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Premature termination--clinicians' perspectives : a qualitative study of why clinicians prematurely terminate personal psychotherapy

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Perspectives: A Qualitative Study of
Why Clinicians Prematurely
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Abstract

This study was conducted to explore why clinicians prematurely terminate their own psychotherapy. The motivation for this study was to further the existing knowledge about premature termination in general by collecting data from clients who themselves have been trained in the field of psychotherapy. This exploratory qualitative study aimed to further clinicians, researchers and clients understanding of why premature termination occurs. One of the primary goals for this research was to determine whether clinicians could provide more in-depth and descriptive language about premature termination.

This research study was conducted through an online survey of 49 in-training, licensed and retired psychologists, Marriage and Family therapists and social workers. The survey asked clinicians to describe their experience of prematurely terminating personal psychotherapy in a brief paragraph. The survey was created on SurveyMonkey and distributed through email and online mediums using snowball sampling.

A major finding of this research was that clinicians terminated personal psychotherapy for the same reasons as general population clients. Clinicians terminated personal psychotherapy due to (a) lack of attunement (b) lack of rapport (c) conflict of modality (d) circumstantial reasons (e) resistance (f) transference and counter-transference and (g) ethical reasons. Resistance was indicated more by participants in this research then in past studies, suggesting

that resistance may play an important role in client-initiated termination and should be examined in further research. At the end of this research study, suggestions are given about how the findings of this research can be incorporated into future research and clinical practice.

PREMATURE TERMINATION—CLINICIANS' PERSPECTIVES: A QUALITATIVE

STUDY OF WHY CLINICIANS PREMATURELY TERMINATE PERSONAL

PSYCHOTHERAPY

A project based upon an independent investigation, submitted in
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CHAPTER ONE

INTRODUCTION

In the HBO show *In Treatment (*Garcia, 2008)*,* a 50-something year old psychoanalyst named Paul sees his own psychotherapist, Gina, for weekly sessions. In sessions with Gina, Paul processes the countertransference he experiences with his own clients. Gina helps Paul see the connections between his own past and what his clients are presently experiencing. In treatment with Gina, Paul also experiences his own transference, which gets in the way of the therapeutic relationship. He vacillates between wanting Gina to be more direct and give him the advice he wants to hear from him, and questioning her expertise once she gives him that advice. Gina helps Paul work through issues with his father, his crumbling marriage, and his erotic transference with one of his clients. Although viewers see how helpful the personal therapy is for Paul, they also see how complicated it is to be a therapist in therapy.

Long before it became a Hollywood clique, psychotherapists have sought personal psychotherapy. Some research indicated that as many as 84% of therapists seek personal therapy at some point in their careers (Pope & Tabachnick, 1994). Freud (1937/1963) recommended that "every analyst ought periodically... to enter analysis once more, at intervals of, say, five years, and without any feeling of shame in doing so" (pp. 267-268).

By the end of the second season, Paul is still seeing Gina on a weekly basis, despite his transferential issues. However, outside of Hollywood many therapists and non-therapist clients do prematurely terminate psychotherapy with their personal psychotherapists. Moore, Hamilton, Crane and Fawcett (2011) found that between one quarter and one half of psychotherapy patients

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prematurely terminate therapy. Therapists in their own psychotherapy may have different reasons for prematurely terminating than other patients. However, there is little research available about why therapists in therapy terminate prematurely.

In addition to helping therapists work on their own presenting problems, research has shown that personal therapy can help prevent burn-out, allow therapists to be more forgiving of themselves as clinicians, and encourage self-reflection (Bellows, 2007; Daw & Joseph, 2007). Better understanding why clinicians terminate their own therapy could help therapists who treat therapists to keep them in treatment. This research could also help therapists in treatment to understand why they feel like prematurely terminating. Therapists who are clients also they have access to clinical language which non-therapist clients do not. Therefore, clinicians who prematurely terminate their own therapy may also be able to describe the reasons why they terminated in ways that other clients cannot. Research of why therapists in therapy prematurely terminate may help to inform the literature about premature termination of non-therapist clients.

The purpose of this research study is to explore and describe the reasons why clinicians prematurely terminate with their psychotherapists. I will seek patterns and themes in the experiences of therapists in therapy to determine what behaviors or circumstances lead to a negative experience in treatment and subsequent termination. My presumption is that clinicians may be better able to articulate what did not work in therapy than other clients.

The primary research question is: why do some clinicians in psychotherapy terminate the therapy prematurely? Keeping the research question in mind, I will gather data about what reasons motivate clinicians to terminate their own personal therapy prematurely. This thesis is divided into five chapters. The following chapter will provide an outline of the relevant research on (a) negative experiences in therapy (b) premature termination and (c) clinicians in therapy.

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Chapter Three will then describe the methodology of the current study. Chapter Four will give a description of relevant findings. I will end this thesis with a discussion of how this current study compares to the literature, make implications for further research and discuss what implications this thesis has for therapists.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of my research study is to explore the experiences of premature termination from the perspective of clinicians terminating with their own personal therapists. While researching this topic, I did not find any evidence to suggest that research exists solely focused on why clinicians prematurely terminate therapy with their own therapists. The literature review follows into the following categories: negative experiences in psychotherapy, premature termination and clinicians in therapy.

Negative Experiences in Psychotherapy

Although therapists aim to produce positive experiences in therapy, both negative and positive experiences occur. The variability in the research makes defining what constitutes or causes negative experiences in psychotherapy difficult. However, the literature shows negative experiences in therapy are often linked to harmful experiences. A negative experience does not always cause harm and in fact may be a catalyst for therapeutic growth, but both harmful and negative experiences in therapy do often cause premature termination. The NASW Code of Ethics stated that therapists' primary responsibilities are to serve the need of their clients and to do no harm in the process (National Association of Social Workers, 2008). Psychologists, psychiatrists and other clinicians are also held to similar standards. Nevertheless, negative experiences in therapy do occur and should be minimized to decrease the likelihood that harm is done. Sarkozy (2010) found that 97% of clinicians thought that there were potential risks to

clients engaging in psychotherapy. This section shows what is indicated in the literature about negative experiences in therapy.

Many factors could lead to negative experiences in therapy. An imbalance in the participation of client and therapist could cause a negative experience in therapy (Friedlander & Thibodeau, 1985; Reynolds, 2001). The therapists' reaction to the resistance of the client many cause the client to have a negative experience in therapy (Sandell, Rönnås & Schubert, 1992). Reynolds (2001) found that there are many factors that could contribute to a patient having a negative experience in therapy including therapists breaking ethical barriers and showing up late to therapy.

There are several definitions of what constitutes negative experiences in therapy. In a review article, Dimidjin and Hollon (2010) asserted that treatments cause harm when they make people worse or prevent people from getting better. Strupp and Hadley (1976, p. 446) defined negative treatment effects as "patients getting worse as a function of the therapeutic influence." Wildman (1995) took a look at harmful treatments by examining a case of a client who had committed suicide while in therapy.

Dimidjin and Hollon (2010) suggested that one way of preventing further harm in therapy is for clinicians to develop systems for monitoring untoward events such as suicide. In an article which described various ways that harm could be detected, Dimidjin and Hollon suggested that the collection of anecdotal evidence from people who have experienced harmful treatment is the best way of preventing harm because this gives therapists an in-depth understanding of the exact circumstances surrounding the harmful treatment. Other methods recommended by Dimidjin and Hollon included reporting descriptive case studies and research, making use of controlled

trials, examining a range of outcomes over time and examining the active ingredients of treatments that find harm, examining mechanisms in which harm is produced, examining whether harm is universal or moderated and promoting standards about replication. Dimidjin and Hollon highlighted the importance of "reporting descriptive case studies and qualitative research" to further the prevention of harm in psychotherapy (2010, p. 25).

Dimidjin and Hollon (2010) were proactive in their approach to preventing and minimizing harm. They suggested that therapists and organizations should devise systems which track harm while it is occurring, rather than simply dealing with the consequences. One possible limitation with their article is that their methods included an in-depth review of the literature, but they did not conduct a study of their own.

Sarkozy (2010) wrote a dissertation hypothesizing that the possibility of harm occurring during psychotherapy is of ethical importance, and also that some therapists may abstain from discussing the possibility of harm because they are worried about breaking the therapeutic alliance. Sarkozy surveyed clinicians about their experiences of gaining informed consent from clients. Sarkozy used Beahrs and Gutheil's (2001) definition of informed consent: "a process of sharing information with patients that is essential to their ability to make rational choices [for psychotherapy] among multiple options in their perceived best interest" (p. 4). Sarkozy surveyed 161 licensed psychotherapists, examining their attitudes and practices. Sarkozy found that "the majority of participants (89.4%) agreed that a discussion of the risk, including potentially negative treatment effects during the informed consent is of ethical importance" (p. 73). Sarkozy found that many of the psychotherapists who stated that they did think it was important to address the possibility of harm, also stated that they often failed to do so during the informed

consent process. Sarkozy implied that psychotherapists should be more careful to address the possibility of harm during the informed consent process.

