ABSTRACT

A QUALITATIVE STUDY OF PERSPECTIVE DIVERGENCE AND PREMATURE TERMINATION FROM PSYCHOTHERAPY

by Valerie A. Loeffler

Approximately one-third of clients that therapists label 'premature terminators' will, if asked, say that they were no longer in need of services when they ended therapy. While the current literature assumes that this disjoint in opinion is due to therapist miscalculation of therapy outcome, this study explored an alternative model based on a divergence of perspectives between therapists and clients. Three former psychotherapy clients (who indicated that they were no longer in need of services) and their therapists (who indicated that their clients were still in need of services) participated in interviews during which they described the problems they were working on in therapy, the process of termination, and their views on therapy in general. The results suggested that therapist-client differences in problem conceptualization and therapy values contributed to divergent perspectives on the appropriateness of termination. A final section of this paper includes a discussion of the implications of these results for psychotherapy practice and research.
A QUALITATIVE STUDY OF PERSPECTIVE DIVERGENCE
AND PREMATURE TERMINATION FROM PSYCHOTHERAPY

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A Qualitative Study of Perspective Divergence and Premature Termination from Psychotherapy

Therapists typically have an average of 48% of their clients terminate prematurely, according to their own professional judgments (Wierzbicki & Pekarik, 1993). About a third of these clients, however, indicate that they terminated because they were improved or no longer in need of services. Researchers have yet to explore empirically the typical explanation for this discrepancy: that therapists are misjudging therapy outcomes. In addition, alternative hypotheses have yet to be both proposed and explored.

The current study explored the literature’s current hypothesis, as well as a new alternative hypothesis. This alternative hypothesis, based on Reis & Brown’s (1999) “perspective divergence” model of premature termination, outlines several potential ways that clients and therapists might differ in the ways they evaluate and describe outcome. This study looked in depth at three former psychotherapy clients (who indicated that they were no longer in need of services) and their therapists (who indicated that their clients were still in need of services) and explored their experiences with respect to these two hypotheses. Before describing the development of the new alternative hypothesis in more depth, I will provide a brief look at the current literature on premature termination.

Premature termination in the literature

Premature termination of psychotherapy services has been defined in many ways, including client failure to complete some predetermined number of psychotherapy sessions, client failure to attend the last scheduled session, and therapist judgment of a need for further services. The spirit of the concept, however, most closely matches this last definition (Pekarik, 1985a). Premature terminations are those terminations made unilaterally by clients whose therapists believe the work has not been completed.

The literature views premature termination of psychotherapy services as a “significant obstacle to the delivery of effective mental health services” (Wierzbicki & Pekarik, 1993, p. 190). In addition to limiting the cost effectiveness of therapy, premature termination poses morale problems for therapists and credibility problems for the profession (Pekarik, 1985b; Garfield, 1994). Most importantly, premature
termination often is assumed to indicate treatment failure, or that the therapeutic relationship has failed to adequately meet the needs of the client (Duehn & Proctor, 1977).

Much of the research on the topic of premature termination has focused on those variables that may be used to predict treatment dropout. Researchers have looked at the influence of client demographic variables (e.g., sex, race, social class, education, SES, occupation), therapist demographic variables (e.g., sex, experience, degree, orientation), and administrative variables (e.g., time on a waiting list, referrals) on premature termination rates (Garfield, 1994). Despite the large size of the premature termination literature, researchers have characterized the results as “replete with conflicting findings, replication failures, and small differences between dropouts and completers” (Wierzbicki & Pekarik, 1993, p. 190). Therapist, client, and administrative variables alone tend to be inconsistently associated with dropout, with only socioeconomic status and race emerging as consistent (but not strong) predictors according to recent meta-analyses (Reis & Brown, 1999; Wierzbicki & Pekarik, 1993).

Researchers have identified relationship-oriented variables, such as working alliance, as more fruitful targets for research on premature termination than demographic variables. For example, perceptions of therapist expertness and trustworthiness (e.g., McNeill, May & Lee, 1987), liking for the therapist, and helping alliance (e.g., Tryon & Kane, 1990) are much more reliably associated with premature termination than static client or therapist attributes. Reis & Brown (1999, p. 129) have deemed the therapeutic alliance – as characterized by an affective bond and sense of collaboration between therapist and client – “the most decisive component of client’s decisions regarding termination.”

A sense of shared goals and expectations for the process of therapy appears to be important as well. For example, researchers have documented widely the “expectation-reality discrepancy” as a precursor to dropout (Horenstein & Houston, 1976; Mennicke, Lent, & Burgoyne, 1988; Garfield 1994). In essence, clients whose expectations of therapy are very different from their perceptions of the therapy they actually receive tend to terminate sooner. In addition, client pretreatment therapy preparation (usually consisting of videotapes or brochures describing therapy), designed to bring client
therapy expectations closer to those of their therapists, significantly decreases treatment dropout (Reis & Brown, 1999).

Reis & Brown (1999) proposed that all of the factors reliably associated with premature termination (e.g., expectation-reality discrepancies, poor therapeutic alliances, and certain demographic variables) can be subsumed under the concept of “perspective divergence.” Perspective divergence is characterized by differences in viewpoint, expectations, and preferences between the therapist and client. Reis & Brown view the expectation-reality discrepancy as a way that clients and therapists differ in their expectations for therapy. In addition, they describe the quality of the therapeutic alliance mainly in terms of the similarity of client and therapist ideas and beliefs. Reis & Brown even proposed that demographic variables like race and SES predict dropout because they tend to be ways that clients differ from their therapists. In other words, demographic differences between therapist and client are interpersonally relevant, especially when they become a source of conflicting worldviews. In sum, “perspective divergence,” whether in the form of conflicting worldviews or conflicting expectations regarding therapy, does not bode well for the therapeutic enterprise.

The population

Research studies on premature termination generally have one of two goals: 1) to predict dropout from preexisting variables or 2) to explain dropout after the fact using retrospective client accounts of the circumstances surrounding termination. Though both kinds of research attempt to determine why premature termination occurs, retrospective studies reveal “why” from the client’s subjective point of view. In addition, they can test directly the assumption held by many therapists, noted earlier, that premature termination is tantamount to treatment failure.

Several studies have directly surveyed clients who have terminated prematurely to determine their reasons for termination. Acosta (1980) found that 24% of dropouts terminated due to negative feelings about their therapist, 19% due to perceiving therapy as of no benefit, 26% due to environmental constraints and situational impediments, 18% because of perceived improvement, and 13% due to appointment mix-ups or perceived therapist termination. Pekarik, in two different studies, (1983a, 1994) found that 39% and 37% of dropouts terminated due to a felt lack of need for services or improvement,
26% and 33% due to dislike of services or therapist, and 35% and 31% due to environmental constraints. Martin, McNair & Hight (1988) found that 37% of dropouts terminated due to lack of time, and 27% due to a felt lack of need for services.

These four studies can be interpreted as indicating that premature termination is not a unitary phenomenon. A sizeable portion of the dropout population (between 26% and 37%) terminates because of various environmental constraints (e.g., lack of transportation, financial resources, childcare, time). Another sizeable portion (26% to 43%) terminates because of dissatisfaction with services (e.g., dislike of therapist, not benefiting from treatment). A final group of premature terminators (18% to 39%) indicate that they simply discontinued because they had improved, accomplished their goals, or were no longer in need of services. What makes this last group most interesting is that these clients were identified as premature terminators precisely because their therapists believed they had not accomplished their goals, or that they hadn’t been in therapy long enough for any change to have taken place.

Is it possible that some clients that therapists identify as not having improved have indeed made some concrete gains in therapy? Do therapists wrongly perceive a lack of progress for a portion of the clients they designate as premature terminators? Is “premature” termination necessarily therapeutic failure? Because dropouts, especially those who terminate within the first two sessions, do in fact demonstrate poorer adjustment (higher symptom levels) than those who do not terminate prematurely (Pekarik, 1983b), it seems that therapists are justified in their perceptions of dropout being related to actual treatment failure. However, clients who report different reasons for termination also report different outcomes. Clients who terminate due to “no need for services” and “problem improved” show significant symptom reduction at follow-up, while those who terminate due to “dislike of services” do not (Pekarik, 1983a; 1992). In sum, while these outcome studies show that on average, therapists are justified in their assessments of prematurity, a good portion of clients may well disagree as to the prematurity of their termination, as well as to an assessment of treatment failure. This study investigated those “premature” terminators who discontinued because they felt they had improved.
The problem

How can such a discrepancy in perspective between therapist and client be explained? Garfield (1994) speculates that, in this case, therapists simply fail to recognize that client concerns have lessened. Researchers tend to take this stance throughout the literature whenever clients cite self-perceived improvement as a reason for termination. They conclude that therapists have simply misjudged the prematurity of the termination, and that the therapy should not be regarded as a failure (e.g., April & Nicholas, 1997). (I will call this the ‘miscalculation hypothesis’.)

By emphasizing the ‘miscalculation hypothesis,’ however, researchers neglect to consider the reasons why therapists choose to designate certain terminations as “premature.” The current study asks that instead of assuming that a good portion of therapist’s judgments are inaccurate, researchers ask “what values and priorities do therapists have that lead them to conclude that certain terminations are premature? What observations have they made, and what conceptualizations have they formed that lead them to believe that a client is in need of further treatment?” Similar questions can be asked of clients: “What makes clients believe that they are no longer in need of services? How is it that they think about their problems that leads them to believe that they have been solved?”

Reis & Brown (1999) have already proposed a “perspective divergence” model for premature termination. While these authors used the term to explain only why certain prematurely terminating clients have become dissatisfied with therapy, the current study used the model to explore the dynamics of the discrepancy between therapist and client assessments of termination appropriateness. In other words, a discrepancy between therapist and client outcome evaluations can be characterized as a divergence in perspectives that is ripe for exploration, rather than as a miscalculation by the therapist. Several questions needed to be answered in order to fully explore this model, including, ‘How can this divergence be described?’ and ‘What process is involved in making judgments concerning whether a certain person qualifies as improved?’ The groundwork for this alternative to the miscalculation hypothesis has already been laid in the literature, as I will show now.
Proposed Model: Perspective Divergence

The nature of the population that the current study targeted by definition involved a certain perspective divergence: the therapists believed that the termination was premature, while the clients did not. However, there are a myriad of issues and questions suggested by the clinical literature that may be involved in making outcome judgments – issues and questions that also involve perspective taking. Any one of these areas could have been a fruitful source of the overall disparity in viewpoints. In this section I will describe two examples: problem conceptualizations and outcome criteria.

Problem conceptualization. Several studies have shown that therapists who can accurately recognize client problem conceptualizations have lower rates of premature termination (Epperson, Bushway, & Warman, 1983; Krauskopf, Baumgardener, & Mandracchia, 1981; Pekarik, 1988). Premature terminators are between 30% and 40% less likely than appropriate terminators to have had their problem conceptualizations correctly identified by their therapists (e.g., both therapist and client independently characterize the problem as educational/personal/interpersonal, or the therapist can predict which category the client will choose). In other words, therapists who inaccurately identify the client’s understanding of the problem being addressed (i.e., choose a different category than the client has) are more likely to have their clients terminate prematurely.

Epperson et al. (1983) concluded that therapists interested in reducing the incidence of premature termination should give additional issues (problems and conceptualizations identified by the therapist) lower priority in the first few therapy sessions than those specifically identified by the client. This advice is consistent with the empathic approach toward clients generally advocated for in the literature. One must wonder, however, if establishing such a hierarchy of importance has a more complicated effect. Clients whose therapists concentrate solely on the client’s understanding of the problem may feel understood, but they may also remain unaware of additional problem areas that could provide incentive for additional sessions. Without an awareness of problem areas beyond those they have brought to therapy themselves, how are clients to justify continuing therapy?
The situation just described is an ideal one for a divergence of perspectives relating to the appropriateness of termination. For example, a therapist who identifies three different areas of concern for a particular client may count a termination premature if it occurs following discussion of only two of those areas. If the client does not identify the third issue as an area that needs to be addressed, that same termination may be right on time from his or her perspective. The current study examined the hypothesis (not yet suggested in the premature termination literature) that clients and therapists have divergent perspectives of the issues that needed to be addressed in therapy. Most importantly, it was hypothesized that the areas that were identified by therapists but not revealed to clients (the ‘third issue’ in the example just given) would be those areas that formed the basis for the differences in outcome judgments.

The following example may help illustrate the concepts just described: Joe came to therapy following his parent’s divorce and indicated that he would like help overcoming a newfound “laziness” causing his grades in school to decline. After a few sessions concentrating on improving his motivation, Joe’s grades started to improve and he decided to discontinue therapy. His therapist considered this termination to be premature – she felt that Joe’s “laziness” was more aptly characterized as great sadness and feelings of guilt regarding the breakup of his parent’s marriage. In order to make Joe feel safe in the therapy room, she decided to wait for him to bring up his feelings regarding the divorce, which he never did. Joe did not see the connection that his therapist did; thus, he was satisfied with being able to resume his studies and pleased with the outcome of therapy.

Whether or not this termination was premature depends upon the perspective from which one views Joe’s problem. If his failing grades are a result of laziness, then overcoming laziness is a good outcome. If his failing grades are somehow connected with his parent’s divorce, then the therapist is justified in designating the termination premature, and Joe’s symptomatic improvement may be irrelevant to a determination of success. The concern here is not merely with problem recognition (both Joe and his therapist agreed that his failing grades were a problem), but with problem conceptualization (in this case, laziness as opposed to sadness and guilt).
There is good reason to believe that therapists and clients actually do differ in their views of the origins of psychological distress. The training that therapists receive in theories of psychopathology provides them with access to perspectives that many clients may not be familiar with. Several empirical studies have examined this possibility. For example, in one study 46% of non-clinicians endorsed the statement “most problems can be traced to a lack of enough money,” while only 4% of clinicians did (Kupst & Schulman, 1979). Obviously, criteria for a good outcome in therapy follow directly from one’s conceptualization of the problem being addressed.

In order to test the hypothesis that problem conceptualization can be a source of perspective divergence in judgments of termination appropriateness, client and therapist case conceptualizations need to be compared to find out if the two are speaking about the same problems when they evaluate outcome. Comparisons will reveal whether clients are unaware of important additional issues identified by the therapist, or whether they simply disagree with their therapists regarding the extent to which agreed-upon problems have been resolved. This second possibility forms the basis for my second example: outcome criteria.

**Outcome criteria.** The psychotherapy literature on values extensively discusses the issue of convergence and divergence of therapist and client perspectives. Convergence of therapist and client values over time in therapy is associated with diverse measures of improvement, including both client and therapist reports (Beutler, 1981). A more recent study and meta-analysis indicate that it is probably only the therapist’s ratings of improvement that are associated with values convergence (Kelly, 1990; Kelly & Strupp, 1992), suggesting that therapists rate their clients as more improved as client’s values come to coincide with the therapist’s own values.

Value studies tend to measure “values” like preferred personal attributes, (such as “wisdom” and “freedom” [e.g., Kelly & Strupp, 1992]). Less often, they measure values regarding the actual process of therapy. For example, the chosen goals of therapy can be conceptualized as value orientations (Madell, 1982; Patterson, 1989). Garfield & Bergin (1986, p.16) note, “subjective value decisions underlie the choice of techniques, the goals of change, and assessment of what is a ‘good’ outcome.” In sum, the values literature suggests that goals for, and attitudes toward, therapy itself (we can term these “therapy
values” [Beutler, Machado, & Allstetter-Neufeldt, 1994]) are an important part of individual value orientations. The current inquiry is concerned with both personal and therapy values: both have the potential to bear directly on decisions regarding preferred continuance or termination of therapy by influencing outcome criteria.

