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Clients' Expected Number of Counseling Sessions, Treatment Effectiveness, and Termination Status: Using Empirical Evidence to Inform Session Limit Policies

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Many counseling centers have session limits to accommodate the increasing number of clients who seek treatment. The current study explored clients' expectations for the number of sessions over the course of one year at a large university counseling center. In contrast to previous research that has suggested clients want ten or fewer sessions, our results suggest that over 60% of clients wanted 20 or more sessions. Moreover, clients who expected 20 or more sessions reported therapy was less effective than clients who expected less than 20 sessions. While actual number of sessions was related to expected number of sessions, termination status appeared to be related to clinical factors and not clients' expected number of sessions. Implications for clinical practice and agency session limit policies are discussed.

KEYWORDS *treatment duration, dose response, session limits, working alliance, treatment outcome*

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INTRODUCTION

The therapeutic contract, including the session limits, creates an organizing system within which clients and therapists frame their clinical work. In university counseling centers (UCC), the clinical and policy issues related to session limits are complicated by many factors, such as the increase in students needing services, limited staffing (Gallagher, 2007), client severity, and constraints in the referral process (Hatchett, 2004; Owen, Devdas, & Rodolfa, 2007; Stone & Archer, 1990). Nearly half of UCCs have session limit policies, with more than 80% of those UCCs allotting 15 or fewer sessions (median 12 sessions) (Gallagher, 2005). However, clinically it is questionable if 12 to 15 sessions are sufficient for the majority of clients to significantly improve their functioning. That is, studies examining the average number of sessions needed for clinically significant change reveal that for 50% of clients to demonstrate clinically significant change, 14 to 20 sessions are necessary (Anderson & Lambert, 2001; Wolgast, Lambert, & Puschner,, 2003; Wolgast, Rader, Roche, Thompson, & Goldberg, 2005).

Despite the growing evidence that longer-term services may be necessary for some clients, evidence shows clients may not want longer term services. For years it has been documented that the majority of clients attend 10 or fewer sessions (Draper, Jennings, Baron, Erdur, & Shankar, 2002; Garfield, 1994). Consistently, the literature in outpatient settings exploring clients' anticipated number of sessions has shown that clients generally expect 10 sessions (Garfield, 1994; Pekarik & Wierzbicki, 1986). However, to date, limited known studies have examined UCCs clients' expectation for treatment duration. Moreover, clients' expectations for treatment duration should not be conflated with attendance. For instance, clients' expectation for treatment duration does not fully account for the reasons why 40% to 50% of clients unilaterally terminate services (Hatchett, 2004; Wierzbicki & Pekarik, 1993).

Additionally, today's college student populations, commonly referred to as the millennium generation, show more acceptance of therapy (Kitzrow, 2003) and have received more support by parents, teachers, and mentors (Textor, 2007). Moreover, UCCs have experienced an increase in students seeking treatment (Gallagher, 2007) and some studies have noted an increased in college students' psychological distress (e.g., Benton, Robertson, Tseng, Newton, & Benton, 2003; Cornish, Kominars, Riva, McIntosh, & Henderson, 2000; Erdur-Baker, Aberson, Barrow, & Draper, 2006). As such, new research is needed to disentangle current college students' expectations for treatment duration from their need for services. In other words, it is unclear to what extent today's college students expect long (or short) term services and to what degree their expectation are related to clinical indicators such as treatment effectiveness and dropout. The current study sought to address these gaps in the literature, which should supplement the treatment dose-response research and practical considerations (e.g., staffing) to assist UCCs in clinical decisions and administrative policies regarding session limits.

Session Limits, Expected Number of Sessions, and Treatment Outcome

UCCs with or without session limits appear to have few differences in their students' likelihood for seeking counseling (Uffleman & Hardin, 2002) and their clients' attendance in therapy (Gallagher, 2005; Gyorky, Royalty, Johnson, 1994). Moreover, Orlinsky, Ronnestad, and Willutzki (2004) noted the results for the overall effectiveness of treatment for time-limited versus unlimited vary. They suggested that other factors (e.g., clients' expectations, process variables, etc.) might better explain the variance seen in treatment outcome.

