What went wrong? Therapists’ reflections on their role in premature termination

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Abstract
The present study used Consensual Qualitative Research methodology to explore how experienced therapists understand and learn from impactful cases of premature termination. Eleven board certified psychologists were interviewed regarding a former client who left treatment prematurely. Participants were asked to reflect on client and therapist factors that may have contributed to premature termination, and on how the termination affected their work and professional development. Results indicated that therapist reactions and mistakes may contribute to the risk of premature termination, and that therapists may experience complex and lasting personal reactions to such outcomes. While they may face considerable uncertainty, therapists can learn valuable lessons by reflecting on departed clients. Implications for research and practice are discussed.

Keywords: Psychotherapy; premature termination; professional development

When clients leave psychotherapy without explanation, their therapists often wonder what went wrong? While therapists may assume personal responsibility for the unexplained outcome, they are more likely to attribute premature termination to client factors (Murdock, Edwards, & Murdock, 2010). Past estimates indicate that, depending on how terminations are classified, between 30 and 60% of clients drop out of treatment prematurely (Reis & Brown, 1999). Although scholars have long recognized that premature termination is costly for both clients and service providers (Pekarik, 1985), they have struggled to identify specific factors that predict such unwanted outcomes. In a review of the literature, Corning and Malofeeva (2004) concluded that “to date there has been almost no concrete identification of the factors that influence the likelihood of [premature termination]” (p. 354). While low socio-economic status (SES) of clients has been the most consistent predictor of premature termination (Arnow et al., 2007; Connell, Grant, & Mullin, 2006), some argue that the association is better explained by divergence between client and therapist with regard to expectations about treatment (Wierzbicki & Pekarik, 1993) or cultural perspective (Maramba & Nagayama Hall, 2002). More recently, Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson (2008) summarized growing evidence of an association between weakness in the therapeutic relationship and higher rates of treatment dropout. Given the inconclusiveness of the current body of research, we set out to explore therapists’ reflections on especially memorable cases of premature termination, the reasons for the outcome, and the subsequent impact on their professional development.

Efforts to understand premature termination are complicated by the fact that clients and therapists have distinct perspectives and offer different explanations for why therapy ends. Broadly speaking, clients tend to report reasons for leaving treatment that fall within three categories: problem improvement, environmental obstacles, and dissatisfaction with services (Pekarik, 1983). In contrast, therapists tend to perceive all dropouts as treatment failures (Pekarik, 1985), they have struggled to identify specific factors that predict such unwanted outcomes. In a review of the literature, Corning and Malofeeva (2004) concluded that “to date there has been almost no concrete identification of the factors that influence the likelihood of [premature termination]” (p. 354). While low socio-economic status (SES) of clients has been the most consistent predictor of premature termination (Arnow et al., 2007; Connell, Grant, & Mullin, 2006), some argue that the association is better explained by divergence between client and therapist with regard to expectations about treatment (Wierzbicki & Pekarik, 1993) or cultural perspective (Maramba & Nagayama Hall, 2002). More recently, Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson (2008) summarized growing evidence of an association between weakness in the therapeutic relationship and higher rates of treatment dropout. Given the inconclusiveness of the current body of research, we set out to explore therapists’ reflections on especially memorable cases of premature termination, the reasons for the outcome, and the subsequent impact on their professional development.

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In recognition of the challenges to understanding the reasons for premature termination, some researchers have turned their attention to factors that influence the client-therapist relationship. Reis and Brown (1999) found that client personality characteristics, such as counseling readiness and psychological mindedness, were associated with continuation in therapy, while characteristics such as defensiveness, impulsivity, low frustration tolerance, and poor motivation were associated with premature termination. Frayn (1992) found that therapists rated clients who were treatment dropouts as having lower levels of introspection, frustration tolerance, impulse control, and motivation, as well as greater hostility toward past caregivers and their present life circumstances. Hilsenroth, Handler, Toman, and Padawer (1995) compared treatment terminators and completers on personality measures and found that clients who ended therapy prematurely tended to be less aggressive, more cooperative, and less in need of closeness. Mahon (2000) reviewed the literature on clients diagnosed with eating disorders and concluded that those with less secure attachment styles were more likely to drop out of treatment. More recently, Barrett and colleagues (2008) conducted a review of the literature and concluded that, despite unresolved methodological problems, a growing body of evidence suggests that there is an association between weakness in the therapeutic alliance and increased likelihood of premature termination.

In light of methodological problems that limit the conclusiveness of findings, scholars have encouraged the use of a broader array of research methods. Corning and Malofeeva (2004) summarized the shortcomings of conventional studies on premature termination, and suggested that process-oriented research could produce more meaningful findings. Similarly, Maramba and Nagayama Hall (2002) suggested that, rather than searching for predictors of premature termination among static client or therapist traits, researchers should explore the effects of process variables on the course of treatment. To that end, Barrett and her colleagues (2008), as well as Mahon (2000), recommended the use of qualitative analysis to explore the phenomenon of premature termination and its precipitants during the course of therapy.

**Impact on the Therapist**

Though rarely discussed in the literature, the premature departure of a psychotherapy client may negatively impact a therapist’s approach to future clients, professional development, and personal well-being. Guy (1987) noted that therapists may feel hurt, abandoned, or betrayed by their clients, as well as disappointed that they failed to complete treatment. Reis and Brown (1999) added that therapists may feel demoralized in the empty time created by their clients’ absence. Ogrodniczuk, Joyce, and Piper (2005) pointed out that “for therapists whose own self-esteem is closely tied to their ability to help others, the loss of a patient through premature termination threatens their sense of self-worth” and may be experienced as a “narcissistic injury” (p. 58). Frayn (1992, 2008) highlighted the feelings of impotence and rage that can arise in therapists, particularly when the client leaves in the midst of a transference-countertransference enactment.

Premature termination may trigger powerful negative emotions that can interfere with a therapist’s ability to work effectively. Farber (1983) found premature termination to be the third greatest source of stress (behind client suicidal threats and hostility) among psychologists, psychiatrists, and social workers. Several authors have warned that the failure of treatment can erode therapists’ sense of confidence and effectiveness (Connell et al., 2006; Frayn, 1992, 2008; Ogrodniczuk et al., 2005). Meanwhile, therapists may overcompensate for these painful experiences by distancing themselves from, or becoming overly connected to, their current and future clients (Guy, 1987). Pekarik (1985) cautioned that repeated instances of treatment dropout can chip away at the job satisfaction of therapists, and may ultimately contribute to “burnout.”

If unchecked, the loss of pleasure and interpersonal satisfaction associated with premature termination can also bleed into the therapist’s personal life (Norcross & Guy, 1989; Ogrodniczuk et al., 2005). As Guy (1987) pointed out, therapists face the paradoxical goals of fostering both attachment and independence, closeness and separation. The constant coming and going of clients may generate “feelings of loss, loneliness, abandonment, and isolation” (p. 90) in therapists. Ironically, the threat of treatment failure may loom larger for therapists who strive to maintain genuine warmth and empathy in their therapeutic relationships.

