# REASONS FOR TERMINATING PSYCHOTHERAPY: CLIENT AND THERAPIST PERSPECTIVES

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**Abstract**

Given the high prevalence of client unilateral termination from psychotherapeutic services, elucidating client reasons for ending therapy is an important activity for researchers. Three studies were designed to shed light on reasons for both premature and appropriate termination from the perspective of adult clients and therapists: 1) In Study 1, I examined data from the Canadian Community Health Survey, Cycle 1.2, to establish base rates of client reasons for psychotherapy termination in Canada, along with their demographic and clinical correlates, 2) In Study 2, I used training clinic data to examine client and therapist perspectives of reasons for termination, working alliance, and barriers to treatment participation in mutual versus unilateral terminators, and 3) In Study 3, I collected data from Canadian clinical psychologists to examine their perspectives of client reasons for early versus later termination, and their use of engagement strategies to reduce client-initiated unilateral termination. In Study 1, 43.1 percent of respondents reported terminating therapy for reasons other than feeling better or completing treatment. In general, individuals with low income and diagnosable mental disorders had significantly increased odds of premature termination. Study 2 revealed that when clients made unilateral decisions to end therapy, therapists were only partially aware of either the extent of clients' perceptions of their success in therapy or with their dissatisfaction with therapy. Although working alliance and barriers to treatment participation were rated as lower in the context of unilateral termination by both clients and therapists than in the context of mutual decisions to terminate therapy, all clients, in general, rated the early alliance and barriers to treatment as higher than did their therapists. In Study 3 psychologists assigned differential importance to reasons for termination depending on whether termination was before versus after the third session. Theoretical orientation (CBT versus other) did not influence views of reasons for

termination, but influenced use of some engagement strategies. Results are discussed in terms of research and clinical implications.

## Statement of Co-Authorship

The three manuscripts included in this dissertation were prepared in collaboration with my dissertation supervisor. I was the primary author and Dr. John Hunsley was the secondary author for the first manuscript, entitled "Reasons for terminating psychotherapy: A general population study" (Chapter Two), and the third manuscript, entitled "Psychologists' Perspectives on Therapy Termination and the Use of Therapy Engagement Strategies" (Chapter Four). For the second manuscript, "Client and therapist views of contextual factors related to termination from psychotherapy: A comparison between unilateral and mutual terminators" (Chapter Three), I was the primary author, Dr. John Hunsley was the second author, and Drs. Marlene Best, Orly Rumstein-McKean, and Dwayne Schindler were also included as authors. Drs. Best and Rumstein-McKean collected the data for the study, and Dr. Dwayne Schindler provided statistical consultation. As the primary author on all manuscripts, I was responsible for conceptualization of the research question and methods, planning and execution of statistical analyses, and preparation of manuscripts. Dr. Hunsley provided guidance and assistance in all aspects of the project, especially in the refinement of study hypotheses, and editing of manuscripts.

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# CHAPTER 1

## Reasons for Terminating Psychotherapy: Client and Therapist Perspectives

For decades, clients' ending psychotherapy prematurely has been a concern for clinicians and a focus for researchers (e.g., Baekland & Lundwall, 1975; Persons, Burns, & Perloff, 1988). Meta-analytic evidence, based on the findings of 125 studies, indicates that nearly 50% of clients terminate psychotherapy before having completed the full course of recommended services (Wierzbicki & Pekarik, 1993). Many clients discontinue before they are able to fully benefit from psychotherapeutic services (Hansen, Lambert, & Forman, 2002; Hunt & Andrews, 1992; Kazdin, Mazurick, & Siegel, 1994; Phillips, 1987). Elucidating the factors that influence why clients leave before they have fully benefitted is an important activity for researchers. One avenue for understanding why clients leave is to examine their reasons for doing so. In this dissertation, my primary objective is to shed light on reasons for both premature and appropriate termination from the perspective of adult clients and therapists, in three separate studies: 1) a population study of client reasons for termination of services across mental health care providers and settings, 2) a training clinic study comparing client and therapist perspectives of reasons for termination and related contextual variables, and 3) a survey of psychologists' perspectives of client reasons for termination at different points in therapy, as well as psychologists' actions to engage and retain clients in therapy. In this general introduction I outline the prevalence and correlates of premature termination from therapy, the methods by which premature termination has been studied and the resulting findings, and the importance of examining clients' and therapists' perspectives of reasons for termination. I will also outline studies that have examined therapists' actions to engage and retain clients in therapy.

### Prevalence of Premature Termination

Hunsley and Lee (2007) comprehensively reviewed effectiveness studies of evidence-based treatments, and found that over half the reported studies had completion rates greater than 75%, which is substantially higher than the rates of around half of participants completing therapy reported by Wierzbicki and Pekarik (1993) in their meta-analysis. Despite these encouraging steps forward with respect to evidence-based treatments, completion rates in routine practice continue to remain much lower. Hansen, Lambert, and Forman (2002) conducted a large, multi-site, multi-treatment review of 6,072 clients in routine mental health practice and found that the mean number of sessions completed was 4.3. After this brief exposure to therapy, the treatment site exhibiting the most successful clients had fewer than 10% of its clients recover, and fewer than 25% achieved any improvement. Indeed, dose-response studies generally indicate that between 13 and 18 sessions of therapy are necessary for clinically significant change in psychiatric symptoms, across various treatments and client diagnoses (Hansen et al, 2002). Results of the Hansen et al. study demonstrate that five decades of research on premature termination of psychotherapy has failed to result in reduced rates of client dropout in routine practice. Furthermore, premature termination clearly has consequences for the effectiveness of therapy (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008; Swift, Callahan, & Levine, 2009).

Premature termination has been defined a number of ways, including nonattendance after the intake assessment (Longo, Lent, & Brown, 1992), nonattendance of two consecutive sessions (Kolb, Beutler, Davis, Crago, & Shanfield, 1985), nonattendance at the last scheduled session (Hatchett, Han, & Cooker, 2002), client termination of therapy within a particular time period (Frayne, 1992), and making a unilateral decision to end treatment without agreement of the therapist (Pekarik, 1992; Richmond, 1992; Tutin, 1987; Wierzbicki

& Pekarik, 1993). Pekarik (1985b) suggested that the client's unilateral decision to terminate best captures the construct of premature termination. This approach differentiates clients who unilaterally terminate from clients who make mutual decisions with their therapists to end treatment. It also avoids the problem of defining premature termination as the failure to complete a prescribed number of sessions, as some clients achieve their goals prior to the end of a set number of sessions (Barkham et al., 2006). Defining premature termination according to the type of decision addresses the problem of appropriately classifying clients who meet their treatment goals with few therapy sessions as well as clients who may remain in therapy for a longer period of time, but leave before their goals have been reached. Since Pekarik's recommendation, most researchers have used this operationalization (e.g., Callahan, Aubuchon-Endsley, Borja, & Swift, 2009; Chisolm, Crowther, & Ben-Porath, 1997; Keijsers, Kampman, & Hoogduin, 2001; Richmond, 1992; Smith, Subich, & Kalodner, 1995; Tryon & Kane, 1993). Accordingly, Pekarik's operationalization of unilateral termination will be used throughout the dissertation.

**Correlates of Unilateral Termination**

In order to intervene to prevent client unilateral termination, we need to better understand why clients leave before completing treatment. Most research in this area has examined *who* leaves, focusing primarily on demographic variables. Severity of presenting problems and diagnoses have also been examined in a limited number of studies. Results of studies examining diagnoses have been inconsistent (e.g., Greenspan & Mann Kulish, 1985; Hoffman, 1985), as have those for problem severity. For example, Thormählen, Weinryb, Norén, Vinnars, and Bagedåhl-Strindlund (2003) examined predictors of unilateral termination from supportive-expressive therapy for personality disorder ($n$ = 80) and found that clients with more severe diagnoses and more complex diagnostic pictures were more

likely to unilaterally terminate. In contrast, Edlund et al. (2002), using data from the United States National Comorbidity Survey and the Mental Health Supplement to the Ontario Health Survey, found no significant effect of diagnosis (DSM-III-R) on dropout rate.

**Age and gender.** Although several researchers failed to find reliable associations between unilateral termination and client age and gender (e.g., Cartwright, 1955; Craig & Huffine, 1976; Dubrin & Zastowny, 1988; Frank, Gliedman, Imber, Nash, & Stone, 1957; Rubenstein & Lorr, 1956; Sledge, Moras, Hartley, & Levine, 1990), the meta-analytic results of Wierzbicki and Pekarik (1993) indicated that younger clients were more likely to prematurely terminate (mean $d$ = .34). Three more recent studies also found that younger clients are more likely to unilaterally terminate than are their older counterparts. Smith, Koenigsberg, Yeomans, Clarkin, and Selzer (1995) found that younger age was associated with higher rates of unilateral termination in treatment for individuals with borderline personality disorder. Thormählen et al. (2003) found a similar pattern for individuals with treated for personality disorder. Edlund et al. (2002) found, in a population-based sample of 1,261 individuals that younger age (15 – 24 years) was associated with higher odds of drop out. No associations with gender were found in more recent studies (Edlund et al.; Wierzbicki & Pekarik).

**Ethnicity.** Researchers have consistently found that unilateral termination is associated with non-White ethnicity (Greenspan & Kulish, 1985; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue, McKinney, Allen, & Hall, 1974; Vail, 1978; Wierzbicki & Pekarik, 1993). Across 21 studies, Wierzbicki and Pekarik (1993) found that increased risk for premature termination was significantly associated with African–American (and other minority) race ($d$ = .23; $SD$ = .34). Non-white ethnicity and socioeconomic disadvantage tend to be correlated (Garfield, 1994), however, more recent research suggests that the association between non-

White ethnicity, socioeconomic disadvantage, and unilateral termination reflects an interaction of client-therapist differences in culture, attitudes, and experiences (e.g., Illovsky, 2003). In line with this, researchers attempting to maximize perspective convergence by matching therapist-client ethnicity and language reported an increased number of sessions attended in a sample of 1,746 Asian clients in several Community Mental Health Centres (CMHCs; Flaskerud & Liu, 1991). However, Hill, Koocher, and Norcross (2005), in their review of client-therapist ethnic matching, concluded that insufficient research has been conducted to uniformly recommend this as a way to improve treatment outcome.

**Socioeconomic status (SES).** Consistent associations have also been found between unilateral termination and socioeconomic disadvantage (Baekland & Lundwall, 1975; Garfield, 1994; Wierzbicki & Pekarik, 1993; Williams, Ketring, & Salts, 2005). In their meta-analysis, Wierzbicki and Pekarik found that socioeconomic status ($d$ = .37, $SD$ = .27, across 30 studies) and education ($d$ = .28, $SD$ = .44, across 22 studies) were significantly associated with premature termination. Researchers and clinicians have historically attributed this phenomenon to socioeconomic status-related educational disadvantages resulting in reduced psychological mindedness, verbal skills, and lower capacities for abstract thinking, all of which are fundamental requirements of any therapeutic approach (Reis & Brown, 1999). No empirical evidence has supported these assumptions; however, researchers have found that the association between low SES and dropout are significantly attenuated when client expectations for treatment duration are considered (Pekarik, 1991; Pekarik & Stephenson, 1988; Pekarik & Wierzbicki, 1986).

## Client Expectations

Client expectations, both for the effectiveness of treatment and the process of treatment, have been shown to influence posttreatment outcomes. Constantino, Arnkoff,

Glass, Ametrano, and Smith (2011) conducted a meta-analysis of the effects of pretherapy or early-therapy client outcome expectations on posttreatment outcomes ($N$ = 8,016 clients, 46 independent samples). The overall weighted effect size was $d$ = .24, $p$<.001, indicating a small effect of outcome expectations on positive treatment outcomes. Fewer studies have specifically examined expectations and unilateral termination. Gunzburger, Henggeler, and Watson (1985) prospectively studied 30 therapy completers versus 15 unilateral terminators (clients who terminated before the 4$^{th}$ session) at a training clinic. Client expectations, and whether their expectations were met, were assessed before and after the first session. Although the pre-session expectations of unilateral terminators did not differ from those of continuers, the unilateral terminators were less likely to report that the first session generally fulfilled their expectations and were less likely to rate the session as helpful. These findings indicated that clients who terminated might have been well on their way to making unilateral decisions to leave by the end of the initial session. The authors were at a loss to explain these findings given that unilateral terminators did not differ from continuers in their perceptions of therapist empathy, warmth, or genuineness. Moreover, based on observational data, there were no significant differences in client-therapist interaction during the first 15 minutes of the session. Unilateral terminators rated themselves as improving to the same extent as continuers did, however, therapists did not recognize this improvement to the same degree as they did for continuers. This study was quite underpowered, so it is difficult to interpret null findings.

Other researchers have also found significant associations between unmet expectations and unilateral termination. Elkin et al. (1999), using data from the Treatment of Depression Collaborative Research Program, examined client predictions about the types of therapy strategies they believed would be helpful. Clients whose treatment assignment matched what

they thought would be helpful were more likely to continue beyond 4 sessions than clients who received a treatment that was not congruent with their beliefs. These research findings highlight the importance of examining the effects of contextual factors in psychotherapy, such as client expectations, on both outcome and unilateral termination.

**Client Reasons for Termination**

One way to examine factors relevant to unilateral termination is to ask clients why they terminated services. As outlined in Table 1, several clinic-based studies have investigated clients' reasons for terminating psychotherapy (Bados, Balaguer, & Saldana, 2007; Hunsley, Aubry, Vestervelt, & Vito, 1999; Hynan, 1990; Pekarik, 1983, 1992; Renk & Dinger, 2002; Roe, Dekel, Harel, & Fennig, 2006; Todd, Deane, & Bragdon, 2003). Broadly, reasons generally reflect one of three main themes: a) goal attainment or improvement in therapy, b) therapist or therapy-centered reasons, such as perceptions of therapist incompetence or dislike of therapist or therapy, and c) circumstantial barriers, such as lack of money or scheduling conflicts. One of the most frequent reasons clients provide is that they ended treatment due to satisfaction with the gains they had made. Across studies, the percentage of clients ending treatment early because they had achieved their goals ranged from 14% (Todd et al., 2003) to 45.5% (Roe et al., 2006). Researchers have also found that many clients decide to end treatment because of dissatisfaction with the therapy or the therapist. Across studies, the range of clients ending treatment early for dissatisfaction reasons is from 8% (Todd et al., 2003) to 34% (Hunsley et al., 1999). Finally, many clients also cite circumstantial barriers as factors in ending treatment early. Reasons such as difficulties with scheduling, difficulties making child care arrangements, and financial barriers have been given by 8.5% (Hunsley et al., 1999) to 54.6% (Roe et al., 2006) of clients.

Some researchers have examined reasons for termination exclusively among those who were viewed by therapists as unilaterally terminating therapy. Pekarik (1992), for example, examined reasons for unilateral termination in clients at a public mental health clinic. Of 49 clients contacted by researchers, 39% indicated that they unilaterally terminated because their problem was solved or improved, 35% indicated circumstantial barriers, and 26% cited dissatisfaction with therapy or therapist. In a training clinic setting, Bados et al. (2007) surveyed 60 clients out of 89 who unilaterally terminated therapy from their clinic. Of the 60 clients, 46.7% dropped out due to low motivation or dissatisfaction with treatment or therapist, 40% because of circumstantial barriers (transportation problems, scheduling, illness, etc.), and 13.3% because they believed they had improved.

These studies provided invaluable information regarding common reasons given by clients for ending psychotherapy. Although similar themes emerge in clients' reasons across these studies, the percentage of clients reporting these reasons varies greatly from study to study. With so little systematic research in this area, it is impossible to determine whether this variability is due to differences in measurement, sampling strategies, or unique aspects of the settings in which the clients received services. I designed Study 1 to contribute to the literature by examining clients' self-reported reasons for ending psychotherapy across various settings, client problems, and service providers. Using a large, representative, Canadian community sample, client reasons for termination were examined, along with the demographic (age, gender, and income) and clinical (mental disorder caseness) characteristics of clients who selected them. A second study goal was to examine the influence of these demographic variables, mental disorder caseness, and type of mental health care provider on client odds of selecting each reason for termination. Based on previously outlined findings in the literature, I expected that low income, younger age, and

meeting caseness criteria for mental disorders (anxiety disorder, mood disorder, or substance dependence) would decrease the odds of selecting feeling better or having completed a full course of treatment as a reason for termination. I also expected that these variables would increase the odds of selecting other termination reasons (other than feeling better or completing the recommended treatment).

**Working Alliance**

Another factor often examined in the psychotherapy research literature is the working alliance. Working alliance is a widely studied and broadly conceptualized construct, however, most theoretical definitions of the working alliance have three themes in common: a) the collaborative nature of the relationship, b) the affective bond between client and therapist, and c) client-therapist agreement on therapy goals and tasks (e.g., Bordin, 1979; Horvath & Symonds, 1991). Perhaps the most consistent and durable finding in the psychotherapy research literature is that a strong working alliance predicts treatment outcome (e.g., Horvath & Symonds, 1991; Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000; Weerasekera, Linder, Greenberg, & Watson, 2001), accounting for approximately 5% of the variability in outcome (e.g., Castonguay et al., 1996; Siqueland et al., 2000). Martin et al. (2000) conducted a meta-analytic study of the working alliance and therapy outcome. They found an overall weighted alliance-outcome correlation of .22, which they deemed a moderate relation ($n$ = 68 studies, $SD$ = .12). Martin et al. failed to find any significant moderators of the alliance-outcome relationship (e.g., type of outcome measure, type of outcome rater, time of alliance assessment, type of alliance rater, type of treatment, publication status). More recently, Horvath et al. (2011) conducted a similar meta-analysis and found a correlation of .28 ($k$ = 190 studies), also finding that alliance measure,

rater, time of assessment, type of treatment, and publication source failed to significantly moderate the alliance-outcome relationship.

A poor working alliance between client and therapist is predictive of unilateral termination (Johansson & Eklund, 2005; Saatsi, Hardy, & Cahill, 2007; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976; Sharf, Primavera, & Diener, 2010). In a meta-analytic review of 11 studies that included 1,301 clients (mean *n* per study = 118), Sharf et al. (2010) found a moderately strong relationship between the working alliance and premature termination (*d* = .55). Notably, this effect size is greater than that found for SES and ethnicity (*d* = .37 and *d* = .23, respectively) by Wierzbicki and Pekarik (1993). In particular, problems with client-therapist agreement on therapeutic tasks have been found to be associated with ending treatment early (Hawley & Weisz, 2003; Tracey, 1986; Tryon & Winograd, 2011), however, Sharf et al. did not test this hypothesis in their meta-analysis. Interestingly, Sharf et al. found that education moderated the relationship between working alliance and dropout. Studies with larger proportions of clients who completed high school or more education resulted in reduced correlations between alliance and dropout. Given fairly consistent findings that clients with less education are more likely to drop out of psychotherapy, Sharf et al. speculated that individuals with more education are more likely to complete treatment in the first place, rendering the association between alliance and dropout less robust. Alternatively, perhaps highly educated clients are more similar to their highly educated therapists, facilitating convergent expectations regarding treatment (Garfield, 1986; Wierzbicki & Pekarik, 1993).

Other researchers have found that the working alliance mediates the relationship between pretreatment expectancies and outcome. In the Treatment of Depression Collaborative Research Program dataset, although client expectancies for outcome predicted

actual improvement (e.g., Sotsky et al., 1991), the positive correlation between clients' pretreatment outcome expectancies and clinical improvement was mediated by the client's contribution to working alliance quality (Meyer et al., 2002). Consistent with Meyer et al.'s (2002) findings, Joyce, Ogrodniczuk, Piper, and McCallum (2003) found that the working alliance (rated by both client and therapist) mediated the effect of client pretreatment outcome expectations on client improvement in short-term individual therapy for various conditions.

Individual researchers have found mixed results in terms of whether client-rated (Fitzpatrick, Iwakabe, & Stalikas, 2005; Tryon & Kane, 1990) or therapist-rated alliance (Tryon & Kane, 1993) predicted session impact, outcome, and unilateral termination. However, Sharf et al., in their meta-analysis, found no significant differences between client-rated, therapist-rated, and observer-rated alliance in the prediction of dropout. Tryon, Blackwell, and Hammel (2007), conducted a meta-analytic investigation examining the convergence of client and therapist ratings of working alliance ($n$ = 53 studies). Although client ratings were consistently higher than therapist ratings ($d$ = .63), client-therapist ratings tended to be moderately positively correlated ($r$ = .36), regardless of client disturbance, therapist experience, therapy length, alliance measure, or type of treatment. This moderate correlation tends to be stable over time. Fitzpatrick, Iwakabe, and Stalikas (2005), in a study of convergence of client-therapist views of the working alliance over the course of a mean number of 14 sessions ($n$ dyads = 48), found that perspective convergence did not increase as therapy progressed. Moreover, convergences in perspective did not influence clients' evaluations of the positive impact of sessions. To date, however, no research has examined how client-therapist convergence in ratings of the working alliance may differ when termination is unilaterally versus mutually determined. Study 2 was designed to address this

question by comparing client-therapist ratings of the working alliance between two groups were a) both client and therapist agreed that termination was the client's unilateral decision, versus b) both the client and therapist agreed that termination was mutually determined. I expected that both client and therapist alliance ratings would be both higher and more congruent in the mutual versus unilateral group.

**Barriers to Treatment Participation**

Kazdin and colleagues have focused on the importance of therapy-specific barriers in the search for causes of unilateral termination (Kazdin, Holland, Crowley, & Breton, 1997; Kazdin & Wassell, 1998). In Kazdin's barriers to treatment model, barriers include the extent of: a) practical obstacles to participation in treatment (e.g., transportation difficulties, scheduling conflicts), b) perceptions of treatment as demanding, costly, too long, or difficult, c) perceptions of treatment as irrelevant to the problems experienced by the client, and d) a poor therapeutic relationship with the therapist. Kazdin et al. (1997) studied treatment barriers in the context of family treatment for youth with conduct problems ($n$ = 260 children). Barriers to treatment added to the prediction of unilateral termination beyond the contribution of client characteristics (income, ethnicity, level of education), and that both therapist and parent perspectives contributed uniquely to predict dropping out of treatment. The shared variance between parent-rated and therapist-rated barriers was about 15%. In study 2, I examined whether these barriers to treatment found to be significant contributors to dropout in child and family services could also serve as useful ways to distinguish adult clients who unilaterally terminated from those who mutually decided with their therapists to end treatment. Client-therapist ratings of the barriers to treatment participation were examined between two groups in which a) both client and therapist agreed that termination was the client's unilateral decision, or b) both the client and therapist agreed that termination

was mutually determined. I expected that both client and therapist ratings of barriers would be both lower and more congruent in the mutual versus unilateral group.

**Concordance between Client and Therapist Perspectives on Termination**

Clients and therapists tend to have divergent perspectives about several aspects of therapy. For example, clients generally anticipate that they will require fewer sessions to address their problems than do their therapists (Garfield, 1994; Swift & Callahan, 2008), and therapists tend to overestimate treatment length and underestimate the number of clients who will terminate unilaterally (Lowry & Ross, 1997; Mueller & Pekarik, 2000; Pekarik, 1992; Pekarik & Finney-Owen, 1987; Pulford, Adams, & Sheridan, 2008). Some perspective divergences are more potentially problematic than others. For example, research on the working alliance shows that clients reliably rate the alliance as higher than do their therapists, but that this does not impact treatment outcome (Fitzpatrick et al., 2005). However, as discussed, divergent expectations for the content and process of treatment can lead to an increased risk of unilateral termination (Corning, Malofeeva, & Bucchianeri, 2007; Gunzburger et al., 1993; Horenstein & Houston, 1976).

In line with this, it is important to consider both client and therapist views in order to understand reasons for termination. Researchers have shown that client and therapist perspectives on reasons for termination tend to diverge (e.g., Gager, 2004; Hunsley et al., 1999; Pekarik & Finney-Owen, 1987; Todd et al., 2003). There are only three studies that have examined the views of therapists with respect to clients' reasons for termination (Hunsley et al., 1999; Perkarik & Finney-Owen, 1987; Todd et al., 2003). These studies have compared client and therapist reasons for termination and have found that therapists and clients tend to agree about reasons related to improvement in therapy and circumstantial

barriers, however, clients' negative perceptions of therapy often go unnoticed by therapists, or are attributed to low client motivation or to clients' lack of time.

Pekarik and Finney-Owen (1987) surveyed 173 therapists from community mental health clinics regarding the primary reasons why clients left therapy unilaterally. They asked therapists, in general, to list top reasons why clients leave, and compared these with reasons given by a sample of clients ($n$ = 46) from one community mental health clinic (Pekarik, 1983b). Clients were contacted by researchers 3 months after unilateral termination and directly asked their reasons for termination. They found that therapists and clients tended to agree about positive reasons for termination (*problem solved or improved* was endorsed by 39% of clients and by 31% of therapists) and obstacles to treatment (*environmental constraints* was endorsed by 35% of clients and by 37% of therapists). However, when the focus was on termination due to failed therapy, there was very little agreement between clients and therapists (*resistance* was endorsed by no clients and by 22% of therapists; *dislike of therapy/therapist* was endorsed by 26% of clients and by 11% of therapists). Because both sets of researchers asked about reasons for client decisions, in general, memory and heuristic biases (Garb & Boyle, 2004) might have affected their abilities to accurately report on reasons for termination. Given evidence that therapists spend most of their time with longer term, mutually terminating clients, their perceptions of the proportion of unilaterally terminating clients may be inaccurate (Vessey et al., 1994).

In order to garner therapist perspectives on specific clients, Hunsley et al. (1999) compared training clinic therapists' reasons for client termination written in their final reports with reasons reported directly from interviews with former clients ($n$ = 87). They also found that therapists and clients made different attributions about failed therapy. Their results suggest that therapists were not aware of, or did not report, clients' dissatisfaction with

therapy as the primary reason for termination; no client was described by a therapist as terminating because of dissatisfaction with therapy. However, 10 clients reported that the fact that therapy made things worse for them was very important in their decision to end therapy. Almost half (*n* = 4) of these clients were described by therapists as terminating because they no longer had the time or interest to continue therapy. Thirteen clients reported that the feeling that therapy was going nowhere was very important in their decision to end treatment. For these clients, one-third (n=4) were described by therapists as ending therapy because they had achieved many or all of their goals, and another third (*n* = 4) were described as terminating because they no longer had the time or interest in continuing therapy. In sum, therapists were not accurate at detecting treatment failure, and the reasons for the failure, from the client's perspective. Hunsley et al. also found that therapists did not always recognize client perceptions of improvement. Among the 32 clients who were identified by therapists as leaving because they achieved their goals, 75% of the clients reported this reason as important to their decision to leave. On the other hand, of the 33 additional clients who reported ending therapy because of achieving their goals, only 16 (48%) were identified by therapists as having achieved their goals.

Also examining therapist perspectives on specific clients, Todd et al. (2003) found similar lack of concordance using a qualitative coding methodology to examine training clinic therapists' reasons for client termination provided on routine clinic forms with reasons reported on similar forms given to clients at termination. Their results suggest only moderate overall agreement between therapist and client reasons (Cohen's $\kappa = .43$). More specifically, clients and therapists showed good agreement on *client environmental* and *therapist environmental* reasons, fair agreement on *improvement* reasons, and poor agreement on *client negative* and *other* reasons. Therapists were significantly more likely than clients to

endorse *improvement* as a reason for termination, and clients were more likely to endorse *client environmental* and *other* reasons.

Both Hunsley et al. (1999) and Todd et al. (2003) used a file-review methodology whereby either final reports or standard clinic forms were reviewed to obtain therapist reasons for termination. It is possible that graduate student therapists' reports may reflect efforts to please their supervisors, or other constraints on report writing and record keeping, rather than actual therapist perceptions. Study 2 of the proposed dissertation was designed to fill this gap by examining within-dyad client-therapist perspectives, with information collected prospectively by an impartial researcher, and garnering parallel data from clients and therapists at the same point in time. Furthermore, Study 2 was designed to examine perspective divergence in the context of unilateral versus mutual termination from therapy. I predicted that, in dyads where termination was mutual, compared with dyads where termination was a unilateral decision on the client's part: 1) both clients and therapists would rate having accomplished therapy goals as more important to the termination decision, and circumstantial and therapy-specific reasons as less important to the termination decision. I also predicted that client and therapist perspectives on the client's reasons for termination would be more congruent in the mutual versus unilateral group. In other words, I expected that therapists would be more aware of their clients' reasons in the mutual versus unilateral group.

Beyond simply elucidating perspective divergences between client and therapists reasons for termination, it is important to understand the factors that contribute to perspective divergence. Therapists may underestimate clients' positive therapy gains due to differences in expectations and because clients may not communicate positive changes, and therapists may be unable to fully appreciate negative reactions in treatment because clients may hide

these feelings (e.g., Hill, Thompson, Cogar, & Denman, 1993; Hannan et al., 2005; Regan & Hill, 1992). For example, Regan and Hill (1992) asked 24 clients at a training clinic to write down thoughts and feelings they had during a therapy session that they did not share with therapists. They also asked therapists to write down thoughts and feelings they thought clients had but did not share. Most things clients left unsaid were negative, and therapists were able to match only 17% of the total number of things clients left unsaid during sessions. Further research suggests that experienced therapists may not be more adept at perceiving client negative reactions than are trainees (Hill, Thompson, Cogar, & Denman, 1993).

Whether due to attributional biases (Malle, 2006; Campbell & Sedikides, 1999; Kendall et al., 1992; Murdock, Edwards, & Murdock, 2010) or other phenomena, existing research indicates that even experienced therapists may fail to fully recognize their roles in unilateral termination and less than ideal treatment outcome for some clients. Kendall et al. (1992) asked 315 experienced therapists about specific clients who had failed to benefit from therapy. Therapists, across theoretical orientations, rated their clients' inability to benefit from and lack of motivation for treatment as the most important reasons for lack of progress, although rating themselves as the least likely cause of their clients' lack of progress. Theoretical orientation influenced therapist perspectives: although ranking their clients' inability to benefit from therapy as the most important cause of negative outcomes, cognitive-behavioural therapists attributed significantly less responsibility to the client compared to attributions made by psychodynamic, humanistic, and eclectic therapists. Murdock et al. (2010) presented two vignettes to 243 psychologists describing client unilateral termination that varied only in whether the client was referred to as "your client" or "the client". Psychologists rated the causes of the unilateral termination on a continuous scale; Psychologists showed a self-serving bias, showing a tendency to blame the therapist

when the vignette was “the client” and showing a tendency to blame the client in the “your client” condition. These researchers also found that, although both men and women showed a self-serving bias, the size of the bias was larger for men, and for psychodynamic therapists compared with cognitive-behavioural and existential/interpersonal therapists. Cognitive-behavioural therapists did not make different attributions for termination in cases where clients were their own versus others’. It may be that cognitive-behavioural therapists’ training emphasizing environmental influences on behaviour partially mitigates natural tendencies toward the fundamental attribution error. In addition to examining therapists’ perspectives of client reasons for termination early versus later in therapy, Study 3 was designed to shed light on how theoretical orientation may influence therapists’ perspectives on client reasons for termination. Based on this research, Study 3 was designed to test the hypothesis that psychologists reporting dominant CBT versus other orientations ascribed less importance to termination reasons that attributed fault to the client.

**Reasons for Early versus Later Unilateral Termination**

Clients end psychotherapy at various stages during its process (Armbruster & Kazdin, 1994; Barrett et al., 2008). Roughly 50% of individuals scheduling an initial outpatient mental health appointment actually attend (Sparks, Daniels, & Johnson, 2003; Weirzbicki & Pekarik, 1993). Of those completing the intake, between 35% and 50% do not attend the first therapy session (Garfield, 1986; Hansen et al., 2002; Phillips, 1985), and roughly 40% attend fewer than three sessions (Pekarik, 1983a). Clearly, some clients seek services but choose not to engage in treatment, other clients engage in treatment but then make unilateral decisions to end it earlier than therapists deem appropriate, and still other clients engage in treatment and make mutual decisions with therapists to end. Given that most unilateral

terminators end very early in their treatments, it is especially important to examine factors that contribute to unilateral termination early in treatment.

Two sets of researchers reported reasons for termination collected exclusively from clients who terminated very early in treatment. These clients were on a wait-list, attended an intake, and refused services. Client reasons were heterogeneous: Archer (1984) surveyed 59 clients from a university counselling centre who were on a wait list and refused services. Clients could indicate multiple reasons: Fifty-one percent felt the intake was enough or that their problem was resolved, 39% were still interested in services; 19% felt the wait list was too long, 12% had sought services elsewhere, and 10% were disappointed with their intake session. Christensen, Birk, and Sedlacek (1975) surveyed 20 wait-list clients from a university counselling centre who missed their first appointment after an intake session. Sixty percent reported that their presenting problem was unchanged; 50% sought services elsewhere; 20% reported that their problem had resolved. These studies suggest that individuals who drop out before attending any therapy, or terminate after attending one or two sessions, are a heterogeneous group and further investigation is required to determine the reasons why some people choose not to follow through with services (Manthei, 1996). It is clear, however, that many clients who terminate before engaging in therapy do not do so because their problems have resolved.