There have been only a few studies that have addressed the role of values in premature termination. Schoenfield, Stone, Hoehn-Saric, Imber, & Pande (1969) showed that therapist and client outcome ratings were related to convergence of values regarding appropriate therapy behavior. In other words, both parties made lower ratings of improvement when they have a divergence of beliefs about appropriate therapy behavior. However, it is unclear what role therapy values play for those therapist-client pairs who differ in their perceptions of improvement. Do they also have a divergence of beliefs about what is to happen in therapy? Another study (Tracey, Heck, & Lichtenberg, 1981) showed that clients and therapists with similar role expectations for therapists follow each other’s topic initiations more successfully, a practice that is related to continuance in therapy (Tracey, 1986). Again, it is unclear what role expectations for behavior play for those dyads that do not agree on whether or not continuance is warranted.

In sum, research on “therapy values” indicates that these values may be important in determinations of improvement, and in decisions to continue in therapy. Convergence of values leads to determinations of improvement, while divergence of values leads to determinations of lack of improvement. What the literature does not address, however, is how, and in what way, values are involved when determinations of improvement (and appropriateness of termination) differ between therapist and client. The current study aims to rectify this situation by examining three specific value issues that may play a role in disagreements regarding the appropriateness of termination. I will outline these three issues here.

*Outcome criteria a) What is the goal of therapy?:* While problem conceptualizations (discussed before) may play a significant role in choosing outcome criteria, other factors also may be important. For example, there is widespread general speculation in the literature that therapists and clients use different criteria (e.g. personality change vs. symptom reduction) to determine the value of a certain therapy outcome (Lowry & Ross, 1997). In addition, therapists and clients may have different
ideas about what things are supposed to happen in order for therapy to be “finished.” Laypersons, for example, are much more likely than therapists to believe that a person with a problem needs advice (Kupst & Schulman, 1979). Different visions of the proper goals of therapy could be relevant to decisions about when to terminate therapy.

Returning to our example, suppose that after the initial session, Joe and his therapist agree that his feelings regarding his parent’s divorce are indeed at the root of his failing grades. Problem conceptualization is not a problem here: both have similar perspectives regarding the origins of the problem. After a few sessions discussing the divorce, Joe finds that his grades are improving, and decides to discontinue therapy, happy with the results. Again, his therapist feels that this termination is premature: although his grades have improved and he seems to have come to terms with his parent’s divorce (a symptom oriented measure), he has no awareness of the ways in which the problems he experienced in regard to the divorce are present in other areas of his life as well (a personality measure). Joe believes that therapy is very helpful in getting people through the “rough spots.” Joe’s therapist agrees, but in addition, believes that therapy can be useful in addressing personality issues in the absence of any acute crisis.

In other words, different intended goals may lead a therapist-client pair to value different kinds of outcomes. While the literature has provided the theory to make this hypothesis viable, there has been no study addressing whether or not different visions of therapy between therapist and client are relevant to determinations of termination appropriateness. Therefore, research needs to examine the preferred outcomes and perceptions of therapy of individual therapist-client pairs who differ in this regard. Each needs to be asked: “what is psychotherapy for?” While the answer to this question obviously will be influenced by individual problem conceptualizations, it goes one step further. The question is not only “how do we conceptualize this problem?” but also “what will the problem look like when it has been solved?” In addition, what is it that both believe can and should be achieved in therapy? Into what areas should therapy delve, and what are its limits?

**Outcome criteria b- how long should therapy last?:** The outcome of therapy is evaluated not only according to a vision of the proper ends of the therapeutic process, but also by how close to those ends therapy proper should be reasonably expected to take the
client. In other words, while therapist and client may agree about what needs to be accomplished, they must still negotiate how much of that work is to be attempted jointly, and how much the client is expected to do alone following the termination of therapy.

Therapists tend to have very different ideas about what therapy should entail than clients do (Hunsley, Aubry, Vestervelt & Vito, 1999). For example, therapists view between 30 and 40 sessions as optimal for short-term therapy, while clients expect to attend between 8 and 10 (Lowry & Ross, 1997). Where does this tremendous discrepancy come from? One possible interpretation is the one just mentioned: that therapists and clients may tend to have different ideas about how far toward a specified goal therapy should go. These differences may be the result of beliefs regarding the importance of independent mastery of problems. There is good reason to believe that this is the case, as most of the general population (62%) believes that it is best to work problems out on your own, while only a minority of clinicians (8%) agree (Kupst and Schulman, 1979). While clients as a group are most likely more amenable to seeking help than the general population, they may still value independent growth and problem solving to a greater extent than their therapists do. Research is needed to determine if the resumption of the ability to ‘cope on one’s own’ with a particular problem is a more powerful indicator of termination appropriateness to clients than to therapists. Research has not yet examined whether differences in expected therapy duration or the importance of independent coping are relevant to determinations of the appropriateness of termination.

In our example, suppose that Joe and his therapist both conceptualize his problem as originating with his parent’s divorce, they agree that the problem generalizes to other areas of his life, and they agree that therapy can continue to be helpful to him even now that his grades have improved and he has come to terms with his parent’s divorce. Joe continues in therapy for a while longer, at which point he decides to terminate. He feels that he has a sufficient knowledge of problem patterns evident in his life, and can continue to work on them independently without his therapist’s assistance. Joe’s therapist finds this termination to be premature. She wishes to continue working with him until he masters these problems completely.
This example illustrates how different opinions of the value of independently working through problems may be relevant to termination decisions. In order to determine the relevance of this issue in actual therapist-client dyads, however, both need to be asked some very simple questions. First, when should therapy end? When the client feels able to continue work independently? When the therapist is satisfied that such independent work is possible? When no more work is really necessary? Until the client believes that therapy can accomplish no more? Until things are “as good as they can get?” Second, how long should therapy last? Until the number of sessions starts to exceed what the client expects would be necessary to produce a good outcome? Until a good outcome occurs, regardless of actual number of sessions? The inquiry must establish the viability of the current hypothesis and the alternative one: Do therapists fail to see when clients have reached certain milestones, as the current view suggests, or are they aiming for entirely different milestones?

*Outcome criteria c-in reference to what should clients be “better”?*: The thorniest issue of all in a discussion of outcome criteria is that there are many different ways that a person can determine that an outcome criteria actually has been met. For example, even agreement that the goal of therapy should be symptom alleviation leaves one wondering what counts as a “symptom” and what precisely is meant by the term “alleviation.” A mutual goal of being able to “cope independently” still leaves room for interpretation of what, or who, one is independent in reference to. The issue is one of language – of the idiosyncratic nature of the meanings that are attached to interpersonal communications. The main problem here is that concepts like “improvement,” “lack of need for services,” and “better” mean different things to different people. These concepts have no unambiguous empirical referents, and are therefore defined relative to some unique and personal meaning system or reference point. For example, one may be “better” or “no longer in need of services” in reference to pre-treatment functioning levels, in reference to the functioning of a certain group of people, or in reference to some ideal state. The current premature termination literature lacks empirical investigations of meanings inherent in such phrases as “in further need of services” (as well as theoretical speculation about what such terms may mean). Research needs to determine if
differences in reference points lead to differences in opinion regarding the prematurity of termination.

Suppose that Joe and his therapist have agreed on a conceptualization of his problem, a common vision of what therapy can be for, and that people should remain in therapy until they have mastered their problems completely. Joe continues until he feels that he has mastered his problems completely and then terminates. He believes that his self-awareness now greatly exceeds that of his friends and members of his family. Joe’s therapist again feels that this termination is premature. In reference to her peers and some of her other clients, Joe is not very self-aware. They differ in their opinions of what constitutes “mastery” due to comparison with two very different reference groups.

This example illustrates how a common terminology for the goals of psychotherapy does not guarantee shared meanings for those terms. Therapist and client may share language for goals, yet not share the goals themselves. To determine if this issue is relevant to termination decisions in actual therapy dyads, both participants need to be asked to clarify what they mean by the terms used to describe outcome criteria. Questions like “what do you mean by mastery/independence/openness/insight/understanding?” may be important here. Reference points should be specifically addressed as well: in comparison to what or who are the valued outcomes being measured? In addition, what value orientations are reflected in the choice of reference point? In other words, why does each person choose to define outcome criteria in the way that they do? A comparison of therapist and client meaning systems as they relate to the language of outcome criteria will yield much information regarding any divergence of perspectives that may impact on determinations of termination appropriateness.

**Summary**

In essence, the term “premature termination” refers to those situations in which a client’s decision to discontinue therapy meets with therapist disapproval and a determination that further treatment is indeed warranted. Though premature termination implies treatment failure to therapists, some “prematurely” terminating clients perceive the same therapy as a success. While the literature to date concludes that this discrepancy reflects therapist miscalculation of treatment outcome, the current study explored several potential sources of “perspective divergence” (Reis & Brown, 1999) between therapist
and client that may lead to equally reasonable (though different) determinations of the appropriateness of termination and outcome of therapy. The two major hypothesized sources of perspective divergence between therapist and client included problem conceptualization and outcome criteria. The former deals mainly with individually oriented questions like ‘What is the problem we are working on here?’ and the latter with therapy process questions like, ‘What is therapy for?’ ‘How long should therapy last?’ and ‘In reference to what should outcome be evaluated?’

The current study was a qualitative analysis of two psychotherapy cases. In both cases, the therapist(s) felt that the termination was premature, while the client(s) did not. There are several advantages to conducting a small-scale qualitative study. First, no study to date has looked specifically at the population described here, despite having been widely acknowledged in the literature for more than twenty years. Therefore, a study of a descriptive nature could provide the material necessary to suggest solid starting places for further research. Second, focusing on a small number of clients-therapist pairs allows for the exploration of nuanced perspectives that would otherwise be lost in a larger study. Third, the results will have immediate clinical implications. If specific areas of “perspective divergence” between specific therapy dyads can be identified, it will provide therapists with ideas regarding what kinds of therapy process issues may be beneficial to bring up in all therapy sessions.

Method

Participants

A total of three clients and three therapists participated in this study. I used various methods to recruit these participants. First, I asked all therapists at the Miami University Psychology Clinic to complete a post-termination questionnaire on which they were asked to state whether or not they believed that their client was in continued need of services at the time of termination (see Appendix A). Next, I made follow-up phone calls to those clients designated as “in further need of services” by their therapists. During these phone calls, I asked clients to state their reason for ending therapy. One client that I contacted by phone stated that she was no longer in need of services and agreed to participate along with her therapist. After this point, I began asking therapists who had upcoming planned termination sessions to directly invite their clients to participate in my
study if they appeared to meet the criteria (i.e., therapist and client disagreed about the need for further services). This process resulted in two more clients, a married couple, volunteering to participate along with their two therapists.

**Procedure**

I interviewed all of the participants in the study separately, with the exception of the two therapists who had conducted the marital therapy. (These two therapists agreed that their views of the therapy were sufficiently similar to make separate interviews redundant.) I interviewed all of the participants approximately one month after their final sessions. I tape recorded and transcribed all of the interviews, which were each about an hour in length.

Each participant gave his/her informed consent (see Appendix B) for a confidential interview (i.e., they all understood that their responses would not be shared with their client/their therapist). While all of the therapists knew that their clients felt that they were no longer in need of services (because they were familiar with the criteria for my study), I did not share with the clients the specific reason they were invited to participate. I told each client that the purpose of my study was to “examine similarities and differences between therapist and client views of the therapy experience and outcome.”

**Client interviews.** I devoted the first part of the interview to a discussion of problem understandings and conceptualizations. (This part of the interview was designed to elicit responses that could be used to evaluate the “problem conceptualization” portion of the “perspective divergence” model.) I began by asking clients to describe, to the extent that they felt comfortable, the circumstances that brought them to therapy. Next, I asked them to describe their individual understandings of these problems and how these understandings did (or did not) change over the course of therapy. Finally, I asked them specifically about the ways that their therapist(s) influenced how they came to understand these problems. I used the following types of questions to guide the first part of the client interview: “Can you describe what was going on for you in the time right before you decided to enter therapy?” “What was your understanding of where these problems were coming from?” “During the course of therapy, did your understanding of your situation
change at all? How so?” “What influence would you say your therapist had in the
development of your understanding of these problems?”

I devoted the second portion of the interview to a discussion of the outcome of
therapy. (This part of the interview was designed to elicit responses that could be used to
evaluate both the “miscalculation hypothesis” and the “outcome criteria c” portion of the
“perspective divergence” model.) I began this section by asking clients to describe the
outcome of therapy and how they had been faring since termination. Second, I asked the
clients to discuss how they came to the decision to end therapy. I used the following
types of questions to help guide the second portion of the interview: “How would you
describe the outcome of your therapy?” “What has changed since you decided to begin
therapy?” “How did you come to decide that it was time to end therapy?” “Is there
anything else that you would have liked to address in therapy?”

For the third portion of the interview, I invited clients to discuss their opinions
about therapy in general and how these opinions were related to their evaluation of the
outcome of their own therapy. (This part of the interview was designed to elicit responses
that could be used to evaluate the “outcome criteria a and b” portion of the “perspective
divergence” model.) I used the following types of questions to guide this portion of the
interview: “If you were to describe to a friend what happens in therapy, what would you
say? What kinds of problems would you tell him/her that therapy can help with?” “What
is supposed to happen in therapy?” “How long should therapy last?” “If a friend were
trying to decide whether or not to end therapy, how would you help him/her decide?”
“Have any of your opinions about the previous questions changed from the time you
began therapy?” “You mentioned X as an important aspect of therapy in general. How
was X important in your particular therapy, and how has it affected your assessment of
the outcome?”

Therapist interviews. I conducted the therapist interviews using the same general
format as the client interviews. I began by asking therapists to describe the client and the
issues that brought the client to therapy. Next, I asked the therapists to describe how they
themselves conceptualized these problems, as well as how they thought their client(s) did
so. Third, I asked them to discuss what place the discussion of such conceptualizations
had in therapy. (This part of the interview was designed to elicit responses that could be
used to evaluate the “problem conceptualization” portion of the “perspective divergence” model.) I used the following types of questions to guide the first portion of the interview: “What kinds of problems did the client bring to your attention when he/she came to therapy, and how did the client understand these problems?” “How did you conceptualize these particular problems?” “Were there issues other than the ones the client specifically brought to your attention that you felt needed to be addressed?” “How much of your understanding of these issues did you convey to the client?”

The second portion of the therapist interviews concerned perceptions of the outcome of therapy. (This part of the interview was designed to elicit responses that could be used to evaluate both the “miscalculation hypothesis” and the “outcome criteria c” portion of the “perspective divergence” model.) I asked therapists to describe the outcome of therapy from their point of view. I then asked them why they decided that the termination was premature. I used the following types of questions to guide this section of the interview: “What kinds of changes did you see in your client over the course of therapy?” “How was your client getting along when he/she decided to end therapy?” “How did the termination proceed?” “How did you decide that this termination was premature?” “What issues did you feel had been left unresolved?” “What goals did you have for this particular therapy?”

The third portion of the interview dealt with each therapist’s perceptions of therapy in general from his/her particular orientation, as well as how this orientation related to his/her outcome evaluation. (This part of the interview was designed to elicit responses that could be used to evaluate the “outcome criteria a and b” portion of the “perspective divergence” model.) I used the following types of questions to guide this portion of the interview: “How would you describe the purpose of therapy?” “What kinds of things can therapy be helpful for?” “What is your vision of the ideal end state of therapy?” “When should therapy end?” “How long should it last?” “In reference to what should client change be evaluated?” “How do you think the vision of therapy you just described impacted the way you evaluated outcome in this case?”

Data Analysis

A research group consisting of two other clinical graduate students and myself began the data analysis by reading and verbally summarizing the five transcribed
interviews. (This initial step of the data analysis was designed to make sure our understanding of each participant’s story was clear and accurate before proceeding with any kind of interpretation.) Based on these discussions, I prepared written summaries of each participant’s views and presented these summaries back to the members of the research group, who edited them for completeness and accuracy. In addition, the group prepared several questions for each participant that we believed would help us clarify our understanding of their statements or assist us in our analysis of the case as a whole. I then gave each study participant a copy of the summary of his/her interview and the list of questions. I asked each participant to provide feedback on the accuracy and completeness of the report, and invited each to consider the additional questions. All of the participants, with the exception of the married couple, provided feedback. (At the time I contacted the couple by phone to get their feedback, they were in the midst of dealing with several family crises and had been unable to find the time to read the interview summaries that I had mailed to them previously. I invited them to contact me in the near future if they felt that they were able to provide feedback, but after several weeks we decided to proceed with the data analysis without their feedback.) The remaining participants felt that the summaries accurately reflected their views, and they all answered the additional questions. The same interview summaries that were given to (and approved by) the study participants are included in the results section of this paper under the participant’s pseudonym.