Across therapies, clients' expectations have emerged as a consistent common factor related to treatment outcome (Imel & Wampold, 2008; Lambert & Ogles, 2004; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003). Of the many expectations clients have about therapy, their expectations about session limits serve as a framework for their engagement in the therapy process. For instance, Barkham and colleagues (1996) randomized clients to either 8 or 16 sessions of treatment for depression and found that clients who received 8 sessions demonstrated quicker rates of improvement as compared to the clients who received 16 sessions; however, the clients who received 16 sessions demonstrated the greatest improvement at the end of treatment.

Additionally, clients' expectation for more sessions likely conveys a meaning about their desire for psychological help. In a discussion of the effectiveness of time-limited sessions, Tryon (1995) noted a client's concern regarding the amount of treatment he or she was to receive: "Most of us need care. A limitation set from the beginning makes us feel not really cared for." Furthermore, Owen (2005) noted another student's concern:

> The eight meeting limit feels very restrictive. I was hesitant to begin counseling knowing that I would have to meet (and pay a higher price for) a counselor outside of campus if I wanted to discuss more complicated issues. It created the qualification, "Can my problem be solved satisfactorily in eight weeks?"

These anecdotal statements may reflect the attitudes of a sizable number of clients at UCCs; however, at the present time, little empirical data exists on the topic. For UCCs to consider clients' expected number of sessions in the formation of session-limit policies, empirical evidence should explore the need for sessions and the clinical implications of clients' needs. We posit that clients' expected number of sessions might relate to their current psychological distress and is also likely related to treatment effectiveness. Given that expected number of sessions may be seen as a relatively arbitrary metric—possibly related to generational attitudes or other cultural factors (e.g., stigma of counseling, exposure to counseling, etc.) about therapeutic services— it is important to discern expectations from distress.

Treatment Dose Response, Termination Status, and Clients' Expected Number of Sessions

Of the many factors under consideration in session limit policies, UCCs should also entertain studies that examine the average number of sessions need for clinical gains (e.g., treatment dose-response literature). In UCCs, approximately 14 to 20 sessions are needed to significantly increase the functioning of 50% of clients, and nearly 40 sessions are necessary for 75% of clients to make clinically significant change (e.g., Anderson & Lambert, 2001; Howard, Kopta, Krause, & Orlinsky, 1986; Wolgast et al., 2003; Wolgast et al., 2005). These studies add to the growing treatment outcome literature, which has commonly found that most gains in therapy occur prior to session 10, then subsequent, changes occur at a slower rate (Lambert & Ogles, 2004). Additionally, clinical wisdom and empirical evidence both suggest that symptom distress appears to abate quicker than interpersonal and characterological problems (Lambert & Ogles, 2004). In combination, these studies can be informative for UCCs to guide policies about the types of presenting problems and severity levels that can be feasibly treated within the session-limit framework.

Yet, the benefit of the treatment dose response literature is only as helpful as clients utilize the services offered. For instance, in one of the largest studies of treatment outcomes in UCCs, which included over 40 centers, Draper and colleagues (2002) found that 38.2% of the clients improved (any increase in Outcome Questionnaire–45 [OQ-45] scores) by the end of treatment (only clients who attended 1 to 10 sessions were analyzed; median 3 sessions). Furthermore, 54% of clients did not change, and nearly 8% deteriorated at the end of treatment (Draper et al., 2002). Given the needed number of sessions for clinically significant change, it is perplexing that many clients leave therapy prior to benefiting as indicated by self-report measures.

In fact, nearly 50% of clients unilaterally drop out of therapy (Hatchett, 2004; Wierzbicki & Pekarik, 1993). Some explanations for this dropout rate include client's expectations for length of therapy, clinical distress, improvement of problems, and lower reports of working alliance with their therapist (Garfield, 1994; Miller, Duncan, & Hubble, 2004; Mueller & Pekarik, 2000; Pekarik, 1985; 1992). However, there are a few studies examining clients' expected number of sessions as it relates to termination status, especially in UCCs. We proposed that clients might expect longer treatment, but other clinical processes, such as low working alliance with their therapist, influence their desire to continue therapy. Working alliance is one of the most consistent predictors of treatment outcome (Orlinsky et al., 2004), and low alliance scores are related to dropout (Duncan et al., 2003). Furthermore, we posited that the clients who were less clinically distressed would be more likely to end therapy of their own volition, regardless of their expectation for more

sessions. Simply, clients' perceived distress, and thus need for services, would influence their attendance more than their expectation for more sessions.

