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Client–Therapist Agreement in the Termination Process and Its Association With Therapeutic Relationship

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There is no consensus among different therapeutic approaches on the process of termination when therapy does not have a prefixed duration. Moreover, both clinicians and researchers are still exploring decision making in the termination of treatment. The present study assessed former client's perspective of therapy termination in a nonprobabilistic sample from Buenos Aires, Argentina. Seventy-three semistructured interviews, lasting ~60 min each, were conducted with participants that had finished a therapeutic treatment or dropped out. They were asked about several aspects of therapy, including their experience of termination, specifically who decided to terminate, if there was agreement on termination or not, and their thoughts on the termination process. All interviews were transcribed and analyzed using an adaptation of Consensual Qualitative Research (CQR). Quantitative analyses were also conducted to examine associations between variables. Two main factors emerged from the analysis: client/therapist initiative on termination; and level of agreement between client and therapist regarding termination. Whereas nearly all (95%) of therapist-initiated termination cases agreed on termination, client-initiated termination cases could be sorted in agreed (49%) and disagreed (51%) terminations. Both therapist-initiated terminations and agreed upon terminations presented more categories of positive termination motives, better therapeutic bond, and higher overall satisfaction with treatment. Implications for research and clinical practice are discussed.

Keywords: termination, client's perception, therapeutic alliance, mixed qualitative quantitative methods

Termination in psychotherapy poses a theoretical and practical challenge for clinicians and researchers, bringing up issues which to this date no clear consensus has been reached. Distinct theoretical approaches present their own conceptualization of the psychotherapy process and hence, of its final stage. These differ on key aspects such as criteria proposed for termination, as well as the degree of preplanned, explicit structure given to this stage of therapy (for a review, see Delgado & Strawn, 2012). Moreover, compared with other aspects of therapy, literature on termination is mostly theoretical, and there have been scarce efforts dedicated to gather evidence on what actually happens in daily practice (Ogrodniczuk, Joyce, & Piper, 2005; Roe, Dekel, Harel, & Fennig, 2006a).

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Premature Termination

Empirical literature on termination has primarily focused on the subject of premature termination (Hardy & Woodhouse, 2008; Ogrodniczuk et al., 2005). Research on this area has been somewhat hindered by varying definitions of the concept of premature termination, also referred to in the literature as (client-initiated) unilateral termination, client attrition, discontinuing, early withdrawal, or dropping out (Nuetzel & Larsen, 2012; Ogrodniczuk et al., 2005; Reitzel et al., 2006). Although many studies have relied mostly on therapists' appraisal, the question of whether treatment ending is premature has been operationalized in a number of different ways (Swift & Callahan, 2011). These include the number of sessions attended, client attendance to the last session, improvement rates, and conformation to an initial contract (Philips, Wennberg, & Werbart, 2007; Piper et al., 1999; Swift & Callahan, 2011; Swift, Callahan, & Levine, 2009).

Regardless of criteria chosen for defining it, studies have consistently shown that premature termination is of common occurrence (Ogrodniczuk et al., 2005; Renk & Dinger, 2002; Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993). Accordingly, notable efforts have been made in identifying the factors contributing to premature termination and in developing strategies to prevent it (Ogrodniczuk et al., 2005; Swift & Callahan, 2011; Swift, Greenberg, Whipple, & Kominiak, 2012). Premature termination has been associated with different variables: baseline client character-

istics such as gender, minority status, level of education, diagnosis, attitudes to therapy, or personality traits (Hilsenroth, Holdwick, Castlebury, & Blais, 1998; McCabe, 2002; Nuetzel & Larsen, 2012; Philips et al., 2007; Westmacott & Hunsley, 2010); external barriers to treatment, such as scheduling difficulties or financial barriers (McCabe, 2002; Reitzel et al., 2006); and psychotherapy process variables such as client experiences and therapeutic alliance (Hynan, 1990; Nuetzel & Larsen, 2012; Piper et al., 1999).

Termination Motives

There appears to be a high level of consensus within studies as to what the most common reasons cited are: improvement attributed to therapy, discomfort/dissatisfaction of the client with services, therapy, or the therapist, and situational constraints or external barriers to treatment (Hynan, 1990; Roe, Dekel, Harel, Fennig, & Fennig, 2006b; Todd, Deane, & Bragdon, 2003; Westmacott & Hunsley, 2010). However, percentages attributed to each of these reasons vary across different studies (for a review, see Westmacott & Hunsley, 2010).

Researchers have also focused on the lack of agreement found between clients' and their therapists' motives for termination (Hardy & Woodhouse, 2008; Hunsley, Aubry, Verstervelt, & Vito, 1999; Olivera, Braun, Gómez Penedo, & Roussos, 2013; Todd et al., 2003; Westmacott, Hunsley, Best, Rumstein McKean, & Schindler, 2010). In 1999, Hunsley et al. compared clients' and therapists' reasons by reviewing therapists' treatment termination reports in client files and conducting telephone interviews with the former clients. Their findings indicated little concordance between both sources regarding improvement due to treatment and dissatisfaction with provided services. In fact, they found that although dissatisfaction with the therapy/therapist was reported by many clients as an important factor in their decision to terminate, it was rarely cited by the therapists (Hunsley et al., 1999).

Along the same lines, there is evidence that there are differences in identified reasons for termination in mutually determined versus (client-initiated) unilaterally ended treatments. In cases where termination was mutually determined by therapist and client, there were no differences between their ratings of termination motives. On the other hand, when clients unilaterally ended their treatment, their therapists were only partially aware of either the extent of the clients' perceived improvements or their dissatisfaction with services (Westmacott et al., 2010).

Furthermore, therapists are more prone to attribute causality to the client or the environment when they consider their own clients compared with when they consider the premature terminations of clients in general (Murdock, Edwards, & Murdock, 2010). These results suggest the existence of a *self-serving bias* in the therapists' attributions of termination (Murdock et al., 2010) and reinforce the need for incorporating the clients' perspective when analyzing what goes on in psychotherapy and particularly how the termination process unfolds.

Further attention to discrepancies between client and therapist expectations of therapy termination is needed if we are to advance in reducing the rates of premature termination in psychotherapy practice (Hunsley et al., 1999).

Clients' Perception of Therapy Termination

Although less in number, empirical studies have yielded some interesting results when exploring the clients' feelings, thoughts, and experiences during psychotherapy termination. For example, studies exploring the clients' feelings have found that the majority of them express mostly positive feelings during termination of psychotherapy, such as pride, calmness, and a sense of well-being and accomplishment (Hardy & Woodhouse, 2008; Marx & Gelso, 1987; Roe et al., 2006a). In addition, clients highly value the chance to talk openly and share their feelings about termination with their therapists (Hardy & Woodhouse, 2008; Marx & Gelso, 1987; Roe et al., 2006a). Negative feelings such as loneliness, abandonment, and anger have been associated with the clients' perception of the therapists not genuinely accepting or respecting the clients' decision to terminate (Roe et al., 2006a). Also, not having the opportunity to process their dissatisfaction contributed to the clients' feelings that their treatment had not been completed, leaving them with a sense of frustration and failure (Roe et al., 2006a).

Studies that analyze the clients' perspectives of termination mainly use quantitative research designs, with methods such as rating scales, checklists, and questionnaires (Hynan, 1990; Marx & Gelso, 1987; Roe et al., 2006a; Roe et al., 2006b; Westmacott & Hunsley, 2010). This methodology has allowed for a structured and systematic study of psychotherapy termination but has limited the exploration of the subjective experience of clients at the end of a treatment (Knox et al., 2011). A more idiographic approach, using qualitative methodology to explore meanings and emotions in clients regarding this topic, could enable a more profound analysis of psychotherapy termination and contribute to generating new hypotheses on the subject. An exception to this quantitative trend is a study where interviewers asked former clients about their termination process and conducted Consensual Qualitative Research (CQR; Hill, Thompson, & Williams, 1997) to analyze their data (Knox et al., 2011). Based on the participants' rich descriptions of their experiences during the termination process, the authors found an association between perceived alliance and therapy results. Those clients that reported a strong therapeutic alliance also mentioned positive therapy results, describing a favorable picture of psychotherapy termination as a positive and self-affirming experience. In contrast, participants that described strong negative components in the therapeutic relationship talked about the termination process as catalyzed by unresolved ruptures, leading clients to an abrupt, unilateral ending of the therapy. These clients had little opportunity for discussing their feelings or planning the termination process with their therapists (Knox et al., 2011).