After confirming the accuracy of our impressions of the interviews, the research group analyzed them for evidence supporting or refuting the literature’s current model (‘the miscalculation hypothesis’) as well as the proposed alternative “perspective divergence” model. We met as a group and addressed the two models by answering the following questions. (While these questions served as the backdrop for investigating the miscalculation and perspective divergence models, we did not limit our discussion to these comparisons alone. Rather, we let our spontaneous impressions of the interviews guide our discussion, returning to these questions periodically as they seemed relevant.)

*Miscalculation hypothesis:* (Therapists have not recognized ways in which clients have improved.)
• What improvements did the client report? What improvements did the therapist observe?

• To what extent do therapist and client reports of improvements correspond? Was the therapist able to accurately recreate the client’s perception of therapy?

**Perspective divergence model** – problem conceptualization: (Therapists and clients will have different problem conceptualizations. Portions of the therapist’s case conceptualizations that were not shared with the client will have been particularly important in the determination of prematurity.)

• What were the client’s and therapist’s separate conceptualizations of the problem being addressed?

• To what extent did client and therapist conceptualizations correspond? If they did not, were both the therapist and client aware of the difference? Was the client able to accurately recreate the therapist’s perception of therapy?

• Did the client mention any of the problems that the therapist felt were unresolved? If so, how did the client evaluate the current status of these problems?

**Perspective divergence model** – outcome criteria: (Therapist and client will have used different outcome criteria.)

• (a) How did the therapist and client describe the ideal goal or end state of therapy? How do these goals compare, and what role did they play in the formation of outcome judgments?

• (b) How did therapist and client describe the ideal length of therapy and extent of problem mastery? Again, how do these ideas compare, and what role did they play in the formation of outcome judgments?

• (c) What meanings have clients and therapists attached to the words used to describe outcome (e.g. ‘better,’ or ‘improved’)? To what did these words refer? How do these meanings compare?

The research group met once to initially discuss comparisons between the interviews of the therapist and client who had participated in the individual therapy. We then met again to go over a written summary of the audiotape of that meeting. We
clarified any analysis that remained ambiguous and made additional comparisons as needed. We followed the same procedure for the marital therapy interviews, except that each client’s interview was compared separately with the combined therapist interview. We did this because we suspected that each of these client’s stories would compare to the therapists’ account in unique ways. We also met one last time to consider the case as a whole.

The process of the data analysis itself was enhanced by the fact that the members of the research group knew each other and were members of the same clinical training program. As a result, the group quickly established rapport and found it relatively easy to reach a consensus of opinion. Of course, the analysis contained in the final version of this manuscript is not a verbatim transcript of the group’s process. Parts of the group’s analysis and conclusions were difficult to link directly to participant’s statements and were omitted. Other conclusions are my own, reached during the process of writing itself. For the most part, however, the following analysis is the combined product of the entire group.

Results
Amy and Jean: A case of individual therapy

Amy was an 18 year-old Caucasian woman who came to see Jean for “help transitioning in a relationship.” She had just begun her freshman year at college, several hours away from where she grew up. On her intake form, Amy wrote that she hoped to “be able to determine [her] feelings, stabilize, and learn how to deal with things and be happy.” Amy saw Jean for 5 sessions, after which the two ended therapy for winter break. Although both had agreed that Amy would continue in the spring semester with a new therapist, Amy decided not to return when the new therapist contacted her after the break. While Jean felt that Amy was still in need of services, Amy reported to me that she was feeling much better and had decided that she didn’t need to return to therapy.

Amy

Presenting Problems. Amy reported that when she initially came to therapy, she had just broken up with her boyfriend of 3 years. She was experiencing mood swings, not sleeping well, and hanging out with people who liked a “party lifestyle.” Amy described this lifestyle as being very different from the one she experienced growing up in a
relatively conservative and hardworking family, where she was often responsible for taking care of her sisters and was happy with “low key” activities. She began to feel homesick, and for a period of time went home almost every weekend. During these times, Amy had some problems with her family, including having to deal with their disapproval of her decision to break up with her boyfriend, and with feeling like she wasn’t being treated like an adult.

**Course of therapy.** Over the course of therapy, Amy discussed the fact that she had not had any kind of emotional reaction to the breakup with her boyfriend, and wondered why she had initiated the breakup and why it was not bothering her. At some point, Amy identified feeling the need to be independent from her parents. Since her parents very much approved of her boyfriend, and had essentially welcomed him to the family as the son they were not able to have, she felt that breaking up with him was part of a move for independence from them.

However, after losing her boyfriend as her "moral backbone," and deciding that she wanted to see “life on the other side,” Amy started hanging around with people and participating in activities that she normally wouldn't have. She now considers some of the people she hung out with at this time to have been bad influences on her, trying to encourage her to do things she thought were wrong. Amy found that life was not “greener on the other side.” This led to a feeling of instability in her life, and she started going home as a way to reconnect with a stable environment that she was familiar with.

In therapy, Amy talked about her relationship with her mother, whom she admired for her competence as a working woman. At the same time, Amy felt that her mother had been treating her more like an employee than a daughter, and was upset that her mother was always too busy to spend time with her. As a result, Amy felt disconnected from her. Amy discovered that she needed more attention from her mother than her siblings did. In addition, she connected her mother’s tendency to discourage emotional expression with her own lack of feelings about the breakup with her boyfriend.

Amy also discussed her feelings about relationships with others in therapy. She tended to feel uncomfortable around others, expecting that they would do something to betray her and that they could not be trusted. As a result, Amy felt like she did not really need people, and that spending time with others was a waste of her time. She discovered...
that this was a philosophy that had worked well for her mother, and that her mother had taught her this throughout her childhood.

**Outcome.** After ending therapy, Amy joined a sorority so that she was forced to participate in social activities. She reports that she still has trouble doing these things unless they are scheduled. Amy likes that she can spend time with girls who talk about serious things at the sorority, and she tries to trust people more and give them a chance. However, she did decide to not be friends with several people that she felt were not good for her.

Amy learned to be more open-minded and allow herself to feel things in therapy. She feels that she now has a wider range of emotional experience, and can allow herself to feel pain. At the same time, she feels more emotionally stable, without the mood swings she had when she first came to therapy.

Amy had originally decided to continue therapy when she returned in the spring semester, but found that two weeks at home fixed some of the things that she had intended to work on. During break, she got along better with her parents, who started treating her more like an adult and finally accepted her decision to break up with her boyfriend. When Amy’s parents realized that it was her choice to date him or not, Amy no longer felt the need to fight against what they wanted for her, and she chose to get back together with her boyfriend. In addition, Amy reported that she and her boyfriend have made positive changes in their relationship. For example, they each have a much busier schedule now, which eliminates time for problems to come up between them. Amy feels that she and her boyfriend benefited from having time apart to make separate friends and that, because she is a more social person now, their relationship is more fun. Because the breakup was the reason she started therapy, Amy didn’t feel the need to return once she and her boyfriend got back together.

There are still some things that Amy feels she needs to work on. For example, she reports that she has some strict ideas about what competent women do. She has a tendency to take on more responsibilities and schedule more activities than she feels she can handle. However, because it is important to her to prove to herself and others that she can handle things, she typically will not admit that she feels overwhelmed. Amy finds it difficult to relax her expectations for herself, and feels guilty when she isn't being
productive. Amy also describes herself as "money-driven" -- being motivated to have things even if she can't afford them -- and she thinks this is a problem for her. Amy believes that her vision of what it means to be a competent woman is related to her admiration of her mother. However, she wonders if her mom is as put-together on the inside as she appears to be on the outside.

During her interview, Amy reported that, while she wanted to ask her mom to spend more alone time with her, she had not done so yet. When I contacted her several months later, Amy had talked to her mother about wanting to spend this time with her, and said that they now talk on the phone every day. Her mother had hired some extra people at work, and was less overwhelmed and less likely to dismiss Amy when Amy called her. Amy shared that “I miss my family a lot and can’t wait to go home for the summer and see them everyday.”

*Views of therapy.* Before Amy began therapy, she thought that only people with mental illnesses or those needing medication came to therapy. She was concerned when she came that her problems were not serious enough to warrant therapy. Now she believes that anyone who even thinks they need therapy probably does, and that therapy can help with even small problems. Amy doesn't believe people should be embarrassed about coming to therapy, because it can only help them and does not mean there is something very wrong with them. She encourages other people not to be scared of the process, because she believes they can only benefit from knowing themselves better.

Amy believes that therapy could last forever, because there is always something left to work on. However, she decided to end when she felt that her bigger problems had been taken care of. She feels that sometimes “overanalyzing” is not worth the time or the money. Amy believes that people don't necessarily need to be no longer hurting to end therapy -- sometimes people can just learn to deal with their pain better. She believes that if the problem you came in for is solved, or you can go through your daily life, it is appropriate to end therapy.

Amy views therapists as helpful because they are neutral people who don't have a personal or selfish investment in the decisions that clients make (like her parents and several friends did in her decision to break up with her boyfriend). Therapists help clients make decisions for themselves by not giving advice. They ask questions to help
clients clarify their feelings and make connections between things. Amy believes that therapists are more helpful than others are because they have education and experience.

Jean

Presenting Problems. Jean reported that when Amy came in initially, she was concerned about mood swings and concentration problems. Amy’s main goal for therapy was to stabilize her moods so that she could get back to doing her schoolwork as efficiently as she had before. In addition, Amy had just broken up with her boyfriend, and thought her lack of emotional reaction to this breakup meant that she was a cold person. She reported having trouble forming close relationships with others. Amy did not know where these problems were coming from, and tended to report that she had no reason to be down and no right to be sad. She thought she needed medication for ADHD.

Course of therapy. During therapy, Jean came to believe that Amy’s mother had discouraged expression of emotion. As a result, Amy tended not to process sad feelings when she had them – instead, they came out at odd times when she wasn’t busy enough to keep the feelings at bay. When Amy broke up with her boyfriend, she felt “cold” because she wouldn’t let herself be sad about the breakup. However, those sad feelings were still there and were expressed as “mood swings” with “no cause.” Although Jean was uncertain why Amy had chosen to break up with her boyfriend, she speculated that perhaps Amy came to college interested in exploring her own identity and gaining independence by totally freeing herself from the roles she had previously played. Jean felt that Amy’s choice to break up with her boyfriend might have been part of this struggle, but did not share these ideas with Amy.

In Jean’s opinion, Amy experienced a form of neglect from her parents, but she was certain that Amy would not view it this way. Amy reported that her mother in particular had a habit of not being there for her physically (e.g. making promises to spend time together and then breaking them as a result of work obligations). Jean felt that Amy learned from her mother to be emotionless and independent, and that she idolized her for this attitude. Until one of their therapy sessions, when Jean expressed her sadness that Amy’s mother had not been there for her emotionally, Amy had not considered the drawbacks to her mother’s busy-ness and independence. One effect of this pattern that
Jean identified was Amy's tendency to feel guilty in relationships for wasting other people's time.

Jean reported that at the beginning of therapy, Amy was going home a lot due to her inability to form non-superficial relationships at school. She was hesitant in relationships due to feelings of guilt and fear of rejection. When Amy started dating a young man right before Thanksgiving, she had a lot of struggles with opening up to him. She felt that sharing her feelings with him or calling him first meant losing control or “giving him the upper hand.” Jean saw Amy as insecure in relationships, to the point where she would require others to prove their affection for her before she would trust them. In the case of this young man, Amy decided to cut off all contact with him because he didn’t pay enough attention to her.

Jean reported that Amy had struggles in relationships with women as well. Jean believes that Amy couldn’t have relationships with women because she did not have a close relationship with her mother. Amy tended to despise women who weren't always in control and independent like her mother (e.g. housewives, women with boyfriends they had to call, women who needed people or cried). She perceived these women as not living “up to standards.” Also, Amy thought she was better than other people who partied instead of doing their work.

**Outcome.** At the time of their last session, Jean felt that Amy had made some progress in reaching out to other people. She was able to spend some time watching movies with some women in her dorm, and decided to join a sorority. However, Jean had concerns about Amy’s motivation for doing these things -- initially Amy seemed to want to make friends because other people had friends and it was the thing to do, not because she needed relationships in her life. Jean was also not sure how much Amy was actually enjoying the time she was trying to spend with others. Jean saw it as a sign of progress that Amy decided to start staying at Miami over the weekends to make efforts to be social, and that she started talking to her ex-boyfriend again.

When Jean and Amy ended therapy at the end of the fall semester, Amy told Jean that she still had several things she needed to work on, including forming better relationships with others and not suppressing emotions. Jean now believes that Amy did not return to therapy because her desire to be independent overrode her wish to continue.
working on these things. In addition, Jean thinks that Amy may have been upset that she
could not continue to work with her.

Jean predicts that in the future, Amy is going to have problems forming
relationships with women. She thinks Amy will eventually experience anger in peer
relationships that stems from early relational injuries with her mother, and that the anger
will scare her. Jean believes that Amy continues to see her mother as a one-dimensional
person, as either a "wonderful superhero" or "the devil." Similarly, Jean predicts that
Amy will continue to experience others in this way, as either all good or all bad.

While Amy was able to talk about some of the ways her mother hurt her, and
expressed in therapy a desire to spend more time with her, she did not get to the point of
talking to her mother about these things before therapy ended. Jean believes that Amy
still tends to downplay the hurt and anger she feels toward her mother when her mother
breaks promises to her. At the time therapy ended, Jean was uncertain that Amy had
worked through these issues to the point where she would be able have this conversation
with her mother. While Jean would have liked for Amy to have been able to talk to her
mother about these issues, she viewed Amy’s dismissal of the seriousness of the situation
as an effective coping device that helped her deal with a difficult childhood.

In general, Jean thinks Amy is going to be fine. Through therapy, Amy became
aware of many of the issues she was facing, and is now going into the process of acting
on those insights. However, Jean wanted Amy to have the support of therapy while she
tried to do this. While Amy reported to Jean that she felt better at the end of therapy, and
that her mood swings were essentially gone, Jean was not sure whether this was a sign of
progress or a signal that Amy was still interested in overcontrolling her emotional
responses. Jean believes that Amy will be happy in her future life, but that she could do
even better with continued therapy.

Views of therapy. Jean described her approach to Amy as “cognitive-behavioral,”
a framework that allowed her to do journaling and other activities designed to help Amy
express herself more freely. Jean believes that the main purpose of therapy is to help
people get in touch with how they truly feel about their experiences and learn that it is
acceptable to have those feelings. She believes that symptoms often are an expression of
Jean reported that she views the goals of therapy differently depending on the population that she is working with. When she consults for schools, or works with people of limited resources, she plans to stay very practical and focuses on getting the client back to functioning. She believes that CBT is a good framework for meeting these goals. On the other hand, Jean thinks that clients with more time and money might benefit more from a client centered approach. In Amy’s case, Jean felt that the termination was premature because Amy had the resources and the time to continue.

**Analysis of Amy and Jean’s termination**

**Miscalculation hypothesis.** The essence of the miscalculation hypothesis is that different evaluations of outcome occur when therapists fail to recognize the ways that clients have improved. In Jean and Amy’s case, the research group started by looking at the changes that both Jean and Amy reported and examining their reports for any discrepancies. Our initial impression was that their reports contained more similarities than differences. For example, both reported that Amy’s mood swings were essentially gone, and that she was spending more time with friends and less time feeling homesick and going home on the weekends. Both noted that Amy had gained some insight into her relationship with her mother and her tendency to suppress emotions.

