

**Premature Termination of Psychotherapy in an Outpatient Clinic:  
Exploring Risk Factors and Contributing Elements**

**by**

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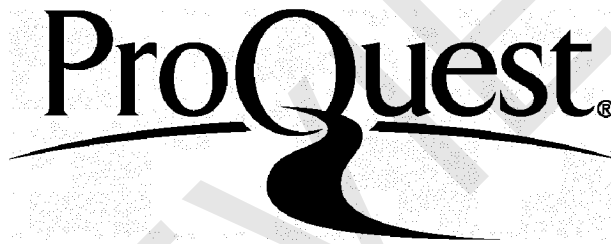
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## **ABSTRACT**

This study explored personality features on the PAI and Rorschach that predicted early termination from psychotherapy in a sample of 104 individuals receiving treatment at a University-Affiliated Training Clinic. Early or premature termination was characterized in several ways – patients who terminated during the intake and patients who commenced treatment but terminated before the eighth session. In addition to the two categorical outcome variables, the number of attended sessions at point of termination was a third outcome variable. The findings indicated that four PAI scales (PIM, INF, WRM, PAR) were able to predict intake-completion and commencement of therapy, as well as the total number of attended sessions at point of termination. In addition, one composite Rorschach (RPAS) variable (SC-COMP) was able to predict the number of attended sessions. After interpreting the significant findings, several psychological/personality constructs seem to be related to therapeutic attendance - self-defeating patterns of behavior, interpersonal interest/desire, openness and authenticity, suspiciousness/trust toward others, and degree of task or activity engagement.

**Keywords:** premature termination, early termination, Rorschach, PAI, psychotherapy



## **CHAPTER I**

### **INTRODUCTION**

#### **Overview**

For just over one hundred years research has found psychotherapeutic treatment – be it behavioral, cognitive-behavioral, psychodynamic, or another variety, to have significant benefits for children, adolescents, and adults (Paris, 2013; Wampold, 2001). Psychotherapy has been shown to mitigate feelings of stress, anxiety, and depression (Weisz, McCarty, & Valeri, 2006; Westen & Morrison, 2001); treat tic disorders and symptoms related to psychosis (Bate, Malouff, Thorsteinsson, & Bhullar, 2011; Hutton, Wood, Taylor, Irving, & Morrison, 2014); and even assist patients in managing the pain and discomfort caused by various medical conditions (Eccleston, Morley, Williams, Yorke, & Mastroiannopoulou, 2002). Although not effective in every case, psychotherapy has the potential to improve the overall wellbeing and psychological health, as well as the day-to-day functioning of those that adhere and engage with the process.

There are many important variables that contribute to psychotherapy outcome – patient's perceptions and expectations of therapy (Carr & Ball, 2014; Constantino et al., 2007), type of modality utilized by the therapist (Bass & Swart, 2014), and therapeutic alliance between patient and therapist (Zeeck & Hartmann, 2005). The patient may have negative expectations of therapy and the alliance may be weak, and even still the therapy can continue uninterrupted, and benefit may even be derived despite a suboptimal

arrangement of these factors. The variable of *attendance*, however, is a therapeutic requisite and an absolute necessity, because without it there can be no opportunity for therapeutic gains to be made. This may be best characterized by the proverb, “nothing ventured, nothing gained.” Compared to individuals who never seek treatment, those that do indeed seek and attend are more likely to experience even some temporary relief from their distress and an improvement in their day-to-day functioning. This may come about through the decrease of symptom presence and/or severity, or by the betterment of the individual’s tolerance for stress, or even through strengthening the patient’s social support network. Simply by creating the opportunity or possibility for relief one has already improved his or her chances of making such gains.