Several aspects of clinical work may predispose therapists to feeling threatened by an unexpected termination. Guy and his colleagues have written lucidly about the personal challenges faced by those who work as therapists (Guy, 1987; Guy, Poelstra & Stark, 1989; Norcross & Guy, 1989). Guy (1987) points out that “many are drawn to a career in psychotherapy due to a hunger for closeness, intimacy, and meaningful attachment” (p. 86), adding that it is not uncommon, or necessarily undesirable,
for a therapist to become attached to his or her clients. Therapists' personal investment in their clients may increase their vulnerability to the emotional toll of premature termination. Also, in order to maintain a positive self-image, therapists may prefer to see themselves as the “good therapist” for their clients (Guy, 1987), an image that is particularly attractive given the difficult and only intermittently rewarding task of conducting psychotherapy. Finally, it is important to acknowledge that therapy is a paid service, and that the departure of a client may result in financial strain for a therapist.

Given the potential consequences of premature termination, therapists may find ways to protect their sense of competence and well-being. In a recent study, Murdock and colleagues (2010) asked practicing therapists to read clinical vignettes describing cases of premature termination and rate the likelihood that client, therapist, or environmental factors had caused the outcome. The researchers manipulated the perceived relationship to the client by randomly assigning participants to read a vignette that contained language referring to either “your client,” or “the client.” Those who read vignettes referring to “your client” were more likely to attribute termination to causes associated with the client and the situation, while those who read vignettes describing “the client” attributed termination to therapist factors. Murdock and colleagues concluded that the therapists had engaged in a self-serving bias in which those who were prompted to think of the client as their own tended to avoid responsibility for the premature termination by blaming the client. This bias may serve to protect therapists from threats to their self-esteem which arise when clients leave treatment abruptly.

The Present Study

Given that therapists and researchers alike face unanswered questions about the causes of premature termination, we speculated that our limited understanding is meaningful in and of itself. As such, we chose to examine how therapists grapple with this uncertainty. The aim of the present study was to examine how therapists understood salient cases of premature termination, and what impact these cases had on them personally and professionally. Given the personal nature of these questions, the scarcity of existing research on the topic, and the call for process-oriented research, we chose to collect narrative data from interviews with experienced therapists, and to analyze the data using qualitative research methods. In order to obtain data on influential cases, we asked each therapist in the study to describe a single case of premature termination that he or she found particularly impactful or perplexing. Using a semi-structured interview, we asked these therapists to reflect on a number of issues, including the following: warning signs observed during treatment; assumed reasons why the client left therapy; their own contribution to the outcome; what they would do differently in retrospect; and the impact the termination had on them personally and professionally.

Method

This study followed the Consensual Qualitative Research (CQR) methodology developed by Hill, Thompson, and Williams (1997) and later revised by Hill and her colleagues (2005). Philosophically constructivist, CQR assumes that reality is experienced subjectively, and that our shared understanding of reality is created socially. As such, the CQR method uses semi-structured interviews in order to obtain first-hand accounts of phenomena from a small group of participants (eight to 15). CQR employs a team of researchers who code the ideas expressed by participants into comparable units (e.g., core ideas). A CQR research team strives to represent the data as accurately and objectively as possible by attending to their biases and expectations, remaining true to the words of the interviewees, requiring agreement on all coding decisions, and having an outside auditor check the coding. Meaning is derived from the data through a recursive process in which data are coded first to reflect the statements of individual participants, and second to reflect themes emerging across the sample. CQR offers a number of benefits, including: (a) a means to accurately reflect participants' reports of their internal experiences, (b) a rigorous and replicable research design, and (c) a systematic process for identifying common themes in interview data while also managing researcher bias. The results of CQR analysis are not intended to generalize beyond the study sample, but are meant to accurately reflect themes emerging from the data, and to achieve applicability to the relevant areas of practice.

Participants

Therapists. Eleven practicing clinical psychotherapists were recruited through the public database of the American Board of Professional Psychology (ABPP), an organization composed of experienced psychologists. The principal investigator obtained email addresses for recruits by searching the ABPP online member directory (ABPP, 2008) for Clinical Psychologists listed as practicing in Massachusetts, Vermont, New Hampshire, Rhode Island,
Connecticut, and New York. The resulting list of ABPP therapists was then limited to 122 clinical psychology diplomates whose listed addresses fell within a 2-hour drive of the University of Massachusetts Amherst. Of the 122 therapists contacted, 42 responded, and 11 met selection criteria. Participation was limited to psychotherapists who identified their approach to treatment as integrative or eclectic in order to disassociate the research findings from any specific theoretical orientation. The resulting sample was composed of 11 psychologists in private practice (four women and seven men), all of whom were over the age of 40 and had at least 15 years of clinical experience.

Participating therapists were asked to identify a former client who terminated therapy prematurely and whose primary diagnosis was not an Axis I psychotic or substance abuse disorder or an Axis II personality disorder. We asked each participant to identify a single impactful case, rather than to comment on their accumulated experience with premature termination, in order to obtain a detailed and coherent narrative about a case that was likely to affect his or her work with subsequent clients. Consequently, the data collected apply to therapists’ experiences with influential cases in particular, rather than cases of premature termination in general. Participants were asked to select a case from their work in which the termination: (a) was premature in that the therapy ended before significant therapeutic progress had been achieved, (b) occurred after at least four therapy sessions, and (c) was not due to a geographical move or a change in the client’s ability to pay for treatment. We chose to omit early terminators in light of evidence that clients who discontinue treatment within the first month may do so because of low motivation or overly strong and immediate transference (Frayn, 1992). Participants were asked to identify a case from within the past 10 years about which they could recall the significant details. While this criterion permitted therapists to choose cases that began years ago (one therapist selected a client whom he had seen 12 years prior to the interview), it enabled them to speak about outcomes that they found personally or professionally meaningful.

**Research team.** The research team was composed of six coders, one auditor, and one research mentor. The coders included the principal investigator and five research assistants (RAs) who were advanced psychology undergraduates at the University of Massachusetts Amherst or Amherst College. RAs were selected based on their maturity, their understanding of psychotherapeutic phenomena, their ability to work both independently and on a team, and their willingness to engage in intense dialogue about the topics under investigation. The auditor was an advanced graduate student who had previously conducted a study using the CQR methodology. The research mentor was a licensed psychologist and expert psychotherapist who provided consultation and training to the principal investigator. The principal investigator was an advanced graduate student who had previously served as auditor and consultant on a CQR study.