However, there were some changes that Amy reported that Jean did not. For instance, Amy was pleased that she had gotten back together with her boyfriend, that her parents had started treating her more like an adult, and that she had successfully spoken with her mother about wanting to spend more time with her. However, all of these particular improvements that Jean failed to mention actually occurred after Amy and Jean ended therapy for the winter break. Thus, Jean was never in a position to observe these improvements taking place. While Jean was unaware of some of the changes that Amy reported, this difference was due to lack of information rather than failure to accurately assess Amy’s situation.

There was one particular area in which Jean provided a prediction about what Amy would be able to do in the future (as opposed to a description of what she thought Amy was doing now.) This prediction provided us with the opportunity to explore the
extent to which Jean “miscalculated” Amy’s future potential. Jean reported that she would have liked to have seen Amy have a conversation with her mother about the ways her mother had hurt her and about her need to spend more time with her. Jean said, “I think for her to have that conversation with her mom would have been huge. Gigantic. And I don’t know if she was ready for that yet. It might have taken a while . . . And I don’t know if she would have been able to face that in five sessions.” However, when Amy was asked several months after her interview (approximately 4 months post-therapy) whether she had been able to talk to her mother about wanting to spend more time with her, Amy replied that “Yes, I’ve talked to her about it. We talk on the phone every day now and she does not seem as overwhelmed at work now that she has hired a few extra people so she does not push me off when I call her.”

When our group discussed these two reports with regard to the “miscalculation hypothesis,” we had several reactions. Initially, it appeared from what Amy was saying that she exceeded Jean’s expectations for her in this area. While Jean predicted that Amy would have found it exceedingly difficult to have this conversation with her mother, four months later Amy did exactly that, with apparently wonderful results. However, we felt that there were several ambiguities to this situation that made it difficult to definitively say that Jean had indeed misjudged Amy. First, Amy did not provide details about the conversation she had with her mother, leaving us wondering if the conversation Amy had was the same as the one that Jean had envisioned. For example, Jean thought that it was particularly important that Amy be able to talk with her mother about the ways that she had hurt her, as well as her need to spend more time with her. Amy, however, seemed to find it more important to talk about spending more time together than to discuss relatively trivial past injuries. When Amy talked about wanting to have a conversation with her mom during her interview, she said that she wanted to talk about “. . . just now, because I can forget, forgive it. I still don’t think it’s a big deal. But for me, it’s important to get the personal time with her.” Unfortunately, our question for Amy at follow-up (“Have you been able to talk to your mom about your desire to spend more alone time with her?”), and her answer (“Yes, I’ve talked to her about it.”) left us uncertain as to whether or not their conversation had included the topic of past relational injuries.
Second, we wondered how Jean would react to hearing about the changes Amy reported in her relationship with her mother following this conversation: When we read Amy’s report of the changes that had occurred, we were struck by the tremendous change that this one conversation seemed to have effected (“We talk on the phone every day . . . I definitely miss my family a lot and can’t wait to go home for the summer and see them every day.”) We also considered Jean’s statement in her interview that when Amy first came to therapy, “her mom was this wonderful superhero. And then when we talked about the bad things, then she was the devil. So it was one or the other.” We speculated that Jean might be skeptical of Amy’s glowing account of her relationship with her mother, viewing this as part of Amy’s difficulties seeing both good and bad in the same person.

While there is, of course, no way to be certain how Jean would have reacted to hearing Amy’s reports of progress in an area Jean thought would be problematic for her in the future, we felt that there was enough evidence to suggest that the two might not have interpreted the same events in the same way. Thus, while the miscalculation hypothesis seemed to apply at first glance, it did not seem to adequately describe what was going on for Jean and Amy. Instead, we felt that the perspective divergence model provided a better rubric for understanding their differences in this area.

There also were several other areas that initially seemed to fall under the rubric of “miscalculation” but later seemed to be better described by the perspective divergence model. For example, Amy and Jean disagreed about the extent of the progress that Amy had made in the area of ‘suppressing/controlling emotions.’ Amy felt that she had developed the capacity to feel things that she couldn’t before: “. . . now I have a wider range of experiences because of what I went through last semester. And I think I’m a little more open-minded, I can see more than I did before . . . I can feel what it’s like to be in pain.” Paradoxically, she also felt that she was “much more stable in [her] decisions, [her] opinions, [her] moods, and [her] beliefs.” Jean, on the other hand, felt that when Amy left therapy, she still had work left to do in the area of controlling emotions. One reason Jean felt this way was apparently because Amy had told her this was the case: “she said she believed that she was still suppressing some of the emotions that she had from the past and from her breakup with her boyfriend.” In addition, Jean
reported that at the end of therapy, Amy had expressed concern about the possibility of her mood swings returning. Jean interpreted this statement as evidence for Amy’s desire to eliminate painful feelings: “she said another reason she would continue therapy next semester is if her emotions get out of control again. So she still had the need to control her emotions and toward the end of therapy she had more of the control.” In sum, we felt that Jean interpreted Amy’s newfound stability as an improvement only to the extent that it was not a reflection of her desire to suppress emotions. Feeling stable and having a wider range of emotional experience seemed to be much more compatible in Amy’s eyes than in Jean’s. In the group’s opinion, because Amy and Jean interpreted the meaning of Amy’s “stability” in different ways, they evaluated her mastery of the ‘suppressing emotions’ problem differently as well.

**Perspective divergence: Problem conceptualization.** There were a myriad of subtle differences between Amy and Jean’s conceptualizations of the nature and source of the problems they were addressing. The research group found these differences to be the richest area of analysis for the case. I will outline here those differences that we felt offered the some insight into Amy and Jean’s opinions about the appropriateness of termination.

Amy and Jean both indicated that Amy’s breakup with her boyfriend was the precipitating factor for her difficulties and her decision to seek therapy. Both also viewed Amy’s decision to break up with her boyfriend as a move for independence from her parents. (Amy and Jean apparently came to this conceptualization independently without ever having discussed it during therapy itself.) There were, however, several differences between Amy’s and Jean’s thinking with regard to the role of the breakup in Amy’s subsequent difficulties. First, the breakup in general seemed to play a much more important role in Amy’s story than in Jean’s. While Amy focused on the role of the breakup as essential to her subsequent problems (“... everything that happened during that time was an effect of the breakup”), Jean focused mainly on Amy’s efforts to be like her mother (“... she would suppress everything and try to be happy all the time, try to be productive all the time ... that was her main issue”). Jean did not even mention her thoughts about why Amy had broken up with her boyfriend until asked specifically at follow-up.
Second, the breakup appeared to be connected to Amy’s mood swings in different ways in Amy’s and Jean’s accounts. For example, Amy viewed losing her boyfriend itself as a destabilizing factor in her life: “. . . sometimes when you lose your backbone, it just, everything just kind of collapsed without him . . .” Amy reported that losing her boyfriend as basically a moral guide left her in a position of acting in ways that she normally would not have, contributing to her feelings of instability and her subsequent mood swings. Jean, however, focused on Amy’s mood swings as a consequence of Amy learning from her mother not to feel painful emotions. Jean told her, “you’re trying to deal with [negative situations in your life] the way you think your mom would have dealt with them, emotionless and so . . . your body still has to deal with it, so it comes out at odd places.” In her interview, Amy also mentioned that she and Jean had discussed the relationship between her tendency to suppress feelings and her initially inexplicable mood swings. However, suppressing emotions for Amy seemed to take on a less important role in her mood swings than her own failed attempts to “experience life on the other side.”

Third, the breakup seemed to play a different role in Amy’s overall life story for Amy and Jean. The research group characterized this difference as “breakup as problem” (Amy) vs. “breakup as catalyst for the expression of underlying issues” (Jean). When we asked Amy at follow-up what role getting back together with her boyfriend played in her decision not to return to therapy, she replied that “the reason I started coming to therapy was because of the breakup. Once we got back together, I didn’t feel the need.” However, Jean’s conceptualization of Amy’s problem as resulting from a tendency to suppress emotions suggested to us that Jean viewed the breakup as just one of many possible painful events that Amy would have trouble dealing with. In other words, Amy appeared to view the turmoil of her time in therapy as an encapsulated event specifically tied to her breakup with her boyfriend. Jean, on the other hand, apparently viewed Amy’s problems as essentially lying in wait of an appropriate precipitating event.

In summary, Amy and Jean’s accounts of the issues surrounding Amy’s breakup with her boyfriend had very similar content. However, they differed in the amount of emphasis they placed on the breakup in general and the extent to which they believed it was responsible for Amy’s symptoms. We felt that these subtle differences were
essential to Amy’s and Jean’s evaluations of the appropriateness of termination. Because
the breakup with her boyfriend played a much more pivotal role in problem
case conceptualization for Amy than it did for Jean, we believe that getting back together with
her boyfriend following her final therapy session probably had a different meaning for
Amy than it would have for Jean (had she known about it). While getting back together
with her boyfriend seemed to eliminate “the problem” for Amy, we interpreted Jean’s
statements as indicating that this reunion would not have eliminated “the problem” in her
eyes.

A second subtle area of difference between Amy’s and Jean’s conceptualizations
of the problem they were addressing was conveyed in their tendencies to describe certain
problems as “individual” vs. “relational” respectively. For example, though both Amy
and Jean noted that Amy had some fairly strict ideas about how women should behave
(e.g., they should always be in control and independent), they each found these beliefs to
be problematic for different reasons. Amy focused on how (even after therapy) she still
gets overwhelmed by the things she expects herself to do:

I kind of have an issue with being in all these clubs and doing all these things . . .
I almost feel like I can do anything . . . I have a big issue with the whole working
woman thing, almost like feminism issues. I always want to push myself and
push myself . . . When I hear of some girls who have nothing really going on
whine about how they have homework, it just bothers me . . . I think I’m always
trying to make myself do more than I can handle, and I won’t admit that I don’t
have time, or I’m busy . . . it’s not even like I’m getting straight A’s or in a
million things. Even in what I have I feel a little overwhelmed but I wouldn’t
even admit that to anyone . . . I can never relax . . . I try so hard to be more than
the average woman.

Jean, however, focused on the way Amy’s attitudes about women’s roles were affecting
her relationships with other people:

She wanted to be hyper-independent, didn’t want to depend on anyone for
anything ever. Even felt guilty for saying how she felt about things. Just wanted
to take care of everything herself. And then to the point where she looked down
on other people who expressed their feelings, looked down on other people who
were a little more dependent. So it was one issue of being so independent to the point where she couldn’t form strong relationships. And the second was her looking down on people who she thought wasn’t independent enough or strong enough. And that helped her push away other people who she didn’t think fit her standards . . . She just despised housewives and women who weren’t totally in control and women who had boyfriends that they just had to call everyday.

In summary, Amy thought that her efforts to be a competent woman were problematic because they exhausted her, while Jean thought these same efforts were problematic because Amy used them to push others away. We felt that these differences were important in understanding Amy’s and Jean’s opinions about termination. Because Amy and Jean both agreed that working on Amy’s relationships was an essential part of their therapy, their evaluations of the status of those relationships presumably had direct bearing on their feelings about the appropriateness of termination. Since Amy seemed to view her “feminism issues” as a personal (rather than a relational) problem, she was able to characterize her current relationships in more positive terms than Jean was. Amy did note that what she had planned to work on when she returned to therapy after winter break was “probably my personal relationships . . . trying to enjoy my time, instead of thinking that I should be doing something productive.” However, even as Amy described her current struggles with “feminism issues,” it did not appear that she connected them with the “personal relationship” problems that she had intended to work on the month before. She reported that, “I think I’ve been ok with [the personal relationship problems] too, enough that I don’t need therapy as much anymore.” In conclusion, we felt that because Jean and Amy differed on what problems they considered “relational” in nature, they also differed in their evaluations of Amy’s relationships at termination.

A third subtle difference between Amy’s and Jean’s problem conceptualizations also concerned Amy’s relationships. While both noted that part of Amy’s troubles in adjusting to school were due to her having difficulty forming new relationships there, they had slightly different ideas concerning the origins of these difficulties. Amy contributed that fact that she “didn’t feel comfortable with a lot of people here” to certain negative characteristic of those other people: “I started hanging out with people that I know now were not real friends. When people try to encourage you to do bad things,
that’s never a good thing. . . . I started realizing that the girls on my hall were not really
doing anything good for me. . . . I was with the wrong people, making bad decisions.”
Jean, on the other hand, felt that Amy had a tendency to alienate herself from some people by focusing on their faults: “She always talked about people like they were beneath her. ‘The kids in my dorm,’ she would say, ‘these aren’t girls I would hang out with. They don’t do their work, and they like to go out and party’. . . Just making them bad people. Instead of seeing what good things they had.” In sum, while Amy felt that she was having trouble with relationships because she was hanging out with the wrong people, Jean felt that Amy’s troubles lay in her evaluation of those people as “wrong” to begin with.

We felt that these differences were important in understanding Amy’s and Jean’s outcome evaluations. Amy reported that one of the important changes she made after therapy was, “deciding who [I] wanted to be friends with. [I] should hang out with people who make [me] a better person, not people who are going to bring [me] down to make themselves feel better. Not hanging out with a couple people can make a big difference.” We felt that Jean would have interpreted Amy’s reported improvement in this area as part of the problem she believed that Amy needed to continue to address in therapy. In other words, because Amy and Jean had different views of the origins of Amy’s relationship difficulties, the change that ‘fixed’ the problem in Amy’s eyes would have looked like a confirmation of the problem in Jean’s.

Perspective divergence: Outcome criteria. During their interviews, I asked both Amy and Jean to share some of their views on the process and purpose of therapy itself. Their statements about these theoretical topics were generally less elaborate than their statements about their own personal experiences in interaction with each other. As a result, the research group found it much more difficult to perform a detailed analysis in this area than in the others. Despite this difficulty, we did find one specific area in which Amy’s and Jean’s perspectives differed. We believed that this difference was important enough to explain (at least in part) why Amy felt that she no longer needed therapy while Jean felt that she did.

Amy and Jean shared the view that, in theory, therapy can be a very lengthy process. For example, Amy stated, “I think [therapy is] supposed to take a really long
time. I think it’s a really slow process.” Similarly, Jean said, “people would probably really benefit from being in therapy for years.” Both Amy and Jean used language (e.g., “supposed to,” “probably”) that suggested that although they believed that therapy could last indefinitely, they both knew that it probably would have an ending point.

In analyzing Amy’s and Jean’s accounts, however, we found that their methods for determining the acceptable ending point for therapy were different. Some of Amy’s statements suggested that having eliminated symptoms was important. For example, she described the way she would evaluate outcome in the case of a hypothetical person with bulimia: “if the bulimia hasn’t gone away, it looks like you need to keep going.” Others suggested that having learned to cope with continued pain was an appropriate goal: “Some people come in with painful childhood experiences . . . I’m sure you’ll always be hurt over it, but maybe you can learn to deal with it better.” Amy evaluated her own termination in terms of goals like these: “I guess I feel like the bigger problems have been taken care of. And the ones that are left are like, everybody’s little quirks, individualities, everyone has issues.”

Jean, on the other hand, focused on practical constraints: “a lot of people don’t have the time for [long term therapy], or money, and they need help right then.” She felt that for clients with limited resources, appropriate goals included, for example, the ability to function effectively enough to work and provide for a family. However, Jean placed no restrictions on the actual length of therapy for those client with resources, preferring an approach “. . . where the client is really given forever.” Jean felt that Amy belonged in this latter category of clients: “she does have a lot of issues still, she does have the time to work through those issues, she does have the money to handle it, so why not?”

While Amy thought that appropriate terminations were ones that were based on having solved essential problems, Jean thought that absent practical constraints like time and money, therapy really had no bounds. Ironically, Amy also mentioned that money and time were important factors in her decision to terminate, although in a different way. She reported that, “I sometimes feel like overanalyzing . . . I don’t know if it’s worth the time or the money for it.” The research group felt that Amy’s and Jean’s philosophies could be aptly characterized as a deceptively simple “why should I continue?” (Amy) versus “why shouldn’t she continue?” (Jean) dichotomy. We felt that even if Amy and
Jean had agreed completely on nature of the problems they were addressing and the extent to which those problems had been resolved, this dichotomy alone might have resulted in Amy calling for termination and Jean calling for continued therapy.