These findings suggest an interrelation between therapeutic alliance (as a psychotherapy process variable) and the clients' views and evaluation of the psychotherapy termination. Previous research has also provided evidence on this association in which Hynan (1990) found that late terminators rated their therapists significantly higher than early terminators in three dimensions: therapist respect for clients, therapist warmth, and therapist competency.

The above described scenario derives the need to keep on exploring the clients' feelings and thoughts toward treatment ending and how these interrelate with their perception of other relevant therapeutic process variables. In particular, the extent of the association between the patients' perceptions of therapy termination and therapeutic relationship needs to be analyzed.

Therefore, the aim of the present study is to examine the clients' subjective experiences of therapy termination using both qualitative and quantitative research methods.

In-depth interviews with 73 former clients were conducted, inquiring on their perception of the psychotherapy termination process and associated psychotherapeutic process variables. Salient characteristics of termination, motives for termination, and therapeutic relationship characteristics were explored. Interviews were analyzed using a qualitative analysis based on CQR criteria (Hill et al., 1997) and quantitative methods.

Methods

This study is part of a research project conducted by the Clinical Psychology Research Team (Equipo de Investigación en Psicología Clínica), directed by Andrés Roussos, about the clients' perspectives of psychotherapy. This project has multiple aims, one of which is intended to explore the clients' perspectives on termination. The methods subsection will refer to this specific study, which has a different sample than prior research and original analyses. Further publications using the same sample will address themes different from termination and will have their own particular analyses.

Sample

Participants. Seventy-three former psychotherapy clients whose treatment had ended between 1 week and 36 months before the interview ($M = 8$ months; $SD = 11$ months) participated in this study. There were 53 women and 20 men (72.6%; 27.4%, respectively), within an age range from 19 to 71 years ($M = 33.75$; $SD = 10.23$ years). All of them lived in the Buenos Aires Metropolitan Area and their treatments were held in outpatient independent settings. From this sample, 43.8% had university degrees, 52.1% had completed secondary school, and the remaining 4.1% had elementary school education. Participants presented a large variety of occupations, including psychotherapists (13.7%), other professionals (17.8%), clerical workers (31.5%), students (17.8%), and others (19.2%). In this study, only the last treatment of each client was taken into account. For 19.2% of participants it was their first treatment, for 30.1% their second, for 17.8% their third, and the remaining 32.9% of participants had at least three prior treatments. Researchers had no contact with therapists; however, participants provided information about the concerns that led them to start a psychotherapy treatment. Their reasons for seeking therapy (not mutually exclusive) included couple and family concerns (46.6%), anxiety (20.5%), sadness and loss (26%), studies and work difficulties (20.5%), life crisis event (34.2%), and other reasons such as interpersonal or health concerns (6.8%).

Therapists and treatments. Therapists' demographic information was gathered from participants. As described by the clients, 74% of therapists were women and 26% were men; among them, 83.6% were psychologists, 9.6% were psychiatrists, and the remaining 6.8% had one of those degrees but participants were unable to identify which one. Also, from the information participants reported of their therapists' framework, 41.1% were psychoanalysts, 8.2% were cognitive–behavioral, 1.4% were family system, and 1.4% were humanistic. The remaining 47.9% of the sample could not provide information on this matter.

Treatments were conducted in the Buenos Aires Metropolitan Area and lasted from 2 months to 23 years ($M = 32$ months, $SD = 44$ months). Frequency of sessions was typically once a week (80.8%), while nine clients went twice a week (12.3%), and two clients went once every 2 weeks (2.8%). Most treatments were held in independent practice settings (84.9%), some in a psychotherapy clinic (9.6%), and others in a public hospital where psychotherapy is provided for free (5.5%). All but three treatments (95.9%) were open ended, as they did not have a fixed number of sessions to attend.

Researchers. Nine trained researchers, including the first, second, and third authors, interviewed participants (six women, three men; with graduate (three) or undergraduate (six) degrees in psychology, whose age range was between 26 and 50 years ($M = 37.11$ years; $SD = 6.45$) and with varied therapeutic approaches as clinicians. See Table 1 for further details). For CQR analysis, the primary team was integrated by the second author of the study (a 34-year-old woman, trained CBT clinician with experience in CQR analysis) plus two undergraduate students (women, 23- and 22 years old) who did not participate as interviewers. The first author (a 36-year-old woman, postdoctoral student, full-time researcher with experience in CQR analysis) served both as coordinator of the analysis process and auditor of the CQR analysis. All researchers that participated in this study received specific training in open interviewing and/or CQR analysis prior to conducting the interviews and data analyses (see Table 1).

Table 1
Researchers' Demographics and Participation in the Study

Researcher	Gender	Age	Theoretical background	Role	Performed interviews	CQR analysis
1	Female	36	Integrative	Postdoctoral fellow	Yes	Yes
2	Female	35	CBT	Graduate student	Yes	Yes
3	Male	26	Integrative	Graduate student	Yes	No
4	Female	42	Integrative	Researcher	Yes	No
5	Female	35	CBT	Graduate student	Yes	No
6	Female	35	Psychodynamic	Graduate student	Yes	No
7	Female	50	Psychodynamic	Researcher	Yes	No
8	Male	39	CBT	Postdoctoral fellow	Yes	No
9	Male	36	Psychodynamic	Postdoctoral fellow	Yes	No
10	Female	23	—	Undergraduate student	No	Yes
11	Female	22	—	Undergraduate student	No	Yes

Note. CBT = cognitive behavioral therapy; CQR = consensual qualitative research.

Recruitment. The sampling method followed the same criteria as previous studies conducted by this team (see Olivera et al., 2013). The sample collected for this study is unique and has not been presented in prior published research. Participants were recruited by a snowball sampling. The members of the clinical research team directed by Andrés Roussos (three male and six female psychologists) sent emails to their acquaintances asking if they or somebody they know had been in psychotherapy and had ended that treatment. The research team did not contact their prior clients, but only relatives and friends. The answers were forwarded to the first author who gathered contact information (by email and/or phone). The first author contacted the potential participants, sending information about the research. Participants that responded to the email were then contacted by phone by an interviewer they did not previously know, who restated the aims of the research and characteristics of their participation. Before the interview, participants signed an informed consent form that specified the confidentiality of data and their right to withdraw from the research at any point. Participants also consented to publish their comments anonymously in research papers. The research was approved by the University's Ethical Committee. After participants agreed to be part of the study, a date and time for the interview to take place was set. The interviews took place in a location chosen by the participants; most of them were held in the interviewer's workplace, the university where this study took place, or the participant's home. Of all the people that were invited to participate (93), 16 did not answer the email, and four declined participation owing to time or location difficulties. Former clients were not contacted via therapists to reduce bias (e.g., the therapist referring only clients with better outcome or clients not feeling comfortable disclosing their feelings about their therapists). Thus, members of the research analysis team did not recruit their own clients for this study.

Materials

Clients' Perspectives of Therapy Interview. A semistructured interview was designed by the research team. Based on questions from a previous study (Olivera et al., 2013), the modified protocol was intended to explore the clients' overall psychotherapy experience, their therapeutic relationship, and the termination phase (Olivera, Braun, & Roussos, 2013). The beginning phase of therapy and the clients' perspectives of the therapists' interventions were also inquired about but were not analyzed for this study. The interview included open-ended questions, and interviewers were encouraged to seek deep and meaningful answers by redirecting questions and asking participants for examples and further details on their statements. Appendix presents the guiding questions included in this study. The protocol finished with a direct question: How satisfied are you with your treatment? This one item variable was intended to assess the global satisfaction with therapy. A 10-point scale was provided for the answers, a 1 being completely unsatisfied and a 10 being highly satisfied. No other descriptors were provided to participants for other points of the scale.

Bond Scale of the Working Alliance Inventory-Short Revised. The Bond Scale of the Working Alliance Inventory-Short Revised (BS-WAI-SR) is a 12-item self-reported measure on a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*), that explores therapeutic alliance in three dimensions: Bond, Tasks, and Goals (the intermediate points are 2 = *rarely*; 3 = *occasionally*; 4 = *sometimes*; 5 = *often*; 6 = *very often*; Hatcher & Gillaspy, 2006). For this research, only the Bond Scale from the Argentine adaptation of the WAI-SR client's form (Gomez Penedo, Waizmann, & Roussos, 2015) was used. The included items were the following: (a) I believe my therapist liked me; (b) My therapist and I respected each other; (c) I feel that my therapist appreciated me; and (d) I feel my therapist cared about me even when I did things that he or she did not approve of. In order not to overload the respondents, only these items were included, as they were most representative of the aims of the study. Benchmarks from two different US samples were $M = 5.93$, $SD = 0.78$, and $M = 5.12$, $SD = 0.96$ (Hatcher & Gillaspy, 2006), and from the Argentina adaptation, $M = 5.76$, $SD = 1.27$ (Gomez Penedo et al., 2015). This adaptation has demonstrated adequate psychometric properties with evidence of internal consistency and convergent and discriminant validity (Gomez Penedo et al., 2015; Waizmann & Roussos, 2011).

