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When a therapist leaves a client: Closing the therapeutic relationship effectively

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When a therapist leaves a client:
Closing the therapeutic relationship effectively

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GRSW 682: Project Proposal

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Abstract

Premature termination of the therapeutic relationship occurs when the therapist leaves a client before the clinical work reaches a natural conclusion. This exploratory research study asked the following research question: What are best practices for the facilitation of premature termination of the therapeutic relationship? The conceptual framework guiding this research was based on common factors research in psychotherapy. This was explored through a mixed-methods research design, combining quantitative and qualitative questions in an online survey completed by mental health therapists about their experience with premature termination. The sample consisted of 31 psychotherapists who had all completed graduate training and had an active practice of individual psychotherapy clients. Data was collected through an online survey. Quantitative data was analyzed using Qualtrics Survey Software, and qualitative data was analyzed through the use of grounded theory techniques. 90% of participants reported having encountered premature termination during their careers. From qualitative data, seven themes emerged: 1) Facilitate referral and identify other resources; 2) Reflect on progress and identify unmet goals; 3) Therapist reflect own feelings and reflect on relationship (both sides); 4) Provide early notice; 5) Validate loss of relationship; 6) Honesty; and 7) Highlight client strengths. The researcher wishes to emphasize the ethical imperative of a departing therapist to arrange for an effective transfer of care and the importance of graduate education coursework, continuing education credits, and supervisor training on premature termination. Strengths of this study include a targeting of clinicians closest to the problem of premature termination and a relevance for clinical social work students currently in field placement. Limitations of this study include the lack of follow-up questions in an online survey, which could be remedied in future studies by using qualitative interviews instead.

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Acknowledgments

First and foremost, the researcher would like to thank Dr. Michael Chovanec, MSW, PhD, LICSW, LMFT, for his patient, flexible, and encouraging guidance as Research Chair. He went above and beyond his role for each student this year, providing outlines of what to include in each section of the paper and setting incremental deadlines to keep us on track. Research Committee members Angela Lewis-Dmello, MSW, LICSW, and Sean Fields, MA, provided valuable feedback which greatly improved the final product.

Additional gratitude goes to the researcher's clinical supervisors Denise Morcomb, MSW, LICSW, and Michael Peterson, PhD, LP. Their constant reassurance and empathy for the writing process made a big difference. Similar gratitude goes to the researcher's dog, Peekay, whose earnest sighs and powerful non-verbal communication fostered much-needed levity during this year-long process.

To the researcher's parents, Margaret Redfield, MD, and James Utz, MD: I could not have done this (any of it) without you. You have given me the gift of education. I promise to pay it forward through this soul-affirming work.

When a therapist leaves a client:

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Introduction

Case Example to Illustrate Problem

As an intern therapist at community mental health agency, the author saw “Jane” in individual therapy for eight months. Jane came to the agency seeking safety and guidance regarding her abusive relationship, the most recent chapter in a lifetime of complex trauma. Having been hurt and abandoned by trusted others, Jane struggled to let herself be vulnerable and had learned “to leave others before they can leave me.”

The first months of therapy centered primarily on immediate safety concerns and legal proceedings related to the domestic violence. As Jane came to trust the author over time, attention shifted to her childhood trauma and how the relational patterns she had internalized were keeping her stuck. Slowly Jane grew in her capacity to identify her true needs, which were not getting met in her abusive relationship. Exploring how to get these needs met in a healthy way then became the new goal of therapy. Unfortunately, the author’s internship placement ended shortly after this goal was established. Though much therapeutic work remained to be done, the therapeutic relationship had to be terminated.

Jane agreed to be transferred to another therapist at the agency to continue her work, though expressed significant anxiety. “This is why I don’t let myself get close to people – because goodbyes are so hard,” she explained tearfully. “Now I have to start all over with another new person I don’t trust.” The author’s expression of confidence in the new therapist helped slightly. Still, it did not abate Jane’s experience of loss or abandonment, nor did it quell the author’s feelings of guilt or sadness.

Problem: Premature Termination of the Therapeutic Relationship

Under ideal circumstances, when to terminate the therapeutic relationship is determined mutually by client and therapist (Auld & Hyman, 1991). Termination criteria vary by therapeutic dyad but can include a decrease in distress or mental health symptoms experienced by the client (Beatrice, 1982-1983); a decrease in client's attachment anxiety achieved through earned secure attachment to therapist (Gabbard, 2010); or an increase in client functioning, autonomy, and mastery of developmental tasks (Joyce et al, 2007). When a therapist leaves an agency as in the case example, however, these termination criteria often remain unmet. Termination can thus feel premature, as the therapeutic *relationship* ends before the therapeutic *work* is concluded.

Premature termination of the therapeutic relationship occurs for a variety of reasons in modern clinical practice. Sometimes therapists take parental leave, change roles within an agency, retire, or leave an agency for a position in a different agency or geographic region. Importantly in these cases, the therapeutic relationship is prematurely terminated due solely to a change in therapist's employment circumstances – not because the clients did anything to bring on the termination.

Of chief relevance to this study, however, is premature termination of the therapeutic relationship following the completion of practicum rotations by intern therapists in the fields of social work, psychology, or marriage and family therapy. These intern therapists must terminate therapeutic relationships with each client they served in the previous months.

Effects and Prevalence of the Problem

Given the importance of the therapeutic relationship as healing agent across treatment methods, premature termination of the therapeutic relationship can be disruptive for both client and therapist (Asay & Lambert, 1999). Transference reactions by clients may include an increase

in anxiety (Glenn, 1971); reliving past experiences of loss or abandonment (Dewald, 1965); resurgence of mental health symptoms or defensive acting out behavior (Penn, 1990); or resurgence of conflicts around separation, dependence, sibling rivalry, or parental rejection (Auld & Hyman, 1991). Countertransference reactions by departing therapists may include guilt at abandoning vulnerable clients, self-criticism, a perception that therapist has not done enough for the client, or sadness (Weddington & Cavenar, 1979).

In one study of 26 therapists, 58% reported experiencing premature termination of the therapeutic relationship at least once in their clinical practice (Chang, 1977). Unfortunately, many therapists report having received inadequate training and supervision around facilitating this termination process (Bostic et al, 1996; Weddington & Cavenar, 1979). In one study, only 16% of therapists surveyed reported satisfaction with how they managed the termination process (De Bosset & Styrsky, 1986). In another study, fewer than 20% of therapists surveyed perceived their clients to be ready for termination at the time it occurred, suggesting unmet therapeutic goals (Bostic et al, 1996).

Importance of Problem for Social Work

According to the National Association of Social Work (NASW), 60% of mental health services in the United States are provided by clinically trained social workers (NASW, 2015). The next highest percentage are psychologists (23%), psychiatrists (10%), and psychiatric nurses (5%). This means that clinical social workers are providing a great deal psychotherapy, which inevitably involves terminating the therapeutic relationship (prematurely or otherwise).

The NASW Code of Ethics includes “Importance of Human Relationships” as one of its six core values (NASW, 2008). Clinical social workers recognize that “relationships between and among people are an important vehicle for change,” and “engage people as partners in the

helping process,” (NASW, 2008). As such, it is critical that clinical social workers be attuned to the impact that terminating the therapeutic relationship can have on clients – especially when that termination is the result of a therapist leaving a client prematurely.

The Current Study

Because of the frequency of premature termination and its potential for harm, it is imperative that the training and supervision of new therapists include adequate attention to this subject. This may include technical matters of termination facilitation, anticipation of client responses, and management of countertransference by therapists. The current exploratory study asked the following research question: What are best practices for the facilitation of premature termination of the therapeutic relationship? This was explored through a mixed-methods research design, surveying mental health therapists about their experience with premature termination.

