A Structured Approach to Processing Clients' Unilateral Termination Decisions

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Research over several decades reveals that close to half of clients in the United States terminate psychotherapy before finishing their work, sometimes without discussing the matter with their therapist. As a result, therapists may experience significant distress, both because they had no input into the termination decision, and because they wonder if they were unhelpful, unskillful or even harmful to their clients. This article proposes a structured approach to enable therapists to process unilateral termination experiences. Its six steps are designed to help therapists honor their initial reaction response to the termination; appraise possible causes of the termination; determine most probable causes of the termination, and take commensurate responsibility; mourn; perform reparative tasks for the benefit of current and future clients; evaluate their subsequent well-being and sense of self-efficacy; and take a broader perspective. Designed as pantheoretical, the proposed structured approach is based on empirical data as well as commonly held theory.

KEYWORDS: unilateral termination; competency; accountability; mourning; therapist well-being

INTRODUCTION

Studies indicate that the most effective therapists see 70% of their clients through the completion of their work; however, the rest do so in far fewer cases, for an average national premature termination rate of 47% (Beutler, Harwood, Alimohamed, & Malik, 2002; Joyce, Piper, Ogrodniczuk, & Klein, 2007; Lambert & Ogles, 2004; Roe, 2007; Wierzbicki & Pekarik, 1992). These statistics have changed little in the past few decades (Baekeland & Lundwall, 1975; Beutler et al., 2002; Garfield, 1986; Lambert & Ogles, 2004). They have held across various theoretical orienta-

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tions, settings, levels of education (Joyce et al., 2007; Roe, 2007) and even years of experience (Schwartz & Flowers, 2010). Early termination is clearly an occupational problem.

Premature termination can be demoralizing to therapists (Ogrodniczuk, Joyce, & Piper, 2005). Therapists may distress over the possibility that they contributed to, or even caused, the termination. Therapists may believe they have failed or were rejected by the patient, and such a belief may impair therapists' confidence and effectiveness (Ogrodniczuk et al., 2005). Their level of skill might have resulted in their client not being helped, perhaps even harmed. In addition, because unilateral decisions preclude feedback from clients, therapists find their self-confidence and self-efficacy undermined by unanswered questions (Joyce et al., 2007; Lambert, 2004; Ogrodniczuk et al., 2005; Roe, 2007; Sledge, Moras, Hartley, & Levine, 1990; Van Denburg & Van Denburg, 1992). Thus, therapists need to process a unilaterally determined termination experience somewhat differently from one that is mutually determined.

There is no standardized definition for premature termination (Self, Oates, Pinnock-Hamilton, & Leach, 2005). Some define the concept as ending therapy prior to expiration of the treatment contract (Philips, Webart, Wennberg & Schubert, 2007) while others regard it as failure to keep the last appointment (Pekarik, 1985) or a client's decision to terminate therapy contrary to the therapist's advice (Ogrodniczuk et al., 2005). Moreover, components of the concept vary depending on treatment context and theoretical orientation about treatment objectives, expectations concerning the client's length of therapy, and criteria for success (Ogrodniczuk et al., 2005).

This article proposes a structured approach for working through therapists' experiences of their clients' unilaterally determined terminations; that is, those decided upon by clients who do not seek their therapist's input (Pekarik, 1985). To describe the construct, we prefer to use the phrase *unilateral termination* rather than *premature termination* since the former both captures the construct of premature termination and avoids problems related to diverse theoretical definitions of *premature* (Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010).

Our structured approach is comprised of six steps to be undertaken seriatim. A step not completed in one attempt may be revisited. The six steps are pantheoretical in that they interweave the affective, somatosensory, cognitive, and behavioral work necessary for therapists to meet both their personal needs and their professional responsibilities. We believe a pantheoretical approach is viable because therapists utilizing this approach

will be analyzing their mental representations; how they experience themselves and their clients (Jacobson, 1954). Mental representations have pantheoretical components (Blatt, Auerbach, & Levy, 1997) that impact therapist/client relationships and thus play a part in unilateral termination decisions.

STEP ONE—HONORING AN INITIAL REACTION

We recommend that therapists first take time to honor their initial reaction to a unilateral termination; a reaction derived from natural assessments made routinely and automatically by their perceptual system (Kahneman, 2003). Occurring within 150 milliseconds, these assessments are not cognitive in the sense of being mediated by conscious awareness (Huron, 2006). Rather, they are the quick and efficient "work" of a specialized neural circuitry (Kahneman, 2003).

One frequently occurring natural assessment is that what happened is "good" or "bad" (Kahneman, 2003). Another is that what happened is surprising (Kahneman & Miller, 1986), unexpected, or out of place. In performing this first step, we suggest therapists refrain from trying to understand or justify their affective-somatosensory reactions. Rather, we suggest they purposefully honor their idiosyncratic response to an unanticipated event, expressing whatever they are experiencing. If, for instance, surprise is conflated with relief, therapists should take time to enjoy their relief. If, as is more common, surprise is conflated with sadness, therapists should embrace their sense of loss.

Therapists can process their affective-somatosensory distress by exercising (Crone & Guy, 2008) or massaging the muscles of their cheeks and mouth (Porges, 2003). They can journal (Tokolahi, 2010). They can allow both dominant and non-dominant hands to draw, crayon, or paint (Bradshaw, 1990). They can sculpt, letting their emotions take shape in whatever way they wish (Hughes, 2009). They can reach out, as confidentiality permits, to a trusted colleague or allow themselves to be alone and take refuge in their place of sanctuary.