Researchers who have examined models of engagement in therapy have been unsuccessful in their attempts to uncover reliable associations between client characteristics and engagement in therapy. For example, Rumstein-McKean (2005), in a sample of 155 clients at a university training clinic, examined whether engagement in therapy (defined in multiple ways as attendance at the third session, client satisfaction, and ratings of the working alliance) could be predicted by demographic (age, gender, referral source, time on

the waiting list, and psychological distress) and motivational aspects (stage of change, type of motivation). These factors were not predictive of engagement in therapy. Only time on the waiting list was a significant (inverse) predictor of attendance of at least three sessions.

Although Rumstein-McKean (2005) did not find support for the above factors in therapy engagement, there is evidence to suggest that other factors are particularly relevant to clients' decisions to terminate their treatments early on. In the following sections, I present studies examining time on the waiting list, first impressions of clinic facilities and therapists, satisfaction with the intake session, and circumstantial barriers.

**Wait list time.** Longer wait times have been repeatedly associated with early unilateral termination (Barrett, Chua, & Thompson, 2007; Chua & Barrett, 2007; Festinger, Lamb, Marlowe, & Kirby, 2002; Manthei, 1996; Rumstein-McKean, 2005; Saporito, Barrett, McCarthy, Iacovello, & Barber, 2003; Stasiewicz & Stalker, 1999). Rumstein-McKean (2005) found that time on the waiting list strongly predicted whether a client would attend therapy until at least the third session. The longer a client was on the waiting list, the less likely the client was to attend at least three sessions of therapy. Even once the intake is completed, there is some evidence that any uncertainty around the beginning of treatment contributes to dropout. Rodolfa, Rapaport, and Lee (1983) examined 334 post-intake returners (93%) and 25 (7%) post-intake unilateral terminators at a university counselling centre; number of days between intake and counsellor assignment was significantly longer for non-returners than for returners.

**Clinic facilities.** Some initial research has shown that factors such as clinic accessibility and office environment can be salient considerations to early termination. Barrett et al. (2008) pointed out that many clients complain that the building is uninviting, waiting rooms are congested and uncomfortable, all clients wait in a single room, and

therapy rooms are small and poorly ventilated. Furthermore, subtle effects of social and cultural biases of agency personnel have been argued to reduce engagement (Lo & Fung, 2003). However, very little research has examined whether these factors serve to influence non-return. Chua and Barrett (2007) retrospectively reviewed 127 client records at an urban community mental health centre. After refurbishing the waiting area and therapy rooms, the clinic experienced a significant 10% (81 to 91%) increase in attendance at the first treatment session post-intake. Clients reported significantly greater comfort and satisfaction in the new facilities as well. Unfortunately, evidence-based guidelines for optimal design of healthcare environments are lacking (Dijkstra, Pieterse, & Pruyn, 2006).

**First impressions of therapists/intake session.** Client perceptions of therapist expertise, attractiveness, and trustworthiness have repeatedly been associated with dropout. Alcázar Olán, Deffenbacher, Hernández Guzmán, Sharma, and de la Chaussée Acuña (2010), in a retrospective study, compared 141 post-intake returners to 32 non-returners (participants were psychology students, and no information was provided about therapists) and found that clients were less likely to return when they reported feeling badly at the end of the intake interview. McNeill, May, and Lee (1987) retrospectively studied 56 unilateral terminators versus 148 mutual terminators at a university counselling centre. They found that early terminators perceived counsellors as significantly less expert and less attractive than did mutual terminators. Hynan (1990) mailed out questionnaires to 31 early (fewer than 5 sessions) and later (more than 5 sessions) terminators from a university clinic. Early terminators retrospectively rated their therapists as less respectful, less warm, and less competent than did later terminators. All of these studies were retrospective in nature, which means that they may be affected by biased client perceptions.

When assessed prospectively, several types of therapist characteristics have been shown to predict unilateral termination. The results in this literature are, however, mixed. Some studies showed that perceptions of therapists were salient to client dropout (Beckham, 1992; Kokotovic & Tracey, 1987; Mohl et al., 1991), and other did not (Gunzburger et al., 1985; Grimes & Murdock, 1987). Unfortunately, there is no consistency across studies in measures, methodology, or definition of premature termination, and all studies are plagued by relatively small sample sizes. Beckham (1992), in a study of 31 dropouts vs. 24 mutually terminating clients seen in an outpatient training clinic, found that dropouts rated their therapists more negatively (i.e., less warm, empathic, and genuine) than did mutual terminators following the intake session. Kokotovic and Tracey (1987) prospectively examined return after intake at a university counselling centre in 30 dropouts versus 104 continuers at a university counselling centre and found no differences in perceptions of counselor attractiveness. However, dropouts rated their therapists as significantly less trustworthy and expert than did continuers. Dropouts were also significantly less satisfied with their intake session than were continuers. Mohl et al. (1991) studied 48 continuers vs. 32 early dropouts from a university counselling centre where intakes were conducted with screening psychiatrists. Clients who chose to continue liked the screening psychiatrist more, felt that they had gained more understanding, felt they were treated with greater respect, were more satisfied with the intake, perceived the screening psychiatrist as more active and rated psychotherapy as significantly more potent than did early dropouts. Grimes and Murdock (1987) examined 51 clients at a counselling centre. Expertness, attractiveness, and trustworthiness, rated after the first session, were significantly predictive of outcome at the fourth session. However, these factors were not predictive of premature termination. Gunzburger et al. (1985), in a prospective study of 30 therapy completers versus 15

unilateral terminators, found no association between client perceptions of therapist empathy, warmth, or genuineness and termination status.

**Circumstantial barriers.** Circumstantial barriers, as previously discussed, are relevant throughout the therapy process. However, barriers can be a particularly salient impediment to getting therapy off the ground. Hynan (1990) found that early terminators retrospectively reported that they left therapy because of situational constraints and discomfort with services significantly more frequently than did late terminators. Manthei (1996) retrospectively interviewed 33 no-show and 13 post-intake terminators from a community clinic. No-show clients cited reasons such as excessive cost (27%), being waitlisted (36%), and seeking help elsewhere (15%). Clients who attended only one session provided two main reasons: excessive cost (47%), and seeking help elsewhere (38%). Taken together, comments from both groups indicated that many clients had practical, rather than negative, reasons for early termination.

In summary, client reasons for termination may systematically vary at different points in the therapy process, and our understanding of early termination is likely to be obscured if researchers examine unilateral terminators as a homogeneous group (Barrett et al., 2008; Kokotovic & Tracey, 1987). There is a need for studies examining termination reasons given by clients who unilaterally terminate early in treatment versus at later stages of psychotherapy. Furthermore, no research has examined therapists' perspectives of early versus later client unilateral termination. As discussed, therapists may provide different perspectives that are important to consider in our understanding of unilateral termination. Study 3 of this dissertation was designed to examine psychologists' perspectives of reasons for termination for clients who unilaterally terminated before the third session, after the third session, and mutually with the psychologist in order to determine reasons that may be unique

to ending therapy at these distinct points. The third session was chosen as a cut-off because of its identification as an important milestone in the psychotherapy literature (e.g., Salta & Buck, 1989), during which the quality of the working alliance is established (Eaton, Abeles, & Gutfreund, 1988). Furthermore, follow-up studies have shown that clients who terminate services after attending only one or two sessions of therapy tend to improve less or fare worse than do clients attending three or more sessions (Pekarik, 1983a; 1983b; 1992). I expected that client reasons potentially more important to early versus later unilateral termination might include circumstantial barriers, wait list length, and negative first impressions.

**Therapists Use of Engagement Strategies to Foster Mutual Decisions to End Therapy**

A small research literature outlines several therapeutic strategies that therapists can use to increase engagement in psychotherapy and reduce unilateral termination (Ogrodniczuk, Joyce, & Piper, 2005; Walitzer, Dermen, & Connors, 1999). In the interest of brevity, I will refer to these henceforth as *engagement strategies*. Ogrodniczuk et al. (2005) conducted a review of 39 clinical and empirical articles describing engagement strategies. Of these 39 articles, 15 empirical studies were found in which the researchers explicitly set out to investigate such interventions. Pretherapy preparation was examined in 12 studies, 7 of which showed support for the use of these strategies. Additionally, empirical support was found for the use of patient selection methods (two studies) and case management strategies (one study). Ogrodniczuk et al.'s review included discussion of pretherapy preparation, client selection, time-limited treatment contracts, treatment negotiation, case management, appointment reminders, motivation enhancement, facilitation of therapeutic alliance, and facilitation of affect expression. Although Ogrodniczuk et al. distinguished between facilitating a good working alliance and facilitating affect expression (which Ogrodniczuk et

al. defined as providing a safe environment in which clients can explore both negative and positive feelings), there is no empirical support for this distinction, so they are considered together in the current review. In my own review of the literature, I found at least preliminary empirical support for each of the strategies, although not all of the strategies have been tested in controlled, prospective evaluations (i.e., treatment negotiation). In the following section, I present these empirical research findings. In addition, I present information on tracking client progress (also referred to in the literature as systematic client monitoring, therapist feedback, etc.), given the abundance of research showing its effectiveness in improving outcome and increasing retention in therapy.

**Pretherapy preparation.** Pretherapy preparation techniques are the most widely studied engagement strategy, and include role induction (educating clients about the rationale for therapy, treatment process, and prognosis), vicarious therapy pretraining (providing clients with examples of therapy, such as videos), and experiential pretraining (engaging clients in a simulation of therapy that is typically conducted in a group therapy context). Walitzer et al. (1999) reviewed empirical studies of pretherapy preparation and found that 11 of 16 studies evidenced reduced rates of attrition (e.g., Kushner & Sher, 1991; Latour & Cappeliez, 1994; Walitzer et al., 1999). Role induction is the most commonly described pretherapy preparation technique in the literature, usually occurs within a single 1-hour session (Ogrodnizuk et al., 2005), and has been shown to improve client attendance. Pretherapy preparation can also include presentation of a prototypical therapy session via video or audiotape. For example, Reis and Brown (2006) randomly assigned 125 outpatients to either 12-minute videotape preparation or a control condition and found that, on a continuous measure of the therapist's perspective of client dropout, clients who were prepared via videotape had significantly lower scores.

**Client selection.** Client selection (or client-treatment matching) involves ensuring that clients are appropriately suited to the modality of therapy offered. Two studies have shown that client characteristics can be measured and predict success in psychodynamic psychotherapy or cognitive-behavioural therapy (Baumann et al., 2001; Keijsers et al., 1999). For example, Baumann et al. (2001) found that the Capacity for Dynamic Process Scale (which assesses nine client qualities that are believed necessary for success in dynamic psychotherapies) discriminated between clients who unilaterally terminated versus completed therapy. Keijsers et al. (1999) found scores on the NML2 (Nijmen Motivation List 2) discriminated between clients unilaterally terminating versus completing cognitive-behaviour therapy (CBT). Ogrodniczuk et al. (2005) suggested that, following an intake assessment, clients assessed to be at high risk for unilaterally terminating a particular therapy may be offered a different treatment, or may be offered pretherapy preparation (e.g., social skills training prior to group therapy) to increase the likelihood of therapy completion. In sum, despite the high probability that therapists do engage in client selection to some extent, there is little empirical evidence to guide their selection decisions for the purpose of reducing unilateral termination.

**Time-limited treatment contracts.** Treatment contracts in the context of short-term services have been found to reduce premature termination rates by half (Sledge et al., 1993). With regard to less severe disorders (e.g., subsyndromal depression and panic disorder), planned brief treatments can significantly reduce stress and have been shown to be equally as effective as time-unlimited therapy (Barkham et al., 1999; Newman, Kenardy, Herman, & Taylor, 1997; Shapiro et al., 2003). For example, when clients expected treatment to last 8 sessions they showed significantly more improvement than clients who expected treatment to last 16 sessions (Shapiro et al., 2003). Short-term treatment contracts may be less appropriate

in the context of treatment for interpersonal problems, given evidence that interpersonal changes usually require longer treatment than do symptomatic concerns (Barber, Morse, Krakauer, Chittamsn, & Crits-Cristoph, 1997; Barkham, Rees, Stiles, Hardy, & Shapiro, 2002).

**Treatment negotiation.** Establishing an explicit, agreed-upon treatment plan (e.g., establishing agreement on goals and tasks of therapy) prior to therapy commencing is often advanced as a useful strategy for decreasing unilateral termination (Rainer & Campbell, 2001; Reis & Brown, 1999). Reaching consensus regarding the nature of the client's problem, and how the problem should be addressed in therapy, are central components of establishing a viable plan. Although, to date, no study has directly tested the effectiveness of establishing an explicit treatment plan, a number of retrospective studies have documented that unilateral termination was more prevalent when client and therapist could not agree on the nature of the client's problem. Tryon and Winograd (2002) reviewed literature on goal consensus and collaboration in psychotherapy and noted that six of nine studies reviewed found positive associations between client-therapist goal consensus and therapy engagement. For example, Epperson, Bushway, and Warman (1983) conducted a study of independently-rated counsellor ($n$=34) and client ($n$ = 533) agreement at a university counselling centre. Only 19% of clients whose therapists recognized their specific problem definition unilaterally terminated after the intake, compared to 55% of clients who unilaterally terminated when the therapist failed to recognize the problem. Tracy (1977) examined the effect of two different types of intake interviews on client return for therapy: a) a traditional interview where therapists did not share problem formulations with clients, and b) a behavioural analysis interview where therapists shared case conceptualizations and negotiated mutual treatment goals. Significantly more clients returned for therapy after the

behavioural analysis interview compared with traditional intakes. Tryon (1986) found that therapists of engaged clients were better at clarifying client concerns than were therapists of nonengaged clients. Specifically, engaged clients rated their therapists higher on the item "To what extent did your therapist identify concerns for which you did not initially seek counselling?" Tryon and Winograd (2011) recently updated their review, meta-analyzing studies that examined the relation between goal consensus/collaboration and treatment outcome from 2000 through 2009. Fifteen studies with a total sample size of 1,302 yielded a goal consensus-psychotherapy outcome effect size of $d = .34$ ($SD = .19$), $p<.0001$.

**Facilitation of the early working alliance.** As reviewed earlier in this introduction, research indicates that the quality of the working alliance between client and therapist is predictive of unilateral termination (Horvath et al., 2011; Johansson & Eklund, 2005; Saatsi, Hardy, & Cahill, 2007; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976; Sharf, Primavera, & Diener, 2010; Tryon & Kane, 1990, 1993). It is therefore essential that therapists work to form a strong alliance with clients in early sessions, particularly the first three (Rainer & Campbell, 2001).

**Motivational enhancement.** Once therapy commences, other psychotherapy preparatory techniques such as motivational interviewing (MI) are relatively brief and easy to incorporate into existing practice (Arkowitz & Westra, 2009). MI is a method of questioning clients that aims to reduce ambivalence and increase motivation to change (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992). Rubak, Sandbaek, Lauritzen, and Christensen (2005) conducted a systematic review and meta-analysis of 72 randomized controlled trials (RCTs) using motivational interviewing as the intervention. MI was shown to be significantly more effective than treatment as usual in three-quarters of the studies, having equal effects on psychological and physiological

problems. When integrated into the initial intake evaluation, it has been found to reduce dropout rates by 50% (Carroll, Libby, Sheehan, & Hyland, 2001). Carroll et al. examined its effectiveness in an RCT of MI versus standard evaluation of 60 individuals referred for substance abuse evaluation. Clients who received MI were significantly more likely to attend at least one additional treatment session after the intake (59% versus 29%). Joe, Simpson, Greener, and Rowan-Szal (1999) found that the use of MI increased both engagement in treatment and outcome in a sample of 396 daily opioid users from three methadone maintenance treatment sites. Humfress et al. (2002) found that MI increased clients' motivation for and attitudes toward treatment. Results are not always positive, however, as other researchers have shown that MI does not influence treatment retention and outcome (e.g., Baker, Kochan, Dixon, & Heather, 1994; Colby et al., 1998; Feld, Woodside, Kaplan, Imsted, & Carter, 2001).

**Case management.** Practical strategies such as case management, which involves therapists directly intervening in client affairs such as obtaining employment or housing, has been found to be effective for keeping clients with serious mental illness engaged in outpatient community treatment (Stein & Santos, 1998). One group of researchers has examined its effectiveness for preventing premature termination from psychotherapy. Miranda, Azocar, Organista, Dwyer, and Arean (2003) found the addition of case management to group CBT for depressed, low SES medical outpatients resulted in a nearly 50% reduction in unilateral termination relative to group CBT alone. Presumably, at least some involvement with case management may be particularly beneficial early in treatment given that everyday life events can significantly influence an individual's motivation and serve as barriers to treatment (Barrett et al., 2008).

**Appointment reminders.** The use of appointment reminders is frequently recommended in the literature, and they are often used by health care professionals, but only one study has examined the effectiveness of their use in psychotherapy (Turner & Vernon, 1976). Turner and Vernon found, using an *ABAB* experimental design alternating baseline and phone message reminder conditions ($N$ = 1,355) that these appointment reminders significantly increased attendance (32% baseline versus 11% experimental condition; 25% baseline versus 14% experimental condition) at intake appointments in a community mental health setting.

**Tracking client progress.** A number of studies have suggested that providing therapists with periodic feedback allows them to adjust treatment activities to both keep clients who are not on track in therapy longer and foster superior outcomes (e.g., Lambert, Harmon, Slade, Whipple, & Hawkins, 2005; Lambert & Shimokawa, 2011; Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). Lambert and Shimokawa (2011) summarized meta-analyses of the effects of different client feedback systems, which ranged from $r$ = .23 (Partners for Change Outcome Management System, $k$ = 3, $n$ = 558) to $r$ = .33 (Clinical Support Tools feedback condition among clients shown to be off-track in therapy, $k$ = 3, $n$ = 535), noting that the number of clients who deteriorate can be cut in half by use of client monitoring systems. Most of this research has focused on feedback about client functioning (e.g., Lambert et al., 2005). The strength of these results are tempered by Knaup, Koesters, Shoefer, Becker, and Puschner's (2009) findings. These authors conducted a meta-analysis of the effects of providing feedback of treatment outcome to specialist mental health providers ($N$ = 12 studies). These authors found a significant but small ($d$ = .10) positive short-term effect on mental health outcome, but not on long-term mental health outcomes measured by follow-up studies of clients ($d$ = -.06).

### Therapist Use of Engagement Strategies in Routine Practice: Impact of Theoretical Orientation

To date, there has been no research examining the extent to which therapists employ engagement strategies in routine practice. Furthermore, although the effectiveness of these strategies has been investigated across a range of therapeutic approaches, and all of the strategies could conceivably be used by therapists of any theoretical orientation, it is also unclear whether therapeutic orientation serves to guide therapists in their use of these strategies. Given that cognitive-behavioural therapy, compared with psychodynamic, interpersonal, and humanistic therapies, is a more structured, time-limited, circumscribed intervention, CBT therapists may be more inclined to use more engagement strategies (i.e., setting a time limit on treatment, making an explicit treatment plan, and using appointment reminders; Blagys & Hilsenroth, 2002). Traditionally, these other approaches have been more centrally focused on the role of the therapeutic relationship in the treatment process, therefore, therapists of other dominant orientations may place considerable emphasis on building the early working alliance. These speculations remain untested, and study 3 was designed to examine psychologists' use of explicit strategies in an effort to engage clients in therapy and reduce unilateral termination. Study 3 was also designed to examine the potential influence of theoretical orientation (dominant CBT versus other) on the frequency of psychologists' use of engagement strategies.

### Summary

Several studies have examined reasons for termination from the client's perspective (Bados et al., 2007; Hunsley et al., 1999; Pekarik, 1983, 1992; Renk & Dinger, 2002; Roe et al., 2006; Todd et al., 2003). However, there is significant variability in reasons for termination across these relatively small clinic studies. It remains unclear whether variability

in client reasons for termination is due to differences in measurement, sampling strategies, or unique aspects of the settings in which the clients received services. A population study examining reasons for termination as garnered by an impartial interviewer, across mental health settings, is an important contribution to our understanding of client reasons for termination. The literature also lacks a longitudinal, prospective study examining parallel client-therapist perspectives of contextual variables in therapy, reasons for termination, and therapy outcome. This type of study is essential to understand the unique perspectives of both members of the dyad, and examine perspective divergence in the context of unilateral and mutual termination decisions. As the majority of the studies in the area have collected data from trainee therapists, research on experienced therapists' perspectives of client reasons for termination remains limited. Furthermore, there is a paucity of research examining early disengagement from therapy as distinct from attrition occurring later in treatment (Barrett et al., 2008). Studying and comparing these groups is important to inform our understanding of issues related to very early termination, particularly given that most unilateral terminations occur early in treatment. Therapists can use several strategies to heighten client engagement and increase retention in therapy. However, there is no research examining whether therapists use these strategies in routine practice. It is necessary to learn what therapists actually do before initiating efforts to intervene in graduate training and continuing education.

**Overview of Studies and Hypotheses**

The present dissertation consists of three separate studies which examine: 1) base rates of client reasons for psychotherapy termination in Canada, along with their demographic and clinical correlates, 2) client and therapist perspectives of reasons for termination, including working alliance and barriers to treatment participation in mutual

versus unilateral terminators, and 3) practicing psychologists' perspectives of client reasons for termination at different points in therapy, and their use of engagement strategies to reduce client-initiated unilateral termination. These studies are drawn from three data sources. I used data from existing data sets for the first two studies, whereas I collected new data for the third study: 1) In Study 1, I examined data from the Canadian Community Health Survey, Cycle 1.2. 2) In Study 2, I examined data collected at the Centre for Psychological Services at the University of Ottawa from supervised doctoral students in a clinical psychology program and their clients, 3) In Study 3, I examined data that I collected via a web survey of Canadian clinical psychologists.

**Study 1.** Study 1 was designed to examine clients' self-reported reasons for ending psychotherapy, across all types of health care providers. An additional goal of the study was to examine the influence of demographic variables (age, gender, and income), mental disorder caseness, and type of mental health care provider on odds of indicating each reason for termination. Based on previous findings in the literature, I hypothesized that low income, younger age, and meeting caseness criteria for mental disorders (anxiety disorder, mood disorder, or substance dependence) would decrease the odds of indicating that: a) feeling better or b) having completed a full course of treatment was the reason for termination. I also predicted that these variables would increase the odds of selecting other termination reasons (other than feeling better or completing the recommended treatment). Study 1, which was published in the *Journal of Clinical Psychology,* follows this general introduction.

**Study 2.** Study 2 was designed to examine the congruence in perspectives of client-therapist dyads regarding important contextual factors in therapy, including clients' reasons for termination, working alliance, and barriers to treatment participation. I compared dyad perspectives between two groups where a) both client and therapist agreed that termination

was a unilateral decision on the client's part, versus b) both client and therapist agreed that termination was a mutual decision. I predicted that, in dyads where termination was mutual, compared with dyads where termination was a unilateral decision on the client's part: 1) both clients and therapists would rate having accomplished therapy goals as more important to the termination decision, and circumstantial and therapy-specific reasons as less important to the termination decision; 2) both clients and therapists would rate the early working alliance as stronger, and barriers to treatment participation as fewer and; 3) client-therapist perspectives would be more congruent regarding reasons for termination, quality of the early working alliance, and barriers to treatment participation. Study 2 has been published in the journal *Psychotherapy Research*.

**Study 3.** The final dissertation study was designed to examine psychologists' perspectives of client reasons for termination for three groups of clients: 1) clients who did not engage in therapy (who unilaterally terminated before the third session), 2) clients who attended at least three sessions and then unilaterally terminated, and 3) clients who mutually decided to terminate therapy with the psychologist. When comparing clients who terminated mutually with the psychologist and clients who terminated unilaterally (both before and after the third session), I predicted that psychologists would assign higher importance to clients having achieved their therapy goals, and less importance to all other reasons. I also predicted that the importance assigned to reasons for early versus later unilateral termination would differ. For clients who terminated before the third session, versus after the third session, psychologists would rate circumstantial barriers, a longer wait list time, and client's initial negative impressions as significantly more important. I was also interested in how theoretical orientation served to guide psychologists' perspectives of reasons for termination. I predicted that psychologists reporting dominant CBT versus other orientations would ascribe less

importance to reasons that attributed fault to the client (i.e., insufficient motivation; clients unable to benefit from therapy).

A second study goal was to examine whether psychologists, in routine practice, used explicit strategies in an effort to engage clients in therapy and reduce unilateral termination. Several specific hypotheses were formulated: Theoretical orientation would influence the frequency of psychologists' use of engagement strategies. Psychologists reporting dominant CBT versus other orientations would be more likely to use practical strategies such as appointment reminders, case management, setting a time limit on the number of therapy sessions, and systematic client monitoring.

Table 1

*Studies of Client Reasons for Termination*

| Study | Site/Data collection procedures | Treatment | *N* | Client Reasons for Termination (not mutually exclusive) | | |
|---|---|---|---|---|---|---|
| | | | | Improvement | Dissatisfaction | Circumstantial Barriers |
| Bados et al. (2007) | Training clinic/ therapists interviewed clients upon termination | CBT | 60 unilateral terminators | 13.3% | 46.7% | 40% |
| Hunsley et al. (1999) | Training clinic/file review | Variable | 87 | 44% | 34% | 8.5% |
| Hynan (1990) | University counselling centre/mail-out survey | Variable | 31 | 55% | 38% | 23% |
| Pekarik (1983b) | CMHC/phone and mail-out survey | Variable | 46 unilateral terminators | 37% | 17% | 28% |
| Pekarik (1992) | Public mental health clinic/mail-out survey | Variable | 49 unilateral terminators | 39% | 26% | 35% |
| Renk & Dinger (2002) | Training clinic/file review | Variable, largely CBT | 407 | 23.5% | 8.5% | 19.9% |
| Roe et al. (2006) | Private practice/mail-out survey | Long-term psychodynamic therapy | 84 | 45.5% | 36.4% | 54.6% |
| Todd et al. (2003) | Training clinic/file review | Variable | 123 | 14% | 8% | 50% |

*Note*. CBT = Cognitive-behavioural therapy. CMHC = Community Mental Health Centre.

# CHAPTER 2

## Reasons for Terminating Psychotherapy: A General Population Study

Westmacott, R., & Hunsley, J. (2010). Reasons for terminating psychotherapy: A general population study. *Journal of Clinical Psychology, 66*, 965-977.

Abstract

Clients' (*N*=693) reasons for ending psychotherapy and their associations with demographics, mental disorder caseness, and type of mental health care service provider were examined. The most frequently reported reason for termination was feeling better, however, a substantial minority of individuals reported terminating due to treatment dissatisfaction or wanting to solve problems independently. Lower income was associated with lower odds of termination due to feeling better and higher odds of termination due to a perception that therapy was not helping. Meeting criteria for an anxiety disorder, mood disorder, or for substance dependence decreased the odds of termination due to feeling better. These findings provide important information on the challenges to the successful completion of psychotherapy.

## Reasons for Terminating Psychotherapy: A General Population Study

For decades, clinicians providing mental health services have been concerned that many clients end treatment prematurely (e.g., Baekland & Lundwall, 1975; Persons, Burns, & Perloff, 1988). Meta-analytic evidence, based on the findings of 125 studies, indicates that nearly 50% of clients terminate psychotherapy before having completed the full course of recommended services (Wierzbicki & Pekarik, 1993). As a result, this means that a substantial number of clients discontinue therapy before they are able to fully benefit from psychotherapeutic services (Hansen, Lambert, & Forman, 2002; Hunt & Andrews, 1992; Kazdin, Mazurick, & Siegel, 1994; Phillips, 1987).

Despite the longstanding nature of concerns about early termination of therapy, there is only limited information about why so many clients choose to end their treatments early (Mash & Hunsley, 1993). Although clinicians have their own perspectives on clients' reasons, research often finds that there is limited correspondence between clinicians' views and the reasons given by clients (e.g., Gager, 2004; Hunsley, Aubry, Vestervelt, & Vito, 1999; Pekarik & Finney-Owen, 1987; Todd, Deane, & Bragdon, 2003). Several clinic-based studies have investigated the reasons given by clients for terminating psychotherapy (Bados, Balaguer, & Saldana, 2007; Hunsley et al., 1999; Pekarik, 1983, 1992; Renk & Dinger, 2002; Roe, Roe, Dekel, Harel, & Fennig, 2006; Todd et al., 2003). One of the most frequently provided reasons is that clients ended treatment because they were satisfied with the gains they had made in treatment. Depending on the study, the percentage of clients ending treatment early because they had achieved their goals ranged from 14% (Todd et al., 2003) to 45.5% (Roe et al., 2006). The frequency with which this reason is given underscores the importance of not assuming that termination is *premature* simply because the client ended

services sooner than expected by the therapist (Gager, 2004; Hunsley et al., 1999). Researchers have also found that many clients decide to end treatment because of dissatisfaction with the therapy or the therapist. Across studies, the range of clients ending treatment early for dissatisfaction reasons is from 8% (Todd et al., 2003) to 34% (Hunsley et al., 1999). Finally, many clients also cite circumstantial barriers as factors in ending treatment early. Reasons such as difficulties with scheduling, difficulties making child care arrangements, and financial barriers have been given by 8.5% (Hunsley et al., 1999) to 54.6% (Roe et al., 2006) of clients.

These studies provide invaluable information regarding common reasons given by clients for ending psychotherapy. Although there are a number of similarities in the reasons given across these studies, the percentage of clients reporting these reasons varies greatly from study to study. With so little systematic research in this area, it is impossible to determine whether this variability is due to differences in measurement, sampling strategies, or unique aspects of the settings in which the clients received services.

Furthermore, very little is currently known about whether specific reasons for terminating treatment are associated with client demographic or clinical characteristics. For example, Roe et al. (2006) found no significant associations between reasons given for termination and client gender, age, family status, or education. Pekarik (1983) found evidence of improvement during treatment among clients who cited circumstantial barriers and those who reported no longer needing services as their reasons for terminating. However, he also found no improvement occurred during treatment among clients who terminated because they were dissatisfied with therapy. Thus, although some clinic-based studies have examined correlates of specific reasons for termination, too few studies have been conducted to allow any general conclusions to be drawn.

Most of the studies of clients' reasons for termination used data obtained from client files or former clients of clinics in which mental health services were routinely provided. In most instances, these clients had received services from psychology training clinics. Exceptions to this include Pekarik (1983, 1992), who sampled outpatients of community mental health centers, and Roe et al. (2006), who sampled patients in psychodynamically oriented private practice. The limited variability in the types of client samples and clinical settings that have been examined poses considerable challenges in trying to generalize the results of the individual studies to typical psychotherapeutic practice. Furthermore, previous studies have indicated that, compared to other practice settings, the rate of client change in training clinics is likely to be slower and treatment is likely to be less effective in reducing symptomatic distress (e.g., Callahan & Hynan, 2005). Therefore, studies of reasons for termination in training clinics may have limited generalizability.

Data collected in national population surveys can provide a more accurate and comprehensive picture of why clients end psychotherapy, due to the absence of any demands on the client to please the therapist, the random sampling of clients of diverse demographic characteristics, and the inclusion of a diversity of psychotherapy providers and service locations. Several clinic-based studies found that many clients left treatment without providing any reasons for terminating (Bados et al., 2007; Renk & Dinger, 2002; Todd et al., 2003); data from a national survey can also serve to elucidate reasons given by individuals such as these by obtaining termination information from a random sample of former clients, not only those willing to share potentially negative information with therapists. Thus knowledge of these population-based rates of reasons for client termination can contribute to therapists' awareness of clients' reasons for ending therapy.

Data from two large scale epidemiological survey studies indicated that low income, young age, lack of insurance coverage for mental health treatment, viewing mental health treatment as ineffective and being embarrassed about seeing a health provider, minority ethnic status, having severe psychological distress, and having a diagnosed mental disorder are all associated with premature termination from mental health services (Edlund et al., 2003; Wang, 2007). However, both Edlund et al. (2003) and Wang (2007) examined premature termination from all forms of mental health treatments, including pharmacotherapy and psychotherapy, and from all types of service providers, including general health care providers, specialist mental health care providers, and providers outside of any health care system (e.g., members of the clergy). Therefore, the extent to which their findings are relevant to client reasons for terminating psychotherapy, specifically, is unclear.

**The Present Study**

The present study used data collected for the population-based Canadian Community Health Survey, Cycle 1.2 (Mental Health and Well-Being; Statistics Canada, 2003). The first aim of the study was to examine clients' self-reported reasons for ending psychotherapy, across all types of health care providers and regardless of whether the decision to terminate services was made unilaterally by the client or in consultation with the treating health care provider. Despite their dual role in providing medication and psychotherapy, we included general practitioners and psychiatrists in the present study. General practitioners are the most widely consulted professional for mental health reasons (Robiner, 2006). Furthermore, a small but significant number of general practitioners concentrate their practice around the provision of psychotherapeutic services (V. Winterton, personal communication, January 26, 2010). Despite many psychiatrists who favour psychopharmacological approaches to treatment, the provision of psychotherapy remains a central aspect of psychiatric services.

Attesting to this, the Canadian Psychiatric Association issued a position statement characterizing the provision of psychotherapy as an integral component of psychiatric care (Chaimowitz, 2004). American data indicate that close to 30% of visits to a psychiatrist involve psychotherapy, and that over 10% of psychiatrists provide psychotherapy to *all* of their patients (Mojtabai & Olfson, 2008). Therefore, we viewed including these practitioners as crucial to determining representative reasons for termination.