The principal investigator ensured that all members of the research team were familiar with the CQR methodology and received training in the philosophy and implementation of the method. All members of the research team read the guides published by Hill and colleagues (1997, 2005). The principal investigator, auditor, and research mentor had applied the CQR methodology in a previous study, and used their collective experience to inform the present study and train the coding team. RAs were trained through direct instruction and practice coding exercises. Members of the coding team were instructed to seek consensus by forming and sharing their individual perspectives, and by respectfully resolving disagreements.

Prior to coding data, all members of the research team reflected on and recorded their expectations and biases. Members of the research team shared similar expectations, for example that clients would leave treatment by missing appointments, that therapists would notice problems and respond, that clients would become withdrawn or defensive, that clients would feel dissatisfied with their therapists, that therapists would judge their own work positively and attribute the termination to their clients, that therapists would feel disappointed and frustrated, that therapists would acknowledge mistakes but continue to see themselves as competent, and that therapists would make corrections to their work by being more sensitive and attentive to their clients and to the therapeutic relationship. The research team members were instructed to “bracket” these expectations by remaining aware of them, and by checking the accuracy and objectivity of their work against the raw interview data, the coding decisions of other team members, and the feedback of the auditor.

**Semi-Structured Interview**

In accordance with the CQR methodology outlined by Hill and colleagues (1997, 2005), study data were collected using a semi-structured interview consisting of a series of open-ended prompts that addressed the study’s broad and specific questions. These prompts were designed to probe important themes emerging from the research literature on premature
termination, while also allowing participants to share their personal experiences freely. For example, the interview prompted participants for information regarding the three broad categories of reasons for premature termination identified in the literature: problem improvement, signs of client dissatisfaction, and factors that interfered with treatment (Pekarik, 1983). In addition, interview questions addressed other factors relevant to cases of premature termination such as the duration of treatment, the therapist’s awareness of problems both during and after treatment, and the degree to which the therapist assumed responsibility for the outcome. Finally, the interview prompted participants to discuss the personal and professional impact of the termination, and to reflect on what lessons they learned from the case. The interview protocol was tested and revised through pilot interviews conducted with two experienced practicing therapists (see Table I).

### Procedure

**Recruitment and interviews.** The principal investigator recruited participants by email. Recruits were sent a brief description of the study, and those who responded were sent additional detail about the study question and selection criteria. The 11 study participants were asked to select a former client who fit the study parameters, and were then scheduled for a 1-hour research interview to be conducted by the principal investigator in the participant’s psychotherapy office. Research interviews consisted of an informed consent procedure, an audio-taped research interview, and a study debriefing. The confidentiality of the participants and their former clients was maintained through the control of identifying information, the use of pseudonyms for clients, and the removal of any and all identifying information from audio-recordings. Members of the research team later transcribed the interviews, and reviewed both the transcriptions and the audio-tapes to ensure accuracy.

**Data coding.** Following the CQR process outlined by Hill and her colleagues (1997, 2005), data coding began with the creation of core ideas intended to capture the participants’ statements accurately but “in fewer words and with more clarity” (Hill et al., 1997, p. 546). The coding team enumerated segments of text containing discrete thoughts within each interview, and then coded these thoughts into core ideas. Coders ensured the accuracy of their work by using the participants’ words, and by refraining from adding or inferring meaning. (Interviews contained an average of 154 core ideas after coding was complete.) Related core ideas were grouped within topical domains that represented distinct topics related to premature termination. The coding team derived an initial set of domains from the literature on premature termination and the interview prompts (e.g., duration of treatment, causes of termination, and professional impact of the case). These domains were refined throughout the coding process in order to achieve the best possible organization of the data.

Throughout the coding process, team members sought the most accurate coding of the data possible by requiring agreement on all coding decisions. Team members first coded individually, and then met as a group to compare their work and to reach consensus on the best possible coding of the data. The principal investigator facilitated group discussions with the goal of avoiding biasing processes such as groupthink or the dominance of one group member. Group members were encouraged to disagree and to resolve their disagreements through discussion of the most accurate representation of the raw interview data. The entire team engaged in this process for the first interview, and then rotating pairs did so for the remaining interviews. When pairs failed to reach agreement, due to divergent coding or uncertainty, the entire team worked together to review the raw data and agree on the best possible coding.

In addition to requiring group consensus, the research team consulted with an outside auditor

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**Table I. Semi-structured interview**

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Why did this client seek your help initially?</td>
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<tr>
<td>How long did you see this client in therapy?</td>
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<tr>
<td>What progress, if any, did the client make in therapy?</td>
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<tr>
<td>What indication did you have that the client might leave therapy?</td>
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<tr>
<td>What did you do to avert early termination?</td>
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<tr>
<td>How did the client respond to your efforts?</td>
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<tr>
<td>How did the client end treatment with you?</td>
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<tr>
<td>What was your understanding, at the time, of why this client left treatment?</td>
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<tr>
<td>How did you feel when this client left therapy?</td>
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<tr>
<td>How did the departure of this client affect your sense of competence?</td>
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<tr>
<td>What characteristics of this client contributed to her/his premature departure?</td>
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<tr>
<td>What missteps, if any, do you feel that you made in your work with this client?</td>
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<tr>
<td>In what way might your actions have contributed to the client’s departure?</td>
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<tr>
<td>Since the termination, how have your thoughts about this termination changed?</td>
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<tr>
<td>What questions linger in your mind regarding this case?</td>
</tr>
<tr>
<td>How has this experience affected your work with subsequent clients?</td>
</tr>
<tr>
<td>What would you do differently if you were treating this client again?</td>
</tr>
<tr>
<td>What advice would you offer a beginning therapist faced with a similar client?</td>
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</tbody>
</table>
to ensure accuracy, consistency, and absence of bias in their work. The auditor reviewed samples of coding selected to represent the team’s work across both interviews and stages of the coding process. The auditor flagged coding that diverged from the data, indicating the possible effects of team expectations, biases, or group dynamics (e.g., groupthink or deference to one group member). In turn, the coding team responded by reviewing the transcript and audio-tape for each section of flagged coding, and then agreeing on revisions in order to achieve the most accurate possible coding of the data.

Data analysis. The coding phase was followed by a process referred to as cross-analysis in which common themes across interviews, labeled categories, were identified. While core ideas were created to remain true to the ideas expressed by each interviewee, categories were intended to highlight commonalities across all interviews. The coding team began this process by grouping all of the core ideas in the study, over 1600 in total, by domain. Coders then worked within each domain to identify and label common categories of ideas that were shared by multiple participants. Categories of ideas were considered to be more or less common within the sample based on the number of interviews in which they appeared. Again, the team members first worked individually, then met as a group to achieve consensus, and finally used the auditor to review their work for accuracy and bias.