STEP TWO—APPRAISING PROBABLE CAUSES

General Purpose of Cognitive Appraisal

Lest therapists base future professional plans solely on their initial perceptions, a conscious, cognitive appraisal must follow relatively soon (Kahneman, 2003). For instance, if therapists' initial unconscious assessment is that what happened is "bad" and they have failed, that assessment may prevail unless input is provided to qualify or contradict it. Indeed,

even in cases of contrasting input, unconscious assessment reactions tend to function as powerful suppressors of alternative interpretations (Kahneman, 2003). Internally generated images created by the brain combine with original external stimuli to create neural "maps" (Kandel, 2006; Siegel, 2001) that subsequently function as enduring mediators. Provided nothing is done to interrupt the process, neurons consistently firing in the same patterns govern and facilitate future responses to similar external stimuli (Siegel, 2001). Fast and powerful the first time a therapist experiences a unilateral termination, a natural assessment becomes even faster and more potent and impervious in subsequent cases.

Cognitive appraisal is a key mediator in transactional models of stress (Lazarus & Launier, 1978) and is helpful in analyzing therapists' responses to unilateral termination. Lazarus and Launier suggest that a situation perceived as a threat might result in avoidance; whereas a situation perceived as a challenge would result in problem-solving and emotion-focused coping. With regard to secondary appraisal, Folkman and Lazarus (1985) found that individuals with a feeling of control over a distressful situation assessed the situation as a challenge rather than as a threat. As a result, they are likely to choose a more cognitive, less emotional, more effective corrective strategy (Wong & Reker, 1985).

Reviewing Research and Theory

We suggest that therapists begin their cognitive appraisals by reviewing research regarding common causes of terminations and transtheoretical explanations for unsuccessful therapy, keeping in mind the cognitive appraisal factors outlined by Lazarus and colleagues. As therapists review, we suggest they hold several hypotheses in mind, for in most cases several reasons will carry explanatory power.

We also recommend that therapists shift the weight from their own explanations for the termination to empirical data and sound theory, for research reveals therapists' self-serving tendencies. They may attribute causality to clients and/or environmental factors when evaluating their own termination cases but not the termination cases of other therapists (Murdock, Edwards, & Murdock, 2010).

The following reasons clients terminate are based on three broad categories developed by Pekarik (1992). We have also added a fourth category suggested by other research.

Category One: Improvement

Some clients terminate because they believe they have reached their goals (Hunsley, Aubry, Verstervelt, & Vito, 1999; Roe, Dekel, Harel, &

Fennig, 2006). They have benefited from therapy; i.e. solved the problem(s) and lessened the pain that brought them to treatment. They are ready and able to end their therapeutic commitment (Kramer, 1986; Roe, 2007).

Indeed, many clients do not experience what therapists define as "terminating too soon" or terminating inappropriately (Ellington, 1990; Hunsley et al., 1999). Because they regard goals therapists cherish, like "acceptance of self," as never fully attainable, some believe partial attainment is good enough (Roe, 2007). Others regard their experience of having diminished their pain, usually by solving their presenting problem(s), as an empowering "truth." They are cognizant of additional work they need to do but prefer not to do it at that time. They judge that they will do better in the future if they "bask in the sun" of their present accomplishments (Todd, Deanne, & Bragdon, 2003). Still others believe that, having achieved their goals, they are able to deal with other barriers to their well-being without additional therapy (Arnow, Blasey, Manber, Constantino, Markowitz, & Klein, 2007; Roe, 2007; Wierzbicki & Pekarik, 1992).

If therapists believe their clients had only Category One reasons for terminating, they can probably move to confirmation work and mourning. Their cognitive appraisal could be that they were not at fault.

Category Two: Dissatisfaction with Treatment

About one-third of all clients terminate because they experience their therapists as unhelpful (Hunsley et al., 1999; Pekarik & Finney-Owen, 1987). In some cases, they regard their therapists as deficient or unskilled and consequently have no faith in them (Roe, 2007).

Some clients find their therapists unskilled in managing the therapist's own reactions from earlier or extra-therapeutic experiences that are indistinguishable from those presently occurring in therapy (Levinson, McMurray, Podell, & Weiner, 1978; Mohr, 1995; Nagliero, 1996; Van Wagoner, Gelso, Hayes, & Diemer, 1991). They appear to be angry, which makes clients fear aggression in the therapeutic setting (Frayn, 1992). Select clients even perceive their therapists as malevolent persecutors they must leave in order to protect themselves (Dewald, 1971). Others experience their therapists as caught in sustained, heightened anxiety (Berry, 1970; Gamsky & Farwell, 1966) or pervasive depression that keeps them self-focused in spite of their desire to help. Still others experience their therapists as giving subtle but unnerving indications that they are sexually aroused and might be unable to contain that arousal (Frayn, 1992). In

brief, clients may find their therapists incapable of offering adequate empathy (Robbins & Jolkovski, 1987) and/or real assistance.

Ironically, other clients terminate because they find their therapists deficient in detecting and managing their own emotional involvement in the therapeutic interaction. Some experience their therapists as overly or purely empathic: having an excessive need to nurture or an inordinate need for approval from clients (Bandura, Lipsher & Miller, 1960; Mills & Abeles, 1965; Robbins & Jolkovski, 1987). Thus, they refrain from using confrontations and interpretations that challenge their clients' worldviews and facilitate change. Yet, on an unconscious if not conscious level, clients know that for them to get better, they must engage in the change process (Bollas, 1987).

For other clients, when another finally meets their needs, they find it extremely difficult to maintain the relationship (Arnow et al., 2007; Kohut, 1977). Therapists attempting to treat them may not be overly empathic from an objective standpoint, but they are too empathic in their clients' judgment. Clients' anxiety becomes intolerable as they experience their therapists as unable to extricate themselves from affective empathy (Arnow, et al., 2007; Greenson & Wexler, 1969; Newman, 1994; Reich, 1960).