Demographics form. The demo-form is a structured form that included questions about participants and their therapists.

Procedures

Seventy-three semistructured qualitative face-to-face interviews, lasting from 34:26 to 98:09 min ($M = 62{:}44$ min; $SD = 16{:}06$ min) were conducted. After the qualitative interview was performed, researchers provided the client with the global satisfaction item, the BS-WAI-SR, and the demographics form. For data analysis, interviews were audio-taped and then transcribed verbatim. All the interviews and their transcriptions, along with the scales and forms were stored on a safe hard disk, identifying participants with a code number without including their real names. To guarantee speech fidelity, translations of the clients' speech were made by a bilingual researcher who was not involved in the data analysis process. Participants' speech was sometimes reduced or edited for space or comprehension reasons. Another researcher performed back translations to guarantee that the participants' statements had not been conceptually modified.

Analytic Strategy

Qualitative analysis. Researchers conducted a qualitative approach analysis, inspired by consensual analysis such as CQR (Hill et al., 1997, 2005) and adapted to large samples (CQR-M—Consensual Qualitative Analysis Modified; Spangler, Liu, & Hill, 2012). The CQR method has two main characteristics that are different from other qualitative methodologies: data analysis is highly structured, and its results are based on consensus (Timulak, 2012). Nevertheless, the authors state that it is a flexible method that has to adapt to the needs of each research study (Hill et al., 2005). Therefore, following some of the recommendations from the CQR-M adaptation, researchers developed a three-phase analysis scheme.

In the first stage, classic CQR was conducted with 10% of the sample (eight randomly selected interviews), performing the three basic steps. First, the team identified topic areas in the material, creating domains. Transcriptions of the eight interviews were classified according to these domains. Next, core ideas were abstracted from the material by synthesizing concepts and meanings in the

participants' speech. Finally, researchers created categories by cross-analyzing the core ideas of each domain in different interviews. Similar core ideas, representing common notions became conceptual categories. During this stage, a primary group composed of three researchers analyzed data individually, then discussed it and elaborated a consensual version that was then revised by the auditor. Finally, the primary group and the auditor agreed by consensus on a definite version. At the end of stage one, a final list of 39 categories, organized in six domains was obtained. The final step of CQR includes establishing the frequency of each category. This step was left for the final stage of the analysis, which included the whole sample.

Stage two was created both as a stability check of the categories created and to measure the interrater agreement among researchers. Six interviews were randomly selected and assigned to researchers (each researcher analyzed three interviews, and each interview was analyzed by two researchers simultaneously). Cohen's Kappa (1960) was conducted on three interviews (using categories as cases), and results showed moderate to substantial agreement among researchers with Kappa coefficients ranging from .54 to .72 (mean $\kappa = .6$; Landis & Koch, 1977). Landis and Koch (1977), when describing the relative strength of agreement associated with kappa statistics, provide the following labels to the corresponding ranges of Kappa: < 0.00 = Poor; 0.00–0.20 = Slight; 0.21–0.40 = Fair; 0.41–0.60 = Moderate; 0.61–0.80 = Substantial; and 0.81–1.00 = Almost Perfect (see Table 2 for detailed scores of each pair of researchers). After these individual analyses, the research group met and discussed once more the inclusion criteria for each category. Researchers provided minor changes for the category list, including four merges, three new categories, and two rewritings of category names. These decisions intended to avoid an excessive number of categories and the overlapping between categories, generating a list of meaningful broad categories. Finally, another interview was randomly selected and all four researchers identified the categories in it. Cohen's Kappa (1960) results showed moderate to substantial agreement among researchers with Kappa coefficients ranging from .58 to .78 (mean $\kappa = .64$; Landis & Koch, 1977; see Table 2).

The third and final stage of analysis consisted of each researcher identifying categories in a set of the sample. All interviews were randomly assigned to researchers, although for time reasons the first and second authors of this study analyzed a larger number of interviews (25 interviews each) than Researcher #10 (11 interviews) and Researcher #11 (12 interviews; see Table 1 for more information about the raters). Interviews that had already been analyzed in stages one and two were reanalyzed, incorporating the changes made in the final list of categories and the difference in the process. Tables 3 and 4 show the list of domains, with their categories and frequency in the whole sample. Frequency labels were set by the following criteria: categories with less than four participants were not included in the category list; four to 10 categories were considered rare (<15% of the sample); 11 to 36 variant (15% to 50%); 37 to 62 typical (50% to 85%); >62 (general). No general categories were found in the sample.

Table 2
Kappa Values of Each Pair of Researchers From the Analysis Team

Researchers	Mean Kappa 2nd phase	Kappa 3rd phase
R1 × R10	.580	.625
R1 × R11	.571	.630
R1 × R2	.721	.584
R2 × R10	.540	.659
R2 × R11	.601	.609
R11 × R10	.600	.777

Note. Researchers were named after Table 1 (e.g., R1 is Researcher 1).

Quantitative analysis of selected factors. From the qualitative analyses mentioned, two pairs of dichotomous categories (i.e., mutually exclusive) of special interest for researchers were identified. They allowed us to divide the sample into two sets of groups (factors): (1) Who initiated termination: (a) clients versus (b) therapists; and (2) (a) agreement on the termination process versus (b) disagreement. Agreement on termination means that both client and therapist talked about the termination and agreed upon a time and manner for it. Disagreement, on the other hand, means that there was no conversation about termination or that the therapists expressed to be in disagreement with the clients' decision to terminate. Only clients' accounts were available about the therapists' level of agreement, so there was no information on the therapists' opinion. Please see the qualitative results for a complete description of each category. All participants had given information about who of the therapeutic dyad had initiated the termination process and on which terms the treatment had ended (there is the exception of four participants that stated the termination as being agreed upon but did not identify if the termination process was initiated by the therapist or himself/herself). The client-initiated termination versus therapist-initiated termination groups had a total of $n = 69$, while the agreed on termination versus disagreed on termination groups had a total of $n = 73$.

Once these groups were formed, the analysis team observed the frequencies and percentages of the other categories according to each group. Consequently, we conducted quantitative analysis based on those dichotomous categories, in terms of the degree of overall satisfaction with the treatment and the scores from the BS-WAI-SR. All the analyses were conducted using SPSS version 22.0. Due to the violation of the normal distribution assumption in the variables, we conducted nonparametric tests (Spearman Rho, Mann–Whitney U, and Kruskal-Wallis test) to see if the clients' bond with their therapists and satisfaction with their treatment significantly differed by these two factors: client-initiated termination versus therapist-initiated termination and agreement versus disagreement; and their combination, client-initiated with agreement, client-initiated with disagreement, and therapist-initiated with agreement. As therapist-initiated termination with disagreement was found in only one participant (see Participant #23 in the Results section), that case was excluded from the quantitative analysis.

To calculate the effect sizes between groups, we computed Cohen's *d* (Cohen, 1992).

Results

Domains Qualitative Analysis

Thirty-eight categories organized into six domains regarding the variables of this study (termination and therapeutic relationship) emerged from the consensual qualitative analysis conducted. Every final domain included all participants, thus representing a

Table 3
Frequency and Percentage of Termination Categories Within Compared Groups

Domain and category	*f*	Label	Who initiated termination? (*n* = 69)				Level of agreement (*n* = 73)			
			Client (*n* = 49)		Therapist (*n* = 20)		C and T disagreed (*n* = 27)		C and T agreed (*n* = 46)	
			f	%	*f*	%	*f*	%	*f*	%
Termination mode										
C initiated therapy's termination	49	Typical	—	—	—	—	25	93%	24	52%
T initiated therapy's termination	20	Variant	—	—	—	—	1	4%	19	41%
C and T disagreed on termination	27	Variant	25	51%	1	5%	—	—	—	—
C and T agreed on termination	46	Typical	24	49%	19	95%	—	—	—	—
There was a closing period / session	26	Variant	13	27%	12	60%	3	11%	23	50%
Therapy did not have closure	18	Variant	16	33%	1	5%	16	59%	2	4%
Termination was conflictive	7	Rare	7	14%	1	5%	7	26%	0	—
Motives for termination										
C reached her/his goals	29	Variant	12	24%	17	85%	3	11%	26	57%
C felt better	24	Variant	13	27%	9	45%	3	11%	21	46%
Therapy had run its course (naturally finished)	8	Rare	6	12%	1	5%	2	7%	6	13%
C felt bored/ there was nothing new to talk about	14	Variant	11	22%	3	15%	4	15%	10	22%
C needed time off from therapy	10	Rare	9	18%	1	5%	3	11%	7	15%
Therapy had reached a limit	8	Rare	6	12%	2	10%	3	11%	5	11%
C was dissatisfied with therapy/ therapist	18	Variant	18	37%	0	—	16	59%	2	4%
C wanted to start a new/different therapy	10	Rare	8	16%	2	10%	4	15%	6	13%
C had financial difficulties	10	Rare	9	18%	0	—	7	26%	3	7%
Post therapy relationship										
T left the "door open" for another treatment	41	Typical	25	51%	15	75%	8	30%	33	72%
C would go back to therapy with T	40	Typical	21	43%	15	75%	9	33%	31	67%
C would not go back to therapy with T	19	Variant	17	35%	1	5%	13	48%	6	13%