The second study aim was to examine the influence of demographic variables (age, gender, income), mental disorder caseness, and type of mental health care provider on odds of indicating each reason for termination. In accord with previous research, we hypothesized that low income, younger age, and meeting caseness criteria for mental disorders (anxiety disorder, mood disorder, or substance dependence) would decrease the odds of selecting feeling better or having completed a full course of treatment as a reason for termination. We also hypothesized that these variables would increase the odds of selecting other termination reasons (other than feeling better or completing the recommended treatment). Although rather broad in nature, our hypotheses were designed to reflect what is currently known about the correlates of specific client reasons for termination.

## Methods

### Participants and Procedure

Data for this study came from the Canadian Community Health Survey 1.2 (CCHS Mental Health and Well-being; Statistics Canada, 2003). Developed by Statistics Canada, the CCHS 1.2 was the first national mental health survey conducted in Canada. The total sample size for the CCHS 1.2 comprised 36, 984 individuals aged 15 years and over living in private dwellings in the 10 Canadian provinces. The survey sample was limited to individuals living in the community, and therefore excluded persons living on Indian reserves, residing in

institutions (e.g., long-term care facilities), employed full-time with the Canadian Armed Forces, or inhabiting remote regions. The CCHS 1.2 sample was randomly selected from an area probability frame designed for the Canadian Labour Force Survey. A multistage stratified cluster design was used to select a sample of dwellings in this area frame. The households in the selected dwellings then formed the sample of households. One person, aged 15 or older, was randomly selected from the sampled households. In designing the sampling frame, a decision was made to over-sample respondents 15 to 24 year olds and those 65 years and older in order to obtain adequate samples for these age groups.

The provincial response rate for the survey ranged from 73.4% to 82.4% (provincial average = 77%). Data collection began in May 2002 and extended over seven months. The content of the interviews was described to potential respondents, and verbal informed consent was obtained before beginning the interviews. More than 85% of all interviews were conducted face-to-face and used a computer-assisted application, whereas 14% of interviews nationally were completed by telephone. The average length for all interviews was less than 70 minutes. The description of the aims, development, and methodology of the CCHS 1.2 are part of the documentation accompanying the publicly available survey data (Statistics Canada, 2003) and have also been outlined in detail by Gravel and Beland (2005).

The current study uses data from CCHS respondents who reported that they had seen a general medical practitioner or mental health professional (psychiatrist, psychologist, social worker, counselor, or psychotherapist) in the past 12 months about self-defined problems with emotions, mental health, or use of alcohol or drugs. These respondents were asked, "*With any of these professionals, did you ever have a session of psychological counselling or therapy that lasted 15 minutes or longer?"* If respondents indicated *yes,* we examined their subsequent responses to determine if they were eligible for inclusion in our study. This

included respondents who indicated that these contacts took place at (a) a hospital as an overnight patient, (b) a health professional's office, (c) a psychiatric outpatient clinic, (d) some other hospital outpatient clinic, (e) a walk-in clinic, (f) an appointment clinic, (g) a community health centre/Centre Local de Services Communautaires, drug or alcohol outpatient clinic, (h) work, (i) school, (j) home, (k) or other (specified by the respondent).

Respondents were then asked "*Have you stopped talking to this (health professional) about your problems with your emotions, mental health or use of alcohol or drugs?"* If the answer was *yes*, data from these respondents were initially included in the present study. In total, this yielded a sample of 1,080 participants (711 women, 369 men) who (a) received psychotherapy for self-defined problems with "emotions, mental health or use of alcohol or drugs" at some time during the 12 months preceding the interview, (b) terminated treatment at some point prior to the interview, and (c) provided reasons for ending psychotherapy. Most participants (96.3%) received fewer than 26 sessions of psychotherapy in total. The proportion of missing data was less than 5% for all variables. Cases with missing data were removed from logistic regression analyses. Unfortunately, it was not possible for us to consider the possible role of client ethnicity in the study because data on ethnicity was not available in the public use dataset from the survey.

Some respondents reported receiving mental health services from multiple health care providers. Therefore, to ensure that each respondent contributed only one data point to each analysis, it was necessary to choose among provider types for respondents who terminated with more than one provider. Given the present study's focus on psychotherapy, data on terminations with medical providers (general practitioners and psychiatrists) were eliminated from consideration when the respondent also terminated with a non-medical provider (psychologist, social worker, counselor, or psychotherapist). This ensured the maximum use

of data on service terminations with professionals in which the primary services were psychotherapy or counseling (as opposed to medical professionals, who may provide counseling/psychotherapy *and* medication). When a respondent terminated with both a social worker and psychologist (*n*=19), or with a psychiatrist and general practitioner (*n*=41), the provider data to be included in the analyses were randomly chosen. One hundred and seven (9.9%) respondents who were between the ages of 15 and 19 were eliminated due to known differences in the way youth terminate psychotherapy (Kazdin, 1996; Pekarik & Stephenson, 1988). These left data from 973 respondents (331 men, 642 women) who were included in descriptive analyses regarding reasons for termination: 275 (28.3%) individuals who terminated with a social worker, counselor, or psychotherapist, 276 (28.4%) who terminated with a psychologist, 239 (24.6%) who terminated with a general practitioner, and 183 (18.8%) who terminated with a psychiatrist.

**Measures**

**Reasons for terminating psychotherapy.** Respondents who reported terminating counselling or psychotherapy services were asked "*Why did you stop?"* Respondents could report more than one reason from the following response choices: (a) *You felt better*; (b) *You completed the recommended treatment*; (c) *You thought it was not helping*; (d) *You thought the problem would get better without more professional help*; (e) *You couldn't afford to pay*; (f) *You were too embarrassed to see the professional*; (g) *You wanted to solve the problem without professional help*; (h) *You had problems with things like transportation, childcare, or your schedule*; (i) *The service or program was no longer available*; (j) *You were not comfortable with the professional's approach*; and (k) *other reason – specify*.

**Demographic variables.** Variables selected to be used in the present study were age, gender, and household income (low income versus middle/high income). The mean age of

participants fell within the 35 to 39 age bracket. Low income was defined by self-reported gross income of less than $15,000 if one to two people per household, less than $20,000 if three or four people, and less than $30,000 if five or more people. Middle or high income was defined by the reverse (i.e., more than $15,000 if one or two people, etc.). These income levels are based on Statistics Canada definitions of low income in Canada. One hundred and eighty seven (19.2%) respondents fell into the low-income bracket, whereas 762 (78.3%) of participants fell into the middle to high income bracket. Twenty-four respondents did not provide data on income (2.5%).

**Mental disorder diagnoses.** Interview questions for mental health disorders covered in the CCHS 1.2 were based on the World Mental Health-Composite International Diagnostic Interview (Kessler & Ustun, 2004), a lay-administered instrument based partially on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision criteria (American Psychiatric Association, 2000). The 12-month prevalence of these disorders was assessed. For the present study, respondents were classified as either meeting or not meeting criteria for the occurrence of at least one disorder from each of three classes of disorders in the past 12 months: mood disorders (major depressive episode, mania), anxiety disorders (panic disorder, social phobia, agoraphobia), and substance dependence (alcohol dependence, illicit drug dependence). In terms of likely mental disorder diagnoses, 220 (23.7%) of the sample met criteria for an anxiety disorder, 399 (41.5%) met criteria for a mood disorder, 111 (11.4%) met criteria for substance dependence, and, overall, 506 (52.0%) met criteria for either having an anxiety disorder, a mood disorder, or substance dependence.

## Results

### Reasons for Termination: Self-Reported Reasons for Termination

The first aim of the present study was to present self-reported reasons for ending psychotherapy. Given that respondents could indicate more than one reason, we first examined the frequency of selecting one or multiple reasons. Of the total sample of 973, 159 respondents (16.3%) did not select one of the predetermined reasons, but instead *only* selected "*other reasons"*. These respondents were excluded from main analyses due to the unknown, heterogeneous nature of the "other" category. Of the remaining individuals, the vast majority ($n$ = 693, 85.1%) indicated only one reason for termination. Eighty-three respondents chose two reasons and a total of 38 respondents endorsed three or more reasons. The data from these respondents who indicated more than one reason were not included in analyses examining variables associated with specific reasons for termination given the requirement for independence of outcome in the logistic regression analyses used to test our hypotheses.

As seen in Table 2, the most frequent reason for termination, reported by just over 40 percent of respondents, was that they felt better. The other most common termination reasons, each reported by just under 15% of respondents, were (a) that the respondent perceived that psychotherapy was not helping and (b) that the recommended course of treatment had been completed. Most of the other possible reasons were reported by around 5% of respondents, except for "*you were too embarrassed to see the professional*," which was indicated by less than 1% of respondents and "*You had problems with things like transportation, childcare, or your schedule*", indicated by 2.1% of respondents. Due to their low prevalence, these two reasons were not examined further.

*Insert Table 2 here*

**Odds of Selecting Reasons for Termination According to Demographic Variables, Mental Disorder Diagnoses, and Mental Health Care Provider**

Logistic regression was used to determine odds ratios for selecting a reason for termination as a result of the level of each predictor variable. Age, gender, income level, 12-month anxiety disorder caseness, 12-month mood disorder caseness, 12-month substance dependence caseness, and provider type (general practitioner, psychologist, psychiatrist, or social worker category) were entered into direct logistic regression equations to predict the odds of selecting a particular reason for termination. Separate models were tested for each reason for termination. Only the most frequently provided reasons for termination (*You felt better*, *You completed the recommended treatment*, and *You thought it was not helping*) were examined with logistic analyses as the remaining reasons were endorsed by so few individuals that they did not meet assumptions for logistic regression analyses.

Binary logistic regression analyses were conducted on 693 respondents (235 men, 458 women): 202 (29.1%) individuals who terminated with a social worker, counselor, or psychotherapist, 213 (30.7%) who terminated with a psychologist, 150 (21.6%) who terminated with a general practitioner, and 128 (18.5%) who terminated with a psychiatrist. One hundred and thirty-five (19.5%) respondents fell into the low-income bracket, whereas 539 (77.8%) of participants fell into the middle to high income bracket. Nineteen respondents did not provide data on income (2.7%). In terms of likely mental disorder diagnoses, 149 (21.5%) of the sample met criteria for an anxiety disorder, 270 (39.0%) met criteria for a mood disorder, 64 (9.2%) met criteria for substance dependence, and, overall, 338 (48.8%) met criteria for either having an anxiety disorder, a mood disorder, or substance dependence (Table 3).

*Insert Table 3 here*

**Reason for termination: You felt better.** The following characteristics were associated with significantly decreased odds of selecting *you felt better* as a reason for

termination: having a low income, meeting criteria for 12-month substance dependence, 12-month anxiety disorder, or 12-month mood disorder, and having terminated with a psychiatrist. In accordance with our hypotheses, individuals with middle/high income were about two and a half times more likely to report terminating due to feeling better ($p<.001$, *OR*, 2.54, *95% CI*, 1.63-3.93). Furthermore, compared to other former clients, individuals meeting 12-month criteria for substance dependence were less than half as likely to report terminating due to feeling better ($p<.05$, *OR*, 0.45, *95% CI*, 0.24-0.86). Individuals meeting 12-month criteria for selected anxiety disorders ($p<.01$, *OR*, 0.56, *95% CI*, 0.37-0.86) and mood disorders ($p<.01$, *OR*, 0.63, *95% CI*, 0.44-0.89) were less likely than other former clients to report terminating due to feeling better. Finally, individuals who terminated with a psychiatrist were less likely to report feeling better ($p<.05$, *OR*, 0.57, *95% CI*, 0.34-0.94). Contrary to hypotheses, neither age (*OR*, 0.99, *95% CI*, 0.93-1.06), nor gender (*OR*, 0.88, *95% CI*, 0.61-1.26) influenced the odds of terminating due to feeling better.

**Reason for termination: You completed the recommended treatment.** Compared to other former clients, meeting 12-month criteria for substance dependence significantly increased the odds of selecting *you completed the recommended treatment* as a reason for termination: they were more than twice as likely to report completing treatment ($p<.05$, *OR*, 2.23, *95% CI*, 1.08-4.59). Contrary to hypotheses, age (*OR*, 1.00, *95% CI*, 0.91-1.11), gender (*OR*, 0.93, *95% CI*, 0.56-1.57), income (*OR*, 0.62, *95% CI*, 0.35-1.08), 12-month mood disorder (*OR*, 1.03, *95% CI*, 0.61-1.74), 12-month anxiety disorder (*OR*, 1.10, *95% CI*, 0.61-1.98), or health professional (*OR* range .75 to 1.29, all *ns*) did not influence the odds of terminating due to completing treatment.

**Reason for termination: You thought [psychotherapy] was not helping.** Having low income and having terminated with a psychiatrist increased the odds of selecting *you*

*thought [psychotherapy] was not helping* as a reason for termination. Individuals with middle/high income, compared to those with low income, were approximately half as likely to report this reason ($p<.05$, *OR*, 0.52, *95% CI*, 0.31-0.89). Individuals who terminated with a psychiatrist, compared to other psychotherapists, were over twice as likely to report terminating due to perceiving psychotherapy as unhelpful (*OR*, 2.79, *95% CI*, 1.42-5.50). Age (*OR*, 0.99, *95% CI*, 0.90-1.09), gender (*OR*, 0.85, *95% CI*, 0.52-1.42), 12-month mood disorder (*OR*, 1.51, *95% CI*, 0.92-2.50), 12-month anxiety disorder (*OR*, 1.00, *95% CI*, 0.56-1.78), and 12-month substance dependence (*OR*, 0.80, *95% CI*, 0.34.-1.88), did not influence the odds of selecting this reason.

Because of their ability to both prescribe psychotropic medication and provide psychotherapy, we assumed that one explanation for the different pattern of results for psychiatrists compared to other professionals was that they were more likely to treat clients with more severe psychopathology. Because research consistently shows that problem severity is associated with poorer progress in psychotherapy (Castonguay & Beutler, 2006), this might explain the pattern of results for former clients of psychiatrists. Therefore, in an effort to better understand why individuals who terminated with psychiatrists had higher odds of feeling as though psychotherapy was unhelpful and lower odds of ending treatment due to feeling better, we examined whether individuals who terminated with psychiatrists (compared to other professionals) were more likely to be diagnosed with mental disorders. Indeed, a higher percentage of individuals who terminated with psychiatrists (60%) were diagnosed with any 12-month substance dependence, anxiety, or mood disorder, compared with individuals who terminated with other health professionals, (48.30%) , $\chi^2(1) = 5.52$, $p<.05$.

## Discussion

The main purpose of this study was to examine data on clients' self-reported reasons for ending psychotherapy. In our dataset, the broad sampling of clients and the nature of the psychotherapy services they received enhance the external validity and generalizability of our results. On the other hand, the data we used provided no information on the specific nature of the counseling or psychotherapy services. Undoubtedly, factors such as type of psychotherapeutic treatment and therapist competence influence reasons for termination; however, information on these important factors was not included in the survey. The method of measuring reasons for termination is inherently limited; respondents varied in the length of time passed between psychotherapy termination and the administration of the survey, during which time recall biases may have affected their responses. As well, individuals do not necessarily have access to all the reasons for their decisions, and a more complete picture of termination is possible when therapist and client perspectives are simultaneously considered (Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). Despite these inherent limitations in retrospective self-report methodology, we believe it is essential for both researchers and therapists to be aware of clients' understanding of their reasons for terminating psychotherapy.

Given differences in health care systems in Canada and other countries, particularly the United States, where costs of mental health care fall at least partially to the individual, the prevalence and predictors of reasons for termination in the present study may not be generalizable to all health care systems. Edlund et al. (2002) compared mental health treatment dropouts (defined as individuals who did not select symptom improvement as a reason for termination) in Ontario, Canada, and the United States, and found no difference in the proportion of dropouts, the cumulative probability of dropping out across sessions, or the

effects of predictors (sociodemographic variables, mental disorder caseness, and patient attitudes). However, in the American dataset only, a lack of insurance coverage increased the odds of dropping out by 1.5 (Edlund et al., 2002). Lastly, the infrequency of some of the reasons for termination affected our plans to examine patterns of association existing in the data. All of these limitations must be kept in mind when interpreting our results.

At the most general level, our findings indicated that, despite being given the opportunity to endorse multiple reasons, a large majority (85.1%) of respondents chose to indicate only one reason for termination. The most frequently reported reason, ending therapy because of feeling better, was reported by almost half of respondents (43.4%). This value is consistent with the proportion of respondents leaving psychotherapy for this reason in studies involving both a private practice setting (45.5%; Roe et al., 2006) and a university training clinic setting (44%; Hunsley et al., 1999), but is substantially larger than the values reported in other recent clinic studies (25% in Renk & Dinger, 2002; 23.5% in Todd et al., 2003). This underscores the importance of using population-based data to provide estimates that will have the broadest applicability across settings and service providers.

*You completed the recommended treatment* was reported by far fewer respondents (13.4%). The relatively low number of respondents reporting having completed treatment may reflect the limited number of therapeutic services in Canada that have a predetermined set of sessions (i.e., limits set by third party payers). *It was not helping* was endorsed by 14.1% of respondents, and the remainder of the termination reasons were each reported by about 5% of respondents, with two exceptions. The low prevalence of the first exception, *You were too embarrassed to see the professional* (0.4%) may be due to the fact that the experience of embarrassment surrounding psychotherapy may be a more salient issue in decisions around treatment seeking and initial engagement rather than treatment termination.

In terms of the second exception, *You had problems with things like transportation, childcare, or your schedule* (2.1%) was rated much lower than what would be expected based on evidence from clinic studies: for example, 35% (Pekarik, 1983), 19.9% (Renk & Dinger, 2002), 54.6% (Roe et al., 2006), and 53% (Todd et al., 2003). The inability to overcome circumstantial barriers is undoubtedly an important reason that some people end treatment, however, it may be that individuals are more apt to provide honest reasons for termination to an anonymous interviewer rather than clinic staff or research staff affiliated with the clinic where termination occurred. Despite the prevalence of each of these reasons being low, taken together, results indicated that at least 44.7% of respondents left psychotherapy due to some barrier to treatment, preference for solving the problem on one's own, or dissatisfaction with psychotherapy (i.e., circumstantial barriers, dissatisfaction, perceived unhelpfulness, wanting to solve problems without professional help).

The present study is the first population-based study to examine the associations among specific reasons for terminating therapy with demographic variables, mental disorder diagnoses, and mental health care provider. Based upon what is known about premature termination in general, we hypothesized that the odds of selecting *You felt better* or You *completed the recommended treatment* would be decreased by low income, younger age, and meeting 12-month criteria for mental disorders. We hypothesized that the remaining reasons for termination would be increased by younger age, low income, and meeting 12-month criteria for mental disorders. Among these reasons for termination, the only one we were able to examine statistically was *It was not helping*, as remaining reasons were not endorsed by a sufficient number of individuals to be included in inferential analyses. Overall, age and gender were not found to be associated with odds of selecting any reason for termination. In accord with previous research (Wierzbicki & Pekarik, 1993; Williams, Ketring, & Salts,

2005), the socioeconomic status indicator low income was a meaningful predictor of untimely termination from psychotherapy. Low income decreased the odds of termination due to improvement and increased the odds of termination due to perception that therapy was not helping.

In terms of clinical variables, meeting criteria for an anxiety disorder, a mood disorder, or substance dependence decreased the odds of termination due to feeling better. This finding is particularly troubling as individuals with clinical disorders require the most help from psychotherapy and, based on the survey data, they are less likely than those without diagnosable conditions to report that they received the help that they needed to make improvements in their lives. Meeting criteria for 12-month substance dependence doubled the odds of completing treatment. This could reflect the typical practice of providing intensive time-limited treatment programs for substance abuse. The lack of association with other predictor variables may be due to the heterogeneous reasons underlying treatment having been completed, including the possibilities that treatment completion may be largely determined by therapists and that the prescribed number of sessions has only a limited relation to the clinical profile of clients.

In terms of mental health service provider, only termination with a psychiatrist significantly affected odds of selecting two reasons for termination. Individuals who terminated with psychiatrists had decreased odds of terminating due to symptom improvement and increased odds of terminating due to perceiving therapy as unhelpful. However, in the present study, there was evidence that, compared to other professionals, psychiatrists treated more individuals with diagnosable conditions and, thus, more severe psychopathology. This should be considered when interpreting this finding. Aside from the data from former clients of psychiatrists, there were no differences in reasons for termination

across mental health professionals and general practitioners. Despite what are likely sizeable differences in training, experience, and therapeutic approach, differences across professions were not meaningfully related to reasons for termination.

In sum, the present study examined clients' self-reported reasons for ending psychotherapy and the associations among specific termination reasons with demographic variables, mental disorder diagnoses, and mental health care service provider. The most frequently reported reason for terminating therapy was that the client felt better. This is clearly good news for clients and psychotherapists, but it must be tempered by the recognition that less than half of clients reported leaving psychotherapy due to this reason. Nearly half of respondents reported leaving psychotherapy due to some barrier to or dislike of treatment, or because of wanting to solve problems in a different manner. In general, individuals with low income and diagnosable mental disorders had significantly increased odds of premature termination. Clearly more attention needs to be paid to identifying client dissatisfaction and failing psychotherapy before clients leave in order to take steps to enhance the likelihood that treatment ends in a successful manner (cf. Persons & Mikami, 2002).

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Table 2

*Endorsement of Reasons for Termination (N = 973)*

| Reason for termination | All providers<br>*n* (%) |
|---|---|
| You felt better | 422 (43.4) |
| You completed the recommended treatment | 130 (13.4) |
| You thought it was not helping | 137 (14.1) |
| You thought the problem would get better w/o more professional help | 64 (6.6) |
| You couldn't afford to pay | 49 (5.0) |
| You were too embarrassed to see the professional | 4 (0.4) |
| You wanted to solve the problem without professional help | 50 (5.1) |
| You had problems with things like transportation, childcare, or your schedule | 20 (2.1) |
| The service or program was no longer available | 41 (4.2) |
| You were not comfortable with the professional's approach | 70 (7.2) |
| Other reasons | 188 (19.3) |

Table 3

*Demographics of Participants Included in Inferential Analyses (N = 693).*

| | *N* = 693<br>*%* |
|---|---|
| Income | |
| Low | 19.5 |
| Middle/High | 77.8 |
| Age (years) | |
| 20 – 39 | 53.2 |
| 40 – 59 | 38.9 |
| 60 + | 7.9 |
| Gender | |
| Female | 66.1 |
| Male | 33.9 |
| Health Professional | |
| Social worker, counselor, or psychotherapist | 29.1 |

| | |
|---|---|
| Psychologist | 30.7 |
| General Practitioner | 21.6 |
| Psychiatrist | 18.5 |
| Mental disorder caseness | |
| Anxiety disorder | 21.5 |
| Mood disorder | 39.0 |
| Substance dependence | 9.2 |
| Any disorder | 48.8 |

# CHAPTER 3

## Client and Therapist Views of Contextual Factors Related to Termination from Psychotherapy:

## A Comparison between Unilateral and Mutual Terminators

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*, 423-235.

Abstract

Contextual variables potentially influencing premature termination were examined. Clients (*n*=83) and therapists (*n*=35) provided parallel data on early working alliance, psychotherapy termination decision (unilateral versus mutual), clients' reasons for termination, and barriers to treatment participation. When clients unilaterally ended therapy, therapists were only partially aware of either the extent of clients' perceived improvements or their dissatisfaction. When termination was mutually determined, there were no differences between client and therapist ratings of termination reasons. Although working alliance and barriers to treatment participation were rated as lower in the context of unilateral termination by clients and therapists, all clients rated the early alliance and barriers to treatment more highly than did therapists. Results have implications for understanding premature termination, and suggest future research examining the utility of therapist feedback regarding contextual variables in terms of retaining clients in therapy.

## Client and Therapist Views of Contextual Factors Related to Termination from Psychotherapy

Premature termination of treatment has been a perennial problem in psychotherapy. Up to 50% of clients discontinue psychological services prematurely (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008; Swift, Callahan, & Levine, 2009; Wierzbicki & Pekarik, 1993), which undermines the potential benefits of treatment and reduces the cost-effectiveness of these services (Garfield, 1994; Ogrodniczuk, Joyce, & Piper, 2005; Pekarik, 1985a). Compared to clients who complete treatment, those who leave treatment prematurely tend to be less satisfied with services (Lebow, 1982), are less likely to have improved (Pekarik, 1986; Prinz & Miller, 1994; Saatsi, Hardy, & Cahill, 2007), and are more likely to be impaired, and therefore, more in need of services (Kazdin, Mazurick, & Siegel, 1994).

In order to intervene to prevent premature termination, we need to better understand why clients leave before their treatments are completed. Most research in this area has examined *who* leaves, focusing primarily on static client or therapist factors. Although few replicable results have been found, there is consistent evidence that premature termination is associated with socioeconomic disadvantage and non-White ethnicity (Wierzbicki & Pekarik, 1993; Williams, Ketring, & Salts, 2005). Closer examination of findings such as these raise the possibility that the association with ethnicity can be largely accounted for by socioeconomic disadvantage (Garfield, 1994) which, in turn, may be at least partially explained by differences in client expectations for the duration of treatment (Pekarik, 1991; Pekarik & Stephenson, 1988; Pekarik & Wierzbicki, 1986). Thus, this line of evidence suggests that there may be considerable value in examining contextual factors potentially related to premature termination. In the present study, we examine three such factors: the

reasons clients terminate services, early treatment alliance, and possible barriers to clients' involvement in therapy.

Premature termination has been defined a number of ways, including failing to attend a scheduled session, failing to complete a prescribed number of sessions, and making a unilateral decision to end treatment without agreement of the therapist (Wierzbicki & Pekarik, 1993). Pekarik (1985b) suggested that a unilateral decision on the part of the client to terminate best captures the construct of premature termination. This approach differentiates clients who unilaterally terminate from clients who make a mutual decision with their therapist to end treatment. It also avoids the problem of defining premature termination as the failure to complete a prescribed number of sessions, as some clients achieve the necessary gains in functioning *prior* to the end of a set number of sessions. Defining premature termination according to the type of decision addresses the problem of appropriately classifying clients who meet their treatment goals with few therapy sessions as well as clients who may remain in therapy for a longer period of time, but leave before their goals have been reached. Since Pekarik's suggestion, most researchers have used this operationalization (e.g., Callahan, Aubuchon-Endsley, Borja, & Swift, 2009; Chisolm, Crowther, & Ben-Porath, 1997; Keijsers, Kampman, & Hoogduin, 2001; Richmond, 1992; Smith, Subich, & Kalodner, 1995; Tryon & Kane, 1993).

A wealth of evidence indicates that obtaining data from both clients and therapists is necessary to understand the process of psychotherapy. Some perspective divergence between clients and therapists is expected, and a growing body of research documents that both similarities and differences in perspective can provide insight into the nature of client and therapist experiences in therapy (e.g., Reis & Brown, 1999; Tryon, Blackwell, & Hammel,

2007; Weiss, Rabinowitz, & Spiro, 1996). Accordingly, it is important to consider both client and therapist views in order to understand clients' unilateral termination. For example, clients generally anticipate that they will require fewer sessions to address their problems than do their therapists (Garfield, 1994; Swift & Callahan, 2008), and therapists tend to overestimate treatment length and underestimate the number of clients who will terminate prematurely (Lowry & Ross, 1997; Mueller & Pekarik, 2000; Pekarik, 1992; Pekarik & Finney-Owen, 1987; Pulford, Adams, & Sheridan, 2008). Research has shown that any major discrepancy between a client's expectations and actual treatment content can lead to an increased risk of premature termination (Horenstein & Houston, 1976). Client-therapist divergences in estimations of problem severity also decrease the likelihood of mutual termination decisions (Corning, Malofeeva, & Bucchianeri, 2007). On the flipside, there is evidence that addressing clients' role expectations prior to treatment can decrease the rate of dropout (e.g., Reis & Brown, 2006; Scamardo, Bobele, Biever, 2004; Walitzer, Dermen, & Conners., 1999; Zwick & Attkisson, 1985). It is thought that this education may decrease unilateral termination by developing client expectations that are more congruent with what actually happens in therapy, and more similar to the expectations therapists hold for clients (Reis & Brown, 2006; Swift & Callahan, 2008).

**Reasons for Termination**

Studies of client reasons for termination have shed light on why clients leave (e.g., Bados, Balaguer, & Saldana, 2007; Hunsley, Aubry, Vestervelt, & Vito, 1999; Pekarik, 1983, 1992; Renk & Dinger, 2002; Roe, Dekel, Harel, & Fennig, 2006; Todd, Deane, & Bragdon, 2003). Although the proportion of clients reporting a given reason varies greatly across studies, common reasons reported by clients tend to be that they left because they

were satisfied with progress in treatment, they encountered circumstantial barriers (including any external obstacles such as difficulties with scheduling, making child care arrangements, or financial barriers), or that they were dissatisfied with the therapy or the therapist. In line with our emphasis on the importance of obtaining information from both client and therapist, research has shown that client and therapist perspectives on reasons for termination tend to diverge (e.g., Gager, 2004; Hunsley et al., 1999; Pekarik & Finney-Owen, 1987; Todd et al., 2003). Even when there is some general agreement on the reasons for termination, there are likely to be important differences in accounting for some termination factors. For example, Pekarik and Finney-Owen (1987) surveyed therapists and clients from community mental health clinics in order to compare the ratings of the primary reasons why clients left therapy. They asked therapists, in general, to list top reasons why clients leave, and compared these with actual reasons given by a sample of clients. They found that therapists and clients tended to agree about positive reasons for termination (*problem solved or improved* was endorsed by 39% of clients and by 31% of therapists) and obstacles to treatment (*environmental constraints* was endorsed by 35% of clients and by 37% of therapists). However, when the focus was on termination due to failed therapy, there was very little agreement between clients and therapists (*resistance* was endorsed by no clients and by 22% of therapists; *dislike of therapy/therapist* was endorsed by 26% of clients and by 11% of therapists). Pulford et al. (2008) recently replicated these results in another adult outpatient sample.

Hunsley et al. (1999) also found that therapists and clients made different attributions about failed therapy. These researchers compared training clinic therapists' reasons for client termination written in their final reports with reasons reported directly from interviews with

former clients. Their results suggest that therapists were not aware of, or did not report, clients' dissatisfaction with therapy as the primary reason for termination; no client was described by therapists as terminating because of dissatisfaction with therapy. However, 12% of clients reported that the fact that therapy made things worse for them was very important in their decision to end therapy. Almost half of these clients were described by therapists as terminating because they no longer had the time or interest to continue therapy. Fifteen percent of clients reported that the feeling that therapy was going nowhere was very important in their decision to end treatment. For these clients, one-third were described by therapists as ending therapy because they had achieved many or all of their goals, and another third were described as terminating because they no longer had the time or interest in continuing therapy. These results indicate that therapists were not accurate at detecting treatment failure, and the reasons for the failure, from the client's perspective. With respect to attributions for treatment success, among the clients who were identified by therapists as leaving because they achieved their goals, 75% of the clients reported this reason as important to their decision to leave. On the other hand, of the clients who reported ending therapy because of achieving their goals, only half were identified by therapists as having achieved their goals.

Todd et al. (2003) found similar lack of concordance using a qualitative coding methodology to examine training clinic therapists' reasons for client termination provided on routine clinic forms with reasons reported on similar forms given to clients at termination. Their results suggest only moderate overall agreement between therapist and client reasons (Cohen's $\kappa = .43$). More specifically, clients and therapists showed good agreement on *client environmental* and *therapist environmental* reasons, fair agreement on *improvement* reasons,

and poor agreement on *client negative* and *other* reasons. Therapists were significantly more likely than clients to endorse *improvement* as a reason for termination, and clients were more likely to endorse *client environmental* and *other* reasons.

Both Hunsley et al. (1999) and Todd et al. (2003) used a file-review methodology whereby either client termination reports or standard clinic forms were reviewed to obtain therapist reasons for termination. Due to the possibility of the graduate student therapists trying to please supervisors, as well as other constraints on report writing and record keeping, actual therapist perceptions regarding reasons for termination might have been absent from the final report or clinic data. These authors' results highlight the importance of examining both client and therapist perspectives on whether termination was unilateral or mutual. The methodologies used in this research to date have been either file review, general surveys about reasons for termination given to therapists or clients, or routine administrative forms used in clinic settings (Hunsley et al., 1999; Pekarik & Finney-Owen, 1987; Renk & Dinger, 2002; Todd et al., 2003). No study, to our knowledge, has used data from a research protocol that obtained parallel information from both members of the client-therapist dyad to examine specific reasons why the client terminated services and how perspective divergences may be related to unilateral termination.

**Therapeutic Alliance**

It is well-established that therapeutic alliance, particularly agreement on therapeutic tasks, is strongly associated with psychotherapy outcome (e.g., Weerasekera, Linder, Greenberg, & Watson, 2001). In terms of predicting premature termination, although there have been inconsistencies in the research, working alliance (generally measured after the third treatment session) has been found to predict premature termination (Saatsi, Hardy, &

Cahill, 2007; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976). In particular, problems with client-therapist agreement on therapeutic tasks have been found to be associated with ending treatment early (Tracey, 1986). Meta-analytic research on client and therapist ratings of working alliance suggest that, although client ratings were higher than therapist ratings ($d$ = .63), their ratings tend to be moderately positively correlated ($r$ = .36), regardless of client disturbance, therapist experience, therapy length, alliance measure, or type of treatment (Tryon et al., 2007). To date, however, no research has examined how client-therapist congruence in ratings of the working alliance may differ as a function of mutual versus unilateral termination.