The Current Study

The purpose of the current study was to examine UCCs clients' expected number of sessions. We first examined, descriptively, clients' expected number of sessions and then comparatively based on clients' termination status (e.g., currently in therapy, client-initiated end of therapy, mutually decided termination, etc). Second, we tested the relationship between expected number of sessions and actual number of sessions. Similar to previous research, we anticipated that clients who expected more sessions would attend more sessions. Third, we predicted that clients who reported that they would like to have more sessions would indicate that therapy was less effective (i.e., lower levels of current psychological well-being) after controlling for their initial emotional state and termination status. Last, we expected that other clinical factors, such as working alliance, initial emotional state, and current psychological distress, would predict clients' termination status; whereas clients' expected number of sessions would not significantly contribute to this prediction.

METHODS

Participants

Six hundred thirty clients were recruited to participate over one year at a large UCC in the Western United States. This study utilized two samples. The first sample was recruited at mid year (n = 319) and second sample was recruited at the end of the year (n = 311). Clients were only sent recruitments once even if they were in treatment over the entire year. The final sample consisted of 478 clients who answered the required questions or received individual therapy. The clients' education levels were 9.4% freshmen, 9.2% sophomores, 12.9% juniors, 19.7% seniors, 32.9% graduate students, and 1.4% other (14.6% did not indicate their educational level). Seventy-three percent of the participants were female (27% male) with a median age of 22 years old (range 17 to 50). For the factor of race/ethnicity, 49.8% were Caucasian, 14.6% identified as Asian American, 7.3% identified as Hispanic/Latino(a), 10.6% identified as Multiethnic, .5% were African American, 1.6% identified as Other, and 15.6% did not indicate their ethnicity.

These demographics are similar, but not identical, to the total client population at this UCC. The client population was 26% graduate students, 28% seniors, 20% juniors, 12% sophomores, 11% freshman, and 3% other. Sixty-seven percent were female (33% male) and the racial/ethnic identification was 51% Caucasian, 28% Asian American, 14% Hispanic, 4% African American, 1% Native American, and 2% did not indicate. There is no data on the average age of the clients at this UCC.

Procedure

During the intake process, clients endorsed, on their intake card, if they would be willing to receive a survey about their therapy experience. Clients who agreed were sent an e-mail that contained a link to the survey instruments online (response rate 31%). Clients were initially given the informed consent, then they responded to the psychological well-being, alliance, and questions about their therapy experience. They also responded to some open-ended questions (not analyzed here) that were primarily used for evaluation purposes of the clinic.

Measures

Expected number of sessions

Clients were asked, "How many sessions would you like to have at [UCC] if there were unlimited resources?" The response format was open-ended. These responses were consensus coded by the first two authors. The agreed on groupings were "10 or fewer" (n = 46), "11 to 20" (n = 82), "20 or more" (n = 297), and "Not sure" (n = 53).

Schwartz Outcome Scale–10

The Schwartz Outcome Scale–10 (SOS-10; Blais, et al., 1999) is designed to assess current psychological well-being through 10 items on a seven-point scale (range 0–6). The reference sample ($N > 9{,}000$) for the SOS-10 was drawn from various clinical populations (e.g., inpatient, outpatient, college counseling centers) and nonclinical populations (e.g., adults from the community and college students; Blais, et al., 1999; Owen, Rhoades, Fincham, & Stanley, in press; Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003; see Owen & Imel, in press). Across studies, the SOS-10 has exhibited strong reliability (test/retest, r = .88; Cronbach's alpha = .91; Blais & Baity, 2005). Furthermore, the SOS-10 has strong convergent and divergent validity as it correlates in the predicted direction with a variety of clinical and psychological well-being scales (e.g., Beck's Hopelessness Scale, OQ-45, the Positive and Negative Affect Schedule, the Personality Assessment Inventory) and can reliably discern between clinical and nonclinical samples (Blais et al., 1999; Owen et al., in press; Young et al., 2003).

Working alliance scales

We used two different working alliance measures for the two samples. The first sample completed the College Treatment Alliance Scale (CTAS; Blais, 2004; Owen et al., 2007), which is a measure of working alliance adapted

from the Inpatient Treatment Alliance Scale (Blais, 2004). The CTAS consists of 10 items reflective of concepts from the popularly used alliance measures that assess clients' perceptions of agreement on goals of therapy, methods or tasks to reach those goals, and the emotional bond (Blais, 2004). In the current study, Cronbach's alpha was .94.