Results

The study results can be summarized as a set of categories of ideas grouped within thematic domains. Table II contains a list of the categories of ideas that were shared among six or more of the 11 interviewees. In accordance with the CQR methodology (Hill et al., 1997, 2005), the terms variant, typical, and general are used to indicate the frequency with which each category appeared across the sample of interviews. Categories are labeled variant if they appear in three to five interviews, typical if they appear in six to 10, and general if they appear in all 11 interviews. General and typical categories are reported below within their topical domains. (Variant categories are reported when a domain contained no general or typical categories.) The results are grouped broadly under the following headings: Progress and Parameters of Treatment, Problems in Therapy, Termination, and Professional Development.

Progress and Parameters of Treatment

Clients’ presenting problems. Therapists reported that their clients presented with a range of problems. Therapists generally (i.e., in all 11 cases) recalled that clients were experiencing mood disturbance (most commonly depression), interpersonal problems (e.g., marital conflict), and at least three other presenting problems. Typically (i.e., in six to 10 cases), therapists said that their clients were troubled by damage from childhood trauma, characterological problems (e.g., narcissism), unresolved personal conflicts (e.g., spiritual crisis), or repetitive and problematic patterns of behaviors (e.g., cycles of confrontation and withdrawal).

Duration and frequency of treatment. Therapist descriptions of treatment frequency and duration varied (i.e., all categories appeared in three to five cases). Therapists said that their clients came for sessions, weekly, bi-weekly, or multiple times per week, and that treatment lasted between two months and four years.

Therapists’ strategies. Therapists typically reported having used a number of complementary therapeutic strategies. Typically, therapists attempted to provide support (e.g., through listening and validation), address presenting problems or symptoms (e.g., by focusing on the client’s functioning), facilitate insight (e.g., by “getting him to look at how he was continually trying to fill this empty hole with drugs and alcohol”), and conduct their work carefully.

Clients’ progress in treatment. Despite the premature nature of the terminations, all but one therapist believed that their clients had made substantial progress over the course of therapy. Typically, therapists noted that their clients had engaged in the process of therapy successfully (e.g., “He kept on coming back, he never left the sessions early, he said he liked them”), and had formed a relationship with the therapists (e.g., they had established mutual trust).

Problems in Therapy

Client circumstances that interfered with therapy. Therapists believed that a variety of problems outside treatment had complicated the work of therapy. Typically, therapists said that their clients had difficulty continuing in treatment because of problems with family (e.g., marital conflict). Other external factors varied, and included problems with work, finances, health, and distance from the psychotherapy office.

Problems with the clients’ readiness or willingness. All but one therapist reported that their
clients seemed unready or unwilling to change. Typically, therapists said that their clients became defensive, felt threatened by progress (e.g., “It was too threatening for her to think about herself”), or found the work of therapy too difficult (e.g., “It became easier to just retreat to the status quo”).

Client emotional reactions to therapy. Therapists noted that their clients had strong emotional reactions to treatment. Typically, therapists reported that their clients felt overwhelmed or vulnerable (e.g., “I think she was just flooded and overwhelmed”), hurt or angry (e.g., the client felt emotionally injured by the therapist), or dissatisfied.

### Client absences from therapy

Therapists identified absences from treatment as signs of trouble in therapy. They typically reported that their clients failed to show for appointments. In a variant number of cases, therapists said that their clients were absent from treatment for prolonged periods or cancelled sessions frequently.

### Table II. The most common categories across all interviews (n = 11 therapists)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients’ presenting problems</td>
<td>Depression and other mood disturbance</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Interpersonal problems</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Damage from childhood abuse and trauma</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Characterological problem</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Unresolved personal conflicts</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Repetitive and problematic patterns of behavior</td>
<td>Typical</td>
</tr>
<tr>
<td>Duration and frequency of treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists’ strategies</td>
<td>Provided support or empathy</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Addressed problems or symptoms</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Facilitated insight</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Proceeded slowly, and carefully</td>
<td>Typical</td>
</tr>
<tr>
<td>Clients’ progress in treatment</td>
<td>Engaged in therapy</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Formed a relationship with the therapist</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Gained insight</td>
<td>Typical</td>
</tr>
<tr>
<td>Client circumstances that interfered with therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family problems</td>
<td>Typical</td>
</tr>
<tr>
<td>Problems with the clients’ readiness or willingness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Client felt threatened by progress</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Client found the work of therapy too difficult</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Client became defensive or avoidant</td>
<td>Typical</td>
</tr>
<tr>
<td>Client emotional reactions to therapy</td>
<td>Client felt overwhelmed or vulnerable</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Client felt hurt or angry</td>
<td>Typical</td>
</tr>
<tr>
<td>Client absences from therapy</td>
<td>Client did not show for sessions</td>
<td>Typical</td>
</tr>
<tr>
<td>Problems with treatment</td>
<td>Treatment resulted in incomplete or inconsistent progress</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Therapist’s intervention was ineffective</td>
<td>Typical</td>
</tr>
<tr>
<td>Mistakes made by the therapists</td>
<td>Client had difficulty with changes in the structure of treatment</td>
<td>Typical</td>
</tr>
<tr>
<td>Problems in the therapeutic relationship</td>
<td>Therapist failed to see a problem</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Therapist failed to address a problem</td>
<td>Typical</td>
</tr>
<tr>
<td>Therapist emotions that presented a challenge</td>
<td>Therapist felt frustrated, discouraged, or burnt-out</td>
<td>Typical</td>
</tr>
<tr>
<td>Therapists’ foresight of the termination</td>
<td>Therapist did not foresee the termination</td>
<td>Typical</td>
</tr>
<tr>
<td>How treatment ended</td>
<td>Client did not communicate intention to the therapist</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Therapist attempted to contact the client to offer additional support</td>
<td>Typical</td>
</tr>
<tr>
<td>Personal impact of the termination on the therapists</td>
<td>Therapist experienced sadness or loss</td>
<td>Typical</td>
</tr>
<tr>
<td></td>
<td>Therapist felt angry or frustrated</td>
<td>Typical</td>
</tr>
<tr>
<td>How the therapists made sense of the termination</td>
<td>Attributed termination to client psychopathology</td>
<td>General</td>
</tr>
<tr>
<td></td>
<td>Focused on the positive aspects of the case</td>
<td>Typical</td>
</tr>
<tr>
<td>What therapists would do differently in retrospect</td>
<td>How to improve upon the treatment that he or she offers?</td>
<td>Variant</td>
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<td>Therapists’ remaining questions about the case</td>
<td>How to improve upon the treatment that he or she offers?</td>
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<td>Lasting effects of the termination on the therapists</td>
<td>What went wrong in the case?</td>
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<td>Advice or lessons offered by the therapists</td>
<td>A sense of uncertainty</td>
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<td>Be prepared for difficult clients</td>
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<td></td>
<td>Recognize problems with client readiness, or resistance</td>
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**Note.** Categories that apply to fewer than six cases are not shown. Where no category applied to six or more cases, the domain is labeled as variant.
Problems with treatment. In addition to attributing problems to their clients, therapists said that treatment itself had backfired or failed to result in progress. All but one therapist said that his or her interventions had been ineffective (e.g., “I was just doing what I do, and it didn’t work”), or that treatment had resulted in incomplete or inconsistent progress. Typically, therapists reported that their clients had difficulty with changes in the structure of treatment (e.g., the client responded poorly to family sessions).