Literature Review

In reviewing the literature on premature termination of the therapeutic relationship, the author noted three main themes. The first was technical matters of premature termination, including topics like when to notify clients of upcoming departure from the agency, how to facilitate client transfer to a different therapist, and the importance of therapist tone in announcing departure. The second theme outlined the subjective experience of clients and therapists who experience premature termination, known in psychodynamic therapy as transference and countertransference. The third theme described tools for therapists of a variety of theoretical orientations to use in facilitating premature termination. Overall, the research is limited here – underscoring the need for increased training and supervision for new therapists in facilitation of premature termination.

Technical Matters of Premature Termination

Fair warning: When to notify clients of upcoming departure

Research has produced inconsistent recommendations for how much warning time departing therapists should give clients in advance of premature termination. Findings vary from as short two weeks (Chang, 1977) to as long as three to six months (Auld & Hyman, 1991; Bostic et al, 1996). Some research indicates that the length of warning time should increase according to the length and depth of work that the client and therapist have done together (Bostic et al, 1996).

For clients with a history of multiple losses or insecure attachment, warning time should also be increased (Penn, 1990). For clients who have become significantly attached to the therapist, too, warning time should be increased. This allows for the trauma of the loss of that attachment relationship to be processed by the client while still within the safety of the

therapeutic relationship (Bostic et al, 1996). If the departure date is known at the onset of therapy (as may be the case for practicum students or other trainees) the therapist should inform the client of that date early on. This allows the client to exercise choice of whether they are comfortable beginning work with a therapist whose tenure is time-limited (Penn, 1990).

In one study of 26 therapists, all but one subject said that their rationale for deciding a sufficient warning period was “an intuitive guess,” (Chang, 1977). This suggests a lack of data to support clinical decisions around termination. Training programs must provide therapists with more sophisticated rationale than guesswork.

Soft hand-off: Facilitating client transfer to different therapist

Several studies point to the importance of dedicating a portion of the therapeutic hour to processing feelings brought up by the therapist’s upcoming departure after it is announced (Chang, 1977). This allows for feelings of loss or abandonment to be processed if necessary, as well as to work towards closure (Penn, 1990). Seeking closure should include summing up major themes of therapy, including progress the client has made or therapeutic skills they have acquired (Penn, 1990). It may also include a reflection on what qualities of the therapist or the therapeutic relationship have been helpful for the client, so that the therapist might remain with the client as an “internalized image” even after their work together ends (Auld & Hyman, 1991).

Seeking closure might also include a discussion of what goals remain unmet, goals which did not come to fruition because of time constraints (Chang, 1977; Penn, 1990; Wachtel, 2002). To acknowledge that therapeutic work remains to be done requires humility on the part of the departing therapist, but it is in the best interest of the client because it leaves room for continued growth (Wachtel, 2002).

Identifying unmet goals may influence a client's decision about whether they feel confident enough to continue working towards those goals on their own or to seek out a new therapist once the current one departs (Penn, 1990). If the client does want to transition to a new therapist, they often desire that the departing therapist assist in this transition by providing trusted referrals (Chang, 1977). If the client does not want to pursue a new therapist, then the termination phase becomes a "supervised practice in self-analysis," in which the departing therapist helps the client identify the tools they need to continue managing their treatment alone (Auld & Hyman, 1991).

Therapist tone in announcing departure

The tone in which the therapist speaks about the upcoming termination can significantly influence how the client experiences it. If the therapist maintains a detached, clinical stance or does not express any of their own emotions associated with the upcoming termination, the client may feel prematurely abandoned (Glenn, 1971). From a psychodynamic perspective in particular, the client is left vulnerable to "narcissistic injury" because the realness of their feelings associated with termination as a loss are not mirrored back to them by the therapist (Goldberg, 1975).

On the contrary, the therapist can validate the client's subjective experience of termination as a loss simply by naming it as such (a loss) and normalizing the client's emotional response as something that makes sense given the positive attachment they had built together (Penn, 1990). A therapist can even invite that response, if the client is not forthcoming with it, by bringing the topic of termination up regularly during preceding therapy sessions (Penn, 1990). The client may have distinct feelings about the two prongs of termination: the end of therapeutic work and of the relationship itself. The therapist must validate both (Penn, 1990).

The therapist can also help by warmly stating their own positive feelings towards the client or relating how the therapist, likely to a smaller degree, experiences a loss in termination too. To that end, it can be helpful for both therapist and client to be reminded that the reason termination of the relationship is hard is in part because their time together was meaningful and real (Penn, 1990). That meaningful impact need not go away when the therapist leaves, as the internalized image of the departing therapist remains with the client even after they leave. To aid in that internalization, the therapist can facilitate a discussion around what qualities of the therapist or what aspects of the therapeutic process and relationship have been helpful. Even if the therapist is no longer physically present, these qualities can live on with the client.

Subjective Experience of Premature Termination

While the therapeutic relationship is professional in nature, it is also made up of two human persons with real emotions which inevitably get stirred up as the relationship comes to an end. It is important for therapists to anticipate these emotional responses so that they can be expressed and validated rather than suppressed or acted out.

Transference: Client Response to Premature Termination

Clients may experience any number of emotions in response to premature termination of the therapeutic relationship, just as they might experience emotions in response to any other kind of separation. The affective responses may include anxiety, depression, pain, and abandonment (Bostic et al, 1996; Glenn, 1971). The client may feel rage over what they experience as betrayal or abandonment by the therapist, or sadness over the loss of the therapist as a “significant object” (Penn, 1990). Often these affective responses to premature termination mirror the client’s responses to losses earlier in life (Bostic et al, 1996).

Transference reactions to premature termination may include a resurgence of unresolved conflicts around separation, dependence, sibling rivalry, or parental rejection – exacerbated during termination when “one sees the last residuals of the dependence that was the core of the positive transference,” (Auld & Hyman, 1991). The client may blame themselves for the loss, wondering if the therapist would have stayed if they had only been a better client (Penn, 1990). The client may feel unworthy of the therapist’s time or attention, convince themselves that the therapist does not care about them, or interpret the termination as yet another confirmation that they are incapable of sustaining meaningful relationships (Bostic et al, 1996).

If these painful emotions are prohibitively uncomfortable for the client to experience directly, they may come out indirectly via defense mechanisms – sometimes primitive ones – that they developed in response to previous separations (Bostic et al, 1996). The client may act out in anger towards the therapist, withdraw from the relationship by missing appointments, or deny the upcoming loss (Penn, 1990). The client may also seek out “substitute transference objects” or deny their attachment to the therapist or the therapeutic process (Bostic et al, 1996).

Alternatively the client may engage in increased “self-defeating behavior” as a means to instill guilt in the therapist by showing them how much their departure has hurt them (Bostic et al, 1996). An increase in self-injurious behaviors or suicidal ideation after the announcement of upcoming termination may be the client’s defensive way of expressing grief and loss if verbalizing it is overwhelming (Beatrice, 1982-1983).

The therapist must anticipate these defenses and draw the client’s attention to the painful emotions underneath the defenses, so that the client’s true emotions can be validated and processed – not only the reactive ones (Glenn, 1971). This can be a painful process but is also an

opportunity to master inevitable experiences of loss within safe holding container of therapy relationship:

“Forced terminations afford powerful opportunities for contending with abandonment, disappointment, and loss directly in therapy. While these experiences are certainly not comfortable, they can be used constructively to benefit patients if the issues surrounding the forced termination are carefully considered and addressed within the therapy,” (Bostic et al, 1996, p. 358).

Countertransference: Therapist Responses to Premature Termination

Therapists may have strong emotional responses to premature termination of the therapeutic relationship, just as their clients do. Though the therapeutic relationship is intentionally one-sided (focused on client), therapists are still bound to develop some feelings towards their clients – whether positive, negative, or somewhere in between. Depending on the nature of their departure from their current position, departing therapists may also have strong feelings associated with the loss of a familiar agency, colleagues, supervisors, or training program (Penn, 1990).