Some clients terminate because they find their therapists lacking expertise in dealing with *them*: human beings with such stable or chronic traits that challenges in living are virtually insurmountable. Clients may be so masochistic, for example, they can scarcely engage with anyone, especially healthy individuals, on a long-term basis (Levinson et al., 1978). Or they have become so pervasively angry and/or sadistic, they have irresistible desires to rebel, manipulate, control, or devalue those with whom they come in contact (Freud, 1937/1968; Novick, 1982), including therapists (Winnicott, 1975). Other clients are so envious that they cannot tolerate the thought that their therapist has other relationships, as evidenced by fellow clients in the waiting room (Frayn, 1992). Yet other clients are so chronically impulsive that they cannot handle any form of separation from their therapists who have gone on holidays as it may cause anxiety (Masterson, 1981). This "separation" may even be simply an internal experience resultant from therapists' relatively lower number of empathic responses during the working phase of therapy (Newman, 1994; Frayn, 1992; Levinson et al., 1978). Chronically impulsive, as well as intensely fearful of rejection, these clients leave therapy rather than *be* left by their therapist. They reject before *being* rejected (Mahler, Pine, & Bergman, 1975).

Insurmountable philosophical and coping style differences, which di-

rectly affect their therapeutic relationship, may also motivate clients to drop out of therapy. Some terminate because their therapist seems unable to reconcile striking differences with regard to theories of change and well-being (Philips et al, 2007; Safran, Crocker, McMain, & Murray, 1990). Clients uncomfortable with introversion, withdrawal, social restraint, self-attribution, self-blame, self-criticism and inhibition, for instance, can find it too taxing to work with insight-oriented and interpersonally focused therapists who keep to a steady, theoretically determined course (Beutler et al., 2002). Similarly, clients uncomfortable with expression and excitation, impulsivity, gregariousness, or expressiveness—often combined with a propensity to blame others and rely on external attributions of cause—can find it too difficult to work with therapists who use behavioral and skill-focused interventions (Beutler et al., 2002). Still others determine that their therapists are not able to meet their high need for approval (Strickland & Crowne, 1963). They quickly experience negativity if their therapists evaluate them, even unconsciously, as immature and approval-seeking persons (Strickland & Crowne, 1963). They become desperate to protect their vulnerable self-image. Fearing that continuing in therapy will erode self-image even more, they terminate.

Similarly, chronically dependent clients may terminate for fear their nondirective therapists cannot or will not meet their dependency needs (Heilbrun, 1970). In contrast, dependent clients who finally embrace their need for independence may terminate from therapists they experience as too consistently directive (Roe, 2007; Smith, 1971). In either case, these clients lie at the distancing end of the approaching-distancing continuum (Philips et al., 2007) and see ending therapy as a way to get the distance they need.

A caveat is in order in therapists' review of Category Two. Therapists should not automatically conclude that either they or their clients are at fault. Rather, therapists need to assess their expertise in working with clearly challenging clients. High levels of expertise raise the question of whether therapists were able and/or willing to use their expertise. Low levels of expertise, by contrast, make therapists think about either acquiring sufficient expertise or referring to others in the future.

Category Three: Environmental Obstacles

Some clients terminate because of external reasons beyond their control, such as too little money, incapacitating medical problems, family responsibilities and having to relocate (Roe, 2007). They regret having to end therapy but believe they have no choice.

Revealing these environmental obstacles to their therapists, of course, is significantly different from simply not keeping the last appointment and not returning phone calls or evaluations. Therapists who are not informed can only review their work, hoping to discover data that shed light on what eventually happened.

Category Four: Other Reasons

About 10% of clients who enter therapy find the emotional pain they begin to suffer sufficient motivation for leaving therapy (Hynan, 1990). They determine that they have already suffered too much either before therapy or during trauma work. Some simply want to put pain behind them while others want to avoid new painful discoveries and fear such discoveries in therapy (Dickes & Strauss, 1979).

Other clients believe they can safely terminate because they have other resource persons. Involved in new, meaningful relationships (Roe, 2007), they can achieve their goals in collaboration with other professionals or simply supportive persons. Thus they prefer to put their time and energy into their non-therapeutic relationships.

Finally, some clients terminate simply because they do not have the ability to relate to a therapist and make use of therapeutic interventions in spite of their objective suitability (Henry & Strupp, 1994). Some are not ready to change; some will never be (Todd, et al., 2003). Some have such powerful, disorganizing resistance to change that they cannot form a therapeutic alliance (Frayn, 1992). Others are in a permanent contemplative or precontemplative state that prevents them from moving into action. That situation will not change because a therapist tries to influence them. In fact, it will get worse. They are caught in an approach-avoidance conflict in which the fundamental dilemma they face is giving up their defensive self-esteem or defying the one who implies their self-esteem is not valid. "The outcome of such an approach-avoidance conflict [will inevitably be their] leaving the field" (Strickland & Crowne, 1963, p. 100).

STEP THREE—DETERMINING PROBABLE REASONS AND TAKING RESPONSIBILITY

Having reviewed empirical data and theory in the light of a specific client's termination, therapists need to choose the most likely explanation(s) for what happened from the various contenders. We suggest therapists aim for high probability rather than certainty, however, for overly long analytic work will preclude timely movement to remaining steps.

During the third step, in order to minimize confirmation bias (Baron, 2000) and heuristics (Kahneman, 2003), it is important that therapists distance themselves from what they have deduced thus far. They need to increase their objectivity by searching for evidence that *disconfirms* rather than confirms their favored hypotheses. Such evidence includes statistical information regarding percentages of terminating clients who fall into the four categories, heretofore unexamined verbal and nonverbal "messages" from clients; analysis of their own countertransference, especially that which was operant toward the end of treatment; and the viewpoint of an unbiased colleague.