Mistakes made by the therapist. Although no single clinical error was common across the sample, therapists acknowledged that they had made mistakes in the course of treatment. Therapists typically believed that they had either failed to recognize a problem in therapy (e.g., “I made some mistakes and I didn’t anticipate everything”), or had failed to sufficiently address a problem (e.g., “It was a battle that I didn’t want to admit that I should have had. I never fought them about [having more frequent sessions]”).

Problems in the therapeutic relationship. Therapists generally said that their relationships with their clients had been strained in some way. Typically, therapists referred to the following bases of strain: failure to form a strong therapeutic relationship from the beginning (e.g., “I found that . . . we never really established a comfortable connection”), disagreement about the goals of therapy (e.g., “He would look at me like that was the dumbest idea he ever heard”), damage to the emotional bond in the course of treatment (e.g., the therapist forgot a session, and the client “was so hurt and pained, . . . she never really forgave me for that”), or struggle to manage the client’s transference (e.g., “He left me in this way that was so much a reenactment, so much splitting, that he couldn’t really see . . . the whole picture”).

Therapist emotions that presented a challenge. Therapists recalled having experienced a range of difficult emotional reactions by the end of treatment with their clients. Therapists typically reported that, during therapy, they had felt frustrated or burnt-out (e.g., “She had used me up”), sad or guilty (e.g., “I felt terrible”), anxious (e.g., “I think maybe there was a cautiousness in me not wanting to make any mistakes with her”), or surprised (e.g., “I was surprised how dependent he was on me given how . . . [he] could seem fairly distant”).

Termination

Therapists’ foresight of the termination. Therapists typically reported that they had not anticipated their clients’ departures from treatment (e.g., “I was blindsided”). In contrast, a variant number of therapists said that they saw warning signs that their clients might leave treatment (e.g., “There were a couple of times that she indicated that she could bail if things got bad”).

How treatment ended. Therapists typically indicated that treatment had ended abruptly in that their clients had not spoken about wanting to end treatment (e.g., “There was no quote-unquote termination, or winding down. It just stopped”), and had either failed to show for an appointment or had failed to schedule additional appointments. In turn, therapists typically attempted some form of follow-up in order to acknowledge the termination or offer future services and referral information.

Personal impact of the termination on the therapists. Therapists reported experiencing a range of thoughts and feelings in response to their clients’ departures. Typically, therapists reported feeling a combination of sadness or loss (e.g., “I was disappointed . . . really disappointed”), and anger or frustration (e.g., “I found myself a little angry . . . because I took it seriously, and she didn’t”). Additionally, therapists typically reported experiencing one or more other feelings, including responsibility or regret (e.g., “I felt guilty; what did I do wrong?”), relief (e.g., “I was relieved; I was like, okay, it’s time for me to move on too”), failure or shame (e.g., “I felt embarrassed or ashamed a little bit that this would happen”), and surprise or confusion (e.g., “I was surprised by the abrupt nature of the termination because he had been so religious . . . in his attendance”). Despite the emotional impact, therapists typically felt the termination had no effect on their sense of competence (e.g., “I didn’t feel it had anything to do with my competence”).

Professional Development

How the therapists made sense of the termination. Despite having a variety of explanations, therapists generally placed responsibility for the premature terminations on their clients (e.g., “He was just plain difficult”). In addition, as they reflected on the cases, therapists typically highlighted the positive aspects of the case (e.g., “Maybe the progress was her ending treatment”), judged their work positively (e.g., “I did, I think, a very good therapy with a very difficult client”), or recalled efforts to understand the termination by reviewing notes or by consulting with peers.

What therapists would do differently in retrospect. After reflecting on their work, therapists discussed various corrections to their approaches
with clients who left treatment prematurely. While no single adjustment to treatment applied generally or typically across the sample, various therapists said that they would be more supportive, change the timing of their interventions, focus more on symptom reduction, or engage in more exploration of the cause of their clients’ problems. That said, various therapists felt that there was nothing they could have done differently to affect the outcome.

**Therapists’ remaining questions about the case.** As for unanswered questions after treatment ended, therapists typically wondered how they could improve upon the treatment they offer, or expressed a lingering sense of uncertainty about what went wrong or how the termination could have been avoided (e.g., “I can only guess; I don’t know”).

**Lasting effects of the termination on the therapists.** Therapists typically reported that they experienced enduring uncertainty in the wake of the premature terminations. Other lasting effects of premature termination varied, but included diminished professional confidence, ongoing curiosity about the former client, and lingering emotions about the case (e.g., regrets, anger at the client, or worry about the client’s well-being).

**Advice or lessons offered by the therapists.** Therapists offered several thoughts regarding advice and lessons learned from their experiences with these former clients. They typically recommended that therapists prepare for work with difficult clients (e.g., “There are people ... you’re going to hate. There are going to be things that the patient sets off in you which are like small nuclear explosions”), strive to recognize and address problems as they arise in therapy (e.g., “even say directly, I’m not sure where to go; we’ve tried this, we’ve tried that, what do you think?”), and develop an awareness of problems in the therapeutic alliance such as poor bond or agreement between client and therapist.

**Discussion**

The present study provides a rich account of psychotherapists’ reflections on impactful cases of premature termination, a topic only minimally covered in the literature. The narrative that emerged from this project offers a compelling glimpse into the challenges that therapists face when attempting to understand and learn from experiences with clients who leave treatment prematurely.

Although each therapist in the study told a unique story, their experiences converge into a coherent narrative about common issues in psychotherapy. While the study findings were not meant to be generalizable given the sampling procedures, they described cases that were typical of outpatient psychotherapy with adults. Therapists said that their clients came to treatment with compound presenting problems, a characteristic that is typical given the high rate of comorbidity in clinical samples (Kessler, Chiu, Demler, & Walters, 2005). In addition, these therapists employed various strategies to address their clients’ concerns, and they identified their orientation as integrative or eclectic, the most commonly reported orientation in North America (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010).

**Problems in Therapy**

Although the clients described by these 11 therapists made gains in treatment, most therapists described their clients’ progress as inconsistent or incomplete, and indicated that their clients had become dissatisfied with treatment. Negative client attitudes about treatment can be understood within the context of the therapeutic relationship and may, in some cases, have resulted from alliance ruptures (Safran & Muran, 1996), which are events that have been implicated as principal reasons for premature termination (Pekarik, 1992; Reis & Brown, 1999). Although the experiences described by these therapists do not provide sufficient basis for determining whether limited progress caused dissatisfaction with treatment, or vice versa, the narratives shared by these clinicians highlight the importance of monitoring client satisfaction in order to be attuned to possible ruptures in the therapeutic alliance that could lead to premature termination if unaddressed. Evidence suggests that clients who are predicted to have poor therapeutic outcomes remain in treatment longer if their therapists are provided feedback regarding their progress, motivation, and the quality of the therapeutic alliance (Whipple et al., 2003).