If a client has been difficult to work with, the departing therapist may feel relief in terminating that relationship (Bostic et al, 1996). Alternatively if the client has been enjoyable to work with, the therapist may feel sadness at losing them (Auld & Hyman, 1991). This is especially possible if a strong therapeutic alliance has been established or if the termination occurs early enough in therapy that the therapist has not yet had the satisfaction of seeing their client experience positive growth (Penn, 1990). In the latter case, the therapist may also feel anger or frustration at having to terminate the relationship prematurely (Penn, 1990).

The departing therapist may feel they have not done enough for their clients, especially if they perceive the client as not yet ready for termination (Auld & Hyman, 1991). If the client expresses feelings of abandonment, the therapist might experience guilt for betraying their client's trust (Bostic et al, 1996). They may try to minimize a client's sadness in order to assuage their own guilt, perhaps by downplaying the importance of their relationship or being overly confident that the client will be fine with the new therapist (Bostic et al, 1996). This does not validate the client's feelings. Thus, it is important for the departing therapist to have an outlet to discuss their guilt or self-doubt (e.g. clinical supervision), lest they act out that countertransference in a way that harms the client.

It is also possible for the client's feelings of loss or anxiety in response to premature termination to bring up the therapist's own unresolved separation anxiety or abandonment issues. The therapist may feel defensive or resistant to being the cause of their client's pain – to the idea that they have “deserted, betrayed, or abandoned” the client (Penn, 1990). If the client expresses anger towards the therapist for leaving, they can feel “wounded” as well (Penn, 1990).

Whatever emotions or countertransference arises for the departing therapist, it is important that these responses be proactively identified and processed in supervision (Bostic et al, 1996). This is helpful for the therapist's development as a clinician, and it decreases the chance that the therapist will fall back on their own defense mechanisms in response to the uncomfortable emotions (Penn, 1990). Some therapists withdraw emotionally to protect themselves from clients' strong reactions to terminating the relationship. Others become over-invested in clients as termination draws near, trying to absolve their own feelings of guilt by doing more than ever for their clients. Still others “displace, project, or intellectualize” their feelings associated with premature termination (Penn, 1990). Regardless of the therapist's

particular response, clients are likely to pick up on their subconscious feelings if the therapist has not processed them in supervision (Penn, 1990).

Developing therapists must be taught that it is common to experience strong emotions in response to termination (Chang, 1977). Contrary to popular belief that countertransference is unprofessional or indicative of a therapist having become too attached to a client, these feelings are actually quite normative – as they indicate that positive attachment has been built (Chang, 1977). In fact, countertransference is a valuable clue to the client's experience (Penn, 1990). If the therapist feels guilty, perhaps the client is feeling abandoned. Recognizing countertransference and discussing it in supervision allows the therapist to use their own reactions as a tool rather than a hindrance. Thus, supervisors must encourage therapists to bring up their countertransference feelings, rather than try to repress them (Bostic et al, 1996).

Sufficient supervision for departing therapists is necessary not only to avoid the acting out of countertransference feelings in a way that could harm clients, but also because termination is “the phase in which the most positive growth through mastery can occur, not only by the patient but by the therapist as well,” (Weddington & Cavenar, 1979). Loss of important relationships is an inevitable and painful part of life. For clients to practice mastering the grief that accompanies the loss of a significant person (the therapist, in this case) within the safe holding environment of the therapeutic relationship can help them build confidence in their capacity to handle painful emotions associated with loss outside of therapy too (Bostic et al, 1996). Given the opportunity that this grief mastering process presents, “the most therapeutic course therapist and [client] can follow is sticking with their feelings during the leave-taking process, painful though it may be,” (Weddington & Cavenar, 1979).

Guidance Across Treatment Models

The author consulted with a University of Saint Thomas librarian who is a content expert in the fields of social work and psychology, for assistance in reviewing available literature on premature termination. Databases searched were PsychInfo, PubMed, and Social Work Abstracts. Search terms included “therapist or psychotherapist” and “termination.” Broadly speaking, the literature dealt more with premature termination cause by the *client* leaving therapy early – not the *therapist* leaving. This has a decidedly different dynamic, so guidance offered was of limited usefulness. Additionally, a significant portion of search results were written from a psychodynamic orientation, as described in the preceding section on transference and countertransference. However, sources from other theoretical orientations were also collected – main points of which are described below.

Cognitive-Behavioral Therapy (CBT)

According to Beck, the goal of CBT is “to facilitate remission of patients’ disorders and to teach them skills they can use throughout their lifetime,” (Beck, 2011). The therapeutic relationship is important certainly, but it is not emphasized as heavily as in psychodynamic or interpersonal approaches. More emphasis is placed on skills that clients can use to decrease their symptoms, improve their daily functioning, and take with them after therapy ends. CBT-oriented therapists work to prepare clients for termination right from the first session and the goal to “make treatment as time limited as possible, with the aim of helping them become their own therapist,” (Beck, 2011).

As completing therapy is something that the client is hopefully ready for and proud of, it is celebrated. As such, CBT-oriented therapists do not use the term “termination” so much as “completion of goals” or “completion of contract,” (D. Roseborough, personal communication,

January 17, 2016). To increase manageability of eventual ending, CBT-oriented therapists will make efforts to attribute each bit of progress to the client rather than to the therapist (Beck, 2011). They will also proactively prepare the client for setbacks, normalizing that even a positive trajectory will include “intermittent plateaus, fluctuations, or setbacks,” (Beck, 2011). Setbacks are normal, not indicative that the client or the therapy has failed.

In CBT, the frequency of sessions is generally tapered as client status improves. Before ending the original course of therapy, therapist and client will plan for ways to “recognize and avoid relapse,” identifying what symptoms or behavioral changes might indicate the need for additional therapy in future (D. Roseborough, personal communication, January 17, 2016). In fact, “booster sessions” will often be proactively scheduled for a few months after the original ending. This helps closure feel less permanent than in other theoretical orientations (Beck, 2011).

Grief and Loss

For a grief and loss perspective on premature termination of the therapeutic relationship, the author consulted with an adjunct faculty member at the School of Social Work. A content expert in grief and loss, this source emphasized the concept of ambiguous loss. Ambiguous loss involves a lack of closure or finality that can leave those grieving confused about how to properly mourn their loss (Boss, 2000). Mourning the loss of a loved one who has died (with finality) involves a culturally sanctioned set of rituals and grief processes. On the other hand, mourning the loss of a therapist (who generally has not died) would be considered ambiguous loss. The therapist does not cease to exist, but they are out of reach to the client. It is important for the therapist to validate this loss for the client and normalize any grief that the client feels in response to the loss.

Client-Centered or Humanistic

In his review of client-centered therapy and termination, Richard Krebs claimed that “there is no literature on how therapists terminate client-centered therapy,” (Krebs, 1972). Reflecting instead on his own experience as a client-centered therapist, he offers the following theory about when a client might be ready for termination: “Client-centered therapy has a unique criterion available: when the client can ‘really be himself’ without the therapist,” (Krebs, 1972). This goal of therapy mirrors what client-centered therapist and theorist Carl Rogers identifies as what it means to become a person – namely, dropping the masks we wear and showing our authentic selves (Rogers, 1995).

Importantly, Krebs notes that this process of becoming one’s true self both inside and outside the therapeutic relationship is an ongoing process. It is never entirely finished but becomes increasingly consistent by the time the client and therapist are truly ready to say goodbye: “During this final phase, the client reports in a way that feels solid to both of us that he is ‘really being himself’ outside of the therapeutic relationship...this ability to be himself has spread to most of his relationships...I don’t think it is ever completely solid. Some people or situations may throw the client off balance for a while. He may revert to other ways of being that do not really feel like ‘him.’ But by the time we say goodbye the client is ‘really himself’ most of the time,” (Krebs, 1972).