Therapy attendance is indeed problematic for some, if not many patients. In their research into the matter, Hampton-Robb, Qualls, and Compton (2003) reported that approximately 40% of referrals result in the patient refusing treatment, and other studies indicating premature termination to be even greater, with rates north of 60% (Reis & Brown, 1999). It is evident that from one study to another termination rates can range significantly. One explanation for this tremendous variability in research findings has to do with how premature termination – sometimes known as early termination or therapy dropout, is defined. In one of the first meta-analysis concerning psychotherapy dropout rates, Wierzbicki and Pekarik (1993) investigated a total of 125 studies and found that across various treatment modalities up to 46% of referrals result in premature termination. Their investigation focused on a total of 32 variables that existed in one of several categories (study, demographic, psychological, therapist) that could potentially be associated with premature termination. They were also interested in analyzing definitions

of premature termination and whether this made a difference in reported rates.

Ultimately, Wierzbicki and Pekarik (1993), in their analysis of 125 studies, determined that premature termination rates were not significantly associated with treatment modality, setting, or demographic variables. Dropout rates were, however, significantly related to how studies defined premature termination and the parameters they set for the variable. In other words, studies that operationally defined premature termination by failure to attend a scheduled session reported lower dropout rates than did those that determined premature termination by therapist judgment or number of sessions attended. The criteria by which premature termination is defined seems to be one of the reasons why some studies find that 3 out of every 4 patients terminate prematurely (Reis & Brown, 1999; Swift and Greenberg, 2012), while others report ratios closer to 1 out of 5, and therefore, should be very carefully considered.

Martin and Schurtman (1985) were some of the first researchers interested in the complex nature of termination, and they defined termination as a planned ending or conclusion of a productive therapy, a finish that occurs not because of an unavoidable, arbitrary, or unplanned interruption of therapy, but as a collaborative decision (Rainer & Campbell, 2001). Premature termination – a somewhat ambiguous term, is described by Swift, Greenberg, Whipple, and Kominiak (2012) as occurring when a patient, prior to completing their pre-established goals, discontinues treatment unilaterally – without discussing and/or considering the thoughts and recommendations of the clinician treating them (Smith, Subich, & Kolander, 1995). Hatchett and Park (2003) combed the literature and identified four of the most common operational definitions of premature termination – therapist judgment and report (i.e., the patient's therapist reports on the progress of the

patient, the nature of their symptoms and function, and offers a recommendation as to whether or not therapy should be terminated), patient not showing up for scheduled sessions, patient not attending a pre-established and agreed upon number of sessions, and patient not returning after completing an intake. Hatchett and Park (2003) introduced a fifth operational definition, which considers a patient having prematurely terminated based on whether or not they achieved significant reductions in their symptoms as evaluated by psychological measures administered before a patient begins his or her therapy and again after a pre-determined number of sessions. If these instruments are to determine that the patient continues to experience a relatively unchanging amount of distress, and the patient still decides to discontinue their treatment despite lack of improvement, then they are considered a premature terminator. The method used by Hatchett and Park (2003) to identify premature terminators was influenced by the work of Howard, Kopta, Krause, and Orlinsky (1986) and their pioneering research on the topic of the dose-effect relationship in psychotherapy. Subsequent large-sample studies have shown that, at minimum, most patients require approximately eight psychotherapy sessions in order to obtain therapeutic gains or reduce symptoms associated with various psychiatric conditions (Barkham, Rees, Stiles, Hardy, & Shapiro, 2002; Beail, Kellett, Newman, & Warden, 2007; Kadera, Lambert, & Andrews, 1996).

While the definitions of premature termination can vary from one study to another, and although some of the terms are used interchangeably (e.g., early termination, premature termination, therapy dropout, treatment withdrawal, etc.), one important area of distinction regarding the operational definition of premature termination is that of classifying treatment rejecters in a separate category. Researchers tend to agree that there

may be important differences between patients who refuse to begin treatment and those patients who begin treatment but are unable to follow through until its completion, however that completion may be defined (Garfield, 1994; Swift & Greenberg, 2012).