Summary. There were several improvements that Amy reported that Jean did not know about, but almost all of these “improvements” happened after Amy and Jean’s last session (so Jean could not have known about them). Amy also reported doing some things (i.e., talking to her mother) that Jean predicted she would not be able to do, but some of Amy’s statements suggested to us that Jean might not have interpreted these events as positively as Amy did, even if she had known about them. In addition, Jean interpreted some of the “improvements” that she did know about with caution, concerned that they might be evidence for other kinds of problems (e.g., “stability” as evidence for a continuing need to control emotions). In sum, while some of the apparent “miscalculations” appeared to be events that the therapist could not have know about, others appeared to be results of differences in the way certain changes or events were interpreted.

The richest area of analysis for this case was in the area of problem conceptualization. There were several ways that Amy’s and Jean’s conceptualizations of the problems they were addressing differed – and these differences appeared to be directly related to their evaluations of the therapy outcome. They had different opinions about the role and importance of Amy’s breakup with her boyfriend, different ideas about what kinds of problems were “relational” in nature, and different understandings of why Amy was having difficulty making friends. As a result of these differences, Jean would probably have interpreted some of Amy’s “improvements” as evidence that there were additional problems that needed to be addressed. In addition, these differences apparently resulted in some events in Amy’s life (i.e., getting back together with her boyfriend) signaling improvement to Amy but not to Jean.

Amy and Jean had different opinions about the commitment people should make to therapy absent severely distressing symptoms. Jean felt that people should continue in therapy indefinitely if they have the time and money, while Amy felt that once the “bigger problems” have been solved, continuing in therapy constitutes “overanalyzing.”
In the absence of conceptualization differences, this difference alone could have resulted in different evaluations of the appropriateness of termination.

Susan and John & Karen and Brian: A case of marital therapy

Susan and John had been married for five years and had a five year-old daughter. John had been suffering from a degenerative disorder for many years, and originally attended 15 sessions of individual therapy with Karen to learn to “focus on what I can do.” After he ended individual therapy, John and Susan attended 23 sessions of marital therapy with Karen and another therapist, Brian. Following the termination of the marital therapy, Susan attended four sessions of individual therapy with Karen. This analysis will focus on the marital therapy.

Karen invited Susan and John to participate in this study following their termination session. She felt that their comments during this session indicated that they felt more positively than she and Brian did about the outcome of therapy. Because both Karen and Brian thought that Susan and John would have different views of their time in therapy, they were invited for separate interviews. Karen and Brian were interviewed together. These were the stories they told about their time in therapy, their evaluation of the outcome of therapy, and their views on therapy in general.

John

Presenting Problems. John reported that when he initially came to marital therapy, he and his wife had been fighting and not getting along.

Course of therapy. Over the course of therapy, John came to believe that he was acting in a controlling and domineering manner toward Susan. He learned that he tended to demand things from her and their daughter, and that he felt that he deserved to have things done his way because he was the main breadwinner. John assumed that he was right about things most of the time. He was also frustrated with many of the physical limitations he had because of his degenerative disorder. These frustrations caused him to be hard on himself, and consequently demand that others do the things that he could no longer do for himself.

Outcome. John reported that by the time he decided to end marital therapy, he had learned the value of compromising with others, and often decided that it was best to
give in and let Susan have her way. John now thinks of his money as belonging to the family, as opposed to only belonging to him. He now tries to focus on what he can do, rather than on his physical limitations. He also tries not to assume that others should have to do certain things for him just because he cannot do them for himself. John tries to ask for help from others instead of demanding things from them.

Currently, John tries to understand Susan’s point of view on things and respect what is important to her. For example, because he knows that it is important to her to be on time for things, he tries to move faster getting into and out of the car. He also learned to accept that his wife does not pay the bills as early as he would like her to. John no longer thinks there is any sense in arguing over things like this.

Lately, because Susan and John have been trying to have another child, John has been thinking about wanting a closer relationship with his daughter. Right now, he believes that she views him mainly as a monetary provider, which he feels may be his fault.

John is uncertain whether Susan, Karen, and Brian are aware of the changes he had made and that he is trying to do better. He reported that on several occasions during therapy, he was told that he was not changing. These statements made him angry because he did not like being told that he was wasting their time. At the same time, he thought that perhaps they were right that he was not changing, and decided to put his words into action and do the things he said he would. To John, therapy had become a place where he was stuck talking about the same things over and over, and he decided to end therapy in an attempt to move past “words” into action. John reported that this is a problem that he needed to work on by himself.

John reported that he does not see any problems that would be left to work on if he were still in therapy, but hopes that if Susan sees any, that she will tell him about them. John indicated that he would be willing to come back to therapy if Susan indicated that there were additional concerns she wanted to discuss.

_views of Therapy._ To John, therapy is a chance to have an outside person look at what you are doing and tell you what they think of you. If the therapist says things that are similar to what someone else in your life is saying about you, then you know that what the other person is saying is true and that you should take him/her seriously. For
example, before John came to therapy, he thought Susan was just “harping” at him or trying to make him mad because she wanted to hurt him. After hearing Karen and Brian say that they thought Susan’s concerns were legitimate, John began to think that Susan might really mean what she said.

John believes that therapy is a place where you talk about things, but not really a place where you put words into action. He indicated that it is time to end therapy when you start talking about the same things over and over again, and need to just start acting differently.

Susan

Presenting Problems. Susan reported that when she and John initially came to marital therapy, they had not been getting along for some time. She believes that their problems started before they were married, when she got pregnant and her mother-in-law told her husband that it would be better if she got an abortion. For the several years before they began therapy, John had been very angry because of his disability, and he yelled and screamed continuously at both Susan and their daughter. He also was very controlling. For example, he once put all of their money into an account in his name, and gave Susan an allowance that was too small to pay for the things she needed. He also sold Susan’s car and their house without consulting her. John’s mother had encouraged him to do these things, and had also successfully influenced him into thinking that Susan’s needs did not matter and that she should be responsible for taking care of everything in the home. Because John had been disabled, his mother expected Susan to be his caregiver, but ignored the stress that Susan experienced in living with a person with a disability. John did not understand why she felt hurt by his mother’s and his actions, and eventually Susan starting hurting John back intentionally. She left him several times, but always came back.

Course of Therapy. Before they started marital therapy, Susan had told John that she would leave him if he did not come to therapy and take medication to control his anger, which he did. She reported that therapy focused mainly on getting John to understand her feelings and her needs. While Susan knew that there was something she was supposed to work on too, she could not remember what it was at the time of the interview.
During therapy, Susan often discussed her feelings about staying in the marriage versus getting divorced. While Karen and Brian encouraged her to make a decision about whether or not to stay in the marriage based on what would make her happy, she felt that her decision was constrained by several factors, including her Catholic religion, her daughter’s affection for her father, her desire to maintain her current standard of living, and fears that John would commit suicide if she left him. Susan reported that she thought about what she could have done differently to make the marriage better, but felt that because she was so controlled, that there was nothing she could have done except left John, which she felt was not actually an option.

Outcome. Susan reported that John went on medication around the time they started therapy, significantly decreasing his angry outbursts toward her and their daughter. Over the course of their sessions, Susan felt that John was able to begin to see that he had treated her and their daughter badly and to understand her a little bit more. Susan feels that there is still much room for John to improve in these areas, but she questions whether he has the ability to understand everything that has happened.

Susan reported that she still does not like being married because there is no romance in their relationship and because she feels that she has never really had the chance to be herself in her marriage. On a more positive note, Susan has gained more control over her finances because John can no longer write checks, and she has refused to get a joint account with him. While she believes that John’s philosophy is still that people should do what he tells them to do, Susan feels that she has become more assertive because she has found that being nice does not work. She feels that she has nothing left to lose by telling John what bothers her about his behavior because she does not really care if they get divorced. At the same time, Susan indicated that she has committed herself to her marriage because she feels that if she decided to leave right now, her decision would be based on anger, and she does not want her decision to be based on that. Susan learned in therapy that changes take time, and that she needs to be patient.

Susan no longer takes her mother-in-law’s actions personally because she has discovered that her mother-in-law acts in similar ways toward others. Susan no longer
believes that she can change her mother-in-law. Also, her mother-in-law now has a new boyfriend and so is interfering less in her marriage.

Shortly before they decided to end therapy, Susan and John visited a doctor who explained to them that John’s disorder was affecting the areas of his brain that control “cognitive thinking,” and that this made him do things he normally would not do. After this visit, Susan felt better because she had confirmation about something she had already suspected. She also started looking at John differently when she decided that “this is just how he is.”

Susan reported that John never really wanted to come to therapy to begin with because he did not want to hear how awful he had been to Susan and how he needed to change. Susan does not think he has any intentions of changing, and that John believes that he acts the way he does because his father acted that way too. Susan felt that she and John were at a stalemate in therapy continuously because he would say he would change, but then would not follow through. After winter break, Susan could not get John to commit to a time to go to therapy sessions, and when she put him on the phone with Karen and Brian, he told them that they were not coming back. Susan agreed to terminate because she was tired of making John go and decided that she could not drag him in. During their final session, they talked about breaking into separate counseling with Karen and Brian, and Susan decided to continue to come to see Karen individually. One reason that Susan continued to come to see Karen is because she hoped that John would wonder what she was saying about him and decide to come back in and change.

While Susan previously had very negative feelings toward men, having a male therapist helped her realize that she could have a relationship with a man and that men are not all “shit.”

Views of Therapy. Susan views therapy as a place to get things of her chest and have somebody help her with those things. She believes that most people think that people who come to therapy are necessarily crazy (like John does, in her view) but she believes there are “different levels of counseling.” (Unfortunately, I was not able to obtain more information from Susan about her views of therapy during the time we had allotted for the interview.)
Karen and Brian

**Presenting Problems.** Karen and Brian reported that Susan decided that she wanted to engage in marital therapy after John decided to terminate his individual therapy. Susan was unhappy in their marriage and struggling with whether or not to leave John. She felt that John did not listen to her and was generally insensitive to her needs and feelings. She felt that he was not pulling his weight in the relationship (e.g., by not contributing to household responsibilities) and was upset about him not consulting her about major expenditures. Susan and John disagreed about appropriate childrearing and the role of the wife in the home, and Susan felt that her opinion was not valued in these matters. In addition, Susan was angry about John’s tendency to side with his mother instead of her, and felt isolated and unsupported. Susan had most of the complaints in the relationship, especially in the beginning, when John’s only concern was that he did not want Susan to leave him. Eventually, he shared that he did not like the way Susan treated him either (e.g., yelling at him, putting him down, telling him what to do).

**Course of therapy.** During therapy, Karen and Brian noticed that Susan and John had specific ways of hurting each other. Susan hurt John in straightforward ways, by insulting him and demanding things of him. John hurt Susan in more passive aggressive ways, by ignoring her or playing helpless. Both dealt with each other in ways that perpetuated a cycle. When John was insensitive to Susan's feelings or needs, Susan would respond by insulting John, and John would withdraw or try to make her feel guilty by pretending to be helpless (e.g., "I'm trying to do my best.").

Karen and Brian felt that Susan conveyed her needs in ways that made it impossible for John to meet them. Their goal for her was to be able to convey feelings of hurt or other needs to John in a less emotionally abusive manner. They also felt that John had a difficult time understanding Susan's feelings because he would take her very literally and could not infer how his actions would make her feel. Their goal for John was to be able to understand Susan’s feelings without her having to spell them out for him. Karen and Brian gave them several assignments to assist John in developing this empathy, but they did not do them. They eventually changed the assignment to simply talking to each other for five minutes; Susan and John also did not do this assignment.
Karen and Brian believe that John and Susan were engaged in a power struggle, but they do not think John and Susan saw it that way. Though Susan was the more assertive one, Karen and Brian felt that John really held most of the power in the relationship through his strategy of passivity. For example, they believed that Susan likely would have left John if he had been willing to acknowledge that they had problems or that she might be happier without him. He would not do this, instead claming that he did not know what she wanted from him or that he did not understand how she felt. Susan felt too guilty to leave him without this "permission."

Susan often went back and forth on whether or not she wanted to divorce John. While she felt that there were a multitude of things preventing her from actually leaving him (including her religion, her daughter, guilt over leaving a handicapped person, pride, and fear of what other people would think), Karen and Brian’s goal was to get her to acknowledge that she chose to value these things and stay because of them. While she felt that she had no choice but to stay in a miserable marriage, they wanted her to acknowledge that in staying, she was making a choice.

Karen and Brian reported that the theme of responsibility came up often in Susan and John’s therapy. They felt that both Susan and John had tendencies to deny their own role in contributing to the problems that they faced. Susan did this by saying that John was responsible for all of the problems, while John did this by always saying, “I am doing the best I can.” In addition, neither of them appeared to take responsibility for fixing their marriage (e.g., not doing assignments, not following through on things discussed during therapy). Karen and Brian felt that neither of them wanted to give up or compromise, and gave lip service to changing (particularly John).

Karen and Brian reported that it was apparent to them that Susan was dragging John to therapy, and that he did not really want to be there. Susan told them that John would say every week that they should just call and cancel because they did not really need to go. Karen and Brian felt that he did not really want to change, and that the messages that were coming at him were too much for him to hear. They believe that John unconsciously paralyzed the therapy by coming and then refusing to actively engage in the process.
Outcome. Karen and Brian felt that there were several moments during therapy when both John and Susan made progress. Once, Susan had a breakthrough in understanding how her behavior contributed to John’s low self-esteem, and she felt guilty enough about this to cry. However, at the next session, she decided that this was not true and that their problems were all John’s fault. John typically started off sessions confused about what it was that Susan wanted to be different, but by the end of the session tended to become clearer about this. However, he always lost this understanding by the next session and returned to a behavioral formulation of the problem (i.e., that he was doing something objectively wrong), instead of understanding that they were working toward him developing a genuinely caring orientation toward Susan. John did make some attempts to show caring toward Susan (e.g., once by trying to comfort her about a death, and once by putting his hand on her leg when she was feeling sad), but Susan tended to become angry with these attempts and reject them. Karen and Brian described this therapy as, “taking 2 steps forward only to take 1 or 2 steps back,” and felt like they had to go over the same things again and again.

Karen and Brian saw Susan and John for a regular session right before winter break and planned to meet again after the first of the year. There was no talk of termination. When they did not call after the first of the year, Karen called Susan, who said that she was not sure if she and John were coming back. She explained that over the break they had gone to see John’s physician, and that the visit had changed their whole life. Karen and Brian called several times after that point, and eventually Susan said that they were still not sure they were coming back and that they would call them; they never did. During one phone call, John said that he did not think therapy was going anywhere, but that he knew what he needed to do and did not need to come anymore. Susan said that John thought he had gotten the message but that nothing was changing. She also said that she had decided that if John did not see that it was helping, she was not going to force him to go.

John and Susan came in for one last termination session. They explained what had happened at the doctor’s visit. The doctor had told them that John’s degenerative disorder was now affecting the areas of his brain that controlled emotions, thinking, and decision-making. Susan said that she had realized that these were all the things that she
was frustrated with John over, and that it was the disease, not John, that was responsible for his behavior. She said that she had made the choice to stay in the marriage. Some things were different during the termination session. John and Susan seemed to be communicating better, and each was able to refrain from retaliating if the other said something hurtful. They were able to talk things through and apologize to one another. They had found a way to divide up a list of chores. John seemed to feel more empowered to do things. Karen and Brian believe that these changes happened because when Susan decided the problem was John’s disease, she became more tolerant of him, and John consequently became less defensive. They think that Susan had a significant amount of unexpressed guilt for mistreating John, and that their work may have primed her to receive the message from the doctor that finally allowed her to stop blaming John and start treating him more compassionately.