Common Factors Research

As will be further outlined in the Conceptual Framework of this paper, the emphases on extra-therapeutic factors and the therapeutic relationship in common factors research provide guidance to therapists who find themselves facing premature termination. In his synthesis of psychotherapy research which has become a backbone of the common factors research body,

Michael Lambert found that only 15% of therapeutic change was attributable to the theoretical orientation or interventions used by the therapist (Lambert, 1992). The other 85% of therapeutic change was explained by factors common to all psychotherapy regardless of orientation. 40% was explained by extra-therapeutic factors, such as client characteristics, strengths, or supports outside the therapeutic relationship. 30% was explained by the therapeutic relationship itself, emphasizing client perception of therapist warmth, empathy, and acceptance. Lastly, 15% was explained by placebo or expectancy effects – the same percentage explained by theoretical orientation (Lambert, 1992).

According to the common factors model, therapists must be attuned to relational dynamics all throughout therapy – including as the relationship comes to a close (Murphy, 1999). Transparency, mutual caring between therapist and client, and a validation of the loss of an important relationship are important to fostering a good goodbye.

Summary of Literature Review

Despite the frequency of premature termination and its potential effects (either harmful or growth-oriented), it is under-represented in the literature and under-addressed by many training programs (Curtis, 2002; Weddington & Cavenar, 1979). For instance, in one study of 26 therapists, the majority were not aware of specific strategies for handling therapist-initiated premature termination – nor “even how to think about it,” (Chang, 1977). Most indicated that “they [lacked] a clear rationale of how to handle the situation and would like to know more about how others worked with this problem,” (Chang, 1977).

In reviewing the literature, the author became aware of just how little guidance exists for new therapists encountering premature termination of the therapeutic relationship at the onset of their careers. It is helpful to anticipate transference and countertransference responses to the therapist’s departure, certainly – as supported by several past studies. Allotting a sufficient time period to process the therapist’s departure helps clients, too. However, relatively little knowledge exists as far as specific interventions to facilitate a good ending of the relationship. This gap in the literature motivated the current study’s research question: What are best practices in premature termination of the therapeutic relationship?

Conceptual Framework: Common Factors Research

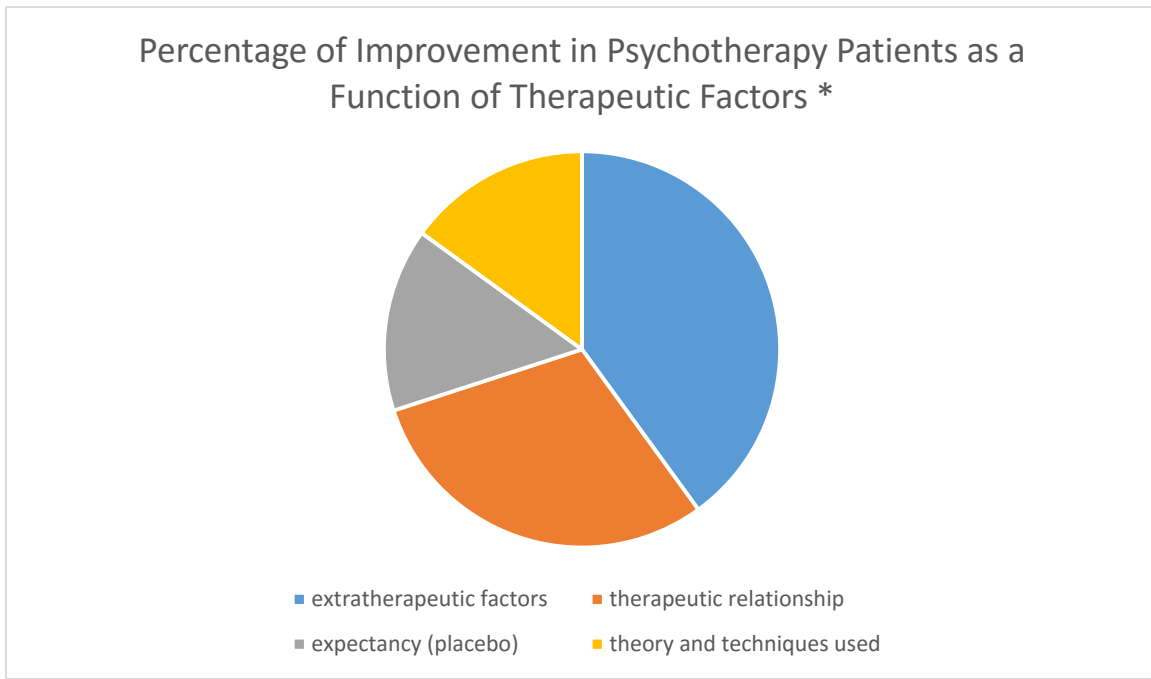
Common factors research refers to a body of knowledge investigating why psychotherapy therapy works. While staunch advocates of various theoretical approaches (e.g. CBT, DBT, psychodynamic) claim that it is their specific method which accounts for therapeutic change, data from common factors research suggests otherwise (Murphy, 1999). With major contributions from James Norcross, Lisa Grencavage, Ted Asay, and Michael Lambert, common factors researchers have suggested that successful psychotherapy shares certain basic commonalities which are more predictive of positive therapeutic outcomes than the theoretical orientation being used.

The language used for these common factors varies by theorist. One prominent model comes from a “comprehensive synthesis of psychotherapy research” conducted by Michael Lambert in 1992 (Murphy, 1999). According to Lambert’s research, only 15% of positive therapeutic change is attributable to the theoretical orientation being used (Murphy, 1999). The other 85% is attributable to what Lambert calls the common factors – which could be present regardless of theoretical orientation. These are described below and represented in Figure 1.

- a) *Extratherapeutic factors (40%)*: This refers to client’s innate strengths or personal characteristics, resources available to client outside of therapy, client’s social supports, or unexpected positive change in the client’s life not caused by therapy. In other words, the success of psychotherapy is impacted greatly by things completely unrelated to the therapy itself – for which the therapist cannot control.
- b) *Quality of the therapeutic relationship (30%)*: This refers to the client’s perception of therapist empathy, warmth, and acceptance. These are traits which a therapist of any theoretical background can (and must) convey to their clients.

- c) *Placebo effects (15%)*: This refers to the influence of client hope, or the expectancy that therapy is supposed to help. (Murphy, 1999)

Figure 1: What Makes Therapy Work?



*Reproduced from Lambert, 1992

The researcher chose common factors research as the conceptual framework for this project because of the primacy of the therapeutic relationship, both in the effectiveness of psychotherapy and in the potential impact of premature termination on either person in that relationship. In designing the survey items, the researcher pulled from common factors research in an effort to assess to what degree participants were considering the common factors in their facilitation of premature termination. The researcher hopes that findings of this study may be useful to clinicians of any theoretical orientation, and urges all clinicians to be attuned to the relational dynamics in creating a good goodbye.

Methods

Research Design

This was an exploratory mixed-methods study designed around the following research question: What are best practices in facilitating premature termination of the therapeutic relationship? Other studies have explored this topic using a variety of research designs, including written surveys, interviews, and focus groups. For feasibility of acquiring a diverse sample size, the current study used an online survey conducted through Qualtrics Survey Software. Most questions were quantitative in nature, assessing the participants' experience with premature termination. The survey ended with one open-ended qualitative question asking participants to reflect on what efforts they have made to close the therapeutic relationship effectively in those cases. Limited demographic information was also be collected regarding participants' years in psychotherapy practice, theoretical orientation, and practice setting.

Sample

To have been included in this study, participants needed to hold a masters or doctorate level degree in the fields of clinical social work, marriage and family therapy, or psychology (PhD or PsyD). They did not need to have achieved full independent licensure but did need to have completed their graduate program in full. As such, graduate students were excluded. To be included, participants also needed to have an active psychotherapy practice with individual clients. Participants were recruited via convenience sampling, utilizing several professional networks and mailing lists to which the researcher had access through former colleagues. These included the Center for Grief Loss and Transition (St Paul), Family Means (Stillwater), the Domestic Abuse Project (Minneapolis), the Cashman Center (Burnsville), and the Minnesota Society for Clinical Social Work.