In some cases, the inconsistency in determining the percentage of treatment attrition has less to do with the definition of early/premature termination and more to do with the particular population being investigated. For instance, several studies have determined age to be a relevant factor in the context of treatment discontinuity, with younger patients more likely than older patients to terminate prematurely (Baekeland & Lundwall, 1975; Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). In a recent meta-analysis of 669 studies, Swift and Greenberg (2012) found the early termination situation to be far less bleak than previous researchers. Their analysis indicated an early dropout rate of approximately 19% throughout the literature, but ranging from 0% to 74%. However, unlike some other studies of the subject, Swift and Greenberg (2012) did not include in their meta-analysis studies that considered child or adolescent clients. Despite this limitation, Swift and Greenberg (2012) shed much needed light on the subject of treatment continuity and discontinuity. For instance, they found that the clinical populations themselves were heavily contributing to the differences seen in premature termination estimates across studies. Some of the highest rates of premature termination are seen among those that require treatment for personality disorders, eating disorders, and substance-use problems. Since these tend to be high risk populations, much research has gone into understanding the reasons as to why person's experiencing these problems prematurely terminate at higher rates than other clinical groups

(Baekeland & Lundwall, 1975; Corrigan & Bogner, 2007; Sly, Mountford, Morgan, & Lacey, 2014).

Aside from the definition of premature termination and the clinical group being researched, Swift and Greenberg (2012) determined that several variables were largely responsible for the substantial range of premature termination rates across studies. Pertaining to institutional factors, they found that time-limited therapies were associated with lower rates of premature termination (higher rates for treatments without pre-established number of sessions), as were manualized treatments when compared to non-manualized treatments. They also found that university-based counseling centers experienced the highest rates of premature termination, and that less experienced therapists were more likely to have higher rates of client premature termination. Pertaining to demographic variables, those that were significantly associated with premature termination were that of client age and client education. While their work offered much clarification on the topic of premature termination, Swift and Greenberg (2012) expressed that future research should focus on slightly different factors, such as that of therapeutic alliance, as well as client expectations and preferences. From their extensive analysis of extant research, they noticed that these variables were not frequently considered, but when they were, the findings were promising. Swift and Greenberg (2012), in their suggestions for future research, understood that a potential explanation for the immense variability of premature termination percentages in the research might have to do with various experiences of the patient, as well as the interaction between patient and therapist – factors that are more difficult to capture than ones easily reported or observed.

In 1979, James O. Prochaska noticed an immense proliferation of psychotherapeutic treatments across the various fields that implemented talk therapy as one of their primary forms of treatment (e.g., psychology, psychiatry, social work). He became concerned that the pace at which these therapies were being created, and their diverging from the central tenets of their overarching systems, would eventually flood the market and make it increasingly difficult to determine which of the therapies were most effective, and more importantly, why they were more effective than others. In an effort to find the most integral factors among the therapies, and save the field from what they believed to be chaotic disorganization, Prochaska and DiClemente (1982) developed the Trans-theoretical Stages of Change Model. Their analysis of eighteen different overarching therapeutic systems revealed a series of common factors, and although these factors were differently titled, they were conceptually related. The findings of Prochaska and DiClemente (1982), and the various factors that they outlined, seem to be intimately related to therapy continuity and discontinuity.

The Trans-theoretical Stages of Change Model (TTM) posits that every patient, regardless of the modality by which he or she is being treated with, enters therapy in one of six stages: pre-contemplation (not ready), contemplation (getting ready), preparation (ready), action, maintenance, or termination (Prochaska & Norcross, 1992). According to TTM, it is the therapist's responsibility to discover their client's current stage, and with such knowledge the therapist can then utilize the strategies and techniques that are most appropriate for the stage that their client is currently within. There is evidence that following the general TTM process results in client's reporting more positive experiences with therapy, increased client motivation and willingness for self-change, client