Both Friedlander and Thibodeau (1985) and Reynolds (2001) conducted studies looking at negative consequences of therapy through the clients' perspectives. Friedlander and Thibodeau (1985) and Reynolds (2001) found that if a therapist does not speak enough during the session this may cause the client to have a negative experience in therapy. Reynolds had a sample size of 319, while Friedlander and Thibodeau only had a sample size of eight. However, Reynolds collected evidence based on clients' assessments post-therapy whereas Friedlander and Thibodeau (1985) actually recorded sessions and calculated the speaking ratio of the client vs. the therapist. One possible limitation in the Friedlander and Thibodeau study is a small sample size. Friedlander and Thibodeau also only employed the use of therapists with only 1-4 years of experience. It would be helpful to research speaking ratios in therapy using a larger sample size, more experienced therapists and recorded sessions.

Friedlander and Thibodeau (1985) found that an uneven talking ratio could cause negative experiences in therapy. In addition to recording sessions, Freidlander and Thibodeau (1985) gathered data through conducting interviews. Each client was interviewed twice, after the first session and after the ninth session and asked to rate each session after it occurred on a 1-7 scale. Based on the recording of sessions, Friedlander and Thibodeau calculated the discourse activity level, distribution of talk and degree of structure for each session. Friedlander and Thibodeau (p. 1) found that "in the bad sessions, these therapists either participated even more actively than their clients or were passive while in their good sessions client–therapist participation levels were more balanced." Friedlander and Thibodeau found that the talk ratio

was more asymmetrical in the bad sessions. Friedlander and Thibodeau also found that, based on client/therapist discourse activity levels, clients participated more actively in the good sessions than the bad. Evidence from Friedlander and Thibodeau may indicate that balanced dialogue is more effective for treatment. Friedlander and Thibodeau also found that a moderate degree of structure is important but too much or too little structure has a negative impact on therapy.

Reynolds (2001) looked at premature termination from a patient's perspective and found that there were many negative experiences which caused clients to terminate. Reynolds gathered data by surveying 319 patients. One strength of Reynolds' study is that it specifically includes a sample that is marginalized and under-researched. One third of the clients in the Reynolds study identified their race and ethnicity as African American. Most of the clients were poor: the median income for this sample was $5,500/year. Reynolds conducted research at an outpatient clinic. Reynolds gathered his sample clients who agreed to be part of a larger research study and who were compensated for their participation in this study. When patients at the clinic gave consent to be part of a larger study, they also agreed that their data could be used by Reynolds in the case that they prematurely terminated treatment. When Reynolds gathered his data, he also contacted terminated clients and had them fill out a survey about their experience in therapy. Reynolds (p. 81) found that some negative experiences that caused patients to terminate therapy included: (a) therapists were unethical, (b) medication was distributed too readily, (c) therapist did not say enough, (d) therapist brought up subject matter that client was uncomfortable with, (e) therapist was often late to therapy.

Pope and Tabachnick (1994) conducted a survey of 476 therapists to elicit information about their experiences in therapy. One section of the questionnaire used by Pope and Tabachnick was devoted to harmful aspects of therapy. Pope and Tabachnick found that 16 of the therapists in the study revealed they engaged in sexual acts or attempted sexual acts with their therapists. Twelve therapists in the study described their therapists as sadistic or emotionally abusive. The therapists also revealed that their therapists had not understood them and that they felt their therapists were incompetent.

Sandell et al. (1992) and Wildman (1992) gathered data about negative experiences based on the perspectives of the therapist. Sandell et al. interviewed 34 therapists: six MDs, eight psychologists and 20 social workers. The therapists in Sandell et al.'s study, were asked to describe one session in which they felt good about their own way of working, and one in which they felt dissatisfied. Sandell et al. clarified that this study did not look at what was an objectively good or bad therapy hour, but simply focused on the therapist's perspective.

Sandell et al. (1992) found that negative experiences occurred when the therapist could not cope with the clients' resistance. Sandell et al. found that if the therapist feels countertransference and acts out as a result this could damage the therapy. Sandell et al. made the argument that the therapist's feeling like a bad therapist may have contributed to the client's having a negative experience in therapy. According to this study, "the ability constructively to utilize the countertransference for understanding the patient and formulating an effective intervention will make an hour feel particularly good" (p. 224). Sandell et al. also showed that therapists felt like bad therapists when they had problems with countertransference, exaggerated activity or passivity, and when they felt that they had the inability to understand latent meaning.

Wildman (1995) used an interesting methodology for his study because he looked at negative experiences in therapy through the perspective of therapists, but not about their own sessions. In his dissertation, Wildman had several therapists examine and critique sessions that had occurred between a therapist and a client who committed suicide while in therapy. The therapists critiquing these sessions did not know that the client had committed suicide. Wildman found that the study participants felt that the therapist seeing to the client who committed suicide had not been empathic enough towards the client and had not followed the proper protocol in the face of suicidal ideation.

Premature Termination

Moore et al. (2011) found that between one quarter and one half of psychotherapy patients prematurely terminate therapy. There are many definitions of premature termination. Reynolds (2001) defined premature termination as follows: "A situation in which patients stop treatment before they have resolved their issues or met their goals" (p. 10). Reynolds mentioned that premature termination has also been defined by patients dropping out after a certain number of sessions, even the second. However, according to Reynolds, defining premature termination based not on the number of sessions attended but on the lack of completion of the course of therapy allows for a more comprehensive and less limiting application of the definition. Ogrodniczuk et al. (2005) defined premature termination similar to the way Reynolds defined it, as the "patient's decision to end therapy, contrary to both the therapist's current recommendation and the initial agreement between the patient and therapist" (p. 57). Cooper and Lesser (2008) discussed therapy termination as being planned or unplanned. They described premature termination of therapy as "dissatisfaction in treatment that did not get addressed" (p. 47). Freud

(1937/1963) preferred to think about premature termination in analysis as being "incomplete" suggesting that perhaps the work would resume at a later time. Freud theorized that termination from analysis should happen when two things are true: the patient no longer suffers and has overcome anxieties and inhibitions, and when the therapist feels that pathological patterns are no longer present.

There are many factors that can contribute to premature termination. Westmacott et al. (2010) looked at information about premature termination from both the client and the therapist in the therapeutic dyad. Westmacott et al. collected data from 83 clients and the 35 therapists who worked with them. Westmacott et al. found that not building an early alliance cause premature termination. Clients also prematurely terminated for a wide breadth of reasons, many of them related to external factors like childcare and transportation. Premature termination may also be caused by clients not properly being prepared for therapy before it begins (Sherman & Anderson, 1987). A lack of attunement between therapist and patient, which exhibits itself in a variety of ways including the patient not feeling heard or feeling judged, was a major cause of client-initiated premature termination of therapy (Ogrodniczuk, Joyce & Piper, 2005).

Alliance may be an important factor in preventing premature termination. Westmacott et al. (2010) found both clients and therapists rated barriers to treatment and a lack of early alliance as reasons for terminating. Westmacott et al. found that clients in the dyad tended to rate the alliance with the therapist as worse than the therapist did. Westmacott et al. showed that therapists did not have the same perceptions of how therapy was going as their clients, both in cases where it was going well and where it was going poorly. One limitation with the

Westmacott et al. study was that all of the therapists were practicum students and interns in a doctoral program in clinical psychology.

Ogrodniczuk et al. (2005) compiled information from thirty-nine different studies to provide preventative strategies for how clinicians could reduce premature termination of therapy. Ogrodniczuk et al. gave a summary of why people prematurely terminate therapy and what can be done to guard against these factors. Most of the reasons Ogrodniczuk et al. found were related to mis-attunement between therapist and patient. This study highlighted the importance of building and maintaining a strong attunement between patient and therapist throughout the course of treatment.

Patients terminate for a number of reasons including a lack of agreement between therapist and patient about how to prioritize issues. Ogrodniczuk et al. (2005) stated that there was some evidence in the literature to suggest that one major reason for termination of therapy was that patients did not agree with the therapists' views of how to prioritize or address issues. Other reasons included "anxiety regarding disclosure, patients felt criticized by the therapist, patients sensed a lack of empathy from therapist, patients lacked motivation, patient-possessed low psychological mindedness and patients possessed irrational expectations" (p. 59).