**Barriers to Treatment Participation**

Using a barriers to treatment model, Kazdin and colleagues have focused on the importance of therapy-specific factors in the search for causes of premature termination (Kazdin, Holland, Crowley, & Breton, 1997; Kazdin & Wassell, 1998). In this model, barriers include practical obstacles to participation in treatment (e.g., transportation difficulties, scheduling conflicts), perceptions of treatment as demanding, unhelpful, or irrelevant to the problems experienced by the client, and a poor therapeutic relationship with the therapist. Kazdin et al. (1997) found that consideration of these barriers added to the prediction of premature termination beyond the contribution of client characteristics (income, ethnicity, level of education), and that these findings were generally consistent across both parent and therapist perspectives for the reasons that families terminated therapy early. Large effect sizes were found for the contribution of the perceived relevance of treatment and stressors, and small and moderate effect sizes were found for the contribution of therapeutic relationship and treatment demands in discriminating between clients who completed and

those that left treatment prematurely. Interestingly, critical events that had occurred in a client's life while they were in treatment (e.g., moving, job loss, illness, change in marital status) were not found to contribute significantly to premature termination (Kazdin et al., 1997). Therefore, the present study examined whether these contextual factors found to be significant contributors to dropout in child and family therapy could also serve as useful ways to distinguish those adult clients who unilaterally terminated from those who mutually decided with their therapist to end treatment. We also examined barriers from both client and therapist perspectives; Kazdin et al. (1997) reported that the shared variance between parent-rated and therapist-rated barriers was only about 15%.

**The Present Study and Hypotheses**

In an effort to better understand unilateral termination, the goal of the present study was to examine the congruence in perspectives of client-therapist dyads regarding important contextual factors, including clients' reasons for termination, working alliance, and barriers to treatment between two groups where a) both client and therapist agreed that termination was a unilateral decision on the client's part, or b) both client and therapist agreed that termination was mutual. Based on previous research, several specific hypotheses were formulated:

1) We hypothesized that, in dyads where both client and therapist agreed that termination was a mutual decision, compared with dyads where both client and therapist agreed that termination was a unilateral decision on the client's part, both clients and therapists would rate:

a. having accomplished therapy goals as more important to the termination decision, and circumstantial and therapy-specific reasons as less important to the termination decision.
b. the early working alliance as stronger
c. barriers to treatment participation as fewer

2) We hypothesized that, when termination decisions were mutual as opposed to unilateral, client-therapist perspectives would be more congruent regarding:
   a. reasons for termination,
   b. quality of the early working alliance, and
   c. barriers to treatment participation

## Method

### Participants

One hundred and fifty-five adult clients seeking individual psychological services from a university clinical psychology training clinic were initially recruited for a study on the process of engagement and termination from psychotherapy. The training clinic serves as a community clinic and operates on the basis of a sliding fee scale. Of these 155 client participants, 39 completed initial measures for the study while they were waiting for services, but never attended an initial treatment session, and 9 received services but did not complete the final set of measures at the end of treatment (either because they could not be reached by the researchers or were no longer interested in participating). Therefore, data were available on a total of 107 client participants who received psychotherapy and completed all study measures. On 12 different demographic measures, there was only one statistically significant difference between the included 107 participants and the 48

individuals who did not complete final measures. Study participants (107) had a slightly higher level of education ($M$ = 7.05, $SD$ = 1.68), characterized by some university courses, than the group who did not complete the study ($M$ = 6.41, $SD$ = 2.09) that was characterized by college graduation. This finding is consistent with literature suggesting that individuals with higher education are less likely to drop out of therapy (Garfield, 1994). A comparison of these two groups on level of psychological distress prior to therapy from both client (SCL-10) and therapist (GAF) perspectives revealed no significant differences.

Thirty-five therapist participants (28 women, 7 men) provided therapy to between 1 and 11 client participants. Therapists were practicum students and interns in a doctoral program in clinical psychology and were supervised by registered psychologists.

To determine the type of termination decision, both clients and therapists were asked whether the decision to terminate therapy was the client's unilateral decision, or whether the decision was made with the mutual agreement of the therapist that treatment goals had been met. Decisions to end therapy based on the failure of the client to attend sessions or to schedule subsequent appointments were considered to be unilateral decisions, and decisions to refer the client to other services for any reason (including when practicum students or interns were ending their training) were considered to be mutual decisions. Thirty-one client-therapist pairs agreed that termination was a unilateral decision on the client's part, 52 client-therapist pairs agreed that termination was a mutual decision made by both client and therapist together. Twenty-four client-therapist dyads (22.4%) did not agree on the type of termination decision, thus indicating the importance of collecting data from both perspectives (12 clients reported unilateral termination whereas their therapists reported mutual agreement, and 12 clients reported mutual agreement whereas their therapists

reported unilateral termination). Data from these dyads were not used for analyses reported in this study.

**Demographic characteristics of the sample.** The mean age of the 83 client participants (19 males, 64 females) was 31.7 years (*SD* = 9.9), with a range from 17 to 60. In general, clients were highly educated (approximately 40% had completed some university or college education and 46% had attained at least a university undergraduate degree): 28.9% were students, 37.3% were employed full-time, 20.5% were unemployed, 12.0% were employed part-time and 1.2% were homemakers. Most participants reported lower to middle income (based on a median income of $29,000 for persons 15 years of age or older in the study region; Statistics Canada, 2001a), with 33.8% of clients earning under $10,000, 25.3% between $10,000 and $20,000, 16.8% between $20,000 and $30,000, 14.4% between $30,000 and $40,000, and 9.6% over $40,000. Most participants reported their ethnic background as white (85.5%); other ethnic groups represented in the sample included black (3.6%), Asian (6%), Aboriginal (1.2%), and other (3.6%). This level of ethnic diversity is consistent with census data for the study region (Statistics Canada, 2001b). Client participants reported a range of presenting problems; 36% reported symptoms of anxiety, 31% reported depressive symptomatology, 29% reported relationship problems, 11% had suffered sexual abuse, and 10% reported anger management problems. Other identified problems included attention deficit disorder, loneliness, personality disorder, posttraumatic stress disorder, problems with sexual functioning, and shyness.

The 83 participants were treated by 31 different therapists, who provided therapy to between 1 and 11 different participants. To determine if there was a problem of dependence in the data, 56 comparisons of independent sample means were conducted on 8 different

therapist variables comparing 7 groups of therapists who had seen 1,2,3,4,5,7,8, and 11 different clients, respectively. On only one variable were two groups significantly different at $p<.05$, suggesting no important differences across study variables in therapists who provided treatment to different numbers of client participants. Three main therapeutic approaches were reported being used by therapists: cognitive-behavioral (69.9%), experiential (15.7%), and interpersonal (14.5%). No statistically significant difference in type of therapeutic approach used was found between participants who unilaterally and mutually terminated therapy, $\chi^2(2)= 3.25$, *ns*.

**Measures**

**Demographic data.** Age, gender, education level, employment status, annual income, and cultural/ethnic background were requested prior to commencing treatment.

**Symptom-Checklist 10 (SCL-10).** Derived from the SCL-90 (Derogatis, Lipman, & Covi, 1973), the SCL-10 (Nguyen, Attkisson, & Stegner, 1983) is a 10-item measure yielding a single global score reflecting the extent of psychological distress. In the present study, this scale was used as a general measure of client self-rated symptomatology. Items were chosen from the three factors from the SCL-90 that were found to be most interpretable and accounted for a large proportion of the variance in an outpatient population: Depression (six items; e.g., *How much were you distressed by feeling lonely?*), somatisation (two items; e.g., *How much were you distressed by feeling weak in a part of your body?),* and phobic anxiety (two items; e.g., *How much were you distressed by feeling afraid in open spaces or on the street?*). Items are rated on a 5-point scale of distress (from *not at all* = 0 to *extremely* = 4). Nguyen et al. (1983) and Rosen et al. (2000) found a high level of internal consistency (Cronbach's $\alpha = .88$), indicating that the instrument is an internally consistent measure. In

the current study, the alpha values were .78 at pre-therapy assessment and .85 at post-therapy assessment. Rosen et al. (2000) found the SCL-10 to show good convergent validity with the well-developed Symptom Checklist-90 (SCL-90) ($r$ = .92) and discriminant validity with several other measures of symptom distress that aim to capture more specific aspects of distress, including the Beck Depression Inventory (BDI) ($r$ = .67), Beck Anxiety Inventory (BAI) ($r$ = .68), and Mississippi PTSD scale ($r$ = .50). As well, pre-post change scores on the SCL-10 were examined in relation to those of other measures, and were found to correlate highly, indicating good sensitivity to change.

**Global Assessment of Functioning (GAF) Scale.** (American Psychiatric Association, 1994). For the purpose of the present study, the GAF was used as an overall measure of psychological distress from the therapist's perspective. The GAF is a rating of overall psychological functioning on a scale of 1 (the most distressed) to 100 (least distressed) published in the Diagnostical and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), designed to be completed by clinicians or researchers. The scale is divided into 10 equal ten-point intervals. For example, a score of 51 to 60 indicates that the client has *moderate symptoms*, whereas a score of 61 to 70 indicates that the client has *some mild symptoms*. Endicott, Spitzer, Fleiss, and Cohen (1976) reported that five studies revealed intraclass correlation coefficients ranging from $\alpha$ = .61 to .91. Assessments of validity of the GAF have indicated moderate to high correlations with other independently rated measures of overall severity, and sensitivity to treatment change.

**Working Alliance Inventory (Short Form).** The 12-item Working Alliance Inventory (WAI-S; Tracey & Kokotovic, 1989) was used to assess working alliance. Based on the original 36-item scale (Horvath & Greenberg, 1986, 1989), it was developed using the

four highest-loading items from each of three subscales (agreement on tasks, agreement on goals, and development of a bond), and has equivalent factor structure and internal consistency (Tracey & Kokotovic, 1989). Busseri and Tyler (2003), in a sample of client-therapist pairs from 54 university counselling centres, found high correlations between WAI and WAI-S scores, comparable descriptive statistics, internal consistencies, and subscale intercorrelations within and across rater perspectives. Predictive validity estimates for WAI and WAI-S total scales were also very similar, supporting the interchangeability of scores on the WAI and WAI-S. The measure is designed to be administered in the early stages of therapy, between the third and fifth sessions. Items are rated on a 7-point scale ranging from 1 (*Does not correspond at all*) to 7 (*Corresponds exactly*). Negative items (4 and 10) were reverse-scored, and all scores were summed to provide a global rating of the working alliance. Both a client version (WAI-C) and a therapist version (WAI-T) of the short form WAI were used. In the current study, total scale score reliabilities (Cronbach's α) were .93 for the client version and .92 for the therapist version.

**Barriers to Treatment Participation Scale (BTPS).** The BTPS was developed by Kazdin et al. (1997) for use in the context of the outpatient treatment of children and families. Written in an interview format, it can be administered in person or by phone, and is phrased so that both treatment dropouts and treatment completers can answer questions. It was modified for use in the context of adult treatment by changing 11 out of 44 items, and eliminating six, therefore leaving a total of 38 items (Best, 2003). In the present study, two versions of the BTPS were completed; one by the client and the other by the therapist. Items are rated on a 5-point scale ranging from 1 (*never a problem*) to 5 (*very often a problem*) and cover four general areas: a) stressors and obstacles that compete with treatment, b) treatment

demands and issues, c) perceived relevance of treatment, and, d) relationship with the therapist. Kazdin et al. (1997) found that principal components analysis revealed a single global scale factor. Therefore, in the current study, analyses were conducted with the global score. In the current study, global scale score reliability (Cronbach's alpha) was .87 for the client-completed version and .83 for the therapist-completed version. Kazdin et al. (1997) found that the measure showed convergent validity with other measures of participation in treatment. Evaluation of the scale revealed either no or low correlation and little shared variance between perceived barriers and critical events occurring while in therapy, or family, parent, and child characteristics, thereby demonstrating discriminant validity.

**Reasons for termination.** Client and therapist perspectives on reasons for termination were assessed with a measure developed by Hunsley et al. (1999). The 10-item measure was developed based on possible reasons for termination found in the literature. Clients and therapists were asked, after the final session, to rate the importance in their decision to end therapy each of 10 possible reasons for termination. Ratings were made on a 4-point scale (*not at all important* to *very important*). The 10 possible reasons for termination were: a) accomplished what you/he/she wanted to do in therapy, b) could no longer fit time for therapy into schedule, c) just lost interest in therapy, d) no longer had money or insurance coverage to pay for therapy, e) felt therapy was going nowhere so ended therapy, f) felt therapy was making things worse so stopped, g) weren't confident in therapist's ability to help, h) uncomfortable talking about personal matters with therapist, i) therapy didn't fit with ideas about what would be helpful, j) decided to go elsewhere for services. The 10 reasons were examined separately in analyses as the measure was not designed to yield a summary score.

### Procedure

Data collection took place over 35 months. Client participants were assessed at three different times: 1) following a request for therapy and prior to the intake session (demographics, client self-rated symptomatology (SCL-10)), 2) after the third therapy session (working alliance (WAI-S), therapist-rated client functioning (GAF), and 3) at the end of therapy (to assess retrospectively for contextual factors which may have influenced the decision to terminate, including reasons for termination and barriers to treatment participation (BTPS); also assessed post-therapy were client self-rated symptomatology (SCL-10) and therapist-rated client functioning (GAF). All client data were obtained via structured telephone interview by a research assistant. Therapist data were obtained by structured self-report. For Time 3 assessments, clients were contacted for a structured phone interview within a week of their last therapy session if they completed treatment in a planned manner. In cases where termination was not planned, clients were contacted within a month of their last session. The collection of data on therapists' perspectives at this time point occurred at the same time as the client data were collected. As indicated previously, the collection of these data took place in the context of a larger study that examined several other factors related to psychotherapy engagement and termination. Research ethics board approval was obtained for all phases of the study, and informed consent was obtained from all participants following a full presentation of the nature of the study

## Results

### Preliminary Analyses

Preliminary analyses compared unilateral and mutual terminators on demographic, psychological functioning, and service variables to (a) ensure that groups were equivalent at

pre-therapy and (b) examine therapy outcome for both groups. Prior to therapy, there were no significant group differences on client-rated (SCL-10) and therapist-rated (GAF) psychological distress, gender, ethnic origin, referral source, or duration of presenting problem. However, unilateral terminators attended significantly fewer sessions; with an average of 9.7 sessions (*SD* = 8.1), whereas mutual terminators attended an average of 20.8 sessions (*SD* = 12.2), $t(79.50) = -6.25$, $p<.001$.

On the SCL-10, unilateral terminators reported a significant decline in distress over the course of therapy, with a mean of 17.2 (*SD* = 6.8) before therapy and 10.3 (*SD* = 6 9) post-therapy, $t(30) = 5.49$, $p<.001$. Mutual terminators reported a similar pattern, with a mean of 14.9 at pre-therapy (*SD* = 7.2) and 6.5 (*SD* = 5.6) post-therapy, $t(52) = 7.72$, $p<.001$. At post-therapy, mutual terminators were significantly less distressed than unilateral terminators when symptom distress scores prior to therapy were controlled for, $F(1, 80) = 5.46$, $p<.05$. Therapists reported unilateral terminators on the GAF as remaining the same over the course of treatment (i.e., no significant change), with a mean of 66.6 (*SD* = 11.0) prior to therapy and a mean of 66.8 (*SD* = 10.6) post-therapy, $t(30) = -2.3$, *ns*. Therapists reported mutual terminators' psychological functioning on the GAF as having significantly improved over the course of treatment, with a mean of 61.8 (*SD* = 13.1) pre-therapy and a mean of 73.5 (*SD* = 14.2) post-therapy, $t(50) = -8.47$, $p<.001$. Post-therapy, mutual terminators were rated by therapists as having significantly higher functioning than were unilateral terminators when therapists' GAF assessments prior to therapy were controlled for, $F(1,79) = 28.60$, $p<.001$.

We examined intercorrelations among variables within each of clients' and therapists' perspectives on the BTPS and WAI-S, and among client and therapist-rated

outcome measures (SCL-10, GAF) and these variables. For both clients and therapists, the WAI-S and BTPS were moderately negatively correlated (clients $r = -.52$, $p<.001$; therapists $r = -.28$, $p<.05$). Both pre- and post-therapy SCL-10 scores were negatively correlated with client-rated WAI-S (pre; $r = -.22$, $p<.05$; post; $r = -.30$, $p<.01$), but not with therapist-rated WAI-S (pre; $r = -.14$, *ns*, post; $r = -.19$, *ns*). Both pre- and post-therapy SCL-10 scores were also positively correlated with BTPS from client (pre; $r = .31$, $p<.01$; post; $r = .32$, $p<.01$) but not therapist (pre; $r = .04$, *ns*; post; $r = .01$, *ns*) perspectives. The GAF, pre- and post-therapy, was positively correlated with both client WAI-S (pre; $r = .22$, $p<.05$, post; $r = .39$, $p<.001$) and therapist WAI-S (pre; $r = .29$, $p<.01$; post; $r = .38$, $p<.001$). Pre-therapy, there was no association between the GAF and BTPS for clients ($r = -.11$, *ns*) or therapists ($r = .04$ , *ns*). Post-therapy, GAF scores were associated with client BTPS ($r = -.29$, $p<.01$), but not therapist BTPS ($r = -.12$, *ns*).

**Mutual vs. Unilateral Terminators: Reasons for Termination. Hypothesis 1a**

We hypothesized that clients' and therapists' mean ratings of the importance of termination reasons would differ between unilateral and mutual termination groups. Specifically, we expected that both clients and therapists in the mutual group, compared with the unilateral group, would rate having accomplished therapy goals as more important, and circumstantial and therapy-specific reasons for termination as less important. A one-way MANOVA was used to compare means between the two groups (unilateral vs. mutual). The omnibus test for client-rated reasons was significant, Wilk's $\lambda = 0.37$, $F(10, 72) = 12.39$, $p<.001$, partial $\eta^2 = .63$. Keeping the familywise alpha at .05, tests of between-subjects effects indicated that clients who terminated therapy unilaterally assigned less importance than mutual terminators to *Accomplished what you wanted to do in therapy* as a reason for

leaving, $F(1, 81) = 15.75$, $p<.001$, partial $\eta^2 = .16$. In contrast, unilateral terminators rated every other reason [except for *Decided to go elsewhere for services,* $F(1, 81) = 0.49$, *ns*] as significantly more important than did mutual terminators. These reasons included *Could no longer fit time for therapy into schedule*, $F(1, 81) = 20.43$, $p<.001$, partial $\eta^2 = .20$, *Just lost interest in therapy*, $F(1, 81) = 13.95$, $p<.001$, partial $\eta^2 = .15$, *No longer had money or insurance coverage to pay for therapy*, $F(1, 81) = 9.66$, $p<.003$, partial $\eta^2 = .11$, *Felt therapy was going nowhere so ended therapy*, $F(1, 81) = 66.17$, $p<.001$, partial $\eta^2 = .45$, *Felt therapy was making things worse so stopped*, $F(1, 81) = 20.64$, partial $p<.001$, $\eta^2 = .20$, *Weren't confident in therapist's ability to help*, $F(1, 81) = 37.68$, partial $p<.001$, $\eta^2 = .32$, *Uncomfortable talking about personal matters with therapist*, $F(1, 81) = 25.78$, $p<.001$, partial $\eta^2 = .24$, *Therapy didn't fit with ideas about what would be helpful*, $F(1, 81) = 25.68$, $p<.001$, partial $\eta^2 = .24$ (see Table 4).

When comparing therapist ratings across groups, the omnibus test was also significant, Wilk's $\lambda = 0.320$, $F(10, 70) = 14.89$, $p<.001$, partial $\eta^2 = .68$. Keeping the familywise alpha at .05, tests of between-subjects effects indicated a pattern of findings similar to those obtained with the client-ratings. Compared to therapists in the mutual group, therapists in the unilateral group assigned less importance to *Accomplished what you wanted to do in therapy* than the mutual group, $F(1, 79) = 36.76$, $p<.001$, partial $\eta^2 = .32$, and more importance to all other reasons except *Went elsewhere for services*, $F(1, 79) = .92$, *ns*, *No longer had money or insurance coverage to pay for therapy*, $F(1, 79) = 5.07$, *ns, Felt therapy was making things worse so stopped*, $F(1, 79) = 6.98$, *ns*, and *Therapy didn't fit with ideas about what would be helpful*, $F(1, 79) = 4.02$, *ns*. Reasons rated significantly more important by therapists of unilateral terminators included: *Could no longer fit time for therapy into*

*schedule*, $F(1, 79) = 32.25$, $p<.001$, partial $\eta^2 = .29$, *Just lost interest in therapy*, $F(1, 79) = 37.27$, $p<.001$, partial $\eta^2 = .32$, partial $\eta^2 = .06$, *Felt therapy was going nowhere so ended therapy*, $F(1, 79) = 10.84$, $p<.001$, partial $\eta^2 = .12$, *Weren't confident in therapist's ability to help*, $F(1, 79) = 15.83$, $p<.001$, partial $\eta^2 = .17$, and *Uncomfortable talking about personal matters with therapist*, $F(1, 79) = 13.82$, $p<.001$, partial $\eta^2 = .15$ (see Table 4).

**Congruence between Client and Therapist Views on Reasons for Termination.**

**Hypothesis 2a**

It was expected that client-therapist perspectives regarding termination reasons would be more similar in dyads that made mutual decisions to terminate therapy, compared with dyads where both client and therapist agreed that termination was a unilateral decision on the client's part. To test this hypothesis, difference scores were calculated by subtracting therapist ratings from client ratings for each reason for termination separately (see Table 5); positive values indicate that, on average, the client assigned higher importance to the reason than did the therapist, and negative values indicate that the therapist assigned higher importance to the reason than did the client. A series of one-sample *t*-tests was conducted to determine whether difference scores were significantly different from zero. In light of the number of analyses, the alpha level for each comparison was set at .005. Difference scores that were significantly different from zero are indicated in Table 5.

For mutual terminators, none of the difference scores differed significantly from zero, indicating that client and therapist ratings of the importance of each reason for termination were very similar. In client-therapist dyads who agreed that the client made a unilateral decision to end therapy, clients rated the importance of one termination reason, *felt therapy was going nowhere so ended therapy*, $t(28) = 3.55$, $p<.001$, $d = 0.64$, significantly higher

than therapists (Table 5). The magnitude of differences between client and therapist importance ratings, although in the expected direction, was not large enough to be considered meaningful for the following reasons: *Accomplished what you wanted to do in therapy*, $t$ (28) = 2.51, *ns* , *Felt therapy was making things worse so stopped*, $t(28) = 2.05$, *ns*, *Weren't confident in therapist's ability to help*, $t(28) = 2.12$, *ns*, and, *Therapy didn't fit with ideas about what would be helpful*, $t(28) = 2.16$, *ns*.

To test whether client-therapist perspectives on reasons for termination differed to a greater extent in the unilateral compared with the mutual termination group, a one-way MANOVA was conducted to compare the magnitude of difference scores between groups. The multivariate test of between-subjects effects was significant, Wilk's $\lambda = 0.58$, $F(10, 70) = 5.11$, partial $\eta^2 = .42$, $p<.001$. Follow-up univariate analyses, keeping the familywise alpha at .05, indicated that client-therapist difference scores were significantly larger in the unilateral group for reasons of *Felt therapy was going nowhere so ended therapy*, $F(1, 79) = 22.37$, $p<.001$, partial $\eta^2 = .22$, *Felt therapy was making things worse so stopped*, $F(1, 79) = 8.14$, $p<.005$,partial $\eta^2 = .09$, *Weren't confident in therapist's ability to help*, $F(1, 79) = 7.93$, $p<.005$, partial $\eta^2 = .09$ and *Therapy didn't fit with ideas about what would be helpful*, $F(1, 79) = 8.44$, $p<.005$, partial $\eta^2 = .10$. Overall, it appears as though clients who unilaterally decided to end therapy rated reasons related to the unhelpfulness of therapy as more important to their termination decisions than did their therapists. It seems as though, even when therapists recognized that the client made a unilateral decision to leave, therapists may not have been aware of the full extent of the importance of clients' negative perceptions of the therapy experience and of the therapist.

**Congruence Between Client and Therapist Views on the Quality of the Working Alliance. Hypotheses 1b and 2b**

Repeated measures analysis of variance with dyad member as the repeated factor was used to examine hypotheses that: (1b) client-therapist dyads who mutually terminated therapy would report a stronger working alliance than that reported by the unilateral decision dyads, and, (2b) clients' and therapists' ratings of the working alliance would be more discrepant when termination was a unilateral decision on the client's part than when the decision was mutual. The test of between-subjects effects indicated that client-therapist dyads in the mutual termination group rated the working alliance slightly but significantly higher than dyads in the unilateral termination group, $F$ (1, 78) = 5.39, $p$<.05, $\eta^2$ = .07. Dyads in the mutual group reported a mean of 69.71 (*SE* = 1.30), whereas dyads in the unilateral group reported a mean of 64.71 (*SE* = 1.72). The test of within-subjects effects indicated that, across termination groups, clients rated the working alliance significantly higher than did therapists, $F$(1, 78) = 5.08, $p$<.05, $\eta^2$ = .06. Clients reported a mean of 68.67 (*SE* = 1.38), whereas therapists reported a mean of 65.74 (*SE* = 1.12). The Dyad member X Termination status interaction was not significant, indicating that the magnitude of the difference between client-therapist ratings of the working alliance was similar in unilateral and mutual terminators, $F$(1,78) = 3.44, *ns*.

**Congruence Between Client and Therapist Views on Barriers to Treatment Participation. Hypotheses 1c and 2c**

Repeated measures analysis of variance with dyad member as the repeated factor was used to examine hypotheses that: (1c) client-therapist dyads who mutually terminated therapy would report fewer barriers to treatment participation than did the unilateral decision

dyads, and, (2c) clients' and therapists' ratings of barriers to treatment would be more discrepant when termination was a unilateral decision on the client's part than when it was a mutual decision. The test of between-subjects effects indicated that client-therapist dyads in the unilateral termination group reported more barriers to treatment than dyads in the mutual termination group, $F(1, 81) = 35.41$, $p<.001$, $\eta^2 = .30$. Dyads in the unilateral group reported a mean of 61.50 ($SE = 1.56$) whereas dyads in the mutual group reported a mean of 49.78 ($SE$=1.20). The test of within-subjects effects indicated that, across termination groups, clients reported significantly more barriers to treatment than did their therapists, $F(1, 81) = 4.94$, $p<.05$, $\eta^2 = .06$. Clients reported a mean of 57.48 ($SE = 1.30$), whereas therapists reported a mean of 53.80 ($SE = 1.27$). The Dyad member X Termination status interaction was not significant, indicating that the magnitude of the difference between client-therapist ratings of barriers to treatment was similar in unilateral and mutual terminators, $F(1,81) = 1.59$, *ns*.

## Discussion

In an effort to better understand unilateral termination, the present study examined the congruence in perspectives of client-therapist dyads regarding important therapeutic variables, including clients' reasons for termination, working alliance, and barriers to treatment between two groups where a) both client and therapist agreed that termination was a unilateral decision on the client's part, or b) both client and therapist agreed that termination was mutual. As hypothesized, results of our study indicated that unilaterally terminating clients, compared with mutual terminators, rated the importance of having accomplished their goals in therapy as less important to their decision to end therapy, and reasons related to circumstantial barriers and dislike of therapist and therapy as more

important to their decision. Therapists reported a similar pattern of results; therapists of unilateral terminators, compared with therapists of mutual terminators, reported that their clients' accomplishing goals in therapy was less important to their decisions, and that reasons related to circumstantial barriers and dislike of therapist and therapy were more important to their decisions.

When client-therapist assessments were examined within each dyad, small, but systematic differences in attributions of clients and their therapists became evident. When termination decisions were mutual, there was no difference between client and therapist ratings of the importance of any termination reason. When clients terminated therapy unilaterally, compared with their therapists, they rated four out of ten reasons for termination as significantly more important to their decision to leave. They ascribed higher importance to all of the reasons related to dislike of therapy or therapist: *felt therapy was going nowhere so ended therapy*, *felt therapy was making things worse*, *weren't confident in therapist's ability to help*, and *therapy did not fit with ideas about what would be helpful*. Clients and therapists rated the importance of more benign and circumstantial barriers similarly.

Outcome data collected in the study also reflect a perspective divergence between clients and therapists in the unilateral, but not the mutual, termination group; unilateral terminators rated their distress as significantly lower at post-therapy whereas their therapists indicated no change in functioning. In contrast, clients in the mutual termination group reported a similar decline in distress from pre-therapy to post-therapy, and their therapists agreed with them, reporting a significant increase in functioning.

These results build on previous research showing that therapists tend to perceive both treatment success and failure differently than clients (Hunsley et al., 1999; Pekarik &

Finney-Owen, 1987). Directly comparing client and therapist ratings, results from the present study indicate that these differences in perception occur exclusively around unilateral termination. When termination was a unilateral decision on the client's part, therapists appeared not to be aware of the extent to which clients' perceived either success in therapy (i.e., symptom improvement) or failure. Given the small differences in client and therapist ratings, therapists were largely aware of clients' dissatisfaction, but tended to rate the importance of clients' dissatisfaction reasons as less important than they actually were. This could reflect both self-serving biases (whereby therapists are not as likely to rate themselves too negatively) and differing expectations about what will be accomplished in therapy. It likely also reflects the limited communication inherent in unilateral decision-making; clients may be unlikely to share the extent of their negative perceptions of therapy and the therapist.

Results from the present study regarding therapeutic alliance data were in line with previous research; the early alliance, rated after the third therapy session by both client and therapist, was related with type of termination decision. As we hypothesized, client-therapist dyads who made mutual decisions to end therapy reported a stronger working alliance early in treatment than did client-therapist dyads where the client terminated unilaterally. Contrary to our expectations that mutually terminating dyads would have more similar perceptions of the working alliance, regardless of how clients terminated therapy, all clients rated the early alliance significantly higher than did their therapists. It seems as though the tendency, well-documented in the literature (e.g., Bachelor & Salame, 2000; Fitzpatrick, Iwakabe, & Stalikas, 2005; Hersoug, Hoglend, Monsen, & Havik, 2001; Hilsenroth, Peters, & Ackerman, 2004; Tryon et al., 2007), for clients to rate the working alliance as higher than their therapists holds true in spite of eventual unilateral decisions to leave, and poorer therapeutic

outcome. Fitzpatrick et al. (2005) assessed client-therapist alliance ratings in early, middle, and late phases of therapy and found that once formed, divergence between client and therapist remained unchanged, and alliance ratings for both clients and therapists increased linearly. Although there has been no systematic investigation into why clients rate the alliance as higher, Tryon et al. (2007) suggested that therapists may rate clients relative to alliances formed with other clients, while clients may rate therapists in comparison to other health professionals who may take a less collaborative, more paternalistic role, or to friends and family members experienced as (naturally) less collaborative.

A similar pattern of results was found for barriers to treatment participation. Both client and therapist dyads who made mutual decisions to end therapy indicated fewer barriers to treatment than did clients and therapist dyads where the client made a unilateral decision to leave. Contrary to hypotheses, there was no difference in client-therapist perspective congruence between unilateral and mutual decision groups. In general, clients rated barriers to treatment participation as higher than did therapists. This was the first study, to our knowledge, that examined Kazdin's barriers to treatment participation scale in adult clients. More barriers to treatment reported by clients and therapists of adult clients are associated with unilateral termination decisions, just as more barriers to treatment reported by parents of children and adolescents with conduct problems are associated with premature termination in Kazdin and colleague's (1997) research on dropping out of child treatment.

Our pattern of results was different than Kazdin et al. (1997) in that clients in our study reported significantly more barriers than did their therapists, whereas parents of conduct-disordered children in Kazdin et al.'s study reported significantly fewer barriers than did their therapists. This may be due to differences in client demographics and presenting

problems, or therapist experience (our study took place in a training clinic). Further research should be conducted to replicate our results, however, our study indicates that therapists can expect that as clients experience more barriers, they are more likely to make unilateral decisions to leave therapy.

As mentioned by Kazdin and Wassell (2000), the timing of assessment of perceived barriers (and reasons for termination) raises issues, as it was conducted at the end of therapy, after termination decisions had already been made. Retrospective reporting always runs the risk of biased recall, however, given the relatively short time frame of treatment, and that the timing of the post-therapy assessment was within one month after termination, recall bias of retrospective reporting is less likely. Due to logistical constraints, the time-lag between end of therapy and completion of the BTPS and the reasons for termination measure was within one month for unilateral terminators, and within one week for mutual terminators, potentially adding further measurement biases of an unknown nature. It is possible that treatment outcome influenced our results: mutually terminating clients were less symptomatic and higher functioning post-therapy and, therefore, may have reported fewer barriers as a result of experiencing greater improvement. As Kazdin and Wassell (2000) discussed, assessing barriers at other therapy points (e.g., early in treatment, or on multiple occasions throughout treatment) have their own methodological and practical liabilities (e.g., clients not having a complete idea of barriers early in treatment, confounding number of assessment administrations with duration in treatment and possibly sensitizing clients to the challenges of attending psychotherapy). Future research should examine other methods of assessing barriers to treatment throughout the therapy process.