persistence in treatment, and treatment outcome (Hovarth & Greenberg, 1989; Lambert, 1989; McConaughy, Prochaska, & Velicer, 1983; Prochaska, DiClemente, Velicer, Ginpil, & Norcross, 1985; Prochaska & DiClemente, 1992; Strupp, 1986). A client's negative reactions and premature termination, therefore, may be the result of poor preparation on the part of the therapist, and a mismatch between the client's preparedness and the therapist's technique. According to the researchers of TTM, and also Motivation Interviewing (MI), depending on a client's stage or level of preparedness, therapist's can devote additional time and effort toward their preparation and treatment planning in several areas: structure, psychoeducation, setting and reviewing goals, the therapeutic alliance, and the depth of focus within the treatment (i.e., a more abstract insight oriented treatment approach may follow a more surface-level solution-focused style) (Beutler, Harwood, Alimohamed, & Malik, 2002; Lazaratou, Anagnostopoulos, Vlassopoulos, Tzavara, & Zelios, 2006; Rainer & Campbell, 2001), and this may be what some intake workers, therapists, or clinics formally or informally provide for their patients. The various samples used for the research investigating premature termination, and the patients that compose each of these samples, typically experience varying degrees of pre-therapy preparation from the clinic, intake worker, or therapist. Some clinical workers may even due this tacitly, without realizing that their actions are creating a more comfortable and engaging experience for the prospective patient. This is perhaps why some have found that experienced therapists are less likely to have their clients terminate prematurely (Greenspan & Kulish, 1985; Rodolfa, Rapaport, & Lee, 1983).

Barrett, Chua, Crits-Christopher, Gibbons, and Thompson (2008), in an effort to help rationally conceptualize the dilemma through aggregation, distinguished six general



categories as to why a patient might prematurely terminate, and they are as follows: client characteristics such as age, gender, ethnicity, income; enabling factors and barriers such as cost of therapy; factors related to need (e.g., distress level, diagnoses); environmental factors (e.g., accessibility, treatment options); perceptions of mental health problems; and perceptions and assumptions of treatment (Barrett et al., 2008; Swift et al., 2012). While the delineation of six categories is indeed useful toward conceptualizing the problem, it is important to keep in mind that persons seeking and undergoing treatment are very likely influenced by many factors simultaneously, and therefore, premature termination occurs due to a variety of elements that interact with one another during the therapy, and also before the formal therapy actually begins (Cartwright, 2004).

Premature termination clearly has immediate and negative consequences for the patient, and models such as TTM and MI suggest that pre-therapy assessment and intervention can impact the motivation and engagement of the patient, which in turn may decrease the likelihood of early termination. Those that do terminate prematurely may not experience symptom relief, and a resolution of the patient's core problem/s, or even their presenting problem (surface complaint), may not have been achieved. Patients' ongoing psychological ailments can in turn negatively impact their family, friends, and coworkers. Patients who terminate treatment prematurely are also less likely to return; they express a greater dissatisfaction of their experience with psychotherapy (Björk, Björck, Clinton, Sohlberg, & Norring, 2009), and in the context of premature termination patient symptoms may actually be exacerbated rather than relieved (Cahill et al., 2003; Klein, Stone, Hicks, & Pritchard, 2003; Lampropoulos, 2010) – a problem known in the literature as deterioration (Jacobson, Roberts, Berns, & McGlinchey, 1999). A

collaborative and planned termination, however, may carry salubrious effects, and can foster the patient's internalization and maintenance of therapeutic gains (Brammer & Shostrom, 1960; Fox, Nelson, & Bolman, 1969).

Aside from the patient, many others that are both directly and indirectly associated with the provision of treatment are negatively impacted by premature termination. Some of those experiencing a disruption include the administrators scheduling and rescheduling sessions, the clinicians attempting to provide therapeutic services, and also disrupted are those who fund the institution. Premature termination, especially within therapeutic training facilities, results in lost time, finances, and training experience (Oldman, Kellett, Miles, & Sheeran, 2012). It is not uncommon for therapists-in-training to blame both themselves and their patient for the early termination. Although, some researchers have found that in the context of premature termination therapist tend to blame the circumstance and the patient, while patients tend to blame the therapist, therapy, or the institution (Crits-Cristoph & Connolly Gibbons, 2001; Hilsenroth & Cromer, 2007; Murdoch, Edwards, & Murdoch, 2010; Norcross & Wampold, 2011; Piselli, Halgin, & McEwan, 2011). Premature terminations tends to evoke a variety of emotions and questions for the new therapist, causing them to doubt their abilities and might even negatively impact their work with other clients (Piselli et al., 2011).