In intentionally distancing from their hypotheses, therapists perform what is perhaps their most crucial task—applying research-supported theory and statistics to an individual case while giving subjective, affective, intuitive and contextual forces the attention *they* deserve. Step Three therapists should also keep in mind that therapists often disagree with clients about whether they have actually attained their goals. In fact, most therapists do not corroborate satisfactory goal achievement by clients whose decision to terminate is unilateral (Hunsley et al., 1999). They tend to regard therapeutic work in its totality. They easily identify parts of the work clients have *not* completed.

Similarly, therapists question reduction in distress as a sufficient condition for termination. Some clients delude themselves into evaluating their original distress at a lower level than what they claimed originally in an effort to bolster their self-esteem or create a positive illusion about themselves. These clients are not actually conducting an honest assessment (Safer & Keuler, 2001). Rather, they are using their decision to terminate as further proof of their self-efficacy when in fact it is further proof of their basic problem: falsely inflating capabilities by using *some* growth as a sign of *sufficient* growth (Safer & Keuler, 2001).

Most therapists also doubt clients' capability to choose termination unilaterally. Those whose life patterns indicate pervasive dependence, in particular, would hardly be able to make sound decisions independently without considerable work (Heilbrun, 1970; Kupers, 1988). Therapists should also bear in mind that clients' decisions to terminate therapy may be based on flawed or limited perceptions of their therapy and therapist. Some clients may not even know why they terminated (Hunsley et al., 1999). Their memories are fallible, and unconscious factors affect ratings of their experiences (von Benedek, 1992). They may well have based their decision to terminate not on what was going on at the time but on earlier, contemplative thoughts or even precontemplative thought frag-

ments (Derisley & Reynolds, 2000; McConnaughy, Prochaska, Velicer, & Di Clemente, 1984; Miller & Rollnick, 1991). They may have based their decision not so much on a conscious evaluation process but on their therapists' unconscious communications of their own discouragement, insecurity regarding their skills, or temporary limitations like fatigue (Schaeffer, 2007).

Once therapists have reached reasonable certitude regarding a given termination, we recommend they set aside their most compelling explanation and entertain a contrasting one. They affirm one for a number of hours or days, then the alternate for an equal amount of time, all the while paying careful attention to their somatic reactions. Bodily reactions will ordinarily support the accuracy of attributions, with pain or discomfort designating what is inaccurate and calm and bodily well-being, what is accurate (Oschman & Oschmann, 1995). Next, therapists determine whether they should assume responsibility for the explanation that resulted from their analysis. They consider whether their personal limitations, such as lack of expertise and/or self-awareness, poor judgment, and burnout, significantly affected their work. They weigh in the characteristics of the client who terminated and the likelihood of effective treatment of the disorder or problem with which the client presented. They give consideration to realistic expectations for actually helping certain kinds of clients.

STEP FOUR—ENGAGING IN MOURNING AND OTHER REPARATIVE TASKS

Once therapists have determined a probable reason or reasons for a termination (as well as their contribution to it) we recommend they set aside their cognitive work and engage in the affective task of mourning. For, according to bereavement theory, mourning is a pre-requisite for skill building and other reparative work. Alternately, in cases in which therapists need not assume responsibility for a termination, mourning becomes the essence of the reparative plan (Weiss, 2001).

Mourning

Whether or not therapists are suffering from ethical guilt in the sense of fearing that they have done harm, they need to deal with the acute and episodic psychological pain of being separated from an emotionally significant other to whom they were attached by virtue of the therapeutic process (Bowlby, 1988; Weiss, 2001).

Although therapists can usually abbreviate their mourning in cases in

which they have judged a termination justifiable, they still need to systematically reorganize, restructure and rebuild the assumptive world that has been jolted—if not broken down—by the termination (Stroebe, Hansson, Stroebe, & Schut, 2001). They have lost both a client and future income.

In cases in which they have contributed to the termination, they also need to mourn the erosion of their sense of self-efficacy. They need to process the additional pain of realizing that they might have been unskilled, unperceptive, and/or wanting in empathy and respect, if not objectively then at least in the eyes of their client.

Some therapists may benefit most from performing the more traditional tasks of mourning—accepting the reality of their loss, working through their grief, adjusting to an environment in which the client is missing, and moving on with life (Worden, 1991). Others may benefit from focusing on meaning-making that more recent research finds is the heart of mourning; meaning-reconstruction that can even include continued symbolic bonds with the client who terminated (Weiss, 2001). For in spite of clients' decisions to leave therapy, therapists who invested time and energy in their work have the right *not* to erase the record of what was accomplished. Highlighting the many interventions that helped clients is no less valid and beneficial than focusing on those that caused the termination. In fact, self-efficacy may not be restored without the former (Bandura et al., 1960).

In any case, we recommend that therapists engage in an individualized mourning process, which simplifies and/or abbreviates their mourning as they honor their unique personalities as well as their responsibilities to remaining clients and to life in general. Therapists who have contributed significantly to a given termination may begin their mourning as a separate step but not complete it before performing reparative tasks called for by their mistakes. In fact, adjusting to a changed environment and moving on with life both depend largely on a future determined by the completion of those tasks and the appreciation of life-enhancing growth that results from integrating the lessons of loss (Weiss, 2001).

Other Reparative Tasks

Having mourned, therapists are in a position to allocate time and energy to other suitable reparative tasks. In some cases, they may engage in self-purification and professional realism; replacing self-serving, ego-inflated attitudes with those that are selfless and altruistic. For example, therapists who continued to treat clients they should have referred to another practitioner might seriously question their humility, honesty and motives for not referring to other professionals. Specialists in personality

disorders, for example, may have been able to help clients with seemingly intractable traits.