The second sample completed the Individual Therapeutic Alliance Scale Revised–Short Form, (ITASr-SF; Pinsof, 1994; Pinsof, Zinbarg & Knobloch-Fedders, 2007). This alliance measure is a systems-oriented alliance measure that includes clients' relationship with the therapist as well as how significant other people would feel about the goals, tasks, and their bond with the therapist. For purposes of this study, we analyzed only the clients' relationship with their therapist in order to have a better comparison with the first sample. The Cronbach's alpha was .92.

We created a z-score for alliance to compare the alliance scores for both samples. There was a small mean level difference in the z-score between the two samples (mean difference = .37; t = 4.38, $p < .05$). This difference could be due to the sample or the measure; however, given the administration we were not able to disentangle the reasons for the differences. Both versions of the alliance measures positively correlated with psychological well-being (i.e., treatment outcome; r = .37 ITASr-SF; r = .29 CTAS), which supported its use in the current study.

Initial emotional state

Initial emotional state was assessed retrospectively by a single item, "How were you feeling when you started therapy," adapted from the Consumer Reports (CR, 1995; see Seligman, 1995). This item was rated on a five-point scale. This item has been validated through correlations with the OQ-45. Nielsen and colleagues (2004) compared clients' recall of emotional state at intake with the OQ-45 (Lambert et al., 1996), which was filled out before every session. The results showed that clients scores at intake on the OQ-45 were strongly correlated with clients' recall of their initial emotional state after 55 weeks, (r = –.57; Nielsen et al., 2004). The negative correlation reported here is due to the wording of emotion-intake item and OQ-45. Nielsen and colleagues (2004) concluded that the relationship was "of sufficient magnitude to fall low within the range of validity indexes generally accepted for measures of psychotherapy outcome" (p. 33). Furthermore, clients' recall of emotional state was not affected by the length of time between when they started therapy and when they completed the retrospective assessment (Nielsen et al., 2004). This item has been used in subsequent studies as to control for pretherapy functioning (e.g., Nielsen et al., 2004; Owen, Stratton, & Rodolfa, n.d.; Seligman, 1995).

How therapy ended

Clients were asked how therapy ended through a forced choice format. Responses were: (a) client initiated the end of therapy without talking with the therapist (client end: no-show; n = 66), (b) client initiated the end of therapy after talking with the therapist (client end: discuss; n = 45), (c) therapist initiated the end of therapy (therapist end; n = 22), (d) the end of therapy was mutually decided (mutual end; n = 123), and (e) currently in therapy (currently in therapy; n = 201).

RESULTS

First, we descriptively examined clients' expected number of sessions. Results demonstrated that 62% of clients expected 20 or more sessions, 17.2% of clients expected 11 to 20 sessions, 9.6% of clients expected 10 or fewer sessions, and 11.1% of clients were "not sure." For parsimony, we excluded the "not sure" group in subsequent analyses since the meaning of this group is unclear. Next, we contrasted how clients ended therapy and their expected number of sessions (see Table 1). Regardless of how therapy ended, over 50% of clients expected 20 or more sessions. For instance, 75% of clients who endorsed that their therapist initiated the end of therapy expected 20 or more sessions and approximately 65% of clients who did not discuss the end of therapy with their therapist (e.g., no-show) wanted 20 or more sessions.

To address our second hypothesis, we examined if clients' actual number of sessions varied based on their expected number of sessions. An ANOVA was conducted with actual number of sessions as the dependent variable and expected number of session groups as the independent variable. The results were statistically significant, $F(2, 407) = 25.03$, $p < .001$, and all comparisons were significant ($p < .01$). Supporting our hypothesis, clients who expected 10 or fewer sessions attended 3.32 (SD = 1.99) sessions, clients who expected 10 to 20 sessions attended 6.20 (SD = 3.68) sessions, and clients who expected 20 or more sessions attended 8.68 sessions (SD = 5.70).