High percentages of premature termination, considered alongside the potential consequences to both the patient (e.g., self-harm, suicide, homicide) and the therapist (e.g., loss of time, self-confidence, money, experience), has resulted in research attempting to explore and explain such phenomena by determining the elements associated with premature termination (Rawlings, 2005). By ascertaining such factors

clinicians may be better equipped to anticipate and circumvent such disruptive occurrences by better accounting for them and planning accordingly. If, however, circumvention of premature termination is not possible, knowledge of the contributing elements might better prepare the clinician to recognize and address such issues once they begin to surface during the treatment. By assisting patients in overcoming such treatment hurdles, patients have the opportunity to experience therapeutic gains and meet their treatment goals, and those charged with the provision of treatment are allowed to perform their duties without the added stressors associated with premature termination.

PREVIEW

## **CHAPTER II**

### **LITERATURE REVIEW**

As previously stated, premature termination results from a variety of patient, therapist, and environmental elements influencing one another prior to the beginning of treatment and also after the treatment has begun. The problem of premature termination has been thoroughly documented, and both researchers and clinicians appreciate the very real consequences that premature termination can have on both the client and the treatment provider. However, those that have sought to learn about the problem have discovered that much of the extant literature regarding premature termination is of a theoretical nature, or exists as clinical descriptions rather than scientific studies (Ogrodniczuk, Joyce, & Piper, 2005). Also contributing to the dilemma is that previous researchers have largely made attempts to isolate the variables contributing to premature termination rather than understand them relationally and dynamically. Only relatively recently have investigators begun to explore how such treatment interfering factors might interact with one another to synergistically produce premature termination, as well as explore what such factors might suggest about a patient's personality (Williams, Ketring, & Salts, 2005). Therefore, despite the plethora of documentation regarding the existence and severity of the problem, the complex nature of premature termination has resulted in a scarcity of solutions for the longstanding dilemma (Piselli et al., 2011). As mentioned earlier, Barrett et al. (2008) outlined six categories of risk factors that could potentially lead a patient to terminate treatment prematurely. With these categories in mind, the aim

of the current research is to better understand, through quantitative and integrative means, the interaction and influence of several patient, therapist, and environmental factors on premature termination in an adult outpatient population. And furthermore, attempt to explain findings in ways that might help outpatient clinicians better address issues of premature termination.

### **Patient, Therapist, Process, and Environmental Factors**

Researchers have found that there exist many factors that seemingly increase the likelihood of premature termination, and other variables that serve as protective factors, increasing the probability of treatment continuity (Rainer & Campbell, 2001). There has been much contradiction within the literature surrounding this issue, with some studies discovering certain relevant factors believed to be associated with premature termination, and others claiming either their inability to reproduce such significant findings, or finding significance but within a series of complex interaction effects, making any practical or useful interpretation of findings incredibly difficult (Garfield, 1986; Rainer & Campbell, 2001; Wierzbicki & Pekarick, 1993). The patient and therapist factors that have been primarily focused on in regard to premature termination have included gender/sex, socioeconomic status (SES), education, and ethnicity. Of all of them, lower patient SES has been the one variable consistently associated with increased likelihood of premature termination, and also of note, SES has been found to serve as a mediating element between premature termination and variables such as education, sex, ethnicity, as well as type of psychopathology (Baekeland & Lundwall, 1975; Hollingshead & Redlich, 1958; Marmot, 2004; McCabe, 2002; Pekarik, 1985a; Richmond, 1992; Wierzbicki & Pekarik, 1993).

Although researchers may have been mild-to-moderately successful in identifying salubrious and detrimental factors, perhaps the biggest problem in using this information effectively is the fact that some of these variables are impossible to alter, and others may change for the better only after a prolonged period of treatment. For example, a therapist cannot change the SES of their patient in order to increase the likelihood of them remaining in therapy, nor can a therapist quickly extinguish various therapy-interfering symptoms of their patients psychopathology.