Note. T = therapist; C = Client. Complete sample: *n* = 73. Labeled following (Hill et al., 2005). Percentages were calculated based on the amount of participants on each group (column, e.g., Who proposed termination? Client) that mentioned any given category (row, e.g., termination was conflictive).

general theme. Tables 3 and 4 show the complete list of domains, with their categories and their frequency. Researchers tried to respect participants' expressions and wording when naming categories and translating examples.

Three domains were identified concerning treatment termination: Mode, Motives, and Posttherapy relationship. (See Table 3)

Termination mode. Regarding Mode, participants expressed how the final stage of their therapy developed. Typically, participants said the decision to end therapy was theirs, while variantly, others indicated their therapist as the one who proposed termination. Among those clients that initiated termination, there were some that dropped out of therapy without letting the therapist know they would terminate:

> I thought about telling my therapist that I didn't want to go to therapy anymore. I felt that I should, because that's how I felt, but then I couldn't do it. I felt uncomfortable, like maybe if I told her she would take it personally. (. . .) She would take it as an insult to herself, more than something to do with me. I also felt that maybe she would say she didn't agree with the decision, and then I would end up agreeing with her to avoid an argument. Then I would end up going anyway out of obligation. So, I didn't want to tell her. One day I simply didn't go. (Participant #8)

Others shared their thoughts about termination with their therapist and agreed to start the termination phase of therapy:

> I was careful because I cared about what my therapist thought. I wanted to tell her about my desire to finish, but I didn't want to impose on the timing of it. It was a joint decision and I value it as very positive the fact that I proposed it and she supported the decision. (Participant #28)

A third group of clients expressed their wish to terminate to their therapists, and their therapists disagreed.

> I told my therapist I was not going to continue, and he didn't take it well. I brought it up one session, and then I told him I was leaving therapy. He said the timing wasn't right, because of the issues we were working on. But I felt stuck. I never went back after that time. (Participant #22)

Clients that stated their therapist proposed termination had a more unified speech. Even though some mentioned feeling resistant at first, all of them could talk with the therapist about goals and achievements and develop a conjunct schedule for the termination phase with their therapist.

> My therapist said in her opinion treatment had come to an end. (. . .) The reasons she gave me were that I had finished my mourning period and was able to sit for exams, that my initial goals had been fulfilled. (. . .) Then she asked if I agreed, and I did. (Participant #32)

There was a sole exception in this group, a participant whose therapist decided to terminate the treatment as she felt disrespected by her client when she abruptly finished a phone call with her. The client did not agree with termination and was unhappy with the way her therapist reacted.

Table 4
Frequency and Percentage of Therapeutic Relationship Categories Within Compared Groups

Domain and category	*f*	Label	Who initiated termination? (*n* = 69)				Level of agreement (*n* = 73)			
			Client (*n* = 49)		Therapist (*n* = 20)		C and T disagreed (*n* = 27)		C and T agreed (*n* = 46)	
			f	%	*f*	%	*f*	%	*f*	%
Positive therapeutic relationship										
C felt comfortable/confident/C trusted T	58	Typical	34	69%	20	100%	16	59%	42	91%
C and T had a colloquial/friendly relationship	38	Typical	21	43%	16	80%	9	33%	29	63%
C felt listened/understood	39	Typical	26	53%	10	50%	11	41%	28	61%
C felt supported	30	Variant	18	37%	10	50%	8	30%	22	48%
The therapeutic relationship strengthened throughout treatment	21	Variant	11	22%	7	35%	4	15%	17	37%
C valued how T faced treatment	28	Variant	18	37%	10	50%	8	30%	20	43%
C valued personality of T	33	Variant	17	35%	12	60%	8	30%	25	54%
C valued flexibility of T	15	Variant	7	14%	8	40%	3	11%	12	26%
C and T had an affective relationship	13	Variant	8	16%	3	15%	5	19%	8	17%
Negative therapeutic relationship										
The therapeutic relationship was not good	6	Rare	6	12%	0	—	5	19%	1	2%
The therapeutic relationship deteriorated throughout the treatment	12	Variant	11	22%	1	5%	9	33%	3	7%
C did not like the way T faced treatment	8	Rare	8	16%	0	—	7	26%	1	2%
There were things C could not say to T	23	Variant	21	43%	2	10%	15	56%	8	17%
C felt retained in therapy	6	Rare	6	12%	0	—	4	15%	2	4%
C felt criticized/rejected	11	Variant	7	14%	4	20%	7	26%	4	9%
C felt T provided scarce feedback	14	Variant	14	29%	0	—	7	26%	7	15%
C did not like personality of T	6	Rare	6	12%	0	—	5	19%	1	2%
Other categories about therapeutic relationship										
The therapeutic relationship was formal	15	Variant	12	24%	3	15%	7	26%	8	17%
The therapeutic relationship had oscillations	5	Rare	4	8%	1	5%	1	4%	4	9%

Note. T = therapist; C = Client. Complete sample: *n* = 73. Labeled following (Hill et al., 2005). Percentages were calculated based on the amount of participants on each group (column, e.g., Who proposed termination? Client) that mentioned any given category (row, e.g., termination was conflictive).

> One day I was having an argument with my mother and she decided to call my therapist. She (the therapist) asked me to come to the phone and I accepted. She tried to tell me to stop making my mom suffer, but I was having a terrible time as well. I ended the phone call and she called again, but this time to tell me that she was not a friend and that I couldn't finish a phone call with her like that. She scolded me. I hadn't asked to talk to her. She abandoned me, said she would recommend another therapist. I said "no thanks". She was not professional, could not separate things. (Participant #23)

Continuing with the "termination mode" domain, the agreed termination category had a typical frequency. It included all those clients whose therapists proposed termination, except for the above-mentioned Participant #23, and those that proposed termination themselves and had a good reception by their therapist, discussing the subject and making the final decisions together.

> I think it was a mutual decision. It wasn't proposed by him or by me alone, we talked about it. (. . .) I had reached my goals and my therapist said at this point, the therapy could be finished. He said some people like to continue on a biweekly or monthly basis, but that I should think about it, he gave me a choice. (. . .) At that point I was feeling ok, and I thought it was a positive thing to end therapy, to move on, see how I did by myself. (Participant #54)

On the other hand, disagreed termination refers to either participants that never talked about termination with the therapist and just abandoned therapy, or those that discussed the subject and perceived a negative response from their therapist.

> I always had that feeling that she wouldn't let go, I had to be very firm and tough because otherwise, somehow she always hooked me back. (. . .) When my husband lost his job, I went to her with my decision made, and I informed her of it. I said it was for financial reasons. She didn't like it, but I gave her no choice. (Participant #6)

Other categories from the "termination mode" domain included the termination perceived as conflictive, which resulted in a rare category, and whether therapy had closure or not, both being variant categories, as not all participants referred to them. The "therapy had closure" category included those participants that stated they had dedicated more than one session to talk about termination issues, as well as those who mentioned that they were able to achieve a sense of closure during their last session with their therapist.

> I didn't go to my therapist saying "I'm not coming back anymore." I said, "Look, I'm thinking about this, what do you think?," and she thought it was right. She proposed to do a few more sessions to achieve closure, and I agreed. (Participant #28)

> In retrospect, I think that having been able to tell my therapist that I wanted to end therapy, for me that was a lot. I'm someone who always tries to do things properly. So being able to sit down with him and tell

> him what I thought was an accomplishment. I got closure, and my therapist supported me in that. I liked that it ended that way. (Participant #9)

There is an example of therapy that did not have closure.