Reynolds (2001) postulated that it was harder to communicate across racial and class categories than within them. Reynolds suggested that an alliance is harder to make in cross-racial dyads and that race and cultural issues may effect premature termination. Reynolds (p. 50) also found that "studies revealed that race, education and income have been consistently associated with premature termination. African Americans and other minorities, the less-educated and low-wage earners are among those most likely to terminate prematurely."

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Barrett et al. (2008) conducted a review study also showing that income is a positive determinant of premature termination occurring. Barrett et al. conducted a review study that examined the literature on attrition in therapy and formulated suggestions for treatment based on the evidence in the literature. Barrett et al. found that studies looking at attrition rates based on demographics such as age, gender and race were inconclusive and inconsistent. "In contrast, low socioeconomic status has fairly consistently been associated with psychotherapy dropout" (p. 4-5). Barrett et al. concluded that this phenomenon may be due to clients with a lower income being perpetually in conflict. "When the need is immediate and critical, it is a priority, and every effort is expended to get the necessary services. However, when both the severity and the immediacy of the problem are lessened, the problem is no longer preeminent, other crises emerge, and the effort is redirected. To follow through with treatment, individuals must feel the need is so constant and significant that the effort required will be sustained" (p. 13).

A lack of formal education may cause people to be more likely to prematurely terminate treatment. Barrett et al. (2008) showed evidence that suggested people without a high school degree were more likely than those with a high school degree to terminate. Chiesa, Drahorad and Longo (2000) also found that people who were less educated were more likely to terminate therapy prematurely. Chiesa et al. found that type of employment played a role in the likelihood to prematurely terminate, and that people in skilled or unskilled manual labor were most likely to terminate. Chiesa et al. conducted a study based on hospital records. Hospital records showed that out of the 134 patients admitted to the hospital within a year, 32% of patients dropped out of treatment within 14 weeks, 11% of patients dropped out after 14 weeks but before the course of treatment had ended, 1.5% committed suicide while in the hospital and 57% completed the

treatment (Chiesa et al., 2000). Chiesa et al. conducted this study looking at psychotherapy taking place at a hospital in England. In England, clients are generally treated for longer because clients don't rely on insurance companies for payment. Therefore, the results of Cheisa et al. (2000) are not necessarily applicable to the United States model of treatment in a hospital setting.

Westmacott and Hunsley (2010) also conducted research outside of the United States. Westmacott and Hunsley found that demographics played a role in clients' likelihood to terminate treatment. Westmacott and Hunsley conducted a study examining data collected from the Canadian Community Health Survey to compile themes about why clients terminated therapy. Themes examined included "demographics, mental disorders and type of mental health care provider" (p. 965). Westmacott and Hunsley found that

> 43.4% of clients terminated because they felt better; 13.4% completed recommended treatment; 14.1% thought treatment wasn't helping; 6.6% thought the problem would get better without more professional help and 5% said they couldn't afford to pay; 0.4% were too embarrassed to see a professional, 5.1% wanted to solve the problem without professional help; 2.1% had problems with things like transportation, childcare or scheduling; 4.2% said the service or program was no longer available; 7.2% said they were not comfortable with the professional's approach and 19.3% gave unspecified reasons. (p. 971)

The data showed that "nearly half or respondents reported leaving psychotherapy because of a barrier or dislike of treatment or because of wanting to solve problems in a different manner" (Westmacott & Hunsley, 2010, p. 975). Less than half of clients left treatment because they felt better. Westmacott and Hunsley (2010) showed that clients are more likely to leave treatment because there is something wrong in treatment, rather than because they have gotten better. In addition, Westmacott and Hunsley found that generally people with a lower income and those with diagnosable mental disorders were far more likely to experience premature termination than those without a low income or a diagnosable mental disorder.

Sherman and Anderson (1987), Barrett et al. (2008), and Ogrodniczuk et al. (2005) found that not preparing clients for treatment can cause premature termination. Sherman & Anderson found two methods to reduce premature termination: 1) send reminders to patients regarding missed and upcoming scheduled appointments and 2) prepare clients for therapy by explaining how therapy can help them and explain the roles of therapist and patient. This second method also includes providing the patient with an outline of course of therapy based on the clients presenting problems. Sherman and Anderson endorsed the exploration of hypothetical or imagined positive outcomes from therapy. Sherman and Anderson found the process of participants imagining positive outcomes to therapy decreased the likelihood of premature termination and contributed to their success in therapy. This type of preparation at the beginning of therapy helps the client visualize and believe in the possibility of a successful outcome.

Ogrodniczuk et al. (2005, p. 60) proposed the following nine points to prevent premature termination of therapy:

> 1) Pre-therapy preparation, a process involving psycho-education to clients 2) patient selection, a process of client screening 3) time limited or short-term contracts, informing patient of short-term treatment goals and duration 4) treatment negotiation, agree on purpose of therapy and method to address it 5) case management, support the patient's basic needs in order to maintain therapy (Maslow's hierarchy of needs philosophy) 6) appointment reminders, some patients will benefit from simple reminders 7) motivation enhancement, evaluate and reinforce patient's treatment goals 8) facilitation of a therapeutic alliance, create and maintain a quality working relationship 9) facilitation of affect expression, provide a therapeutic frame where patient can experience full range of feelings.

Barrett et al. (2008) found that preparation for the nature and process of therapy, motivational interviewing and a treatment service model may positively influence attrition rates in therapy. The treatment service model Barrett et al. began with was a group orientation in which clients were prepared for the process of therapy. Clients were then placed in a problem focused specific

treatment model lasting between 4-16 sessions. Barrett et al. found that this model was successful because it reduced client anxiety and provided clients with a workable structure for therapy.

Clinicians in Therapy

Many clinicians seek their own personal therapy in the course of their careers. Psychotherapy has been defined in the online Oxford Dictionary as, "the treatment of mental disorder by psychological rather than medical means" (Oxford Dictionary, 2008, p. 1159). Another working definition of psychotherapy is that it includes "the use of interpersonal influence skills and psychological techniques by trained professionals toward the goal of relieving the signs and symptoms of psychiatric disorder" (Beahrs and Gutheil, 2001, p. 4). Pope and Tabachnick (1994) found that 84% of psychologists in their study sought psychotherapy at some point in their careers. In some cases, personal therapy has been shown to be more effective than supervision in the training of a therapist (Pope & Tabachnick, 1994). This section explores why clinicians seek psychotherapy, what they get out of psychotherapy and what particular challenges there are for clinicians in therapy.

Freud thought that therapists should experience personal therapy. Freud (1937/1963) stated that "every analyst ought periodically... to enter analysis once more, at intervals of, say, five years, and without any feeling of shame in doing so" (pp. 267-268). Freud encouraged analysts to seek analysis in order to get over their weaknesses and therefore become better therapists themselves. Freud also thought that analysis helped analysts work towards becoming more honest.

Therapists in therapy could experience unique challenges not experienced by non-therapist clients. Freud (1937/1963) warned about some of the traps that analysts can fall into while being analyzed. He discussed the possibility that analysts will be victims to their defense mechanisms and therefore will not be able to able to use psychotherapy as a tool to work through unconscious conflicts. In an essay detailing the experiences of therapists in therapy, Fleischer and Wissler (1985) described how personal therapy could be experienced by a therapist-patient:

> The therapist may experience strong wishes to collude with the patient's need for perfection and omniscience in the treater, resulting in excessive and unrealistic expectations about one's capacities as a therapist; a highly negative and destructive pitfall of this seduction is the failure to analyze the developing positive transference and the identification with the therapist. Thus, both the patient and the therapist may have difficulty acknowledging the patient's negative reactions including hostility toward and dissatisfaction with the therapist. (p. 589)

Personal psychotherapy may help therapists have more positive views of themselves as therapists. Bellows (2007) conducted a study examining the experiences of therapists in therapy through in depth interviews about their previous experiences in therapy with 20 psychotherapists: almost equal parts psychologists, psychiatrists and social workers. This exploratory study focused on how psychotherapists' personal psychotherapy influenced their practices. One limitation of this study was that it based information on self-reporting, which is inherently subjective. This study also used a relatively limited sample size and none of the clinicians in the study had more than five years of experience.

Bellows (2007) found that being in therapy helped clinicians to have a realistic view of the meaning of being a good-enough therapist because they were influenced by their own therapists' fallibility. "Modification of perfectionistic traits was apparently promoted by self-identification with the former therapist's acceptance of personal fallibility. Being able to admit mistakes and be corrected was associated with the respectful treatment of patients with greater

self-acceptance" (p. 213). Personal therapy helped therapists understand that they didn't have to strive to be perfect therapists.

Bellows (2007) also found that having positive experiences with personal psychotherapy could affect psychoanalysts in other positive ways such as a) having a professional role model, b) enhancing their sense of professional identity, c) internalizing of the therapeutic relationship. Bellows found that therapists were more likely to internalize their personal psychotherapist if they had experienced a positive termination with this therapist.