Williams, Ketring, and Salts (2005), in their seminal research on premature termination and its association with sex, ethnicity, income, and education, ascertained a series of significant, and mostly interactional findings within a sample of 527 therapy cases from Auburn University. They were interested in understanding how demographic variables relate to one another and affect a client's attendance of therapy. Consistent with many other researchers in this area, they defined premature termination in three ways: after one session, before six sessions, and from therapist report (i.e., therapist reports client terminating therapy unilaterally). Their work clearly demonstrated the interwoven and complex nature of how both therapist and client demographic variables can influence premature termination, and that the reasons for premature termination may vary considerably from person to person. They were also able to demonstrate how "single variable models of premature termination can be misleading" (p. 227). They did, however, find that some variables were useful even when observed independently from others. The only variables they found to be individually useful for differentiating premature terminators from therapy completers were that of client income and therapist ethnicity. For instance, they initially found that those clients who earned less than

\$10,000 demonstrated higher premature termination rates than clients in higher income groupings. Although they did find some variables to be significant in isolation, the majority of their conclusions were of an interactional nature. They consistently discovered interactions between the variables of client gender, therapist gender, client education, therapist ethnicity, and client ethnicity. Although statistically clear, Williams et al. (2005) had a great deal of difficulty interpreting their many significant findings because their research did not focus on collecting client attitudes, reasoning, or explanations for their premature termination or for their therapy completion, which was the greatest limitation of their investigation.

**Process Factors.** While acknowledging the importance and impact of client and therapist demographics on the continuity or disruption of therapy, it is also important to consider how both client and therapist expectations of therapy may play a role, and also how the readiness of the client to receive therapy may affect their attendance (Cartwright, Lloyd, & Wicklund, 1980; Heilbrun, 1982). These factors may be subtle, but their effect is very much felt. Some researchers have found that a client's negative impression of their therapist can deleteriously impact the therapeutic process (Beckam, 1992), and others have discovered that the initial attitudes of both the client and the therapist regarding their relationship can heavily influence the continuity or discontinuity of treatment (Garfield, 1986). Preparation and planning, which can take the form of providing psycho-education and information to the prospective patient, along with orienting them to the entire process and purpose of therapy, has been shown to significantly reduce premature termination (Barrett et al., 2008; Ogrodniczuk et al., 2005; Reis & Brown, 1999; Swift & Callahan, 2011). Preparation and planning between

clinic/therapist and the patient has been shown to increase and strengthen the therapeutic alliance – perhaps one of the most relevant and influential factors associated with both treatment outcome (e.g., symptoms reduction, maladaptive habit change) and continuity/discontinuity of treatment (Baruch, Vrouva, & Fearon, 2009; Charnas, Hilsenroth, Zodan, and Blais, 2010; Lingardi, Filipucci, & Baiocco, 2005; Morlino et al., 2007; Sharf, Primavera, & Diener, 2010).

**Therapist Factors.** Therapist experience, education, and expertise has been researched and determined to be as relevant a factor as any other within the context of early termination. Therapists with greater training and experience in providing therapy, who are flexible when it comes to the application of various treatments, and those that are capable of exploring and addressing their patient's problems are associated with better treatment outcomes and lower rates of early termination (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Crits-Christoph et al., 1991; Greenspan & Kulish, 1985; Luborsky, McLellan, Digeur, Woody, & Seligman, 1997; Messer & Wampold, 2002; Norcross & Wampold, 2011; Richmond, 1992; Roth & Fonagy, 2004). Several researchers found that compared to patients who terminate prematurely, those who continue treatment tend to do so with more experienced therapists (Baruch et al., 2009). Clinical psychologists – who tend to receive a high degree of training in therapy – are associated with more optimal therapeutic outcomes and lower rates of termination when compared to other therapy-providing professionals (O'Brien, Fahmy, & Singh, 2009). Doctorate-level clinical psychologists receive much training in the provision of psychotherapy, and also tend to be exposed to acute clinical populations – with both experiences sharpening their clinical acumen. When analyzed more thoroughly in order to understand the qualities of more