In conclusion, this was the first study to obtain parallel information from both members of the client-therapist dyad about specific reasons why the client terminated services, and to examine how these perspective divergences regarding reasons for termination, early working alliance, and barriers to treatment participation are related to unilateral termination. When clients made unilateral decisions to end therapy, therapists were only partially aware of either the extent of clients' perceiving success in therapy or with their dissatisfaction. Although working alliance and barriers to treatment participation were rated as lower in the context of unilateral termination by both clients and therapists, all clients, in general, rated the early alliance and barriers to treatment as higher than their therapists. Future research should examine the utility of providing therapists with feedback regarding barriers to treatment and other process variables in terms of retaining clients in therapy. Preliminary research (Manfred-Gilham, Sales, & Koeske, 2002) suggests that therapists use more engagement strategies (particularly direct discussion of barriers) when they perceive clients to have more barriers, however, no research has examined how therapists' use of these strategies impacts client perception of barriers or influences treatment retention.

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## Footnotes

Hierarchical linear modeling (HLM; Maguire, 1999; Raudenbush & Bryk, 2002) was also used to analyze hypotheses concerning the working alliance and barriers to treatment participation. Results identical to those found with the repeated measures ANOVAs were obtained. Therefore, we chose to report the more commonly understood general linear modeling approach.

Table 4

*Means and Standard Deviations of Client and Therapist Ratings of the Importance of Termination Reasons.*

| Reason for Termination | Client Mutual | Client Unilateral | Therapist Mutual | Therapist Unilateral |
|---|---|---|---|---|
| Accomplished goals | 3.2 (1.2)[a] | 2.2 (1.1)[b] | 3.1 (1.1)[1] | 1.6 (0.9)[2] |
| Could no longer fit time or therapy into schedule | 1.1 (0.6)[a] | 2.1 (1.2)[b] | 1.3 (0.6)[1] | 2.5 (1.3)[2] |
| Just lost interest in therapy | 1.1 (0.4)[a] | 1.8 (1.2)[b] | 1.2 (0.5)[1] | 2.1 (1.0)[2] |
| No longer had money or insurance coverage | 1.1 (0.6)[a] | 1.8 (1.2)[b] | 1.1 (0.3) | 1.4 (1.0) |
| Felt therapy was going nowhere so ended therapy | 1.0 (0.3)[a] | 2.5 (1.2)[b] | 1.1 (0.4)[1] | 1.6 (1.1)[2] |
| Felt therapy was making things worse | 1.0 (0.2)[a] | 1.8 (1.3)[b] | 1.1 (0.3) | 1.5 (1.1) |
| Weren't confident in therapist's ability to help | 1.1 (0.3)[a] | 2.2 (1.3)[b] | 1.1 (0.4)[1] | 1.7 (1.0)[2] |
| Uncomfortable talking about personal matters | 1.0 (0.2)[a] | 1.9 (1.2)[b] | 1.1 (0.3)[1] | 1.6 (1.0)[2] |
| Therapy did not fit with ideas of what would be helpful | 1.2 (0.5)[a] | 2.1 (1.2)[b] | 1.2 (0.6) | 1.6 (1.0) |

| | | | | |
|---|---|---|---|---|
| Decided to go elsewhere for services | 1.3 (0.9) | 1.5 (0.8) | 1.3 (1.0) | 1.5 (1.0) |

*Note.* Within clients, columns with different superscript letters differed from each other at least at $p<.005$. Within therapists, columns with different superscript numbers differed from each other at least at $p<.005$

Table 5

*Difference Scores and Standard Deviations (Client Importance Ratings Minus Therapist Importance Ratings) of Reasons for Termination.*

| Reason for Termination | Unilateral<br>*n* = 29 | Mutual<br>*n* = 52 |
|---|---|---|
| Accomplished goals | 0.6 (1.2) | 0.1 (0.9) |
| Could no longer fit time or therapy into schedule | -0.3 (1.4) | -0.1 (0.5) |
| Just lost interest in therapy | -0.3 (1.4) | -0.0 (0.4) |
| No longer had money or insurance coverage | 0.3 (1.0) | 0.1 (0.6) |
| Felt therapy was going nowhere so ended therapy | 0.9 (1.4)*[a] | -0.0 (0.3)[b] |
| Felt therapy was making things worse | 0.4 (1.1)[a] | -0.0 (0.3)[b] |
| Weren't confident in therapist's ability to help | 0.6 (1.4)[a] | -0.0 (0.5)[b] |
| Uncomfortable talking about personal matters | 0.3 (1.4) | -0.1 (0.3) |
| Therapy did not fit with ideas of what would be helpful | 0.6 (1.4)[a] | -0.1 (0.6)[b] |
| Decided to go elsewhere for services | -0.1 (1.2) | 0.0 (0.7) |

*$p<.001$ indicate significant differences from zero.

*Note.* Columns with different superscripts differed from each other at least at $p<.005$

# CHAPTER 4

## Psychologists' Perspectives on Therapy Termination and the Use of Therapy Engagement Strategies

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Abstract

Canadian psychologists ($N = 269$) were surveyed regarding their perspectives on client reasons for termination at different points in therapy and their use of strategies to engage and retain clients in therapy. Psychologists reported that one-third of their caseload unilaterally terminated and assigned differential importance to termination reasons depending on whether termination was before versus after the third session. Psychologists' theoretical orientation (CBT versus other) was not associated with their views of reasons for termination, but was associated with their use of some engagement strategies. Despite these differences, all psychologists reported at least occasional use of most engagement strategies. Future research should examine psychologists' perspectives on and barriers to using these strategies, along with comparative effects of their addition to different forms of therapy and different client problems.

# Psychologists' Perspectives on Therapy Termination and the Use of Therapy Engagement Strategies

Five decades of research on client psychotherapy attrition does not appear to have been translated into consistently reduced rates of client dropout in clinical practice (Barrett, Chua, Crits-Cristoph, Gibbons, & Thompson, 2008; Swift, Levine, & Callahan, 2009). Clients in routine practice settings attend a median of three to five sessions (e.g., Hansen, Lambert, & Forman, 2002), much lower than the 13 to 18 sessions that dose-response studies have repeatedly shown are necessary to achieve clinically significant change for the majority of clients (Hansen et al., 2002; Howard, Kopta, Krause, & Orlinsky, 1986). The reasons for clients' attending so few sessions has been researched for some time, however the extent to which therapists are aware of this research and modify their practices in order to address relevant issues is less well-known. Knowledge of effective methods that therapists can employ to engage and retain clients in therapy is also limited (Barrett et al., 2008). The present study was designed to provide information about psychologists' perspectives of reasons for their clients' termination, and the strategies psychologists use to engage and appropriately retain their clients in therapy.

Numerous studies have examined clients' reasons for ending therapy (Bados, Balaguer, & Saldana, 2007; Hunsley, Aubry, Vestervelt, & Vito, 1999; Hynan, 1990; Pekarik, 1992; Renk & Dinger, 2002; Roe, Dekel, Harel, & Fennig, 2006; Todd, Deane, & Bragdon, 2003; Westmacott & Hunsley, 2010; Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010). Broadly, the reasons emphasized in this research generally reflect a) goal attainment or substantial improvement in therapy, b) client-centered reasons

(demographic or psychological characteristics of the client, or dynamic factors such as insufficient motivation), c) therapist or therapy-centered reasons (such as perceptions of therapist incompetence or dislike of therapist or therapy), and d) circumstantial barriers (such as scheduling conflicts or difficulties in paying for treatment). Clients who make unilateral decisions to end therapy, compared with clients who make such a decision together with their therapists (i.e., mutual terminators), are more likely to meet criteria for a mental disorder, and therefore, are in greater need of services (Kazdin, Mazurik, & Siegel, 1994; Westmacott & Hunsley, 2010), tend to be less satisfied with services (Lebow, 1982), and are less likely to have improved (Pekarik, 1986; Prinz & Miller, 1994; Saatsi, Hardy, & Cahill, 2007). Compared with mutual terminators, they are less likely to report leaving because they accomplished their goals in therapy, and are more likely to report leaving therapy for reasons such as feeling that therapy was going nowhere, a lack of confidence in their therapist's ability to help, or circumstantial barriers (e.g., Westmacott et al., 2010).

**Reasons for Early versus Later Unilateral Termination**

As all therapists know, some clients seek services but do not engage in therapy, other clients engage in therapy but then make unilateral decisions to end therapy earlier than therapists deem appropriate, and still other clients engage in treatment and make mutual decisions with therapists to terminate. There is some evidence to suggest that there are factors that are causally linked to early unilateral termination: failure on the part of the therapist to return calls within a short time period (i.e., more than one day; Saporito, Barrett, McCarthy, Iacoviello, & Barber, 2003), extended time on the waiting list (Festinger, Lamb, Marlowe, & Kirby, 2002; Manthei, 1996; Stasiewicz & Stalker, 1999), first impressions of therapists (Alcázar Olán, Deffenbacher, Hernández Guzmán, Sharma, & de la Chaussée

Acuña, 2010; Beckham, 1992;), support staff and clinic facilities (Chua & Barrett, 2007; Gunzburger, Henggeler, & Watson, 1985), satisfaction with the intake session (Kokotovic & Tracey, 1987), costs associated with therapy (Manthei, 1996), circumstantial barriers (Hynan, 1990; Manthei, 1996), and a longer wait time from intake to first treatment session (Rodolfa, Rapaport, & Lee, 1983). Evidence suggests that individuals who drop out before attending any therapy, or who terminate after attending one or two sessions, are a heterogeneous group and further investigation is required to determine the different reasons why some people choose not to follow through with services. It is clear, however, that many clients who terminate before engaging in therapy do not do so because their problems have resolved. Given that client reasons for termination may vary at different points in the therapy process, therapists' understanding of the processes contributing to early termination is likely to be inaccurate if researchers examine unilateral terminators as a homogeneous group (Barrett et al., 2008; Kokotovic & Tracey, 1987). Accordingly, the present study was designed to examine reasons for termination separately for clients who unilaterally end therapy before attending three sessions (i.e., nonengagers) versus for clients who more fully engage in the therapy process but end their treatments unilaterally. The third session was chosen as a practical cut-off because of its identification as an important milestone in the psychotherapy literature. Specifically, quality of the working alliance is established within three sessions (Eaton, Abeles, & Gutfreund, 1988), and follow-up studies have shown that clients attending one or two sessions of therapy tend to become worse, improve less, or become more symptomatic (depending on the measure) than clients attending three or more sessions (Pekarik, 1983a, 1983b, 1992).

**Therapists Perspectives of Client Reasons for Termination**

Therapist awareness of the extent of client unilateral termination is, presumably, a motivating factor to take action, when appropriate, to actively engage and retain clients in therapy. Unfortunately, research shows that therapists significantly underestimate the proportion of unilateral terminators in their practices (Pekarik & Finney-Owen, 1987; Pulford, Adams, & Sheridan, 2008), perhaps as a result of spending much of their time with longer-term clients (Pekarik & Finney-Owen, 1987; Vessey, Howard, Lueger, Kächele, & Margenthaler, 1994). Together with awareness of the prevalence of unilateral termination, understanding clients' reasons for leaving is a prerequisite for taking appropriate action. For example, therapists who are aware that many clients end their treatments because they are dissatisfied may be more likely to actively elicit and address clients' negative perceptions and to create a therapeutic atmosphere in which clients feel comfortable expressing negative concerns.

Some researchers have investigated therapists' perspectives of client reasons for termination (Hunsley, Aubry, Vestervelt, & Vito, 1999; Murdock, Edwards, & Murdock, 2010; Pekarik & Finney-Owen, 1987; Renk & Dinger, 2002; Roe, Dekel, Harel, & Fennig, 2006; Todd, Deane, & Bragdon, 2003; Westmacott et al., 2010). Researchers who have compared client and therapist reasons for termination have found that therapists and clients tend to agree about reasons related to improvement in therapy and circumstantial barriers, however, clients' negative perceptions of therapy often go unnoticed by therapists, or are attributed to clients' low motivation or lack of time (Hunsley et al., 1999; Pekarik & Finney-Owen, 1987; Todd et al., 2003). Furthermore, therapists appear to have greater difficulty identifying reasons for clients' unilateral decisions to end therapy than they do for mutual decisions to end treatment. This is likely due, in large part, to being involved in such a

decision with mutual, but not unilateral, terminators. Nevertheless, in the context of unilateral termination, therapists tend to underestimate clients' negative perceptions of both therapy and therapist, and clients' perceptions of their goal attainment (Hunsley et al., 1999; Westmacott et al, 2010). Therapists may underestimate clients' positive therapy gains due to differences in expectations and because clients may not reveal all positive changes, and therapists may be unable to fully appreciate negative reactions in treatment because clients often hide these feelings (e.g., Hill, Thompson, Cogar, & Denman, 1993; Hannan et al., 2005; Regan & Hill, 1992).

Attributional biases may also interfere with therapists fully recognizing their roles in unilateral termination (Campbell & Sedikides, 1999; Kendall et al., 1992; Malle, 2006; Murdock, Edwards, & Murdock, 2010). Murdock et al. (2010) presented 243 psychologists with two case study vignettes describing client unilateral termination that varied only in whether the client was referred to as "your client" or "the client". Their results suggested a self-serving bias among psychologists' responses, with participants showing a tendency to blame the therapist when the vignette was "the client" and showing a tendency to blame the client in the "your client" condition. The size of the self-serving bias was larger for male therapists than for female therapists, and larger for psychodynamic therapists than for CBT or existential/interpersonal therapists. Cognitive-behavioral therapists did not have different attributions for termination in the two client conditions. It may be that cognitive-behavioral therapists' training emphasizing environmental influences on behavior partially mitigates natural tendencies toward the fundamental attribution error. In another study, Kendall et al. (1992) asked 315 experienced therapists about specific clients who had failed to benefit from therapy. Therapists cited their clients' inability to benefit from and lack of motivation for

treatment as the most important reasons for lack of progress, although rating themselves as the least likely cause of their clients' lack of progress. Theoretical orientation influenced therapist perspectives: cognitive-behavioral therapists attributed significantly less responsibility to the client compared to attributions made by psychodynamic, humanistic, and eclectic therapists. In addition to examining therapists' perspectives of client reasons for termination early versus later in therapy, the present study is designed to shed light on how theoretical orientation may influence therapists' perspectives on client reasons for termination.

**Therapist Behaviors that Foster Mutual Decisions to End Psychotherapy**

There is an important literature on the types of strategies that therapists can use to increase engagement and reduce unilateral termination. Barrett et al. (2008), Ogrodniczuk, Joyce, and Piper, (2005), and Walitzer, Dermen, and Connors, (1999), have conducted comprehensive reviews of this literature and have identified the following strategies as having some empirical support: Preceding therapy, clinicians can select clients most suitable for a particular treatment (Baumann et al., 2001; Keijsers et al., 1999), set time limits on treatment (Sledge et al., 1993), and engage the client in pretreatment preparation. Pretreatment preparation can include role induction (educating clients about the rationale for, process of, and prognosis for treatment), vicarious therapy pretraining (providing clients with examples of therapy, such as videos), and experiential pretraining (engaging clients in a simulation of therapy that is typically conducted in a group therapy context; Walitzer et al., 1999). Engagement strategies that can be used throughout treatment include case management (providing support to the client regarding life circumstances that may preclude participation in therapy; Miranda, Azocar, Organista, Dwyer, & Arean, 2003), appointment

reminders, motivation enhancement (Carroll, Libby, Sheehan, & Hyland, 2001; Joe, Simpson, Greener, & Rowan-Szal, 1999; Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992), facilitation of therapeutic alliance (Tryon & Kane, 1993), facilitation of affect expression (Bernard & Drob, 1989), and systematic monitoring of client progress (Castonguay et al., 2004; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005; Safran, Muran, Samstag, & Stevens, 2002; Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003).

No research, to our knowledge, has been conducted regarding whether therapists explicitly employ these engagement strategies in routine practice. Furthermore, it is also unclear whether therapeutic orientation serves to guide therapists in their use of these strategies. Given that cognitive-behavioral therapy (CBT), compared with psychodynamic, interpersonal, and humanistic therapies, is likely to be a more structured, time-limited, circumscribed intervention (Blagys & Hilsenroth, 2002), CBT practitioners may be more inclined than others to use these strategies (i.e., appointment reminders, case management, setting a time limit on the number of therapy sessions, and systematic client monitoring). Traditionally, other approaches are more centrally focused on the role of the therapeutic relationship in the treatment process and, as such, may lead therapists using these other orientations to focus more on building the early working alliance than on utilizing other engagement strategies. These speculations remain untested, and the present study is designed to shed light on this issue.

**The Present Study and Hypotheses**

In summary, unilateral terminators may have different reasons for early versus later termination. Therapists' perspectives of clients' reasons for terminating early versus later in

the treatment process have not been explored. Understanding therapist perspectives is essential to understanding processes related to clients' choosing not to engage in therapy and making unilateral decisions to end therapy once it has been initiated. Therapists' awareness of the frequency of unilateral termination, their perspectives of client reasons for terminating, and their theoretical orientation may all influence the actions that therapists take to engage and retain clients in therapy. Although several researchers have demonstrated the effectiveness of some of these strategies, no study, to our knowledge, has been conducted to examine their use in routine practice.

Our goal in the present study was to examine practicing psychologists' perspectives of reasons for termination for their clients who a) unilaterally terminated therapy before the third session, b) unilaterally terminated after attending at least three sessions, and, c) mutually terminated therapy. A second study goal was to examine whether psychologists, in routine practice, used empirically-based strategies to engage clients in therapy and reduce unilateral termination. Several specific hypotheses were formulated:

1) Comparing clients who terminated mutually with the psychologist and clients who terminated unilaterally (both before and after the third session), we predicted that psychologists would assign higher importance to symptom improvement and less importance to all other reasons.

2) We predicted that the importance assigned to reasons for early versus later unilateral termination would differ. For clients who terminated before the third session, versus after the third session, psychologists would assign higher importance to circumstantial barriers, clients having to wait too long for services, and clients having initial negative impressions.

3) We predicted that theoretical orientation would influence psychologists' perspectives of reasons for unilateral termination. Psychologists reporting a CBT orientation, versus other orientations, would ascribe less importance to reasons that attributed fault to the client for both early and later unilateral terminators (i.e., insufficient motivation; clients were unable to benefit).

4) We predicted that theoretical orientation would influence the frequency of psychologists' use of engagement strategies. Psychologists reporting a CBT orientation, versus other orientations, would be more likely to use practical strategies such as appointment reminders, case management, setting a time limit on the number of therapy sessions, and systematic client monitoring.

## Method

### Participants

Psychologists and psychological associates (i.e., in some jurisdictions, those registered at the masters level) who provided individual psychotherapy to adults were recruited through several psychological organizations and regulatory bodies throughout Canada[1]. A notification about the study was sent electronically to members of the clinical section of the Canadian Psychological Association (CPA), the College of Psychologists of Ontario, and the Ottawa Academy of Psychologists. A bulletin was posted in the electronic newsletters of the Alberta Psychological Association and the Association of Psychologists of Nova Scotia. Personalized email requests were sent by the first author to 1,365 members of the Canadian Register of Health Service Providers in Psychology who were listed as

[1] For simplicity, we refer to all participants as psychologists.

providing individual therapy to adults. A link to the survey was also posted on the CPA's online Recruit Research Participants Portal.

**Procedure**

Potential respondents were emailed a brief study description: "*If you are a psychologist or psychological associate in supervised or autonomous practice and you provide individual psychotherapy to adults, we invite you to take 10 minutes to complete a survey examining issues around client termination*." Clicking on the link to the web survey took participants to an informed consent page where they either consented or rejected study participation based on detailed informed consent guidelines. Participants were asked about the proportion of clients in their own practices who terminated (a) before fully engaging in treatment (i.e., who terminated before the third session; the third session was chosen because of its identification as an important milestone in the psychotherapy literature, Eaton, Abeles, & Gutfreund, 1988; Horvath & Symonds, 1991; Reis & Brown, 1999), (b) after the third session, but unilaterally, or without agreement from the therapist, and, (c) mutually with the therapist. Participants were asked to rate the importance of reasons for ending psychotherapy separately, for all three types of terminators.

Participants were requested to provide their sex, age, whether they were registered with a masters or doctoral degree, number of years in independent practice, average number of individual psychotherapy clients per week, percentage of services provided to adults, children, and adolescents, and their dominant theoretical orientation (cognitive-behavioral, family systems, humanistic/experiential, interpersonal, psychodynamic, or other – please specify). Research ethics board approval was obtained for the study.

**Demographic Characteristics of the Sample.** Four hundred and forty-six psychologists consented to participate, but many of these individuals completed only the informed consent before discontinuing their participation. Two hundred and seventy-four psychologists provided complete responses. Data from participants who indicated that their client base was entirely comprised of children ($n$ = 1), or who indicated seeing zero clients per week ($n$ = 4) were removed before proceeding with further analyses, leaving 269 psychologists in the sample.

Two-hundred and seventeen participants (80.7%) were licensed on the basis of a doctoral degree, and 35 (13.0%) on the basis of a masters degree. Seventeen participants (6.3%) did not indicate their highest achieved academic degree. Two hundred and forty-one participants (89.6%) were in independent practice, eleven psychologists (4.1%) were in supervised practice at the time of the survey, and seventeen psychologists (6.3%) did not indicate their practice status. Of the 241 psychologists in independent practice, the mean number of years in practice was 16.4 ($SD$ = 10.4), with a median of 16, and a range from 1 to 40 years.

The mean age of the 246 psychologists who provided this information (23 did not provide age) was 49.8 years ($SD$ = 11.1), with a range from 25 to 71. The sample was comprised of 156 women (58.0%), 94 men (34.9%), and 19 participants (7.1%) who did not report their gender. The survey was available in both English and French: 254 psychologists (94.4%) completed the survey in English, and 15 (5.6%) completed the survey in French. Psychologists reported treating a mean number of 14.6 therapy clients per week ($SD$ = 8.7; range = 2 – 50; mode = 10). Most psychologists reported a primary theoretical orientation that was cognitive-behavioral ($n$ = 124, 46.1%); other psychologists self-identified their

orientations as other (*n* = 64, 23.8%), humanistic/experiential (*n* = 24, 8.9%), psychodynamic (*n* = 22; 8.2%), interpersonal (*n* = 17, 6.3%), and family systems (*n* = 2; 0.7%). Sixteen psychologists (5.9%) did not report a theoretical orientation. Of the psychologists who reported "other," nearly all (87.5%) indicated that they used a combination of the specified orientations. Psychologists' practices comprised a mean percentage of 85.8% adults (*SD* = 20.8), 9.6% adolescents (*SD* = 14.3), and 4.9% child clients (*SD* = 11.2).

**Measures**

**Reasons for Termination.** Participants were asked to rate the importance (0 = *not at all important*; 4 = *very important*) of ten reasons for termination. Reasons were drawn from the termination literature (e.g., Canadian Community Health Survey Cycle 1.2, 2002; Hunsley et al., 1999; Pekarik & Finney-Owen, 1987; Westmacott & Hunsley, 2010). Psychologists were asked to rate the importance of reasons for clients who (a) unilaterally ended treatment before the third session, (c) attended at least three sessions and terminated unilaterally, and, (d) terminated mutually. The ten possible reasons for termination were: a) *Clients reached their goals or symptoms improved*, b) *Clients wanted to solve their problems in another way*, c) *Clients were not ready to change or had insufficient motivation*, d) *Clients were unable to benefit from therapy*, e) *Clients believed that therapy was not helping*, f) *Clients disliked the treatment*, g) *Clients had to wait too long for services*, h) *Clients had negative impressions of my office or staff*, i) *Clients could not afford to pay*, and j) *Clients had circumstantial barriers such as transportation, childcare, or scheduling issues.* Psychologists were also provided with an *other – please specify* category.

**Psychologists' Use of Engagement Strategies.** Participants were asked about their current efforts to increase engagement and reduce unilateral termination in their practices.

Strategies were drawn from Ogrodniczuk et al.'s (2005) review of the literature on therapist strategies to reduce unilateral termination, with the added strategy of client treatment monitoring. Participants were requested to "*Please rate the extent to which you use the following strategies to increase engagement and reduce client unilateral termination in general in your practice."* Participants rated their frequency of use, on a scale of 0 (never use) to 4 (always use), of: a) client selection (either do not accept certain clients for therapy, or stop providing services if services are not working), b) in-depth pre-therapy preparation (i.e., prior to commencing therapy, teaching the client about the rationale for therapy, role expectations, how treatment progresses, common misconceptions about psychotherapy, and possible difficulties one may experience during therapy), c) being explicit about negotiating an agreed upon treatment plan, d) setting a time limit on the number of therapy sessions, e) using motivational enhancement (i.e., prior to beginning therapy, initiate procedures that increase the client's willingness to enter into and remain engaged in treatment), f) explicitly fostering a strong working alliance early in treatment, g) using case management (i.e., provide practical support to the client regarding difficult life circumstances that may preclude participation in therapy, (e.g., directly assisting the client with housing or employment problems, planning a budget, etc.), h) using appointment reminders, i) conducting systematic client monitoring (use of a periodic questionnaire or formal monitoring tool to assess client progress), and j) other – please specify.

## Results

In addition to testing our hypotheses, we conducted several descriptive analyses on factors associated with the reported frequency of different types of client termination and the

use of engagement strategies. We present these analyses first, followed by analyses that address our hypotheses.

**Proportions of Clients who Terminated at Different Points in Therapy**

Psychologists reported that the mean percentage of clients who terminated unilaterally before the third session was 13.1% (*SD* = 12.7%; median = 10%; mode = 5%). The mean percentage of clients who terminated unilaterally after the third session was 20.2% (*SD* = 17.0%; median = 15%; mode = 10%). The mean percentage of mutual terminators was 66.8% (*SD* = 23.3%; median = 75%; mode = 80%). Nine psychologists (3.4%) reported that none of their clients terminated before the third session, and a further 103 (summing to 42.3%) reported that 5% or fewer of their caseload terminated before the third session. Nine psychologists (3.4%) reported that no clients unilaterally terminated therapy after the third session, and a further 49 (summing to 22.0%) reported that 5% or fewer of their caseload terminated unilaterally after the third session. There were 18 (6.8%) psychologists who reported that fewer than 20% of their clients terminated mutually, however, the majority of psychologists (*n* = 105; 40.2%) reported that 80% or more of their clients terminated mutually.

Age, years in independent practice, and number of clients per week were not related to the percentages of clients reported as terminating unilaterally before the third session, unilaterally after the third session, or as being mutual terminators. Male psychologists (*M* = 23.5%, *SD* = 18.3%) reported a significantly greater percentage of clients terminating unilaterally after the third session than did female psychologists (*M* = 17.3%, *SD* = 15.9%), $F$ (1, 245) = 6.99, $p<.01$, $d$ = 0.36, and significantly fewer mutual terminators (*M* = 62.4%, *SD* = 23.2%) than did female psychologists (*M* = 70.6%, *SD* = 22.4%), $F$ (1, 246) = 7.54,

$p<.01$, $d = 0.36$. Male ($M$ =14.4%, $SD$ = 12.4%) and female psychologists ($M$ = 11.8%, $SD$ = 12.2%) did not significantly differ on the reported percentages of therapy nonengagers (i.e., those who terminated before the third session), $F$ (1, 246), = 2.57, *ns*.

**Perspectives of Reasons for Termination Within Client Groups**

As seen in Table 6, psychologists' rated multiple reasons as having some importance to all types of termination decisions. Three one-way repeated measures MANOVAs were conducted to examine differences in psychologists' ratings of reasons for termination within each category of termination. For clients who unilaterally terminated before the third session, the test of within-subjects effects indicated that there were significant differences in psychologists' ratings across reasons, $F$ (7.15, 1666.56) = 65.87, $p<.001$, $\eta^2=.220$. We were interested in examining reasons rated as most and least important. Psychologists rated *Clients were not ready to change, or had insufficient motivation* (65.7% *important* or *very important*) as higher in importance than any other reason (for all pairwise comparisons, $p<.0001$), *Clients had to wait too long for services* (15.8%) and *Clients had negative impressions of my office or staff* (9.5%) as lower in importance than any other reason (all $p<.0001$). For clients who unilaterally terminated after the third session, there were significant differences in psychologists' ratings across reasons, $F(6.25, 1481.52) = 107.59$, $p<.001$, $\eta^2= .312$. Psychologists rated *Clients reached their goals or symptoms improved* (54.8%) as higher in importance than any other reason (all $p<.0001$), and *Clients had to wait too long for services* (8.2%) and *Clients had negative impressions of my office or staff* (7.8%) as lower in importance than any other reason (all $p<.001$). In the case of mutual decisions to terminate, there were also significant differences in psychologists' ratings across reasons,

$F(5.40, 1333.50) = 289.03$, $p<.001$, $\eta^2=.539$. Psychologists rated *Clients reached their goals or symptoms improved* (97.0%) as higher in importance than any other reason (all $p<.0001$), but also rated a number of other reasons as having some importance, e.g., *Clients could not afford to pay* (27.0%).

**Psychologists' Use of Engagement Strategies**

Virtually all psychologists (96.8%) indicated that they often or always explicitly foster a strong working alliance early in treatment, whereas other strategies were reported much less frequently. Explicitly negotiating an agreed upon treatment plan (74.3% *often* or *always use*), and in-depth pre-therapy preparation (58.0% *often* or *always use*) were the next most frequently reported strategies. Between thirty and forty percent of psychologists reported often or always using motivational enhancement (38.7%), client selection (36.6%), and systematic client monitoring (33.0%). Approximately a quarter of psychologists reported frequent use of time-limited treatment (23.6%). Case management (19.3%) and appointment reminders (17.8%)[2] were the most infrequently endorsed strategies.

Age was significantly negatively associated with using engagement strategies in general ($r = -.19$, $p<.01$). More specifically, older psychologist age was associated with less frequent reported use of pre-therapy preparation ($r = -.14$, $p<.05$), explicitly negotiating an agreed-upon treatment plan ($r = -.25$, $p<.001$), setting a time limit on treatment ($r = -.14$, $p<.05$), motivational enhancement ($r = -.14$, $p<.05$), and case management ($r = -.15$, $p<.05$).

[2] Psychologists were also provided an *other-please specify in detail* category to elaborate on engagement strategies. Thirty-eight psychologists provided 49 strategies and 35 of these strategies (71.4%) could be coded into one of the 9 existing response options for the survey question. Of the other statements, several reflected (a) an encouragement to have clients comment on their experience of treatment and (b) the use the use of follow-up calls when clients missed appointments. Given the infrequency of these responses, they were not included in any planned statistical analyses.

Number of clients per week was negatively associated only with frequency of use of time-limited treatment ($r$ = -.20, $p$<.01). Setting the familywise α at .15 (see Tabachnick & Fidell, 2007), ANOVA indicated that female psychologists were more likely to focus on building the early working alliance, $F(1, 235) = 6.80$, $p$<.01, $\eta^2$=.028, and use an explicit treatment plan than were male psychologists, $F$ (1, 235) = 6.91, $p$<.01, $\eta^2$=.029.

**Perspectives of Reasons for Termination (Hypotheses 1 and 2)**

As shown in Table 6, the importance of possible reasons for termination varied according to the nature of the termination[3]. Several separate repeated measures analyses of variance were conducted to examine differences in psychologists' ratings of reasons across the three types of client termination. Multivariate analyses were not conducted because reasons for termination do not theoretically represent the same theme. To keep the familywise alpha at .15, a Bonferroni correction was applied to the 10 tests and only $F$ values below $p$<.015 were deemed significant (this strategy was used for the remainder of analyses in the present study). For tests in which the assumption of sphericity was violated, the Huynh-Feldt statistic was interpreted, as it has been shown to be the most accurate estimate (Tabachnick & Fidell, 2007).

*Insert Table 6 about here*

[3] A number of responses were given for the "*other – please specify*" category: 55 for the clients who terminated prior to the third session, 26 for clients who terminated unilaterally after the third session, and 23 for clients who terminated mutually. The majority of these responses were simply elaborations of the other ten response options available for the survey questions (i.e., 85.5% of responses for clients who terminated prior to the third session, 84.6% for clients who terminated unilaterally after the third session, and 82.6% for clients who terminated mutually). Of the responses that did not fit pre-existing categories, most of the responses for the first two groups of clients reflected that the psychologist did not have clients who terminated early or unilaterally, and most of the responses for the mutual termination clients reflected termination due to institutional policies. Given the infrequency of these responses, they were not included in any analyses on reported reasons for termination.