Transference felt by therapists towards their personal therapists could affect their experiences in therapy. Bridges (1993) found that counter-transferential issues greatly affected clinicians in therapy. Bridges based this research on her own experiences treating psychotherapists and psychotherapists in training. Some issues that Bridges said could come up for therapists treating psychotherapists could included: "managing self-esteem, over-identification with therapist-patients, and ethical dilemmas" (p. 8). Bridges also stated that issues could arise when the therapist-patient came from a different discipline than the therapist treating them. Norcross (2005) also found that therapists tended to seek personal therapists that came from their same discipline.

Pope and Tabachnick (1994) surveyed a large sample of therapists to gather information about therapists' experiences, problems and beliefs about personal therapy. Pope and Tabachnick surveyed 800 psychologists found through the APA about their personal therapy. Out of this sample, 476 therapists completed the survey. Pope and Tabachnick found that the main reason psychotherapists sought therapy was because of depression or general unhappiness. Clinicians in Pope and Tabachnick's study also sought treatment for help with marriage or

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divorce, relationships, self-esteem and confidence, anxiety with careers, work or studies. Pope and Tabachnick found that 13% of the clinicians in the study sought therapy because their graduate programs required them to. Pope and Tabachnick found that 70% of those surveyed thought therapy should be a requirement for therapists in training and 54% thought that state-licensing boards should probably make personal therapy a requirement. Pope and Tabachnick had a relatively large sample size, which included an equal amount of men and women. One possible limitation with this study is that it left a lot of data labeled under miscellaneous and unexplained.

Further research may be needed on what negative experiences clinicians have in their own psychotherapy. Daw and Joseph (2007) conducted a study looking at the reasons why therapists seek personal therapy. Reasons included self-reflection and the prevention of burn-out. Daw and Joseph found that further research was needed that looked at the negative experiences of clinicians in therapy. Daw and Joseph found it was important for clinicians to know what it is like to be on the other side of therapy in order to build their therapeutic awareness. Also, Daw and Joseph found that it was important for negative experiences to be examined so that they will not be repeated.

There was evidence suggesting that therapists in therapy value some characteristics over others. Bike, Norcoss and Schatz (2009) found that clinicians rated competence, clinical experience, personal warmth and reputation as the most important factors in choosing a personal therapist. Bike et al. conducted a replication and extension study of a 1988 study by Norcross looking at how mental health professionals choose their therapists. Norcross et al. gathered data from an anonymous survey sent out to 2,100 randomly selected U.S mental health professionals.

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Bike et al. received 727 useable surveys and 608 surveys from therapists who had experienced at least one episode in personal therapy. A possible strength of this study was its large sample size as well as the relative diversity in terms of gender, age, clinical training etc. in the sample.

The importance of certain characteristics in personal therapists may differ depending on the discipline of the therapy. Bike et al. (2009, p. 34) found that most therapists in their study looked for personal psychotherapists who were caring, competent, experienced, open, professional and flexible. Psychologists in Bike et al.'s study were more likely to choose older, male psychologists as their personal therapists whereas social workers and counselors in Norcross et al. study were more likely to select younger, female social workers and counselors. However, "80% of psychologists, counselors, and social workers chose personal therapists who were older than themselves" (Bike et al., 2009, p. 36).

Norcross (2005) synthesized 25 years of research on the personal therapy of mental health professionals in an article released in 2005. According to Norcross, the primary goal of therapists in psychotherapy was to work on personal issues, while the secondary goal was to improve on their ability as therapists. Norcross (2005, p. 844) found six themes in the literature on how therapists' therapy improves clinical work. According to Norcross (2005, p. 844) "personal treatment provides a first hand, intensive opportunity to observe clinical methods: the therapist's therapist models interpersonal and technical skills."

Bike et al. (2009) further emphasized the importance of personal psychotherapy for psychotherapists. Bike et al. (2009, p. 40) found that "one out of five therapists rely on internalized representations of their own therapists when conducting treatment with their own patients to make moment to moment decisions." The purpose of Bike et al.'s (2009) study was to

examine whom therapists seek for their own therapy and what they regard as of highest importance.

Bellows (2007) found that "participants for whom personal therapy had the highest level of influence on their clinical practice reported that their treatment relationships had promoted the most psychological change. They clearly valued their former therapist as a professional role model and thought about him or her during moments of clinical uncertainty with their own patients" (p. 212). Bellows found that "unresolved treatment relationship problems during termination contributed to ambivalence about continuing (a) therapeutic dialogue" (Bellows, p. 213)

Clinicians Terminating Their Own Therapy Prematurely

There is a breadth of information on termination, and some information on therapists in therapy in the literature. The literature falls short of explaining why therapists terminate their own therapy prematurely and if they do more than non-therapist clients. This is an area that warrants more examination, both because it could provide insight as to what therapists need for personal therapy and because it could shed light on the reasons that most patients terminate.

CHAPTER THREE

METHODOLOGY

Formulation

As detailed in the previous sections, the purpose of this research study was to explore and describe the reasons why clinicians prematurely terminate with their psychotherapists. This research looked for patterns and themes in psychotherapists' experience to determine what behaviors or circumstances led to a negative experience in treatment and subsequent termination. My thesis proposed that clinicians may be better able to articulate what did not work in therapy than other clients.

The primary research question is: why do some clinicians in psychotherapy terminate the therapy prematurely? Through this open-ended question, this study gathered data about what reasons motivated clinicians to terminate their own personal therapy prematurely.

Sample

Number of Participants

Forty-nine participants completed this study by filling out an online survey (see Appendix A). Sixty-five people began the survey. Five of these 65 participants were not able to continue taking the survey because they answered "no" to the initial question: "are you a clinician, clinician-in-training or a retired clinician?" Out of the 60 participants who answered yes to this question, 11 were not able to continue with the survey because they answered "no" to the question: "Have you had at least one experience of prematurely terminating therapy with your personal psychotherapist?" Unfortunately, due to an error in the survey, five participants

were able to skip this question. Forty-nine participants eventually continued on to complete the survey.

How Participants Were Recruited

Participants were recruited through snowball sampling. I sent an email containing a link to the survey to Smith Social Work friends and classmates who then sent on the survey to their friends and coworkers (see Appendix B). Emails were also sent out to family friends, colleagues and other known clinicians. These clinicians went on to forward this email on to their contacts. A link to this survey was also posted on social networking sites such as Facebook and distributed to yahoo groups for clinicians such as Social Work World, NewPsychList and the NASP-Listserv.

In order to participate in the survey participants had to be clinicians, retired clinicians or clinicians in-training who had at least one experience of prematurely terminating with a self-identified psychotherapist. Participants also had to read English and have access to the internet.

Profession

Out of 49 participants, 47 participants answered the question asking about profession. Thirty seven participants, almost 80% of participants were social workers. Psychologists were the second most common participants, equaling seven participants or 15%. Marriage and Family Therapists, Psychiatrists and Mental Health Clinicians each equaled 2%, or one participant each. One participant answered "other" and wrote "psychoanalyst".

Experience

Forty seven participants answered the question about experience. As a whole, this sample lacked experienced. Seventy percent of participants were still training and 8.5% were not yet licensed. Ten point six percent of participants had between zero and fifteen years of

experience. Six point four percent of participants were still practicing and had more than fifteen

years of experience. Four point three percent of participants were retired.

Gender

Forty-six participants answered the question about gender. The vast majority of this

sample, 80.4%, was female. Nineteen point six percent of participants were male. Two

participants wrote in answers to this question. One participant wrote in "trans" and another

wrote in a question mark.

Race

Forty-six participants answered the question asking about race. The vast majority of this

sample, 41 participants or 98% identified as white. One participant identified as "Black or

African American". Two participants identified as Hispanic or Latino. One participant

answered "other" and specified "multi-racial."

Age Range

Forty-seven participants answered the question asking about age. This sample was fairly

diverse in terms of age. Almost half, 48%, of participants were under thirty. Twenty-five

percent of participants were between 31 and 40. Fifteen percent of participants were between 41

and 50. Six percent of participants were between 51 and 60 and six percent were between 61 and

70. No participants indicated that they were older than seventy.

Number of Therapists Seen By Participants

Forty-six participants answered this question. There was a great deal of range in the

number of therapists seen by participants. One participant indicated having seen over ten

therapists in his life. Out of the other 46 participants who answered this question with an exact number, the mean number of therapists seen by participants was 4.5 and the median was 3.