> My treatment finished because I couldn't afford it. When this year started I thought, "I'm not going back, it's too expensive." (. . .) When we said goodbye before I went on vacation we'd said, "See you in February," but then I decided not to go back. There was no closure, she didn't call and neither did I. Now I'm starting a different kind of therapy. (Participant #27)

Termination motives. Termination motives were classified into nine categories, as a big variety of reasons drove participants and therapists to decide on terminating the treatment. Although there were no general or typical categories, those with a higher representation were positive motives such as the client fulfilling her/his goals, and/or feeling better.

> I decided to end therapy because I had been dating someone for the last 8 months, and I felt happy. I was starting a new part of my life, I felt happy again after quite some time, and I was feeling optimistic. (. . .) I said something like, "I think I don't want to come anymore." She said "Ok, if you ever need to, you know, you can call me." (Participant #25)

Rarely, there were participants that felt therapy had run its course, as in "was naturally finished or completed," meaning it as a positive feature. Other reasons for termination were a result of something going wrong in therapy or in the therapeutic relationship. For example, some participants felt bored or felt there was a lack of new themes to address in session.

> During the time I was in therapy I told the therapist the story of my life, and I asked her how can I look at this, what do I have to do. I was looking for a solution, for her to give me something that could help me manage things more easily. I didn't get that. (. . .) I finished each session and tried to remember what we had talked about, and I couldn't recall anything new, she'd only reaffirmed what I had said. We always talked about the same subject; I did not see any changes. (Participant #46).

Also in rare cases, they felt therapy had reached a limit and would not resolve issues that were still pending, as well as feeling dissatisfied with therapy or their therapist.

> My therapist started going into areas of my life that I didn't want to analyze. I had gone to get help with issues at work, and she asked me a lot about my romantic relationship. It didn't end up having a negative effect because I stopped it, I left the therapy. (Participant #60)

Additionally, there were participants that decided to terminate the treatment because they needed to spend time without therapy or because they wanted a different therapy. Finally, there were reasons related to financial difficulties, such as not being able to pay because of the loss of a job.

Posttermination relationship. When asked about their current relationship with their former therapist, participants' answers were classified into three categories. Typically, the clients expressed that they would go back to therapy with the same therapist if needed, while variantly others said they would not consider this possibility. A third category emerged that included those participants whose therapists offered them the option of coming back to therapy in the future. The most common expression participants used for this was that their therapists "left the door open." This category was typical.

> When we decided on termination, she told me the doors were open for me, "You know you can resume therapy whenever you want." (Participant #32)

The three remaining domains gathered categories about the therapeutic relationship and were sorted in terms of how positive or negative they were (see Table 4).

Positive aspects about the therapeutic relationship. The positive therapeutic relationship domain had, by far, the biggest representation from the sample, implying that most relationships had positive aspects. Participants typically highlighted feeling comfortable with the therapist, trusting her/him, feeling listened to, and having a colloquial or informal relationship.

> Her warmth allowed me to be open about everything. She ensured you could say anything and nothing bad was going to happen, no judging, no preconceptions. (Participant #28)

Rarely, clients felt their therapeutic relationship involved affection and that they were supported by the therapist:

> It was an affectionate relationship, although it took some time before it got to that point, I think the professional respect came up first. (. . .) And then afterwards, with time, it was just seeing her and giving her a hug, in a friendly manner. (Participant #17)

> I always felt a very close relationship with my therapist, in which I knew if I needed something I could come to him. I felt supported along the whole therapy process. I think one of the things I do appreciate a lot is support. (Participant #13)

Also rarely, clients valued their therapists being flexible with their schedules, fees, and therapy themes.

> I started working independently, and my financial situation fluctuated; she supported me throughout that process, was flexible about payment. (Participant #11)

> I liked that we could talk about diverse topics, sometimes not specific to her type of therapy. (. . .) We could discuss books, movies, activities. (. . .) If I was interested in something academically, for example, sometimes she would bring me information. (Participant #30)

Even the therapists' personalities were valued by some participants, as well as the way the therapists led the therapy process. These categories did not have an explicit reference to the therapeutic relationship but were included in this domain in terms of their meaning for participants.

> She had a very multifaceted personality. (. . .) She was a very curious person, and I valued that. (Participant #54)

> She was pretty loving, affectionate, even though we didn't talk about her personal life. (Participant #9)

Negative aspects of the therapeutic relationship. Categories that referred to negative aspects of the therapeutic relationship were variant to rare. Some participants expressed that there were

things they could not say to their therapist either because they felt he or she would not approve, or because they were similar to other things they said that had a negative response.

> The relationship was good, a little too formal for me. I knew a relationship with a therapist was not a friendship. There was a certain distance, I would've liked feeling a little more comfortable. Sometimes I told him stuff and felt ashamed, I didn't feel comfortable talking about them. (. . .) After two years I thought I'd feel a stronger bond, a bit more informal, but it didn't happen. It was always very formal. (Participant #67)

Also variantly, clients felt their relationship had deteriorated throughout therapy; they felt criticized or rejected and would have liked more feedback from their therapist. Rarely, they felt retained in treatment without grounds and disagreed on the way the therapists faced treatment and felt the relationship was not good.

> I didn't feel cared for, I felt emptiness when I left. He picked up phone calls from other patients, he was constantly coming and going. (. . .) A lack of interest, that's what I felt from him. It's not like I was hoping for a miracle, but neither was I expecting such a cold manner. (. . .) I felt like he wasn't telling me the truth, he was not clear when speaking, like I was gonna get scared. (. . .) He treated me ok, but like it was all just routine. I didn't feel like he was present with me or my difficulties. (Participant #21)

> I'm married, and one day I told her: "My husband is a quiet person, he knows how to handle things calmly," and she said, "Ok, you haven't learned much from him." (. . .) To me it was the opposite: I felt that since I had met him I had learned a lot from him, had changed a lot, in a good way. So her comment shocked me, it was hurtful. I don't know if she meant to challenge me (probably she did), but I didn't like it. (Participant #18)

Other categories about therapeutic relationship. Finally, three categories could not be classified into the positive/negative scheme because they were valued differently among participants. They were clustered under the "other therapeutic relationship" domain. The relationship being formal, for example, sometimes was valued negatively, as uncomfortable, while other participants related it to the professionalism of the therapist. In the same way oscillations in the therapeutic relationship did not have a positive or negative association, it usually was referred to as a period where clients felt therapy was not fulfilling their expectations, thus perceiving a decrease in their motivation, followed by an improvement.

> Our relationship was mostly very good. There were one or two periods during which I didn't feel like going, we weren't getting anywhere. But then we got back on track. I suppose that is normal through seven years of therapy. (Participant #44)

Comparing Categories Within Factors (Qualitative Analysis)

Researchers explored category frequencies in two selected dimensions of termination mode. As can be seen in Tables 3 and 4, the first factor referred to who initiated termination: (a) client or (b) therapist; the second factor focused on the level of agreement between client and therapist about termination: (a) disagreement and (b) agreement.

First factor: Client- versus therapist-initiated termination. Throughout the whole set of categories, there were differences in terms of who, in the therapeutic dyad initiated termination. Termination was perceived as conflictive exclusively among those clients that made the decision of terminating therapy themselves. Alongside, clients that initiated termination mentioned perceiving a period of closure less frequently than the therapist-initiated termination group. Regarding motives, when therapists proposed termination, it seems clients perceived mainly positive motives for termination, such as feeling better and achieving goals, whereas in the client-proposed termination group, all sorts of motives emerged with similar representation. When analyzing the post therapy relationship, clients whose therapists initiated termination were more prone to go back to therapy with their therapist. As well, this group more frequently mentioned their therapists had left the door open for this possibility. In addition, all but one of those participants that stated they would not go back to therapy with their therapist, were included in the client-initiated termination group.

In terms of perceived therapeutic relationship, although both groups mentioned positive aspects of the relationship, the therapist-initiated termination group showed a larger prevalence in those categories. As an example, all participants of that group mentioned feeling comfortable with their therapist and trusting him/her. The therapist-initiated termination group had little representation of categories regarding negative aspects of the therapeutic relationship, such as the relationship deteriorating throughout treatment or feeling rejected/criticized by the therapist. No participants included in that group mentioned having a "not so good" relationship with the therapist, feeling retained in therapy, or disliking the therapist's personality.

Second factor: Level of agreement about termination. When looking at these results, it seems that the agreement group had the same characteristics regarding category frequencies as the therapist-initiated termination group. Coherently, the disagreement group presented all the conflictive terminations. The agreement group identified more positive termination motives, and the relationship had an overall better feeling in the agreement group than in the disagreement group (please see Tables 3 and 4 for specific differentiation of the comparison groups).