TABLE 1 Descriptive Statistics for Clients Expected Number of Sessions by Termination Status

	Termination status				
Expected sessions	Client end: No-show	Client end: Discuss	Therapist end	Mutual end	Currently in therapy
Under 10	21.6%	19.5%	5.0%	9.7%	7.0%
10 to 20	13.7%	24.4%	20.0%	26.5%	15.1%
20 or more	64.7%	56.1%	75.0%	63.7%	78.0%

Note: Cells reflect the percentage of clients who stated they wanted X number of sessions based on their therapy status.

Third, we predicted treatment outcome (e.g., SOS-10 scores) based on clients' expected number of sessions, working alliance, after controlling for initial emotional state, and termination status. The results of a multiple regression were statistically significant, $F(8, 397) = 19.82$, $p < .001$, $R^2 = .29$. As seen in Table 2, initial emotional state was negatively related and working alliance was positively related to treatment outcome. Clients who initiated the end of therapy by discussing it with their therapist or "no-showed" and clients who reported that therapy ended based on a mutual decision reported statistically significant better outcomes than clients who were still in therapy. However, clients who stated that their therapist ended treatment were functioning equally as well as clients who were still in therapy. Related to our hypothesis, clients who expected 20 or more sessions had lower SOS-10 scores than clients who expected 10 to 20 or fewer than 10 sessions. No significant difference was found between clients who expected 10 to 20 session and those clients who expected fewer than 10 sessions, $B = -.16$, $p > .05$. Accordingly, these results provide partial support for our third hypothesis.

Last, we predicted termination status by clients' expected number of sessions, initial emotional state, current psychological well-being, and working alliance through a multinomial logistic regression. The overall model, with all predictors, was statistically significant, $\chi^2 = 77.50$, $p < .001$. The results in Table 3 are presented as a contrast to clients who are currently in therapy. Regardless of how therapy ended, clients reported lower working alliance with their therapist than clients who are currently in therapy. The results for psychological well-being are consistent to the previous analysis. Clients' expected number of sessions did not predict how therapy ended for any of the comparisons between groups (e.g., client end, no-show versus mutual

TABLE 2 Summary of Prediction of SOS-10 by Working Alliance, Pretherapy Functioning, and Expected Number of Sessions

	B (se)	t	sr
Pretherapy functioning	−.37 (.06)	−6.54**	−.32
Alliance	.44 (.05)	8.42**	.39
Expected sessions (20 plus is the comparison group)			
Under 10	.49 (.17)	2.98**	.15
10 to 20	.33 (.13)	2.60**	.13
Termination status (Currently in therapy is the comparison group)			
Client-end: Discuss	.52 (.17)	3.15**	.16
Client-end: No-show	.30 (.15)	1.97*	.10
Therapist end	.45 (.24)	1.83	.09
Mutual end	.49 (.12)	4.10**	.20

*$p < .05$.
**$p < .01$.
sr = semipartial correlations.

TABLE 3 Summary of Multinomial Regression Predicting How Therapy Ended by SOS-10, Alliance, Expected Number of Sessions

	B (se)	Exp (B)	95% CI for Exp (B)
Client end: No-show[1]			
Pretherapy	.14 (.21)	1.15	.76–1.74
Alliance	−.88** (.20)	.42	.28–.61
SOS-10	.36* (.17)	1.43	1.02–2.00
ES: 10 or fewer[2]	.90 (.50)	2.47	.93–6.54
ES: 10 to 20[2]	−.14 (.49)	.87	.33–2.25
Client end: Discuss[1]			
Pretherapy	.12** (.23)	1.12	.72–1.75
Alliance	−.74** (.23)	.48	.31–.75
SOS-10	.67** (.21)	1.95	1.30–2.92
ES: 10 or fewer[2]	.74 (.55)	2.10	.72–6.12
ES: 10 to 20[2]	.50 (.45)	1.65	.68–4.01
Therapist end[1]			
Pretherapy	.87* (.35)	2.40	1.20–4.78
Alliance	−.97** (.28)	.38	.22–.65
SOS-10	.41 (.26)	1.50	.91–2.48
ES: 10 or fewer[2]	—[3]	—	—
ES: 10 to 20[2]	−.18 (.69)	.83	.21–3.25
Mutual end[1]			
Pretherapy	.40* (.16)	1.49	1.08–2.06
Alliance	−.40* (.18)	.67	.47–.95
SOS-10	.57** (.14)	1.78	1.36–2.33
ES: 10 or fewer[2]	.21 (.46)	1.24	.50–3.06
ES: 10 to 20[2]	.53 (.32)	1.71	.90–3.22

[1]Comparison group is currently in therapy.
[2]ES = expected number of sessions, and the comparison group is 20 or more sessions.
[3]There was insufficient cell size for this comparison.
*$p < .05$.
**$p < .01$.

end, therapist end versus client end–discuss, etc.). These results support our last hypothesis insofar that other clinical factors better predicted termination status than clients' expected number of sessions.