In discussing the ways in which client factors contributed to the premature termination, many therapists noted that their clients had felt overwhelmed, angry, dissatisfied, or threatened by change. Several therapists recalled that their clients became defensive and began missing sessions, and that treatment interventions were ineffective. Although they retrospectively characterized these factors as problematic, therapists reportedly failed to see them as threats needing to be addressed at the time, an oversight that is perhaps understandable. Psychotherapy scholars conceptualize some treatment difficulties, such as client defensiveness or resistance, as natural steps in the process of psychological change, and not necessarily signs of treatment failure (Meissner, 1996; Safran & Muran, 2000). In the words of one participant, “People have their defenses for good reason,” implying that these
barriers are in fact normal, or even necessary aspects of treatment. Similarly, researchers who study the therapeutic relationship note that the client-therapist bond is likely to weaken or become strained at times, and that recovery from these periods is the hallmark of a successful treatment (Gelso & Carter, 1994). The fact that study therapists saw client defensiveness as a treatment issue before termination, and as a warning sign after termination, highlights the paradoxical nature of the therapeutic task: to resolve a problem by first amplifying it. This ambiguity provides therapists with the prerogative to view premature termination as being attributable either to their own mismanagement of the treatment or to the client's unreadiness to change. The acknowledgment that one's efforts were less than pristine requires humility and rigorous self-scrutiny.

In addition to identifying obstacles to treatment, several therapists explained that their clients' premature terminations were precipitated by disagreements about treatment. For example, one therapist recommended that his client obtain medication to mitigate symptoms of depression, but the client refused and they entered into a "battle for the structure of therapy." Another therapist refused to endorse his client's request for medication, a disagreement that the client cited as his reason for terminating treatment. According to Bordin's (1979) widely cited model of the therapeutic relationship, disagreements about the goals or tasks of therapy jeopardize treatment by creating conflict between client and therapist, and by diminishing their shared sense of connection and trust. Several scholars have noted that problems in the therapeutic alliance could lead to early termination (Frayn, 2008; Reis & Brown, 1999; Safran & Muran, 1996), and research has offered evidence of an association between poor therapeutic alliance and premature termination (Samstag et al., 1998; Tryon & Kane, 1990, 1993).

Although rarely discussed in the literature, therapists in the present study acknowledged that they had made mistakes that negatively affected the course of treatment. Some therapists judged that they had made mistakes by failing to recognize or address a problem in treatment, while others reported that they had made more overt mistakes, such as offering too much advice, allowing their feelings about the client to interfere with treatment, or forgetting about a scheduled session. Therapists explained that their mistakes led clients to feel hurt, angry, and dissatisfied. One therapist, who failed to show for a session with her client, commented on the difficulty of repairing the damage to the therapeutic relationship after her mistake, saying that "Something was lost that was really hard to regain, if not impossible." Such mistakes may violate a client's expectation that the therapist is reliable, and may undermine the client's trust in the therapist. Safran and Muran (2000) suggested that addressing client mistrust is a central process in repairing ruptures in the therapeutic alliance, and that therapists may need to accept responsibility for their contributions to the rupture in order to do so. The therapists in the present study acknowledged their own fallibility, and faced the possibility that their misstep had contributed to their clients' departures.

Some therapists reported that they had contributed to the premature termination by making changes to the structure of treatment, which they viewed as mistakes only in retrospect. For example, one therapist augmented treatment by bringing his client into concurrent group therapy, but the client struggled with this change, and ultimately felt betrayed by the therapist. Citing the client's psychopathology, the therapist explained:

In effect, he was re-doing what he did with his family. They hurt him, and he couldn't really differentiate the way that I had hurt him . . . and the way that he was hurt by his family. He couldn't differentiate that his family never took responsibility . . . and that I did.

Several therapists in the study noted that their clients were especially prone to feeling hurt or rejected due to histories of trauma and abuse. Safran and Muran (2000) asserted that clients with traumatic pasts may be more vulnerable to experiencing ruptures in the therapeutic relationship. With such clients, even well-intended and seemingly appropriate interventions may backfire, leaving a client feeling hurt and betrayed.

Upon reflection, therapists acknowledged that their own reactions to their clients may have contributed to treatment failure. Many therapists reported that they had begun to feel frustrated and burnt out even before their clients left treatment. One therapist recalled that her attitude toward her client had changed in the weeks before the premature termination. She stated, "I was no longer looking forward to seeing [the client]." In a study of sessions preceding dropout, Piper and his colleagues (1999) found clients to be engaged in an unproductive pattern of resistance and therapists in a pattern of ineffective transference interpretation. Although it should go without saying, therapists will benefit by scrutinizing difficulties in a relationship, in terms of not only what the client is contributing, but also how they themselves are adding to the problem.
Termination

Although all of the therapists in the study were aware of problems that interfered with treatment, only some interpreted these problems as warning signs of premature termination. Roughly half of the therapists had anticipated their clients’ departures, and attributed their foresight to their clients’ increasingly evident expressions of hopelessness and frustration, while the remaining therapists had been surprised by the terminations. This difference in foresight raises important questions about how therapists understand problems in treatment. Did some therapists observe warning signs which were missed by others? Were there observable warning signs at all? Might some clients have concealed their dissatisfaction? Certainly, when clients refrain from disclosing their dissatisfaction, therapists are less likely to have foresight about an impending termination (Pekarik, 1983; Regan & Hill, 1992). In fact, in the present study, most therapists reported that their clients left treatment without communicating reasons for terminating, thus leaving them guessing.

Most therapists in the study acknowledged having mixed feelings about their clients’ early terminations. One therapist recalled that he had felt sad for not being more helpful to his client, as well as confused about why his client had left treatment. Another therapist expressed regret for his mistakes, curiosity about how his former client was faring, and concern for her well-being. A third therapist said that her frustration and regret over the termination were tempered by a feeling of relief that the client had gone. A few therapists reported that they continued to feel the emotional impact of the termination months, and even years, later. Therapists may have complex reactions to treatment failures (Frayn, 2008; Guy, 1987; Ogrodniczuk et al., 2005; Reis & Brown, 1999), with some clinicians experiencing emotional reactions to such terminations for long after the client’s departure. The accumulation of such unsatisfying clinical experiences very likely contributes to therapist burnout, and can lead to cynicism that eventually chips away at the ideals which are held by most clinicians earlier in their careers.