Given that almost all therapist-initiated terminations had been included in the agreement group, the main difference between the two classifications resides in the client-initiated termination group. Among those participants, some said they never talked about termination, and abandoned the treatment. Others said they communicated their idea of terminating therapy, and their therapist showed reluctance. The third group said they decided to terminate, but their therapists' attitudes were sympathetic and provided a closure period, highlighting the goals reached and the progress done. Posterior analyses will address this difference by comparing not only groups on each factor, but also the combination of factors (see next section).

Quantitative Analyses

Initially, we used the complete sample to analyze the correlations among the variables: WAI-SR Bond Scale, Global Satisfaction, and Treatment length (months in treatment) using Spearman Rho correlations. As it can be seen in Table 5, a strong and significant correlation was found between the WAI-SR Bond Scale and the Global satisfaction rating. However, treatment length was

Table 5
Variables′ Descriptions a Correlation Matrix

				Correlations			
				WAI-SR Bond Scale		Global satisfaction	
Variables	*n*	*M*	*SD*	*r*	*p*	*r*	*p*
WAI-SR Bond	73	5.89	1.17				
Global satisfaction	73	7.78	1.75	.637*	<.001		
Treatment length (months)	73	31.86	44.20	.172	.146	.201	.089

Note. *n* = sample size; *M* = Media; *SD* = Standard deviation; *r* = Spearman's Rho; *p* = p value. * Significative correlation < .001 (bilateral).

not correlated to either the WAI-SR Bond Scale or the Global Satisfaction measure.

Mann–Whitney *U* tests were conducted to determine if there were differences in therapeutic bond and general satisfaction with therapy in client- (*n* = 49). versus therapist-initiated termination (*n* = 20). Scores of the WAI-SR Bond Scale of each participant were added and divided by 4, to place them in the original 7-point Likert scale. See Table 6 for differences in the Bond Scale and overall satisfaction with treatment among groups.

The clients whose therapists initiated termination had significantly higher scores in the WAI bond scale than those who initiated termination themselves. As well, when the termination was proposed by the therapists, clients presented higher satisfaction with therapy compared with treatments where clients initiated termination.

Also, when comparing the agreement (*n* = 46) versus disagreement group (*n* = 27), Mann–Whitney *U* tests results showed that clients that agreed with their therapist in termination presented significantly greater scores in the WAI bond scale than those that disagreed. Higher degrees of satisfaction with therapy were presented as well in those clients that agreed in the termination process compared with those that disagreed.

As those clients whose therapists initiated termination presented a stronger bond and higher satisfaction with therapy, we also conducted Mann–Whitney *U* tests, circumscribed to the subsample of clients that proposed termination (*n* = 49) and compared those that agreed (*n* = 24) with those that did not (*n* = 25) in the termination process. The results showed as well in this subsample that those clients that agreed with their therapists in the termination presented a stronger therapeutic bond than those that disagreed. A greater satisfaction with therapy was also presented by the ones that agreed compared with clients that disagreed.

Finally, using Kruskal Wallis, we compared the differences among the following: (a) clients that initiated termination with agreement (*n* = 24); (b) clients that initiated termination with disagreement (*n* = 25); and (c) therapists that initiated termination with agreement (*n* = 19).

There was a significant difference among the groups in the WAI bond scale. The therapist-initiated termination with their clients' agreement presented the highest scores, followed by client-initiated

Table 6
Differences in Bond Scale and Overall Satisfaction With Treatment Among Groups

		WAI-SR Bond Scale				Satisfaction scale			
Group	*n*	*M* (*SD*)	*U*	*p*	*d*	*M* (*SD*)	*U*	*p*	*d*
Therapist_IT	20	6.60 (.48)	223	<.001	.94	9.05 (1.69)	167.5	<.001	1.25
Client_IT	49	5.56 (1.26)				7.14 (1.69)			
Agreement	46	6.37 (.75)	235.5	<.001	.92	8.33 (1.41)	324	<.001	.92
Disagreement	27	5.07 (1.30)				6.85 (1.89)			
Client_IT(A)	24	6.18 (.89)	130	<.001	1.09	7.71 (1.48)	181	= .02	.68
Client_IT(D)	25	4.96 (1.29)				6.60 (1.73)			
	n	*M* (*SD*)	KW *H*(2)	*p*		*M* (*SD*)	KW *H*(2)	*p*	
Client_IT(A)	24	6.18 (.89)	22.77	<.001		7.71 (1.48)	22.62	<.001	
Client_IT(D)	25	4.96 (1.29)				6.60 (1.73)			
Therapist_IT(A)	19	6.61 (.50)				8.94 (.99)			

Note. Therapist_IT = Therapist-initiated termination; Client_IT = Client-initiated termination; Client_IT (A) = Client-initiated termination with agreement (from the therapist); Client_IT (D) = Client-initiated termination with disagreement (from the therapist). Therapist_IT(A): Therapist-initiated termination with client's agreement. There was only one participant whose therapist decided on termination with client's disagreement, so no group was gathered for this condition. The clients′ informed about agreement and disagreement from their own perspective, there is no information regarding the therapists′ actual thoughts about the termination. *M* = Media; *SD* = Standard deviation; *U* = U de Mann Whitney; *p* = p value; *d* = Cohen's d effect size; KW *H* (2)= Kruskal Wallis′ H (degrees of freedom). Scores of the WAI-SR Bond Scale were divided by 4 to place them in the original 7-point likert scale (being 7 indicative of better bond). The satisfaction scale is a 10-point scale ranging from 1 (*completely unsatisfied*) to 10 (*highly satisfied*).

termination that agreed with their therapists, and with the lowest scores were the client-initiated termination group that disagreed with their therapist. Also, there was a significant difference among the groups in the degree of satisfaction with therapy.

To see if the differences between each pair of groups were significant, we conducted Mann–Whitney *U* tests. As multiple comparisons increased the likelihood of a Type I error, we used a Bonferroni correction adjusting the alpha by the 3 comparisons done in each analysis ($\alpha = .05/3$). Thus, for this analysis the hypothesis was tested at $\alpha = .016$.

Therapist-initiated termination with agreement presented higher satisfaction with therapy ($n = 19$, $M = 9$, $Mdn = 9$, $SD = 1$) than client-initiated termination with agreement ($n = 24$, $M = 7.71$, $Mdn = 8$, $SD = 1.48$; $U = 111.5$, $p < .01$, $d = 0.99$). Regarding the therapeutic bond, the difference between the group was the therapist-initiated termination with agreement ($n = 19$, $M = 6.59$, $Mdn = 6.75$, $SD = .49$) and the client-initiated termination group with agreement ($n = 24$, $M = 6.18$, $Mdn = 6.50$, $SD = .89$) was nonsignificant ($U = 161$, $p < .095$, $d = 0.55$).

Significant differences were also found between clients who initiated termination and agreed with their therapists, and clients who initiated termination but disagreed with their therapists. Those that agreed presented a stronger bond with their therapists ($n = 24$, $M = 6.18$, $Mdn = 6.5$, $SD = .89$) than those that disagreed ($n = 25$, $M = 4.96$, $Mdn = 5$, $SD = 1.29$; $U = 53.5$, $p < .001$, $d = 1.09$). Additionally, the clients that initiated termination and agreed presented a significantly higher satisfaction with therapy ($n = 24$, $M = 7.71$, $Mdn = 8$, $SD = 1.48$) than the clients that initiated termination with disagreement group ($n = 25$, $M = 6.60$, $Mdn = 7$, $SD = 1.73$; $U = 181$, $p < .014$, $d = 0.68$).

As expected, clients who agreed on therapist-initiated termination presented higher satisfaction with therapy ($n = 19$, $M = 9$, $Mdn = 9$, $SD = 1$) than client-initiated termination and therapists that disagreed ($n = 25$, $M = 6.60$, $Mdn = 7$, $SD = 1.73$; $U = 54.5$, $p < .001$, $d = 1.64$). Also, the clients which agreed on therapist-initiated termination presented a stronger bond with their therapist ($n = 19$, $M = 6.59$, $Mdn = 6.75$, $SD = .49$) than the client-initiated termination group in disagreement with the therapist ($n = 25$, $M = 4.96$, $Mdn = 5$, $SD = 1.29$; $U = 53.5$, $p < .001$, $d = 1.58$).