Protection of Human Subjects

This study was submitted to the Saint Catherine's University Institutional Review Board (IRB) at the Exempt Level of Review. IRB approval was secured before data collection began. The study was approved at the Exempt Level of Review based on meeting several exemption criteria (Saint Catherine University). For instance: Participants were professionals, not clients. As such the participants were not considered vulnerable. Their participation was anonymous, and no identifying information was collected. Participation was through an online survey, not a face-to-face interview. The researcher had no way of knowing if any invited participant chose to participate or not.

Participation in this study was entirely voluntary. Known risk to participation was limited, though an emotional reaction by participants may have been triggered if premature termination material is difficult for them. Known benefits to participation were indirect via contribution to growing clinical knowledge base.

Before accessing the survey, participants reviewed a Consent Form describing the purpose, background information, and procedures of the study (Appendix B). The Consent Form also reviewed the strict confidentiality policy and made clear that participants could choose to end their participation at any point during the survey without consequence. Participants were also provided contact information for the researcher, should they have any questions regarding their participation. As the survey was anonymous, no signature was required. However, participants indicated their acceptance of participation terms by clicking an "Accept" button before they gained access to the survey.

Participants' responses to the survey were stored on a password-protected account using the Qualtrics Survey Software. Printed transcripts of their open-ended responses to the one

qualitative question were be used to aid in the researcher's data analysis and were kept in a locked drawer at the researcher's office. All survey materials (printed and electronic) will be destroyed by the researcher's graduation on May 21st, 2016.

Instrument

The survey instrument was constructed by the researcher to investigate best practices around premature termination of the therapeutic relationship (Appendix D). Survey items were generated from a review of existing literature, filtered through the lens of the researcher's theoretical orientation, and influenced by the researcher's own experience with termination as a therapist in training. All items were edited by committee members to increase validity and mitigate bias. Items were predominantly quantitative in nature, followed by one open-ended quantitative question at the end.

Data Collection

Data was collected through a secure online survey using the Qualtrics Survey Software. In addition to survey questions, limited demographic information was collected. Participants were asked to identify how many years they have been in practice as a psychotherapist, their educational background, and their primary theoretical orientation. As no personally identifiable information was collected, data remained anonymous and confidential.

Data Analysis

Quantitative findings from closed-ended quantitative questions were analyzed using descriptive and inferential statistics via the Qualtrics Survey Software. Qualitative findings from the one open-ended qualitative question were analyzed using a grounded theory of data analysis wherein the researcher immersed herself in the data and inductively identified codes and themes which emerged from the data (Charmaz, 2006). First, the researcher employed the open-coding

technique by summarizing the essence of each sentence of the responses in a one to two word code, hand-written in the margin of the transcript. Second, the researcher compiled a list of all the codes identified and sorted them into three broader themes.

Bias

The current study was conceived due to the researcher's personal interest in the topic of premature termination of the therapeutic relationship. It has been her experience as a therapist in training that premature termination due to therapist departure is a common occurrence, yet is under-addressed in training programs and clinical supervision. This personal experience is both a strength (as the researcher is sensitive to the issue and motivated to learn best practices) and a potential liability (as personal experience may lead to biased or leading questions). To mitigate against this bias, survey items were reviewed by the research committee members.

Findings

This survey generated both quantitative and qualitative data, as well as demographic information about the sample. Quantitative data was analyzed with descriptive measures via the Qualtrics Survey Software. Qualitative data was analyzed via grounded theory of data analysis, according to the methods outlined by Charmaz (Charmaz, 2006).

Sample

Sample consisted of 31 psychotherapists who held a graduate degree in mental health and have an active practice of individual psychotherapy clients. Participants were invited to participate via the email list-servs of various professional organizations including: Center for Grief Loss and Transition (St Paul), Family Means (Stillwater), Domestic Abuse Project (Minneapolis), Cashman Center (Burnsville), and Minnesota Society for Clinical Social Work. Survey remained live for two weeks (March 8-22, 2016).

Of the 31 participants, 77% reported an educational background in clinical social work (n = 24). Others were marriage and family therapy (n = 4), masters in psychology (n = 2), and doctorate in psychology (n = 1). Over half of participants (55%) reported being in practice at least seven years (n = 17) and 39% reporting 16+ years (n = 12). The most common theoretical orientations identified by participants were psychodynamic (45%, n = 14) and systems theory (29%, n = 9). Others were cognitive-behavioral (16%, n = 5), humanistic/client-centered (6%, n = 2), and solution-focused (3%, n = 1). Most common practice settings reported were for-profit group or private practice (55%, n = 17) and non-profit community agency (29%, n = 9). Others were school-based counseling center (n = 4) and county or state agency (n = 1).

These demographic characteristics are displayed in Figures 2-5 below.

Figure 2. Educational Background of Participants

#	Answer	Response	%
1	Clinical Social Work (Masters)	24	77%
2	Marriage and Family Therapy (Masters)	4	13%
3	Psychology (Masters)	2	6%
4	Psychology (PsyD)	0	0%
5	Psychology (PhD)	1	3%
	Total	31	100%

Figure 3. Length of Time in Practice as Psychotherapist

#	Answer	Response	%
1	0-2 years	4	13%
2	3-6 years	10	32%
3	7-10 years	3	10%
4	11-15 years	2	6%
5	16+ years	12	39%
	Total	31	100%

Figure 4. Theoretical Orientation of Participants

#	Answer	Response	%
1	Cognitive-Behavioral	5	16%
2	Psychodynamic	14	45%
3	Solution-Focused	1	3%
4	Humanistic/Client-Centered	2	6%
5	Systems	9	29%
	Total	31	100%

Figure 5. Practice Setting of Participants

#	Answer	Response	%
1	Community agency (non-profit)	9	29%
2	School-based counseling center	4	13%
3	Mental health group practice (for-profit)	3	10%
4	Mental health private practice (for-profit)	14	45%
5	County or state agency	1	3%
	Total	31	100%

Quantitative Data: Circumstances of Premature Termination

Perhaps the most basic question asked of the data was: How common is premature termination? Item 8 assessed this via the following question: “In your career as a psychotherapist, how often have you experienced the need to terminate a therapeutic relationship prematurely for reasons unrelated to the client?” Figure 6 shows the distribution of responses.

Figure 6. Frequency of Premature Termination

#	Answer	Response	%
1	Never	3	10%
2	Rarely	13	42%
3	Occasionally	12	39%
4	Frequently	3	10%
	Total	31	100%

Participants who had encountered premature termination did so under a variety of circumstances, as assessed by Item 9: “What was (were) the reason(s) for your departure(s)?” Participants were instructed to select all reasons that applied. The most common reasons were

leaving the agency (53%, n = 16) and practicum rotation ending (47%, n = 14). Other reasons were change in life circumstances (20%, n = 6), losing job (10%, n = 3), and switching roles within the same agency and cannot carry clients over (7%, n = 2).

Participants who had experienced premature termination did a variety of things to cope, as assessed by Item 12: “What coping strategies or supports did you utilize to guide your facilitation of premature termination and/or your own emotional reaction to the experience?” Participants were instructed to select all options that apply. 90% of participants reported consulting with colleagues (n = 26), while 76% reported consulting with a supervisor (n = 22). 28% reported attending their own psychotherapy (n = 8), while 24% reported increasing self-care practices (n = 7).

Even though premature termination can be a stressful experience, 86% of participants reported being “very satisfied” or “somewhat satisfied” with their own facilitation of premature termination in the past (Item 13). In addition, 79% reported being “very satisfied” or “somewhat satisfied” with the clinical supervision they received around premature termination (Item 14). Participants were markedly less satisfied with their graduate program’s attention to premature termination (Item 15). Only 29% reported being “very satisfied” or “somewhat satisfied” (n = 8). 46% reported “neutral” feelings (n = 13), while 25% reported being “somewhat dissatisfied” or “very dissatisfied” (n = 7).