Psychologists assigned differential importance to all reasons across the three types of terminators: *Clients reached their goals or symptoms improved*, $F$ (1.79, 365.90) = 292.28, $p$<.001, $\eta^2$=.590 ; *Clients wanted to solve their problems in another way*, $F$ (1.92, 393.36) = 28.96), $p$<.001, $\eta^2$=.125; *Clients were not ready to change, or had insufficient motivation*, $F$ (1.88, 382.01) = 145.52, $p$<.001, $\eta^2$=.418; *Clients were unable to benefit from therapy*, $F$ (1.83, 371.31) = 19.23, $p$ <.001, $\eta^2$=.087; *Clients believed that therapy was not helping*, $F$ (2, 406) = 58.28, $p$<.001, $\eta^2$=.223; *Clients disliked the treatment*, $F$(2, 406) = 59.18, $p$<.001, $\eta^2$=.226; *Clients had to wait too long for services*, $F$ (1.51, 306.87) = 52.64, $p$<.001, $\eta^2$=.206; *Clients had negative impressions of my office or staff*, $F$ (1.64, 332.03) = 34.01, $p$<.001, $\eta^2$=.144; *Clients could not afford to pay*, $F$ (1.74, 355.63) = 47.15, $p$<.001, $\eta^2$=.189; *Clients had circumstantial barriers such as transportation, childcare, or schedule issues*, $F$(1.96, 397.98) = 46.15, $p$<.001, $\eta^2$=.185. Examination of pairwise comparisons indicated that Hypothesis 1 was fully supported; psychologists assigned significantly higher importance to *Clients reached their goals or symptoms improved,* and significantly lower importance to all other reasons, when clients mutually versus unilaterally terminated (see Table 6).

Hypothesis 2 was partially supported. As indicated in Table 6, the importance psychologists assigned to reasons for early versus later unilateral termination differed. For clients who terminated before versus after the third session, psychologists rated *circumstantial barriers*, *clients had to wait too long for services*, and *clients had negative impressions of my office or staff* as significantly more important. In addition, psychologists also rated *Clients were not ready to change, or had insufficient motivation*, and *Clients*

*disliked the treatment*, as significantly more important for clients who unilaterally terminated before versus after the third session, and significantly lower importance to *Clients reached their goals or symptoms improved.*

**Perspectives of Reasons for Termination: Impact of Theoretical Orientation (Hypothesis 3)**

One hundred and thirty-three psychologists who either indicated CBT as their dominant theoretical orientation, or explicitly indicated one of cognitive, behavioral, or cognitive-behavioral in combination with another orientation after selecting *Other orientation*, were compared with 106 psychologists who did not explicitly indicate CBT as a dominant approach (or as part of their response to *Other orientation*)[4]. Multiple between-subjects analyses of variance were conducted to examine differences in CBT vs. other psychologists' ratings of reasons for unilateral (before vs. after the third session) termination. CBT versus psychologists of other dominant orientations differed only on the importance assigned to *Clients could not afford to pay*, $F$ (1, 201) = 12.22, $p$<.001, $\eta^2$= .057, given as a reason for termination before the third session. CBT psychologists rated as significantly less important *Clients could not afford to pay* ($M$ = 1.9, $SD$ = 1.6) vs. other orientations ($M$ = 2.7, $SD$ = 1.3) $p$<.001, $d$ = 0.6. Psychologists with CBT versus other orientations did not rate other reasons for unilateral termination before the third session differently: *Clients reached their goals or symptoms improved*, $F$ (1, 201) = 0.47, *ns*; *Clients wanted to solve their problems in another way*, $F$ (1, 201) = 1.91, *ns*; *Clients were not ready to change or had insufficient motivation*, $F$ (1, 201) = 0.58, *ns*; *Clients were unable to benefit from therapy*, $F$

[4] Analyses were also conducted comparing only psychologists who explicitly selected CBT as their dominant orientation with psychologists who explicitly selected another dominant approach. Results were analogous.

(1, 201) = 0.48, *ns*; *Clients believed that therapy not helping*, *F*(1,201) = 0.30, *ns*; *Clients disliked the treatment*, *F*(1,201) = 0.03, *ns*; *Clients had to wait too long for services*, *F*(1, 201) = 0.40, *ns*; *Clients had negative impressions of my office or staff*, *F* (1,201) = 2.56, *ns*; *Clients had circumstantial barriers such as transportation, childcare, or schedule issues*, *F*(1,201) = 1.89, *ns*.

In terms of reasons for unilateral termination after the third session, no significant differences were found between psychologists reporting a CBT versus other orientation: *Clients reached their goals or symptoms improved*, *F* (1, 201) = 0.34, *ns*; *Clients wanted to solve their problems in another way*, *F* (1, 201) = 0.05, *ns*; *Clients were not ready to change or had insufficient motivation*, *F* (1, 201) = 0.37, *ns*; *Clients were unable to benefit from therapy*, *F* (1, 201) = 0.38, *ns*; *Clients believed that therapy was not helping*, *F*(1,201) = 0.85, *ns*; *Clients disliked the treatment*, *F*(1,201) = 0.15, *ns*; *Clients had to wait too long for services*, *F*(1, 201) = 2.10, *ns*; *Clients could not afford to pay*, *F*(1,201) = 6.55, *ns*; *Clients had negative impressions of my office or staff*, *F* (1,201) = 0.32, *ns*; *Clients had circumstantial barriers such as transportation, childcare, or schedule issues*, *F*(1,201) = 4.19, *ns*.

**Theoretical Orientation and Use of Engagement Strategies (Hypothesis 4)**

Multiple between-subjects analyses of variance were conducted to examine differences in CBT vs. other psychologists' ratings of the frequency of use of engagement strategies. Multivariate analyses were not conducted because strategies to retain clients in therapy do not theoretically represent the same theme.

*Insert Table 7 about here*

As indicated in Table 7, the only strategies used differentially by cognitive-behavioral psychologists were *Systematic client monitoring*, $F(1, 236)=9.84$, $p<.01$, $\eta^2=.040$, and *Set a time limit on the number of therapy sessions*, $F(1, 236) = 6.04$ $p=.015$, $\eta^2=.025$. CBT psychologists reported more frequent use of *Systematic client monitoring* ($M = 2.1$, $SD = 1.4$) versus psychologists reporting other orientations ($M = 1.6$, $SD = 1.3$), $d = 0.4$, and *Set a time limit on the number of therapy sessions* (CBT: $M = 1.9$, $SD = 1.1$; other: $M = 1.5$, $SD = 1.1$), $d = 0.4$. CBT versus other psychologists did not significantly differ in frequency of their use of other strategies: *Client selection*, $F$ (1, 236) = .08, *ns*; *In-depth pre-therapy preparation*, $F(1,236) = 0.83$, *ns*; *Be explicit about negotiating and agreed upon treatment plan*, $F(1,236) = 0.01$, *ns*; *Motivational enhancement*, $F(1,236) = 0.77$, *ns*; *Explicitly foster a strong working alliance early in treatment*, $F(1,236) = 1.98$, *ns*; *Case management*, $F(1, 236) = 0.04$, *ns*; or *Appointment reminders*, $F(1, 236) = 0.37$, *ns*.

## Discussion

The main purposes of this study were to examine (a) psychologists' perspectives of client termination from psychotherapy and (b) their self-reported use of engagement strategies. Psychologists in this study reported that relatively few clients terminated unilaterally before the third session ($M = 13\%$). Although direct comparisons cannot be made, consistent evidence from client data suggest that psychologists likely underestimated the proportion of clients who terminated treatment very early. For example, the estimation of 13% is inconsistent with actual client data showing that 35% - 50% of clients completing an intake do not attend the first therapy session (Garfield, 1986; Hansen et al., 2002; Phillips, 1985), and data showing that 40% of clients attend fewer than 3 sessions (Pekarik, 1983a).

Psychologists in this study reported that a mean of 20% of their clients unilaterally terminated after the third session, summing to a combined unilateral termination rate of 33%. This value is consistent with Pekarik and Finney-Owen (1987)'s sample of CMHC therapists who estimated dropout rates in their overall clinics (32.8%). Pekarik and Finney-Owen also collected clinic data for a portion of their therapist sample and found that although those therapists estimated their own dropout rate to be 31.3%, the actual clinic dropout rate was 64.1% (based on 64 consecutive terminations). Pulford et al. (2008) replicated the Pekarik and Finney-Owen study at an outpatient alcohol and drug treatment service, finding that therapists estimated that 32% of their clients unilaterally terminated (their proxy dropout measure was failure to attend a scheduled treatment session), although agency records indicated the mean rate of this form of client unilateral termination was actually 65%. Furthermore, the value of 33% reported by psychologists in Study 3 is low when compared with meta-analytic data showing that 47% of clients prematurely terminate (Wierzbicki & Pekarik, 1993). Although it is not possible to determine from Study 3 data without corresponding data on actual unilateral termination, it is likely that psychologists underestimated unilateral termination in their own practices, perhaps due to spending most of their time with longer term, mutually terminating clients (Vessey et al., 1994). This is problematic to the extent that psychologists take action to increase the likelihood appropriate termination decisions as a function of recognizing that unilateral termination is a significant problem.

**Psychologists Perspectives of Clients' Reasons for Termination**

**Unilateral termination.** We examined psychologists' perspectives of their clients' reasons for making unilateral decisions to end treatment both early and later in therapy. As

seen in Table 7, at least 30% of psychologists rated several reasons for termination as important or very important to clients' decisions to leave either before or after the third session, indicating that they perceived numerous reasons as potentially important to clients' unilateral decisions to end therapy. Despite attributing importance to a range of reasons, psychologists viewed insufficient motivation as the most important barrier to treatment engagement. These results indicate that psychologists in this study viewed clients as primarily responsible for failure to engage in treatment (Kendall et al., 1992). This view fits with Lambert's (1992) conclusion that up to 40% of the variance in outcome is attributable to client variables and extratherapeutic factors, including but not limited to internal and external factors such as social support, ego strength, psychological mindedness, and severity of distress. Lack of readiness for change is undoubtedly a reason for unilateral termination for some clients (e.g., Prochaska, Rossi, & Wilcox, 1991), regardless of whether or not psychologists accurately detect the frequency of such clients (i.e., psychologists' recall may be biased because of being able to recall such clients with particular ease due to the frustration they experienced with these unmotivated clients). A growing body of literature documents the dynamic nature of client motivation for change, and the role of motivational interviewing techniques in heightening client motivation (e.g., Arkowitz, Westra, Miller, & Rollnick, 2007). Accordingly, the potential for using motivational enhancement strategies for clients early in service provision seems as relevant now as it has been in the past.

For clients who terminated before versus after the third session, we expected that psychologists would view circumstantial barriers, wait list time and negative initial impressions as more important. Our hypotheses were supported in that psychologists rated these reasons as relatively more important to early terminators. Small to moderate in

magnitude, these differences should be viewed in the context that, across unilateral terminators, psychologists assigned the lowest importance of any reasons to the influence of wait time and client negative impressions of clinic and staff. In contrast to research showing that wait list length and negative impressions of office space or staff are important predictors of engagement in therapy (e.g., Festinger et al., 2002; Stasiewicz & Stalker, 1999), psychologists in this study did not view these factors as salient.

In addition to rating these reasons as particularly important for early terminators, psychologists rated insufficient motivation, and clients disliking treatment as significantly more important for clients who unilaterally terminated before versus after the third session. Psychologists rated symptom improvement as significantly more important for late versus early unilateral terminators. In fact, psychologists rated symptom improvement as the most important reason for drop out after the third session. This finding runs counter to previous conceptualizations of unilateral terminators as treatment failures (e.g., Garfield, 1986), and adds to existing research showing that at least a portion of unilateral terminations experience significant improvement in psychotherapy (Westmacott et al., 2010). In our view, it also provides evidence that later unilateral terminators should not be studied together with early unilateral terminators.

**Mutual Termination.** As hypothesized, when their clients made mutual decisions with them to end services, psychologists viewed symptom improvement as most important, and viewed all other reasons as far less important. As well, nearly 30% of psychologists rated as important or very important to their mutual decisions to terminate that clients could not afford to pay. In Canada, where the cost of psychological services often falls on consumers, this finding is unsurprising. However, only 2% of clients interviewed in the Canada-wide

Canadian Community Health Survey (Cycle 1.2, 2003) provided this reason (Westmacott & Hunsley, 2010). Approximately 20% of psychologists rated as important or very important that clients left because they wanted to solve their problems in another way, that clients had circumstantial barriers, and even that clients were not ready to change. These results indicate that psychologists did not always view mutual termination as an unqualified success.

**Theoretical Orientation**

Given preliminary evidence that CBT therapists may be less vulnerable than other therapists to the fundamental attribution error (i.e., attributing responsibility for failed therapy to clients; Kendall et al., 1992; Murdock et al., 2010), we hypothesized that theoretical orientation would influence psychologists' perspectives of client reasons for ending therapy. This hypothesis was not supported; theoretical orientation did not influence psychologists' perspectives of reasons for termination. Psychologists with CBT versus other orientations assigned higher importance to financial constraints for clients who terminated before versus after the third session. This was a small effect, and all other reasons were rated equivalently by therapists of different theoretical orientations, including insufficient motivation and clients being unable to benefit from therapy. This result provides evidence that specific reasons for unilateral termination are viewed similarly across both CBT and therapists of different theoretical orientations, perhaps reflecting increasing integration of psychotherapies (Norcross & Goldfried, 2005).

**Use of Engagement Strategies**

Nearly all psychologists (96.8%) reported that they often or always focus on building the early working alliance. Using an explicit treatment plan (74.3% *often or always use*), and pre-therapy preparation (58.0% *often or always use*) were the next most frequently reported

strategies. Nearly 40% of psychologists reported the regular use of client selection and motivational enhancement, and 33% of psychologists reported regular use of systematic client monitoring. Less than a quarter of psychologists reported frequent use of time-limited treatment, appointment reminders, or case management. Only one study is available for limited comparison; Cook, Biyanova, Elhai, Schnurr, & Coyne (2010) surveyed 2,200 mental health practitioners ($n$ = 374 psychologists) regarding what proportion of their clients in the preceding month received each of 60 psychotherapy techniques. Eighty-six percent reported that they focused on building the working alliance with most or all of their clients, and 18% reported that they used case management on most or all of their clients. Although a small effect, older psychologist age was associated with using over half of the engagement strategies significantly less often. This may reflect differences in graduate training as research demonstrating the effectiveness of engagement strategies continues to become more prominent in research and teaching.

We hypothesized that theoretical orientation would influence psychologists' choice of engagement strategies. This hypothesis was partially supported; psychologists reporting a CBT orientation reported more frequent use of systematic client monitoring, and time-limited treatment. In contrast to hypotheses, CBT versus psychologists reporting other orientations did not significantly differ in their use of appointment reminders and case management. Overall, it appears as though engagement strategies largely transcended theoretical orientation, and did not reflect theoretical or training differences given their similar self-reported use across psychologists. However, it is possible that these conclusions would not hold if use of engagement strategies were measured objectively (e.g., coding videotaped therapy sessions). Furthermore, more focused research may reveal different

patterns of use of engagement strategies for different client problems. It would be worthwhile for researchers to compare the additional utility of such engagement strategies when used for specific types of client problems.

The low frequency of use of case management and appointment reminders is notable. Clients with mental health problems often experience concurrent difficulty with practical life problems. Sometimes these practical issues become barriers to proceeding with therapy. Indeed, we have found that unilateral terminators perceive more barriers to treatment than do mutual terminators, and that therapists are not aware of the extent of client barriers (Westmacott et al., 2010). Given their ubiquity in medical and health-related professions, the use of appointment reminders would seem a simple and easy strategy to implement (Turner & Vernon, 1976). It would be worthwhile to examine psychologists' views of the utility of these strategies, as well as barriers to using them.

In summary, in this survey of Canadian psychologists regarding their perspectives on client reasons for termination at different points in therapy and their use of strategies to engage and retain clients in therapy, psychologists reported that one-third of their caseload unilaterally terminated. They also assigned differential importance to termination reasons for this depending on whether termination was before versus after the third session. Notably, psychologists rated multiple reasons as having at least some importance to all clients' decisions to leave therapy. Nevertheless, psychologists viewed lack of motivation as the most important barrier to treatment engagement. Theoretical orientation (CBT versus other) did not influence views of reasons for termination, but influenced use of engagement strategies. Psychologists reporting a CBT orientation, compared to psychologists reporting other orientations, reported more frequent use of time-limited treatment and systematic client

monitoring. Despite these differences, all psychologists reported at least occasional use of most engagement strategies. Future research should examine psychologists' perspectives on and barriers to using these strategies, along with comparative effects of their addition to different forms of therapy and different client problems.

**Limitations**

Although it was conducted with a relatively large group of psychologists recruited from diverse locations in Canada, a limitation of this study is that exact generalizability is unknown given the lack of data on nationally representative samples of psychologists. There are larger American and international surveys of therapists across mental health professions (Cook et al, 2010; Orlinksy, Botermans, & Ronnestad, 2001). In terms of Canadian psychologists, no representative studies exist for comparison.

Nomothetic survey data of psychologists' perspectives of their clients in general cannot speak to how psychologists view reasons pertaining to specific clients, or how they tailor their treatments and use of engagement strategies to specific clients. The method of measuring reasons for termination and engagement strategies is also limited in that recall biases may have prevented psychologists from accessing a proportionately accurate portrayal of both their clients' reasons for termination and their own use of engagement strategies. In other words, self-reported practices might not accurately represent what psychologists actually believe and do (Hoyt, 2002). This may be especially true for engagement strategies such as the early working alliance, which has become a truism in the psychotherapy literature (Watkins, 1997). Psychologists may vary in their conceptualizations about what building early working alliance looks like in practice. More objective measures might include video samples of random therapy sessions (as suggested by Cook et al., 2010) or real-time

sampling. It is also important to keep in mind that information on use of engagement strategies does not endorse their effectiveness (Prochaska & Norcross, 1983). Furthermore, as we have discussed previously (Westmacott & Hunsley, 2010), a more complete understanding of termination is made possible by gathering parallel data from clients and therapists (Cook et al, 2010; Westmacott et al., 2010). Despite these limitations, in order to improve psychotherapy services, it is essential to be aware of how practicing psychologists' perspectives generally fit with what is known about client termination and the present study serves as a an important first step.

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Table 6

*Psychologists' Perspectives of the Importance of Reasons for Termination for Clients Who Unilaterally Terminated Before the Third Session, After the Third Session, or Mutually Terminated (Mean, Standard Deviation, and Proportion of Psychologists Reporting the Reason as Important or Very Important to Clients' Termination Decisions)*

| | | Before third session *M (SD)* % Important or Very Important | After third session *M (SD)* % Important or Very Important | Mutual *M (SD)* % Important or Very Important |
|---|---|---|---|---|
| a) | Clients reached their goals or symptoms improved | 1.8 (1.5)[a] 32.7 | 2.7 (1.2)[b] 54.8 | 3.8 (0.5)[c] 97.0 |
| b) | Clients wanted to solve their problems in another way | 2.1 (1.2)[a] 36.6 | 2.0 ( 1.2)[a] 33.3 | 1.4 (1.2)[b] 21.1 |
| c) | Clients were not ready to change, or had insufficient motivation | 2.8 (1.2)[a] 65.7 | 2.2 (1.2)[b] 41.5 | 1.3 (1.3)[c] 18.4 |
| d) | Clients were unable to benefit from therapy | 1.5 (1.2)[a] 22.4 | 1.6 (1.2)[a] 25.5 | 1.1 (1.3)[b] 16.5 |
| e) | Clients believed that therapy was not helping | 2.0 (1.2)[a] 33.3 | 2.0 (1.2)[a] 38.8 | 1.2 (1.3)[b] 17.0 |
| f) | Clients disliked the treatment | 1.9 (1.2)[a] 31.4 | 1.7 (1.2)[b] 25.3 | 1.0 (1.3)[c] 14.3 |

| | | | | |
|---|---|---|---|---|
| g) | Clients had to wait too long for services | 1.0 (1.3)[a]<br>15.8 | 0.6 (1.0)[b]<br>8.2 | 0.4 (1.0)[c]<br>6.6 |
| h) | Clients had negative impressions of my office or staff | 0.9 (1.2)[a]<br>9.5 | 0.6 (1.0)[b]<br>7.8 | 0.4 (1.0)[c]<br>5.0 |
| i) | Clients could not afford to pay | 2.3 (1.5)[a]<br>48.1 | 2.2 (1.5)[a]<br>47.3 | 1.6 (1.4)[b]<br>27.0 |
| j) | Clients had circumstantial barriers such as transportation, childcare, or schedule issues | 2.1 (1.2)[a]<br>37.9 | 1.9 (1.2)[b]<br>33.5 | 1.4 (1.2)[c]<br>18.5 |

*Note.* Reasons were rated from 0 (Not At All Important) to 4 (Very Important). Within each reason, column entries with different superscripts differ from each other at least at $p<.01$.

Table 7

*Psychologists' Use of Engagement Strategies: A Comparison Between Psychologists with a CBT versus Other Orientation*

| | Dominant CBT | Other orientations |
|---|---|---|
| | *M (SD)* | *M (SD)* |
| Client selection | 2.2 (1.1) | 2.1 (1.0) |
| Pre-therapy preparation | 2.6 (1.2) | 2.5 (1.4) |
| Explicit treatment plan | 3.0 (0.9) | 3.1 (1.0) |
| Time-limited treatment | 1.9 (1.1)[a] | 1.6 (1.1)[b] |
| Motivational enhancement | 2.0 (1.3) | 1.9 (1.4) |
| Fostering early working alliance | 3.7 (0.6) | 3.8 (0.6) |
| Case management | 1.6 (1.1) | 1.5 (1.1) |
| Appointment reminders | 1.4 (1.3) | 1.2 (1.2) |
| Systematic client monitoring | 2.1 (1.4)[a] | 1.6 (1.3)[b] |

*Note.* Engagement strategies were rated from 0 (Never Use) to 4 (Always Use). Column entries with different superscripts differ from each other at least at $p<.017$.

# CHAPTER 5

## General Discussion

### Introduction

This dissertation was designed to improve understanding of client reasons for termination from adult psychotherapy from the perspectives of clients, trainees, and licensed psychologists. A handful of researchers had examined reasons for termination, however, the variability in treatment settings and small sample sizes rendered the generalizability of these reasons uncertain. Therefore, in Study 1, I used national data from the Canadian Community Health Survey (Cycle 1.2, 2003) to identify the prevalence and correlates of client reasons for termination in an epidemiological survey. A more complete picture of termination results from parallel consideration of client and therapist data, therefore, Study 2 was designed to examine the congruence in perspectives of client-therapist dyads regarding reasons for termination and other factors in therapy. Most researchers have surveyed trainees, and have assessed unilateral termination in general as opposed to assessing reasons separately for clients who leave early versus later in the therapy process. Therefore, Study 3 was designed to examine psychologists' perspectives of client reasons for termination at different points in the therapy process. A second study goal was to examine the strategies psychologists used to engage and retain clients in therapy. I will present and discuss the findings and limitations of each study individually. Following this, I will discuss implications of this research for future investigation and clinical practice.

### Study 1: Reasons for Terminating Psychotherapy: A General Population Study

I examined clients' self-reported reasons for ending psychotherapy and the associations among specific termination reasons with demographic variables (age, gender, income), mental disorder diagnoses (anxiety disorder, mood disorder, and substance dependence) and mental health care service provider (social worker/counselor/psychotherapist, psychologist, general practitioner, and psychiatrist). Despite being given the opportunity to endorse multiple reasons, most respondents (85.1%) chose to indicate only one reason for termination. Ending therapy because of feeling better, the most frequently reported reason, was reported by almost half of respondents (43.4%). This value is consistent with some clinic studies (44%, Hunsley et al., 1999; 45.5%, Roe et al., 2006), but is substantially larger than the values reported in others (25% in Renk & Dinger, 2002; 23.5% in Todd et al., 2003), underscoring the importance of using population-based data to provide estimates broadly applicable to various settings and service providers.

*You completed the recommended treatment* was reported by far fewer respondents (13.4%), potentially reflecting the limited number of therapeutic services in Canada that have a predetermined set of sessions (i.e., limits set by third party payers). *It was not helping* was endorsed by 14.1% of respondents, and the remainder of the termination reasons were each reported by about 5% of respondents, with two exceptions. The low-frequency of the response *You were too embarrassed to see the professional* (0.4%) may be due to the fact that the experience of embarrassment surrounding psychotherapy may be a more salient issue in decisions around treatment seeking and initial engagement rather than treatment termination. The second low-frequency response, *You had problems with things like transportation, childcare, or your schedule* (2.1%), was rated much lower than what would be expected based on evidence from clinic studies: for example, 35% (Pekarik, 1983), 19.9%

(Renk & Dinger, 2002), 54.6% (Roe et al., 2006), and 53% (Todd et al., 2003). The inability to overcome circumstantial barriers is undoubtedly an important reason that some people end treatment. However, it may be that individuals provide this reason as an acceptable excuse, and are more apt to provide honest reasons for termination to an anonymous interviewer rather than clinic staff or research staff affiliated with the clinic where termination occurred. Despite the prevalence of each of these reasons being low, taken together, results indicated that at least 44.7% of respondents left psychotherapy due to some barrier to treatment, preference for solving the problem on one's own, or dissatisfaction with psychotherapy.

**Demographic variables.** Study 1 was the first population-based study to examine the associations among specific reasons for terminating therapy with demographic variables, mental disorder diagnoses, and mental health care provider. Overall, age and gender were not associated with odds of selecting any reason for termination. Consistent with previous research (Edlund et al., 2002; Wierzbicki & Pekarik, 1993; Williams, Ketring, & Salts, 2005), the socioeconomic status indicator low income was a predictor of untimely termination from psychotherapy. Low income decreased the odds of termination due to improvement and increased the odds of termination due to perception that therapy was not helping.

**Mental disorder caseness.** In terms of clinical variables, meeting criteria for an anxiety disorder, a mood disorder, or substance dependence decreased the odds of termination due to feeling better. This finding is particularly troubling as individuals with clinical disorders require the most help from psychotherapy and, based on the survey data, they are less likely than those without diagnosable conditions to report that they received the help that they needed to make improvements in their lives. Meeting criteria for 12-month

substance dependence doubled the odds of completing treatment. This could reflect the typical practice of providing intensive time-limited treatment programs for substance abuse. The lack of association with other predictor variables may be due to the heterogeneous reasons underlying treatment having been completed, including the possibilities that treatment completion may be largely determined by therapists and that the prescribed number of sessions has only a limited relation to the clinical profile of clients.

**Mental health service provider.** In terms of mental health service provider, only termination with a psychiatrist significantly affected odds of selecting two reasons for termination. Individuals who terminated with psychiatrists had decreased odds of terminating due to symptom improvement and increased odds of terminating due to perceiving therapy as unhelpful. However, in the present study, there was evidence that, compared to other professionals, psychiatrists treated more individuals with diagnosable conditions and, thus, more severe psychopathology. This should be considered when interpreting this finding. Aside from the data from former clients of psychiatrists, there were no differences in reasons for termination across mental health professionals and general practitioners. Despite what are likely sizeable differences in training, experience, and therapeutic approach, differences across professions were not meaningfully related to reasons for termination.

**Limitations.** It is important to distinguish that this study examined reasons for termination in general and not premature termination in particular. For example, feeling better could be given as a reason for either unilateral or mutual decisions to terminate with the therapist. Therefore, the results do not inform us about factors exclusively associated with unilateral termination. External validity and generalizability of results was enhanced by the broad sampling of clients, however, the data provided no information on the nature of

psychotherapy services provided. Type of psychotherapeutic treatment and therapist competence influence reasons for termination; however, information on these important factors was not included in the survey. The method of measuring reasons for termination is inherently limited; respondents varied in the length of time passed between psychotherapy termination and the administration of the survey, during which time recall biases may have affected their responses. As well, individuals do not necessarily have conscious access to all the reasons for their decisions, and a more complete picture of termination is possible when therapist and client perspectives are simultaneously considered. Despite these inherent limitations, it is essential for both researchers and therapists to be aware of clients' understanding of their reasons for terminating psychotherapy.

Furthermore, the prevalence and predictors of reasons for termination in the present study may not generalize to all health care systems. For example, Edlund et al. (2002), comparing mental health treatment dropouts in Ontario, Canada, and the United States, found no differences in proportion of dropouts, cumulative probability of dropping out, or effects of various predictors. However, a lack of insurance coverage increased odds of dropping out in the American dataset by 1.5. Lastly, the infrequency of some of the reasons for termination affected plans to examine patterns of association existing in the data. All of these limitations must be kept in mind when interpreting the results.

**Summary.** The most frequently reported reason for terminating therapy was that the client felt better. This positive result is tempered by the recognition that less than half of clients reported leaving psychotherapy due to this reason. Nearly half of respondents reported leaving psychotherapy due to some barrier to or dislike of treatment, or because of

wanting to solve problems in a different manner. In general, individuals with low income and diagnosable mental disorders had significantly increased odds of premature termination.

## Study 2: Client and Therapist Views of Contextual Factors Related to Termination from Psychotherapy: A Comparison between Unilateral and Mutual Terminators

In Study 2, I examined the congruence in perspectives of client-therapist dyads regarding clients' reasons for termination, working alliance, and barriers to treatment between two groups where a) both client and therapist agreed that termination was a unilateral decision on the client's part, or b) both client and therapist agreed that termination was mutual. As hypothesized, unilaterally terminating clients, compared with mutual terminators, rated the importance of having accomplished their goals in therapy as less important to their decision to end therapy, and reasons related to circumstantial barriers and dislike of therapist and therapy as more important to their decision. Therapists reported a similar pattern of results; therapists of unilateral terminators, compared with therapists of mutual terminators, reported that their clients' accomplishing goals in therapy was less important to their decisions, and that reasons related to circumstantial barriers and dislike of therapist and therapy were more important to their decisions.

**Client-therapist perspective divergence.** When client-therapist assessments were examined within each dyad, small, but systematic differences in attributions of clients and their therapists became evident. When termination decisions were mutual, there was no difference between client and therapist ratings of the importance of any termination reason. When clients terminated therapy unilaterally, compared with their therapists, they rated four out of ten reasons for termination as significantly more important to their decision to leave. They ascribed higher importance to all of the reasons related to dislike of therapy or

therapist: *felt therapy was going nowhere so ended therapy*, *felt therapy was making things worse*, *weren't confident in therapist's ability to help*, and *therapy did not fit with ideas about what would be helpful*. Clients and therapists rated the importance of more benign and circumstantial barriers similarly.

Outcome data collected in the study also reflect a perspective divergence between clients and therapists in the unilateral, but not the mutual, termination group; unilateral terminators rated their distress as significantly lower at post-therapy whereas their therapists indicated no change in functioning. In contrast, clients in the mutual termination group reported a similar decline in distress from pre-therapy to post-therapy, and their therapists agreed with them, reporting a significant increase in functioning.

These results build on previous research showing that therapists tend to perceive both treatment success and failure differently than do clients (Hunsley et al., 1999; Pekarik & Finney-Owen, 1987). Directly comparing client and therapist ratings, results from the present study indicate that these differences in perception occur exclusively around unilateral termination. When termination was a unilateral decision on the client's part, therapists appeared not to be aware of the extent to which clients' perceived either success in therapy (i.e., symptom improvement), or their dissatisfaction (i.e., felt therapy was going nowhere, lack of confidence in therapist's ability, lack of helpfulness). Given the small differences in client and therapist ratings, it appears that therapists were largely aware of clients' dissatisfaction, but tended to rate the importance of clients' dissatisfaction reasons as less important than they actually were. This could reflect both self-serving biases (whereby therapists are not as likely to rate themselves too negatively) and differing expectations about what will be accomplished in therapy. It likely also reflects the limited communication

inherent in unilateral decision-making; clients may be unlikely to share the extent of their negative perceptions of therapy and the therapist.

**Therapeutic alliance.** In line with previous research, and as hypothesized, client-therapist dyads that made mutual decisions to end therapy reported a stronger working alliance early in treatment than did client-therapist dyads in which the client terminated unilaterally. Contrary to my hypothesis that mutually terminating dyads would have more similar perceptions of the working alliance, all clients rated the early alliance significantly higher than did their therapists regardless of how they terminated therapy. The tendency for clients to rate the alliance higher than their therapists is well-documented in the literature (e.g., Bachelor & Salame, 2000; Fitzpatrick, Iwakabe, & Stalikas, 2005; Hersoug, Hoglend, Monsen, & Havik, 2001; Hilsenroth, Peters, & Ackerman, 2004; Tryon et al., 2007), and holds true in this study despite clients' eventual unilateral decisions to leave, and poorer therapeutic outcome. Although there has been no systematic investigation into why clients rate the alliance as higher, Tryon et al. (2007) suggested that therapists may rate clients relative to alliances formed with other clients, whereas clients may rate therapists in comparison to other health professionals who may take a less collaborative, more paternalistic role, or to friends and family members experienced as (naturally) less collaborative.

**Barriers to treatment participation.** A similar pattern of results was found for barriers to treatment participation. Both client and therapist dyads who made mutual decisions to end therapy indicated fewer barriers to treatment than did clients and therapist dyads where the client made a unilateral decision to leave. Contrary to hypotheses, there was no difference in client-therapist perspective congruence between unilateral and mutual

decision groups. In general, clients rated barriers to treatment participation as higher than did therapists. This was the first examination, to my knowledge, of Kazdin's barriers to treatment participation scale in adult clients. The current pattern of results was different than Kazdin et al. (1997) in that clients in the present study reported significantly more barriers than did their therapists, whereas parents of conduct-disordered children in Kazdin et al.'s study reported significantly fewer barriers than did their therapists. This may be due to differences in client demographics and presenting problems, or therapist experience given the trainee therapist sample in the present study. Further research should be conducted to replicate these results, however, this study indicates that therapists can expect that as clients experience more barriers, they are more likely to make unilateral decisions to leave therapy.