Discussion

The current study has several characteristics that differentiate it from previous research on therapy termination. One of the most salient strengths is that participants have not been contacted by their therapists. This was intended to reduce the possibility of social desirability bias, where clients overreport positive aspects of therapy and underreport negative aspects. This could occur both if clients have doubts on the extension of confidentiality and if they feel protective toward their therapists, wanting to show an agreeable image to their colleagues. Guaranteeing no relationship between therapist and researcher should have reduced at least some of this bias. Additionally, whereas previous research focused mostly on short term therapies and public clinic clients, treated by trainees (Roe et al., 2006a), the present sample included different kinds of treatment providers (5.5% public hospitals, 9.6% psychotherapy clinic, and 84.9% private practitioners) and various therapy lengths (2 months to 23 years; $M = 32$ months; $SD = 44$ months). In terms of the selected methods of analysis, CQR procedures were strengthened by the use of an interrater reliability measure to ensure an equivalent judgment and assessment of the material.

Let's Talk About Termination

More than 65% of the former clients interviewed for this study reported having initiated the therapy termination process themselves. Certainly not all of these cases represented premature terminations. The high number of independent practice treatments without an initial arrangement on the number of sessions in our sample could be responsible for this trend. However, when comparing groups, negative termination motives such as "feeling bored" and "lacking new themes" were found more frequently in the client-initiated termination group. Therapist-initiated termination, on the other hand, seemed positively valued by clients, and was associated with a higher therapeutic bond and overall treatment satisfaction.

One possibility is that some of the therapists in the first group were not aware of their clients' improvement. Strauss et al. (2015) found that outcome monitoring therapy and subsequently providing feedback to therapists can improve the cost effectiveness of psychotherapy. Feedback helps the therapists identify their clients' changes, thereby reducing treatment duration.

However, the current study revealed that problems seemed to surface in cases where the client was not aware of the therapists' plans or aims and began feeling adrift within therapy. Clients in these cases did not feel comfortable enough to talk about termination, even when they appeared to have a solid therapeutic relationship to begin with.

> She never said anything about treatment expected length. I never told her this (maybe someday I will) but a negative aspect of therapy was that she never said to me, "You are improving, you are doing better." I think it's important for a therapist to tell you that. It was hard for me to be the one who decided to end the treatment, it was a huge issue. . . . I thought she would disagree. And in the end, when I told her she said she thought I was fine. (. . .) I told her I had been thinking about termination for a while, and I thought it would be a gradual process, but it ended that same day. She said she thought I was doing better in several aspects. I asked her which, in her opinion, my unresolved issues were and we talked about them. (. . .) I would have liked a more gradual process, for her to tell me I was better and maybe reduce the frequency of the sessions before termination. I don't know why she didn't do that. (Participant #17)

Regardless of their particular view of the termination process, its timing, valid motives, and who they think should take the initiative, clinicians could benefit by fostering open discussions with their clients about any concerns about treatment evolution. These findings are consistent with previous research where clients that did not talk about the termination process with their therapist reported more negative emotions (Roe et al., 2006a).

Agreement on Termination

As a result of the qualitative analysis conducted, we found relevance in the level of agreement on termination between client and therapist. Although therapist-initiated terminations mainly shared agreement with their clients, client-initiated terminations varied. Half

of those clients agreed on the termination terms with the therapist, whereas the other half disagreed on termination. The group comparison revealed that the level of agreement was associated with variations among the domains. Agreed termination, regardless of being initiated by therapists or by clients, was related to positive termination motives, a stronger therapeutic bond, and higher satisfaction levels. It seemed that when clients and therapists agree on the termination terms, there was a better perception of the therapeutic relationship and the complete treatment. In effect, most participants in this group stated they would go back to therapy with the same therapist.

This association could be understood in two ways: (a) an adverse process could have led to a disagreed termination; or (b) a disruptive termination could have resulted in negative memories of the treatment affecting the overall perception.

Regarding alliance, the same two ways associated could be hypothesized. On the one hand, a stronger therapeutic bond could facilitate a positive experience of termination. The resolution of therapeutic alliance ruptures, for example, has been associated with decreased levels of dropping out (Muran et al., 2009). Furthermore, given the association found between a strong therapeutic alliance and therapy induced change (Horvath, Del Re, Flückiger, & Symonds, 2011), it could have been expected that clients with strong therapeutic relationships would have achieved better treatment results, favoring a more satisfactory ending to treatment. On the other hand, a particular experience of treatment ending may have also had a unique impact on the clients' rememoration and assessment of their psychotherapeutic process due to the recency effect (Ashby & Rakow, 2014; Neath & Saint-Aubin, 2011). In this way, psychotherapy termination may have had an effect on cognitive representation of the psychotherapy process and particularly the therapeutic alliance as seen in the example of Participant #17.

In this study, a number of participants expressed being satisfied with therapy up to the point where they started feeling retained in treatment by their therapists. Those with disagreed or conflictive termination processes expressed either the feeling that their therapist would not consider their opinion on the matter if they had proposed termination, or that they actually proposed termination to their therapists and were met with disapproval. Consequently, we hypothesize that a conflictive ending of treatment might hinder the whole process, including perceived therapeutic relationship and outcome. Further research should be conducted to pursue testing of this hypothesis.

Importance of Client's Perception of Termination

Freud (1910) stated that therapy should not just produce good results, but it is important that the client perceives those results and talks about them. He even considered that a negative representation of therapy, procedures, and its results could undermine the actual outcome of treatments. A client that feels that his or her therapist wanted to retain him/her, rejected him/her, or who could not share certain things with him/her might talk about those things with other people prejudicing the social perception of psychotherapy and, in the long term, its results. Instead, a client might change his or her view of therapy if the therapist manages to agree on the termination terms, even when the therapeutic process has been perceived as unsuccessful by the client, as can be seen in Participant #73.

> I was thinking about termination, I was feeling somewhat uncomfortable. I felt no desire to go. (. . .) At one time I thought it was better to stop for a while or try with another therapist, a female therapist for example. (. . .) When I told him I wanted to end therapy, my therapist took it well. He proposed to have a few more sessions and I agreed. (. . .) The last session I felt was special because we achieved closure. He told me that I could call him if I needed someone later on, even if it wasn't him, that he could refer me to someone else. (. . .) I think it's a possibility, going back to therapy. Maybe even with him. (Participant #73)

Implications for Practice and Training

Results of this study suggest that discussing termination with clients throughout treatment could benefit the therapeutic process. Whether clinicians expect clients to take the initiative or whether they think termination should always be therapist-initiated, communicating about this with clients could help to reduce premature treatment endings and facilitate the termination process. Therapists could benefit from openly asking about clients' ideas of how termination should unfold, in order to acknowledge their expectations and try to settle a common ground. In addition, if a client presents his or her wishes to terminate, a mutual agreement on the terms while providing the option to continue in another moment or situation could foster a better remembrance of the therapy process. Clients more satisfied with treatment are prone to start another one or recommend it to others.

Limitations and Further Research

Although this study is not intended to be generalized to the population, it should be noted that as participants were recruited with a snowball sampling method, the sample representativeness cannot be established. All the treatments were conducted in a Latin American city, and most of them were held in private offices. Additionally, as researchers had no contact with therapists, the analysis could not include information about their perspective of the treatment, diagnosis, or therapeutic relationship. Moreover, no information about their theoretical background, therapeutic approach, or opinion about termination was collected. Given that most participants had several prior multiple treatments, their opinion on therapy could be influenced by these previous experiences. We could also hypothesize that this high number of treatments reflected a particular type of client in more severe cases. Nevertheless, this could be related to specific features of psychotherapy in Buenos Aires, where people attend therapy more frequently than in most North American and European cities (Alonso, 2000). Finally, as interviews were conducted once therapy was terminated, they required retrospective recall from participants. The fact that interviews were conducted on average eight months posttermination, this could have increased the possibility that the clients' recollections of their treatments were affected by memory loss or posterior events.

Regarding the qualitative analysis procedures, many precautions were taken into account to ensure bias minimization, such as consensus in the first two stages and an interrater agreement measure before the third stage of analysis. Nevertheless, this article's first and second authors conducted the final analysis of 68.5% of the interviews, which could be considered a methodological limitation.

In this study, only the bond subscale of the working alliance inventory was tested. Moreover, research should include the agreement on tasks and goals of therapy and their association with termination to observe if either scale is related to termination or independent from it.

Further research could also benefit from comparing therapist and client representations of the termination process with a qualitative approach. Likewise, a more profound exploration of precedents and consequences of disagreement on the termination phase of therapy could be helpful for clinicians that wish to reduce premature termination.

References

Alonso, M. M. (2000). Psicología en Argentina [Psychology in Argentina]. *Psicodebate Psicología, Cultura Y Sociedad, 1,* 3–17.