However, Karen and Brian had some reservations about the progress that Susan and John had made at the time of their last session. It was clear that things were not that much better. Though Susan was more tolerant of John, she still was frustrated with many things. Karen and Brian also felt that John’s physical disability served as a scapegoat that allowed things to get better while both John and Susan were able to disown responsibility for their problems. Also, they were saying that their problems began two years ago (at the same time the disease supposedly started effecting John’s brain) – which Karen and Brian did not believe was true, considering they were having problems even before they could tell that John had the disease. Karen and Brian reported that they spent a lot of time in therapy trying to combat the fallback onto the disease as the cause of Susan and John’s problems, principally because using this explanation did not always have positive effects on their relationship. For example, Susan tended to use the fact that John was disabled as an excuse for staying in a marriage that she hated (i.e., “I can’t leave a handicapped person”), which increased her resentment of him.

Karen and Brian’s concerns at termination were consistent with what Karen observed in subsequent sessions with Susan. In general, things were always very up and down with John and Susan – one week everything was great and they were staying together, and the next Susan would want a divorce. Sometimes knowledge of John’s disability would help Susan be more empathic to John, other times it increased her
resentment of him. Karen and Brian think that it is possible that John and Susan’s termination session was part of one of their “things aren’t that bad” swings. Since Susan and John typically made short-lived improvements, Karen and Brian remain skeptical about the longevity of the positive things they saw them doing in their termination session.

Views of Therapy. Brian believes that people have ways of adapting to the circumstances of their lives, and that sometimes those ways of adaptation come into conflict with the world’s response. When old ways of being become less useful over time, therapy can be a place where people come to look at the current usefulness of the ways they approach the world. In understanding how those ways have and haven’t worked for them, they can learn to develop new ways. Therapy is essentially the process of creative experimentation with these new ways of being in the world. Along these lines, his goal for John and Susan was for them to be able to experiment with shifting out of the very rigid system they had set up for themselves.

Karen agreed with Brian on this point. She also believes that what people can get out of therapy is a deepening of relationships and an experiential “presence.” She believes that many problems that people face are because they have numbed themselves to their own experience and are not present in their relationships with others. Therapy can help people find ways to be more alive. Along these lines, her goal for John and Susan was for them to be able to hear each other, instead of being closed off from and threatened by each other’s experience. She also believes that they were closed off from their own experience and not truly present with each other. Karen would have liked them to let their individual walls down so that they could have become respectful and empathic toward each other. She would have liked them to feel that they were responsible for and in control of their own lives and their relationship, instead of feeling like they were being manipulated by fate.

Karen reported that she does not think there is a prescribed time that therapy should last. In couple’s therapy, she can tell when they are ready to terminate because she can actually witness the way the couple interacts in the therapy room. (In individual therapy, she assesses how the client interacts with her.) Karen believes that people could
always be in therapy because there is always something left to talk about. Therefore, a successful therapy is not necessarily one in which all problems have been solved.

Brian agreed with Karen on this. He also reported that he has no specific criteria that he uses to determine when a client is ready to terminate therapy. In addition, he thinks the length of therapy should be related to the original goal that the client and therapist set. For John and Susan, it was difficult to evaluate the outcome of therapy because they never seemed to be able to settle on a goal. Sometimes it appeared that they were working toward a clean divorce, while other times it appeared they were working toward Susan and John being able to live together without “killing each other.” Many clients come in wanting to get rid of a specific symptom (like depression), but Brian never assumes that he will be able to actually eliminate a symptom or that doing so will wind up being the appropriate goal for that client. Instead, he and the client have to reevaluate where they stand in relation to that symptom to determine the outcome – a good outcome may be coming to accept a symptom, rather than eliminating it.

Successful therapy can even be “getting through the worst of it.” The most important thing for Brian is to have clarity about the purpose of his time with the client and what they are working toward. Regardless of what the goal is, having that clarity usually helps him feel better about a termination. In addition, time and money are important to people, and play a role in whether termination is acceptable.

Analysis of John’s termination with Karen and Brian

After reading Susan’s and John’s interviews, the research group felt that it would be prudent to complete separate analyses of their reports for several reasons. Not only did Susan and John offer different accounts of their problems and the time they spent together in therapy, but they also evaluated the outcome of therapy differently. Since we did not feel that we could synthesize their reports into a joint account, we essentially considered them as separate clients when we compared their accounts to Karen and Brian’s. I will begin with our analysis of John’s case.

Miscalculation hypothesis. The miscalculation hypothesis seemed to deserve special attention in this case because the client, John, specifically suggested during his interview that his therapists were unaware of the changes that he had made: “They said I wasn’t making change. Well, I’m trying to do it.” John mentioned several times during
his interview that he had heard through Susan and directly from Karen and Brian that none of them thought that he was changing. In contrast, John himself felt that he was making sincere and successful efforts to change.

However, in this case, as in Amy and Jean’s, we felt that there were several factors that made it difficult to accept the miscalculation hypothesis as the most accurate model for describing differences in outcome evaluation. First, John himself was unclear about whether or not he had changed over the course of therapy. At one point he suggested that he had changed and that his therapists could not recognize this: “[Karen] told my wife, ‘[John] really didn’t change with 36 sessions.’ And couldn’t really see the change.” However, when asked how he felt about being told that he had not changed, John replied that, “it made me feel like, well yeah, I guess I am wrong. I need to change . . . what I had to do is accept that they’re probably right and maybe I’m wrong [in thinking that I had changed].” We were initially confused by John’s statements because they seemed to suggest that while he thought that he had changed, he also was persuaded by other’s arguments that he had not. (One question that we had prepared for John’s follow-up was designed to clarify this ambiguity. Unfortunately, we were not able to get his feedback.) One possible interpretation that we considered was that John felt that he had not changed during therapy itself, and that the changes he did report actually occurred after the completion of therapy. John himself reported that his major reason for ending therapy was so that he could make the changes that he was not making in therapy: “Instead of still keeping going [to therapy], you just gotta change.” If it was indeed the case that John made his changes after the completion of therapy, then Karen and Brian’s less positive evaluation of the outcome represented not so much a miscalculation of the outcome as a lack of access to the relevant information.

Second, we felt that John’s vision of “change” differed substantially from Karen and Brian’s. John said that one of the important changes he had made was that he now tries to put himself in Susan’s shoes and change his behavior to accommodate her wishes. For example, John reported that because he has noticed that being on time is important to Susan, he now tries to move faster so that they are not late: “I go ahead and get in the car, and sitting there waiting, instead of when she decides to go that’s when I go, and then it holds us up. Because it takes me longer to get in the car.” Karen and Brian, on the other
hand, reported that part of John’s problem was that he tended to “take things very literally,” interpreting Susan’s distress as indicating that there was something objective and specific that he was doing wrong. Brian said:

He would always go back to a behavioral formulation of it . . . that there was some action that he was doing wrong. So we would have to spend a lot of time working back through what [Susan] had seen was the more core issues, which was his sensitivity to her. A more fundamental orientation toward her, genuinely caring for her, genuinely understanding her. And that would be manifested in his being able to take her side instead of the mother’s side. That would be manifested in his seeing things that needed to be done. Seeing times when she was stressed and picking up the slack . . . “

The research group felt that while John and his therapists reported apparently similar views of what needed to change (in John’s words, “. . . trying to understand [Susan’s] views of it and put myself in her shoes”), their visions of what it would look like when this goal was achieved were different. To John, understanding Susan meant that he was aware of and willing to accommodate to the ways that she preferred to accomplish certain concrete tasks (like getting places on time or paying bills at the last minute). To Brian and Karen, however, understanding meant that John would have a spontaneous awareness of Susan’s feelings so that his behavior was empathy driven, rather than rule driven. In the group’s interpretation, John’s reported “improvements” exhibited those same characteristics that Karen and Brian had aimed to change. Therefore, we felt that John’s and Karen and Brian’s different outcome evaluations were rooted in different interpretations of what it meant to “understand,” rather than a “miscalculation” of outcome on the therapist’s part.

Third, we felt that Karen and Brian both were well aware of how positively John was evaluating his own progress. When asked to predict what John had said in his interview, Karen said, “he probably said that he learned in therapy what he was doing wrong, and that now he knows what to do with [Susan].” Similarly, Brian said, “I would guess that [John] probably said that he learned about some things he thought he should be doing better, such as listening to her and helping out around the house.” As a whole, we felt that Karen and Brian’s comments accurately reflected John’s description of therapy
as a place where he had discovered his faults and learned how to change certain behaviors.

However, Karen and Brian also interpreted John’s tendency to report improvement itself as problematic. Karen, for example, explained why she thought John would report improvement during his interview: “I think he would have said this if he thought this is what you wanted to hear or was in the mood to please. If he was in a different mood, he might have said that he thought therapy was somewhat pointless, that nothing had changed, and he didn’t need it. But, my guess is that he aimed to please.” In other words, Karen felt that if John reported improvement, it would reflect his tendency to cater to the expectations of others rather than his honest evaluation of therapy outcome. Karen and Brian felt that in general, John was unmotivated for therapy and tended to avoid active participation in “passive aggressive” ways, by paying “lip service” to the idea of changing. In sum, the miscalculation hypothesis did not appear to apply in this case because 1) the therapists were aware of the client's reports of progress and 2) they interpreted those reports as evidence for some of the problems they were trying to work on with him.

**Perspective divergence: Problem conceptualization.** There were several striking differences between John's and Karen and Brian's conceptualizations of the problems they were addressing that appeared to influence their evaluations of outcome. The first major difference we identified was in the emphasis they placed on John's frustration with his physical disability as a factor in his marital difficulties. John felt that before therapy, his own frustrations led him to be inappropriately demanding of his wife and daughter:

"I'm disabled and I can't do things. Accepting that, that has been the hardest thing for me, to accept my limitations. You used to be able to do it, and when you can't do it now, instead of beating on myself cause I can't do it, and just cause I can't do it means that she should have to do it. I've tried to do it the best I can and not be so -- wanting her to take over what I used to be able to do, not thinking that she has to do it, just because I can't."

In other words, John felt that a major reason he had been fighting with his wife was that he had been focusing his anger at his physical limitations on her instead: “. . . in a way I
was blaming her because I couldn't do [things as fast as her]. And it's not her fault, it's the disease."

Karen and Brian, on the other hand, felt that John's disability was more a complicating factor than a root factor in his problems with Susan. For example, when asked about the role of John’s illness in Susan and John's marriage, Karen said:

"It's horribly debilitating for [John], and it makes his life miserable, and I know that it affects him in certain ways, emotionally, cognitively. But I don't think that's the main issue. I never have felt that way . . . They've been having these problems for a long time, even . . . when you could barely tell that he had [the disease] . . . the problems have been there since day one of their relationship."

While Karen and Brian acknowledged that having a physical disability was very difficult for John, they felt that other issues were more central to Susan and John's problems, especially since their problems preceded the onset of the disease. They felt that John's condition was problematic mostly because of its effects on his ability to change. Brian thought, "[John's] organic cognitive problems were definitely a factor, if nothing else, in making it very difficult for him to . . . think, process, and make decisions about how to change."

Overall, we felt that John and his therapists conceptualized the role of John’s disability in his life differently. While John thought that his adjustment to having a physical disability was a major root cause of his marital difficulties, Karen and Brian felt that the disease was problematic mainly because it made it difficult for John to cognitively process the changes that he needed to make. As such, one of the fundamental improvements that John reported ("instead of beating yourself about what you can't do . . . It's helped me to accept what I can do. That has helped me a lot.") did not appear to be one of the major goals his therapists had for him. We felt that this was one reason why their outcome evaluations differed so substantially.

The second major difference between John's and his therapists’ account was in the way they conceptualized the nature of John's problems with aggression. John, for example, felt that before therapy he was a "controlling" and "domineering" person: "I was closed minded and it was my way or no way . . . I felt like it had to be my way because I was the one contributing the most . . ." Karen and Brian, on the other hand, characterized
John's aggression as "passive" in nature. They noted that he tended to hurt Susan the most by doing subtle things, like pretending to be helpless with the aim of making her feel guilty. For example, Brain said:

"... even though he would acknowledge mistakes, it was always couched in the passive aggressive 'I know I'm not perfect, but I love you and I'm doing the best I can here' voice. That voice seemed to have a self-protective function rather than being a genuine expression of concern for another person's pain. We tried on several occasions during therapy to help him pay attention to how his passive aggressive voice would make [Susan] more upset rather than making her feel sympathy for him, but every week without fail he would always return to trying to convince her that he was an imperfect but good person who wants to love her and be with her."

While John thought that his problem was that he straightforwardly demanded to have his way, Karen and Brian thought that John's problem was that he tried to get what he wanted (e.g., to get Susan to stay with him, to avoid changing) in indirect ways, either by making insincere acknowledgements of his faults or by pretending that he didn't understand what Susan was upset about.

Because John felt that his problem was that he always demanded to have his way, he thought that learning to let Susan have her way sometimes was a major improvement for him: "... instead of coming to battle and who's going to be right and who's going to be wrong, I've come to the conclusion that there you just have to give in." Karen and Brian, on the other hand, aimed to help John develop awareness of the more subtle ways he "had maintained the position of dominance over [Susan] through the passive strategy that he used." In summary, while both John and his therapists thought that John was controlling, they thought that this control manifested itself in different ways. Though John's reported improvements reflected the way he felt he controlled Susan, they did not reflect an awareness of the subtle ways his therapists thought he tried to control her. As such, they continued to see problems with aggression and control, while he did not.

Perspective divergence: Outcome criteria. During their interviews, I asked John, Karen, and Brian to share some of their views on the purpose of therapy in general, as well as the way they prefer to evaluate outcome. While Karen and Brian answered these
questions as they were intended, John chose to continue addressing his specific experiences in therapy, as opposed to his views on therapy in general. While this initially made it difficult to compare their views, the research group eventually decided to interpret John’s statements about his own therapy as personal examples of his values with regard to therapy in general. Thus, we felt that we had enough information to conduct a limited analysis of John’s and Karen and Brian’s similarities and differences in this area. There was one specific area in which they differed that we felt probably influenced their outcome evaluations.

John noted at several points throughout his interview that he had decided to terminate therapy because he had made a vow to change. For John, termination symbolized the beginning of the change process: “It’s time to do this instead of talking about it. There’s an old saying – ‘talk’s cheap, it takes money to buy whiskey.’ Instead of talking about it, I need to put them magic words into action and do things.” When asked if talking more in therapy would have helped him “put words into action,” John answered with an emphatic, “No.” In the group’s interpretation, John viewed therapy as a place where people talk about changing, but not a place where they actually enact those changes. We felt that his frequent use of the phrase “instead of,” suggested that he felt a strong dichotomy between talk and action. Because John associated therapy with “talk,” it was apparent to us that he did not view “action” or “change” as possible outcomes or goals for therapy.

Karen and Brian, on the other hand, each had specific changes that they looked for in their clients to evaluate the outcome of therapy. Karen reported that she looks for an “experiential presence” and a sense of being alive and aware of one’s choices. Brian reported that he looks for the ability to “experiment with new ways of being in the world.” Karen’s and Brian’s goals contrasted with John’s in that they were changes that could be observed in the therapy room itself. Karen noted that one of the ways she evaluates whether or not termination is appropriate is “[seeing] in the room the way [the clients are] relating to one another.” While neither Karen nor Brian felt that there was always one standard by which an outcome could be labeled a good one, they nevertheless conveyed the sense that they believed that some sort of movement or observable change could and should happen in the therapy room itself.
John and his therapists differed in their views of the extent to which change is part of the therapeutic process. While John felt that “talk,” or therapy, was antithetical to the process of change, Karen and Brian felt that having enacted some kind of change (which they defined in a wide variety of ways) was an integral part of therapy and at least one component of a good outcome. We felt that John’s view of therapy as a precursor to change enabled him to evaluate positively the outcome of a therapy during which no change occurred. Because Karen and Brian were waiting to see the change itself, they would have evaluated the “same” outcome in less positive terms even if they had had similar visions of what needed to change.