**Limitations.** The retrospective assessment of perceived barriers and reasons for termination raises issues of biased recall, as it was conducted at the end of therapy, after termination decisions had already been made. However, given that the timing of the post-therapy assessment was within one month after termination, recall bias is less likely. Due to logistical constraints, the time lag between end of therapy and completion of the BTPS and the reasons for termination measure was within one month for unilateral terminators, and within one week for mutual terminators, potentially adding further measurement biases of an unknown nature. It is possible that treatment outcome influenced the results: mutually terminating clients were less symptomatic and higher functioning post-therapy and, therefore, may have reported fewer barriers as a result of experiencing greater improvement. As Kazdin and Wassell (2000) discussed, assessing barriers at other therapy points (e.g., early in treatment, or on multiple occasions throughout treatment) have their own methodological and practical liabilities (e.g., clients not having a complete idea of barriers

early in treatment, confounding number of assessment administrations with duration in treatment and possibly sensitizing clients to the challenges of attending psychotherapy). Future research should examine other methods of assessing barriers to treatment throughout the therapy process.

**Summary.** This was the first study to obtain parallel information from both members of the client-therapist dyad about specific reasons why the client terminated services, and to examine how these perspective divergences regarding reasons for termination, early working alliance, and barriers to treatment participation are related to unilateral termination. When clients made unilateral decisions to end therapy, therapists were only partially aware of either the extent of clients' perceiving success in therapy or with their dissatisfaction. Although working alliance and barriers to treatment participation were rated as lower in the context of unilateral termination by both clients and therapists, all clients, in general, rated the early alliance and barriers to treatment as higher than did their therapists.

## Study 3: Psychologists' Perspectives on Therapy Termination and the Use of Therapy Engagement Strategies

The main purposes of this study were to examine (a) psychologists' perspectives of client termination from psychotherapy and (b) their use of engagement strategies.

**Prevalence of unilateral termination.** Psychologists reported on the prevalence of unilateral termination in their own practices. Psychologists reported relatively few clients who terminated before the third session ($M$ = 13%). Although direct comparisons cannot be made, consistent evidence from actual client data suggest that psychologists underestimated the proportion of clients who terminated treatment very early (e.g., on average, 35% - 50% of clients who complete an intake do not attend the first therapy session: Garfield, 1986;

Hansen et al., 2002; Phillips, 1985; 40% of clients attend fewer than 3 sessions, Pekarik, 1983a). Psychologists reported that a mean of 20% of their clients unilaterally terminated after the third session, summing to a combined unilateral termination rate of 33%. This value is consistent with Pekarik & Finney-Owen (1987)'s sample of CMHC therapists who estimated dropout rates in their overall clinics (32.8%). Pekarik and Finney-Owen also collected clinic data for a portion of the sample of therapists and found that although therapists estimated their own dropout rate to be 31.3%, the actual clinic dropout rate was 64.1% (based on 64 consecutive terminations). Pulford et al. (2008) replicated the Pekarik & Finney-Owen study at an outpatient alcohol and drug treatment service, finding that therapists estimated that 32% of their clients unilaterally terminated (their proxy dropout measure was failure to attend a scheduled treatment session), although agency records indicated the mean rate of this form of client unilateral termination was actually 65%. Furthermore, the value of 33% reported by psychologists in Study 3 is low when compared with meta-analytic data showing that 47% of clients prematurely terminate (Wierzbicki & Pekarik, 1993). Although it is not possible to determine from Study 3 data without corresponding data on actual unilateral termination, it is likely that psychologists underestimated unilateral termination in their own practices, perhaps due to spending most of their time with longer term, mutually terminating clients (Vessey et al., 1994). This is problematic to the extent that psychologists take action to increase the likelihood appropriate termination decisions as a function of recognizing that unilateral termination is a significant problem.

**Psychologists' perspectives of unilateral termination.** I examined psychologists' perspectives of their clients' reasons for making unilateral decisions to end treatment both

early and later in therapy, as well as mutual decisions. Overall, at least 30% of psychologists rated each reason for termination as important or very important to clients' decisions to leave either before or after the third session, indicating that they perceived numerous reasons as potentially important to clients' unilateral decisions to end therapy. Despite attributing importance to a range of reasons, psychologists viewed lack of motivation as the most important barrier to treatment engagement, suggesting that psychologists in this study viewed their clients as playing a decisive role in failure to engage in treatment.

For clients who terminated before versus after the third session, I hypothesized that psychologists would view circumstantial barriers, clients having to wait too long for services, and clients having initial negative impressions as more important. This hypothesis was supported in that psychologists rated these reasons as relatively more important to early terminators than they did for later unilateral terminators. However, these differences should be viewed in the context that, across unilateral terminators, psychologists assigned the lowest importance of any reasons to the influence of wait time and client negative impressions of clinic and staff in contrast to research showing that wait list length and negative impressions of office space or staff are important predictors of engagement in therapy (e.g., Festinger et al., 2002).

In addition to rating these reasons as particularly important for early terminators, psychologists rated insufficient client motivation, and clients disliking the treatment, as significantly more important for clients who unilaterally terminated before versus after the third session. Psychologists rated symptom improvement as significantly more important for late versus early unilateral terminators, also rating this as the most important reason for unilateral termination after the third session.

**Psychologists' perspectives of mutual termination.** As hypothesized, when their clients made mutual decisions with them to end, psychologists viewed symptom improvement as most important, and viewed all other reasons as far less important. As well, nearly 30% of psychologists rated as important or very important to their mutual decisions to terminate that clients could not afford to pay. In Canada, where the cost of psychological services often falls on consumers, this finding is unsurprising. However, only 2% of clients interviewed in the Canada-wide Canadian Community Health Survey (Cycle 1.2, 2003) provided this reason (Study 1). Mutual termination was not always viewed as an unqualified success; approximately 20% of psychologists rated as important or very important that clients left because they wanted to solve their problems in another way, that clients had circumstantial barriers, and even that clients lacked motivation or were not ready to change.

**Theoretical orientation and reasons for termination.** Given preliminary evidence that CBT therapists may be less vulnerable to the fundamental attribution error than other therapists (i.e., attributing responsibility for failed therapy to clients; Kendall et al., 1992; Murdock et al., 2010), I hypothesized that theoretical orientation would influence psychologists' perspectives of client reasons for ending therapy. This hypothesis was not supported; theoretical orientation did not influence psychologists' perspectives of reasons for termination. It appears that specific reasons for unilateral termination are viewed similarly across both CBT and psychologists of different theoretical orientations. Indeed, Kendall and et al. (1992) found, although rating the importance of this factor lower than did therapists of other orientations, CBT therapists did rank their clients' inability to benefit from therapy as the most important cause of negative outcomes as did other therapists in their study.

**Use of engagement strategies.** Nearly all psychologists (96.8%) reported that they often or always focus on building the early working alliance. Using an explicit treatment plan (74.3% *often or always use*), and pre-therapy preparation (58.0% *often or always use*) were the next most frequently reported strategies. Nearly 40% of psychologists reported the regular use of client selection and motivational enhancement, and 33% of psychologists reported regular use of systematic client monitoring. Less than a quarter of psychologists reported frequent use of time-limited treatment, appointment reminders, or case management. Older psychologist age was associated with using over half of the engagement strategies less often. This may reflect differences in graduate training as research demonstrating the effectiveness of engagement strategies continues to become more prominent in research and teaching.

I hypothesized that theoretical orientation would influence psychologists' choice of engagement strategies. This hypothesis was partially supported; CBT versus psychologists of other orientations reported more frequent use of systematic client monitoring, and time-limited treatment, but equivalent use of appointment reminders and case management. Overall, it appears as though engagement strategies largely transcend theoretical orientation, and do not reflect theoretical or training differences given their similar use across psychologists.

**Limitations.** Although it was conducted with a relatively large group of psychologists living in diverse locations in Canada, a limitation of this study is that exact generalizability is unknown given the lack of data on nationally representative samples of psychologists. There are larger American and international surveys of therapists across

mental health professions (Cook et al, 2010; Orlinksy, Botermans, & Ronnestad, 2001), but no representative samples of Canadian psychologists exist for comparison.

As well, nomothetic survey data of psychologists' perspectives of their clients in general cannot speak to how psychologists view reasons pertaining to specific clients, or how they tailor their treatments and use of engagement strategies to specific clients. The method of measuring reasons for termination and engagement strategies is also limited in that recall biases may have prevented psychologists from accessing a proportionately accurate portrayal of both their clients' reasons for termination and their own use of engagement strategies. As discussed in reference to Study 1, parallel client or service data would provide an ideal comparison for psychologists' perspectives. In terms of measurement of engagement strategies, it would be ideal for psychologists to monitor their use of strategies in real time (e.g., track use of engagement strategies on a sessional, daily, or weekly basis). Another more objective method involves coding for frequency and context of engagement strategies in videotaped sessions (Cook et al., 2010). Despite these limitations, in order to improve psychotherapy services, it is essential to be aware of how practicing psychologists' perspectives generally fit with what is known about client termination and use of engagement strategies.

**Summary.** In summary, in this survey of Canadian psychologists regarding their perspectives on client reasons for termination at different points in therapy and their use of strategies to engage and retain clients in therapy, psychologists reported that one-third of their caseload unilaterally terminated. They also assigned differential importance to termination reasons for this depending on whether termination was before versus after the third session. Notably, psychologists rated multiple reasons as having at least some

importance to all clients' decisions to leave therapy. Nevertheless, psychologists viewed lack of motivation as more important than all other barriers to treatment engagement, and symptom improvement as the most important reason for unilateral termination after the third session. Theoretical orientation (CBT versus other) did not influence views of reasons for termination, but influenced self-reported use of some engagement strategies. Psychologists reporting a CBT orientation, compared to other therapists, reported more frequent use of time-limited treatment and systematic client monitoring. Despite these differences, all psychologists reported at least occasional use of most engagement strategies.

**Research Implications**

Results from this series of studies on client and therapist perspectives of psychotherapy termination move us closer to a more complete understanding of termination, and point to interesting directions for future research. Results from Study 1 provide population-based evidence that low income increases the likelihood of premature termination, fitting with meta-analytic data (Wierzbicki & Pekarik, 1993) but not epidemiological data collected in the United States and Ontario (Edlund et al., 2002). This discrepancy might be at least partly due to Edlund et al's different definition of unilateral termination (individuals who did not select symptom improvement as a reason for termination, therefore including treatment completers with unilateral terminators). Although the current study cannot speak to the mechanism of action, the empirical literature provides some evidence that client-therapist differences in culture, attitudes, and experiences may contribute (e.g., Ilovsky, 2003). At the present time, the evidence, although incomplete, supports the utility of client-therapist ethnic matching (Hill et al., 2005), pre-therapy preparation to increase congruence between client and therapist expectations, and other

strategies to reduce barriers to treatment for these populations such as case management, time-limited treatment, and very simple additions such as appointment reminders. These would be fruitful avenues of inquiry with regard to populations at the highest risk of unilateral termination.

Study 2 was designed to capture longitudinal, parallel data from clients and therapists. The first study of its kind in the termination literature, Study 2 provides evidence that clinicians are more accurate in providing information with regard to specific clients than they are with regard to their practice as a whole. In the case of mutual termination, there were no differences in client-therapist ratings of reasons for why termination occurred. Although differences were systematic and statistically significant with regard to unilateral termination, they were smaller than what would be suggested by researchers who have surveyed clinicians based on their practice in general (Pekarik & Finney-Owen, 1987; Vessey et al., 1994). Garnering parallel data from clients and therapists greatly reduced method variance that very likely inflated differences in client-therapist perspectives in previous studies examining this issue (Hunsley et al., 1999; Pekarik & Finney-Owen, 1987; Todd et al., 2003). Future researchers should continue to include both client and therapist perspectives and take steps to reduce method variance.

Results from Study 2 also underscore the utility of obtaining parallel data from clients and therapists because each party offers unique and important information about the therapeutic process (for example, 22.4% of client-therapist dyads disagreed on whether or not therapy had terminated prematurely). Results from Study 2 also provide evidence that clinicians were not fully aware of the barriers clients experience to treatment participation. This pattern of results was in contrast to Kazdin et al. (1997) in that clients in Study 2

reported significantly more barriers than did their therapists, whereas parents of conduct-disordered children in Kazdin et al.'s study reported significantly fewer barriers than did their therapists. This discrepancy may be due to differences in client demographics and presenting problems, or therapist experience given the trainee therapist sample in Study 2. Further research should be conducted to replicate these results by taking parallel measurements of barriers from adult clients and their therapists, ensuring the inclusion of experienced therapists and a variety of client demographics and presenting problems. Furthermore, given evidence from Study 2 and from meta-analytic research (e.g., Sharf et al., 2010) that the working alliance is poorer when measured at the third session for unilateral terminators, it would be helpful to examine what therapists can do to improve alliances with clients they find more challenging early in treatment. Safran, Muran, and Eubanks-Cater (2011) conducted a meta-analysis of studies ($k$ = 8) of the effect of training therapists in alliance rupture intervention principles on treatment outcome and found that this training effectively improved outcome (pre-post $r$ = .65). Building on evidence that obtaining regular feedback from clients about their symptoms (Lambert et al., 2005), the working alliance (Safran, Muran, Samstag, & Stevens, 2002), and even stage of change (Whipple et al., 2003) allows clinicians to intervene when clients are off track and improve outcome, it would be worthwhile to continue this line of research by examining the utility of soliciting regular feedback about barriers to treatment participation. For example, it would be worthwhile to examine whether clinicians are more likely to intervene or adjust treatment, and in turn, whether this improves outcome, if they are more aware of clients' perceived barriers to treatment.

It is evident from Study 1 and the termination literature in general that pre-therapy client characteristics have limited predictive power in terms of alerting therapists to impending unilateral termination (e.g., Edlund et al., 1992; Wierzbicki & Pekarik, 1993). Given findings that contextual factors such as barriers to treatment and working alliance are associated with premature termination, it is important to move toward further monitoring and investigating the therapeutic process at an even more micro level to identify warning signs of treatment failure at the level of on-going process. Keijsers, Kampman, and Hoogduiin (2001) proposed that factors contributing to unilateral termination may be very individualistic and circumstantial than has been assumed in the research to date. One way to explore these factors is through qualitative research. For example, Knox et al. (2011) used consensual qualitative research (a method wherein researchers arrive at consensus via open discussion of data classification; classification is then reviewed by auditors) to analyze interviews with 12 clients about their termination from psychotherapy. Seven of 12 clients reported unilaterally terminating. These individuals usually terminated abruptly due to a therapeutic rupture and perceived harmfulness of therapy. One person reported the rupture as a gradual but continuous process of invalidation as therapy progressed due to the therapist insisting on focusing on day-to-day coping skills versus processing painful traumatic experiences. Although limited in terms of generalizability, small qualitative studies can provide a window into clients' experiences of termination and therefore provide avenues for further investigation.

Greenberg (1986) provided specific methods of investigating change in therapy by identifying patterns of in-session client and therapist behaviours and connecting them with client change in functioning. In the context of unilateral termination, researchers might study

what kind of in-therapy interventions, resulting client performances (behavioural responses to the therapist's intervention), and in-session outcomes lead to further commitment to remaining in therapy.

The methodology used in Study 3 of asking psychologists to rate importance of termination reasons on a continuous scale allowed for the observation that psychologists consider multiple factors as important to all of their clients' decisions to terminate. Asking therapists for their top three reasons only (Pekari, & Finney-Owen, 1987), or any forced choice methodology, restricts the range of clinician responses and leads to the false conclusion that clinicians are not aware of multiple factors involved in termination processes for clients. Future researchers should continue to provide opportunities for respondents to report on nuances in their perspectives by including multiple sources of information or gathering supplemental qualitative data.

In Study 3, separating unilateral terminators into early versus later dropouts allowed for more accurate information about how psychologists in the study viewed client processes. Indeed, psychologists viewed client termination differently depending on whether it occurred early (before the third session) or later (after the third session). An important next step is the operationalization of this division in research on clients in order to better understand unique factors influencing early versus later termination. In other words, researchers should continue to divide early versus later unilateral terminators and examine the correlates, experiences, and reasons for ending therapy separately in these groups.

From Study 3, it is evident that psychologists routinely used some engagement strategies (i.e., building the early working alliance, in-depth pre-therapy preparation) and neglected others (i.e., appointment reminders, time-limited treatment). The data suggest that

engagement strategies largely transcended theoretical orientation, and did not reflect theoretical or training differences given their similar use across psychologists. Sampling clinicians in real time (or at least closer to the therapy session) would provide more accurate data regarding their use of engagement strategies. These data could be collected after every session, daily, or weekly basis. This method of collection would also allow for assessment of which strategies clinicians use, and which clinicians perceive as effective, with particular types of client problems. However, self-reported practices might not accurately represent what clinicians actually do (Hoyt, 2002). For example, clinicians may vary in their conceptualizations of what building a working alliance looks like due to varying ideas of how empathy is conveyed, what is helpful, etc. As suggested by Cook et al. (2010), another more objective but time-consuming method might be to examine random videotaped sessions of therapy and code for use of engagement strategies. Of course, it is necessary that clinicians see a pressing need for these strategies and experience them as both practical and as having clinical utility in order to be willing to implement them. Therefore, it would be worthwhile to examine clinicians' views of the utility of these strategies, as well as barriers to using them.

In addition to greater focus on under-researched strategies (i.e., appointment reminders), it seems worthwhile for researchers to compare the additional utility of engagement strategies among different forms of therapy and for various types of client problems. This would ideally be accomplished using a randomized and controlled design. It is also worth considering whether the use of multiple strategies is feasible, or outperforms the concerted use of one or two strategies. For example, it may be that client monitoring is

sufficient unto itself, and further strategies serve to detract focus from core therapeutic processes such as the therapeutic relationship and theoretically-based techniques.

Another avenue would involve examining the frequency, context, and timing of strategies used by expert therapists. Some researchers have examined clinicians who consistently achieve superior outcomes (Miller, Hubble, & Duncan, 2007). Beyond examining impressionistic or characterological variables such as therapist experience and perceived trustworthiness, examining therapist *behaviours* that differentiate therapists who have the highest rates of mutual termination would be a very fruitful endeavour. Indeed, Luborsky et al. (1980) suggested that the key factors affecting a client's decision to leave may not become evident until the client and therapist begin to interact. For example, Miller et al. (2006), in a study of the use of client monitoring to improve outcome, found that therapists who shared their baseline level of success (proportion of client base who experience clinically significant improvement) with clients experienced a 50% decline in unilateral termination. Miller et al. speculated that the act of sharing this information served to elicit a shared engagement with clients. In their work observing sessions of therapists who achieve superior outcomes, Miller et al. (2007) provided a case description of an expert therapist. Observers noted her gentle persistence in uncovering clients' barriers to participating fully in therapy. This therapist continuously checked in with clients and paid attention to very slight indicators of ambivalence. Miller et al. described her continuous attempts to uncover ambivalence and then re-engage the client as differentiating her from less prodigious therapists. It would appear fruitful for these observations to be examined in systematic process research, whereby markers for client engagement could be identified.

Finally, Pekarik's (1985b) definition of the client's unilateral decision to terminate best captures the construct of premature termination, as it addresses the problem of appropriately classifying clients who meet their treatment goals with few therapy sessions as well as clients who may remain in therapy for a longer period of time, but leave before their goals have been reached. However, the reality is that some clients who have made unilateral decisions classify themselves and/or are classified by therapists as mutual terminators because they discuss their decision with the therapist. This likely occurred in Study 2, where 24 client-therapist dyads (22.4% of the sample) did not agree on the type of termination decision (12 clients reported unilateral decisions whereas their therapists reported that the decision was mutual and vice versa). Therefore, the category of mutual termination as defined this way likely includes unilaterally terminating clients. Furthermore, the category also includes cases of therapist unilateral termination. Therapists have an ethical obligation with respect to the way in which termination and referrals are managed. For example, if termination is initiated by a psychologist, it has to be discussed with the client, therefore rendering the decision mutual. Indeed, this is the way it is managed in the psychotherapy termination literature as no studies I found labeled or discussed implications of therapist unilateral termination. However, many terminations occurred in these studies due to trainee therapist graduation or practicum rotation. This reality leaves many terminations in which, to the client, it feels like the termination is entirely determined by the therapist. Indeed, multiple reasons for mutual decisions to terminate were acknowledged by psychologists in Study 3. This way of classifying terminations increases the variability in outcomes among mutual terminators, and does not imply treatment success. Further to obtaining both client and therapist perspectives on the nature of termination decisions, researchers examining

psychotherapy termination might inquire into the client's reasoning for labeling the decision as mutual or unilateral.

Future research might also examine the effects of therapist unilateral terminations on clients, as well as factors that moderate this impact. For example, factors such as whether an appropriate and timely referral was made, whether the decision was known in advance (such as in the case of a maternity leave, training completion, or service mandate) or came unexpectedly as a result of the therapist's difficulty working with the client or life circumstances, may determine the impact on the client. Unexpected therapist unilateral termination may be very disruptive to client progress in light of evidence that the therapeutic alliance is crucial to therapy outcome. On the other hand, in addition to using engagement strategies and trying alternative techniques, appropriately referring clients who do not progress may be the most ethical decision for the client (eg., Keith-Spiegel & Koocher, 1985; Kendall et al., 1992).

**Clinical Implications**

A few main clinical implications emerge from these studies. First, therapists need to be aware that many clients make unilateral decisions to leave their treatments before their goals have been reached. Base rates suggest that over half of clients choose to end their treatments for reasons other than completion of treatment or feeling better. Although it is not possible to directly compare different samples, and thus the evidence from these studies is indirect, discrepancies in client reports of premature termination in Study 1 and psychologist reports in Study 3 fit with previous evidence showing that therapists tend to underestimate unilateral termination in their own practices, perhaps due to spending most of their time with longer term, mutually terminating clients (Vessey et al., 1994). Therapists need to recognize the

possibility of memory bias and maintain their awareness of actual versus perceived rates of unilateral termination. They might accomplish this by setting up a system of monitoring the proportion of their clients who unilaterally terminate, which would fit easily into existing systems of monitoring outcomes (e.g., Whipple et al., 2003). Furthermore, there are readily identifiable risk factors for unilateral termination: non-White ethnicity, low income, and having a diagnosable mental health disorder. In an effort to target these at-risk groups, clinicians can educate themselves in culturally appropriate methods, and tailor engagement strategies to target at-risk groups (e.g., pre-therapy preparation and case management).

Some discrepancies in client and therapist reports merit attention. Many psychologists in Study 3 cited circumstantial barriers and financial limitations as important reasons why clients unilaterally terminated, whereas these reasons had exceptionally low prevalence in the population survey of clients. This discrepant reporting is very likely at least partially due to method variance, however, discrepant reporting about financial limitations may partially be accountable to the type of service reported on (psychological versus a range of publicly funded mental health services) as well. Clients commonly cite circumstantial barriers when surveyed in the context of clinic studies, however, very few clients cite this reason on a population level. This low endorsement could be due to the nature of the specific examples provided in the reason (transportation, schedule, childcare), that former clients are more apt to provide honest reasons rather than acceptable excuses for termination to an anonymous interviewer rather than clinic staff or research staff affiliated with the clinic where termination occurred, or even that, when clients have time to make sense of their termination decisions, they realize that their dissatisfaction with therapy, or wanting to solve problems in another way, were more salient factors. Indeed, Hunsley et al. (1999) found that

circumstantial reasons for ending therapy were highly correlated with dislike of therapy. Clinicians should be mindful of the possibility that clients who report circumstantial barriers to therapy continuance, including financial limitations, may also be dissatisfied with the services they are receiving.

Therapists should be cognizant that when treatment ends because of a client's unilateral decision, their perspectives on the reasons why therapy ended likely diverge from their client's. Specifically, therapists are likely to underestimate the extent of both clients' dissatisfaction (including clients' perceptions of therapy going nowhere, making things worse, lack of confidence in the therapist, and lack of congruence in ideas about what would be helpful) and goal attainment. Undoubtedly, clients do not always share either their positive or negative experiences (Hill et al., 1993), however, therapists may be unaware of their clients' feelings for other reasons. Some research has shown that therapist failure to recognize shortcomings is associated with decreased competence. For example, Brosan, Reynolds, and Moore (2008) found that less competent cognitive therapists (as rated by expert observers) rated themselves as significantly more competent than experts did when rating a tape of one of their sessions from the middle of therapy. In contrast, more competent therapists showed greater convergence in self and expert ratings. Najavits and Strupp (1993) examined therapist effectiveness as measured by outcome data. More effective therapists, according to clinic outcome data, had greater regrets about their performance, rating themselves as making more mistakes during the session than less effective therapists. These results suggest that more effective therapists may be more realistic and less afraid to critique their own performance or contributions to failed therapy. These findings have direct implications for training: therapists should be indoctrinated in the idea that reflecting upon

one's performance and constructively criticizing one's clinical decisions indicate the presence, and not the absence of, competence or confidence. The literature on experts – not just expert therapists – is useful to illustrate what learning therapists might be taught: experts continually seek out areas of weakness, practice in their leading growth edge, consistently look for feedback, and follow up to determine the effectiveness of their new behaviours (Miller et al., 2007). Although further research is required to fully delineate factors that differentiate therapists who achieve superior versus average outcomes, Miller et al. (2006) reported results of a case investigation in which they found that novice or non-expert therapists were more likely to attribute client failure to engage to denial, resistance, or lack of motivation, whereas expert therapists were more likely to reflect on their interventions and think of new alternatives to responding to a particular client, and then further anticipate how the client will respond and plan therapeutic strategies for each response. This places the therapist in a position to try new ways of engaging clients, and expanding their skills in terms of what works for specific clients.

Miller et al. (2006) advocate knowing one's baseline level of success so that therapists may be aware of the extent of improvement as a result of deliberate practice. Perhaps it might be useful for trainees to track client outcomes for this purpose in addition to receiving supervisor feedback. In terms of additional training implications, it would seem that the most facilitative supervision environment would be one in which trainees are reinforced for developing an awareness of both their strengths and weaknesses, and sharing moments of perceived poor performance or great challenge. Further, trainees should be reinforced for deliberately soliciting negative feedback from their clients. Presumably, trainees feel more comfortable raising issues of competence and client dissatisfaction in a supervisory context

in which open discussion of these problems is normative. It behooves clinician training programs to evaluate whether deliberately fostering these competencies in trainees is effective for improving client outcomes and reducing unilateral termination.

Study 2 elucidated one prospective cue for unilateral termination – a poorer working alliance at the third session. Furthermore, unilaterally terminating clients as a group were characteristic of lower therapist-rated functioning, higher self-rated symptomatology, and more barriers to participation in treatment. This lack of congruence in perspectives speaks to the importance of pre-therapy preparation to establish a shared vision of treatment, tracking client progress and soliciting client feedback on the working alliance, barriers to treatment, and client perceptions of how therapy is progressing. Only then are therapists able to take steps to bring therapy back on track by collaboratively problem-solving with the client to repair alliance ruptures, shift the focus of therapy, or help clients to overcome circumstantial barriers. There is good evidence that soliciting and modifying therapy based on client feedback has the potential to get therapy back on track (e.g., Lambert et al., 2005; Miller et al., 2006; Whipple et al., 2003).

Study 3 data from psychologists indicate that insufficient motivation/lack of readiness for change was the primary reason that psychologists in this study believed clients unilaterally terminated treatment before the third session. Lack of readiness for change is undoubtedly a reason for unilateral termination for some clients (e.g., Prochaska, Rossi, & Wilcox, 1991), regardless of whether or not therapists accurately detect the frequency of such clients (i.e., therapists' recall may be biased because of being able to recall such clients with particular ease due to the frustration they experienced with these unmotivated clients). Fortunately, client motivation for change is dynamic in nature, and a growing body of

literature shows that therapists can influence it with the methods they use in therapy (e.g., Arkowitz, Westra, Miller, & Rollnick, 2007). Therapists should be aware that they might view unilaterally terminating clients as unmotivated when the client is experiencing problems with the process of therapy additional reasons (e.g., dissatisfaction, lack of fit, feeling as though therapy is going nowhere). It is important for therapists to be aware of multiple reasons for unilateral termination, and the potential fallacy of attributing responsibility to the client for failed therapy (e.g., Kendall et al., 1992).

The empirical literature provides ample evidence that it is often beneficial (and never detrimental) for therapists to deliberately employ strategies to engage and retain clients in therapy (Barrett et al., 2008; Ogrodniczuk et al., 2005). The results from Study 3 provide evidence that engagement strategies largely transcend theoretical orientation, and reflect neither theoretical nor training differences given their similar use across psychologists. It seems worthwhile for therapists of any theoretical orientation to consider how some of these strategies fit with their approach to therapy and their clients. Notably, psychologists in Study 3 reported a low frequency of use of case management and appointment reminders. Clients with mental health problems often experience concurrent difficulties with practical life problems. Sometimes these practical issues become barriers to proceeding with therapy. Indeed, results from Study 2 indicate that therapists underestimated the extent of clients' perceived barriers to treatment participation. Therapists should actively solicit clients' barriers in an effort to increase awareness of them, as results from Manfred-Gilham et al. (2002) showed that therapists who were aware of client barriers used more engagement strategies to keep the client in treatment. Additionally, it would be worthwhile for therapists to consider appropriate use of case management in an effort to assist clients in overcoming or

managing these barriers. Given their ubiquity in medical and health-related professions, the use of appointment reminders would seem a simple strategy to implement, particularly with clients who have forgotten at least one appointment.

In Study 3, psychologists assigned the lowest importance of any termination reasons to the influence of wait time and client negative impressions of clinic environment and staff in contrast to research showing that wait list length and negative impressions of office space or staff are important predictors of engagement in therapy (e.g., Festinger et al., 2002; Stasiewicz & Stalker, 1999). Clinicians should be mindful that these factors can play a significant role early in the therapy process. Fortunately, there are ways of dealing with these risk factors such as temporarily closing down the wait list and providing a referral so that they client may access services in a timely manner, paying attention to office décor, and training reception staff in sensitive etiquette.

**Conclusion**

In conclusion, despite five decades of empirical attempts to discriminate unilateral versus mutual terminators, few replicable results have been found further to non-White ethnicity and socioeconomic status. Knowledge of these general demographic risk factors provides little help in understanding what therapists can change to improve retention for all clients. Moving away from static demographic variables and closer to the therapeutic experience, examining reasons for termination provides a way to learn about a multitude of factors that contribute to unilateral termination. Furthermore, examining reasons from the perspective of both clients and therapists is necessary for a complete understanding of termination. In this series of three studies, I used population data to examine the prevalence of client reasons and their correlates, parallel and longitudinal clinic data from clients and

their therapists to provide an accurate assessment of the congruence of their perspectives, and data from psychologists to provide the first information about how experienced therapists view client termination at different points in therapy, and the strategies they use to engage and retain their clients. In the context of the empirical literature, this research provides evidence that researchers may best focus their efforts on helping therapists to bridge key gaps in perspective between themselves and their clients. With further refinement of applied research methods, we can proceed to more accurately and systematically identifying clients at risk and intervening to reduce the number of clients who end therapy before meeting their objectives.

