group therapy if they had engaged in individual counseling in the past, and another study found that dropouts were more likely to have no previous experience of therapy (Connelly et al., 1986).

Interpersonal Relationships. The quality of a client's relationships may indicate whether the client may be at risk for dropout. For example, in one study, predictors of drop out in group therapy in a university setting included roommate difficulties and interpersonal conflicts with others (MacNair, 1993).

Impulsivity and Labile Emotions. Impulsivity, or acting without forethought, is correlated with treatment dropout (Black et al., 2009). Binging and purging are impulsive behaviors used by clients with eating disorders to manage uncomfortable levels of emotions, and in one study of eating disorder treatment, non-compliance was correlated with frequency of binging and purging behaviors (Riebel, 1990). Another study found that women in group treatment for bulimia were likely to impulsively drop out if their immediate concerns were not addressed (McKisack & Waller, 1996). Emotional lability, or frequent and intense experience of emotions, often leads to impulsive decisions when clients are faced with the difficult emotions that present themselves in treatment. For example, in one study, those who were found to experience and express anger more frequently were more likely to drop out of treatment (Erwin, Heimberg, Schneier, & Liebowitz, 2003).

Treatment Characteristics

Group Cohesion. Group cohesion is essential to the success of any group intervention (Yalom, 1985). Research has shown that clients who dropped out of group treatment reported experiencing less positive feelings during group than those that stayed (McCullum, Piper, Ogrodniczuck, & Joyce, 2002). In addition, therapists' ratings of cohesion to the group are significantly lower for clients that terminate early (Ogrodniczuk et al., 2006). In another study, difficulties trusting and relating to others increased the likelihood of group dropout (Blouin, Schnarre, Carter, Blouin, & Al, 1995).

Cohesion not only decreases dropout, but it increases treatment compliance. Research has shown clients who dropped out of therapy participated significantly less while in treatment than their compliant counterparts (Oei & Kazmierczak, 1997; Miller & Mason, 2001). Similarly, in a study of group treatment for domestic offenders, clients were less likely to continue abusive behaviors if they felt they had an alliance with the therapist and the group (Taft, Mur-

phy, King, Musser, & DeDeyn, 2003).

Therapeutic Alliance. The therapeutic alliance, or the working relationship between the client and therapist, is imperative in any therapeutic setting (Horvath & Luborsky, 1993). Despite the need of a pre-treatment orientation, simply having the client in individual therapy before group treatment (and during) can build the therapeutic alliance and is related to higher levels of attendance (Stone & Rutan, 1994). Studies have shown the therapeutic alliance is a significant predictor of compliance in all types of treatment, and pre-treatment can also facilitate the client's relationship with the therapist (McMurran et al., 2010; Daley & Zuckoff, 1999). Murphy and Cannon (1986) also found that the establishment of a relationship between therapist and patient during orientation to group therapy was the highest predictor of compliance in group. Thus, encouragement, feedback, and support from the therapist are factors that predict treatment compliance (Blake, Owens, & Keane, 1990).

Therapist Perceptions and Behavior. While there have been studies of treatment compliance based on therapist demographics, (i.e. gender or race) these studies are inconclusive at best (Joyce et al., 2007). However, other therapist factors have a role in treatment compliance, including therapist attitude and perceptions. While this may seem obvious, often factors that can be attributed to the therapist are overlooked when examining client dropout. It may simply be easier to look at the client-related reasons for non-compliance as opposed to those associated with the clinical experience (Roth, 1990). For example, in one study, researchers found that therapists had a tendency to individualize and interact more with clients that were more engaged in session, leading to those clients staying in treatment, while the less engaged clients were more likely to dropout. Therapists also exhibited a tendency to rationalize group instability, citing client contributing factors as opposed to acknowledging their part in the disturbances of the group (Stwine, 1994).

There is evidence that how mental health workers and counselors perceive clients can be related to whether clients are compliant with treatment. In a study of mental health case workers' attitudes towards clients given a hypothetical situation, participants viewed clients more favorably, and were more likely to help them in the face of treatment noncompliance, (e.g. help with transportation or resources) if the client's noncompliance was infrequent and seemed related to factors out of his or her control, as opposed to clients who have frequent problems with noncompliance (Forsyth, 2007). This can have significant implications for treatment. If clinicians are less likely to help and work with clients that have a history of non-compliance or problems with treatment, they could be setting these clients up for failure.