DISCUSSION

UCCs often need to establish administrative policies regarding session limits to provide adequate care with limited staff. Beyond practical factors, such as available staffing, UCCs should also utilize empirical evidence to guide their decision-making process. Our results highlight three main points: (a) the majority of clients (62%) want 20 or more sessions; (b) clients' expected number of sessions predicted treatment outcome even after controlling for initial emotional state, working alliance, and how therapy ended; and (c) other clinical factors, and not clients' expected number of sessions,

predicted termination status. These results should accompany other salient empirical evidence, namely the treatment dose-response literature, and clinical expertise (e.g., treatment for studies who have varying developmental needs [see Webb & Widseth, 1988; Widseth & Webb, 1992] to assist UCCs in their policy decisions.

College students today are growing up in an era where they expect (and possibly need) more from the UCC services than universities offer. Our study shows a marked increase in clients' expected number of sessions in contrast to previous research (e.g., 10 or fewer; Garfield, 1994). Potentially, the difference is generational as previous studies were primarily conducted in the 1980s. As commonly noted, this generation of college students are consumer-savvy, resourceful, and for some, expect more from those around them (Textor, 2007), which may also include UCCs. Alternatively, previous studies were primarily conducted with outpatient samples and not with college student samples. Nonetheless, the majority of clients want more sessions than are typically offered at this UCC (e.g., 6 to 10) or nationally at UCCs with session limits (e.g., 10 to 15; Gallagher, 2005). Accordingly, some clients will likely be disappointed about their potential to get the help they believe they need at UCCs.

In our study, students' expectation for more sessions appears to be rightfully justified. For instance, clients who wanted 20 or more sessions reported fewer gains in treatment. Thus, their expectation for more sessions could indicate a continued need for psychological help. Interestingly, this finding holds true for clients who decided to end therapy unilaterally, mutually with their therapist, or were still in therapy. This finding is consistent with studies that suggest approximately 20 sessions are necessary for 50% of clients to experience clinically significant change (Anderson & Lambert, 2001; Wolgast et al., 2003; Wolgast et al., 2005).

Similar to previous research (e.g., Mueller & Pekarik, 2000), we found clients who expected more sessions attended more sessions. While the corollary relationship does not allow us to interpret the directionality of this result, it does show clients' expected number of sessions relates to their attendance in therapy. However, it did not predict their termination status. For instance, 64% of clients who endorsed that they agreed with their therapist about the end of therapy and 65% of clients who initiated the end of therapy by "no-show" expected 20 or more sessions.

In contrast, termination status was predicted by other clinical factors, such as working alliance and psychological well-being; that is, clients who are no longer in therapy reported lower levels of working alliance with their therapist as compared to clients in therapy. Potentially, it would be incongruent for clients who are currently in therapy to report a low alliance with their therapist. It is also likely and consistent with previous research (e.g., Duncan et al., 2003) that clients who initiate the end of therapy, for instance, would have a lower alliance with their therapist. Regardless, clients'

expected number of sessions did not significantly relate to termination status. Thus, by using clients' continuation in therapy as an indicator of what session limits to set might not fully account for clients' expected or needed number of sessions. Furthermore, this finding highlights the need for more attention to clinical processes at UCCs that may be related to more successful therapy.

As it relates to the termination process, clients' who endorsed that they initiated the end of therapy or that they mutually decided to end therapy with their therapist demonstrated better outcomes than clients who were currently in therapy. In contrast, and unexpectedly, clients who reported that their therapist initiated the end of therapy demonstrated similar levels of psychological well-being as clients who were currently in therapy. Of these clients, nearly three-quarters expressed an expectation for 20 or more sessions. While it is unclear the steps that the therapists took to end therapy (e.g., referrals) and the reasons for termination, it highlights the need for further inquiry into the finer aspects of the termination process. Potentially, therapists who intended to end treatment might want to prepare the client to ensure a better transition (see Quintana & Holahan, 1992).