How Many Times Participants Terminated Prematurely

Forty-six participants answered this question. Most participants, 61% had terminated therapy prematurely only once. Thirty-seven percent of participants had terminated therapy prematurely two to five times and 2% had terminated prematurely six to ten times. No participants said they had terminated therapy prematurely more than ten times.

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Data Collection

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Data was collected using an online survey (see Appendix A). The email link to the survey was sent to over 300 personal contacts (see Appendix B). These contacts went on to resend the survey to contacts of theirs. In order to get a sample size of 50, I knew that I needed over 143 people to be interested in taking my survey, since only 84% of therapists have been in therapy and only 50% have terminated prematurely. I estimated that only a third of the clinicians who received the email would have the time and interest to open my email in order to determine whether or not they qualified. In order to reach 143 interested people, I knew that my email had to reach a minimum of 450 people. My desired sample size was 50. The survey was kept open for two months and was closed when the minimum sample size of 50 was reached.

The recruitment email described the study and what was expected of participants (see Appendix B). When participants clicked on the link contained in the email they reached a page of the SurveyMonkey survey asking them if they were a) a clinician, a clinician-in-training or a retired clinician and b) if they had a least one experience of prematurely terminating with a personal psychotherapist. If potential participants answered "no" to either of these questions

they reached a page thanking them for their interest but telling them that they were ineligible. If the participants answered yes to both of these questions, they were brought to the consent form (see Appendix C).

Participants then filled out a short survey asking them about their reasons for prematurely terminating therapy. Appendix A contains the full contents of the survey. The survey collected brief demographic data including type of degree, age-range, race, gender and years of experience. Participants were also asked how many therapists they had had. Participants were then asked why they prematurely terminated psychotherapy and were asked to write a paragraph explaining the details of termination. Participants were then invited to discuss a second experience with premature termination. Participants were told that opening the survey, reading the informed consent and taking the survey should take a maximum of ten minutes of their time.

Benefits of Participation

One possible benefit from this study is that the process of self-examination could have caused insight, awareness or possible growth. Participants also benefitted from participating in this study because they were able to contribute to the knowledge about negative experiences in therapy. Knowledge about the reasons for premature termination may help to develop best practices in the field of mental health. Development of best practices may be helpful to all clinicians, including the ones who participated in this study. No compensation was provided for participation.

Informed Consent Procedures

The second page of the survey contained the Informed Consent form (see Appendix C). Participants had to click that they had read and understood the form before they were able to

continue to the rest of the survey. The Informed Consent Form told participants that if they felt

triggered or distressed, they could terminate the survey at any time simply by exiting the screen.

Precautions Taken to Safeguard Confidentiality and Identifiable Information

This study was completely anonymous. Participants were not asked to give their names

or any identifying information.

When presenting and publishing information my research I regarded the participants as a

whole group. I carefully disguised illustrative vignettes and quoted comments. Demographic

data about participants and specific quotes will be stored on a password protected document on

my computer. All data will be kept secure for three years as required by Federal regulations.

After this time, they will be destroyed or continue to be kept secure for as long as they are

needed. When I no longer need this data, it will be destroyed.

Participation in this study was entirely voluntary and participants were free to refuse to

answer any questions they choose. If a question was required and a participant did not want to

answer it, participants were free to leave the site at any time. However, once participants

finished and submitted the survey, it was not possible for them to withdraw their particular

questionnaire because it cannot be identified.

In order to protect demographic information about participants, I did not use the

participants' gender when quoting their responses in the Findings and Discussion chapters.

Instead, I rotated between using male and female gender pronouns in these sections.

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Data Analysis

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Data were analyzed using open coding. Categories were developed based on the themes I

discovered through close examination of the survey results. Certain terms and phrases such as

"countertransference," "alliance," and "resistance" came up often in participants' results. I

marked these terms or phrases when they came up. I then went back through my data and looked

for other places where participants wrote similar responses but may have not used these key

terms. For example, some participants' responses clearly indicated that countertransference was

an issue, however participants did not use this term. Using coding and memoing techniques, I

divided my data into the categories that are detailed the following Findings chapter.

CHAPTER FOUR

FINDINGS

This chapter describes the major findings of my research. Lack of attunement was by far the most prevalent reason given for premature termination. The second most common reason for prematurely terminating had to do with the therapist wanting to use modalities the client wasn't interested or comfortable with. Rapport, circumstantial reasons and resistance were also often mentioned as causing premature termination. Less common than the above reasons but still common reasons for prematurely terminating had to do with counter-transference and transference issues and ethical issues. Only a few participants seemed not to know or remember why they prematurely terminated.

Lack of Attunement

Attunement was perhaps the most prevalent reason for premature termination. Seventeen participants mentioned some issue related to attunement as affecting their decisions to prematurely terminate. Many different reasons contributed to participants feeling that their therapist was not attuned to them. This section is divided into a) therapist did not understand client's needs or had different goals, b) therapist was not competent, c) therapist had demographic differences d) therapist was judgmental, and e) therapy wasn't progressing.

Therapist Did Not Understand Client's Needs or Had Different Goals

Nine participants terminated because they did not feel that the therapist was addressing their needs or goals. One participant described terminating without really being able to understand what had gone wrong in the therapy: "I felt like I was at an impasse with the work

with this therapist. It was hard to talk about what was going on and why I felt that way, so I just ended the relationship. I didn't really feel like the therapist was attuned to me or knew what was going on."

Many participants terminated because the therapists seemed to have their own agenda that did not relate to the clients' needs. Several participants said that they didn't feel heard, that the therapist didn't understand their needs or where they were coming from and that they had different goals from the therapist. One participant said that the therapist spent too much time giving advice, without listening to the participant. Another participant came in wanting to talk about early childhood experiences and the therapist instead focused on talking about the participant's training program. Another participant said that the therapist "was very invested in telling me what to do with my life without having fully explored what it was I wanted to do with my life." Another participant said that she wasn't ready to talk about what the therapist wanted to talk about. One participant cited an example of a therapist being overly directive with treatment:

> Therapist was very overbearing and opinionated. On my second session, she instructed me to bring my mother into the next session so she could confront her. Luckily I knew better than to bring my mom but I was completely intimidated by the therapist and came back for two more sessions.

Another participant said that the therapist was not interested in working on what the client wanted to work on at that time. Another participant said: "I felt the therapist could a not give me enough psychic space and also felt there was a basic misunderstanding of which dynamics were most vital to me."

Participants also prematurely terminated because the therapist did not push them enough or pushed them too much. One participant mentioned being unimpressed with the therapist's

inability to understand him, and said that the therapist didn't push him in a way he wanted to be pushed. Another participant indicated being pushed too much, and terminated because the therapist was not "respecting what I was comfortable with sharing."

Competency

Two participants terminated because they did not feel that the therapist was competent enough. One of these participants didn't feel the therapist was well-trained. The other participant was upset that the therapist never picked up on the participants' depression so the participant felt that the therapist was ineffectual and therefore terminated.

Demographic Differences

Two participants thought that demographic differences may have caused them to prematurely terminate. One of these participants felt that there was a generation gap with the therapist. Another participant felt that the gender of the therapist caused the therapist to misunderstand the participant.

Felt That Therapist Was Judgmental

Three participants mentioned feeling judged as contributing to premature termination. One of these participants explained, "I came to her with a problem and she made an interpretation that felt both wrong and judgmental."

Therapy Wasn't Progressing

Two participants terminated because they did not feel that they were progressing in therapy. One participant said, "I terminated because I felt the work was at a stand-still and I was frustrated and angry at the therapist because of this and I did not know how to address my feelings at the time of this treatment and therefore prematurely terminated."

<center>**Modalities**</center>

Eleven participants wrote about prematurely terminating therapy due to the therapist and the client not agreeing about modality or style. This section is divided into 1) therapist and client did not agree on the type of therapy, 2) therapist talked too much or too little, and 3) therapist did not provide enough collaboration or structure.

Therapist and Client Did Not Agree on the Type of Therapy

Participants terminated therapy because they were encouraged, and weren't interested in mind-body work, role playing, medication and group therapy. In all of these cases, participants wrote that the therapist pushed these modalities and that they terminated because they felt pressure to do something they weren't comfortable or weren't interested in. One participant wrote, "When I told her I wasn't comfortable with role playing and did not want to do it, she insisted, so I quit." One participant did not mention a particular modality or intervention that was suggested, but simply stated that she quit because she did not like the therapist's style.

Therapist Talked Too Much or Too Little

One participant prematurely terminated because the therapist talked too much. This participant wrote that it was not until 30 minutes into the first session that the therapist stopped talking about herself and asked why the participant had come to therapy.

Three participants terminated because the therapist did not talk or participate enough in therapy. One participant felt he wasn't getting anything out of therapy because of how little the therapist talked. Another participant said that the therapist was "too neutral" and the third participant said he was "bothered by [the therapist's] demeanor in the session which was very reserved and quiet.