Item 7 asked participants: “Of the clients on your caseload at the time of your departure, what percentage did you perceive to be clinically ready for termination at the time it occurred?” This item attempted to assess whether the termination really was premature, in those cases – if the therapeutic relationship ended before the therapeutic work had concluded. As shown in

Figure 7, the distribution of responses suggested that termination was indeed premature in at least half of cases.

Figure 7: Percentage of clients clinically ready for termination at the time it occurred

#	Answer	Response	%
1	0-19%	13	45%
2	20-39%	3	10%
3	40-59%	8	28%
4	60-79%	3	10%
5	80-100%	2	7%
	Total	29*	100%
		*=-missing data for two participants	

Item 11 attempted to assess the influence of common factors theory on participants’ decision-making during instances of premature termination. It asked: “Which factor most impacts how you talk with a client about premature termination of the therapeutic relationship?” 62% of participants indicated that “quality of therapeutic alliance” was most important (n = 18), while 21% indicated “client expectations” was most important (n = 6). The remaining 5 responses were split between “client motivation,” “what treatment model you are applying,” and “extent of social supports available to client outside of therapy.”

Qualitative Data: How Participants Have Handled Premature Termination

Qualitative data came from participants’ written responses to Item 16, an open-ended question which asked: “In your experience(s) with premature termination, what efforts did you make to close the therapeutic relationship effectively?” The goal was to access participants’ existing knowledge on what techniques or interventions aid in creating this ‘good goodbye.’ 23 of 31 total participants provided a response to Item 16.

From the transcript of responses to Item 16, the researcher identified brief codes from the transcript. Those codes which appeared in three or more participant responses became themes.

Ten themes were identified initially, then condensed to seven themes according to similar content. The researcher also identified quotes that best represent each of the seven themes. The number in parentheses after each theme indicates the number of times that theme was represented by codes. Thus, the seven themes are listed from strongest to weakest.

Theme 1: Facilitate Referral (13x) & Identify Other Resources (6x)

This theme speaks to participants' desire to prevent causing harm to clients upon their departure by arranging a continuation of care plan. This may include community resources and/or a referral for a new therapist. If a new therapist is desired, several participants mentioned the usefulness of a warm hand-off from one therapist to the next. The departing therapist might refer to a clinician he or she knows well, trusts, and believes to be a good fit for the client. Ideally this new therapeutic relationship would be established before termination occurs, as one participant explained: "...Gave referrals and, in some cases, let the clients meet said referrals or at least speak to them in advance of scheduling before transitioning to the new therapist," (Participant #2, page 1).

Theme 2: Reflect on Progress (8x) & Identify Unmet Goals (5x)

This theme echoes the idea that premature termination is about ending a specific therapeutic *relationship*, while not necessarily ending the therapeutic *work*. It is important to reflect on progress that the client has made within this present therapeutic relationship, while also identifying progress left to make. In other words, the departing therapist can help the client identify remaining unmet goals which the client can work towards going forward. As one participant explained, they "offered positive feedback regarding therapeutic work accomplished by client and areas client could get continued support to further achieve aspirations," (Participant #3, page 1).

Theme 3: Therapist Reflect Own Feelings (4x) & Reflect on Relationship - Both Sides (3x)

While the therapeutic relationship is focused on the client, the therapist is a person too and is bound to be affected by the client and their relationship. For some clients, it is helpful to hear the therapist reflect their own feelings about the relationship and its ending. It can suggest to them that the therapist has been paying attention and cares about them as an individual: “Making space to say goodbye and/or acknowledge mutual caring in the therapeutic relationship in well-established clients...conveying (in a way that is appropriate to the therapeutic relationship) ways in which their work has been meaningful/touching to me,” (Participant #17, page 1).

Theme 4: Early Notice (5x)

No two clients are alike. While a long-term client may need six months or more of warning time to process the upcoming termination, other short-term clients may only need a week or two. Some clients want to know more about why the ending is occurring, while others prefer to know less. It is the departing therapist’s responsibility to ascertain how much warning time each client needs and provide early notice whenever available. In order for the termination to be sufficiently processed, one participant “gave early notice and opportunities to reflect on meaning of our termination as relevant to each client,” (Participant #3, page 1).

Theme 5: Validate Loss of Relationship (4x)

The therapeutic relationship is unique to other relationships in life (e.g. friends, family, or partner) because of its inherently one-sided nature. It is a unique relationship, but a real one too. Especially for clients who lack other strong attachment relationships outside of therapy, termination can be a real loss. It is important for the therapist to validate that loss as real and potentially painful. One participant suggested a concise way of doing so: “Validate that no one wants to leave a good therapeutic situation before its time,” (Participant #6, page 1). It may also

help to remind the client that part of why ending is hard is because the therapy was meaningful.

While grieved as a loss, it can also be celebrated.

Theme 6: Honesty (4x)

Several participants spoke to the importance of giving clients an honest and transparent explanation of why the termination is occurring. It is up to each therapist to decide how many details he or she would like to give the client about the reason for his or her departure from the agency or position, as well as where he or she may be working next. The most important point is to reassure clients that the relationship is not ending because the client did anything wrong:

“Remind clients that this is not their fault,” (Participant #9, page 1).

Theme 7: Highlight Client Strengths (3x)

Several participants mentioned the importance of highlighting client strengths and attributing the success of therapy to the client themselves. The relationship may have been important and the therapist influential, but ultimately it is the client who did the work. In fact, the client can continue to do that work even after the current therapeutic relationship ends – as spoken to in the following participant response: “Highlighting clients’ strengths in continuing on their healing journey in whatever form that takes next,” (Participant #17, page 1).

Discussion

Sample

The researcher cannot report a precise response rate since the exact number of people who were invited to participate is unknown. In recruiting participants, the researcher targeted agencies and where she knew that alumni of the School of Social Work at Saint Thomas and Saint Catherine were employed, in hopes that they might be empathetic to the requirement of this clinical research project for the researcher's graduation. Each agency distributed to their staff members via email a flyer designed by the researcher which described the present study and provided a link to the survey should they like to participate. Members of the Minnesota Society for Clinical Social Work were also emailed the same flyer.

The sample was predominantly clinical social workers, with 77% identifying an MSW as their educational background. Masters level clinicians in general made up for all but one of participants. Only one participant reported having a doctorate degree. This high percentage of clinical social workers compared to other clinicians is consistent with prior research which has demonstrated that 60% of psychotherapy in the United States is provided by MSWs (NASW, 2015). This suggests that the current sample was representative of psychotherapists who primarily do clinical work.

A Common Occurrence

Item 8 attempted to assess the frequency of premature termination for participants via the following question: "In your career as a psychotherapist, how often have you experienced the need to terminate a therapeutic relationship prematurely for reasons unrelated to the client?" Notably, 90% of participants had encountered premature termination at least once in their careers as psychotherapists – suggesting that premature termination is not a fluke but a regular part of

clinical practice. This is a higher percentage than previous studies cited in the literature review, in which the prevalence rate of premature termination was 58% (Chang, 1977).

One possible explanation for this study's higher prevalence rate of premature termination is that participants self-selected to be included in a study on premature termination. It is possible that they were already attuned to the dynamics of premature termination or had already gotten training on how to facilitate it. Since participants in this study tended to be fairly experienced, as well, many had more years of practice to draw from. To get a more nuanced picture of therapist experiences, future studies might specifically target new therapists.

Common Factors Research

When asked what factor most influenced the way they made decisions about premature termination, only two participants (of 31) indicated that "what treatment model you're using" was the most important factor. On the contrary, 62% of participants (18 of 31) indicated that "quality of therapeutic alliance" was most important. This reinforces the literature on common factors theory, which touts the importance of the therapeutic relationship across theoretical frameworks (Lambert, 1992; Murphy, 1999).