Implications and Recommendations for Treatment

Many themes have emerged from the research on group treatment noncompliance. These themes include client characteristics, treatment characteristics, and therapist perceptions and behavior. Though it is clear all of these variables are related to group therapy dropout, the extent to which they predict noncompliance, or how much they are related to each other is uncertain. For example, if attitude toward treatment is directly affected by pre-treatment orientation, structure of treatment, and therapeutic alliance, but mediated by impulsive behaviors and diagnosis, it may be much more difficult to address these factors individually. Counselors must consider all of these factors when developing and maintaining a group therapy intervention in order to improve successful outcomes and to continue to serve clients in the most efficacious and beneficial means possible. Instead of looking solely at the client, it is necessary to look at treatment non-compliance as an interaction between client factors, therapist factors, and group factors (Roback & Smith, 1987). Unfortunately, other research findings suggest that many therapists remain unaware of the potential for clients to dropout, and this contributes to high rates of non-compliance (Stone, Blaze, & Bozzuto, 1980). The following sections discuss interventions to reduce group therapy dropout.

Pre-therapy orientation

Pre-treatment orientation includes addressing client expectations, as well as engaging the client in in treatment and building the therapeutic alliance. A study by Murphy and Cannon (1986) found that presenting the idea of group treatment so the client can take time to consider treatment increased the client's positive attitudes toward the group. Many other studies have found that implementing pre-treatment orientation increases the likelihood of compliance with group therapy and reduces dropout (France & Dugo, 1985; Garrison, 1987; Tolman & Bhosley, 1989). Clients are more likely to complete group therapy if they have realistic expectations about the length of treatment and effort needed (Kuusisto et al., 2011).Therapists should discuss client expectations before group treatment commences to be sure his or her expectations are in line with the treatment goals.

Research has also shown that pretreatment orientation can lead to higher group cohesiveness and more progress during group sessions, and it may be helpful to interview group members beforehand and consider the interaction between these individuals in order to increase cohesiveness in the group (France & Dugo, 1985). Finally, clients that receive pre-treatment orientation are also more likely to be viewed as engaged and compliant by the therapist (Garrison, 1978). Spending time engaging clients in pre-treatment orientation can often be overlooked and though the length of pre-treatment orientation needed may vary by modality, it is an aspect that is paramount in preventing dropout.

Risk Factors

Several risk factors for dropout have been delineated in this manuscript. An initial assessment for these risk factors is crucial. For example, though further research is necessary to replicate these findings, clients under the age of 35 may be at higher risk for dropout. In addition, SES and education level could be contributing factors. It is important for clinicians to address the fact that minority clients may not perceive treatment in the same manner as non-minority clients, and thus therapists must engage in multiculturally competent counseling strategies. This includes the knowledge, skills, and beliefs related to working

with clients of different cultures (Arredondo et al., 1996). Diagnosis may also be a risk factor, including schizophrenia, substance dependence, or a personality disorder.

To begin, a clinician should assess whether the client has had previous treatment, his or her attitude toward treatment, and his or her propensity for impulsivity and labile emotions (this can be assessed through reported history and client diagnosis). The quality of a client's relationships may indicate whether the client is at risk for dropout, and this aspect should be explored with the client before commencement of group sessions. Similarly, other studies have shown that adequate social support may be an important protective factor to keep clients in group treatment **(**Ayuso-Mateos et al., 2007).

Once these factors have been identified, it may be helpful to have a discussion with the client regarding the possible barriers that will keep them from completing treatment. Discuss possible conflicts with culture, or with transportation. If a client has a low education level, consider the type of group and material to be covered to be sure it is appropriate for his or her comprehension. If a client has a history of impulsivity and/or labile emotions, problem solve ways to cope when emotions do arise, or when the client feels like ceasing therapy.

Therapeutic Interventions

Assessing the structure and length of treatment can help increase treatment compliance. For example, behavioral interventions, such as positive and negative reinforcement, have been found to be helpful in increasing compliance with group treatment, especially in the area of substance dependence (Brooner et al., 2004). However, though these interventions increase compliance, they may not always increase patient satisfaction with treatment (Blake et al., 1990). Younger clients and clients diagnosed with schizophrenia may be more successful with shorter group sessions, and shorter overall treatment length.

Clients often give signs that they may terminate prematurely, such as decreasing engagement in group, or telling the therapist and/or group members that they are considering leaving group. Clients may also be more likely to drop out if they have a poor attendance record at the beginning and throughout treatment (Hunnicutt Hollenbaugh, 2011).When a client does voice unhappiness with treatment, immediate response by the therapist is necessary, and confronting the situation directly with encouragement, support, and problem solving can be helpful in maintaining the client's compliance (Riebel, 1990; Valbak, 2003). In a study of AoD aftercare group treatment, participants who received feedback and prompts during group therapy were more likely to attend groups and less likely to relapse (Lash & Blosser, 1999).

Conclusions

Though the available research does provide significant insight into the risk factors for dropout in group treatment, all clients should be assessed individually for their own personal risk of dropout. Further research on treatment compliance in group treatment is necessary, with specific regard to multicultural considerations in therapy dropout. Research may also identify specific modalities that increase compliance with certain diagnoses and personality factors. Regardless of the effectiveness of our treatment interventions, if we are unable to keep clients in treatment, we are unable to effectively help them. Further research and applying interventions to protect against treatment dropout not only benefits the individual, but the local and national community.

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