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## Appendix A: Study 2 Client Demographic Information

ID Number

1. Gender M F 2. Age

3. Who referred you to the Centre? Self Other

4. Are you:

1. Single
2. Living with your partner
3. Married
4. Separated
5. Divorced
6. Widowed

5. Do you have any children? Y N If yes, how many?
   Living with you? Y N

6. Have you ever been in therapy before? Y N If yes, when?

7. Are you currently seeking psychological services elsewhere? Y N

8. What is your highest level of education?

1. 1.Some elementary school
2. Finished elementary school
3. Some high school
4. Graduated high school
5. Some college
6. Graduated college
7. Some university
8. Graduated university
9. Graduate school
10. Professional school

9. What is your current employment status?

1.Unemployed
2.Student
3.Employed full time
4. Employed part time
5. Retired
6. Homemaker

10. What is your current annual income?

1. 0 - $5,000
2. $5,001 - $10,000
3. $10,001 - $15, 000
4. $15,001 - $20,000
5. $20,001 - $25,000
6. $25,001 - $30,000
7. $30,001 - $35,000
8. $35,001 - $40,000
9. $40,001 or more

ID Number

11. What is your ethnic background?

1. White (e.g., Europe, S. America)
2. Black
3. Korean
4. Filipino
5. Japanese
6. Chinese
7. Native/Aboriginal People of North America
8. South Asian (e.g., India, Uganda, Pakistan)
9. South East Asian (e.g., Vietnamese, Thai)
10. Middle Eastern/North African (e.g., Armenia, Syria, Morocco)
11. Other

## Appendix B: Study 2 Symptom Checklist - 10 (SCL-10)

ID Number

Here is a list of problems and complaints that people sometimes have. Consider each item carefully, and indicate which response best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST WEEK INCLUDING TODAY. Before we start, please write down the rating scale because it will make it easier for you to answer items.

| | 0<br>Not at all | 1<br>A little bit | 2<br>Moderately | 3<br>Quite a bit | 4<br>Extremely |
|---|---|---|---|---|---|
| 1 | How much were you distressed by feeling lonely? | | | 0 1 2 3 4 | |
| 2. | How much were you distressed by feeling no interest in things? | | | 0 1 2 3 4 | |
| 3. | How much were you distressed by feeling afraid in open spaces or on the streets? | | | 0 1 2 3 4 | |
| 4. | How much were you distressed by feeling weak in part of your body? | | | 0 1 2 3 4 | |
| 5. | How much were you distressed by feeling blue? | | | 0 1 2 3 4 | |
| 6. | How much were you distressed by heavy feelings in your arms or legs? | | | 0 1 2 3 4 | |
| 7. | How much were you distressed by feeling afraid to go out of your house alone? | | | 0 1 2 3 4 | |
| 8. | How much were you distressed by feeling tense or keyed up? | | | 0 1 2 3 4 | |
| 9. | How much were you distressed by feelings of worthlessness? | | | 0 1 2 3 4 | |
| 10. | How much were you distressed by feeling lonely even when you are with people? | | | 0 1 2 3 4 | |

## Appendix C: Study 2 Working Alliance Inventory–Client Form

ID Number_____

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items.

| | **Does not Correspond at all** | | | **Corresponds Moderately** | | | **Corresponds Exactly** |
|---|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 1. My therapist and I agree about the things I will need to do in therapy to help improve my situation. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. What I am doing in therapy gives me new ways of looking at my problem. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I believe my therapist likes me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. My therapist does not understand what I am trying to accomplish in therapy. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. I am confident in my therapist=s ability to help me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. My therapist and I are working towards mutually agreed upon goals. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. I feel that my therapist appreciates me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. We agree on what is important for me to work on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. My therapist and I trust one another. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. My therapist and I have different ideas on what my problems are. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. We have established a good understanding of the kind of changes that would be good for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. I believe the way we are working with my problem is correct. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## Appendix D: Study 2 Working Alliance Inventory–Clinician Form

ID Number

Below is a list of statements about your relationship with your client. Consider each item carefully and indicate your level of agreement for each of the following items.

| | **Does not Correspond at all** | | | **Corresponds Moderately** | | | **Corresponds Exactly** |
|---|---|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 1. My client and I agree about the things he/she will need to do in therapy to help improve his/her situation. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. What my client is doing in therapy gives him/her new ways of looking at his/her problem. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I believe my client likes me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. My client does not understand what I am trying to accomplish in therapy. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. I am confident in my client=s ability to help him/herself. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. My client and I are working towards mutually agreed upon goals. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. I feel that my client appreciates me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. We agree on what is important for my client to work on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. My client and I trust one another. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. My client and I have different ideas on what his/her problems are. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. We have established a good understanding of the kind of changes that would be good for him/her. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. I believe the way we are working with my client=s problem is correct. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

## Appendix E: Study 2 Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

**Code** (**Note:** Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 Superior functioning in a wide range of activities, life=s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities.

91 No symptoms.

90 Absent or minimal symptoms (*e.g., mild anxiety before an exam*), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (*e.g., an occasional argument with family members*).

81

80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (*e.g., difficulty concentrating after family argument*); no more than slight impairment in social, occupational, or school functioning (e.g., *temporarily falling behind in schoolwork*).

71

70 Some mild symptoms (*e.g, depressed mood and mild insomnia*) **OR** some difficulty in social, occupational, or school functioning (*e.g., occasional truancy, or theft within the household*), but generally functioning pretty well, has some meaningful interpersonal relationships.

61

60 Moderate symptoms (*e.g., flat affect and circumstantial speech, occasional panic attacks*) **OR** moderate difficulties in social, occupational, or school functioning (*e.g., few friends, conflicts with peers or co-workers*).

51

50 Serious symptoms (*e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting*) **OR** any serious impairment in social occupational, or school functioning (*e.g., no friends, unable to keep a job*).

41

40 Some impairment in reality testing or communication (*e.g., speech is at times illogical, obscure, or irrelevant*) **OR** major impairment in several areas, such as work or school, family relations, judgement, thinking, or mood (*e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school*).

31

30 Behaviour is considerably influenced by delusions or hallucinations **OR** serious impairment in communication or judgement (*e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation*) **OR** inability to function in almost all areas (*e.g., stays in bed all day; no job, home, or friends*).

21

20 Some danger of hurting self or others (*e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement*) **OR** occasionally fails to maintain minimal personal hygiene (*e.g., smears feces*) **OR** gross impairment in communication (*e.g., largely incoherent or mute*).

11

10 Persistent danger of severely hurting self or others (*e.g., recurrent violence*) **OR** persistent inability to maintain minimal personal hygiene **OR** serious suicidal act with clear expectation of death.

1

0 Inadequate information.

## Appendix F: Study 2 Barriers to Treatment Participation Scale - Client

ID Number

There can be a number of things that get in the way of someone participating fully in their treatment. Below is a list of possible barriers or obstacles you may have encountered while in therapy. Please indicate how much of a problem **for you** each potential barrier was.

**HOW OFTEN DID THIS STRESSOR OR OBSTACLE CREATE A PROBLEM FOR YOU WHILE YOU WERE IN TREATMENT?**

| 1 Never | 2 Once in a while | 3 Sometimes | 4 Often | 5 Very Often |
|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Transportation (getting a ride driving, taking a bus) to the clinic for a session | 1 | 2 | 3 | 4 | 5 |
| 2. Scheduling of appointment times for treatment | 1 | 2 | 3 | 4 | 5 |
| 3. Treatment was in conflict with another of my activities (classes, job, friends) | 1 | 2 | 3 | 4 | 5 |
| 4. During the course of treatment I experienced a lot of stress in my life | 1 | 2 | 3 | 4 | 5 |
| 5. I was sick on the day when treatment was scheduled | 1 | 2 | 3 | 4 | 5 |
| 6. Crises at home made it hard for me to get to a session. | 1 | 2 | 3 | 4 | 5 |
| 7. Treatment added another stressor to my life. | 1 | 2 | 3 | 4 | 5 |
| 8. There was bad weather and this made coming to treatment a problem | 1 | 2 | 3 | 4 | 5 |
| 9. I did not have time for the assigned work | 1 | 2 | 3 | 4 | 5 |
| 10. There was always someone sick in my home | 1 | 2 | 3 | 4 | 5 |
| 11. Getting a baby-sitter so I could come to the sessions | 1 | 2 | 3 | 4 | 5 |
| 12. Finding a place to park at the clinic | 1 | 2 | 3 | 4 | 5 |
| 13. I had a disagreement with my husband/wife, boyfriend/girlfriend, partner about whether I should come to treatment at all | 1 | 2 | 3 | 4 | 5 |
| 14. I was too tired after work to come to a session | 1 | 2 | 3 | 4 | 5 |
| 15. My job got in the way of coming to a session | 1 | 2 | 3 | 4 | 5 |
| 16. Treatment took time away from spending time with my children | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DID THESE ISSUES CREATE A PROBLEM FOR YOU WHILE YOU WERE IN TREATMENT?**

| | | | | | |
|---|---|---|---|---|---|
| 17. Treatment lasted too long (too many weeks) | 1 | 2 | 3 | 4 | 5 |
| 18. I felt that treatment cost too much | 1 | 2 | 3 | 4 | 5 |
| 19. I was billed for the wrong amount | 1 | 2 | 3 | 4 | 5 |
| 20. Information in the session and any handouts seemed confusing | 1 | 2 | 3 | 4 | 5 |
| 21. I had trouble understanding the treatment I received | 1 | 2 | 3 | 4 | 5 |
| 22. I felt this treatment was more work than expected | 1 | 2 | 3 | 4 | 5 |
| 23. The atmosphere at the clinic makes it uncomfortable for appointments | 1 | 2 | 3 | 4 | 5 |

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Once in a while | Sometimes | Often | Very Often |

| | | | | | | |
|---|---|---|---|---|---|---|
| 24. I did not feel that I had enough to say about what goes on in treatment | 1 | 2 | 3 | 4 | 5 |
| 25. The assigned work for me to do as part of this treatment was much too difficult | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DID YOU FEEL THIS WAY ABOUT YOUR TREATMENT?**

| | | | | | |
|---|---|---|---|---|---|
| 26. Treatment did not seem necessary | 1 | 2 | 3 | 4 | 5 |
| 27. Treatment was not what I expected | 1 | 2 | 3 | 4 | 5 |
| 28. I lost interest in coming to sessions | 1 | 2 | 3 | 4 | 5 |
| 29. I felt treatment did not seem as important as the sessions continued | 1 | 2 | 3 | 4 | 5 |
| 30. I feel treatment did not focus on my life and problems | 1 | 2 | 3 | 4 | 5 |
| 31. I now have new or different problems | 1 | 2 | 3 | 4 | 5 |
| 32. My problems seem to have improved, therefore, treatment no longer seems necessary | 1 | 2 | 3 | 4 | 5 |
| 33. Treatment did not seem to be working | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DID YOU FEEL THIS WAY ABOUT YOUR THERAPIST?**

| | | | | | |
|---|---|---|---|---|---|
| 34. I did not like the therapist | 1 | 2 | 3 | 4 | 5 |
| 35. I felt I had to give too much personal information to the therapist | 1 | 2 | 3 | 4 | 5 |
| 36. The therapist did not seem confident that treatment would work for me | 1 | 2 | 3 | 4 | 5 |
| 37. The therapist did not seem confident in my ability to make changes | 1 | 2 | 3 | 4 | 5 |
| 38. I do not feel the therapist supported me or my efforts | 1 | 2 | 3 | 4 | 5 |

## Appendix G: Study 2 Termination Questions for the Client

ID Number

1. In essence, was the decision to terminate therapy (check one only)

a) a unilateral, explicit decision on your part to end therapy?_____

b) based on your own decision not to attend sessions or to schedule subsequent appointments? ____

c) a mutual agreement between you and your therapist that treatment goals had been met? ____

d) due to a decision that you would receive services elsewhere?____

## Appendix H: Study 2 Reasons for Termination – Client

People choose to end therapy for a number of reasons. Below is a list of reasons that may have influenced your decision to end treatment. Please indicate how important you believe each reason was in your decision to end therapy.

| | | | | | |
|---|---|---|---|---|---|
| 1<br>Not at all important | | 2<br>Somewhat Important | 3<br>Important | | 4<br>Very Important |
| 1. | You accomplished what you wanted to do in therapy | 1 | 2 | 3 | 4 |
| 2. | You could no longer fit time for therapy into your schedule | 1 | 2 | 3 | 4 |
| 3. | You just lost interest in therapy | 1 | 2 | 3 | 4 |
| 4. | You no longer had money or insurance coverage to pay | 1 | 2 | 3 | 4 |
| 5. | You felt therapy was going nowhere so ended therapy | 1 | 2 | 3 | 4 |
| 6. | You felt therapy was making things worse so stopped | 1 | 2 | 3 | 4 |
| 7. | You weren't confident in your therapist's ability to help | 1 | 2 | 3 | 4 |
| 8. | You were uncomfortable talking about personal matters | 1 | 2 | 3 | 4 |
| 9. | Therapy didn't fit with your ideas about what would be helpful | 1 | 2 | 3 | 4 |
| 10. | You decided to go elsewhere for services | 1 | 2 | 3 | 4 |

## Appendix I: Study 2 Barriers to Treatment Participation Scale - Therapist

ID Number _____

There can be a number of things that get in the way of someone participating fully in their treatment. Below is a list of possible barriers or obstacles your client may have encountered while in therapy. Please indicate how much of a problem **you think** each potential barrier was **for your client**.

**HOW OFTEN DID THIS STRESSOR OR OBSTACLE CREATE A PROBLEM FOR YOUR CLIENT WHILE HE/SHE WAS IN TREATMENT?**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Once in a while | Sometimes | Often | Very Often |

| | | | | | |
|---|---|---|---|---|---|
| 1. Transportation (getting a ride driving, taking a bus) to the clinic for a session | 1 | 2 | 3 | 4 | 5 |
| 2. Scheduling of appointment times for treatment | 1 | 2 | 3 | 4 | 5 |
| 3. Treatment was in conflict with another of their activities (classes, job, friends) | 1 | 2 | 3 | 4 | 5 |
| 4. During the course of treatment they experienced a lot of stress in their life | 1 | 2 | 3 | 4 | 5 |
| 5. They were sick on the day when treatment was scheduled | 1 | 2 | 3 | 4 | 5 |
| 6. Crises at home made it hard for them to get to a session. | 1 | 2 | 3 | 4 | 5 |
| 7. Treatment added another stressor to their life. | 1 | 2 | 3 | 4 | 5 |
| 8. There was bad weather and this made coming to treatment a problem | 1 | 2 | 3 | 4 | 5 |
| 9. They did not have time for the assigned work | 1 | 2 | 3 | 4 | 5 |
| 10. There was always someone sick in their home | 1 | 2 | 3 | 4 | 5 |
| 11. Getting a baby-sitter so they could come to the sessions | 1 | 2 | 3 | 4 | 5 |
| 12. Finding a place to park at the clinic | 1 | 2 | 3 | 4 | 5 |
| 13. They had a disagreement with their husband/wife, boyfriend/girlfriend, partner about whether they should come to treatment at all | 1 | 2 | 3 | 4 | 5 |
| 14. They were too tired after work to come to a session | 1 | 2 | 3 | 4 | 5 |
| 15. Their job got in the way of coming to a session | 1 | 2 | 3 | 4 | 5 |
| 16. Treatment took time away from spending time with their children | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DID THESE ISSUES CREATE A PROBLEM FOR YOUR CLIENT WHILE HE/SHE WAS IN TREATMENT?**

| | | | | | |
|---|---|---|---|---|---|
| 17. Treatment lasted too long (too many weeks) | 1 | 2 | 3 | 4 | 5 |
| 18. They felt that treatment cost too much | 1 | 2 | 3 | 4 | 5 |
| 19. They were billed for the wrong amount | 1 | 2 | 3 | 4 | 5 |
| 20. Information in the session and any handouts seemed confusing | 1 | 2 | 3 | 4 | 5 |
| 21. They had trouble understanding the treatment they received | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 22. They felt this treatment was more work than expected | 1 | 2 | 3 | 4 | 5 |
| 23. The atmosphere at the clinic made it uncomfortable for appointments | 1 | 2 | 3 | 4 | 5 |

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Once in a while | Sometimes | Often | Very Often |

| | | | | | |
|---|---|---|---|---|---|
| 24. They did not feel that they had enough to say about what went on in treatment | 1 | 2 | 3 | 4 | 5 |
| 25. The assigned work for them to do as part of this treatment was much too difficult | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DO YOU THINK YOUR CLIENT FELT THIS WAY ABOUT THEIR TREATMENT?**

| | | | | | |
|---|---|---|---|---|---|
| 26. Treatment did not seem necessary | 1 | 2 | 3 | 4 | 5 |
| 27. Treatment was not what they expected | 1 | 2 | 3 | 4 | 5 |
| 28. They lost interest in coming to sessions | 1 | 2 | 3 | 4 | 5 |
| 29. They felt treatment did not seem as important as the sessions continued | 1 | 2 | 3 | 4 | 5 |
| 30. They felt treatment did not focus on their life and problems | 1 | 2 | 3 | 4 | 5 |
| 31. They now have new or different problems | 1 | 2 | 3 | 4 | 5 |
| 32. Their problems seem to have improved, therefore, treatment no longer seems necessary | 1 | 2 | 3 | 4 | 5 |
| 33. Treatment did not seem to be working | 1 | 2 | 3 | 4 | 5 |

**HOW OFTEN DO YOU THINK YOUR CLIENT FELT THIS WAY ABOUT THEIR THERAPIST?**

| | | | | | |
|---|---|---|---|---|---|
| 34. They did not like the therapist | 1 | 2 | 3 | 4 | 5 |
| 35. They felt they had to give too much personal information to the therapist | 1 | 2 | 3 | 4 | 5 |
| 36. The therapist did not seem confident that treatment would work for them | 1 | 2 | 3 | 4 | 5 |
| 37. The therapist did not seem confident in their ability to make changes | 1 | 2 | 3 | 4 | 5 |
| 38. They do not feel the therapist supported them or their efforts | 1 | 2 | 3 | 4 | 5 |

## Appendix J: Study 2 Termination Questions for the Clinician

ID Number

1. In essence, was the decision to terminate therapy (check one only)

a) a unilateral, explicit decision on the part of the client to end therapy?____

b) based on the failure of the client to attend sessions to schedule subsequent appointments? ____

c) a mutual agreement between you and the client that treatment goals had been met? ____

d) due only to reaching the limit of 20 treatment sessions? ____

e) due to a decision for the client to receive services elsewhere?____

## Appendix K: Study 2 Reasons for Termination – Therapist

People choose to end therapy for a number of reasons. Below is a list of reasons that may have influenced your client's decision to end treatment. Please indicate how important you believe each reason was in your client's decision to end therapy.

| | | | | | |
|---|---|---|---|---|---|
| 1<br>Not at all important | | 2<br>Somewhat Important | 3<br>Important | 4<br>Very Important | |
| 1. | My client accomplished what he/she wanted to do in therapy | 1 | 2 | 3 | 4 |
| 2. | My client could no longer fit time for therapy into your schedule | 1 | 2 | 3 | 4 |
| 3. | My client just lost interest in therapy | 1 | 2 | 3 | 4 |
| 4. | My client no longer had money or insurance coverage to pay | 1 | 2 | 3 | 4 |
| 5. | My client felt therapy was going nowhere so ended therapy | 1 | 2 | 3 | 4 |
| 6. | My client felt therapy was making things worse so stopped | 1 | 2 | 3 | 4 |
| 7. | My client wasn't confident in my ability to help | 1 | 2 | 3 | 4 |
| 8. | My client was uncomfortable talking about personal matters with me | 1 | 2 | 3 | 4 |
| 9. | Therapy didn't fit with their ideas about what would be helpful | 1 | 2 | 3 | 4 |
| 10. | My client decided to go elsewhere for services | 1 | 2 | 3 | 4 |

## Appendix L: Study 3 Email List Recruitment Script

As part of my doctoral dissertation research, along with Dr. John Hunsley, C. Psych., I am conducting a 10-minute online survey of psychologists and psychological associates regarding their experiences and views on adult clients' termination from psychotherapy. If you are interested in participating in this survey, please go to the following link for further information:

http://www.surveymonkey.com/s/endingtherapy

Thank you in advance,

Robin Westmacott, M.A.
PhD Candidate, University of Ottawa

Dr. John Hunsley, C.Psych. and Robin Westmacott, MA, of the University of Ottawa are conducting a brief online survey of psychologists and psychological associates regarding their experiences and views on adult clients' termination from psychotherapy. If you are interested in participating in this survey, please go to the following link for further information:

http://www.surveymonkey.com/s/endingtherapy

## Appendix M: Study 3 CPA Recruit Research Participants Portal Script

Title: C**lients' reasons for ending psychotherapy.**

Abstract: For my dissertation research, I am seeking psychologists or psychological associates in supervised or autonomous practice who provide individual psychotherapy to adults to complete a short questionnaire about issues around client termination. Results of this study will provide useful information regarding client termination at different points in therapy. Furthermore, the results will provide information about the use of strategies for retaining clients that are used in regular practice. I invite you to take 15 minutes to complete this online survey examining issues around client termination. Participation in research is voluntary. If you choose to participate in this study you may withdraw at any time. No identifying information will be collected. Researchers: Robin Westmacott, M.A. & John Hunsley, Ph.D. (C. Psych). Please contact Robin Westmacott if you have any questions. A summary of findings will be provided when the study is complete. This research has been approved by the University of Ottawa Research Ethics Board.

Researcher: Robin Westmacott, M.A.

Study Population: Psychologists or psychological associates who provide individual psychotherapy to adults.

Participant Obligation: Completion of questionnaires will take approximately 15 minutes.

Location: Online-Ottawa

Study Runs: September 1, 2010 to December 1, 2010

URL: http://www.surveymonkey.com/endingtherapy

## Appendix N: Study 3 Informed Consent

**Title of the study**: Clients' Reasons for Ending Psychotherapy

**Researchers:** Robin Westmacott, M.A., School of Psychology
John Hunsley, Ph.D. (C. Psych), School of Psychology

**Invitation to Participate:** If you are a psychologist or psychological associate in supervised or autonomous practice, you are invited to complete a short questionnaire about issues around client termination.

**Purpose of the Study:** The purpose of the study is to shed light on psychologists' perspectives of client termination at different points in therapy. Furthermore, results will provide information about the use of strategies for retaining clients that are used in regular practice.

**Participation:** Your participation will consist of completing an online survey that will take approximately 10 minutes.

**Risks:** Your participation in this study will not incur any risk.

**Benefits:** Your participation in this study will contribute to the advancement of knowledge around issues related to client termination from therapy. If requested, a summary of findings will be provided when the study is complete.

**Confidentiality and anonymity:** The information you will share will remain strictly confidential. The contents will be used only for purposes outlined above, and your confidentiality will be protected as you will not be asked for identifying information.

**Anonymity** is assured as you will not be asked for identifying information. IP addresses will not be collected.

**Conservation of data:** The data collected will be kept in a secure manner (password protected survey, computer, and locked laboratory).

**Voluntary Participation**: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be entered as incomplete. If you wish to withdraw all of your responses, you may do so by contacting us.

**Acceptance (check one)**:

_____ I accept to participate in the above research study conducted by Robin Westmacott, M.A. of the University of Ottawa, whose research is under the supervision of John Hunsley, Ph.D. (C. Psych).

_____ I refuse to participate in the study.

If you have any questions about the study, you may contact the researcher or her supervisor. Please print a copy of this consent form for your records and for future reference.

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa

## Appendix O: Study 3 Survey

### SURVEY

We are conducting a study about how psychologists/psychological associates view their clients' reasons for ending therapy. If you are a psychologist/psychological associate in supervised or autonomous practice and you provide individual psychotherapy to adults, we invite you to take 15 minutes to complete this survey examining issues around client termination.

**Clients in your practice:**

We are interested in three distinct groups of clients who end therapy; 1) clients who initiate services but fail to engage in psychotherapy, 2) clients who engage in services and make a unilateral decision to end, and 3) clients who engage in services and make a mutual decision with their therapist to end therapy.

1. In your own practice, what proportion of clients would you estimate end treatment (responses should add to 100):

    a. _____ After the intake session but before session 3 (i.e., the proportion of clients who fail to engage in psychotherapy)
    b. _____ After session 3, but making a unilateral decision to terminate
    c. _____ After engaging in therapy, but making a mutual decision with you to terminate

2. In your own practice: For clients who attended an intake session but who left therapy before session 3, how important, from your perspective, are the following reasons to the decision to terminate?

| | | Not important at all | | Somewhat important | | Very important |
|---|---|---|---|---|---|---|
| a. | Clients reached their goals or symptoms improved | 0 | 1 | 2 | 3 | 4 |
| b. | Clients wanted to solve their problems in another way | 0 | 1 | 2 | 3 | 4 |
| c. | Clients were not ready to change, or had insufficient motivation | 0 | 1 | 2 | 3 | 4 |
| d. | Clients were unable to benefit from therapy | 0 | 1 | 2 | 3 | 4 |
| e. | Clients believed that therapy was not helping | 0 | 1 | 2 | 3 | 4 |
| f. | Clients disliked the treatment | 0 | 1 | 2 | 3 | 4 |
| g. | Clients had to wait too long for services | 0 | 1 | 2 | 3 | 4 |
| h. | Clients had negative impressions of my office or staff | 0 | 1 | 2 | 3 | 4 |
| i. | Clients could not afford to pay | 0 | 1 | 2 | 3 | 4 |
| j. | Clients had circumstantial barriers such as transportation, childcare, or schedule issues | 0 | 1 | 2 | 3 | 4 |

3. In your own practice: For clients who engage in psychotherapy (attend an intake and at least 3 sessions), and make unilateral decisions to end therapy, how important are the following reasons to their decision to terminate (from your perspective)?

| | | Not important at all | | Somewhat important | | Very important |
|---|---|---|---|---|---|---|
| a. | Clients reached their goals or symptoms improved | 0 | 1 | 2 | 3 | 4 |
| b. | Clients wanted to solve their problems in another way | 0 | 1 | 2 | 3 | 4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| c. | Clients were not ready to change, or had insufficient motivation | 0 | 1 | 2 | 3 | 4 |
| d. | Clients were unable to benefit from therapy | 0 | 1 | 2 | 3 | 4 |
| e. | Clients believed that therapy was not helping | 0 | 1 | 2 | 3 | 4 |
| f. | Clients disliked the treatment | 0 | 1 | 2 | 3 | 4 |
| g. | Clients had to wait too long for services | 0 | 1 | 2 | 3 | 4 |
| h. | Clients had negative impressions of my office or staff | 0 | 1 | 2 | 3 | 4 |
| i. | Clients could not afford to pay | 0 | 1 | 2 | 3 | 4 |
| j. | Clients had circumstantial barriers such as transportation, childcare, or schedule issues | 0 | 1 | 2 | 3 | 4 |

4. In your own practice: for clients who engage in psychotherapy and make mutual decisions with you to terminate, how important are the following reasons to their decision to terminate (from your perspective)?

| | | Not important at all | | Somewhat important | | Very important |
|---|---|---|---|---|---|---|
| a. | Clients reached their goals or symptoms improved | 0 | 1 | 2 | 3 | 4 |
| b. | Clients wanted to solve their problems in another way | 0 | 1 | 2 | 3 | 4 |
| c. | Clients were not ready to change, or had insufficient motivation | 0 | 1 | 2 | 3 | 4 |
| d. | Clients were unable to benefit from therapy | 0 | 1 | 2 | 3 | 4 |
| e. | Clients believed that therapy was not helping | 0 | 1 | 2 | 3 | 4 |
| f. | Clients disliked the treatment | 0 | 1 | 2 | 3 | 4 |
| g. | Clients had to wait too long for services | 0 | 1 | 2 | 3 | 4 |
| h. | Clients had negative impressions of my office or staff | 0 | 1 | 2 | 3 | 4 |
| i. | Clients could not afford to pay | 0 | 1 | 2 | 3 | 4 |
| j. | Clients had circumstantial barriers such as transportation, childcare, or schedule issues | 0 | 1 | 2 | 3 | 4 |

In addition to information on general patterns in your practice, we would also appreciate having information on some specific clients who recently terminated therapy. As you are reporting on specific clients in the following questions, your ratings may be either similar to or different from the ratings you just gave on general patterns in your practice

**Thank you for responding to questions about reasons clients end therapy in your practice. We would appreciate knowing a few other things about you and your practice.**

1. Please rate the extent to which you use the following strategies to increase engagement and reduce unilateral termination in general in your practice?

| | Never use | | Sometimes use | | Always use |
|---|---|---|---|---|---|
| a. Client selection (either do not accept certain clients for therapy, or stop providing services if services are not working) | 0 | 1 | 2 | 3 | 4 |
| b. in-depth pre-therapy preparation (i.e., prior to commencing therapy, teaching the client about the rationale for therapy, role expectations, how treatment progresses, common misconceptions about psychotherapy, and possible difficulties one may experience during therapy) | 0 | 1 | 2 | 3 | 4 |
| c. Be explicit about negotiating an agreed upon treatment plan | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| d. Set a time limit on the number of therapy sessions | 0 | 1 | 2 | 3 | 4 |
| e. Motivational enhancement (i.e., prior to beginning therapy, initiate procedures that increase the client's willingness to enter into and remain engaged in treatment) | 0 | 1 | 2 | 3 | 4 |
| f. Explicitly foster a strong working alliance early in treatment | 0 | 1 | 2 | 3 | 4 |
| g. Case management (i.e., provide practical support to the client regarding difficult life circumstances that may preclude participation in therapy, including directly assisting the client with housing or employment problems, planning a budget, etc.) | 0 | 1 | 2 | 3 | 4 |
| h. Appointment reminders | 0 | 1 | 2 | 3 | 4 |
| i. Systematic client monitoring (use of a periodic questionnaire or formal monitoring tool to assess client progress) | 0 | 1 | 2 | 3 | 4 |
| j. Other – please describe _____ | 0 | 1 | 2 | 3 | 4 |

2. On average, how many clients per week do you see in individual psychotherapy?

_____

3. Which approach best describes your *primary* theoretical orientation?

    a. Cognitive-behavioural
    b. Family systems
    c. Humanistic/experiential
    d. Interpersonal
    e. Psychodynamic
    f. Other (please specify) _____

4. How many years have you been in independent practice?
    a. Currently in supervised practice
    b. _____ years in autonomous practice

5. What is your gender?
    a. Male
    b. Female

6. What is your age

    _____

7. What is your highest achieved professional degree
    a. Doctorate
    b. Masters

8. Approximately what percentage of your services are provided to :
    a. Adults _____
    b. Children _____
    Adolescents _____

## Appendix P: Examination of Therapist Effects in Study 2

Given that Study 2 had been published, no changes to it are possible. However, in light of research findings that approximately 8% of the variability in treatment outcomes can be attributable to therapists (Kim, Wampold, & Bolt, 2006), researchers increasingly use hierarchical linear modeling with therapist included as a random factor so that variability among therapists is accounted for in the model when testing for significant differences between clients. Significant variability attributable to therapists, i.e., dependence in the therapist data, violates assumptions of parametric tests and can result in incorrect estimation of error terms and an inflated risk of Type I error (Crits-Cristoph & Mintz, 1991).

I conducted a post hoc analysis of therapist effects in Study 2 using HLM 7 software. I examined the variability in each dependent variable accounted for by therapists using procedures described in Kim et al. (2006). The proportion of variance resulting from therapists is the intraclass correlation coefficient, $\rho_I$, defined as the ratio of variance attributable to therapist $\tau^2_0$ to the total variance, which is the sum of the therapist variance and error variance $\sigma^2$ so that:

$$\rho_I = \tau^2_{0/} \tau^2_0 + \sigma^2$$

Table 8 contains intraclass correlation coefficients ($\rho_I$) for each dependent variable in the analyses. Kenny, Kashy, and Bolger (1998), pp.238, have calculated the probability of making a type I error for nested designs as a function of $\rho_I$, group size (clients per therapist; $M$ = 3.3), and total sample size (number of therapists; 31). I used Kenny et al's formula = .05/ (new probability of making a Type I error/.05) = .036 to adjust the Type I error rate to account for inflation caused by dependence in the

therapists' data. See Table 8 for adjusted I-values for each dependent variable. The mean therapist $\rho_I$ was .09. Based on their calculations, the actual probability given an average therapist $\rho_I$ of .09 is $p = .07$. Given that the Bonferroni correction was applied in Study 2 (10 reasons for termination for each analysis, thus the familywise alpha was divided by 10), the adjusted Bonferroni correction produced an adjusted $\alpha$ of .004 for pairwise comparisons. Using this adjusted *p*-value does not change interpretation of results from Study 2. Furthermore, the Bonferroni correction is exceptionally conservative with increasing comparisons, and an acceptable familywise alpha for multiple comparisons can be as high as .15 (Tabachnick & Fidell, 2007). I used a familywise alpha of .05 in the first place, taking a conservative approach to Type I error. Therefore, I feel confident that the results from Study 2 hold despite dependence caused by therapist effects in the data.

Table 8
*Therapist Effects (Intraclass Correlation Coefficient, $\rho_I$) and Adjusted Type I Error Rate (p-value) for Each Dependent Variable*

| Dependent Variable | $\rho_I$ | Adjusted Type I error |
|---|---|---|
| Client: Accomplished goals | .07 | .04 |
| Client: Could no longer fit time for therapy into schedule | .15 | .03 |
| Client: Just lost interest in therapy | .22 | .02 |
| Client: No longer had money or insurance coverage | .00 | .05 |
| Client: Felt therapy was going nowhere so ended therapy | .22 | .02 |
| Client: Felt therapy was making things worse | .24 | .02 |
| Client: Weren't confident in therapist's ability to help | .17 | .03 |
| Client: Uncomfortable talking about personal matters | .14 | .03 |
| Client: Therapy did not fit with ideas of what would be helpful | .17 | .03 |
| Client: Decided to go elsewhere for services | .00 | .05 |
| Therapist: Accomplished goals | .06 | .04 |
| Therapist: Could no longer fit time for therapy into schedule | .00 | .05 |
| Therapist: Just lost interest in therapy | .08 | .03 |
| Therapist: No longer had money or insurance coverage | .00 | .05 |
| Therapist: Felt therapy was going nowhere so ended therapy | .21 | .03 |
| Therapist: Felt therapy was making things worse | .10 | .03 |
| Therapist: Weren't confident in therapist's ability to help | .00 | .05 |
| Therapist: Uncomfortable talking about personal matters | .21 | .03 |
| Therapist: Therapy did not fit with ideas of what would be helpful | .04 | .04 |
| Therapist: Decided to go elsewhere for services | .00 | .05 |
| Difference score 1 | .00 | .05 |
| Difference score 2 | .02 | .05 |
| Difference score 3 | .28 | .02 |
| Difference score 4 | .00 | .05 |
| Difference score 5 | .26 | .02 |
| Difference score 6 | .01 | .05 |
| Difference score 7 | .10 | .03 |
| Difference score 8 | .09 | .04 |
| Difference score 9 | .05 | .04 |
| Difference score 10 | .00 | .05 |
| Working Alliance Inventory total score client | .00 | .05 |
| Working Alliance Inventory total score therapist | .09 | .04 |
| Barriers to Participation in Treatment Scale total score client | .23 | .02 |
| Barriers to Participation in Treatment Scale total score therapist | .04 | .05 |
| SCL-10 pretest | .01 | .05 |
| SCL-10 posttest | .00 | .05 |

*Note.* Difference score = (client score – therapist score for the importance of each termination reason)