Graduate Programs Need to Address Premature Termination

Participants were generally dissatisfied with their graduate program's attention to premature termination (Item 15). Only 29% reported being "very satisfied" or "somewhat satisfied" (n=8). 46% reported "neutral" feelings (n=13), while 25% reported being "somewhat dissatisfied" or "very dissatisfied" (n=7). This suggests to the researcher that how to facilitate termination is something that psychotherapists generally learn on the job, rather than during graduate school. Thus, graduate programs might better serve their students by more explicitly attending to the experience of premature termination of the therapeutic relationship.

The Problem with Self-Report Data

Participants in this study reported 86% satisfaction with their own facilitation of premature termination (Item 13). This contradicts the literature that the author reviewed during the research process, which suggests much lower satisfaction rates. For instance, one study of 26 therapists found that the majority were not aware of specific strategies for handling premature termination – nor “even how to think about it,” (Chang, 1977). Most indicated that “they [lacked] a clear rationale of how to handle the situation and would like to know more about how others worked with this problem,” (Chang, 1977). One possible explanation for this study’s higher rate of self-reported satisfaction is social desirability bias, referring to participants’ desire to be seen as doing their jobs well and tendency to assess their own performance as more favorable than it actually is (Grimm, 2010).

The Importance of Clinical Supervision

79% of participants reported being satisfied with the clinical supervision they received around premature termination (Item 14). While that seems positive at first glance, it also indicates that 21% of participants did not receive that quality supervision. In a field where clinical supervision is vital to responsible service delivery, this means that one in five therapists were providing therapy without that quality control function. This needs to be improved. One way to do this would be requiring clinical supervisors to receive continuing education on premature termination.

Researcher Reaction to Qualitative Findings

The qualitative findings were generally consistent with the researcher’s intuition and advice from the literature, emphasizing the importance of the therapeutic relationship in both the healing process of therapy and goodbye process of termination. Many participants mentioned

that the present (termination) must be validated as a real loss of a relationship, consistent with grief and loss research that likens premature termination to ambiguous loss (Boss, 2000).

Additionally, the meaning of the work done together must be validated as meaningful – which is in part why saying goodbye can feel painful. Several participants mentioned that it is helpful for the therapist to reflect back to the client what their work together meant to them, to show that the relationship does go both ways.

Findings were also consistent with the strengths perspective paramount to social work practice (Saleebey, 2002). After therapist and client identify what growth has occurred while working together, the client is encouraged to internalize that growth as their own. Even if the therapeutic relationship ends, the growth can continue if the client owns the change. The client may continue with or without a new therapist, depending on their wishes and clinical acuity.

Many participants in this study mentioned the potential usefulness (if a referral is in order) of the client meeting the new therapist prior to having the last session with the departing therapist. This ‘warm hand-off’ can help build trust and continuity for the client, perhaps even having a session with all three persons present for a session. This also gives the client a chance to verbalize to the new therapist what has felt safe or helpful about working with the departing therapist – style, energy, interventions, communication patterns, etc. This process of identifying their needs and asking for them from the new therapist is a growth opportunity for the client (Bostic et al, 1996).

Limitations and Recommendations for Future Research

The survey instrument used in this study had limitations, namely that it lacked follow-up questions which could have translated key findings more clearly into implications for social work. For instance, one key finding was that participants reported dissatisfaction with their

graduate programs' curriculum on premature termination. However, the survey did not ask what was missing from the curriculum or how the curriculum could have been improved. The researcher recommends that future studies alter the survey instrument to include more detailed questions about what participants' graduate programs did and did not prepare them for regarding premature termination. Survey might also ask participants what they have learned through clinical supervision (on the job) that would have been helpful to be exposed to while still in graduate school. This would involve having more open-ended questions in the survey.

A broader limitation was in research design. This study used an online survey with primarily close-ended questions for ease of accessing a sufficient sample size. However, the ability to examine actual experiences of the premature termination process based on quantitative data was limited. The researcher recommends that future studies include more opportunities for open-ended, qualitative responses. This might be accomplished by changing the research design to qualitative interviews with a variety of professionals. Even if the quantity of responses would be lower using qualitative interviews, the depth of participant responses and case examples may prove valuable in generating practice recommendations.

A third limitation could be in the generalizability of results to therapists working with different client populations. Therapists who participated in this survey were required to have an active individual therapy practice with adult clients. Thus, therapists who work only with children or only in groups were excluded. Different termination techniques would be necessary to be developmentally appropriate to child clients (as well as adults with certain developmental or cognitive disabilities) or to be sensitive to group dynamics. Future studies might target these group therapists or child therapists specifically.

Implications for Social Work

The majority of participants in this study identified that the training they received around premature termination during graduate school was inadequate. Thus, it would be in the interest of MSW programs to address premature termination more thoroughly in their curriculum. That way, every MSW student will at least begin to consider premature termination while still within the structure of an MSW program with access to guidance from knowledgeable faculty members. It is also the researcher's hope that more research will be done on premature termination, as to provide therapists with guidance in better serving their clients throughout the entire arch of the therapeutic relationship.

The strongest theme in this study was the importance of the departing therapist aiding the client in arranging a referral before premature termination occurs. Of the 23 participants who provided a response to the open-ended Item 16, 13 identified this referral theme. Many emphasized that the sooner the referral is arranged, the better – perhaps even overlapping for a period of weeks so that the client can adjust to the new therapist. This cannot be arranged last minute, especially if the departing therapist wants to influence the referral based on goodness of fit for the client. Any social worker who anticipates leaving their position should have a working list of referrals in place, enabling them to connect clients with multiple sources of support before the termination occurs. In keeping with the guiding principles of social work practice, these referrals should be appropriate to the client's broader social systems and available resources.

Conclusion

One strength of this study is that it targeted those professionals closest to the clinical problem of premature termination, psychotherapists providing individual psychotherapy. These professionals work with the therapeutic relationship every day, and 90% of them reported encountering premature termination at least once in their careers. If the current sample is at all representative of psychotherapists in general, the current study suggests that premature termination is a common occurrence and needs to be addressed via graduate education and clinical supervision.

A second strength of this study is its relevance for clinical social work students currently in field practicum. These students are likely to encounter premature termination during their practicum placements and thus need guidance in doing so skillfully. The author, for instance, had to terminate relationships with all her clients upon conclusion of her foundation level practicum in August 2015. She will do the same with all her clients at her current clinical practicum upon graduation in May 2016. The author and numerous colleagues have expressed a desire to learn more about how to foster this good goodbye.

In closing, the researcher would like to emphasize the ethical imperative of facilitating premature termination in a way that is sensitive to each client. As clinical social workers, we are ethically bound to do no harm to our clients. We must provide effective transfer for continuation of care. To not do so would be to risk causing harm to clients. Regardless of the theoretical orientation from which one is practicing, the therapist is the one responsible for achieving mastery over the termination process. This mastery can (and ethically must) be developed through increased attention to premature termination in MSW programs, required continuing education on premature termination, and supportive clinical supervision.

Appendix D
Survey Instrument

When a therapist leaves a client:

Best practices in premature termination of the therapeutic relationship

Instructions: The following mixed-methods survey includes both quantitative and qualitative questions, as well as demographic information. It will approximately 10-15 minutes to complete.

The researcher wishes to emphasize the importance of the open-ended, qualitative question at the end of the survey, which offers the best chance of identifying best practices. Your thoughtful responses are much appreciated.