Although some therapists in the study described personal consequences that were complex and lasting, others reported that their sense of professional competence had remained unaffected by their clients’ terminations. Most attributed this lack of professional impact to their years of clinical experience and accompanying wisdom about the challenges of conducting psychotherapy, stating that these factors had insulated them from events that were disappointing or perplexing. While therapists need to maintain self-confidence and resiliency in order to practice, this finding begs a question: If premature termination does not affect therapists’ sense of professional competence, then what would motivate them to reflect on their contributions to problems in therapy? Given that therapists appear to engage in a self-serving bias when considering cases of premature termination (Murdock et al., 2010), this question merits further attention.

Professional Development

Upon reflection, the therapists in the study identified what they might have done differently given the benefit of hindsight. They offered various lessons and advice, typically emphasizing actions that would have resolved particular problems which they believe contributed to premature termination. Therapists offered warnings about particularly difficult clients, concluded that the maintenance of a strong therapeutic relationship is essential, and recommended gaining awareness of one’s own strengths and weaknesses through consultation and supervision.

Although most therapists in the study felt that they had derived valuable lessons from their experiences, many remained uncertain about how to prevent future premature terminations. In the words of one therapist, “I am still curious. I don’t know if I’ll ever get the answer.” As discussed earlier, a client may conceal the reasons for terminating treatment, limiting the therapist’s ability to know how to improve treatment. Despite having ideas about what went wrong, most therapists remained uncertain about how to avoid repeating the same problems in the future.

Limitations

A few limitations warrant attention before discussing the implications of these findings for psychotherapy practice and research. First, the study sample is not assumed to be representative of board certified psychologists in particular or experienced therapists in general. The CQR methodology recommends the use of small sample sizes (eight to 15 participants) in order to allow the researcher to examine each case in depth. Moreover, the present study focused on therapists’ recollections regarding a single case that they had found especially impactful. As such, the findings are not generalizable, but nevertheless shed light on the ways in which a case involving premature termination can have significant personal and professional impact for therapists. Also, the findings may be influenced by sample biases to the extent that they reflect characteristics of diplomates certified by
the American Board of Professional Psychology, a subset of professional psychologists who, due to their experience and vetting, may be more resilient to threats to professional competence. Additionally, the fact that all participants identified their theoretical orientation as integrative or eclectic may have predisposed them to attend to non-technical aspects of treatment such as the quality of the therapeutic alliance. In assessing the value of the study results, it is important to bear in mind that qualitative research findings are best evaluated in terms of the degree to which they are accurate representations of the data, coherent with regard to the topic at hand, and applicable to relevant practice (Hill et al., 1997). We feel that the findings of this study score highly in all three regards.

Second, the data were drawn entirely from the participating therapists’ self-reports, and are therefore trustworthy only to the extent that the participants’ recollections were accurate, honest, and insightful. Moreover, participating therapists were asked to discuss the sensitive topic of a “failed” case, a task that could arouse the self-serving bias described by Murdock and colleagues (2010). Some participants chose to describe cases that had ended many years prior to the interview. Although the passage of time and the potential for bias might have led to distorted recollections, the strength and value of this study lies not in the facts of the cases, but in the subjective and enduring impressions of the therapists. Despite these limitations, therapists in the study shared openly, recalled their experiences with candor and detail, and acknowledged their roles in the premature terminations.

Third, as with all research, qualitative study findings can be influenced by the expectations and biases of the research team. However, our research team members worked diligently to mitigate the effects of their biases by: (a) recording and discussing their assumptions and expectations before encountering the data, (b) setting ground rules for group work to avoid potentially biasing group processes, and (c) striving for quality debate and group consensus during the coding process. The findings aligned with many of the expectations held by members of our research team. For example, team members anticipated that therapists would describe experiencing a sense of failure, report that their sense of professional competence had remained unaffected, identify their own missteps, and resolve to form better therapeutic relationships with future clients. While alignment between researcher expectations and study findings raises questions about the potential influence of researcher bias, we are confident that the study findings are trustworthy due to the rigor of the research method employed and persistence of our team members in bracketing their own biases.

Implications for Practice

The present study provides a rich and coherent account of therapists’ experiences with premature termination. The study findings offer a uniquely intimate and practical perspective on a set of professional challenges that are typically experienced in isolation and rarely discussed in depth. We discuss the implications of these findings for clinical practice relative to four broadly stated results: (a) that various problems influence the likelihood of premature termination; (b) that therapists can contribute to that likelihood through their actions, reactions, and attitudes; (c) that therapists face a number of professional challenges after their clients leave therapy prematurely; and (d) that therapists may experience complex and enduring emotional reactions in the wake of their clients’ departures.

First, the study findings indicate that therapists should consider a variety of possible explanations when attempting to understand why a client has left treatment prematurely. Clients who leave treatment may do so because of interfering life circumstances, challenging emotional reactions to therapy, defensiveness, avoidance, unreadiness or unwillingness to change, inconsistent attendance, limited insight, or barriers associated with the presenting problem itself. Clients may also become dissatisfied with treatment due to incomplete or inconsistent progress, ineffective interventions, changes in the structure of treatment, or problems in the therapeutic relationship such as disagreement about treatment goals or poor client-therapist bond. Finally, therapists may contribute to these problems by hurrying interventions, sticking with ineffective strategies, failing to manage their own frustration or discouragement, failing to recognize or address a problem, or making errors that undermine the client’s trust.

This array of contributing factors corresponds to suggestions made by psychotherapy scholars regarding strategies for keeping clients engaged in treatment. In a review of the literature on premature termination, Ogrodniczuk and colleagues (2005) recommended eight strategies for reducing the likelihood of premature termination: (a) educating clients about psychotherapy, (b) matching clients with the appropriate form of treatment, (c) limiting the duration of therapy, (d) negotiating with clients to establish agreement regarding the focus of treatment, (e) supporting clients’ ability to manage life stressors through case management, (f) providing appointment reminders, (g) utilizing motivational
enhancement techniques, (h) attending to the quality of the therapeutic alliance, and (i) facilitating clients’ emotional expression. Barrett and colleagues (2008) later echoed some of these suggestions, and highlighted the importance of maintaining a strong therapeutic relationship. The study findings and these strategies point to two conclusions: (a) that clients may feel unready, unwilling, or unable to fully engage in treatment for any number of reasons, and (b) that therapists can facilitate client engagement by maintaining an approach to treatment that is supportive, flexible, transparent, and collaborative.