In the case of clients who suffered what felt like insurmountable traumas, therapists may need to examine carefully their own emotional involvement in the therapeutic interaction. Perhaps they were unable to let clients determine the pace and nature of their trauma work because they, as therapists, brought to sessions their own unprocessed trauma anxiety. Perhaps they accepted too many clients whose trauma bore too close a resemblance to their own. Perhaps they even unconsciously decided to reverse abuser–victim roles in an attempt to deal with their own painful memories of victimhood. In pushing their clients forward with trauma work, they may have hoped to replace a feeling of powerlessness with power over their clients. Reparative work in this case would then take the form of therapists entering into their own therapy and/or consulting with colleagues.

In the case of clients with coping styles and philosophies strikingly different from their own, therapists might need to examine their inflexibility. Therapists might also need to become more familiar with theories of change and with methods of discussing those theories. As Philips and others (2007, p. 243) have admonished, "The interplay between [client] and therapist concerning their theories about how the [client] could be cured [must be] a crucial part of the therapeutic collaboration."

In cases in which clients determined that therapy was going nowhere and the therapist was unskilled, therapists might consider whether their skill-levels were commensurate with their clients' problems and personality patterns. If they did not actually practice outside the areas of their expertise, they might have failed to tailor their interventions to particular clients' needs. They might not have given clients the opportunity to rate progress toward goal achievement and the helpfulness of their therapists at least two times within the first five or six sessions, as Duncan and Miller (2000) highly recommend.

In the case of clients who experienced their therapists' negative emotional involvement in the therapeutic interaction, therapists' reparative work might be learning to identify and manage—indeed benefit from—awareness of their emotional involvement (Schaeffer, 2007). In cases where clients experienced troubling positive emotional involvement by the therapist, therapists' reparative work might be to learn to skillfully introduce other interventions, such as confrontations, in order to make the therapeutic setting a place for clients to balance dependence with interdependence and independence.

Other recommendations are to ask clients for feedback regarding how well therapy is working and, based on that information, to adjust coping styles or approaches (Schwartz & Flowers, 2010); to maintain the therapeutic alliance no matter how tempting it is to forge ahead with work (Schwartz & Flowers, 2010); and to bring up termination issues at the beginning of therapy (Duncan & Miller, 2000).

Finally, regardless of the specific reasons for unilateral termination decisions, reparative work might call for therapists allocating time, money and energy to adopting strategies for reducing the number of unilateral terminations in the future. Ogrodniczuk and colleagues (2005) suggest providing prospective clients with information about what therapy can and cannot do for them, how long it will take to address the issues they bring, and difficulties they might have during the course of therapy. They also recommend screening prospective clients: selecting only those suitable for the kind of therapy one provides; making therapy more time-limited; offering a short-term treatment contract that can be renewed; negotiating an agreement on the nature of the client's problems and the manner in which they should be addressed; and calling clients to remind them of their appointment times.

STEP FIVE—EVALUATING WELL-BEING AND SENSE OF SELF-EFFICACY

We recommend that upon completing reparative tasks therapists evaluate their current well-being and sense of self-efficacy. In some cases, a series of unilaterally decided terminations—or one unilaterally decided termination that has required extensive reparative work—has taken a heavy toll. Therapists might still be suffering from significant distress, perhaps even heretofore unacknowledged burnout. In other cases, therapists may need to conduct another cognitive appraisal, re-discern their contributions to a treatment failure, and perform additional reparative tasks. In still other instances, therapists may simply have to accept the limitations of their efforts and thereby free up energy for work with other clients.

Some therapists may have to acknowledge their own psychological impediments to successfully completing an appraisal and/or reparative tasks and thus their need for personal therapy. One such impediment might be constant self-reproach that leads to an excessive sense of personal responsibility (Shapiro, 2006), causing the therapist to engage in self-punishment for having done or not done something.

Another such impediment might be the experiencing of shame. Shame

involves an excessive and critical focus on the self rather than on the offensive behavior (Tangney, 1991). When experiencing shame, therapists may define themselves, not as professionals who have made errors in judgment, but as innate professional failures. Thus no reparative act or series of acts can repair the damage they have done; and forgiveness of the self is hampered (Tangney, 1991). Therapists in these instances should consider doing their own work or seeking consultation.

In yet other cases, therapists may simply have to accept the limitations of their efforts to make reparation for their mistakes, such as their inability to quickly perfect a new skill or possess the wisdom of a highly experienced clinician. In doing so, they may well need to engage in additional mourning, followed by taking a broader perspective.

STEP SIX—TAKING A BROADER PERSPECTIVE

Finally, we recommend that therapists consider ending their processing of an experience of unilateral termination by pondering the broader perspective of Carl Jung (1931). Jung believed well-being to be based on a balance between what would be ideal and what is realistic due to human imperfections and limitations and the constraints of the environments within which human beings exist. Thus, even though therapists hope to help those who begin therapy, they cannot be successful with every client. In some cases, their best efforts will result not in a positive outcome but in painful humiliation and a weakened sense of self-efficacy. At the same time, therapists can prize the outcome of their reparative work: professional and personal growth that has placed them in a better position to prevent similar terminations in the future.

Therapists have also placed themselves in a position to make a contribution to the profession (Jung, 1931). By sharing what they have learned, they can enlarge professional understanding of what will never be fully understood—the mystery of human beings working with other human beings to bring about change; not through miraculous cures, but through hard-won victories over egocentricity. Therapists can also model for their clients how to benefit from unconscious displacement of one's feelings onto others even as they are occurring.

Therapists can also take comfort in the fact that in some cases, in making a unilateral decision to terminate, clients have taken responsibility for themselves. They have released in themselves "all those helpful forces which have always enabled humanity to rescue itself from all danger and to endure the longest night" (Jung, 1931, pp. 70-71).