Demographics

1. How many years have you been in practice as a psychotherapist? (Please include time spent in relevant internship or practicum placements.) Select one:
 - a) 0-2 years
 - b) 3-6 years
 - c) 7-10 years
 - d) 11-15 years
 - e) 16 or more years

2. What is your clinical background? Select one:
 - a) Clinical Social Work (Masters)
 - b) Marriage and Family Therapy (Masters)
 - c) Psychology (Masters)
 - d) Psychology (PsyD)
 - e) Psychology (PhD)
 - f) Other

3. Please select the theoretical orientation with which you most closely align. Select one:
 - a. Cognitive Behavioral
 - b. Psychodynamic
 - c. Solution-Focused
 - d. Humanistic or Client-Centered
 - e. Systems
 - f. Other

4. Please describe your current practice setting. Select one:
 - a. Community non-profit agency (e.g. Catholic Charities or Walk-In Counseling Center)
 - b. School-based setting (e.g. college counseling center)
 - c. For-profit mental health agency (e.g. Emily Program or Nystrom and Associates)
 - d. Private practice mental health (for-profit)
 - e. County or state agency
 - f. Other

Quantitative Questions

1. In your career as a psychotherapist, how often have you experienced the need to terminate a therapeutic relationship prematurely for reasons unrelated to the client (e.g. your departure or a leave of absence)? Select one:
 - a. Never
 - b. Rarely
 - c. Occasionally
 - d. Frequently

2. If so, what was (were) the reason(s) for your departure(s)? Select all that apply:
 - a. Change in life circumstances: (e.g. illness, pregnancy, personal hardship)
 - b. Internship or practicum rotation ended
 - c. Lost your job (e.g. laid off, fired, position eliminated)
 - d. Switched roles within the agency
 - e. Left the agency for a new position elsewhere
 - f. Other

3. How much notice did you give your clients in advance of your departure? Select one:
 - a. 1-2 weeks
 - b. 3-4 weeks
 - c. 1-2 months
 - d. 3-5 months
 - e. 6 months or more

4. How much notice do you think is ideal to give your clients in advance of your departure? Select one:
 - a. 1-2 weeks
 - b. 3-4 weeks
 - c. 1-2 months
 - d. 3-5 months
 - e. 6 months or more

5. Of the clients on your caseload at the time of your departure, what percentage did you perceive to be clinically ready for termination at the time it occurred?
 - a. 0-19%
 - b. 20-39%
 - c. 40-59%
 - d. 60-79%
 - e. 80-100%

6. Which factor most impacts how you talk with a client about premature termination of the therapeutic relationship?
Select one:
 - a. Quality of therapeutic alliance with client
 - b. What treatment model you are applying
 - c. Client expectations
 - d. Client motivation
 - e. Extent of social supports available to client outside of therapy

7. What coping strategies or supports did you utilize to guide your facilitation of premature termination and/or your own emotional reaction to the experience? Select all that apply:
 - a. Discuss in clinical supervision
 - b. Consult with colleagues
 - c. Attend your own psychotherapy
 - d. Increase self-care practices
 - e. Other

8. How satisfied are you with your facilitation of premature termination in the past?

very satisfied---somewhat satisfied---neutral---somewhat dissatisfied---very dissatisfied

9. How satisfied are you with the clinical supervision you received around premature termination?

very satisfied---somewhat satisfied---neutral---somewhat dissatisfied---very dissatisfied

10. How satisfied were you with your graduate program's attention to premature termination?

very satisfied---somewhat satisfied---neutral---somewhat dissatisfied---very dissatisfied

Qualitative Question

1. In your experience(s) with premature termination, what efforts did you make to close the therapeutic relationship effectively? Please describe:

[Text box for open-ended typed response.]

Conclusion

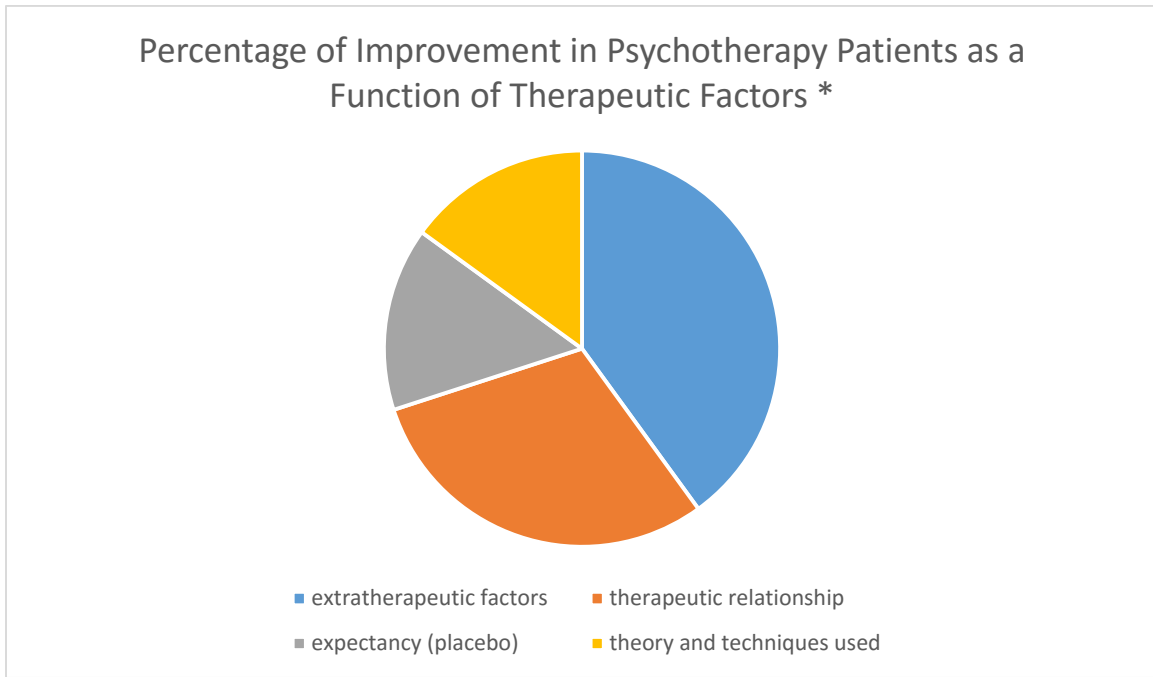
Thank you for participating in this survey. Your responses are much appreciated. If you have any questions or feedback about your participation, you are free to contact the researcher at maryutz719@gmail.com.

Would you like to be emailed the results of this study after data has been analyzed?

- a. Yes (Provide email address here: _____)
- b. No

Figures

Figure 1: What Makes Therapy Work? (p. 19)



*Reproduced from Lambert, 1992

Figure 2. Educational Background of Participants (p. 25)

#	Answer	Response	%
1	Clinical Social Work (Masters)	24	77%
2	Marriage and Family Therapy (Masters)	4	13%
3	Psychology (Masters)	2	6%
4	Psychology (PsyD)	0	0%
5	Psychology (PhD)	1	3%
	Total	31	100%

Figure 3. Length of Time in Practice as Psychotherapist (p. 25)






#	Answer		Response	%
1	0-2 years		4	13%
2	3-6 years		10	32%
3	7-10 years		3	10%
4	11-15 years		2	6%
5	16+ years		12	39%
	Total		31	100%

Figure 4. Theoretical Orientation of Participants (p. 25)






#	Answer		Response	%
1	Cognitive-Behavioral		5	16%
2	Psychodynamic		14	45%
3	Solution-Focused		1	3%
4	Humanistic/Client-Centered		2	6%
5	Systems		9	29%
	Total		31	100%

Figure 5. Practice Setting of Participants (p. 26)

#	Answer	Response	%
1	Community agency (non-profit)	9	29%
2	School-based counseling center	4	13%
3	Mental health group practice (for-profit)	3	10%
4	Mental health private practice (for-profit)	14	45%
5	County or state agency	1	3%
	Total	31	100%

Figure 6. Frequency of Premature Termination (p. 26)

#	Answer	Response	%
1	Never	3	10%
2	Rarely	13	42%
3	Occasionally	12	39%
4	Frequently	3	10%
	Total	31	100%

Figure 7: Percentage of clients clinically ready for termination at the time it occurred (p. 28)

#	Answer	Response	%
1	0-19%	13	45%
2	20-39%	3	10%
3	40-59%	8	28%
4	60-79%	3	10%
5	80-100%	2	7%
	Total	29*	100%
	* = missing data for two participants		

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