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Needed More Collaboration

One participant terminated therapy because the therapist did not provide enough structure and did not direct the participant. Another participant said that she had enjoyed the first few sessions with this therapist but that things went downhill when the therapist asked why she was in therapy:

> I really enjoyed working with this person, but at the end of our 3rd or fourth session she asked me what it was that I was coming in for help with. I felt really upset with that, because part of my problem was that I didn't really know what I needed, but I knew that I was struggling with something that made me not feel right. In this case, I would have like the person to collaborate with me about what I was coming in for instead of putting it all on me.

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Circumstantial

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Ten participants terminated due to the following circumstantial reasons: 1) financial, 2) geographic, 3) scheduling, and 4) therapist retired.

Financial

The most common circumstantial reason was financial. Six participants prematurely terminated for financial reasons. Of these six participants, only one mentioned terminating strictly for financial reasons. Five participants indicated that they did not like their therapist enough to justify spending money, or allotted insurance sessions, on therapy. Financial reasons also got in the way of therapy for one participant: "I was paying out of pocket, had limited income and felt pressure to stay in therapy by the therapist which was a complete turn off."

Geographic Reasons

Two participants terminated because they were moving away from their therapists. Both participants listed geographic constraints as the only prohibitive factor. One of the participants

scheduled but never attended a final session with the therapist. The participant thought that this may have been due to his anxiety related to termination.

Scheduling Reasons

One participant wrote that she terminated because "scheduling became difficult due to a sudden increase in work intensity and acuity."

Therapist Left

Two participants terminated because their therapists retired. One participant wrote: "The therapist gave me one month notice that she was closing her practice, and I did not return to any therapy for many years after."

Resistance

Ten participants seemed to indicate some kind of resistance as their reason for prematurely terminating therapy. Issues related to resistance which caused participants to terminate includes a) client didn't want to take time for therapy, b) client was forced or mandated to be in therapy, c) client felt uncomfortable after disclosure, and d) client didn't think he or she needed therapy

Client Didn't Want to Take Time for Therapy

Two clients prematurely terminated because they no longer wanted to take the time to go to therapy. One of these clients indicated that they did not find the therapy helpful, and that is why she decided to terminate.

Client was Forced or Mandated to be in Therapy

Three participants discussed prematurely terminating therapy that they were forced to attend. All three of these participants were adolescents at the time of being in therapy and two of

them were 16 at the time of the experience. One of these participants said that they were

mandated to have 10 sessions of therapy due to an incident at school. This participant wrote: "I

did not clearly understand the relevance of therapy for me and wanted to get beyond the mistake

I had made in school, which forced me to end up in therapy in the first place. Going to see a

therapist every week was only a constant reminder of my poor judgment."

Another participant wrote about feeling: "overwhelmed, annoyed and lacked the insight

to use this therapist as a tool in my life. Basically, I terminated because I never actually got

started - I often spent the hour silent, and then concluded that it was a waste of time."

The third participant was state-mandated to receive family therapy with his parents. He

did not indicate that he himself was resistant, but that the parents and the therapist thought that

the family didn't need the therapy.

Client Felt Uncomfortable After Disclosure

Four participants indicated that they prematurely terminated therapy because they were

uncomfortable before or after a disclosure. One participant identified that she might have been

resistant due to it being her first time in therapy. One participant indicated that he terminated

following the sharing of a significant trauma. This participant wrote that he: "avoided returning

to therapy because I did not want to deal with the feelings that had been evoked." Another

participant wrote that she had begun looking at "real issues" in therapy and "did not feel safe

enough in life or with her to explore them." Another participant recognized that she terminated

due to her fears of disclosure:

> We had gotten to talking about some issues I wasn't ready to address - stuff about
> underlying sexual issues. I brought up the fact that there was something I hadn't told him
> yet, in sort of a veiled way, and he didn't pick up on it. Then all of a sudden at the next
> session I felt bored and didn't have anything to say. I just told him I didn't see the point of

therapy anymore, and he had just suggested we start meeting twice a week. Only in retrospect did I realize the connection between my fears of disclosure and the termination.

Client Didn't Think They Needed Therapy

Four participants indicated that they prematurely terminated therapy because they either didn't think they needed it in the first place, or they had gotten what they needed out of therapy.

One participant said that he had only started therapy because he thought he should be in therapy, but that he didn't have any presenting concerns.

> I think I was only going to therapy because I felt like I 'should be in therapy' but in reality I didn't have any presenting concerns. At first I was really annoyed with the therapist because he kept pushing me for a reason for why I was there but in hindsight I think he probably had a point.

Three participants thought they had gotten what they needed out of therapy and therefore terminated, even though the therapist did not think it was time for termination. One participant said: "I felt as though I had gotten a tremendous amount from this therapist and that the rest was on me."

Two participants wrote that they went into therapy because of depression. Both participants felt that their symptoms had been relieved, one through the assistance of antidepressant medication. Both of these participants terminated therapy after experiencing symptom relief. One of these participants wrote: "Psychoanalytical therapist felt there was a great deal more work to do, but I wasn't interested in going deeper."

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Rapport

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Nine participants cited problems with rapport as reasons for prematurely terminating with their therapists. This section is divided into the following sections: 1) client did not experience connection or alliance with the therapist and 2) client did not feel important to the therapist.

Client Did Not Experience a Connection or Alliance with the Therapist

One participant simply stated that she didn't feel that the therapist "got" her, and related it to a "lack of rapport." Five participants used the word "connection" in their responses to describe what was missing from the therapy. Three of these participants stated that they did not feel a "personal connection" with their therapist, and one of these participants added not a "good therapeutic match." One of these participants talked about how he decided not to see a particular therapist after realizing, through being in school himself, that it was not the "right fit." "Went to school and then didn't think he was the right fit. The alliance was not strong, I didn't feel a connection or that he understood me." Another one of these participants also mentioned having a weak alliance with the therapist.

One participant wrote about knowing that a rapport may develop over time, but preferring to begin with another therapist rather than wait and see if it did. This participant wrote:

> I did not feel a connection with her and as a result knew I would not be entirely forthcoming. I had initially planned to give it more than one session to see if a rapport would develop and decided against it, choosing instead to not return. I was not willing to do the work I believed would have been necessary to build a relationship with her and preferred trying another clinician.

One participant said that he did not feel comfortable with the therapist but did not elaborate further about why this may have been. Another participant was able to identify not enough "relational stuff going on." This participant wrote that she didn't feel cared for and did not feel an attachment to the therapist.

Another participant wrote about an early experience of premature termination with a therapist he saw in his adolescence. This participant merely said that he did not like the therapist and that he was scared to terminate, and so he had his mom call for him.

Client Did Not Feel Important to the Therapist

Four participants discussed feeling unimportant to their therapists as reasons for terminating prematurely. Two participants said that they did not feel important to their therapists because the therapist answered the phone during the session. One participant wrote that in addition to answering the phone during a session, this therapist also left the session to pick up a dinner someone had dropped off. This contributed to the participant feeling: "unseen and uncared for, and like I had to take care of her during the session and talk about everything she wanted to talk about." The other participant was bothered by the way the therapist did not apologize after answering the phone during a session.

Two participants felt unimportant because their therapist did not remember things they had told them. One participant explained: "I brought up, in a veiled way, certain issues I was not ready to disclose. She didn't ask much about it or seem to remember in the next session. I suddenly felt bored. I cancelled our next session and ignored her phone calls after that."

Counter-Transference and Transference Issues

Seven participants either directly cited or seemed to be referring to counter-transference and transference issues as their reasons for prematurely terminating. This section is divided into 1) transference, 2) counter-transference, and 3) transference and counter-transference. Although transference and countertransference are often linked, the section is divided this way to highlight what the participants identified as most important.

Transference

Three participants indicated that they prematurely terminated because of transference issues. One participant indicated that positive transference caused premature termination of

therapy. This participant said that the therapist "was the most attractive person I've ever met. I spent the next 6 months hoping I would see him on BART." Another participant mentioned that she did not like the therapist because the therapist reminded her of her mother. A third participant thought that the premature termination was caused by the transference felt around both the therapist and the client being social workers.

Counter-transference

One participant prematurely terminated due to the therapist acting upon countertransference. This participant stated:

> My therapist disclosed to me about going through a divorce herself and began to structure our sessions to encourage me to start dating again. I felt like it was her transference and that she was not looking out for my best interests.

Both Transference and Countertransference

Three participants terminated due to the combination of transference and countertransference. In these cases, participants appeared to have prematurely terminated because the therapist did not allow for space in the therapy for the transference to be discussed and/or reacted to the transference of the client. One participant who terminated didn't agree with her therapists' politics and felt that the therapist "had a substantial amount of negative transference" towards her.