Similarly, therapists can take comfort that their mourning and other reparative work have facilitated personal and professional transformation. They have used termination distress as an opportunity to enlarge expertise and refine skills. They have chosen self-evaluation over others' evaluation and reduced their dependence on external proof of their capability. Their transformation has entailed sacrifices of their ego to that of their client; of having control over a situation; and of being regarded as powerful, influential, and efficacious (Jung, 1931). Through these sacrifices, they have enabled at least some of their terminating clients to have an experience of being capable, self-determining persons.

Finally, by undertaking reparative work, therapists may have brought into focus a damaging self-image: one of being extraordinarily influential over others, much like gods or goddesses (Goldbrunner, 1965). We highly recommend that they now nurture a self-image that is more realistic and therefore more wholesome for both themselves and clients.

CONCLUSION: IMPLICATIONS, APPLICATIONS, AND LIMITATIONS

Unilaterally determined termination, though often painful and humiliating, offer therapists an opportunity for personal and professional growth in ways not usually prompted by mutually determined termination. Therapists deal more effectively with their termination distress when they use a structured approach to allocate time for expression of their initial affective–somatosensory reaction, cognitive appraisal work, mourning, and other reparative tasks. They thereby preserve time and energy for making attitudinal and practical changes that increase their ability to help clients complete their work. Perhaps even more important, therapists cast what has been painful and humiliating in a positive light: an opportunity to bring about professional and personal growth and contribute to our understanding of why unilateral terminations are so common and what might prevent those that can be prevented.

A challenge that now lies before us is to subject this structured approach to empirical study. Another challenge is theoretical. We have not by any means exhausted the constituents of the categories into which terminations fall. There are other bases on which clients make decisions to terminate as well as other mistakes therapists make. The theory on which our structured approach is based must undergo further conceptual analysis and integrate new research findings.

REFERENCES

Arnow, B. A., Blasey, C., Manber, R., Constantino, M. J., Markowitz, J. C., & Klein, D. N. (2007). Dropouts versus completers among chronically depressed outpatients. *Journal of Affective Disorders, 97,* 197-202. doi: 10.1011/j.jad.2006.06.017

Baekeland, F. & Lundwall, L. (1975). Dropping out of treatment: A critical review. *Psychological Bulletin, 82,* 738-783. doi: 10.1037/h0077132

Bandura, A., Lipsher, D. H., & Miller, P. E. (1960). Psychotherapists' approach-avoidance reactions to patients' expression of hostility. *Journal of Consulting Psychology, 24,* 1-8. doi: 10.1037/h0043403

Baron, J. (2000). *Thinking and deciding.* 3rd Ed. NY: Cambridge University Press.

Berry, J. W. (1970). Therapists' responses as a function of level of therapist experience and attitude of the patient. *Journal of Consulting and Clinical Psychology, 34,* 239-243. doi: 10.1037/h0029019

Beutler, L. E., Harwood, T. M., Alimohamed, S., & Malik, M. (2002). Functional impairment and coping style. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 145-170). NY: Oxford University Press.

Blatt, S. J., Auerbach, J. S., & Levy, K. N. (1997). Mental representations in personality development, psychopathology, and the therapeutic process. *Review of General Psychology, 1,* 351-374.

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* NY: Columbia University Press.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Bradshaw, J. (1990). *Homecoming: reclaiming and championing your inner child.* NY: Bantam Books.

Crone, D. & Guy, H. (2008). "I know it is only exercise, but to me it is something that keeps me going": A qualitative approach to understanding mental health service users' experiences of sports therapy. *International Journal of Mental Health Nursing, 17,* 197-207. doi: 10.1111/j.1447-0349.2008.00529.x

Derisley, J., & Reynolds, S. (2000). The transtheoretical stages of change as a predictor of premature termination, attendance and alliance in psychotherapy. *British Journal of Clinical Psychology, 39,* 371-382. doi: 10.1348/014466500163374

Dewald, P. (1971). *Psychotherapy: A dynamic Approach.* 2nd Edition. NY: Basic Books.

Dickes, R. & Strauss, D. (1979). Countertransference as a factor in premature termination of apparently successful cases. *Journal of Sex & Marital Therapy, 5*(1), 22-27. doi: 10.1080/00926237908403715

Duncan, B. & Miller, S. (2000). *Heroic client: Doing client-directed outcome-informed psychotherapy.* San Francisco, CA: Jossey-Bass.

Ellington, A. G. (1990). *Early premature termination from a university counseling center: A qualitative research study.* Dissertation Abstracts International, i51, 05B. (University microfilms No. AAD90-28269).

Folkman, S. & Lazarus, R. S. (1985). If it changes it must be a process: Study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology, 48,* 150-170. doi: 10.1037/0022-3514.48.1.150

Frayn, D. H. (1992). Assessment factors associated with premature psychotherapy termination. *American Journal of Psychotherapy, 46*(2), 250-261.

Freud, S. (1937/1968). Analysis terminable and interminable, and other works. In J. Strachey (Ed. and Trans.), *The standard edition, 23* (pp. 209-253). London: Hogarth Press.

Gamsky, N. R. & Farwell, G. F. (1966). Counselor verbal behavior as a function of client hostility. *Journal of Counseling Psychology, 13,* 184-190. doi: 10.1037/h0023397

Garfield, S. L. (1986). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 191-232). NY: Wiley.

Goldbrunner, J. (1965). "*Individuation" A study of the depth psychology of Carl Gustav Jung.* Notre Dame, IN: University of Notre Dame Press.

Greenson, R. R. & Wexler, M. (1969). The nontransference relationship in the psychoanalytic situation. *International Journal of Psychoanalysis, 50,* 27-38.