Implications for Clinical Practice and UCC Policies

Administrative and clinical implications regarding the session limits of UCCs extends past the fact that some clients may expect more sessions than universities can offer. For many students, UCCs may be their only avenue to psychological treatment. Therapists typically make referral decisions based on financial issues or other barriers (e.g., transportation) to treatment (Lacour & Carter, 2002; Quintana, Yesenosky, Kilmartin, & Macias, 1991). Moreover, Owen and colleagues (2007) found that over 40% of clients did not follow through or could not follow through with referral recommendations. Therefore, clinicians need resources that will support clients who expected more sessions, need more sessions, and/or are not able to connect with community providers. UCCs could consider the following: (a) A structured longer-term treatment program for clients. Such a program should have established criteria to ensure fairness for clients. (b) Establish a longer term group therapy, which may be more economically viable. (c) Ensure insurance coverage will be sufficient for clients to be adequately covered by community mental health providers and encourage these providers to be paneled.

Clinically, clients' expected number of sessions provides a foundation for the therapeutic work. Clients differed in their expectations for treatment duration and these expectations were linked to the progress they had made in therapy. Simply asking clients at the start of treatment their expectations for treatment length may assist clinicians and therapists to clarify the frame of therapy and therefore, increase the ability for therapy to meet the needs

of clients. Since termination status was related to clinical factors (e.g., working alliance) and not clients' expected number of sessions, therapists could also benefit from monitoring their alliance with clients to ensure better treatment. We suggest that therapists: (a) periodically discuss the therapeutic relationship to ensure agreement for the goals of therapy and relational alignment; (b) collect session by session systematic feedback to therapists via self-report measures, which has been shown to be efficacious in previous research, to decrease dropout and increase therapeutic effectiveness (see Lambert, 2007; Miller et al., 2004); and (c) consider supervision or peer-consultation in an environment where they can honestly express their reactions about clients (e.g., countertransference), process feelings of burnout (if applicable), and continue to learn new approaches with clients.

LIMITATIONS AND FUTURE RESEARCH

This study, similar to most, is not without its limitations, and the results should be examined within these constraints. First, our study was retrospective in nature. While this assessment method is viable and provides a wealth of information, especially about clients who have terminated, it does not provide the control of prospective designs. In particular, clients' expected number of sessions may have been inflated. However, given the large percentage of clients who expected 20 or more sessions (e.g., >60%), it would take a large correction to adjust this findings with previous research. Nonetheless, future studies should use prospective designs to explore the relationship between clients' expected number of sessions with the average number of sessions needed for clinical significant change.

Second, our response rate, while consistent with other electronic surveys (Northey, 2005), may also have a response bias. Third, this study examined only one large UCC that had session limits (e.g., 6 to 10 sessions), thus it is unknown to what degree this session-limit policy might have impacted students' expected number of sessions. Furthermore, we do not have data on students' proclivity to return to the UCC. In prior studies, students tend to use therapy at UCC periodically over their academic career, which may reflect developmental needs at different times in their lives (Webb & Widseth, 1988; Widseth & Webb, 1992). Fourth, we did not assess generational attitudes or cultural factors (e.g., attitudes about therapy) that could related to expectations for number of sessions. Last, the current study was one of the first studies to operationalize termination status from the client's perspective. Most studies have relied on therapists' account of termination (Wierzbicki & Pekarik, 1993). While there are advantages and disadvantages to both approaches, each have the potential for bias as they only reflect one perspective (either the therapist's or the client's).

Summary

With nearly half of college students reporting significant distress affecting their daily functioning (Federman, 2007), it is important that UCCs understand the implications that result from limiting clients' sessions. Clearly, the results from this study show that clients want more sessions than available in the short-term model at most UCCs with session limits. Furthermore, clients' need for more sessions is linked to their psychological distress. Thus, UCCs may benefit from examining their policies on session limits in order to (a) accommodate for students expecting more sessions and (b) act accordingly to the empirical evidence on treatment dose-response. Ultimately, it is our hope that this study will increase the dialogue at UCCs about session-limit policies and clinical practices to effectively treat students who need additional services.

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