Second, by acknowledging that therapists can inadvertently contribute to the risk of premature termination, the study findings suggest that therapists should work proactively to insulate their clients against such errors. Presumably, all therapists strive to avoid making mistakes of consequence, but the fallibility of human nature suggests that clinicians will occasionally trip up. Accepting that mistakes will occur, therapists will benefit from attempts to: (a) establish strong therapeutic bonds from the outset of treatment, (b) know when circumstances in therapy or in their own lives increase the likelihood that they will err in treatment, (c) understand the situations in which a mistake is most damaging to the therapeutic relationship and use extra caution when those situations arise, and (d) take corrective action as soon as a mistake has been made. A therapist who has worked to establish a strong therapeutic bond from the outset of treatment will probably gain his or her client’s forgiveness more readily. A therapist who is alert to precarious moments in the course of therapy will be better equipped to work effectively when the client is especially vulnerable, or when the therapist is under personal stress. Lastly, once an error is made, a therapist needs to find strategies to repair the hurt before the therapy is undermined. Brief Relational Therapy (Safran & Muran, 2000) is an example of a therapeutic approach that offers a theoretically coherent framework for responding to ruptures in the therapeutic alliance.

Third, the study findings suggest that therapists are faced with professional challenges after clients terminate prematurely. One challenge is that the therapists may be left guessing why clients have ended treatment. Given that clients may be reluctant to express dissatisfaction or discuss their desire to terminate, therapists may have difficulty assessing the extent to which they contributed to the outcome. Another challenge is that, in seeking to learn from cases of premature termination, a therapist may be confronted with his or her own responsibility and fallibility. Interestingly, the very sense of professional security reported by the experienced therapists in this study may have made them less inclined to second-guess their work.

These professional challenges may deter therapists from engaging in potentially valuable reflection following premature termination. More generally, these challenges may help to explain both the limited discussion of premature termination in the field, and the self-serving bias identified by Murdock and colleagues (2010). To the extent that a therapist avoids reflecting on cases of premature termination, he or she may fail to recognize and address relevant issues for professional development. In contrast, a therapist who reflects on such cases can identify and manage his or her emotional responses, seek a greater understanding of the reasons for premature termination, and identify strategies for reducing the likelihood of premature termination in future cases.

Fourth and finally, therapists may experience complicated and enduring reactions when their clients leave treatment. They may face a host of emotions such as sadness, anger, confusion, remorse, frustration, and even occasional relief in response to premature termination. Moreover, therapists may find that emotional reactions may linger for months or years after the case has ended. Ultimately, such troubling experiences may contribute to professional fatigue, and may reduce their ability to be emotionally available to future clients. In order to continue providing the best quality treatment, therapists need to sustain an awareness of their level of professional fatigue (Miller, 1998) and recharge their emotional energy periodically by engaging in activities such as peer supervision (Norcross, 2000).

Implications for Research

This study carries implications for psychotherapy research as well. The results outlined above raise important questions for future research on the following four topics: (a) predictors of premature termination, (b) therapist mistakes, (c) professional development following premature termination, and (d) long-term consequences of premature termination for therapists.

First, the study findings offer some indication of why premature termination is difficult to predict. For one, the therapists in the study did not point to a single factor or event as the cause of termination. Rather, they explained termination as the consequence of interactions between client factors (e.g., psychopathology and readiness to change), environmental factors (e.g., financial or travel difficulties), therapist factors (e.g., reactions and missteps), treatment factors (e.g., lack of progress), and relational factors (e.g., trust, agreement, and bond
between client and therapist). The variety of potential risk factors and the complexity of the interactions among them may impede researchers from isolating a single reliable predictor of premature termination. While future research could examine these factors exhaustively, a more strategic approach will be to assess the dynamic and evolving interactions among these variables over the course of treatment. This perspective is supported by growing evidence of an association between the likelihood of premature termination and the quality of the therapeutic alliance, a concept that encompasses an entire class of overlapping and interactive variables (Barrett et al., 2008). Future studies can build upon existing research on meaningful fluctuations in the therapeutic relationship (Gelso & Carter, 1994) by assessing whether there are particular periods during treatment when clients are at heightened risk of premature termination as the strength of the alliance waxes and wanes.

Second, the study findings demonstrate that therapists do in fact make mistakes, and that these mistakes can negatively affect treatment. Despite their best efforts, therapists are fallible and will inevitably err from time to time. This fact raises a number of research questions, including the following: (a) What constitutes a clinical error? (b) When are therapists at the greatest risk for making clinical errors? (c) Which client, therapist, or situational factors determine the impact of an error? (d) How well do clients tolerate less serious errors? (e) What differentiates a tolerable clinical error from a more serious mistake, such as an ethical violation? and (f) What part do these errors play in the professional development of less experienced therapists? In their work on alliance ruptures, Safran and Muran (2000) encouraged therapists to accept responsibility for real or perceived clinical errors in order to reestablish collaboration and open dialogue with their clients. Further research of this kind may help therapists to know how to respond to errors, and to reduce the frequency with which their clients terminate treatment prematurely as a result.

Third, the study findings suggest that therapists may miss a valuable opportunity for professional development when they fail to reflect on cases of premature termination. Moreover, therapists may be limited in their ability to learn from such outcomes when they are unaware of the reasons for their clients’ departures. As such, future research should explore whether therapists who invite their clients to express dissatisfaction openly, or who engage in peer consultation following premature termination, have access to more information about their clinical effectiveness, and are more likely to learn from these cases. Further research could identify the barriers to seeking external support, and could explore methods for obtaining useful client feedback during treatment and following termination.

Finally, the study findings indicate that therapists may experience lasting and complicated emotional reactions after a client leaves treatment prematurely. Future research could assess the extent to which such reactions contribute to significant impairment in therapists’ emotional and professional well-being. Building on the finding that therapists display a self-serving bias (Murdock et al., 2010), researchers could examine the extent to which therapists avoid burnout by attributing premature termination to their clients. It is possible that premature terminations affect therapists on an emotional or motivational level regardless of their rational understanding of the outcome. In either case, questions remain about how the experience of premature termination might impact a therapist’s work with subsequent clients.

Conclusions

The present study offers a detailed account of the challenges therapists face following the premature termination of therapy by their clients. The findings demonstrate that therapists can learn a great deal from cases of premature termination that are initially troubling or difficult to understand, and they suggest that several barriers may deter therapists from questioning their work and engaging in professional development following such cases. Some therapists may attribute the termination to the client’s pathology in an effort to expediently conclude the case, but such shortsightedness limits their ability to learn from unsatisfying clinical events. Therapists who attempt to understand what went wrong will benefit personally from such explorations, and will be better prepared to recognize and respond to the warning signs of premature termination. Despite this potential for professional development, therapists are likely to encounter cases of premature termination that go unexplained and challenge their ability to understand what went wrong. The therapists in this study can serve as models for the type of self-reflection and self-care needed in order to remain effective and healthy as practitioners.

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Melissa Gosian, Jillian Guskin, Stephen Grigelevich, Paul Levitan, and Garret Sacco.

Notes
1 While scholars have used a variety of terms to describe a client who leaves treatment early, the term premature termination is used here because it is preferred within the literature.
2 Though not a part of the CQR process, the research team chose to enumerate ideas within the interview data in order to facilitate the coding process. Core ideas were segmented at the most basic level in order to avoid biasing the subsequent coding.

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