Heilbrun, A. B. (1970). Toward resolution of the dependency-premature termination paradox for females in psychotherapy. *Journal of Consulting and Clinical Psychology, 24* (3), 382-386. doi: 10.1037/h0029350

Henry, W. P. & Strupp, H. H. (1994). The therapeutic alliance as an interpersonal process. In A.O.

Horvath & L. S. Greenberg (Eds.). *The working alliance: Theory, research and practice* (pp. 51-84). NY: Wiley.

Hughes, S. (2009). Leadership, management and sculpture: how arts based activities can transform learning and deepen understanding. *Reflective Practice, 10*(1), 77-90. doi: 10.1080/14623940802652854

Hunsley, J. L., Aubry, T. D., Verstervelt, C. M., & Vito, D. (1999). Comparing therapist and client perspectives on reasons for psychotherapy termination. *Psychotherapy, 36*(4), 380-388. doi: 10.1037/h0087802

Huron, D. (2006). *Sweet anticipation: Music and the psychology of expectation.* Cambridge, MA: The MIT Press.

Hynan, D. J. (1990). Client reasons and experience in treatment that influence termination of psychotherapy. *Journal of Clinical Psychology, 46* (6), 891-895. doi: 10.1002/1097-4679(199011)46:6<891::AID-JCLP2270460631>3.0.CO;2-8

Jacobson, E. (1954). The self and object world: Vicissitudes of their infantile cathexes and their influence on ideational affective development. *The Psychoanalytic Study of the Child, 9,* 75-127.

Joyce, A., Piper, W. E., Ogrodniczuk, J. S., & Klein, R. H. (2007). *Termination in psychotherapy: A psychodynamic model of processes and outcomes.* Washington, DC: American Psychological Association.

Jung, C. G. (1931). Seelenprobleme der Gegenwart (Spiritual Problems of the Present Day). Zurich: Psychologische Abhandlunger, III.

Kahneman, D. (2003). A perspective on judgment and choice: Mapping bounded rationality. *American Psychologist, 58,* 697-720. doi: 10.1037/0003-066X.58.9.697

Kahneman, D. & Miller, D. T. (1986). Norm theory: comparing reality to its alternatives. *Psychological Review, 93,* 136-153. doi: 10.1037/0033-295X.93.2.136

Kandel, E. R. (2006). *In search of memory: The emergence of a new science of mind.* NY: W. W. Norton & Company.

Kohut, H. (1977). *The restoration of the self.* NY: International University Press.

Kramer, S. A. (1986). The termination process in open-ended psychotherapy: Guidelines for clinical practice. *Psychotherapy, 23*(4), 526-531. doi: 10.1037/h0085652

Kupers, T. A. (1988). *Ending therapy: The meaning of termination.* NY: University Press.

Lambert, M. J. & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin & Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). NY: Wiley.

Lazarus, R. S. & Launier, R. (1978). Stress-related transactions between persons and environment. In L. A. Pervin & M. Lewis (Eds.), *Internal and external determinants of behavior* (pp. 287-327). New York: Plenum.

Levinson, P., McMurray, L., Podell, P., & Weiner, H. (1978). Causes for the premature interruption of psychotherapy by private practice patients. *American Journal of Psychiatry, 135*(7), 826-830.

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant.* NY: Basic Books.

Masterson, J. F. (1981). *The narcissistic and borderline disorders.* NY: Brunner/Mazel.

McConnaughy, E., Prochaska, J., Velicer, W., & DiClemente, C. (1984). *Replication of the stages of change in psychotherapy.* Unpublished manuscript.

Miller, W. & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior.* NY: Guilford.

Mills, D. H. & Abeles, N. (1965). Counselor needs for affiliation and nurturance as related to liking for clients and counseling process. *Journal of Counseling Psychology, 12,* 353-359. doi: 10.1037/h0022767

Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice, 2*(1), 1-27. doi: 10.1111/j.1468-2850.1995.tb00022.X

Murdock, N. L., Edwards, C., & Murdock, T. B. (2010). Therapists' attributions for client premature termination: Are they self-serving? *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 221-234. doi: 10.1037/a0019786

Nagliero, G. (1996). Countertransference in adolescent psychotherapy. *Group Analysis, 29,* 69-79. doi: 10.1177/0533316496291007

Newman, C. F. (1994). Understanding client resistance: Methods for enhancing motivation to change. *Cognitive Behavioral Practice, 1,* 47-69. doi: 10.1016/S1077-7229(05)80086-0

Novick, J. (1982). Termination: Themes and issues. *Psychoanalytic Inquiry, 2,* 329-365. doi: 10.1080/07351698209533458

Ogrodniczuk, J. S., Joyce, A. S., & Piper, W. E. (2005). Strategies for reducing patient-initiated premature termination of psychotherapy. *Harvard Review of Psychiatry, 13,* 57-70. doi: 10.1080/10673220590956429

Oschmann, J. L. & Oschman, N. H. (1995). Somatic recall: Part I—Soft tissue memory. *Massage Therapy Journal, 34,* 60-65.

Pekarik, G. (1985). Coping with dropouts. *Professional Psychology: Research and Practice, 16,* 114-123. doi: 10.1037/0735-7028.16.1.114

Pekarik, G. (1992). Relationship of clients' reasons for dropping out of treatment to outcome and satisfaction. *Journal of Clinical Psychology, 48,* 91-98. doi: 10.1002/1097-4679(199201)48:1<91::AID-JCLP2270480113>3.0.CO;2-W

Pekarik, G. L. & Finney-Owen, K. (1987). Outpatient clinic therapist attitudes and beliefs relevant to client dropout. *Community Mental Health Journal, 23,* 120-130. doi: 10.1007/BF00757166

Phillips, B., Werbart, A., Wennberg, P., & Schubert, J. (2007). Young adults and ideas of cure prior to psychoanalytic psychotherapy. *Journal of Clinical Psychology, 63*(3), 213-232. doi: 10.1002/jclp.20342

Porges, S. W. (2003). The polyvagal theory: Phylogenetic contributions to social behavior. *Physiology and Behavior, 79*(3), 503-513. doi: 10.1016/S0031-9384(03)00156-2

Reich, A. (1960). Further remarks on countertransference. *International Journal of Psychoanalysis, 41,* 389-395.