**Summary:** Though John specifically suggested that his therapists had not noticed or acknowledged his improvements, and he did report improvements that his therapists did not, we nevertheless felt that the miscalculation hypothesis was a poor fit for understanding the differences in outcome evaluation between John and his therapists. First, John reported that he had terminated therapy in order to start the process of changing – suggesting that he also thought he had not changed during therapy itself. Second, John appeared to have a more concrete understanding of the changes he needed to make than his therapists did, suggesting that they would have evaluated the same outcome differently. Third, John’s therapists were aware of how positively he was evaluating his own progress and interpreted this as evidence that further treatment was indicated.

John and his therapists had one important difference in the way they viewed therapy that we felt may have resulted in their different evaluations of the appropriateness of termination. Whereas Karen and Brian viewed therapy as a place where change takes
place, John viewed therapy as a place where people can only talk about changes that need to be made. For John, making an honest decision to change marked the appropriate end to therapy. Because Karen and Brian wanted to see change during the process of therapy itself, they felt that continued treatment was warranted while John did not.

**Analysis of Susan’s termination with Karen and Brian**

Immediately following my interview with Susan, I doubted that she met the criteria I had established for this study. Her continuing dissatisfactions with her marriage were so clear that I wondered why her therapists had felt that she was an appropriate candidate. Therefore, I asked both Karen and Brian at follow-up to explain exactly how Susan was evaluating the outcome of therapy at the time of termination. Their responses made it clear to me that, at that point, Susan had indeed met criteria for the study. Karen stated:

“At our last session, [Susan] seemed ready to terminate couples therapy. She felt like she had some issues she wanted to work on individually, but as a couple, she felt like things were much better as a result of her new attitude toward [John] and his changed behavior. I think she was happy, on that day, with the outcome, but did not necessarily attribute a lot of it to the therapy.”

Similarly, Brian reported, “At termination, [Susan] seemed fine with termination and seemed convinced that things would get better now that she knew that the problems could be traced to [John’s disability].” After reading their reports, I felt that it was important to include Susan in the study because her case illustrated an important point – that asking clients to evaluate the outcome of therapy or state their reason for terminating at any one point may result in a misleading or incomplete understanding of their views.

Another reason I decided to include Susan in the study was because as the research group began analyzing Susan’s report in more depth, it became increasingly clear to us that even though she still had numerous complaints about her marriage at the time of the interview, she did not feel that she personally needed therapy. Susan shared that her motivation for continuing in individual therapy with Karen was actually to motivate John to change: “I felt like if I kept coming, [John] would be like ‘you’re going there talking about me’ and I felt like he would come back and try to change.” Karen was aware of this as well, and said, “As [Susan] and I continued to meet in individual
sessions, it became clearer that [Susan] was not as satisfied as she had thought and wished [John] would return to therapy with her. She was still holding the view that he was the problem and that he needed to change.” While Susan did not think that the problems in her marriage were solved, we felt that she nevertheless met criteria for the study because she believed that it was John, not her, that was “in further need of services.”

*Miscalculation hypothesis.* Susan reported that she had made several important changes prior to ending therapy, the most important of which was deciding to commit herself to her marriage, at least temporarily: “... for now, I’m here. I’ve committed myself to my marriage. Because I feel that if I made a decision right now, it would be based on anger, and that’s not what I want the end of my marriage to be based on.” Having Susan make an honest choice about staying or leaving also was a goal that her therapists had for her. Brain summarized their goal for Susan:

“The only reason she was in the marriage was because of guilt. She didn’t want to get divorced, and because of [their daughter]. And because of pride. She thought his family would look down on her if she was the one to leave. We sort of viewed that together and in supervision as a ditching of responsibility... She wasn’t saying ‘I’m staying in this marriage because I choose it.’ She was saying ‘I’m staying in it because I’m forced to, and I’m caving to all these other responsibilities, and what everyone else thinks.’ We were trying to focus on getting to the point where she could see that as a conscious decision she was making to stay in the marriage.”

At first glance, it appeared to us that Susan had done what her therapists had hoped she would do – make a conscious decision. However, upon further analysis it became clearer that a “perspective divergence,” rather than a “miscalculation” model was a better fit for understanding their different evaluations of the outcome.

One obvious reason that we felt the miscalculation hypothesis did not fit was that Karen and Brain were aware that Susan had made a decision to stay in her marriage. They nevertheless felt that she had not met their goal because her reasons for staying in the marriage were problematic. In their view, Susan had decided to stay because she had shifted the blame for their problems from John to his disability. Karen reported, “[Susan]
was saying, ‘well this is everything that I’m so frustrated with, so it’s all the [disability].
I realize now that it’s not [John], it’s just because he has [this disability]. And so she said
‘I have chosen to stay in this marriage’ . . . It was a convenient way for neither of them to
have to take responsibility [for the problems in their marriage].” In essence, Karen and
Brian felt that Susan had replaced one kind of avoidance of responsibility with another.
Whereas before her major reason for staying in her marriage was because she felt that her
religion, her daughter, and John’s family left her with no choice but to stay, she was now
staying because John’s disease left him with no choice but to act the way he did. In
addition, placing the blame for their problems on John's illness absolved Susan of her
responsibility for looking at her own contributions to their problems. Thus, even though
Susan met her therapists’ goal in that she made an agential choice about her marriage, she
violated the spirit of that goal by making the choice based on reasons that denied both
John’s agency and her own. (While Susan did not directly state in her interview that she
was staying with John because she had decided that their problems were due to his
disability, we felt that she alluded to it. One of the questions that we had prepared for her
follow-up was designed to clarify whether or not this was the case, but we were not able
to get her feedback.) In sum, we felt that Susan’s decision to stay in her marriage was an
improvement for her but not for her therapists because they had different views of the
importance of agency and choice in making that decision.

Susan reported several other improvements that her therapists did not, including
learning not to take her mother in law “personally,” and coming to realize that men
“aren’t all shit.” Again, we felt that the “miscalculation” model was a poor fit for
understanding why Susan’s therapists didn’t report these changes. First, Susan reported
that her change in attitude toward her mother-in-law came following the termination of
therapy when she spoke with other family members who validated her concerns.
Therefore, her therapists couldn’t have known about this change at the time of
termination. Second, one of Karen’s statements at her follow-up suggested that she and
Brian had been working toward changing John’s attitude toward his mother rather than
helping Susan take her “less personally,” and that their efforts had been at least partially
successful: “[John] started to become angry with his mother when he realized her role in
keeping him infantilized. He then stopped spending as much time with her and sharing
information with her.” This statement suggested to us that Karen and Brian may not have been working toward the same specific “improvement” that Susan reported. Third, Susan’s discovery that “men aren’t all shit” also appeared to be an improvement that her therapist’s weren’t specifically working toward. In sum, these two improvements that Susan reported didn’t appear to major ones that her therapists were looking for to make an evaluation of a good outcome. While Karen and Brian were apparently unaware of these specific” improvements,” it was clear from their conceptualization of the case that knowledge of these “improvements” wouldn’t have substantially changed their evaluation of the outcome of this therapy. Thus, the miscalculation hypothesis (which implies that if therapists knew about client perceived changes, they would have evaluated the outcome more positively), did not seem to apply in this case.

**Perspective divergence: Problem conceptualization.** There were several differences between Susan’s and her therapists’ problem conceptualizations that we felt influenced their evaluations of the outcome of therapy. The most important difference, mentioned previously, was obvious: Susan felt that their marital problems could be traced to John’s behavior, while Karen and Brian felt that both Susan and John contributed to their difficulties. Therefore, when Susan became convinced after their doctor’s appointment that John was unlikely to change (“This is just how [John] is. This is just how it is.”), we felt that it signaled to her that there was no longer any reason to attend therapy. (In other words, if the purpose of therapy is to change John, and John is incapable of change, then therapy is not necessary or appropriate.) Since Karen and Brian not only disagreed that John was incapable of change, but also thought that Susan made significant contributions of her own to their marital problems, they continued to feel that therapy was warranted.

Another important difference between Susan and her therapists was in their evaluations of the appropriateness of some of Susan’s ways of communicating with John. For example, Karen and Brian felt that one of Susan’s major problems was that she tended to communicate her feelings and needs to John in an abusive manner. Brian reported that they focused on “[Susan] recognizing that she had needs, things that she wanted to communicate to [John], but that she was communicating them in such a way that it was making it impossible for him to do what she wanted. She was conveying her
feelings to him by beating the hell out of him emotionally.” Susan, on the other hand, described having made a positive transition over the years from passivity to assertiveness:

“For years I was submissive and I took all his crap, and I’m not doing it anymore . . . I’ve tried it the nice way . . . But that didn’t work. So now, I basically tell [John] how it is. I do what I want to do. I don’t give a shit. I don’t care. What’s the worst that could happen? We get divorced? Who cares!”

We felt that these statements indicated that Karen and Brian identified as a problem something that Susan thought was an important and positive change that she had made. This difference of opinion seemed to be essential to their different evaluations of Susan’s progress. Since Susan was pleased with the same newfound “assertiveness” that her therapists thought was problematic, she evaluated her own status more positively than they did.

**Perspective divergence: Outcome criteria.** Susan’s comments about the nature and purpose of therapy in general were very brief, and generally not elaborate enough to provide for a detailed analysis of any differences between her and her therapists. However, she did make a few comments about her own motivations for attending therapy that we felt were important in understanding her decision to terminate in this case. In general, her comments suggested that she thought of therapy as a tool to get John to change. For example, in describing her frustration with John’s behavior, she said, “maybe I wanted a communicator to tell him in different ways why he shouldn’t do this or shouldn’t do that.” To us, this comment suggested that she thought of her therapists as people whose voices would add strength to her own when she spoke to John about things she wanted to be different. In addition, Susan’s decision to attend individual therapy to get John to “come back and try to change” suggested that she viewed attending therapy itself as a way to communicate that he should take her level of distress seriously. In sum, Susan apparently viewed therapy as a place where her feelings and concerns would be accorded their due weight in John’s eyes.

There was nothing in Karen and Brian’s reports that suggested that they disagreed with the idea that therapy can be a place where clients are given the chance to be heard. However, they did have a more reciprocal view of marital therapy – one in which both clients have a responsibility to work together toward hearing each other and coming up
with new ways of interacting. For example, Karen said that her goal for Susan and John was for them to “hear each other and attempt to respond to each other in the ways that they needed to be responded to.” We felt that Karen’s goal for them to hear “each other” contrasted with Susan’s goal to have John hear her. (Susan’s goal for therapy, of course, was consistent with her conceptualization of the problem as residing within John.) As such, Karen and Brain were looking for a change in the interaction between Susan and John, while Susan was looking for a change within John alone. We felt that this was an obvious and important source of perspective divergence regarding appropriate outcome criteria. (It also shows how problem conceptualization leads directly to the criteria clients and therapists establish for a good outcome.)

Summary: Susan’s was an interesting case because her evaluation of the outcome of therapy changed for the worse between the time she ended therapy and when she was interviewed. However, she was included in this study because she continued to feel that she herself was not in need of services (but John was).

Susan reported that deciding to stay in her marriage was an improvement she made at the end of therapy, while her therapists continued to feel that Susan had problems making decisions about her marriage. The “miscalculation hypothesis” did not seem to apply in this case both because Karen and Brian knew that Susan had decided to stay with John, but nevertheless found her reasons for doing so problematic. Essentially, they saw the same change but evaluated it differently. Susan reported several other positive changes that her therapists didn’t – but these changes did not seem to be goals that her therapists had for her. We felt that it was more accurate to say that Susan and her therapists had different goals than to say that Karen and Brian failed to notice certain changes.

Susan and her therapists had some significant differences in the way they conceptualized the problems that they were addressing that we felt directly related to their evaluation of the outcome. For example, Susan felt that John’s behavior was the cause of their marital problems, while Karen and Brian thought Susan’s behavior was also problematic. Consequently, an important event (a doctor’s appointment that convinced Susan that John was incapable of change) signaled to Susan (but not to Karen and Brian) that ending therapy was appropriate. In addition, one personality
characteristic that Susan was pleased with (assertiveness with John) Karen and Brian found problematic and in need of change.

Susan thought of therapy as a place where John would be forced to take her feelings seriously and would understand that she really did want him to change. Karen and Brian, on the other had, had a more reciprocal view of therapy, expecting both Susan and John to work toward solutions together. Because Susan viewed therapy as a place for John to change, she never really met her therapists’ goals for her to work toward her own changes.

Discussion

In this study, I looked in depth at two psychotherapy cases – one individual therapy, one marital therapy – in an attempt to gain a fuller understanding of those cases in which therapists and clients disagree about the appropriateness of termination (i.e., when clients think they’re no longer in need of services, but their therapists think they are). I examined these cases from the perspective of two different explanatory models: 1) the literature’s current “miscalculation” model, which asserts that these disagreements are the result of therapists failing to accurately observe client improvements, and 2) an alternative “perspective divergence” model, which proposes that these disagreements are the result of differences in problem conceptualization and criteria used for evaluating outcome. Before examining the implications of the results described in the previous section, I will provide a summary of how these two models fared in the analysis.

Consistent with the premise of the “miscalculation” hypothesis, clients did report some “improvements” that their therapists appeared to be unaware of (or at least did not report). These instances, when taken alone without benefit of further analysis, appeared to affirm the accuracy of the miscalculation model. However, it soon became clear that many of these "improvements" occurred after the final therapy session and were not conveyed to therapists prior to termination. The "miscalculation" model seemed a poor fit for circumstances where therapists were not even afforded the opportunity to "accurately" assess their clients' situations. Even if one could place this pattern under the heading of "miscalculation," it was the least interesting and informative finding in the study. Consideration of the alternative “perspective divergence” model offered a much more comprehensive picture of the differences between therapists and clients. In the end,
this further analysis made the “miscalculation” model appear at best insufficient and at worst completely inaccurate.

The miscalculation model implies that if therapists are aware of client reported “improvements,” they will evaluate outcome and the need for continued services similarly to their clients. In our examination of differences in problem conceptualization, however, it became clear that this is not necessarily the case. We found that therapists and clients thought about the problems they were addressing in different ways (some subtle, some obvious), and that those differences formed the basis for the criteria they established for a good outcome. As a result, therapists often were aiming for different sorts of changes than their clients reported. Therefore, even though there were some “improvements” that the therapists did not know about, it was clear that knowledge of these “improvements” would not have substantially changed their evaluation of the outcome. Knowledge of the “improvements” that clients perceive will change therapist outcome evaluations only to the extent that therapist and client are working toward the same end. In many ways, the clients and therapists in this study were not.

Different conceptualizations of the client’s presenting problems led to differences in outcome evaluations (and “premature” termination) in several ways. First, these differences opened up the opportunity for specific events in the client’s life to differentially impact client and therapist opinion about the need for further services. In several instances, clients reported that they were distressed by something external to them (e.g., Amy was upset about her breakup with her boyfriend; Susan was upset about her husband’s behavior). When those external things changed (e.g., Amy got back together with her boyfriend; a doctor told Susan that John’s behavior was due to organic dysfunction), the client’s experience of need for services greatly diminished. Therapists, who tended to focus on the client’s own intrapsychic processes and/or relational patterns, seemed to be much less affected by these external changes in their evaluation of the client’s need for services.

Second, differences in problem conceptualization formed the basis for attaching different meanings to the changes that clients experienced in their own feelings, attitudes, and relationships. For example, while Amy felt satisfied with her newfound emotional stability, her therapist was concerned that Amy was pleased with this “stability” (and
feared losing it) partly because she was still interested in “suppressing emotions.” In other words, Amy felt that “stability” was an improvement, while Jean felt that it indicated that Amy continued to struggle with a different problem (i.e., suppressing emotions). Even subtle differences in meanings, as shown here, led to clients and therapists lining up on different sides of the “in need of services/not in need of services” dichotomy.