Another participant described a situation in which the therapist reacted to the client's transference in a way that ultimately caused the client to prematurely terminate:

> The therapist was a new psychologist who offered free services at the church I attended. As I expressed a lot of anger arising from early aspects of my life, some of it was directed transferentially at her. She took it personally, reasserted her professionalism, and reminded me that her services were not costing me anything. She wanted me to see a colleague for a consultation. I couldn't afford it so I didn't go. I thought of going to a community mental health counselor but didn't. My therapist called me to check up on why I hadn't seen her colleague for consultation and I told her I wouldn't. She advised me

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that I needed therapy and I told her I assumed full responsibility for my decisions. We did not meet again. I really did need to continue in therapy. Looking back, I realize she was a relative novice who was not able to separate transference/countertransference dynamics from her own feelings.

One participant described a situation in which a therapist was often drowsy and nodded off during sessions. This participant stated:

Some theorists posit that the therapist falling asleep is either a sign of unvoiced anger/aggression/frustration at the client or simply a sign that something important is not being talked about. Those ideas made me feel insecure as if I, as a client, were doing something wrong.

Ethical Issues

Seven participants referenced ethical issues that caused them to terminate therapy. Ethical issues included a) therapist did not have appropriate boundaries b) therapist made offensive comments or assumptions, and c) therapist violated the trust of the client.

Therapist Did Not Have Appropriate Boundaries

Two participants said that their therapists did not have appropriate boundaries. One of these participants elaborated that the therapist was "more interested in becoming my mother than being my therapist."

Therapist Made Offensive Comments or Assumptions

Two participants prematurely terminated therapy because the therapist made inappropriate assumptions about them. One of these participants wrote:

I was given three free sessions with this particular therapist, with the option of continuing services after the third session. During the first session the therapist assumed my sexual orientation, which was a concern that I wanted to address in therapy. I felt uncomfortable correcting him in session, and therefore, uncomfortable bringing up my therapeutic concern. After our third session I decided to move on, and find a different therapist.

Another participant also terminated because of an offensive remark relating to the participant's sexual orientation. Another participant also indicated being offended by his therapist, but did not go into detail.

Therapist Violated the Trust of the Client

One participant wrote that the therapist "violated my trust and acted unethically." This participant did not elaborate.

Unknown Reason(s)

Two participants indicated that they didn't know why they prematurely terminated therapy. One participant wrote that it may have been a combination of things but did not elaborate.

In Chapter Five, I will discuss how these findings relate to the previous literature on this subject. I will also discuss the strengths and limitations of this study. I will also explore the implications for clinicians of the findings of this study and will make suggestions for further research on this topic.

CHAPTER FIVE

DISCUSSION

As described in the previous chapters, this study examined the experiences of premature termination from the perspective of clinicians terminating with their own personal therapists. As described in the Methodology chapter, this study was conducted through a survey of forty-nine clinicians.

According to the findings of this study, lack of attunement was the most prevalent reason for premature termination. The second most common reason had to do with the therapist wanting to use modalities the client wasn't interested or comfortable with. Rapport, circumstantial reasons and resistance were also mentioned as causes for premature termination. Counter-transference and transference issues and ethical problems were also brought up as reasons for premature termination. A few participants did not know or remember why they had prematurely terminated.

Comparison to the Literature

Findings Similar To Those in the Literature

There is little or no research about clinicians' reasons for prematurely terminating with their own psychotherapists. However, some of the findings of this study showed the psychotherapists' reasons for terminating their own therapy agreed with research on overall client premature termination.

Several participants in my study wrote that they terminated because their therapists did not seem to hear or acknowledge their needs. One participant explained that the therapist did not

understand "which dynamics were most vital." Other participants in my study also felt judged by their therapist and this contributed to premature termination. Westmacott et al. (2010) and Ogrodniczuk (2005) found that not building an early alliance with the therapist could cause a client to prematurely terminate. Similarly, alliance was one of the most prevalent reasons given in this study for premature termination. Participants in Ogrodniczuk's study cited not feeling heard, feeling judged and not feeling that the therapist prioritized the right issues as reasons for prematurely terminating.

Four participants in my study also found that an imbalance in the participation of the client and therapist caused them to terminate prematurely. Several other studies have also shown that if a therapist talks too much or too little in therapy this can cause the client to have a negative experience (Friedlander & Thibodeau, 1985; Reynolds, 2001).

As detailed in the Methodology chapter, the majority of participants were white and race was not mentioned as an issue for participants. However, age, gender and sexuality were cited as reasons for premature termination by participants in my study. Reynolds (2003) and Barrett et al. (2008) found that demographic differences increased the likelihood of premature termination. Participants in this current study also felt a lack of attunement due to demographic differences.

Six participants in my study also terminated due to financial reasons. However, for all but one participant, there were other reasons beyond financial which caused them to prematurely terminate. There is some evidence in the literature to indicate that low-economic status and inability to pay for therapy caused clients to prematurely terminate therapy (Barrett et al., 2008; Westmacott & Hunsley, 2010).

Participants in this current study also seemed to think that they could have benefitted from pre-therapy preparation. Two participants wrote that they terminated because they did not feel that the work was progressing. Four participants wrote that they terminated due to feeling uncomfortable before or after a disclosure. If these participants had been prepared for some of the feelings that might come up in treatment, or what they could expect to get from therapy, they may not have terminated therapy. There is evidence in the literature to indicate that pre-therapy preparation could help keep clients from prematurely terminating therapy (Barrett et al., 2008; Ogrodniczuk et al.,2005; Sherman and Anderson, 1987).

Findings Different from Those in the Literature

As expected, therapists who prematurely terminated therapy wrote about these experiences in clinical terms. Many descriptions by participants in my study were more in-depth and specific then those given by participants in other studies. Participants in this study wrote about their experiences using clinical terms such as rapport, transference, counter-transference, attunement, processing, resistance and impasse. While studies of premature termination in non-therapist clients relied on the researcher's interpretation of participants' responses, this study was able to rely more on the words of participants' themselves to infer what had caused the premature termination.

One of the major reasons shown in this study for prematurely terminating was resistance. Ten out of fifty (20%) of participants described situations in which they had prematurely terminated therapy due to their own resistance. Resistance was identified as a more important factor in my study than in previous studies on premature termination. This may have been due to the ability of psychotherapists in therapy to reflect on what had caused them to terminate using

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clinical terms. While non-therapist clients would not necessarily be able to recognize that what they had experienced was resistance, participants in this study were able to recognize resistance. One participant wrote "only in retrospect did I realize the connection between my fears of disclosure and the termination." Another participant wrote that although at the time she had been angry at her therapist at the time for pushing her to relay why she was in therapy "in hindsight I think he probably had a point."

Strengths

My major research question was: Why do psychotherapists in psychotherapy prematurely terminate their own psychotherapy? This research question was answered through the data collection. My research question allowed me to receive the data I was expecting about why clinicians had prematurely terminated with their therapists.

The use of an online survey tool was successful in allowing for the collection of these data.   I was able to distribute this survey to a fairly large sample of clinicians through use of online medium. Due to the online nature of this survey, I was also able to put this survey on social network websites and send the survey through email. I utilized snowball sampling to gather my sample. The online nature of the survey also allowed participants to easily forward the survey along to other friends and acquaintances. My intended minimum sample size was fifty participants and I had a final total of forty-nine participants.

The survey created was fairly easy to use and did not take participants very long to fill out. The survey created asked a single open-ended question and therefore allowed for the collection of responses which were not indicated in the literature. It also allowed for the collection of demographic information. However, since participants were able to skip any

demographic questions they did not want to answer. This allowed for the gathering of data even from those participants who did not want to provide demographic data.

The mean number of therapists seen by participants was 4.5. Most participants had only prematurely terminated with one therapist, however 37% of participants had terminated therapy prematurely two to five times and 2% had terminated prematurely six to ten times. The number of different therapists seen by participants, and the amount of times these participants had terminated showed that this was a sample which had some expertise.

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Limitations

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Forty-nine participants was a large enough sample to gather diverse responses from participants and also gather responses that mimicked one another. However, this sample was very limited in terms of race, gender, age, profession and years of experience. As detailed in the Methodology chapter, 80% of participants were social workers, 70% of participants were still in training, 80% of participants were female, 98% of participants were white, 71% were younger than 40. This sample is therefore not generalizable to non-white or male therapists. The findings of this study are limited in how much the findings can be generalized for therapists who are not social workers, are not still in training and are older than forty.