Robbins, S. B. & Jolkovski, M. P. (1987). Managing countertransference feelings: An interactional model using awareness of feeling and theoretical framework. *Journal of Counseling Psychology, 34,* 276-282. doi: 10.1037/0022-0167.34.3.276

Roe, D. (2007). The timing of psychodynamically oriented psychotherapy termination and its relation to reasons for termination, feelings about termination, and satisfaction with therapy. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 35* (3), 443-453. doi: 10.1521/jaap.2007.35.3.443

Roe, D., Dekel, R., Harel, G., & Fennig, S. (2006). Clients' reasons for terminating psychotherapy: A quantitative and qualitative inquiry. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 529-538. doi: 10.1348/147608305X90412

Safer, M. A. & Keuler, D. J. (2001). Individual differences in misremembering pre-psychotherapy distress: Personality and memory distortion. *Emotion, 1,* 162-178.

Safran, J. D., Crocker, P. L., McMain, S., & Murray, P. (1990). The therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research and Practice, 27,* 154-165. doi: 10.1037/0033-3204.27.2.154

Schaeffer, J.A. (1998). Transference and countertransference interpretations in brief dynamic therapy: Harmful or helpful? *The American Journal of Psychotherapy, 52,* 1-17.

Schaeffer, J. A. (2007). *Transference and countertransference in non-analytic therapy: Double-edged swords.* Lanham, MD: University Press of America.

Schwartz, B. & Flowers, J. V. (2010). *How to fail as a therapist.* Atascadero, CA: Impact Publishers.

Self, R., Oates, P., Pinnock-Hamilton, T., & Leach, C. (2005). The relationship between social deprivation and unilateral termination (attrition) from psychotherapy at various stages of the health care pathway. *Psychology and Psychotherapy: Theory, Research and Practice, 78,* 95-111. doi: 10.1348/147608305X39491

Shapiro, D. (2006). Self-reproach and personal responsibility. *Psychiatry, 69*(1), 21-25. doi: 10.1521/psyc.2006.69.1.21

Siegel, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal, 22*(1-2), 67-94. doi: 10.1002/1097-0355(200101/04)22:1<67::AID-IMHJ3>3.0.CO;2-G

Shapiro, D. (2006). Self-reproach and personal responsibility. *Psychiatry, 691,* 21-25.

Sledge, W. H., Moras, K., Hartley, D., & Levine, M. (1990). Effect of time-limited psychotherapy on patient dropout rates. *American Journal of Psychiatry, 147,* 1341-1347.

Smith, C. E. (1971). An atypical session: Resistance and the negativistic patient. *Psychotherapy Theory, Research, & Practice, 8*(4), 276-279. doi: 10.1037/h0086674

Strickland, B. R. & Crowne, D. P. (1963). Need for approval and the premature termination of psychotherapy. *Journal of Consulting Psychology, 27*(2), 95-101. doi: 10.1037/h0040686

Stroebe, M. S., Hansson, R. O., Stroebe, W., & Schut, H. (2001). *Handbook of Bereavement Research.* Washington, D.C.: American Psychological Association. doi: 10.1037/10436-000

Tangney, J. P. (1991). Moral affect: The good, the bad, and the ugly. *Journal of Personality and Social Psychology, 61,* 598-607. doi: 10.1037/0022-3514.61.4.598

Todd, D. M., Deanne, F. P., & Bragdon, R. A. (2003). Client and therapist reasons for termination: A conceptualization and preliminary validation. *Journal of Clinical Psychology, 59,* 133-147. doi: 10.1002/jclp.10123

Tokolahi, E. (2010). Case study: development of a drawing-based journal to facilitate reflective inquiry. *Reflective Practice, 11*(2), 157-170. doi: 10.1080/14623941003665976

Van Denburg, R. F. & Van Denburg, E. J. (1992). Premature termination in the midst of psychotherapy: Three psychoanalytic perspectives. *Psychotherapy: Theory, Research, Practice, Training, 29*(2), 183-190. doi: 10.1037/0033-3204.29.2.183

Van Wagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. A. (1991). Countertransference and the reputedly excellent therapist. *Psychotherapy, 28*(3), 411-422. doi: 10.1037/0033-3204.28.3.411

von Benedek, L. (1992). The mental activity of the psychoanalyst. *Psychotherapy Research, 2,* 63-72. doi: 10.1080/10503309212331333608

Weiss, R. S. (2001). Meaning making in the dual process model of coping with bereavement. In Robert A. Neimeyer (Ed.), *Meaning reconstruction and the experience of loss* (pp. 55-73). Washington, DC: American Psychological Association.

Westmacott, R., Hunsley, J., Best, M., Rumstein-McKean, O., & Schindler, D. (2010). Client and therapist views of contextual factors related to termination from psychotherapy. *Psychotherapy Research,* 20, 423-435. doi: 10.1080/10503301003645796

Wierzbicki, M., & Pekarik, G. (1992). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*(2), 190-195. doi: 10.1037/0735-7028.24.2.190

Winnicott, D. W. (1975). *Through paediatrics to psycho-analysis.* NY: Basic Books.

Wong, P. T. P. & Reker, G. T. (1985, June). *The coping behavior of Type A individuals.* Paper presented at the annual meeting of the Canadian Psychological Association, Halifax, Nova Scotia.

Worden, J. W. (1991). *Grief Counseling and Grief Therapy.* NY: Springer Publishing Company.