Third, differences in problem conceptualization sometimes led to clients and therapists referring to completely different problems when assessing further need for services. For example, John, who conceptualized his problems as resulting from a problematic adjustment to a physical disability, felt that he no longer needed services when he learned to “focus on what I can do.” His therapists, who felt that John’s major problem was “passive aggression,” continued to feel that he was in further need of services. Just as “adjustment to a physical disability” was essentially irrelevant to Karen and Brian’s assessment of John’s need for continued therapy, “passive aggression” was irrelevant to John’s assessment of need for continued therapy. While in some cases clients and therapists disagreed about the meaning of some change that the client reported, in other cases, like this one, they were focused on completely different problems when they evaluated need for further services.

Having different ideas about what therapy should entail, how long it should last, and what counts as a good outcome (a.k.a. “therapy values”), also played a role in client and therapist opinion regarding need for further services. Each case in this study introduced a different set of contrasts in “therapy values” between therapist and client that impacted termination in unique ways. For example, Amy thought therapy should end when “bigger problems” have been solved, while her therapist thought therapy should be constrained mainly by financial resources. John thought termination signaled the beginning of the change process, while his therapists looked for change within the process of therapy itself. Susan viewed therapy as a place to change someone else, while her therapists expected her to change as well. All of these differences in the way therapists and clients conceptualized therapy itself led them to form different conclusions about the need for further services. There was nothing specific (content-wise) that characterized client values or therapist values as a whole; rather, it appeared to be the
presence of a value contrast itself that led to these different conclusions. In other words, it would have been difficult to take any one of the participant’s statements in isolation and predict that the client would have called for termination earlier than the therapist did.

Limitations of This Study

One of our major conclusions – that therapist outcome evaluations would not have changed if they knew about certain client reported changes – was based on our assumption that we could predict therapists’ responses to information that they did not have. The only way to have actually tested our hypotheses would have been to provide therapists with the information we obtained in confidential client interviews. Here, we decided to privilege confidentiality over the opportunity to check our assumptions. However, future studies may want to specifically recruit clients who are willing to let their therapists have access to their responses. If a future study finds that providing therapists with client responses does consistently change their evaluations of outcome, it would suggest that therapists are persuasively influenced by their client's case conceptualizations and/or ways of thinking about therapy. On the other hand, if a future study shows that therapists consistently maintain their outcome evaluations even when presented with client feedback, it would suggest that therapists work from theories that they are willing to maintain even when their clients think about things differently. The results of this study can be interpreted to suggest that future studies will find the latter, especially since the therapists in this study were aware of many of the "improvements" that their clients experienced and still maintained that there were problems left to address.

In addition, we were forced to proceed with our analyses without the benefit of feedback from two of our client participants. One of the advantages of qualitative research is that it allows investigators to check their understanding of participant’s perspectives with the participants themselves. We valued the feedback that we were able to get from our participants, and found that it changed our understandings on several occasions. Future researchers will want to continue to make attempts to check back with participants, hopefully with 100% success.

Another limitation of this study was inherent in the research design – because this was a small scale qualitative study, I could only survey therapists from a limited range of theoretical orientations. While research has shown that specific therapist variables, like
theoretical orientation, are generally not related to premature termination rates (Wierzbicki & Pekarik, 1993), orientation in this study was relevant. Therapist case conceptualization and outcome criteria are both typically linked to theory, and a study whose scope extends beyond the two orientations represented here may well find that there are specific dangers for each when it comes to divergence of perspectives between therapist and client. For example, client-centered therapists may find that their tendency to “reflect” the way clients understand their problems leads to very large or very small client-therapist disparities in this area, depending on whether they form their own alternative conceptualizations (and keep them to themselves) or conform to their client's understandings. On the other hand, strictly behavioral therapists may find that their tendency to consistently use the same set of very specific structured techniques for a variety of clients leads to large client-therapist differences in therapy values.

Despite its limitations, the qualitative nature of this study has added depth and color to the results of previous quantitative research. Previous research has established that approximately one-third of “premature” terminators believe they are no longer in need of services. However, the nature of these studies did not allow for an examination of the specifics of individual therapy cases, and therefore researchers were left with no option but to speculate about the root of the therapist – client disagreement about need for further services. As a result, researchers were drawn to the most obvious conclusion – that one third of clients designated as “premature terminators” were not “really” in further need of services. One limitation of quantitative research is that it often assumes that all people mean the same thing when they use the same phrase (in this case, the phrase was “in further need of services”). When researchers assume that “in further need of services” means the same thing for both therapists and clients, they are essentially forced to also assume that one party has “miscalculated” when therapists and clients disagree.

This qualitative study, however, was able to reveal many nuances of meaning inherent in outcome evaluation and determination of need for further services. Examination of individual therapist-client pairs was able to reveal that each had unique ways of thinking about the client’s concerns and the process of therapy itself – and that these unique perspectives were intimately linked with opinions about the appropriateness
of termination. Previous quantitative research has typically dealt with aggregates of client data wherein their unique perspectives were lost. In addition, these studies have rarely asked therapists to answer more than a single question (i.e., “Is your client in continued need of services?”). As such, individual client perspectives have been lost amidst clouds of data, and therapist perspectives have scarcely been pursued at all. These drawbacks to previous research designs did not provide researchers with the opportunity to adequately explore a comprehensive model for client/therapist differences in this area. In contrast, this study has expanded the scope of Reis & Brown’s (1999) “perspective divergence” model of premature termination to include those “premature” terminators who no longer believe they are in need of services.

In addition, this study casts doubt on the appropriateness of premature termination researchers using symptom-oriented outcome measures (e.g., the Brief Symptom Inventory) to assess client improvement (e.g., Pekarik, 1983a; 1983b). In this study, clients and therapists alike rarely described problems or outcomes in terms of symptoms. Instead, they described changes in interpersonal or intrapsychic processes that could only sometimes be ‘translated’ into symptomatic language. Researchers should keep in mind that they may not capture important outcomes if they chose to provide clients with a specific (e.g., symptom-laden) language that they must use to describe improvements. In addition, it should come as no surprise to researchers that therapist ratings of “degree of improvement” and client BSI scores do not correspond – therapists may not be referencing the kinds of “improvements” listed on the BSI in their assessments of outcome.

Not only did this study expand on the contributions of previous research, but it also evolved of its own accord. That is, the theory that emerged at the end of this study was slightly different than the theory proposed at its outset. For example, differences in problem conceptualization between therapist and client turned out to be much more subtle and complex than originally predicted. Rarely were these differences simply the result of therapists seeing an entirely distinct "additional" problem that the client did not. Instead, they talked about the "same" problems in different ways, made different kinds of connections between issues, and interpreted events in their own unique ways. Differences in "therapy values" between therapist and client also turned out to be more
complex than initially suspected. Neither clients nor therapists were able to articulate a specific number of therapy sessions that they felt was universally appropriate. Instead, they felt that the appropriate length of therapy was related to other (less quantifiable) measures. Despite these minor alterations, the major aspects of the theory -- that differences in problem conceptualization and therapy values contribute to opinions about the appropriateness of termination -- proved to be fruitful ways of understanding the issue of premature termination.

**Implications for Psychotherapy Practice**

*Implications for therapists.* This study has several important implications for therapists who are interested in retaining those clients who would otherwise believe they are in no longer need of services. First, therapists may want to consider sharing their understanding of their clients’ struggles with their clients on a regular basis. Clients who are aware of how their therapists are conceptualizing their problems may be less likely to terminate when they know their therapists still have concerns. Second, therapists should be attentive to those client statements that convey their understanding of the problems they face. Therapists may be able to pick up on client ideas that differ from their own and specifically address the many different ways of looking at the problem. Third, therapists should strongly consider opening up a discussion at intake about how the client views therapy and what he/she would consider a good outcome. Therapists and clients who negotiate with each other a common vision of what “no longer in need of services” means from the beginning may be more likely to agree about the appropriateness of termination at some later point.

Whether or not these suggestions for therapists would actually translate into lower rates of premature termination is an empirical question that future researchers may investigate. Researchers could design studies where they compare premature termination rates for those therapists who do and do not implement these interventions. For example, a study could examine whether therapists who habitually share their case conceptualizations with their clients have lower premature termination rates than those who do not. Another study could train therapists to develop a “termination plan” (e.g., a contract that outlines what outcomes would signal readiness for termination) with their clients at intake and assess the plan’s effectiveness at reducing premature termination.
Of course, making suggestions about how to “retain” clients who normally would have said they were “better” brings up an ethical question: is it a good idea to work toward getting clients to believe that they are ‘worse off’ than they normally would have thought they were? These suggestions are not designed to imply that the therapist’s view should be privileged, or that “perspective divergence” should be eliminated by making efforts to bring the client’s views closer to those of the therapist. First, having frank and open discussions about problem conceptualization and therapy values is just as likely to change the therapist’s ideas as it is the client’s – as long as the therapist and client have a truly collaborative relationship and the therapist’s views are not presented as ‘truth’ from ‘on high.’ Second, while therapists often have the power to influence their clients, clients also have the power to disagree with their therapists (again, if the relationship is collaborative). Offering an alternative perspective to the client does not automatically ensure that he/she will accept it. Third, therapists go through training for the purpose of having something of value to offer their clients. If their perspectives have the potential to spare clients from additional hardship at a later date (even if they feel “better” now) they may have an ethical obligation to convey that perspective to the client. Fourth, open discussions about therapy process may have a positive effect on the therapeutic relationship, which has been shown to reduce rates of “premature” termination in general.

Researchers can, of course, empirically evaluate the impact of attempts to reduce this kind of “premature” termination on clients themselves. Surveying clients who agree to participate in the studies previously suggested will reveal whether they feel forced to adopt a perspective they otherwise would not have, or enriched by a perspective that ordinarily might not have been offered to them. For example, researchers might evaluate the impact that sharing case conceptualizations has on client ratings of therapeutic alliance and feelings of empowerment. A study might also ask clients to describe the extent to which they feel hopeful or excited about therapy (versus hopeless or unmotivated) after having the chance to create a common vision of end goals with their therapists.

This study differed from most premature termination studies in its use of a marital therapy case. The existing literature focuses almost exclusively on individual therapy, leaving a large area of clinical practice unexplored. Future research could examine
premature termination in marital cases more extensively. For example, a study could explore how each client’s perspective differs from the therapist’s perspective, and how these perspectives interact to determine outcome. Also, a study could explore rates of premature termination for those married couples who share a similar perspective on their problems and/or therapy values versus those who do not.

**Implications for clients.** Considering that therapists may at times convey less than the entirety of their concerns or conceptualize problems differently than clients do, clients may benefit from soliciting their therapist’s opinion about their readiness for termination. In addition, clients may want to consider planning for termination in advance or simply returning for a last termination session should they decide that they feel ready to terminate. These final sessions can serve as opportunities for therapist and client to discuss what they feel has been accomplished and what still may require work. Thinking of termination as a process, as opposed to a decision that a client makes independently and then informs the therapist about after their last session, may lead to both client and therapist evaluating the termination as more appropriate.

Researchers may investigate the utility of these suggestions by experimentally manipulating the circumstances surrounding termination. For example, investigators could compare the “premature” termination rates of those clients who agree at intake to attend a termination session versus those who do not. Such a session would take place after the client had decided that termination was appropriate, and would focus on summing up the therapeutic work from the perspective of both therapist and client. Researchers could also survey both therapist and client before and after this termination session to determine what sorts of changes occur for each as a result. Do clients come out with a greater understanding of problems they have left to work on? Do therapists come out with a greater appreciation for the improvements that clients perceive in their lives? Do any clients change their minds and decide to continue with therapy? Do any therapists decide that the termination was not as “premature” as they supposed it was before the session? (Answering this last question may shed light on the legitimacy of our conclusion that the therapists in this study would not have changed their evaluation of termination appropriateness if they had had access to their client’s statements in their interviews.)
Clients may want to consider eliminating some of the need for termination sessions of this sort by initially screening or interviewing therapists carefully to determine which ones have similar ideas about what constitutes “success” in therapy. Clients who do so might not only be less likely to be labeled “premature” terminators by their therapists, but they may also feel a stronger sense of working alliance and implicit understanding of the therapeutic process (as it occurs with their particular therapist). Researchers can examine the usefulness of this suggestion by assessing rates of premature termination for those therapists and clients who are matched on certain “therapy values” versus those who are not.

In the end, it remains a moot point whether anything at all should be done to try to reduce rates of the particular kind of “premature” termination that this study explored. After all, the “premature” label is one that only the therapists used, and only they found the terminations problematic. Some clients may not be interested in their therapist’s evaluation of progress or in their reservations about termination. Previous research has come down heavily on this side of the debate, suggesting that certain “premature” terminations are not “premature” at all, and nothing need be done about them. However, if this study has added anything to the current literature, it is that it has provided the basis for a counter-argument by illustrating that therapists have a perspective that cannot simply be dismissed as “miscalculation.”


Appendix A

Miami University Psychology Clinic

Therapist Termination Questionnaire

Therapist ____________________  Client number _______
Number of sessions ____________  Termination date ______

Please describe the circumstances surrounding termination for this client (e.g. discussed in therapy, planned in advance, missed appointment, unexpected, etc. Please include any follow-up contacts by phone, with dates).

Do you believe that this client is in continued need of services? Why or why not?

Would you consider this termination premature?  □ Yes  □ No

Are you willing to be interviewed regarding your experience in therapy with this client?  □ Yes  □ No

Comments:
Appendix B

Informed Consent - Client

I understand that I am participating in a research project in the Miami University Psychology Department that aims to explore the similarities and differences between therapist and client views of therapy experience and outcome. My participation will entail my attending one face-to-face interview, as well as reading and making any needed corrections to a written summary of this interview. In my interview, I will be asked questions concerning my reasons for attending therapy, my experience in therapy itself, and my views on therapy in general. I may choose not to answer questions or discuss topics with which I am uncomfortable, and may discontinue the interview at any time. My interview will be tape recorded and transcribed. I give permission for these recordings and transcripts to be used throughout the course of the research project.

My interview responses will remain confidential within the project’s research group, which includes my interviewer, two other clinical doctoral students, and one professor in the clinical psychology department. I understand that as part of this project, my therapist will also be interviewed with respect to my therapy experience. I give my consent to my therapist to speak openly about our time together in this interview, and for the research group to have access to this information as well. My therapist’s responses are also confidential within this group. My therapist and I will not have access to each other’s interview recordings or transcripts. In the event of publication or presentation of research findings, all information that could be used to identify me will be changed to assure my anonymity.

I give my consent to participate in the project described above. If I have questions about my participation in this research project, or about the project itself, I may contact Valerie Loeffler at 529-5430 or Professor Larry Leitner at 529-2410. Additional questions about my rights as a research participant can be directed to Office for the Advancement of Scholarship and Teaching (OAST) at 529-3734.

Signature

Witness
I understand that I am participating in a research project in the Miami University Psychology Department that aims to explore the similarities and differences between therapist and client views of therapy experience and outcome. My participation will entail my attending one face-to-face interview, as well as reading and making any needed corrections to a written summary of this interview. In my interview, I will be asked questions concerning my conceptualizations of my client’s presenting problems, my assessment of the outcome of therapy and appropriateness of termination, and my views on therapy in general. I may choose not to answer questions or discuss topics with which I am uncomfortable, and may discontinue the interview at any time. My interview will be tape recorded and transcribed. I give permission for these recordings and transcripts to be used throughout the course of the research project.

My interview responses will remain confidential within the project’s research group, which includes my interviewer, two other clinical doctoral students, and one professor in the clinical psychology department. I understand that as part of this project, my client will also be interviewed with respect to his/her therapy experience. My client and I will not have access to each other’s interview recordings or transcripts. In the event of publication or presentation of research findings, all information that could be used to identify me will be changed to assure my anonymity.

I give my consent to participate in the project described above. I have been given a copy of my client’s consent form, in which he/she gives consent for my participation in this project. If I have questions about my participation in this research project, or about the project itself, I may contact Valerie Loeffler at 529-5430, or Professor Larry Leitner at 529-2410. Additional questions about my rights as a research participant can be directed to Office for the Advancement of Scholarship and Teaching (OAST) at 529-3734.

_______________________________
Signature

_______________________________
Witness