Ashby, N. J. S., & Rakow, T. (2014). Forgetting the past: Individual differences in recency in subjective valuations from experience. *Journal of Experimental Psychology: Learning, Memory, and Cognition, 40,* 1153–1162. http://dx.doi.org/10.1037/a0036352

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20,* 37–46. http://dx.doi.org/10.1177/001316446002000104

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112,* 155–159. http://dx.doi.org/10.1037/0033-2909.112.1.155

Delgado, S. V., & Strawn, J. R. (2012). Termination of psychodynamic psychotherapy with adolescents: A review and contemporary perspective. *Bulletin of the Menninger Clinic, 76,* 21–52. http://dx.doi.org/10.1521/bumc.2012.76.1.21

Freud, S. (1910). XXV the future prospects of psychoanalytic therapy. In S. Freud (Ed.), *Collected papers. Volume II* (1959). Translated by Joan Riviere. New York, NY: Basic Books.

Gómez Penedo, J. M., Waizmann, V., & Roussos, A. J. (2015). Propiedades psicométricas de la adaptación argentina del Inventario de Alianza de Trabajo breve - versión paciente (WAI-SR-A): Un análisis factorial confirmatorio [Psychometric properties of the Argentinean adaptation of the Brief Working Alliance Inventory—Patient Version (WAI-SR-A): A confirmatory factorial analysis]. *Investigando en Psicología, 20,* 49–62.

Hardy, J. A., & Woodhouse, S. S. (2008). How We Say Goodbye: Research on Psychotherapy Termination. *Division of Psychotherapy, April,* 1–5.

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16,* 12–25. http://dx.doi.org/10.1080/10503300500352500

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. *Journal of Counseling Psychology, 52,* 196–205.

Hill, C., Thompson, B., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25,* 517–572.

Hilsenroth, M. J., Holdwick, D. J., Jr., Castlebury, F. D., & Blais, M. A. (1998). The effects of *DSM–IV* cluster B personality disorder symptoms on the termination and continuation of psychotherapy. *Psychotherapy, 35,* 163–176. http://dx.doi.org/10.1037/h0087845

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9–16. http://dx.doi.org/10.1037/a0022186

Hunsley, J., Aubry, T. D., Verstervelt, C. M., & Vito, D. (1999). Comparing Therapist and Client Perspectives on Reasons for Psychotherapy Termination. *Psychotherapy, 36,* 380–388. http://dx.doi.org/10.1037/h0087802

Hynan, D. J. (1990). Client reasons and experiences in treatment that influence termination of psychotherapy. *Journal of Clinical Psychology, 46,* 891–895. Retrieved from http://psycnet.apa.org/PsycINFO/1991-13247-001. http://dx.doi.org/10.1002/1097-4679(199011)46:6<891::AID-JCLP2270460631>3.0.CO;2-8

Knox, S., Adrians, N., Everson, E., Hess, S., Hill, C., & Crook-Lyon, R. (2011). Clients' perspectives on therapy termination. *Psychotherapy Research, 21,* 154–167. http://dx.doi.org/10.1080/10503307.2010.534509

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics, 33,* 159–174. http://dx.doi.org/10.2307/2529310

Marx, J. A., & Gelso, C. J. (1987). Termination of individual counseling in a university counseling center. *Journal of Counseling Psychology, 34,* 3–9. http://dx.doi.org/10.1037/0022-0167.34.1.3

McCabe, K. M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies, 11,* 347–359. http://dx.doi.org/10.1023/A:1016876224388

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy, 46,* 233–248. http://dx.doi.org/10.1037/a0016085

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

Neath, I., & Saint-Aubin, J. (2011). Further evidence that similar principles govern recall from episodic and semantic memory: The Canadian prime ministerial serial position function. *Canadian Journal of Experimental Psychology/Revue Canadienne de Psychologie Expérimentale, 65,* 77–83. http://dx.doi.org/10.1037/a0021998

Nuetzel, E., & Larsen, R. (2012). Should I stay or should I go? Time as a variable in open-ended psychoanalytic psychotherapy. *International Journal of Applied Psychoanalytic Studies, 9,* 4–22.

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

Olivera, J., Braun, M., Gómez Penedo, J. M., & Roussos, A. (2013). A qualitative investigation of former clients' perception of change, reasons for consultation, therapeutic relationship, and termination. *Psychotherapy, 50,* 505–516. http://dx.doi.org/10.1037/a0033359

Olivera, J., Braun, M., & Roussos, A. (2013). *Clients' perspectives of therapy interview*. Unpublished Manuscript.

Philips, B., Wennberg, P., & Werbart, A. (2007). Ideas of cure as a predictor of premature termination, early alliance and outcome in psychoanalytic psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice, 80,* 229–245. http://dx.doi.org/10.1348/147608306X128266

Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., McCallum, M., Rosie, J. S., O'Kelly, J. G., & Steinberg, P. I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy, 36,* 114–122. http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=1999-11589-002

Reitzel, L. R., Stellrecht, N. E., Gordon, K. H., Lima, E. N., Wingate, L. R., Brown, J. S., . . ., Joiner, T. E. (2006). Does time between application and case assignment predict therapy attendance or premature termination in outpatients? *Psychological Services, 3,* 51–60. http://dx.doi.org/10.1037/1541-1559.3.1.51

Renk, K., & Dinger, T. M. (2002). Reasons for therapy termination in a university psychology clinic. *Journal of Clinical Psychology, 58,* 1173–1181. http://dx.doi.org/10.1002/jclp.10075

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

Roe, D., Dekel, R., Harel, G., Fennig, S., & Fennig, S. (2006b). Clients' feelings during termination of psychodynamically oriented psychotherapy. *Bulletin of the Menninger Clinic, 70,* 68–81. http://dx.doi.org/10.1521/bumc.2006.70.1.68

Spangler, P., Liu, J., & Hill, C. E. (2012). Consensual qualitative research for simple qualitative data. An introduction to CQR-M. In C. E. Hill (Ed.), *Consensual qualitative research. A practical resource for investigating social science phenomena*. Washington, DC: American Psychological Association.

Strauss, B. M., Lutz, W., Steffanowski, A., Wittmann, W. W., Boehnke, J. R., Rubel, J., . . . Kirchmann, H. (2015). Benefits and challenges in practice-oriented psychotherapy research in Germany: The TK and the QS-PSY-BAY projects of quality assurance in outpatient psychotherapy. *Psychotherapy Research, 25,* 32–51. http://dx.doi.org/10.1080/10503307.2013.856046

Swift, J. K., & Callahan, J. L. (2011). Decreasing treatment dropout by addressing expectations for treatment length. *Psychotherapy Research, 21,* 193–200. http://dx.doi.org/10.1080/10503307.2010.541294

Swift, J. K., Callahan, J., & Levine, J. C. (2009). Using clinically significant change to identify premature termination. *Psychotherapy, 46,* 328–335. http://dx.doi.org/10.1037/a0017003

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80,* 547–559. http://dx.doi.org/10.1037/a0028226

Swift, J. K., Greenberg, R. P., Whipple, J. L., & Kominiak, N. (2012). Practice recommendations for reducing premature termination in therapy. *Professional Psychology: Research and Practice, 43,* 379–387. http://dx.doi.org/10.1037/a0028291

Timulak, L. (2012). Review of consensual qualitative research: A practical resource for investigating social science phenomena. *Psychotherapy, 49,* 273–274. http://dx.doi.org/10.1037/a0028025

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

Waizmann, V., & Roussos, A. (2011). Adaptación de inventario de alianza terapéutica en su versión observador: WAI-O-A [Adaptation of the Working Alliance Inventory in its observer form: WAI-O-A]. *Anuario de Investigaciones de la Facultad de Psicología, 18,* 95–104.

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

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

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24,* 190–195. http://dx.doi.org/10.1037/0735-7028.24.2.190

Appendix

Open Questions That Were Included in the Interview Protocol

Termination

1. Who made the decision to terminate?
2. If patient → Did you talk to your therapist about it? What was the therapists' reaction?
3. If therapist → What was your reaction?
4. What were the reasons that motivated termination?
5. How did termination unfold?
6. How much time was there between the decision to terminate being made and the end of therapy?
7. How was your last session with your therapist?
8. How is your relationship with the therapist now?
9. Would you go back to therapy? In which situation?

Therapeutic Relationship

10. How would you describe your relationship with your therapist?
11. Did your relationship change over time in treatment?
12. How would you describe your therapist?
13. What was his or her disposition and attitude during sessions?
14. Were you comfortable with your therapist?
15. What do you value about your therapist?
16. Were there things you did not like about him/her? Could you name the most important?
17. Were you ever in disagreement with your therapist about something? Was it resolved/dealt with? How?
18. Did you ever feel rejected by your therapist?
19. Did you ever feel criticized by your therapist? How did you react?
20. Were there some things you felt you could not talk to your therapist about?
21. Was there contact with your therapist between sessions?

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