The limitation of this sample can likely be attributed to the data collection. An email containing a link to this survey was sent to over 300 personal contacts. Since I am currently a 2nd year student at Smith School of Social Work, many of these personal contacts are fellow Smith students. The majority of my Smith students are younger than forty, white and female. Although this survey was also sent to other personal contacts and posted on online networking sites, the

majority of people who were interested in taking the survey were fellow Smith students. This sample can be said to lack expertise, since the majority of participants were still in-training.

Another limitation of this study was that the study did not ask when a premature termination experience occurred. Some participants seemed to be writing about experiences that had happened before they had starting their clinical training. Some of the experiences that clinicians mentioned happened when they were in their adolescent years. Other clinicians discussed how their experience in therapy was affected by the clinical training they had already received. Most participants did not indicate whether a premature termination experience had occurred before or after they started their training. This information could be very pertinent to making determinations about why therapists who are in therapy terminate their therapy. Some of the information gathered indicated how therapists felt about the therapy they had terminated before they became therapists.

Implications

The findings of this study imply that lack of alliance, difference in modalities, rapport, circumstantial reasons, resistance, counter-transferential, transferential and ethical concerns could all cause therapists to prematurely terminate with their personal psychotherapists. This study also implies that resistance on the part of the client plays a bigger factor in the premature termination of therapy than has been suggested in previous literature.

Other studies have suggested that preparing clients for therapy by explaining the therapeutic process and creating a set of goals could decrease premature termination (Barrett et al., 2008; Ogrodniczuk et al.,2005; Sherman and Anderson, 1987). This study could make a similar argument because participants indicated that they did not feel therapy was progressing,

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and terminated therapy due to feeling uncomfortable after a disclosure. One indication of this study is that even therapists who are clients could benefit from a discussion about the course of therapy before treatment begins. In order to prepare clients for treatment, clinicians could form goals at the beginning of the therapeutic process and continue going over these goals as the therapy progresses.

Preparation for treatment with reminders of the initial goals of treatment could also be helpful to the therapist in the clinical dyad. Nine participants in this study prematurely terminated because they did not feel the therapist was addressing their needs or goals. One implication of the findings of this study is that therapists need to ensure that they are addressing the needs and goals of their clients; and not just addressing the needs and goals they think are significant.

Suggestions for Further Research

The field of psychotherapy could benefit from further research on the topic of premature termination. A bigger and more diverse sample than the one used for this study would help to clarify the trends in premature termination of therapists in therapy. My study found that resistance was a major factor in clients' decision to terminate. A further study could explore the subject of resistance more explicitly and examine how resistance in therapists in therapy is tied to their transferential reactions to their personal therapists. A longitudinal, long-term study examining how therapists experiences with personal psychotherapy changed during the course of their therapeutic training, would help to clarify the effects that being a therapist has on a person's experience with therapy.

Conclusion

It is essential that therapists be in tune with needs of their clients. Three quarters of a century ago, Freud (1937/1963) suggested that psychotherapists seek their own therapy at least once every five years. Today, personal psychotherapy can still be a valuable part of a clinicians' ongoing learning. Clinicians in therapy can provide valuable language about the experience of being a client. In order to make improvements in the field of psychotherapy, we as clinicians need to be willing to sit on the other side of the therapeutic dyad and to experience and examine both the positive and negative feelings that come up so that we can be familiar with the level of personal vulnerability we expect our clients to experience.

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Survey

Qualification for survey

1. Are you a clinician, clinician-in training or a retired clinician?
        -No
        -Yes
2. Have you had at least one experience of prematurely terminating therapy with your personal psychotherapist? (Both "premature termination" and "psychotherapist" are left to your interpretation).
        -Yes
        -No
3. In order to take this short survey, please read and agree to this consent form (see Appendix C)

Please fill out this brief demographic information

1. Which best describes you?
-Psychologist
-Marriage and Family Therapist
-Psychiatrist
-Mental Health Clinician
-Social Worker
-Other (please specify)

2. Which of the following best describes you?
-Still training
-Not yet licensed
-Licensed 0-15 years of experience
-Licensed 15+ years of experience
-Retired

3. Gender (check as many as apply)
-Male
-Female
-Other (please specify)

4. Race (check as many as apply)
-White

-Black or African American
-Hispanic or Latino
-American Indian or Alaskan Native
-Asian
-Native Hawaiian and Other Pacific Islander
-Other (please specify)

5. Age Range
-under 30
-30-40
-41-50
-51-60
-61-70
-71-80
-over 80

6. How many therapists have you seen in your life?
-1
-2
-3
-4
-5
-6
-7
-8
-9
-10
-over 10

7. How many times have you terminated therapy prematurely?
-1
-2-5
-6-10
-over 10

First experience with premature termination

While answering this question, please think of one experience you had of prematurely terminating with a psychotherapist that you were seeing for individual therapy. Terminating prematurely in this case means that the termination was unplanned and initiated by you.

1. Approximately how long did you see this therapist?

2. Why did you terminate? Please write a paragraph about your experience.

3. Have you had another experience with premature termination?
-yes
-no

Second experience with premature termination

While answering this question, please think of a second experience you had of prematurely terminating with a psychotherapist that you were seeing for individual therapy. Terminating prematurely in this case means that the termination was unplanned and initiated by you.

1. Approximately how long did you see this therapist?

2. Why did you stop? Please write a paragraph about your experience.

Appendix B

Recruitment Email

For a research study on clinicians' perspectives on termination of therapy

Looking for Mental Health Clinicians

To Participate in a Short On-Line Survey!

Hello,

Have you ever wondered why clinicians terminate their own therapy early?

My name is Jeff Smith, and I am a graduate student at the Smith College School for Social Work. For my thesis project, I am recruiting clinicians who have had at least one experience of prematurely terminating their own personal psychotherapy. I am gathering data on clinicians' reasons for prematurely terminating with their personal psychotherapist. To access the survey please click on the link http://www.surveymonkey.com/s/ZYGKSKN. Participation in this web-based survey is entirely voluntary and anonymous. Because it will not be possible to determine which submission is yours, you cannot withdraw from the study after submission of the survey.

I want to thank you in advance for your contribution to this study and ask that you please send this email to any and all mental health clinicians, clinicians in-training or retired clinicians. I would appreciate you posting this survey on any related listservs that you know of. Feel free to contact me at the email below if you have any questions.

Thank you for your time and your contribution,

Jeffrey K. Smith

Appendix C

Informed Consent

Dear Participant,

My name is Jeffrey Smith and I am a student at Smith College School for Social Work. As part of my MSW thesis, I am conducting a research study. The purpose of this study is to explore and describe the reasons why mental health clinicians have chosen to prematurely terminate with their own psychotherapists. This data will be used in my research thesis and may also possibly be used in presentations and publications.

You will fill out a short online survey that will take roughly 10-15 minutes. You will be asked to answer a few brief demographic questions and then write a few sentences about your experience. In order to participate in this study you must be a clinician, clinician in training or retired clinician who has prematurely terminated therapy with a therapist who defines him or herself as a psychotherapist, for example, a clinical social worker, psychologist, psychiatrist, or other licensed clinician.

There are no physical risks to participating in this study. However, it may be possible that you experience some discomfort while explaining your experiences. You will not be financially compensated for your participation. The possible benefits to participating in this study include having the opportunity to share your experiences and possibly contribute to advancing knowledge about ways to prevent premature rupture of a therapy relationship in the future.

Only me and my research advisor will have access to this data. All information will be collected anonymously. My research advisor will have access to this data. In publications and presentations, the data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised. All data will be kept in a password secured electronic file for a minimum of three years, after which it will be destroyed when no longer needed.

Participation in this project is entirely voluntary, and you may withdraw at any time before you submit the survey simply by leaving the site. If you withdraw before submitting, your questionnaire will not be recorded. Withdrawal from this study after submission of the survey will not be possible because particular submissions will be impossible to identify. If you have any concerns about your rights or about any aspect of the study, I encourage you to contact me by email or by phone. You can also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. I thank you for your time and participation and suggest that you print a copy of this consent form for your records.

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. PLEASE PRINT A COPY OF THIS CONSENT FORMS FOR YOUR RECORDS.

Appendix D

HSR Approval Form

SMITH COLLEGE
School for
Social Work

February 11, 2011

Jeffrey Smith

Dear Jeff,

Your second revision has been reviewed and it is fine with one exception. You didn't delete the first sentence of the risk paragraph assuring them there would be no physical risk. This really is not necessary and doesn't make any sense with this kind of research. We are glad at this time to give final approval to your study with the understanding that you will delete that sentence and send the corrected Consent to Laurie Wyman for your permanent file.

Good luck with your very interesting and useful project. It will be interesting to see how many therapists want to contribute on this topic.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting and useful project. It will be interesting to see how many therapists want to contribute on this topic.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor