ABSTRACT

Title of dissertation: CLIENTS' PERSPECTIVES ON UNRESOLVED

THERAPEUTIC IMPASSES

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A therapeutic impasse is a stalemate between a client and a therapist that grinds

progress in therapy to a halt. Left unresolved, therapeutic impasses typically lead to the

client dropping out of treatment (Weiner, 1974). Although there is some agreement in the

clinical literature about what factors contribute to therapeutic impasses, there has been

minimal empirical research in this area. Thus, the purpose of this study was to examine

the factors associated with unresolved impasses that result in the client quitting therapy. A

secondary purpose of this study was to examine whether therapeutic impasses evolve

differently for clients with different styles of attachment to their therapists.

In-depth interviews were conducted with 11 former psychotherapy clients who

dropped out of therapy due to unresolved impasses with their therapists. Consensual

Qualitative Research (CQR; Hill, Thompson, & Williams, 1997) was used to analyze

clients' responses. In addition, clients completed the Client Attachment to Therapist Scale

(CATS; Mallinckrodt, Gantt, & Coble, 1995), which assessed clients' degree of secure,

avoidant-fearful, and preoccupied-merger attachment to their therapists.

Results suggest that impasses in therapy are highly emotional events for clients.

Whereas most of the clients reported that the therapists said or did something that

bothered them, clients also admitted that they had difficulty expressing their dissatisfaction to their therapists, were reluctant to explore certain issues in therapy, and had issues or personality styles that interfered with therapy. Indeed, clients had significant pathology and may have been particularly difficult cases for their therapists. Progress in therapy also was impeded by disagreement over the structure and focus of therapy. Few clients felt that their therapists were aware that an impasse existed. Whereas most clients had an avoidant-fearful attachment style, those who also were high in preoccupied-merger attachment seemed to have especially negative experiences with impasses. The results of this study suggest ways in which therapists might decrease or resolve impasses, including assessing client variables that are associated with impasses, inviting feedback from clients about the process of therapy, and educating clients about therapy and the potential for problems.

CLIENTS' PERSPECTIVES ON UNRESOLVED

THERAPEUTIC IMPASSES

by

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CHAPTER 1

Introduction

A therapeutic impasse is a stalemate between a client and a therapist that grinds progress in therapy to a halt. When an impasse occurs, the client, therapist, or both may sense that the therapeutic process is getting nowhere and may feel angry, frustrated, disappointed or guilty (Elkind, 1982; Weiner, 1982). Therapeutic impasses that are not resolved typically result in the client dropping out of therapy (Hill, Nutt, Heaton, Thompson, & Rhodes, 1996; Rhodes, Thompson, Hill, & Elliott, 1994; Weiner, 1974), and once therapy is terminated, the opportunity to reach a mutual understanding of what went wrong is lost. Feelings of anger, disappointment, defensiveness, or hurt that may accompany therapeutic impasses may remain with the client and therapist for some time after therapy ends. Thus, to avoid the negative fallout of unresolved impasses, therapists need to understand why and how they develop.

Clinicians have described the client, therapist, and relationship factors that, in their experience, contribute to impasses. Among suggested client factors are severity of client pathology, insufficient motivation for growth, adverse transference reactions, shame associated with discussion of particular issues, and external realities related to family and work (Elkind, 1992; Hill et al., 1996; Kluft, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1982). Proposed therapist factors include therapist errors, countertransference, failure to set clear treatment goals, failure to enlist the client's understanding of treatment, and not clarifying the practical arrangements of therapy (Bernstein & Landaiche, 1992; Hill et al., 1996, Kluft, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1974).

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Relationship factors include a poor therapeutic alliance, client-therapist mismatches, triangulation, and disagreement about treatment goals (Atwood, Stolorow, & Trop, 1989; Elkind, 1992; Hill et al., 1996; Kluft, 1992; Omer, 1995; Pulver, 1992; Weiner, 1974).

Although there is some agreement in the clinical literature about what factors contribute to therapeutic impasses, there has been minimal empirical research on how impasses develop in therapy. Among the few empirical studies to explore this topic are two that have used a qualitative methodology, one to obtain client perspectives (Rhodes et al., 1994) and one to obtain therapist perspectives (Hill et al., 1996), of misunderstandings and other types of impasses in the therapeutic relationship. Because samples were small and potential bias exists in any qualitative study, both studies need to be replicated.

One of the benefits of further empirical research on impasses would be to identify factors that lead to stalemates and examine how they develop during therapy. A potentially rich yet minimally explored source of information are the subjective experiences of those who have been involved in impasses. Specifically, obtaining accounts from clients who have encountered impasses would be especially useful, since therapists are sometimes unaware that an impasse exists until it is too late and the client terminates from therapy (Hill et al., 1996; Rhodes et al., 1994). Thus, an investigation of client perspectives on impasses may yield valuable information that is not typically available to therapists.

Since impasses, by definition, occur in relationships, an important extension of the current literature would be to look not only at how clients experience impasses but also at the nature of their relationships with their therapists. This may help to understand the

impasse experiences of different clients. Attachment theory, which describes the affectional bond between two people, recently has been used to explain the therapeutic relationship (Mallinckrodt, 1995; Pistole, 1989) and, therefore, offers a useful theoretical base from which to explore the relational aspects of impasses in therapy. One question to explore is whether clients who terminate from therapy that became stuck in an impasse were securely or insecurely attached to their therapists. Likewise, it would be helpful to examine whether different attachment styles are associated with differences among clients in how they perceive and deal with impasses, which may help us identify ways of resolving impasses or avoiding them all together.

The primary focus of this study is the thoughts, feelings, and reactions of the participants. Qualitative research methods, in addition to being useful for exploring the meaning of participants' experiences (Rennie, 1992), also are considered appropriate for investigating previously unexamined phenomena (Strauss & Corbin, 1992). Therefore, a qualitative approach to data collection and analysis, Consensual Qualitative Research (CQR; Hill, Thompson, & Nutt-Williams, 1997), was used in this study. This approach combines grounded theory analysis (Strauss & Corbin, 1990), comprehensive process analysis (Elliott, 1989), and McCracken's (1988) interview approach. Data about unresolved therapeutic impasses were collected using in-depth semistructured telephone interviews, and a brief questionnaire that yields a discrete style of clients' attachment to their therapists was used to assess participants' attachment style.

CHAPTER 2

Literature Review

<u>Definitions</u>

Several different terms are used in the literature to describe stalemates in therapy. For example, Safran, Crocker, McMain, & Murray (1990) referred to impairments in the quality of the therapeutic relationship as "alliance ruptures," whereas Elkind (1992) used rupture and "ruptured termination" to describe an abrupt ending of therapy by a client following an unresolved stalemate with the therapist. Rhodes et al. (1994) investigated "misunderstanding events," defined as occasions in which clients felt misunderstood by their therapists. Misunderstanding events were separated into those that were resolved and those that were not resolved and resulted in the client quitting therapy. Unresolved misunderstandings would be one type of "therapeutic impasse" under the definition used by Hill et al. (1996), who defined impasses as stalemates in therapy that make progress so difficult that clients terminate treatment. Indeed, "therapeutic impasse" may best function as an umbrella term under which we can group alliance ruptures, misunderstandings, and other suggested obstructions to progress, including adverse transference and countertransference reactions, client pathology, disagreement about the tasks and goals of therapy, and mismatches between clients and therapists, to name a few.

Although Hill et al. (1996) implied that impasses are disruptions in therapy for which resolution is not possible, clinicians writing on therapeutic impasses have suggested that impasses can be resolved (Elkind, 1992; Nathanson, 1992; Omer, 1997; Saretsky, 1981; Watson & Greenberg, 1995; Weiner, 1974). Moreover, some authors report that

the process of resolution can provide an important opportunity for exploration and positive change for the client (Atwood et al. 1989; Elkind, 1992; Safran, 1993; Safran et al., 1990).

In summary, different terms have been used to describe a cluster of phenomena related to therapeutic impasse. For this study, therapeutic impasse was defined as a stalemate between a client and therapist that brings progress in therapy to a halt. Moreover, the term impasse as used here describes a condition of therapy rather than a particular event (e.g., misunderstandings or transference reactions). In contrast to the pauses and plateaus that normally occur in the course of insight-oriented therapies, participants who are at an impasse sense that the therapy is going nowhere. The client, therapist, or both may feel anger, rage, frustration, or disappointment (Elkind, 1992; Weiner 1974). Furthermore, while the resolution of impasses allows therapy to move forward, failure to resolve an impasse typically results in the client dropping out of treatment. This definition is consistent with the prevailing view in the literature that impasses are charged with negative emotions and that the continuation of therapy is contingent on resolution of the problem. The focus of the present investigation was on impasses that were not resolved, as it seemed critical to understand a phenomenon in therapy for which the likely outcome is the client quitting therapy prior to attainment of the therapeutic goals.

Clinical Literature

The importance of understanding impasses in psychotherapy has been discussed by a number of theorists (Kohut, 1979; Safran, 1993; Safran et. al, 1990; Safran & Muran,

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1995; Saretsky, 1981; Weiner, 1982). For example, Weiss (1993) suggested that psychotherapy is a process through which clients disconfirm self-damaging beliefs about interpersonal relationships by unconsciously "testing" such beliefs in their relationship with their therapists. According to Weiss, an impasse may result when a therapist fails to pass the client's test. Weiss offered the example of a client who tested his belief that he could intimidate his parents by demanding that the therapist tell him when he would be finished with treatment. Intimidated by the client, the therapist replied that he might be ready to terminate in a year, even though the therapist did not believe it. After a summer break, the client returned to therapy, but no progress was made because the client remained silent in the sessions. When the therapist realized that the client felt angry and rejected by the termination plan, they discussed the problem, and the impasse ended.

Theorists have also suggested that occasional lapses in understanding between clients and therapists are inevitable and represent an important opportunity for exploration of clients' interpersonal issues and the therapeutic relationship (Atwood et al., 1989; Safran, 1993; Safran et al., 1990). For instance, Kohut (1984) argued that therapists' unavoidable empathic failures actually help clients acquire a healthier sense of self-esteem, as long as therapists respond to their clients' retreat following empathic failures with appropriate interpretations. According to Kohut, each time a client survives a disappointing empathic failure, new "self structures" are acquired and the client's ability to withstand subsequent disappointments inside and outside therapy is strengthened.

Similarly, Safran (1993) asserted that working through breaches in the therapeutic alliance allows clients to develop a capacity to be both separate and connected to others,

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which Safran contended is the essential goal of all humans. When therapists empathize with their clients' negative feelings about alliance breaches, Safran explained, clients learn that such feelings are acceptable and that relatedness with others does not require giving up parts of oneself. Likewise, in the process of repairing alliance breaches, clients come to accept their therapists' flaws and, therefore, see them as separate. Moments of togetherness in therapy then become more authentic.

Thus, a therapeutic impasse may represent a turning point in therapy that can facilitate, rather than hinder, progress on the client's goals. Whether an impasse serves as a useful therapeutic tool or as a precipitator of premature termination by the client would seem to depend on how aware the therapist is that therapy has stalled. Therapist awareness of an impasse would likely be facilitated not only by the client expressing dissatisfaction with therapy but by the therapist knowing how impasses develop. Discussions in the literature related to this have focused primarily on describing factors that lead to impasses as observed by clinicians in their clinical work. Although not empirically derived, these discussions are important for their clinical wisdom. Factors in therapeutic impasses that have been associated with the client, therapist, and therapeutic relationship are discussed here.

Clinical Reports of Client Factors Leading to Impasses

Clinicians have described a number of factors in therapeutic impasses associated with the client. Resistance to treatment, for example, has been cited by several authors (Bernstein & Landaiche, 1992; Gans, 1994; Weiner, 1982). Client resistance was defined by Weiner (1982) as an unconscious desire to obstruct the therapeutic process stemming

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from the ego's effort to repress unacceptable drives or memories. In such cases, resistant clients believe they are cooperating as they unconsciously oppose therapists' efforts to help them explore painful issues. Weiner noted that some clients unconsciously resist treatment to maintain certain advantages arising from their symptoms. For instance, attention given by parents to a child who is in treatment may make the child less motivated to end treatment, so he unconsciously prolongs therapy by not cooperating fully with the therapist.

Weiner made a distinction between resistance and non-compliance. When an impasse emerges from non-compliance, the client is consciously and deliberately refusing to cooperate with treatment. That is, a conscious decision is made not to follow treatment suggestions. Weiner proposed that non-compliance is common in unmotivated clients who come for treatment at the urging of someone else, such as a spouse, an employer, or the court. These clients may attend sessions but refuse to participate fully, miss appointments, or fail to pay bills. A resistant client may become non-compliant when forced to abandon unconscious defenses against unacceptable or painful memories. Weiner used the example of a married woman who for years had defended against her guilt for having an affair through repression, denial, rationalization, projection, and somatization. She had successfully resisted self-examination until it was suggested that hypnosis might relieve the muscular pain and weakness that had brought her to the therapist. Rather than face through hypnosis the memories, drives, and wishes she had been denying herself, she terminated treatment. Weiner asserted that various degrees of resistance and noncompliance are exhibited by every client and that they are the primary

sources of therapeutic impasses.

Bernstein and Landaiche (1992) also observed that client resistance is a common occurrence in therapy. Moreover, they argued that resistance is not only normal, it is also essential, as it signifies that the therapist is appropriately requiring the client to confront difficult issues. The authors claimed that it is the therapist's job is to maintain a secure therapeutic environment, or therapy framework, within which the client can resolve resistant behaviors. As such, client pathology is "counterresisted" by this framework, which governs interventions and is based on the therapist's theoretical approach, the ground rules of therapy, and the agreed-to treatment goals. Working within the framework assures clients that they can begin to shed their defenses without fear. Bernstein and Landaiche explained that impasse occurs when the therapist fails to maintain the framework when confronting a resistant client and that this inappropriate counterresistance typically stems from the therapist's countertransference issue. Thus, this view on resistance as a source of impasse in therapy attributes as much of the problem to the therapist's actions as to the client's and, therefore, might best be considered a "relationship factor" in impasses.

From a psychoanalytic perspective, Newirth (1995) rejected the notion that impasses stem from client resistance or failure to cooperate. Drawing from Winnicott's (1971) work, Newirth suggested that impasses represent the client's inability to respond to traditional therapeutic interpretations due to an underdeveloped sense of the subjective self. This theory contends that such individuals have difficulty bringing subjective meaning to objective experiences. They experience themselves as objects in a world that they view

as concrete, rational, isolating, and not personally relevant. Thus, they bring their objective selves to therapy, where an impasse evolves when interpretative interventions aimed at nurturing self-awareness and insight fail to bring about change.

However, change in some clients actually might signal an impasse. A sudden flight into health, according to Kluft (1992), may be an attempt to divert the therapist's focus in therapy when the work becomes too uncomfortable or when the client fears recovery and the loss of the therapist's indulgences of the client's symptoms. In such cases, an impasse is reached because sessions are spent on everything but the main objectives of therapy. Treatment may be prolonged as the client intended, but without any progress, which sets the stage for the client dropping out of therapy.

Alternately, an impasse occurs when the client regresses after improvement. Pulver (1992) noted that regression may have a variety of causes, including guilt. For example, improvement in therapy may come to represent something in the past that is a source of guilt for the client, such as an oedipal triumph. As the client begins to feel better, feelings of guilt grow stronger. As the author explained, one way to make amends for the past behavior and relieve the guilt is to fail in therapy.

Transference, the client's displacing of feelings and attitudes about significant persons onto the therapist, has also been cited as a contributor to impasses (Atwood et. al, 1989; Elkind, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1974, 1982). Transference issues that impede therapy are sometimes called transference resistances (Weiner, 1982). In such cases, clients may be unable to move forward in therapy because of their strong feelings of attraction, fear, or anger toward their therapists. Relatedly, gratification of a

client's infantile wishes, or transference gratification, either unconsciously by the therapist or by the therapeutic situation itself, can lead to impasse for clients who come to therapy to have their wishes indulged rather than to gain understanding or insight (Pulver, 1992).

Client shame was cited by Nathanson (1992) as another major source of impasse. In some cases, clients who reveal to their therapists something they have tried to keep hidden may feel so uncomfortable afterward that they withdraw from the treatment process. Other clients avoid the discomfort of shame altogether by never disclosing information that they believe would make them look bad. For example, Nathanson (1992) described a case in which a client was so fearful of revealing her involvement in an extramarital affair that she endured a six-month stalemate between her and the therapist. When she finally disclosed the affair during one session, progress began again on her therapy objectives.

Client reality factors also have been observed to contribute to impasses (Pulver, 1992; Weiner, 1982). External factors in clients' lives, such as ability to pay, arrange transportation, and enlist family support sometimes interfere with therapy. However, some clients also unconsciously manipulate these factors in an effort to thwart treatment. For instance, a man who decides to pay for his therapy sessions out-of-pocket, ostensibly to prevent his spouse from learning about the therapy from their insurance statements, dismisses the therapist's caution that such an arrangement could intensify the client's anxiety about his financial situation and marriage. The client's imprudent action and disregard of sound advice may be a way to provide himself an exit from therapy. Eventually, the therapist's predictions come true, but the client interprets his increasing

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anxiety as a sign that therapy is not helping and uses this as an excuse to withdraw during sessions and, eventually, to terminate from treatment. Pulver (1992) contended that therapists may inadvertently maintain impasses of this kind by pressuring their clients to remain in therapy rather than helping them examine the role they have in shaping the factors causing the problem.

In summary, a common denominator in clinicians' reports of client sources of impasse is an inability to confront unpleasant issues. Whether unconscious or conscious, this obstacle to change pervades the therapy to such a degree that therapist interventions become ineffective and minimal, if any, headway is made on the client's goals.

Clinical Reports of Therapist Factors Leading to Impasse

Clinicians also have cited therapists' contributions to therapeutic impasses. Several authors (Elkind, 1992; Kluft, 1992; Nathanson, 1992; Omer, 1997; Pulver, 1992; Weiner, 1974) have attributed impasses to therapists' errors, misconceptions, or lack of knowledge about specific types of client problems. Omer (1997) contended that clients' rejection of therapists' non-empathic formulations of their clients' life stories often lead to impasse. These "external narratives" are diagnostic in nature and tend to describe client motivations and problem behaviors in terms of the therapist's theoretical perspective. Clients often fail to recognize themselves in such descriptions because they do not reflect their values, feelings, and experiences or use words that they would use or understand. Thus, as they dismiss their therapists' non-empathic narratives, they begin to feel that they are getting nowhere on their therapeutic goals. Omer urged that in such cases therapists should formulate, perhaps in consultation, a new "empathic narrative" of the clients' personal

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stories and propose it directly to their clients to re-start the therapeutic dialogue.

Similarly, therapeutic interventions can miss their mark when the therapist lacks knowledge related to the client's presenting issues. For example, Kluft (1992) described an impasse encountered by a new therapist to whom many incest victims were referred. The clients were frustrated because the therapist was unfamiliar with incest-related issues and did not attempt to acquire knowledge in this area, so they terminated treatment. Kluft proposed that therapists who are not receptive to certain clients, their issues, and their concerns about the treatment are likely to withdraw and be less empathic. Thus, the author argued, impasses are inevitable for therapists who are unwilling to seek knowledge in areas of inexperience.

However, poorly applied knowledge also may cause problems. Weiner (1982) noted that some therapists are overzealous in applying their particular interventions and become blinded to limitations. The author described a client who was encouraged by his therapist to be spontaneous and follow his gut instincts. This uptight client, having tried unsuccessfully to give up his need for predictability, felt shamed by his failure but remained in therapy because he thought that following the therapist's suggestions was best for him. The impasse worsened with each unsuccessful attempt by the client to comply with the therapist's misdirected advice. In this case, an ineffective technique was repeatedly applied by a therapist who failed to empathize with the client's situation, which in turn undermined the treatment.

Many clinical authors also have identified countertransference, the therapist's emotional reaction to some aspect of a client that is based on the therapist's personal

issues, as a source of impasse (Bernstein & Landaiche, 1992; Elkind, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1974). In such cases, the therapist's reactions are believed to interfere with understanding of the client, which impedes work on the client's goals. Bernstein and Landaiche (1992) observed that therapists' personal issues typically underlie inappropriate responses to clients' resistance in therapy. For example, a therapist with issues related to professional competence might become over-invested in the progress of a client who defies the therapist's interventions. The therapist might become exhausted with the work and, according to the authors, unable to effectively maintain balance in the therapeutic relationship by being "responsively counterresistant" to the client's resistance.

Another way in which countertransference can upset the therapeutic balance, according to Elkind (1992), is when the psychological issues of both persons either agree or clash to the extent that important issues are overlooked. For example, a therapist who is married to a recovering substance abuser might relate so strongly to the client's struggle to deal with a partner in early recovery that the focus of sessions is the objective reality of the situation rather than the client's psychological issues. Elkind argued that therapists contribute to impasses when they fail to acknowledge that they bring personal areas of sensitivity to the therapeutic relationship.

Countertransference issues in impasses are not always as subtle. For example, Nathanson (1992) described a therapist who was so envious of her client's engagement ring that it was impossible for the two to be productive in therapy. Fortunately, when the impasse developed, the therapist recognized her own envy as the source of the problem and referred the client to a colleague.

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It has been noted that the mere presence of countertransference does not always mean that an impasse will develop (Pulver, 1992; Weiner, 1974). Rather, it is the failure of therapists to be aware of the impact of their emotional involvement on the therapeutic process that can be harmful to therapy. For instance, Weiner (1974) recalled a non-cooperative client to whom he felt attracted, but because of his guilt about having such feelings he exerted extra effort trying to get her to talk instead of acknowledging her client's refusal to cooperate. An impasse developed, and when it became clear that therapy was getting nowhere, the client quit treatment.

Finally, therapist failure to clarify the practical arrangements for treatment was cited as a source of impasse by Pulver (1992), who suggested that details such as fees, charges for missed sessions, vacations, and scheduling should be discussed and agreed to by the therapist and client at the beginning of treatment. Pulver contended that unless routine business matters are clarified early, clients may violate them when they feel a need to express negative feelings, and the result may be an impasse.

In summary, commonly observed therapist sources of therapeutic impasses appear to reflect shortcomings in therapists' management of the therapeutic process. Lack of knowledge about client problems, errors such as failure to set clear guidelines of therapy, and countertransference have been implicated by clinicians as contributors to impasses in therapy.

Clinical Reports of Relationship Factors Leading to Impasses

A number of authors have focused their discussions of impasses on problems in the therapeutic relationship (Atwood, Stolorow, & Trop, 1989; Elkind, 1992; Omer, 1995;

Pulver, 1992; Safran, McMain, Crocker, & Murray, 1990; Strean, 1991; Watson & Greenberg, 1995; Weiner, 1974, 1982). For example, Atwood, Stolorow, and Trop (1989) conceptualized impasses as occurring within the "psychological system" created by the interaction of the subjective experiences of the client and therapist. In this formulation of the therapeutic relationship, the client's issues are viewed as existing in this system rather than only in the client's experience. Atwood et al. contended that therapists who acknowledge and reflect on the involvement of their own subjectivity in the therapeutic process will tend to be empathic and introspective in their observations of clients. For instance, a therapist who recognizes that a client's experience of the world resembles her own can use her self-knowledge and examples from her own life when interpreting the meaning of what the client expresses in therapy. However, if the therapist is not self-aware and mindful of the similarity of their subjective worlds, the client's experiences may be interpreted as objective reality rather than as psychologically important material to be examined, which impedes progress on the client's issues.

Elkind (1992) has discussed at length therapeutic impasses from a relationship perspective. She noted that therapy can be disrupted by a clash of the unconscious defenses of the client and therapist. For example, a client who needs to work on expressing anger toward an authoritarian boss may arouse anxiety in a therapist who is having her own difficulty expressing anger toward her father. In session, the therapist might defend against the anxiety by minimizing the client's fears about her boss and, in effect, ignoring the client's need to be more assertive.

Elkind also associated impasses with failure of the therapeutic relationship to fulfill

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the client's relationship needs. The author provided the example of a shy, young female client who felt utterly out of control of her life. In sessions she was silent and unemotional with the therapist despite every therapeutic technique the therapist could muster. Not until the therapist reflected on their vastly dissimilar backgrounds did she understand that her client needed a sense of having common ground before she could feel safe enough in the relationship to open up. The impasse was broken when the therapist shared with the client details from a similar turbulent time in her life.

Clients and therapists also become stuck in therapy if they are inflexible when each other's needs change. Elkind described a therapist who announced to a client that his schedule was changing and he would no longer be able to continue their special arrangement of three sessions a week. The client, unable to change her view of their relationship from one that was harmonious to one that included disappointment and anger, became immobilized in subsequent sessions, and an impasse resulted.

Clinicians also have observed that therapists who overlook poor matches with their clients are likely to encounter impasses in therapy. For example, Elkind (1992) argued that mismatches due to stage of life, limited knowledge, personality, theoretical orientation, and personal issues can obstruct therapy by preventing the formation of a strong therapeutic bond. A situation in which different stages of life lead to impasse might be one in which a 32-year-old therapist working in a community mental health center is assigned to work with a recently retired school teacher having anxiety related to separation from her longtime employer. The therapist is at the beginning of her professional career and has difficulty empathizing with a client more than 30 years her

senior due to minimal experience with older clients and knowledge of the psychological processes common in retirees. According to Elkind, an impasse in this case probably would develop early in therapy, because a good therapeutic bond would be difficult to establish.

In another type of mismatch described by Elkind (1992), an attractive, health-oriented female client was paired with a cigarette-smoking female therapist with a hacking cough whose interpretations felt completely inaccurate to the client. Despite their different personalities and lifestyles, the client tried to ignore the impasse and remained with the therapist because people she knew who were seeing the therapist were happy with her. But the impasse was not resolved, and the client ultimately switched to another therapist.

Elkind (1992) also observed that impasses arise when therapists are unable to shift their mode of therapy to fit their clients' level of psychological development. Since many clients are not familiar enough with different theoretical approaches to know which approach would be most helpful to their case, they may find themselves in an impasse with a therapist devoted to a perspective that is ill-suited to their needs. Elkind described a client who, needing to understand early life experiences with her family, inadvertently began therapy with a Jungian therapist whose only mode of treatment was to attend to dreams and archetypal aspects of the self. The client suffered through an impasse with the therapist and two other therapists before finding a Kleinian therapist whose theoretical approach matched her needs.

A less obvious type of a mismatch is one in which the problem actually is a good

match between the client and therapist in terms of personality. Kluft (1992) noted that in such cases, the relationship is so satisfying that it becomes the focus of therapy. As a result, the therapist and client may unintentionally collude to avoid exploring certain therapeutic goals.

Relatedly, disagreement over the goals of therapy has been associated with impasses by several authors (Nathanson, 1992; Pulver, 1992; Weiner, 1974; Watson & Greenberg, 1995). For instance, Pulver (1992) described a married man with a graduate degree who was in treatment for depression. The therapist assumed the depression was related to the client's role as "house-husband" while his wife earned her degree. An impasse developed because the therapist's goal for the client was to help him overcome his work inhibition and find a job, but the client, who happened to be satisfied with the situation at home, actually needed help understanding other reasons for his feelings. Pulver maintained that therapists need to identify clients' expectations for treatment, convey their suggested treatment goals, and reach agreement on the goals before proceeding.

Nathanson (1992) cautioned that when a client and therapist have differing goals for therapy, an impasse may occur over disagreement about when the client is ready to terminate treatment. For example, a therapist might interpret her client's request to terminate as resistance to treatment, when in fact the client feels the treatment goals have been achieved. In other instances, clients may believe that they have accomplished all they can with a particular therapist even if they haven't completed all their goals for therapy. Hill et al. (1996) speculated that clients who feel they cannot or do not want to work with

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a therapist any longer may intentionally initiate impasses as a way to end therapy.

Experiential therapists view agreement on the tasks and goals of therapy as a central component of the therapeutic alliance (Horvath & Greenberg, 1994; Watson & Greenberg, 1995). From this perspective, "alliance ruptures," or impasses, emerge when there is a breakdown in this agreement or when the therapeutic bond is weak. Watson and Greenberg (1995) observed that a poorly negotiated agreement on tasks and goals can threaten progress in the early stage of therapy because the client may not understand the important task of "experiencing," question the safety or usefulness of therapy, or have expectations for therapy that differ from the therapist's.

Ruptures in the therapeutic alliance emerge in the middle stage of experiential therapy, according to Watson and Greenberg (1995), when the client has difficulty engaging in the therapeutic tasks, such as when the client is asked to experience feelings associated with a significant other or when the client is concerned about losing a sense of control. Furthermore, a breakdown in trust can threaten the therapeutic relationship at this stage. The authors offered the example of a client who minimized her self-disclosures in session because she sensed that the therapist did not care about her and that she was unimportant to the therapist outside their sessions. In other instances, the therapeutic relationship may feel unsafe to some male clients who have difficulty trusting their female therapists because of the clients' issues with women in positions of power.

Similarly, Weiner (1974) gave the example of a therapist who, not recognizing the seriousness of a teenage client's problems, referred the client's mother for personal therapy to work on conflict she was having with her daughter. An impasse developed in the

mother's therapy because she felt she did not need treatment. The daughter was eventually

terminated by her therapist, but a new therapist recommended that she be hospitalized.

The impasse in the mother's therapy ended, and she needed only a few more sessions to

feel reassured that her concerns about her daughter had been appropriate.

In summary, clinicians have reported a variety of relationship factors believed to be

associated with impasses. The interaction of subjective experiences and unconscious

defenses, difficulty in adjusting to individual changing needs, mismatches, and

disagreement over the tasks and goals of therapy have been observed to contribute to

therapeutic impasses.

Thus, the clinical literature proposes numerous potential sources of therapeutic

impasses attributed to clients, therapists, and the therapeutic relationship. These clinical

observations illustrate the ways in which impasses may endanger therapy. However, with

only minimal empirical data to support such observations, it is not possible to know how

relevant they are to therapists and clients in general.

Empirical Research

The limited empirical research related to therapeutic impasse mainly addresses

individual types of impasses. For example, Safran, Crocker, McMain, and Murray (1990)

investigated alliance ruptures, which they defined as impairments or fluctuations in the

quality of the therapeutic alliance. Ruptures were viewed as existing on a continuum on

which minor, nearly undetectable fluctuations in alliance quality were at one end and

impairments serious enough to compel clients to terminate therapy were at the opposite

end. Safran et al. suggested that therapist interventions that confirm a client's

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dysfunctional interpersonal beliefs are most likely to create an alliance rupture. An example was given of a client who, expecting that others would be emotionally unavailable to him, had difficulty establishing an alliance with a passive therapist.

To clarify the dynamics of alliance ruptures, Safran et al. (1990) looked for recurring themes in psychotherapy sessions that both therapists and clients identified on a questionnaire as having problems in the therapeutic alliance. The clients were being treated for depression or anxiety disorders. The researchers listened to audiotapes of the sessions and identified seven client remarks or behaviors that signaled the presence of a problem in the therapeutic alliance. The rupture "markers" were overt expression of negative sentiments, indirect communication of negative sentiments or hostility, disagreement about the goals or tasks of therapy, compliance with the therapist, avoidance maneuvers, self-esteem-enhancing operations, and non-responsiveness to interventions. These markers were then grouped into major types of alliance ruptures: (1) confrontation ruptures, and (2) withdrawal ruptures.

The researchers contended that resolution of alliance ruptures is possible through a process involving metacommunication, in which the therapist and client communicate about and explore what is currently happening between them. A resolution model, based on psychotherapy theory and ratings by independent observers of successfully resolved alliance ruptures, was proposed by Safran et al. (1990) and empirically refined by Safran, Muran, and Samstag (1994). After formulating a theoretical model of the resolution process, the researchers selected a sample of resolved and unresolved alliance ruptures for investigation by asking clients and therapists to make post-session ratings of the beginning,

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middle, and end portions of their sessions using six questions from the Working Alliance

Inventory (WAI; Horvath & Greenberg, 1986). Ratings of each segment of the sessions

provided participants' impressions of changes in the therapeutic alliance during the

sessions.

The researchers contended that sessions in which both clients and therapists rated

the beginning of the session as high, the middle portion as low, and the end of the session

as high had alliance ruptures that were resolved by the end of the session. Sessions rated

as high in the beginning, low in the middle, and low in the end indicated alliance ruptures

that were not resolved by the end of the session. Using audiotapes and transcripts of

sessions identified as having ruptures that were resolved, the researchers compared the

events in the actual sessions to the steps of their proposed model and refined the model

accordingly. An empirical analysis consisted of operationalizing each component of the

refined model using a battery of converging process measures, which Safran et al. (1994)

reasoned would tighten the description of their constructs, facilitate inter-rater reliability,

facilitate future validity testing, and provide clinicians with specific markers that would be

helpful in the process of resolving alliance ruptures.

The final resolution model consisted of four components: attending to the rupture

marker, exploration of the rupture experience, exploration of the client's avoidance of the

rupture experience, and client self-assertion. In the first component, the therapist

responds to the client's expression of a negative sentiment toward the therapist (a

confrontation marker) or compliance with the therapist to avoid a confrontation (a

withdrawal marker) with empathic and validating interventions that focus the client on the

immediate experience. Next, the resolution process moves either toward the second component or directly to the third component. In the second component, the client tries to express dissatisfaction with therapy but withdraws, perhaps by minimizing the importance of the issue. The therapist responds by helping the client experiment with expressing negative feelings more directly. In the third component, the client discloses wanting to avoid exploring the rupture, the therapist probes the block, and the client begins to explore the avoidance. In the fourth component, the client expresses negative feelings with greater self-assertion and the therapist responds with validation.

Pilot verification studies conducted by Safran et al. (1994) appeared to confirm the 4-stage model of resolution. Although the model offers an objective perspective of problems and their resolution in therapy, use of observer ratings rather than the reports of the therapy participants overlooks the actual experiences of clients and therapists involved in alliance ruptures and other types of therapeutic impasses. It seems logical that subjective accounts of impasses would be highly relevant to inquiries about the development of impasses and their impact on therapy.

Indeed, some effort has been made to examine therapists' experiences with impasses. Rhodes et al. (1994) asked 19 participants who were either therapists-in-training or therapists to complete paper-and-pencil questionnaires asking them to recall events when they were clients in which they felt misunderstood by their therapists. Each person also completed a measure of satisfaction with mental health services. Data were obtained on 11 cases involving misunderstandings that were resolved and eight cases involving misunderstandings that were not resolved. A preliminary version of the

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consensual qualitative research approach (Hill et al., 1997) was used to analyze the client reports.

Results showed that cases with resolved misunderstandings were characterized by a good therapeutic relationship, client willingness to assert negative feelings about being misunderstood, and therapist facilitation of a mutual repair process. The resolution path was similar to that reported by Safran et al. (1994) in that client assertion of negative feelings was an integral element of the metacommunication between clients and therapists about the misunderstanding. However, in contrast to the Safran et al. findings, therapists in the Rhodes et al. (1994) study did not initiate the resolution process by focusing attention on the misunderstanding because they were not aware that their clients were dissatisfied until they were told.

The cases with unresolved misunderstanding events were characterized by a poor relationship, unwillingness by therapists to discuss or accept clients' negative reactions to being misunderstood, and therapists' lack of awareness of clients' negative feelings. Clients reported that misunderstandings occurred when the therapist did something that conflicted with what the clients wanted or needed. In some of the unresolved cases, client assertion of negative feelings was not acknowledged or accepted by the therapist, and therapy continued even though the misunderstanding was never resolved. In other cases, the client did not assert but withdrew, the therapist was either unaware of the client's dissatisfaction or unresponsive to it, and the client eventually terminated therapy. In both resolved and unresolved cases of misunderstandings, clients reported that they were discussing important therapeutic issues prior to the misunderstandings and that they had

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negative feelings about the experience. Clients seemed to feel that their therapists' behavior was less than what they had expected.

The Rhodes et al. (1994) study was limited by the use of a questionnaire rather than in-depth interviews to obtain information about client perspectives. It was also limited by the fact that the participants were therapists and therapists-in-training whose perspectives as clients might differ from clients who are not therapists. In addition, the small subsample of eight unresolved misunderstanding events (five who terminated from treatment) limited the generalizability of the results.

Open-ended questionnaires and interviews were used by Hill et al. (1996) to investigate therapist perspectives on impasses that led to clients dropping out of therapy. Twelve therapists completed the self-report questionnaire, comprised of general questions about the therapists' experience with impasse and a request to write about a recent or salient impasse with one client. The therapists were then contacted by telephone and given an opportunity to add to or amend the information they had provided about the specific case of impasse. Data were analyzed using a consensual process methodology.

Therapists described impasses as ongoing disagreements with clients about the process of therapy rather than as single negative events that brought progress to a stop. Therapists experienced negative emotions, such as frustration, disappointment, anger, hurt, confusion, and less self-efficacy and reported that their clients also expressed negative emotions in response to the impasses, including anger, impatience, confusion, and discomfort. About an equal number of the initial therapeutic relationships were described as good, limited/superficial, or poor. However, differences in the sequence of events in

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the impasses did not appear to be a function of the quality of the initial relationship. Moreover, in contrast to what the clinical literature has indicated, there was no clear evidence indicating that a poor therapeutic relationship contributed to the development of impasses. Hill et al. (1996) speculated that it might have been difficult for therapists to recall over time what the initial relationship was really like.

Results did support previous findings associating impasses with disagreement about tasks and goals of therapy, therapist mistakes, transference, countertransference, and situational issues. All therapists in the Hill et al. study reported that clients disagreed with treatment strategies or were dissatisfied with progress on their goals. All therapists reported they may have made mistakes, such as being too confrontative, too supportive, not supportive enough, losing objectivity, being unclear, being inconsistent, or making an inaccurate diagnosis. However, technical blunders were not reported, and general therapist incompetence did not appear to be a typical issue in the impasses.

Most of the therapists mentioned transference issues in their reports of impasses. They believed that their clients expected them to behave in a similar way as the clients' parents, such as angry, controlling, or abusive. Countertransference issues were also implicated in most of the impasse experiences. Several therapists reported difficulty with issues related to families of origin, and others reported having problems with clients whose hostile, irrational, or complaining behaviors reminded the therapists of their own parents. Some therapists reported other personal issues, such as current life stressors and a need to take of their clients, as possible factors in their impasses.

There also was evidence that triangulation, a factor not previously discussed in the

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literature, played a role in impasses. That is, another person, either someone close to the client or another therapist, often interfered with the therapy. In one case, therapy reached an impasse for a client who wanted his therapist to decide for him whether he should get married for a second time. When the client's girlfriend suggested that therapy was going nowhere for him, he began to feel as if he had to choose between the therapist and his girlfriend.

This study also confirmed the observation of Rhodes et al. (1994) that therapists were unaware of client dissatisfaction until clients abruptly terminated therapy. Finally, there was some support for two other sources of impasses mentioned in the literature: power struggles and mismatches. All of the therapists reported power struggles over the tasks and goals of treatment, and some of the relationships that were initially poor and never improved appeared to be mismatched cases.

Limitations of the Hill et al. (1996) study were a low return rate, which limited the sample's representativeness of experienced therapists, and the retrospective nature of the therapists' reports, which may have caused "narrative smoothing," or a forgetting of the actual details of the cases. Also, how clients would have described the impasse experiences remains unknown, as the researchers examined only therapists' perspectives.

In summary, although therapeutic impasses have been recognized as a common and harmful occurrence in therapy, we have minimal empirical data supporting the factors that have been theorized to contribute to them. As Table 1 shows, reports by clinicians exceed empirical findings of various sources of impasses. The purpose of the present study was to extend current understanding of how impasses develop and to gain particular

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Table 1

Proposed Client, Therapist, and Relationship Factors in Therapeutic Impasses

Factors	Clinically observed	Empirically observed
Client factors		
client pathology		Hill et al. (1996)
flight into health	Kluft (1992)	
noncompliance	Weiner (1982)	
reality factors	Pulver (1992) Weiner (1982)	
regression after improvement	Pulver (1992)	
resistance	Weiner (1982)	
shame	Pulver (1992)	
transference	Atwood, et. al. (1989) Elkind (1992) Nathanson (1992) Pulver (1992) Weiner (1982)	Hill et al. (1996)
Therapist factors		
countertransference	Elkind (1992) Nathanson (1992) Pulver (1992) Weiner (1974)	Hill et al. (1996)
failure to clarify practical arrangements of therapy	Pulver (1990)	

(table continues)

Factors	Clinically observed	Empirically observed
Therapist factors		
lack of knowledge	Kluft (1990)	
lack of awareness of client's negative feelings		Rhodes et al. (1994)
therapeutic technique incorrectly applied	Weiner (1982)	
unwillingness to discuss client expression of negative feelings		Rhodes et al. (1994)
Relationship factors		
disagreement over tasks and goals	Nathanson (1992) Pulver (1992) Omer (1995) Weiner (1974)	Hill et al. (1996) Safran et al. (1990)
interaction of therapist and client subjective experiences	Atwood et al. (1989)	
interaction of therapist and client unconscious defenses	Elkind (1992)	
mismatched therapist and client (poor relationship)	Elkind (1992) Kluft (1992)	Rhodes et al. (1994)
triangulation		Hill et al. (1996)

insight into more severe impasses by examining clients' perspectives on impasses that ended when they quit therapy.

Attachment in the Therapeutic Relationship

Since problems in the relationship between clients and therapists are often cited by clinicians as potential factors in the development of impasses, it seems logical to devote attention to clients' perspectives of the therapeutic relationship. In contrast to the literature on therapeutic impasses, there is a substantial body of theoretical and empirical literature that informs our understanding and investigations of the therapeutic relationship. Within this literature, attachment theory has recently emerged to explain relationship processes in therapy.

Attachment theory describes the affectional bonds that evolve in childhood between an infant and caregiver. Bowlby (1988) theorized that children have an innate tendency to form attachments to their principal caregivers, usually parents, who serve as a secure base from which to explore the physical and social environment. The infant and caregiver form a relationship characterized by a set of infant proximity-seeking behaviors and caregiver responses intended to maintain proximity. Internalization of early attachments affects a child's self-concept and expectations of others. Bowlby believed these internal "working models" involve a child's sense of worthiness of care from others and expectations of whether or not others will be responsive to the child's needs. Bowlby argued that working models may be revised with the forming of new attachments, thereby maintaining continuity in attachment style as a person matures and forms adult relationships. Bowlby's theory was empirically investigated by Ainsworth, Blehar, Waters,

& Wall (1978), who developed the "Strange Situation" as a structured method of observing infants' attachment behaviors. In the Strange Situation, infants were placed in a laboratory playroom and observed in several conditions via a one-way mirror. The conditions included exploration of the playroom in their mothers' presence, a brief separation from and reunion with their mothers, time alone in the playroom, and exposure to an unfamiliar adult. From these observations, Ainsworth et al. identified three styles of attachment: (a) Secure children explored the playroom using their mothers as a base, exhibited some anxiety and sought proximity during separation, and were easily comforted upon the mothers' return; (b) Anxious-avoidant children explored without using their mothers as a secure base, showed little distress when their mothers left, and avoided their mothers when they returned; and (c) Anxious-ambivalent children were immediately apprehensive in the unfamiliar setting, became distressed when their mothers left, and displayed both contact-seeking and tantrums upon their mothers' return. These attachment styles were thought to represent differences in infants' perceptions of the availability and responsiveness of the caretaker in time of need. Ainsworth (1989) has suggested that, while attachment forms the basis of early relationships, attachment behavior also continues throughout life.

In recent years, researchers have extended attachment theory to adulthood. Hazan and Shaver (1987) translated descriptions of the three infant attachment styles into a categorical measure of adult attachment to investigate whether adult love and work have functional similarity to attachment and exploration in infancy. Participants completed a questionnaire on job satisfaction and selected one of three brief paragraphs describing a

secure, avoidant, or anxious orientation that best matched their feelings and behavior in romantic relationships. Results revealed that attachment styles among adults exist in proportions similar to those found in studies of infants. Securely attached participants approached work with confidence and valued their relationships, anxious-ambivalent participants tended to allow love concerns to interfere with work performance, and avoidant participants used work to avoid social interactions. One limitation of the Hazan and Shaver measure is that the assessment of attachment with a single-item instrument raises the possibility that other constructs are being measured.

The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985), an hour-long semi-structured interview, was developed to assess parenting style in terms of the parent's attachment history. Transcriptions of interviews are used to assign participants to autonomous (secure), enmeshed (anxious), detached (avoidant), or unresolved (disorganized) attachment categories. Studies using the AAI have demonstrated an association between parents' attachment style and their relationships with their children.

Noting that adults identified as avoidant by the Hazan and Shaver self-report measure and the AAI had different levels of distress, Bartholomew and Horowitz (1991) speculated that a single avoidant category might not capture different patterns of avoidance in adulthood. To investigate this idea, they proposed a 4-category model of adult attachment style based on Bowlby's (1973) suggestion that working models of self differ in term of self-image and image of others. Bartholomew and Horowitz's defined four attachment categories associated with distinct interpersonal problems: secure, dismissing, preoccupied, and fearful. To test the model, a semi-structured interview was

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used to assess participants' correspondence to each of the four attachment styles in their current adult relationships and early family relationships. Attachment ratings resulting from the interviews corresponded with the model and were validated by self- and friend-reports of self-concept and interpersonal functioning. Participants in both avoidant categories, fearful and dismissing, reported having difficulty developing close and trusting relationships, but only fearful participants displayed consistent social insecurity and lack of assertiveness. Bartholomew and Horowitz showed that in interpersonal relationships, acceptance of self and acceptance of others are separate dimensions in how adults orient themselves to close relationships and that the two dimensions can vary separately.

Lopez (1995) warned that results of research on adult attachment should be viewed with caution due to inconsistencies among assessment methods. Lopez argued that because the AAI and Hazan and Shaver's self-report measure emphasize different aspects of attachment, different attachment models are probably being assessed. He also noted that the single-item Hazan and Shaver measure has questionable stability and that existing continuously scaled measures of attachment offer only slightly better stability. Furthermore, across-study comparisons are difficult because both three- and four-category attachment models are used to assess attachment.

Nevertheless, attachment theory may provide a framework for understanding client pathology and formulating clinical interventions (Bowlby, 1988; Dolan, Arnkoff, & Glass, 1993). Recent research has shown that adult attachment styles may be associated with differences in ability to realize change in therapy (Horowitz, Rosenberg, & Bartholomew, 1993), and it has been suggested that the therapeutic relationship is a form of adult

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attachment in which the therapist serves as a secure base from which clients explore their internal worlds and relationships with others (Pistole, 1989; Sable, 1997).

For example, Sable (1997) described a client who, having been raised by demanding and critical parents who did not fulfill her attachment needs, asserted as an adult her need for a close emotional commitment so strongly that she sabotaged relationships with men, which left her anxious about her ability to form secure relationships. In therapy, she experienced an all-accepting attachment with the therapist in which to reexperience suppressed memories and emotions and revise her internal representations. Eventually, she was able to feel less fearful about attachments with others and more deserving of healthy adult relationships.

Viewing the therapeutic relationship as a type of attachment prompted development of the Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, & Coble, 1995). The CATS is a self-report pencil-and paper measure that was developed to identify client feelings and attitudes toward their therapists from an attachment perspective. In addition to the acceptable reliability and validity of the CATS, an advantage of using this measure in the present study was that it is relatively brief (36 items), which complemented the lengthy and in-depth interviews conducted with participants.

Three CATS subscales were derived that appear to measure distinct aspects of clients' attachment relationship to their therapists. Classification of clients is based on levels on all three subscales. Clients classified as secure experienced the therapist as emotionally responsive, sensitive, understanding, and promoting a secure base from which

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to explore frightening or troubling events. Clients in the preoccupied-merger category desired more contact and to be "at one" with the therapist. Preoccupation with the therapist and therapist's other clients and a desire to expand the relationship beyond the bounds of therapy typified these individuals. Clients classified as avoidant-fearful suspected that the therapist was disapproving, dishonest, and rejecting if displeased. These individuals were reluctant to be self-disclosing in therapy, and felt threatened, shameful, or humiliated in sessions.

The possible relation of therapeutic impasses to attachment as assessed by the CATS is suggested in the patterns of client attachment observed by Mallinckrodt et al. (1995) following concurrent validity and cluster analyses on the CATS. Clients who scored as securely attached to their therapists also scored high on measures of positive working alliance, good object relations capacity, and a strong sense of self-efficacy. These clients were viewed as having a highly positive working model of others and a fairly positive working model of self. Thus, impasses in therapy seem less likely for securely attached clients.

Preoccupied-merger clients formed a fairly good working alliance with their therapists, tended to depend on others, and had serious object-relations deficits. Mallinckrodt et al. speculated that these clients had a negative working model of self and a positive working model of others and suggested that forming a working bond was easier for these clients than agreeing on the tasks or goals of therapy. Since disagreement on tasks and goals in therapy has been frequently mentioned as a source of impasses (Atwood, Stolorow, & Trop, 1989; Hill et al., 1996; Kluft, 1992; Omer, 1995; Pulver,

1992; Weiner, 1974), it would not be surprising to observe impasses among clients with a preoccupied-merger attachment style.

The poorest working alliance was reported by avoidant-fearful clients. These clients felt a need to feel emotionally connected to their therapists but also exhibited social incompetence and distrust of relationships. Hence, it seems logical that impasses for these clients would emerge from the negative working alliance and be quite difficult to resolve. Indeed, Mallinckrodt et al. (1995) surmised that avoidant-fearful clients, having a strongly negative working model of self and of others, were not likely to voluntarily remain in therapy for long.

In summary, research using a range of different measures of attachment has generally supported the theory that early affectional bonds endure into adulthood where they continue to shape interpersonal behavior. In recent years attachment theory has been applied to investigations of adult romantic relationships, close adult friendships, parenting styles, change processes in therapy, and the therapeutic relationship. Of the variety of attachment instruments developed to assess adult attachment styles, the CATS stands out as having particular relevance to investigations of impasses between clients and therapists.

To conclude, there has been much speculation about the causes and consequences of therapeutic impasses. Empirical research, although sparse, has provided limited support for factors theorized by clinicians as potential sources of impasses. Even less is known about the thoughts, feelings, and reactions of those who encounter impasses in therapy. Therefore, empirical research is needed that not only identifies sources of impasses but also examines the subjective experience of impasse. In the present study, we believed that

it would be especially helpful to investigate clients' perspectives on impasses that lead to clients dropping out of therapy, since clients rarely reveal their dissatisfaction with therapy before quitting treatment (Hill et al., 1996; Rhodes et al., 1994). Moreover, we thought that assessing clients' style of attachment to their therapists would offer insight into the development and consequences of impasses for different types of clients.

CHAPTER 3

Statement of Problem

Impasses in therapy that are not resolved typically lead to clients quitting treatment before the goals of therapy are achieved. Not all impasses take this course, but the destructive potential of impasses calls for a greater understanding of how they develop so that therapists can make appropriate interventions before they pass the point of being able to be resolved. The purpose of this study was to examine the factors associated with unresolved therapeutic impasses.

The few previous investigations related to impasse that considered clients' experiences relied on observer ratings of therapy sessions (e.g., Safran et al., 1990), on responses to questionnaires by clients who were also therapists or therapist trainees and who may have had a unique perspective on therapy (Rhodes et al., 1994), or on interviews with therapists (Hill et al., 1996). Therefore, the present study extended the current literature by using in-depth interviews with clients, rather than observer ratings or questionnaires, to obtain client accounts of impasses. In contrast to session ratings by independent observers, interviews have the advantage of obtaining information directly from participants. Furthermore, interviews typically are superior in promoting thorough recall and exploration by participants of events.

A consensual qualitative research approach (Hill, Thompson, et al., 1997) has been used in recent empirical studies on therapeutic impasses (Hill et al., 1996; Rhodes et al., 1994) and also seemed appropriate for the present investigation. In this qualitative

approach, all data are collected with a semi-structured interview, and a team of researchers examines the data and formulates by consensus ideas about the phenomenon in question. This method is useful when researchers are interested in exploring the thoughts, feelings, and experiences of the participants in therapy rather than deriving a quantitative representation of events. Hill et al. (1997) contended that the results of consensual qualitative research are often directly relevant to practice. Hence, using this approach to examine clients' experiences with unresolved therapeutic impasses was expected to help clarify an especially difficult problem faced by clinicians.

The primary purpose of this study was to investigate clients' experiences of therapeutic impasses that led to them quitting therapy. Questions that were addressed were: (a) How do therapeutic impasses evolve? (b) What factors are associated with unresolved impasses? (c) How do unresolved impasses affect clients' perceptions of their therapists and therapy? (d) Why are some clients reluctant to express dissatisfaction with therapy to their therapists? (e) What are the consequences of unresolved impasses during and after therapy?

A secondary purpose of this study was to examine clients' perspectives of impasses in terms of their attachment styles. The central question was (a) Do therapeutic impasses evolve differently for clients with different styles of attachment to their therapists? Related questions included (b) Do factors that are associated with unresolved impasses differ according to client attachment styles? (c) Are the affects of unresolved impasses on clients' perceptions of their therapists associated with clients' attachment styles? (d) Is clients' willingness to express dissatisfaction with therapy associated with attachment style? (e)

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What are the consequences of unresolved impasses on clients with different attachment styles? Table 2 shows the correspondence of the primary and secondary research questions to the interview questions and the attachment measure.

Table 2

Research Questions and Corresponding Interview Questions

Research Questions	Interview Questions
Primary questions	
How do therapeutic impasses evolve?	15. Please describe how the impasse developed.
	(probe) When during the course of therapy did you become aware of the impasse?
	(probe) How long were you in an impasse with your therapist before you left therapy?
What factors are associated with unresolved therapeutic impasses?	16. What circumstances in your life may have contributed to the impasse?
	17. What other factors may have contributed to the impasse?
	26. At the time of the impasse, how did your therapist behave or seem similar to other significant people in your life?
	27. In what ways do you think your therapist was contributing to the impasse?

Research Questions	Interview Questions
	28. In what ways do you think you were contributing to the impasse?
	14. Please describe the therapeutic impasses.
	20. At the time of the impasse, what did you understand to be the problem?
	21./22. What feelings were typical for you during/after sessions?
	29. At the time of the impasse, how aware did you think your therapist was of the impasse?
How do unresolved impasses affect clients' perceptions of their therapists and therapy?	23. How did your feelings about your therapist change after the impasse developed?
	24. How did your feelings about therapy in general change after the impasse developed?
Why are some clients reluctant to express dissatisfaction with therapy to their therapists?	30. To what extent did you and your therapist discuss the situation?

(table continues)

Research Questions	Interview Questions
	(probe) Who brought it up?
	(probe) What did you tell your therapist about your feelings?
	(probe) What would it have taken for you to discuss the impasse with your therapist?
What are the consequences of unresolved impasses for clients during and after therapy?	32. How much did you think about the impasse outside of your therapy sessions?
	18. What effect did the impasse have on your therapy sessions?
	19. What effect did the impasse have on your goals for therapy?
	41. How do you feel about the impasse now?
	(probe) What have been the ongoing effects of the impasse on your life?
	42. Would you seek (or have you sought) further therapy?

(table continues)

Research Questions	Interview Questions
Attachment-related secondary questions	
Do therapeutic impasses evolve differently for clients with different styles of attachment to their therapists?	Question 15 and CATS results)
Do factors associated with unresolved therapeutic impasses differ according to client attachment styles?	Questions 14, 16, 17, 20, 21/22, 27-29 (and CATS results)
Are the affects of unresolved impasses on clients' perceptions of their therapists associated with clients' attachment styles?	Question 27 (and CATS results)
Is clients' willingness to express dissatisfaction with therapy associated with attachment style?	Questions 30-33 (and CATS results)
What are the consequences of unresolved impasses on clients with different attachment styles?	Questions 18, 19, 32 41, 42 (and CATS results)

Note. CATS=Client Attachment to Therapist Scale (Mallinckrodt, et al., 1995).

CHAPTER 4

Method

Participants

Eleven former therapy clients were interviewed for this study. Participants were recruited through advertisements placed in 20 local newspapers and on bulletin boards at a major East Coast university. The participants ranged in age from 27 to 63 years ($M =$ 38.45, $SD = 10.39$) and included 9 women (7 Caucasian, 1 Latina, and 1 African American) and 2 men (both Caucasian). Participants met with therapists in private practices ($n = 7$) and clinics ($n = 4$), and the therapy that they discussed lasted from 8 to 180 months ($M = 43.10$, $SD = 55.21$). The last session of therapy occurred from 1 to 27 months ($M = 11$, $SD = 8.90$) prior to this study. Presenting problems (non-mutually exclusive) identified by participants were relationship issues ($n = 7$), depression ($n = 3$), ACOA issues ($n = 1$), bereavement issues ($n = 2$), career issues ($n = 2$), sexual abuse ($n = 2$), and eating disorder issues ($n = 1$).

Researchers

Four researchers participated in this study. The primary research team consisted of the principal investigator (a 41-year-old Caucasian man), and two other people (a 32-year-old Caucasian woman and a 28-year-old Caucasian woman). Team members were doctoral students in a counseling psychology program. A 49-year-old Caucasian female counseling psychologist with 23 years of postdoctoral experience in research and therapy served as the auditor responsible for checking the work of the primary team.

Prior to collecting data, the three primary researchers and the auditor noted their

biases regarding impasses in psychotherapy and their expectations of how they might respond when reading participants' reports of their impasse experiences. By stating their biases ahead of time, the researchers hoped to be more aware of them and to be more objective during data analysis. Three of the research team members expected that transference, countertransference, client resistance, and therapists' empathic misses or other therapist errors would be factors in the impasses described by participants. Failure to set or agree on the goals and tasks for therapy were predicted by two of the researchers to play a role in the impasses, and one researcher believed lack of competence with multicultural issues would play a role in impasses. In addition, one researcher expected impasses would evolve partly from situational events in the client's lives, whereas another team member suggested that a series of negative events in therapy would lead to impasses, and this might make the team member suspicious of participants who reported impasses that happened suddenly.

All of the researchers believed that participants would report that they did not tell their therapists they were unhappy with therapy, which two of the researchers said might make them feel critical or not very understanding of the clients. On the other hand, another team member expected to empathize with participants who reported trying to smooth things over with the therapist in reaction to an impasse, and another researcher anticipated being sympathetic to those who felt dominated by and angry at the silent, withholding therapists.

All of the researchers thought that there would be distinct differences in the descriptions of impasses according to participants' attachment styles. Two researchers

associated an "avoidant" style with repression of feelings and tendency to quit therapy sooner than securely attached clients. One team member suggested that avoidant types would report distrust of the therapeutic relationship, and one researcher believed avoidant types would have impasses that involved therapists doing too much and dominating sessions. Finally, one researcher predicted that disagreement over therapeutic goals would be an issue for clients with a "merger" attachment style, whereas another researcher believed merger types would report impasses that involved not getting enough from their therapists.

Measures

Client Impasse Interview. The Client Impasse Interview was developed for this study to serve as a guide for conducting semistructured interviews. After the interview was drafted by the principal investigator, the other two judges provided feedback. Three pilot interviews were conducted and revisions were made based on feedback. The interview questions (see Appendix A) were intended to provide a framework for conducting the interviews and to ensure that key areas were covered by the interviewer in every interview. The questions were open-ended to promote exploration and more thorough recall by participants. The interviewer also used unstructured probes as was necessary to elicit additional information about particular cases. The questions covered five broad areas: (a) demographic information about the client, (b) demographic information about the therapist, (c) general information about the client's therapy, including number of sessions, the setting for therapy, presenting problems, and ultimate focus of therapy, (d) the therapeutic relationship, including clients' feelings and attitudes

toward their therapists, and (e) specific information about the impasse (including events in therapy and in the clients' life leading up to the impasse, how the client might have contributed to the problem, how the client believed the therapist contributed to the problem, client emotions associated with the impasse, how the client coped with the situation, the degree to which the impasse was discussed in therapy, how the impasse affected the client's life, the outcome of therapy prior to the end, and how the experience affected the client's view of therapy).

Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, & Coble, 1995). The CATS is a 36-item self-report measure that assesses clients' feelings and attitudes toward their therapists from an attachment perspective (see Appendix B). Responses are made on a 6-point scale that ranges from strongly disagree (1) to strongly agree (6). Six items (1, 11, 17, 23, 9, 30) are reverse scored (i.e., 6=1, 5=2, 4=3, 2=1). The CATS is scored by summing the items for each subscale. Higher scores indicate more Secure, Avoidant-Fearful, and Preoccupied-Merger attachments.

Factor analysis identified three subscales. The Secure subscale consists of 14 items and measures the extent to which clients experience their therapist as responsive, sensitive, understanding, and emotionally available; feel hopeful and comforted by the therapist; and feel encouraged to explore frightening or troubling events. The Avoidant-Fearful subscale consists of 12 items and measures a client's suspicion that the therapist is disapproving, dishonest, and likely to be rejecting if displeased; reluctance to make personal disclosures in therapy; and feelings of being threatened, shamed, and humiliated in the sessions. The Preoccupied-Merger subscale consists of 10 items that measure a client's longing for more

contact and to be "at one" with the therapist, wishing to expand the relationship beyond the bounds of therapy, and preoccupation with the therapist and therapist's other clients. Internal consistency (alpha) coefficients for the Secure, Avoidant-Fearful, and Preoccupied-Merger subscales were .64, .63, and .81, respectively. Test-retest reliability coefficients for the Secure, Avoidant-Fearful, and Preoccupied-Merger subscales were .84, .72, and .86, respectively.

Evidence of concurrent validity of the three subscales was demonstrated. The Secure subscale was significantly positively correlated with all three subscales (emotional bond, agreement on tasks, agreement on goals) of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) and negatively correlated with the object relations deficit subscale of the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, Billington, & Becker, 1986). The Fearful-Avoidant subscale was significantly negatively correlated with the WAI and significantly positively correlated with the object relations deficit subscale of the BORRTI. The Preoccupied-Merger subscale was positively correlated with the WAI emotional bond subscale and the BORRTI object relations deficit subscale. The Avoidant-Fearful subscale was negatively correlated with the general and social subscales of the Self-Efficacy Scale (SES; Sherer, et al., 1982), while the Preoccupied-Merger subscale was negatively correlated only with the SES general self-efficacy subscale.

Further evidence of construct validity was demonstrated by the patterns of client attachment to therapists found in a cluster analysis conducted on the CATS using the three CATS subscales and clients' ratings of the working alliance. Four clusters emerged and

were labeled Secure, Reluctant, Avoidant, and Merger. Subsequent analyses were performed in which expected patterns emerged. Secure clients reported positive working alliances and had high scores on the CATS Secure subscale. Reluctant clients reported relatively high working alliances and scored high on both the CATS Secure and Avoidant-Fearful subscales. Avoidant clients reported very low working alliances and scored high on the CATS Avoidant-Fearful subscale. Merger clients reported high working alliances and scored high on the CATS Preoccupied-Merger subscale. Object relation deficits and lower levels of general self-efficacy were evident in the avoidant and merger clusters, although merger clients rated themselves as less socially incompetent that avoidant clients. The reluctant cluster had lower levels of object relations deficits than did the avoidant cluster, and clients in the secure cluster had relatively low levels of object relations deficits.

In the present study, clients were instructed to respond to the CATS items according to how they felt about their therapists prior to the emergence of the impasse. Accordingly, the CATS items were reworded from the present tense to the past tense, and the word "counselor" was changed to "therapist" to be more consistent with the language of therapy used during the interviews (e.g., "My counselor isn't giving me enough attention" was modified to, "My therapist wasn't giving me enough attention.").

Procedure

Recruitment of participants. Participants were recruited through advertisements placed in local newspapers, on bulletin boards at large East Coast university, and on notice boards in several local community centers and cafes. The ad (see Appendix C) targeted

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adults who recently quit therapy feeling angry, frustrated, hurt, or disappointed after reaching an impasse with their therapists. Potential participants were instructed to call a phone number where a recorded message requested that they leave their first name, phone number, and a time to have their call returned. The primary investigator then contacted these respondents by phone to explain the nature of the study and administer a brief screening survey (see Appendix D) to confirm that (a) they had experienced an impasse in recent therapy, (b) they had terminated treatment prematurely feeling angry, disappointed, or frustrated with their therapists, (c) their last session of therapy was no longer than 12 months ago, (d) they were in therapy for at least six months, and (e) they had not returned to therapy. Respondents who did not meet the screening criteria were informed that their experiences did not match the needs of the project and thanked for their time. As a courtesy to respondents who did not participate in the study, a referral to a local therapist was offered. None of these respondents accepted this offer.

Respondents who met the screening criteria were advised of the general goals of the study and of the requirements of participation. Respondents were told that the interviews would be audiotaped and that their responses would be kept confidential. Willingness to complete a 36-item attachment questionnaire was determined. Respondents who expressed interest in participating were then scheduled for the first telephone interview. Mailing addresses were obtained to send participants a letter describing the study (see Appendix E), an informed consent form (see Appendix F), and the attachment measure (see Appendix B). In the first 7 months of the study, 14 persons out of 33 respondents met the screening criteria and were scheduled for interviews.

However, of those persons, 3 did not respond to their scheduled interview phone calls and were dropped from the study when they did not reply to requests to reschedule. Interviews conducted with 6 participants revealed that they were not suited for the study for reasons not discovered during the screening interview (4 participants had disagreements with psychiatrists about medication and had not been in talk therapy, 1 participant had only a vague recall of an impasse that occurred 3 years ago, and 1 participant described an initial mismatch rather than an impasse that developed during the course of therapy). These participants were dropped from the study. The remaining 5 participants who were interviewed about their impasses were retained as appropriate cases. Thus, of the original 29 respondents, 5 were included in the study.

Obtaining enough participants was difficult because of the need to turn down respondents who did not meet the highly specific criteria for participation and because of a low response rate to recruitment efforts. Thus, after 7 months, recruitment was modified in several ways. First, rather than automatically eliminate anyone whose impasse occurred more than 12 months ago, respondents' ability to recall details of an impasse was assessed on a case-by-case basis during the screening call. The stipulation that participants had not been back in therapy since the impasse was retained so that recall was not contaminated by a more recent experience with therapy. Second, respondents were asked whether they had been in "talk therapy" to ensure that no one was accepted for an interview who had seen a psychiatrist primarily for medication. Third, "cash incentive" was mentioned in new recruitment ads, and respondents were informed in the screening call that they would receive $20 for completing the impasse interviews and returning the attachment measure.

During 6 months of advertising and screening with the modified procedures, 10 of 35 respondents passed the screening criteria, and of those respondents, 6 completed the requirements of participation and were included in the study.

Interviews. Prior to beginning the first interview, participants were reminded that the interview would be audiotaped. The principal investigator then conducted the interview using the Client Impasse Interview. During the interview, notes were taken as a precaution against tape-recorder malfunction. Field notes about the interview (see Appendix G) were made by the interviewer during and after the interviews. These notes included observations of the flow of the interview, overall tone of responses, questions asked by the client, interruptions, and problems. At the conclusion of the interview, a second interview (see Appendix H) was scheduled for approximately 1 week later. Participants were advised that the purpose of the second interview was for the interviewer to ask follow-up questions and to provide participants an opportunity to express further thoughts on their impasse experience and to clarify, amend, or expand information they provided in the first interview. The principal investigator listened to the tapes of the first interviews for each case to determine follow-up questions. First interviews were in-depth and ranged in duration from 60 to 80 minutes (M = 69.55, SD = 8.80). Follow-up interviews mainly served to clarify or elaborate on material covered in the first interview and ranged in duration from 10 minutes to 30 minutes (M = 19.27, SD = 6.77).

During the interviews, the principal investigator was prepared to politely end the discussion and offer referrals to local therapists if the recall of painful memories of therapy or other issues caused obvious distress for the participant. However, none of the

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participants exhibited obvious distress during the interviews. In addition, participants were advised in the description of the study and during the first interview that therapist referrals were available. Two participants accepted this offer and received names of several local therapists.

Data Analysis

Training of research team. The principal investigator was experienced in Consensual Qualitative Research (CQR; Hill et al., 1997) methodology and trained the other two research team members in this approach to analyzing interview data. After the judges read Hill et al., which describes the CQR approach, the principal investigator conducted a training session consisting of an in-depth review of the procedures. Training material included sample data (i.e., interview transcripts without identifying information) and results from a previous study that used the CQR method.

Data preparation. The interview tapes were transcribed by undergraduate psychology students. The principal investigator checked the accuracy of the transcripts by reading them while listening to the tapes.

Data coding. Following the Consensual Qualitative Research approach, all judgments about the interview data were made by unanimous agreement of the three primary research team members. The work of these "judges" was checked by the fourth researcher, who served as the "auditor." Coding proceeded one case at a time (each case consisted of the transcripts of the first and follow-up interviews of a participant).

In the first step of the coding process, each judge independently read the transcripts of the same case and assigned related phrases or sentences from the interview

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data to topic categories, called "domains." The 13 broad domains from the Hill et al. (1996) study on therapists' recall of therapeutic impasses were relevant to this study and, therefore, served as the initial domains. Several times during the coding process, the names of the domains were changed or new domains were added to more accurately represent the data that emerged from the interviews. For example, when the judges observed that participants described their reactions to impasses in terms of emotions and behaviors, the domain, "client reactions to the impasse" was replaced by two domains, "client feelings associated with the impasse" and "how clients addressed the impasse," because the researchers believed these domains helped to represent two distinct aspects of the clients' reported experiences. The final 12 domains were: (a) client background, (b) presenting problems or focus of therapy, (c) therapy before the impasse, (d) description of the impasse, (e) client factors associated with the impasse, (f) therapist factors associated with the impasse, (g) relationship factors associated with the impasse, (h) outside factors associated with the impasse, (i) how client addressed the impasse, (j) how therapist addressed the impasse, (k) client feelings associated with the impasse, and (l) impact of the impasse on clients' view of therapy.

Assigning the interview data to domains was accomplished by writing the name of a domain in the margin of the transcript next to the relevant data. After each judge assigned all the data in a case to these domains, the three judges met as a team to discuss their codings until consensus was reached on the best placement of data under the domains. This process was repeated individually for all 11 cases in this study.

Core ideas. Next, each judge independently examined the raw interview data in

each domain in a case and wrote summary statements, called "core ideas," representing what they believed was the essence of the participant's responses in the domain. At this stage of the analysis, the objective was not to interpret what the participant said, but to represent the client's perspective as concisely as possible. For example, under the domain, "therapist factors associated with the impasse," one participant's statement, "I really felt like she had a hard time hearing what I was saying. I did start talking, saying little things about it, and I feel like she had a hard time hearing what I'd say," was summarized as, "Therapist did not seem to hear client's perspective." The number of core ideas written for each domain in a particular case depended on the amount of interview data that was assigned to the domain. After independently formulating their core ideas, the judges met and discussed their work until they reached consensus on the best wording of the core ideas under the domain. Again, to ensure that they were not adding their own perspectives to the participant's responses, the judges consistently referred to the raw interview data to justify the wording of core ideas and reminded one another to be wary of the intrusion of expectations and biases. When the core ideas for an entire case had been formulated, the principal investigator typed the resulting "consensus version" of the case. This consisted of the name of the first domain, under which was typed the core ideas for that domain and the corresponding interview data, followed by the name of the second domain, and so on for the 12 domains.

Audit. The next step was to submit the consensus version of the case to the auditor, who inspected the judges' work. Since the auditor was not part of the consensual process, it was hoped that this step would bring an objective eye to the analysis. The

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auditor first assessed whether the raw interview data had been appropriately assigned to the domains. Next, the core ideas were examined to make certain that judges had summarized all the important data in the interview and that the wording of the core ideas accurately and concisely captured what the participant reported. The auditor's written suggestions then were reviewed in a meeting of the judges, who decided as a team which suggestions to accept. Although the judges were not obligated to accept any of the auditor's comments, some amendments were made to the consensus version of every case based on the auditor's suggestions. A copy of the revised consensus versions and the auditor's original suggestions were returned to the auditor, who reviewed the judges' responses and, in a few cases, made additional suggestions or reiterated suggestions that had not been adopted by the team.

Cross-analysis. In the final step of the analysis, the judges examined the revised consensus versions to identify similarities in core ideas within the domains across cases. Specifically, each judge independently read the material in the same domain for all cases and decided how the core ideas could be grouped or clustered into categories. The judges met and discussed their categories until they reached consensus that best represented the core ideas in the domain. For example, the core ideas in the "therapy before the impasse" domain suggested five categories: some parts of the relationship were positive, therapy was productive, client and therapist did not formalize the therapeutic goals, client and therapist had similar beliefs, and client and therapist discussed goals. After agreement was reached on the names of the categories for a domain, the judges worked separately on assigning each core idea in the domain to one of the categories.

Next, the judges met to discuss their assignments of core ideas until they achieved consensus on the best arrangement of ideas under the themes (see Appendix I). For example, in the "therapy before the impasse" domain, the judges agreed that the core idea, "client believed that she was getting something from therapy" from one case and "therapy was occasionally fun and productive" from another case fit appropriately in the category, "therapy was productive" (in fact, core ideas from 9 cases were placed under this theme). The auditor reviewed the categories and placement of core ideas and provided feedback to the judges, who used the feedback to revise the cross-analysis.

CHAPTER 5

Results

It should be noted that the results reflect only the clients' perspectives of the impasse cases examined for this study. Having the reports of the therapists would provide additional data that, in all likelihood, would alter the findings.

To determine whether the categories resulting from the cross-analysis would change with the addition of more cases, a stability check (Hill et al., 1997) was conducted. That is, although data were collected on all 11 cases, the analyses initially were done on only 9 cases, after which the remaining cases were analyzed and added to the results. No major changes to the findings occurred as a result of adding the new cases, which suggests that the results were stable and generally described the experience of impasses for these cases.

Analysis of the interview data generated 12 domains that were grouped on a chart (see Table 3) under three broad mega-domains: (a) Background (including data about the client, presenting problems, and the therapy prior to the impasse); (b) Description of the Impasse (including clients' descriptions of the impasse, factors associated with the impasse, and the actions taken by the client and therapist in response to the impasse); and (c) Impact of the Impasse (including clients' feelings during the impasse and the effect of the impasse on clients' views of therapy). Categories representing similarities in the core ideas of the data across the 11 cases were place under the appropriate domains. Following Hill et al.'s (1997) criteria, a category was described as general if it applied to all 11 cases, typical if it applied to 6 to 10 cases, and variant if it applied to 2 to 5 cases. Categories

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that applied only to 1 case were dropped from further consideration. Table 3 shows the results of the cross-analysis.

In addition, the results were examined to determine whether differences existed in the results between clients who participated in the study without receiving an incentive and those who were paid for their participation (see Procedure). Out of the 47 categories represented in Table 3, differences between the groups were found in only 1 category, "Client had previous negative experiences with therapy." Specifically, five of the six clients who reported previous negative therapy experiences were among those participants who were recruited with an offer of a case incentive. This difference will be addressed in the Discussion.

Background

There were three domains in this group: Client background, presenting problems or focus of therapy, and therapy before the impasse.

Client Background

Clients typically reported having negative relationships with their parents and other relatives (e.g., one client described her father as emotionally distant and not interested in talking with her and her mother as verbally abusive and critical of her). Clients also typically indicated that they had previous experiences in therapy that were negative in terms of the therapeutic relationship (e.g., one client quit previous therapy after only a few sessions because the therapist seemed to not pay attention to the client).

In addition, there were three variant categories that related to client background

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Table 3
Results of Cross Analysis

Background		
Client Background	Presenting Problems or Focus of Therapy	Therapy Before the Impasse
1. Client had previous negative family relationships (T)	1. Client presented with intrapersonal issues (T)	1. Some part of relationship were positive (G)
2. Client had previous negative experiences with therapy (T)	2. Client presented with relationship issues (T)	2. Therapy was productive (T)
3. Client was previously depressed or suicidal (V)	3. Client presented with work-related issues (V)	3. Client and therapist did not formalize the therapeutic goals (V)
4. Client had previous positive experience with therapy (V)		4. Client and therapist had similar interests and beliefs (V)
5. Client had positive self-view (V)		5. Client and therapist discussed goals (V)

Table 3
Results of Cross Analysis

	Description of the Impasse	
Description of the Impasse	Client Factors Associated with the Impasse	Therapist Factors Associated with the Impasse
1. Progress in therapy seemed to stop or plateau (G)	1. Client had difficulty addressing dissatisfaction to therapist (T)	1. Therapist seemed unempathic or did not listen to client (G)
2. Client questioned the benefit of therapy (T)	2. Client had difficulty addressing certain issues in therapy (T)	2. Therapist was critical or dismissive of client (T)
3. Relationship felt distant (T)	3. Client's issues, personality style, or behavior impeded progress (T)	3. Therapist's business management or motives bothered client (T)
	4. Client had possible transference reactions to therapist (T)	4. Therapist's own issues interfered with therapy (T)
	5. Client did not have clear therapeutic goals (V)	5. Therapist's limitations interfered with therapy (V)
		6. Therapist would not discuss problems in the therapeutic relationship (V)

(table continues)

Table 3
Results of Cross Analysis

Description of the Impasse		
Relationship Factors Associated with the Impasse	Outside Factors Associated with the Impasse	How Client Addressed the Impasse
1. Client and therapist differed over focus or amount of guidance or depth of sessions (T)	1. Other people influenced client's perspective on the impasse (T)	1. Client withdrew in session or cut back on the frequency of sessions (T)
2. Relationship was hampered by cultural differences or dissimilar interests and perspectives (V)	2. Cost influenced client's decision to quit (V)	2. Client tried to give therapy a chance (T)
3. Boundary between professional and personal relationship became blurred (V)		3. Client talked with others about the impasse or sought help or information outside of therapy (T)
		4. Client thought about and reflected on the impasse (T)
		5. Client brought up the impasse with therapist (V)

(table continues)

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Table 3
Results of Cross Analysis

Description of the Impasse	Impact of the Impasse	
How Therapist Addressed the Impasse	Client Feelings Associated with the Impasse	Impact of the Impasse on Clients' View of Therapy
1. Therapist did not directly acknowledge the impasse (G)

2. Therapist encouraged client to return to therapy (V) | 1. Client had negative feelings directed toward therapist (G)

2. Client had negative feelings in general about the impasse (T)

3. Client felt guilty or blamed self for not being a good client (V)

4. Impasse did not have a big impact on client (V) | 1. Client might return to therapy but would do things differently (T)

2. Client became disenchanted with therapy or therapist after impasse (T)

3. Impasse did not change client's view of therapy (V) |

Note. (G) = general, applies to all 11 cases; (T) = typical, applies to 6 to 10 cases; (V) = variant, applies to 2 to 5 cases.

and characteristics: client had previous positive experience with therapy (e.g., brief therapy on two occasions had been helpful and ended well for one client), client was previously depressed or suicidal (e.g., one client reported being hospitalized when she was suicidal), and client had a positive self-view (e.g., one client viewed herself as a mentally healthy person without major problems).

Presenting Problems or Focus of Therapy

Presenting problems typically were intrapersonal and interpersonal in nature. Clients typically mentioned seeking therapy to deal with low self-esteem, grief, depression, anger, childhood, or recent sexual abuse. In one case, the client was at risk of losing her job due to problems associated with anorexia and her depression following a sexual assault. Clients also typically had problems in relationships with parents or romantic partners. For example, one client indicated that she sought treatment to deal both with anger in her relationships with men and with her parents. Work-related issues (e.g., career indecision) were mentioned in the only variant category related to presenting problems.

Therapy Before the Impasse

A positive therapy relationship in which progress was being made on the clients' problems was a selection criterion for this study. And, in fact, the clients in all 11 cases, indicated that, prior to the impasse, some aspects of the therapy relationship were positive. That is, clients generally felt comfortable with their therapists and believed that their therapists cared about them. For example, one client was comfortable talking with her therapist and believed that they had a good rapport. Another client said she trusted the therapist, who seemed competent and interested in the client.

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Furthermore, therapy was typically productive before the impasse. That is, clients typically could point out ways in which they benefitted from therapy before they began to sense that progress had come to a halt. For instance, therapy helped one client resolve issues related to his relationship with his father and reduce his anxiety when dealing with authority figures.

In addition, there were three variant categories related to therapy before the impasse. First, some clients indicated that they did not formalize the therapeutic goals with the therapist. For example, in one case the client needed immediate help with a crisis, so discussion of goals never occurred. Second, a few clients indicated that they shared similar beliefs and interests with their therapists. For instance, one client believed that the therapy relationship was good because she and the therapist were both African American women and Christian. In the third variant category, a few clients reported that they discussed goals for therapy with the therapist. For example, the first three sessions in one case were spent discussing goals.

Description of the Impasse

The seven domains in this group comprised the central focus of the study: clients' perspectives on their impasse experiences. The seven domains included description of the impasse, client factors associated with the impasse, therapist factors associated with the impasse, relationship factors associated with the impasse, environmental factors associated with the impasse, how the client addressed the impasse, and how the therapist addressed the impasse.

Description of the Impasse

In describing the impasse, every client noted that progress in therapy seemed to stop or reach a plateau. For example, therapy was characterized by one client as having lost momentum, whereas another client described therapy as coming to a standstill. Therapy felt like a waste of time to one client who also reported feeling that she had been spinning her wheels for a while. Thus, without exception, clients in this study reported that after experiencing varying degrees of progress, they began to sense that they had reached an impasse.

Clients also typically indicated that they had questioned the benefit of therapy. One client recalled that although he initially believed that therapy was beneficial and effective, he began to think that therapy was a waste of money. Similarly, another client stated that she thought therapy was a waste of time and money and that something was wrong.

In addition, clients typically reported that the therapeutic relationship felt distant at the time of the impasse in contrast to the relationship before the impasse. For example, one client sensed that the therapist's approach was uniform across cases, which made the client feel less connected to the therapist and feel that the therapist didn't care about him personally. In another case, the client described the relationship as strained but cordial.

In discussing the impasses all clients reported that they eventually quit therapy when they realized that the impasses would not be resolved. Since no interview question specifically asked clients to talk about how they actually ended treatment, the extent to which the issues of termination might have been discussed with their therapists is not

known for every case. However, most clients simply indicated that therapy ended abruptly when they stopped going to sessions.

Client Factors Associated with the Impasse

Clients typically indicated that it was difficult for them to address their dissatisfaction with therapy or with their therapists. That is, it was typical for clients not to confront or question the therapists or to express anger or disappointment. For example, when recalling how she might have contributed to the impasse, one client stated that she did not feel comfortable enough to confront the therapist about what she did not like about her behavior. Although she believed that she should have defended herself more, this client had been taught to submit to authority and not to be confrontational and argumentative, which she later thought might have caused her to remain in therapy even when there was an impasse.

In addition to having difficulty expressing their dissatisfaction with therapy or the therapist, clients typically reported having difficulty addressing certain issues in therapy. In one case, the client acknowledged that he had been closed-minded and fearful in therapy about what he might discover if he confronted difficult issues. Similarly, another client reported being fearful of exploring possible childhood sexual abuse. She also believed that her denial about her parents' role in her problems limited what the therapist could understand about her family dynamics and that she might have stopped working in therapy because she did not have it in her to explore her problems further.

Clients provided evidence of possible transference reactions during the impasses, as they typically mentioned that they reacted to their therapists in similar ways that they

had reacted to other significant people in their lives. For example, one client stated that she had been very sensitive to criticism by her therapist because her mother was critical of her. Indeed, this client believed that the therapist responded negatively toward her in the same way that both her parents did. In another case, the client accepted advice from the therapist that she didn't agree with in the same manner that she obeyed without question her domineering and intimidating aunt.

Clients' issues, personality styles or behaviors also typically were associated with the impasses. One client believed that her talkativeness and need to plan ahead what she would talk about in sessions might have kept her therapist from asking questions. Another client admitted being a "difficult" client who wanted to be at the center of the therapist's attention. Relatedly, another client suggested that her sensitivity and insecurity might have caused her to take her therapist's opinions too personally and made it hard for her to handle the problems of therapy. Finally, one client placed her envy of the therapist's life at the core of the impasse.

Clients' lack of clear therapeutic goals was the only variant category in this domain. For instance, one client who described himself as goal-oriented, began therapy without clear goals, which contributed to his frustration with therapy.

Therapist Factors Associated with the Impasse

Typically, clients reported that their therapists seemed unempathic or did not listen to them. Some clients simply said that their therapists lacked understanding of their issues. Others described therapist behaviors or interventions that clients perceived to indicate lack of interest in their concerns or that seemed irrelevant to their issues. For

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example, in one case, an anorexic client reported that the therapist minimized her weight gain and did not seem to understand her need to gain weight gradually. Another therapist failed to read a journal the client gave her, which made the client angry. The nonverbal behaviors of another therapist, including a tendency to watch the clock during sessions, suggested to the client that the therapist was not paying attention.

Another therapist factor that was typically mentioned by clients was that therapists seemed critical or dismissive of them. A vivid example was provided by a client who said that her dissatisfaction with therapy peaked when she let down her usual defenses, became emotional in session, and then felt put down by the therapist, who remarked that client usually spoke of silly things rather than deep issues.

Clients also typically indicated that their therapists' own issues seemed to interfere with therapy. For example, in one case the therapist talked in sessions about her boyfriend and other personal issues instead of discussing the client's issues. In another case, the client believed the therapist's issues with her own father obstructed therapy.

Finally, clients typically described questionable therapist business management or motives, including fee increases announced without advance notice, fees that seemed too high, clashes over clients' ability to pay, and therapists' prolonging treatment to retain business. In one case, the client believed that her therapist manipulated her into staying to support the therapist's new private practice.

The variant therapist factors in this domain were therapists' limitations, such as a therapist who had minimal knowledge of the alternative therapies that interested the client, and therapists' apparent unwillingness to discuss problems in the therapeutic relationship,

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which included a therapist who refused to discuss the diagnosis she gave to the client.

Relationship Factors Associated with the Impasse

Disagreement over the structure of therapy was the most typical relationship factor mentioned by clients. For example, the impasse in one case centered on disagreement about how to explore the client's issues with her father and, specifically, whether the client should attempt to express anger toward him. In addition, several clients indicated that they wanted more in-session guidance from their therapists, who preferred to be less directive. In recounting her impasse in therapy, one client explained that the therapist did not acknowledge the client's need for structure and instead encouraged her to free-associate. This client tried unsuccessfully to bring focus to the sessions by coming with charts and lists related to her goals.

One variant category in this domain was that the relationship was hampered by cultural differences or dissimilar interests and perspectives. For example, one client believed that she didn't connect with or feel warmth from the therapist because the therapist belonged to a cultural group that made the client uncomfortable. Another variant category was that the boundary between professional and personal relationship became blurred. In one case, although the relationship had the feeling of friendship, it also felt confusing and awkward to the client because the therapist limited her self-disclosures.

Outside Factors Associated with the Impasse

Clients typically reported that other people in their lives influenced their perspectives on the impasse. Specifically, friends, spouses, and parents expressed opinions or chose sides in respect to the problems between the client and therapist. For example,

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the husband of one client questioned why she stayed in therapy after the impasse developed, whereas another client's partner took the therapist's side and told the client she should accept what the therapist told her. In another case, the client's mother urged her to find a different therapist. A variant category in this domain was that in a few cases, the cost of therapy influenced the clients' decision to quit, such as in the case of a client who could not justify the expense of non-productive therapy at a time that she felt poor and needed to move to a new apartment.

How Clients Addressed the Impasse

The most typical client action in response to the impasse was to withdraw in session or cut back on the frequency of sessions. For example, one client indicated that she only went through the motions of therapy, stopped and started therapy several times during the final year of treatment, and kept her feelings about the impasse to herself. Similarly, another client began cancelling appointments or coming late to sessions because she felt sick when she thought of going and did not want to see the therapist.

Another typical client action in response to the impasse was to try to give therapy a chance rather than to immediately terminate therapy. For example, one client thought that if she just trusted the therapist and went along with the therapist's agenda, they could resolve the impasse. In another case, the client spent five months deciding whether to quit because she believed she needed therapy and respected the therapist's opinions.

Clients also typically talked with others about the impasse or sought information or help outside of therapy. Clients turned to significant others, friends, and colleagues for support; read about the problems they could not discuss with their therapists; or consulted

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with other therapists. In one case, the impasse prompted the client to join a therapy group, where she sought the validation that her therapist did not provide in individual therapy.

The only variant client action in response to the impasse was to raise the issue with the therapist. For example, one client told the therapist she was frustrated with therapy, and another told her therapist that she was not making progress.

How Therapists Addressed the Impasse

All of the 11 clients reported that their therapists did not directly acknowledge the impasse, even though in most cases the client suspected that the therapist was aware of the problem. For instance, one therapist's remark that the client was emotionally distant signaled to the client the possibility that the therapist was aware of the client's dissatisfaction with therapy. Another therapist acknowledged the client's distress but would not discuss the impasse. The only variant therapist action occurred in two cases in which the therapists encouraged their clients to return to therapy after they decided to quit.

Impact of the Impasse

The domains in this group were client feelings associated with the impasse and impact of the impasse on clients' views of therapy.

Client Feelings Associated with the Impasse

In every case in this study, the client reported having negative feelings directed toward the therapist during the impasse. Anger was mentioned in all but one case. For example, one client recalled that she felt angry that her therapist could help her with other

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issues but not with the impasse. When this client quit, she also felt angry that her therapist made her feel ungrateful. Another client said she was still angry about the impasse two years after she left therapy.

Clients typically reported other negative feelings, including hopelessness, despair, confusion, resentment, frustration, disappointment, and hurt. Variant feelings associated with the impasse included guilt or self-blame for not being a good client. Another variant client response in this domain was indication that the impasse did not have a big impact.

Impact of the Impasse on Clients' View of Therapy

Typically, clients said that they became disenchanted with therapy or their therapists after the impasse. For example, one client became disappointed as his view of the therapist changed from seeing the therapist on a pedestal to seeing him as an ordinary person. Fear of becoming entrenched in ineffectual long-term treatment led another client to conclude that she would not seek therapy again. Another client noted that before seeking therapy she would first use self-help books and talk to friends. In fact, clients typically indicated that the might return to therapy in the future, but would do things differently if they did return, such as making sure that goals were discussed and clarifying payment issues up front.

The only variant category in this domain came from two cases in which the clients believed that the impasse did not change their views of therapy. In one case, the client reported that she still had a generally positive view of therapy.

Client Attachment to Therapist

Clients' total score on each of the three CATS subscales were compared to the

mean scores and standard deviations provided by Mallinckrodt et al. (1995). On the Secure subscale, clients who scored at least .5 standard deviation below the mean were classified as low secure, and clients who scored at least .5 standard deviation above the mean were classified as high secure. On the Avoidant-Fearful subscale, clients who scored at least .5 standard deviation below the mean were classified as low avoidant-fearful, and clients who scored at least .5 standard deviation above the mean were classified as high avoidant-fearful. On the Preoccupied-Merger subscale, clients who scored at least .5 standard deviation below the mean were classified as low preoccupied-merger, and clients who scored at least .5 standard deviation above the mean were classified as high preoccupied merger.

The classification of clients on the Secure subscale of the CATS indicated that eight clients were low in secure attachment and three clients were in the moderate range on secure attachment. On the Avoidant-Fearful subscale, nine clients were high in avoidant-fearful attachment to their therapists. Scores for two clients were in the moderate range on avoidant-fearful attachment. On the Preoccupied-Merger subscale, three clients were high in preoccupied-merger attachment to their therapists, five clients were low in preoccupied-merger attachment, and scores for three clients were in the moderate range on preoccupied-merger attachment. The three clients who were classified as high on the Preoccupied-Merger subscale were also high on the Avoidant-Fearful subscale.

The finding that the Preoccupied-Merger attachment subscale showed variation in terms of the number of clients classified as either higher (n = 3) or lower (n = 5) than average allowed for further inspection of the cross-analyses on the basis of these

classifications. Hence, the cross-analyses were examined to identify categories in which the number of high preoccupied-merger clients and the number of low preoccupied-merger clients in any category differed by at least 40 percent (a priori deemed a large difference). Eight categories met this criterion.

Specifically, all clients who scored high on preoccupied-merger attachment had previous negative therapy experiences in contrast to only two of the low preoccupied-merger clients. Also, more high than low preoccupied-merger clients believed that they shared similar beliefs with their therapists. In addition, all clients who were high on preoccupied-merger attachment reported a blurring of professional and personal boundaries in the therapy relationship, whereas only one client with low preoccupied-merger attachment reported boundary problems. Finally, more high than low preoccupied-merger clients indicated that they responded to the impasses by thinking or reflecting about them.

In contrast, more low than high preoccupied-merger clients described the therapeutic relationship as distant during the impasse and had difficulty addressing certain issues in therapy. Also, more low than high preoccupied-merger clients believed that other people influenced their perspectives on the impasses.

<u>Narrative Examples of Therapeutic Impasse Experiences</u>

<u>Example 1: Mr. A</u>

<u>(Attachment style: low secure, high avoidant, low preoccupied-merger)</u>

The client, "Mr. A," began therapy when he was in his early 50s, deeply depressed, emotionally withdrawn, and a self-described workaholic. His physician, who was treating

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Mr. A for high blood pressure, advised him to seek therapy. The client had been in brief therapy twice in the past, and in both instances the therapy was helpful and ended smoothly. Believing that self-development is a lifelong process, Mr. A followed his doctor's advice and began psychoanalysis with a female analyst who was five years his senior.

Initially, Mr. A believed that the analyst was a good therapist and that she genuinely cared for him and was interested in helping him. Although they did not set specific goals, they agreed that his "success" was a general objective. Prior to the impasse, their relationship was based on mutual respect. Mr. A, a former writer with a hunger for philosophical discourse, was impressed that the analyst had studied with Anna Freud. Likewise, she seemed to appreciate Mr. A's vocabulary and intellect, and she respected his need to remain somewhat autonomous and self-determined.

Mr. A's recollection of his initial feelings about his therapist and therapy were somewhat contradictory. On the one hand, he recalled that he liked her and that the early years of therapy were productive and contributed to his overall self-improvement. On the other hand, he also reported that, in the beginning of therapy, he did not feel that he could relax or trust the therapist, and that she never "connected" with him. His discrepant memories might reflect the ambivalence he experienced about whether to stay in therapy after the impasse emerged.

However, his memory about therapy as the impasse emerged was clear. He recalled that sessions began to feel "like a waste of good effort by two otherwise pretty decent people." One of the problems seemed to be a conflict of dissimilar interests and

perspectives. His liberal views clashed with the analyst's conservative views, and he took exception to her occasionally offensive language. In addition, he wanted more guidance in therapy, but her style was "free-form" and without direction.

Another problem was that communication between the therapist and Mr. A became marred by what he termed "a series of complete verbal disengagements" that indicated to him that the therapist was not listening. As Mr. A reported, "I would talk about things, and her response, when she did respond, would seem to me so irrelevant, so off-the-wall, as if she . . . had a set of earphones on and she was listening to a soap opera or something." When he tried to discuss the problem, the therapist made it clear that their poor communication was his failure.

The therapist also was critical of Mr. A's profession and of his attempts to free-associate in session. He was especially upset when she rejected his interest in reading the works of Freud because she told him that Freud could only be understood in German and since Mr. A could not read German, it would be useless for him to read Freud's works. The therapist's advancing age and diminishing energy also seemed to be related to the problems in therapy. Although she took notes and was engaged in their early sessions, she did not seem to be working very hard in the last few years. Indeed, the medication she was taking at one point in the relationship caused her to sleep during their sessions, and Mr. A. was disturbed that he had to keep her awake.

With regard to his role in the impasse, Mr. A was ignorant of the process of analysis when he began and did not have clear goals in mind. In therapy, his emotional withdrawal, distrust of the therapeutic relationship, defensiveness, and desire to be more in

control of himself also impeded progress. In addition, early in therapy, he expected that the therapist would be a mentor and the "Jewish mother" he never had, and he felt that she failed to fulfill these needs. In retrospect, he believed that he reacted to her in a manner that paralleled his non-communicative relationship with his mother.

The impasse raised many negative feelings in Mr. A. He felt confused when the therapist rejected his interest in Freud, crushed by her non-empathic response to his disclosure of a missed job opportunity, and frustrated that they were not able to communicate effectively. Mr. A also was very angry with her because he felt shortchanged by therapy, and she continued to make him angry even in their last sessions when she tried to convince him to stay in treatment. The impasse also stirred up negative feelings about himself during the impasse. For example, he recalled that he felt "drenched in guilt" about his inability to free associate to the therapist's satisfaction.

However, after eight years of analysis, Mr. A found it hard to quit therapy, even though colleagues suggested that he find a different therapist. His difficulty with terminating stemmed from a tenacious nature that prevented him from giving up his commitment to analysis, and he was worried that if he quit he would end up "going from one analyst to another."

Hence, by the last year of therapy, he had developed several strategies for coping with the situation, such as this tactic for making sessions less tedious: "I would say a buzz word or two, and she would respond in ways that I knew were so predictable, and she would talk and talk in a way that would pass the time and get us through the hour." He also coped by reducing the number of weekly sessions, and he found other ways to work

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on the self-improvement that he believed therapy was no longer providing, such as reading, doing volunteer work, and re-establishing contact with his family.

Finally, Mr. A began to see that the situation was hopeless when the therapist was hospitalized with a brain aneurysm and he consulted with another therapist. Together they decided that Mr. A should be focusing on his future instead of doing the retrospective work of analysis. Thus, when the analyst returned to work after being ill, Mr. A brought up the impasse with her, but she replied that the problem represented his unresolved issues rather than an impasse and that all he needed was more analysis. She insisted on picking up where they left off despite his desire to focus on current and future issues.

Although he knew that he should leave, Mr. A spent a few more months in therapy resisting the therapist's attempts to continue traditional analysis. During this time he suspected that her brain aneurysm had caused some cognitive deficits, so he asked her if she planned to be re-certified to practice. When she dismissed his concern and claimed to be in good shape, he made up his mind to quit.

The impasse experience left Mr. A with ambivalent feelings about therapy. He respected the analyst and recalled therapy as intellectually stimulating and crucial in improving his mental and physical well-being, but it was difficult to reconcile his positive feelings with his sense of frustration, distance, and distrust of the therapist. As he observed, "I would be so bloody frustrated. I'd go out of there saying that I'm spending $17,000 a year on this, and I just can't stand it. I just can't justify it to myself. . . And you know, I knew she was a good person, a good doctor."

Narrative Example 2: Ms. B

(Attachment style: moderate secure, high avoidant, high preoccupied-merger)

The client, "Ms. B," was a 49-year-old clinical social worker who originally was seeing a supervisor for consultation regarding her own clients. Because Ms. B was in crisis over the end of a romantic relationship, had problems in family relationships, and needed help with issues related to low self-esteem, sex, autonomy, and self-actualization, she asked the supervisor to see her as a client. Previously, she had been through two episodes of individual therapy to help her deal with her failing marriage; the first therapist, a male, was not helpful, so she switched to a female therapist and had a more successful experience. Prior to seeing the most recent therapist, she also had participated in group therapy but dropped out because she did not get enough individual attention.

Ms. B felt an immediate connection to the therapist, who was supportive, easy to talk to, and empathic. Ms. B felt awe, respect, and love for the therapist. Indeed, she reported that she put a great deal of emotion into their relationship. She also believed that the therapist liked her and that they worked well together. At the beginning of therapy, they agreed on Ms. B's goals to have a financially successful psychotherapy practice, get remarried, and achieve greater independence.

The impasse in this case emerged after 11 years of therapy. Ms. B described the impasse as feeling that she wasn't getting anywhere with her issues and that she had given up. Although she traced the beginning of the impasse to the therapist's rejection of her belief that she was bipolar and needed medication, she acknowledged that her intense envy of the therapist's successful practice, wealth, and family was the heart of the problem. As

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she struggled to revive her own therapy practice, make more money, and improve her personal relationships, the therapist's own business and private life seemed to get better and better, which made Ms. B angry and intensified her jealousy.

Even so, Ms. B also cited her strong affection for the therapist as a factor in the impasse. Indeed, she described herself as loving the therapist, wanting to "fuse" with her and "swallow" her, and wishing they were sisters. Moreover, she viewed the therapist as a combination of her brother and sister, whom she envied, and of her mother who, like the therapist, was not validating and made her feel "invisible."

Regarding the therapist's contribution to the impasse, Ms. B reported that the therapist seemed unempathic and did not listen to her when she complained that she wasn't making progress. The therapist also disregarded Ms. B's financial concerns, dismissed her interest in alternative forms of therapy, and criticized her for wanting to lose weight and have plastic surgery. As Ms. B recalled, "I felt that I was sinking and she was getting a better life. And I just felt rage and envy. But I loved her."

At the time of the impasse, Ms. B believed that the therapist's own issues made her manipulative, opinionated, arrogant, demanding, draining, and controlling in session. She also seemed self-important when she refused to consider that she had misdiagnosed Ms. B, even though two psychiatrists had told Ms. B that she should be on medication.

In addition, the boundaries of the therapeutic relationship became blurred. For example, Ms. B felt that she loved the therapist as a friend, who also related to her as if they were colleagues and friends. In session, the therapist talked more about her other clients than about Ms. B, who began to worry that she was emulating her by making

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similar breaches of confidentiality in her own business. Furthermore, she felt that the therapist was using her to meet her own relationship needs. Ms. B recalled how this affected her life outside of therapy: "I felt like she contained all of my affect. And it bothered me. I didn't feel as hungry for interaction in the world."

The therapist seemed unaware that progress in therapy had stopped, or might have chosen to ignore it. For example, when Ms. B raised the issue of the impasse with the therapist, she praised Ms. B's accomplishments thus far and urged her not to give up. To cope with her frustration, she sought validation in a therapy group, consulted with a psychiatrist who prescribed medication that lifted her depression, and read about her illness. She also spent a lot of time outside of sessions thinking about the impasse.

Four years into the impasse, Ms. B made up her mind to quit. However, rather than leave abruptly, she began cutting back on sessions and making up excuses for not coming. The last straw occurred when the therapist lost a substantial amount of weight and Ms. B felt as if she had lost her only advantage over her. Finally, unable to contain her intense envy of the therapist, Ms. B quit.

The impasse experience left Ms. B with negative feelings about therapy and the therapist. She would not seek individual therapy again for fear of becoming entrenched in long-term treatment, and she still wonders if she should sue the therapist for malpractice.

CHAPTER 6

Discussion

This chapter will address the results of this study as they relate to the research questions and the literature on unresolved therapeutic impasses, defined as "a stalemate between a client and therapist that brings progress in therapy to a halt" and results in the client dropping out of therapy. Limitations of the study, future research directions, and implications of the findings for practice will also be discussed. Only those findings identified as general and typical will be discussed. Also, because interviews about impasses were conducted only with clients and not their therapists, the findings discussed here must be considered from this perspective.

In addition, interpretation of the results must be made within the context of the background and presenting problems of the clients who were interviewed. That is, the descriptions of therapeutic impasses were provided by clients with histories of significant interpersonal problems, previous negative experiences in therapy, and insecure and avoidant attachments to their therapists, which likely made them difficult cases for their therapists and might have influenced what they recalled and chose to discuss in the interviews.

An overview of the results suggest that impasses in therapy are emotional events for clients that, when not resolved, send therapy on a downward spin. Consistent with the clinical literature on the factors associated with the development of therapeutic impasses (Bernstein & Landaiche, 1992; Elkind, 1992; Kluft, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1974, 1982), the clients interviewed for this study assigned responsibility for the

problems in therapy not only to the therapist, but also to themselves and the therapeutic relationship. Thus, while most of the clients reported that the therapists said or did something that bothered them, clients also admitted that they were reluctant to explore certain issues in therapy and that their issues or personality styles might have interfered with therapy. Progress in therapy also was impeded by disagreements about the structure and focus of therapy.

As upsetting as the impasses clearly were for the clients, few of them directly expressed their concern to the therapists, who seemed to clients to be unaware that an impasse existed. As a result, discussion about how to resolve the problem did not take place. Previous empirical studies (Hill et al., 1996; Rhodes et al., 1994) also found that therapists were unaware of the problems in therapy until their clients abruptly terminated.

Clients in the present study were highly descriptive when discussing their feelings aroused by the impasses. Anger and rage directed toward the therapist were mentioned by most clients, and other negative feelings including disappointment, frustration, hurt, resentment, confusion, and guilt were frequently reported. These results are consistent with previous clinical and empirical reports of the power of therapeutic impasses to stimulate negative feelings (Elkind, 1992; Hill et al., 1996; Weiner, 1974). It is interesting to note that as painful and disappointing as the impasse experiences seemed, many of the clients expressed willingness to seek therapy again should they need it. Thus, although the impasse left clients feeling disenchanted with therapy or the therapist, it appears that such feelings were confined to the specific relationship.

<center>The Primary Research Questions</center>

The interviews conducted for this study generated data that clustered into 12 domains that were then organized under three broad megadomains: Background, Description of the Impasse, and Impact of the Impasse. These data will be used to address the primary research questions of this study: (a) How do therapeutic impasses evolve? (b) What factors contribute to therapeutic impasses? (c) Why are some clients reluctant to express dissatisfaction with therapy? (d) How do impasses affect clients' perceptions of their therapists and therapy? and (e) What are the consequences of impasses both during and after therapy? Results will be discussed in relation to each of the questions and the existing clinical and empirical literature.

How Do Therapeutic Impasses Evolve?

The participants in this study described impasses as occurring after the work in therapy was well underway. In some cases the client was in therapy for years before encountering the impasse, while in other cases the impasse emerged within the first year of treatment. In every case, the client described the therapeutic relationship before the impasse in mostly positive terms. Clients remarked that they felt comfortable with their therapists, that they and their therapists seemed to like each other in the beginning of therapy, and, by most accounts, that communication between them was good.

Thus, the therapeutic relationship appears to have been generally sound prior to the impasse. In fact, therapy also was described as productive by most clients, who recalled that they were making progress on their presenting problems or therapeutic goals before encountering the impasse. For example, one client remembered that therapy helped

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him make a "profound change" in the way he viewed things. These findings are important to the discussion of how therapeutic impasses evolve because they establish the presence of two pre-impasse characteristics that are implicit in the definition of impasses derived for this study from the existing literature (e.g., Elkind, 1992; Nathanson, 1992; Safran et al., 1990): (1) a therapeutic relationship existed and, (2) progress was taking place in therapy.

Therefore, it seems fair to conclude that clients in this study did not report on therapy that simply never got off the ground due to initial mismatches with their therapists. Instead, clients' descriptions of the deterioration of therapy were consistent with the definition of an impasse as "a stalemate between a client and therapist that brings progress in therapy to a halt" as opposed to a single event. Indeed, clients recalled a variety of factors, including events in previous and most recent therapy, that took a cumulative toll and eventually arrested the therapeutic work. Also, the impasses in these cases were unresolved, which, by definition, resulted in the clients deciding to drop out of treatment.

Clients' accounts of how they became aware that therapy was at an impasse also fit previous clinical descriptions and empirical findings related to how impasses evolve (Elkind, 1992; Hill et al., 1996; Pulver, 1992; Safran et al., 1990; Weiner, 1982). The feeling that therapy had plateaued, that therapy suddenly felt like a waste of time, or that the client was not getting anywhere on the therapeutic goals was frequently expressed by clients in this study. For example, after many years of productive therapy, one client felt that therapy had become non-productive, even though he believed he had more work to do on his issues. The reports provided by clients in the present study confirmed previous observations that the development of impasses is characterized by a sense of futility and

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frustration that the therapeutic process had come to a standstill (Elkind, 1992; Pulver, 1992; Weiner, 1982).

As the impasses evolved, clients in the present study also questioned the benefit of therapy and sensed that the therapeutic relationship began to feel distant. This finding contrasts markedly with the positive descriptions of the pre-impasse relationship provided by every client. Although it is not clear from clients' reports whether distance in the relationship was a precipitant or product of the impasse, a transformation occurred that clients clearly associated with the impasse.

Similarly, Hill et al. (1996) noted a deterioration of an initially good therapeutic relationship. Perhaps the clients and therapists in these studies took the early positive alliance for granted. Indeed, these findings underscore the need for therapists need to be aware that even an initially positive relationship can take a negative turn. Although therapist training addresses the importance of the therapeutic relationship, it seems that much of this training emphasizes how to develop a positive therapeutic relationship (Ward, 1984) rather than monitor the relationship over time. The present findings highlight the need of training programs to emphasize also the importance of actively attending to the relationship throughout treatment.

Client attachment and therapeutic impasses. Information about client background variables, presenting problems, and attachment styles for each case provided the context for understanding the development of the impasses. The most noteworthy background variables typically found among the clients in this study were their history of negative relationships with parents, previous negative experiences in therapy, and current

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interpersonal problems. When these findings are considered along with Ainsworth's (1989) assertion that attachment patterns formed in early relationships continue throughout life, it is not surprising that most clients in the present study were found to be low in secure attachment to therapists and high on avoidant-fearful attachment to therapists. Indeed, characteristics of Mallinckrodt et al.'s (1995) avoidant-fearful attachment style were observed in these impasse cases: distrust of the therapist, fear of rejection, reluctance to self-disclose, and poor working alliances. These findings indicate that clients with insecure adult attachments may be at greater risk for impasses in psychotherapy than clients who have secure attachments.

All of the clients in the present study also presented serious intrapersonal issues (e.g., depression, anxiety, personality disorders, sexual abuse). Severity of client pathology was among client background variables reported in Hill et al.'s (1996) investigation of impasses in therapy, and Elkind (1993) suggested that pathology may be a contributing factor in some cases of impasses. Although a causal relationship between client pathology and therapeutic impasses cannot be established from the present findings, it seems clear from the clients' reports that they brought difficult issues to therapy that may have helped to set the stage for the development of impasses. For example, one can speculate that therapists might have responded to these difficult cases by becoming less invested or distant in session, which led clients to view their therapists as unempathic and unaware of the deterioration in the therapeutic relationship.

An interesting and somewhat puzzling finding of the present study related to client background variables was observed when comparing the results of cases in which the

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participants received no incentive with those who were paid for their participation. Of the six clients who reported having previous negative experiences in therapy, five were among those recruited for this study with an offer of a case incentive. One might speculate that the incentive helped to attract participants who felt especially discouraged by yet another unsuccessful therapy experience and thus were less eager to talk about the recent impasse than those who were new to problems in therapy and interested in talking about it.

What Factors are Associated with Unresolved Impasses?

A primary objective of the present study was to identify variables that were associated with therapeutic impasses. The clinical literature has proposed that a variety of factors originating with the client, therapist, and therapeutic relationship contribute to impasses, but there has been minimal empirical research in this area. Previous empirical investigations of misunderstandings (Rhodes et al., 1994) and unresolved impasses (Hill et al., 1996) in therapy have provided some support for previously proposed sources of impasse, including problems in the therapeutic relationship, therapist mistakes, disagreement about the tasks and goals of therapy, transference, and countertransference (Atwood et al., 1989; Elkind, 1992; Mordecai, 1991; Nathanson, 1992; Pulver, 1992; Weiner, 1994). As the empirical studies were limited by the use of questionnaires or brief interviews to examine only clients who were therapists-in-training or therapists' accounts of impasses, the present study used in-depth interviews to obtain detailed subjective reports of clients' experiences.

Thus, clients in the present study were asked to describe how they and their therapists might have played a part in the impasses they encountered. Specifically, clients

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were asked, "In what way do you think you were contributing to the impasse?" and "In what way do you think your therapist was contributing to the impasse?" In addition, clients answered other open-ended questions such as, "What other factors contributed to the impasse?" intended to elicit recall of experiences with impasses that could be compared and contrasted with clinical reports and the Hill et al. (1996) and Rhodes et al. (1994) findings.

Client factors. Clients in this study were willing to take some responsibility for the impasses. Specifically, they acknowledged that, prior to the impasse, they had difficulty expressing their dissatisfaction to their therapists about the problems they perceived to exist in therapy. Furthermore, once they suspected that they had reached an impasse, they were reluctant to speak up. Clients indicated that their hesitancy to confront the therapist stemmed from their respect for the therapist, desire to please the therapist, or belief that the therapist's authority should not be challenged.

Clients' expression of dissatisfaction has been previously addressed in relation to the resolution of problems in therapy. For example, the model of resolution of alliance ruptures proposed by Safran et al. (1990) gave considerable weight to the expression of negative sentiments, or "rupture markers," by clients. The first step in the resolution process is for the therapist to notice these markers, which signal the need to attend to the problem. In the present study, therapists might have been less likely to notice ruptures because their clients did not express their dissatisfaction, and, therefore, resolution of the impasse was never initiated. Indeed, Rhodes et al. (1994) found that unresolved misunderstandings were characterized by therapists' lack of awareness of clients' negative

feelings. These results highlight the need for therapists to expect that clients will not openly express their feelings about them or the therapy. Future research might investigate the extent to which therapists elicit only positive feedback by conveying to clients an unwillingness to be receive negative feedback or change to meet clients' needs.

Clients in the present study admitted that they had difficulty addressing certain issues in therapy and that this may have impeded progress on their goals. Some clients speculated that they defended against exploring certain uncomfortable issues that the therapist wanted to address. For example, one client was afraid to deal with the loss of her father when she was a child, so she resisted working on the loss in therapy. Similarly, another client resisted the therapist's attempt to examine his relationship with his mother because he was fearful of saying anything negative about her. Another client was more direct in her non-compliance by adamantly refusing the therapist's request to sign a treatment plan.

Client resistance and non-compliance have been previously proposed as factors in therapeutic impasses (Bernstein & Landaiche, 1992; Gans, 1994; Weiner, 1982). In the present study, the issues that clients had difficulty addressing typically were not the same issues for which they originally sought treatment. Therefore, it appears that in these cases, impasses were associated with movement in therapy toward exploration of issues that clients had not expected to face.

Clients also typically perceived that their therapists' negative responses were similar to their critical or disapproving parents and that they reacted to their therapists as they had reacted to their parents and other significant people in their lives. Although

clients did not describe their reactions as transference per se, their comments suggest that transference reactions may have played a role in the impasses. Therapists in the Hill et al. (1996) study also identified transference as a factor in unresolved impasses, although it was not possible to assess the accuracy of the therapists' perceptions without having their clients' perspectives on the impasses.

Hence, the present findings lend additional empirical support for the role of transference in impasses previously reported (Atwood et. al, 1989; Elkind, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1974, 1982) and underscore the importance of therapists anticipating and working with client transference reactions. The therapists in the present study may have addressed transference, but this cannot be assessed without having interviewed them about these cases. These results further suggest that transference may be a particular issue in therapy with clients known to have histories of negative personal and therapeutic relationships. As such, assessing past relationship patterns, including childhood and adult attachment styles, and previous therapy experiences seems an essential part of early therapy.

Therapist factors. Most of the clients also reported that their therapists either said or did something that bothered them. Specifically, all clients perceived their therapists as lacking empathy or not listening in session. For example, one therapist repeatedly asked the same questions about the client's relationship with her boyfriend, which suggested to the client that the therapist was not listening to her answers. Another therapist seemed to not understand the client's discomfort with dating when she advised the client to try meeting men through personal ads.

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Therapists also were perceived as critical or dismissive of their clients, which raised heightened transference reactions from some clients and anger or hurt from others. For example, one therapist seemed critical of the client's tendency to joke out of nervousness when she discussed her experience with childhood sexual abuse, which only caused the client to refrain from discussing the issue further. Of course, in interpreting this and other clients' reports, it is not possible to assess exactly how critical and unempathic the therapists were or how much of clients' perceptions about their therapists were due to transference issues. Thus, one of the limitations of this study (which will be addressed later) is not having the therapists' perspectives on the impasses, which highlights the need for future studies that examine both therapists' and clients' views.

Drawing inferences about the therapist factors reported by clients is difficult without therapists' perspectives, which were not the focus of this study. However, if clients' perceptions were accurate, therapists' lack of empathy or tendency to be critical in these cases might have occurred because of the difficulty that therapists had working with these particular clients. Perhaps these clients pulled for negative responses from therapists who otherwise were more empathic and understanding. Conversely, clients' pathology might have distorted their perceptions of therapists who, in fact, were empathic and not as critical as reported in the interviews. Difficult clients notwithstanding, these results highlight the importance, in some cases, of therapists seeking supervision to help guard against possible countertransference behaviors.

Clients also believed that their therapists had personal issues that interfered with therapy. Specifically, several clients thought that their therapists were dealing with family-

of-origin issues and personal relationship problems that affected their objectivity. Two therapists were perceived by clients to have problems in the relationships with their fathers, and another therapist talked about her boyfriend in sessions with the client. One client's assertiveness seemed to intimidate the therapist, whereas another therapist's narcissism seemed to be behind her prohibiting the client from exploring methods of therapy that differed from the therapist's.

Therapist family-of-origin issues and difficulty dealing with challenging clients were also observed by Hill et al. (1996) and have been mentioned by clinical authors (Elkind, 1992; Nathanson, 1992; Weiner, 1974). Indeed, the awareness of clients in this study of their therapists' personal issues suggests that therapists might have been careless with self-disclosure. Although recent studies (Barrett & Berman, in press; Knox, Hess, Petersen, & Hill, 1997) have suggested that therapist self-disclosures may provide clients with new insight or perspectives, improve the therapeutic relationship, and make therapists seem more human, these studies also indicated that self-disclosures that are helpful are used infrequently and typically do not provide personal non-immediate information about the therapists.

The latter findings seem consistent with findings of the present study that suggested that the imprudent disclosure of personal information to clients could have detrimental effects on therapy. Indeed, some of the clients in this study reported that therapists' talking about their personal lives in session actually interfered with progress on clients' issues.

Finally, a therapist factor observed in the present study that has not been discussed

in the clinical or empirical literature was therapists' questionable business practices. Specifically, clients reported that they were troubled by therapists' poor handling of fee increases, unpleasant discussions about pay schedules, and prolonging treatment to retain business. Although these issues were not viewed by clients as central to the impasses, they contributed to clients' unpleasant feelings about their therapists. Indeed, therapists' business practices that were deemed suspect by clients may have served to "de-throne" therapists, most of whom were highly regarded when treatment began.

A contributing factor to the negative impact of therapists' business practices on therapy might stem from the managed care environment. Although the motivations behind therapists' actions in these cases are only speculative, therapists might have taken actions that seemed (or were) abrupt or insensitive to clients to fulfill the requirements of participation on the provider panels of managed care organizations. Clients' concerns with the business side of therapy highlight a need for research that examines the association of business factors, including those related to managed care, with therapeutic impasses.

Relationship factors. Disagreement over the amount of guidance and depth or focus of therapy was associated with the unresolved impasses in this study. Most clients reported not receiving enough guidance from therapists, and a few clients indicated that their therapists were too directive. In addition, clients indicated that they often disagreed with their therapists about the direction of therapy, which might have been related to clients' difficulty with discussing certain issues reported earlier. For instance, prior to the impasse in one case, the client and therapist were in agreement that therapy should focus on exploring the client's feelings toward his father. But they did not share the therapist's

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belief that the client's relationship with his mother also should be explored, and therapy became stalled over this disagreement.

Differences over the structure of therapy found in the present study are consistent with observations made by several authors (Nathanson, 1992; Pulver, 1992; Weiner, 1974; Watson & Greenberg, 1995) and empirical evidence provided by Hill et al. (1996) and Rhodes et al. (1994) that associated disagreement over the goals of therapy with impasses. Perhaps future research could build on these findings by examining session ratings of clients and therapists who either were in agreement or disagreement on the amount of structure and focus of treatment.

Clearly, disagreements over the goals of therapy undermine the need for clients and therapists to work together. Indeed, an early and influential theoretical conceptualization of the working alliance included agreement on goals and tasks and development of an emotional bond in therapy (Bordin, 1979). From the perspectives of the clients in the present cases, therapy seemed to need greater flexibility from their therapists regarding the goals, tasks, structure, and focus of therapy. Perhaps therapists needed to be more open to adjusting their style to meet clients' needs regarding the focus of therapy, the amount of in-session guidance, or the depth of exploration of certain issues when such needs are not based solely on clients' unresolved therapeutic issues. Of course, the dilemma for therapists is that pushing clients to work on certain issues could promote either growth or impasse, as could minimizing the amount of structure in therapy.

Outside factors. Other people influenced the clients' perspectives on the impasses. One mother urged her daughter to find a different therapist, and another client's husband

remarked that therapy was for crazy people and questioned why his wife would remain in therapy that was going nowhere. Some of the clients expressed the feeling that, at a time when they felt confused, frustrated, angry, or hurt by the impasse, the opinions of other people in their lives added to their distress, while some clients found the views of other people supportive and helpful. Hill et al. (1996) found evidence from therapists that clients felt "triangulated" by the interference with therapy of a partner, parent, or other therapist. That is, the clients felt that they had to choose between staying with their therapists or the other person.

Whether clients in the present study felt triangulated is not clear, but it appears that opinions about the impasses expressed by significant others carried some weight and, in some cases, added to the stress associated with the impasse. These findings suggest the need for research that examines how clients' relationships outside of therapy influence therapy process and outcome.

How Do Unresolved Impasses Affect Clients' Perceptions of Their Therapists and Therapy?

In addition to the general negative emotions previously associated with impasses (e.g. Elkind, 1992; Weiner, 1974), negative feelings about therapists were experienced by every client in the present study, from the client who felt rage toward her therapist for not helping her improve her life to the client who was angry that his therapist fell asleep in sessions. In describing how the impasses influenced their perceptions about their therapists, clients also used such words as dislike, annoyed, disappointment, distrust, and pity. The comment of one client that "I lost the woman I originally went to see,"

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suggested that the client thought that the therapist somehow changed during the course of treatment.

Clients' perceptions of therapy during the impasse also became negative. Therapy was described as feeling empty, hopeless, uncomfortable, and frustrating. Some clients became disenchanted with therapy, such as one client who said he lost the optimism he had about therapy before the impasse. Another client predicted that she would have difficulty trusting another therapist after her impasse experience.

These descriptors present a remarkable contrast to the positive impressions of therapists and therapy that clients reported having prior to the impasses. The only previous empirical evidence associating therapeutic impasses and clients' negative perceptions of their therapists came from clients who themselves were therapists or therapists-in-training (Rhodes et al., 1994) or from therapists' perceptions of their clients' feelings about them (Hill et al., 1996). However, although impasses in the present study appeared to have had a powerful and detrimental effect on client's perceptions, the assumption cannot be made that impasses caused clients' to have negative sentiments about their therapists. Perhaps there were other factors (e.g., particular events in therapy, lack of outside support, or client pathology), that contributed to clients' negative emotions. Future research might examine causal relationships among negative feelings and therapeutic impasses.

In addition to clarifying the possible impact of impasses on clients' views of therapy, these results suggest that clients have strong feelings associated with their views of therapy and of their therapist. To some extent these findings are hopeful, as therapists

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who attend to changes in clients' emotions may be able to detect changing views about therapy that can be addressed before (or after) an impasse develops.

Why Are Some Clients Reluctant to Express Dissatisfaction with Therapy to Their Therapists?

The reports in this study of clients' hesitancy to confront their therapists about the problems in therapy provide support for the tendency of clients to hide their dissatisfaction as reported in previous research (Hill, Thompson, & Corbett, 1992; Hill et al., 1996; Regan & Hill, 1992; Rennie, 1994; Rhodes et al., 1994). Not only were most of the clients in the present study reluctant to mention that they perceived problems in therapy, fewer than half of them reported that they raised the issue of the impasse with their therapists.

In explaining why they did not voice their concerns, several clients indicated that their respect for the therapist's authority prevented them from speaking up about what they did not like about therapy. For example, one client said that she had been taught to submit to authority and not to be confrontational or argumentative. Another client said that a combination of her low self-esteem and awe of the therapist prevented her from telling the therapist she was unhappy about the lack of progress in therapy. Clients also indicated that they generally had difficulty with confrontation, did not believe they could change the therapist, or wanted to please the therapist by appearing satisfied with the course of treatment. Thus, the cases in this study suggest that clients stifled their negative sentiments about therapy out of deference to the therapists' perceived authority, difficulty with confrontation, belief that speaking up would not make a difference, and desire to

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please the therapist.

What Are the Consequences of Impasses During and After Therapy?

The harmful consequences of therapeutic impasses were evident in clients' reports of the deterioration in the therapeutic relationship, arousal of negative feelings about themselves and their therapists, disillusion with therapy, and ultimately, the decision to quit therapy. These findings support previous reports by therapists of the negative impact of impasses on the therapeutic relationship and abrupt ending of therapy by clients (Hill et al., 1996; Rhodes et al., 1994).

Other consequences of the impasses were apparent in the way in which clients and therapists in the present study addressed the impasses. For example, most clients tried to give therapy a chance once they realized that progress was at a standstill, which is to say that quitting treatment typically was not an immediate consequence. According to one client who encountered the impasse in the fourth month of treatment, she stayed in therapy for seven months after the impasse emerged because she believed that the therapeutic relationship needed more time to develop. However, other clients expressed regret that they remained in therapy for years before quitting, including the client who, after 11 years with her therapist, stayed four more years in non-productive therapy.

The apparent resilience of clients may be attributed to the ways in which they coped with the situation. For example, many of them talked with others or sought information or help outside of therapy from books, friends, or other therapists. In addition, clients typically coped by withdrawing in session or cutting back on the frequency of sessions. Prior to deciding to quit, they disclosed less to their therapists,

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kept discussions at a superficial level, and canceled appointments more often.

These results highlight for therapists the importance of watching for these and other markers of clients' dissatisfaction and intervene when they are observed. In addition, resolution of impasses might be facilitated when therapists directly address such behaviors with their clients, as has been previously suggested (Safran et al., 1990).

More than half the clients in the present study also spent time outside of sessions thinking about the impasses, which may have served as a non-threatening way to make sense of the situation in the absence of therapist involvement in addressing the problem. Indeed, clients reported that most of the therapists did not directly acknowledge and address the impasses, which suggested to clients that their therapists were not aware that impasses existed. Similarly, the therapists in the Hill et al. (1996) only became aware of the impasses after the clients announced that they were terminating, but in contrast to client reports about the therapists in the present study, most of them attempted to explore the problem with their clients.

Thus, clients in the present study took actions inside and outside therapy that appear to have provided some relief from the negative consequences of impasses as they weighed the problem prior to terminating. In regard to long-term consequences, few clients said that their experiences with impasses continued to upset them after they quit treatment. However, the impasses appeared to influence the way in which clients said that they would approach therapy in the future. Whereas the clients typically indicated that they might seek therapy again, they also suggested that they would do things differently, such as first refer to self-help books or talk with friends, use therapy only in the event of a

crisis, seek a different type of therapist, or seek non-traditional therapy. Thus, one possible "positive" consequence of the impasse may have been to clarify for clients the criteria they would use to decide whether to seek therapy and how to select a therapist.

The Secondary Research Questions

The secondary purpose of this study was to examine whether therapeutic impasses evolved differently for clients with secure, avoidant-fearful, or preoccupied-merger styles of attachment to their therapists as indicated by the CATS. In fact, few differences were found among clients in terms of their styles of attachment. That is, most clients were found to be high on avoidant-fearful attachment and low on secure attachment. These findings suggest that clients with avoidant-fearful attachments to their therapists (i.e., clients who withdraw in therapy, distrust their therapists, and are reluctant to address issues) and insecure attachment (i.e., less likely to perceive therapist as emotionally responsive and providing a "secure base" from which to explore the therapeutic goals) may be at risk for therapeutic impasses.

These findings seem reasonable, as development of the working alliance often relies on trust and requires agreement on the tasks and goals of therapy as well as development of an emotional bond (Bordin, 1979). Therefore, therapists might assess their clients' attachment style early in treatment to gain some understanding of how these styles might influence the therapeutic process. More research is needed with a larger sample that is more diverse in terms of attachment styles to determine whether most clients who experience impasses are avoidant-fearful and insecure.

Despite the overall homogeneity of the cases in this study, avoidant-fearful clients

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who also were high on preoccupied-merger attachment reported somewhat different experiences than clients who were avoidant-fearful but low on the preoccupied-merger subscale. For example, in terms of background variables, all of the "high-avoidant/high-merger" clients had previous experiences in therapy that were negative. Although it is not possible to make a causal statement about clients' previous bad therapy and the impasses in this study, this finding does suggests that these clients might have started therapy with diminished expectations or a negative "set" about how therapy would proceed. In addition, these results suggest a need for research that examines the relation of therapy outcome and previous positive and negative therapy experiences.

The "high-avoidant/high-merger" clients also described impasse experiences that reflected characteristics of both subtypes (i.e., the avoidant-fearful client's reluctance to self-disclose and perception of the therapist as disapproving, dishonest, and rejecting if displeased, and the preoccupied-merger client's desire for more contact with the therapist, desire to expand the relationship boundaries, and preoccupation with the therapist's other clients). For example, high-avoidant/high-merger clients were more likely to perceive that one of the problems in therapy was a blurring of the professional and personal boundaries in the therapeutic relationship. Whereas Mallinckrodt et al. (1995) indicated that preoccupied-merger clients' desire to expand the boundaries of the relationship, the present findings suggest that clients in the present study who were both avoidant and merger in their attachment styles might have become uncomfortable and fearful of rejection (avoidant) once the relationship boundaries began to fade or seemed threatened.

In addition, these clients believed that they shared similar interests and beliefs with

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their therapists prior to the impasse, which is consistent with the desire of clients who endorse the CATS preoccupied-merger subscale to be "at one" with their therapists. Not surprisingly, the high-avoidant/high-merger clients in the present study also were less likely to describe the relationship as becoming distant during the impasses than the "purely" high-avoidant clients. Perhaps the desire to merge with the therapist tempered the avoidant clients' tendency to perceive the relationship as distant.

Relatedly, high-avoidant/high-merger clients were less likely to have difficulty addressing certain issues in therapy. Again, these clients' desire to "merge" with their therapists by being cooperative in therapy may have facilitated the discussion of issues and minimized the development of a poor working alliance, which has been associated with the avoidant attachment style (Mallinckrodt et al., 1995).

Clients' actions in response to the impasses also seemed to take a different course for the high-avoidant/high-merger clients. Specifically, they were more likely than clients with low-merger attachment styles to spend time outside of therapy thinking about or reflecting on the impasse. Such behavior could reflect a tendency to be absorbed not only with thoughts about the therapist (Mallinckrodt et al., 1995) but also with the problems in therapy. Relatedly, these clients did not believe that they were influenced by the advice or opinions of others. Indeed, the influence of others might be more of a factor for clients who are clearly avoidant and struggling with the therapeutic relationship and, thus, more open to and persuaded by the views of other people. In contrast, clients with a compulsive preoccupation with their therapists might have minimal interest in the advice of others, regardless of the supportiveness of the advice.

In summary, the therapeutic impasses experienced by clients with both avoidant-fearful and preoccupied-merger attachment styles appear to have been especially negative. Indeed, clients' merger tendencies posed a menace to therapy that was already at risk, at least in part, due to clients' avoidant attachments to their therapists. Thus, although these results are tentative, they suggest that clients with merger and avoidant attachment styles are at greater risk than others for impasses and that assessment of the this dual attachment style early in treatment might reduce the chances of having unresolvable impasses.

Implications for Practice

Implications for practice suggested by the results of this study are tentative, since the findings represent only the clients' perspectives on the impasses that occurred in these cases. Whereas many of the clients reported that their therapists were not aware of the impasses, it is possible that, in fact, therapists were aware of the impasses and took actions that were not obvious to the clients. Furthermore, without having interviewed the therapists, we do not know the extent to which they would agree with their clients' reports of the problems that developed in therapy.

However, even without confirmation by therapists of the factors associated with the impasses, the results suggest ways in which other therapists might anticipate the development of impasses with certain types of clients or resolve impasses once they emerge. First, many clients indicated that the initially positive and productive therapeutic relationship seemed to deteriorate over time but that they were reluctant to express negative feelings about their therapists or about therapy. Perhaps therapists could take preventative action to minimize impasses by doing occasional "status reports" of the

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treatment in which they directly ask clients what they like about therapy thus far, what could be improved, and how they feel about the treatment.

However, as the present study shows, clients with avoidant attachment styles may not openly express their feelings about them or the therapy. It seems important for therapists not only to be watchful for overt "markers," such as client withdrawal in session, tardiness and absences, but also to clarify at the beginning of therapy with these clients that they want them to feel safe about sharing their thoughts and feelings about therapy. Of course, therapists would need to convey openness to clients' feedback without promising that treatment will be modified anytime the going gets rough.

Another preventative strategy might be to identify client attachment styles early in treatment by administering a pre-therapy attachment measure to new clients. Clients with insecure attachment styles could be educated about the potential for the development of an impasse, that they may have difficulty with self-disclosing and trusting, and that such feelings are not uncommon in therapy.

Although we can not understand sufficiently the role played in impasses by the therapists in this study without having their own reports, clients' perceptions (even if distorted by pathology) that their therapists lacked empathy, were critical, and had personal issues that interfered with therapy at least highlight the importance of training therapists to consider their own contributions to difficult cases early in therapy. For example, training should stress the need to be aware of countertransference thoughts and behaviors as a way to effectively resolve impasses. Training also might encourage therapists to use initial interviews not only to identify clients' presenting issues but also to

assess whether such issues pose particular challenges to therapists' skills and abilities. In addition, therapist trainees (and practicing therapists) could be educated about helpful and non-helpful self-disclosures and the potential consequences of disclosing personal issues on therapy.

Finally, when a potential for an impasse is identified, therapists might consider enlisting the aid of a consultant, which has been recommended as an approach to impasse resolution (Elkind, 1994; Hoffman et al., 1994; Omer, 1997). Individual or peer group supervision might also be used to help therapists manage their feelings about challenging clients. Although we do not know whether therapists in the present study sought similar types of assistance with their clients, we might speculate that consultation or supervision could have been useful in these difficult cases.

<center>Limitations</center>

One of the limitations of this study is the retrospective nature of the clients' reports. Past events may not be accurately recalled because they are filtered through subsequent experiences (Nisbett & Wilson, 1977). In fact, most of the clients in this study had at least one prior experience in therapy, the events of which were potential sources of interference with memories of the recent therapy. However, an effort was made in the initial screening of participants to reduce the degree of filtering and improve the accuracy of clients' reports by only selecting clients who had not subsequently returned to therapy. Thus, the impasses they discussed in the interviews occurred in the most recent therapy experience.

In addition, to reduce the possibility that clients would bring "hindsight" to their

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reports and attempt to interpret what occurred during the impasses, they were instructed to "recall what it felt like for you at the time, rather than how you see it now." Nevertheless, as in any qualitative or quantitative study, there is no way of knowing how much clients were able to accurately recall.

Moreover, it is possible that clients selected only aspects of their experiences that they felt safe in sharing or that they believed were socially acceptable. An attempt was made to make clients as comfortable in the interviews as possible by stressing the confidential nature of the study and assuring them that they could terminate the interviews at any point in the conversation. Although most clients seemed willing to talk about the problems they had with their therapists, it is reasonable to assume that some people had difficulty sharing details about a "failed" experience in therapy.

Another limitation is the small sample size of 11 cases, which reduces the generalizability to other clients and other impasses. Therefore, it is not clear how representative the cases in this study are of unresolved therapeutic impasses. Furthermore, the sample was predominantly White, and all but two of the clients were women, which raises additional concern about the generalizabilty of the sample. Relatedly, clients who responded to the recruitment ad may have been different (e.g., had less hurtful impasse experiences or were more angry with their therapists) from those who would not choose to share information about unsuccessful experiences with therapy. Hence, caution should be used when considering the results, as biases that might have influenced client participation are not fully known.

The small sample size also may have accounted for another limitation of this study,

which is the lack of differences among clients in terms of attachment styles. None of the clients scored high on the secure subscale of the CATS, which leaves in question how impasse experiences might differ for clients who are securely attached to their therapists. Thus, future research on unresolved therapeutic impasses should use a larger sample that is more diverse in terms of client attachment styles.

Another limitation related to the sample is that the therapy conducted in these cases was primarily long-term (i.e., 8 months to 15 years), which reduces generalizability to similar problems in short-term cases. In light of the present managed care-influenced emphasis on time-limited treatment, additional research is needed that focuses on detecting and resolving impasses in short-term therapy.

Difficulty in obtaining enough participants for this study required a change in recruitment procedures that included offering a cash incentive to later recruits. As a result, six of the 11 clients in this study were paid for their participation, whereas five clients were not. Although differences between the data provided by paid and unpaid clients were not apparent, the offer of an incentive clearly influenced some people to respond to the recruitment ad.

Likewise, some people may have chosen not to respond to the ad because they assumed that they would need to discuss their therapy experiences in-person rather than over the telephone. Since the ad only stated that participants would be "talking about your experience," it is possible that the ad attracted only people with minimal concerns about anonymity. Thus, mentioning in the ad that participation would involve telephone interviews might have helped potential respondents feel safer and may have attracted

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participants with even more complex or harmful impasse experiences than those observed in the present cases.

Indeed, the use of telephone interviews seems well-suited to having people discuss unpleasant experiences with an unknown interviewer and seems particularly appropriate for clients, such as those in this study, with histories of poor interpersonal relationships and difficulty addressing certain issues in therapy. Therefore, the anonymity provided by the telephone interviews might have contributed to clients' being more open to providing highly detailed descriptions of their experiences.

One drawback of the telephone interviews is that they prohibited the interviewer from observing clients' non-verbal responses that might have helped cue the interviewer to probe further in particular areas of inquiry. Despite this limitation, an average of nearly 70 minutes was spent on the primary interview for each client in this study, and time spent making additional inquiries in the followup interviews averaged 20 minutes.

Researcher bias might also limit the generalizabilty of these findings to other cases of impasse. Measures were taken to reduce the biases of the research team, such as stating biases prior to collecting and analyzing the data and using a consensual method of judging the data. In addition, having three members on the primary team and an auditor to check their work helped to balance perspectives. In addition, researcher bias and the subjective aspects of the qualitative method were discussed by the primary research team throughout the analysis of the data. Acknowledging that researcher biases cannot be entirely eliminated, the research team attempted to set aside biases and adhered strictly to the consensual process. Nevertheless, replication of this study by a different team of

researchers is needed.

Finally, only clients' perspectives on impasses were examined, which leaves unanswered the intriguing question of whether the therapists in these cases would have perceived the impasses differently. Indeed, whether therapists were as unaware of the impasses and uninvolved in addressing the problem as most of the clients believed remains unknown. Therefore, obtaining clients' and therapists' perspectives of the same impasses would help to solve such puzzles. Future studies that examine both perspectives are needed. Perhaps the next step is to conduct a single in-depth case study involving one client and one therapist, since the amount of data generated by dual interviews in multiple cases of impasses would be massive and perhaps difficult to interpret.

Conclusion

The results of the present study lend additional empirical support to clinical observations of impasses in psychotherapy. Specifically, the accounts of impasses provided by clients in this study provide evidence associating a number of factors originating with clients, therapists, and the therapeutic relationship to therapeutic impasses. Clients' difficulty with discussing unpleasant issues and their dissatisfaction with therapy and clients' perceptions of therapists' empathic failures emerged as central factors in impasses. These factors appear to explain why some impasses go unresolved. That is, clients' difficulty communicating dissatisfaction and therapists' seeming lack of awareness of the clients' distress served as obstacles to addressing and resolving the impasse and moving on in therapy. Thus, these findings serve as a preliminary foundation for helping therapists recognize variables that contribute to the development and formulating

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strategies for resolving impasses in therapy.

Some clients may require "education" about therapy early in treatment. For example, the first sessions should address not only the ground rules of therapy (e.g., payment schedules, cancellation and vacation policies), but also the expectations of both people regarding the structure and amount of guidance, and the therapeutic tasks and goals. Clients may need additional help understanding their roles and responsibilities.

Most of the clients in this study indicated that therapy got off to a productive start but that problems eventually came up that were not addressed and seemed to snowball toward premature termination. Perhaps therapists should occasionally ask their clients what they like about therapy, what problems they perceive to exist, and how they feel about the treatment. In doing so, therapists can involve their clients in the ongoing detection of problems rather than rely solely on their perceptions.

Recognizing that some problems will eventually lead to clients wanting to drop out of therapy, therapists who encourage constructive feedback may be more successful at processing issues with clients in a formal termination session. A primary goal at this point should be to acknowledge clients' unaddressed issues and attempt to process negative feelings related to therapy.

Finally, the present findings suggest how clients' attachment styles influence process issues in therapy. Indeed, therapists who understand their own roles as attachment figures for their clients (Farber, Lippert, & Nevas, 1995) might be better prepared to avoid relationship problems, such as the blurring of therapeutic boundaries and transference and countertransference issues, that contribute to impasses.

Several directions for future research emerge from the present study. First, as mentioned throughout this discussion, investigations that explore clients' and therapists' perspectives of the same impasse are needed to more fully understand the development of impasses. Additional questions related to therapeutic impasse also deserve attention. For example, clients in this study spent months struggling with the question of whether to quit or give therapy a chance. Research is needed that investigates the difficulty some clients have with extracting themselves from ineffectual therapy. Relatedly, the possibility that clients create impasses, consciously or unconsciously, to get out of therapy might also be studied. Perhaps some clients dig their heels in expecting that their therapists will give up focusing on difficult issues only to find that the therapists are equally persistent about continuing treatment.

Future studies also could examine in greater depth the association of client and therapist attachment styles to the development and resolution of impasses. For example, researchers might explore whether impasses are associated with the inability of therapists to provide an adequate "secure base" for their clients' exploration of issues. Researchers also could assess whether certain client-therapist attachment dyads (e.g., secure therapist-insecure client) encounter more (or fewer) impasses than other attachment dyads. Finally, as the present study investigated only clients' attachment to therapists, future research should explore therapists' adult attachment patterns and the way they influence therapists' handling of problems in therapy.

To conclude, this study, although limited, provided additional empirical evidence associating a number of client, therapist, and relationship variables with the development

of unresolved impasses in therapy. In addition, a foundation for understanding the relation

of clients' attachment to therapists to impasses was established, and several approaches

that may assist in detecting and resolving impasses were offered. Future researchers

should study in greater detail the factors that are associated with impasses to provide

therapists additional insight into this frequent and difficult problem. In doing so, therapists

may be more able to engage clients in resolving problems in therapy before anger,

frustration, disappointment, and a sense of hopelessness overwhelm the therapeutic work.

Client Impasse Interview

A. CLIENT DEMOGRAPHIC INFORMATION

Date:

Participant's first name: _____

Present age: _____   Gender: _____ M _____ F

Ethnicity: _____ European American _____ Hispanic _____ Asian-American

_____ African-American _____ Other _____

Education: _____ H.S. _____ Current undergraduate _____ current graduate

_____ undergraduate degree _____ graduate degree _____ other

Your profession _____

B. THERAPIST DEMOGRAPHIC INFORMATION

Therapist's gender: _____ M _____ F   Present age: _____

Ethnicity: _____ European American _____ Hispanic _____ Asian-American

_____ African-American _____ Other _____

Therapist's professional title: ___ psychologist ___ psychiatrist

___ social worker ___ other _____ ___ don't know

Therapist's degree: ___ Ph.D ___ Psy.D ___ M.D. ___ MSW ___ LCSW

___ other ___ don't know

Guess at therapist's orientation:

___ psychoanalytic/psychodynamic: emphasizes insight through association of past

experiences and present problems; uncovering unconscious conflicts and motives.

___ humanistic/experiential: emphasizes personal growth, acceptance of genuine self, self-

determination.

___ cognitive behavioral: emphasizes changing negative thinking and adopting more

realistic thinking; may include specific behavioral goals or tasks.

___ other_____ .

C. GENERAL INFORMATION

1. How did you choose your therapist?

2. What was the setting of therapy?

___ private practice ___ university counseling center ___ outpatient hospital

____ community mental health clinic ____ other

3. Number of sessions with your therapist ____

4. How long ago did you leave therapy? ____

5. What were your original reason(s) for seeking therapy?

6. What were the main issues you ultimately focused on in therapy?

7. What experience did you have with therapy prior to this experience?

    No. of therapists ____   No. of months ____

    Did you leave therapy under similar circumstances?

D. THERAPEUTIC RELATIONSHIP

8. Please describe the relationship you had with your therapist at the beginning of therapy and before you began to feel dissatisfied?

    Probes:

    - How did you feel about your therapist?

    - How did your therapist feel about you?

9. In the beginning of therapy, how much did you and your therapist agree on your goals for therapy?

E. THE IMPASSE

Now I'd like to ask you questions about what led up to the impasse between you and your therapist. It will be very helpful if you try recall what it felt like for you <u>at the time,</u> rather than how you see it now.

10. Please describe the impasse.

      Probes: What was it that brought therapy to a stop?

      Was it a single event or a general situation that developed?

11. Please describe how the impasse developed.

      Probes:

      - When during the course of therapy did you become aware of the impasse?

      - Chart the course of events that you believed created the impasse.

      - How long were you in an impasse with your therapist before you left therapy?

      - What effect did the impasse have on your therapy sessions?

      - How many sessions were affected by the impasse?

      - What effect did the impasse have on your goals for therapy?

12. At the time of the impasse, what did you understand to be the problem?

13. At the time of the impasse, what feelings were typical for you during sessions with your therapist?

14. At the time of the impasse, how did you typically feel after a session?

15. How did your feelings about your therapist change after the impasse developed?

16. How did your feelings about therapy in general change after the impasse developed?

17. What issues or circumstance in your life may have contributed to the impasse?

18. How was the impasse influenced by significant people in your life?

19. In what ways do you think you were contributing to the impasse?

20. What other factors may have contributed to the impasse?

21. At the time of the impasse, how did your therapist behave or seem similar to other significant people in your life?

22. At the time of the impasse, in what ways did you think your therapist was contributing to the impasse?

23. At the time, how aware did you think your therapist was of the impasse?

24. To what extent did you and your therapist discuss the situation?

    Probes:

        - Who brought it up? When?

        - If not discussed, why not?

        - (If yes) What did you tell your therapist about your feelings?

        - How did your therapist respond?

        - What would it have taken for you to discuss the impasse with your therapist?

25. How did you cope with the feelings you had about the impasse?

    Probe: Discuss with others?

    How you handled stress/disappointment/frustration/anger/etc

26. At the time this was happening, how much did you think about the impasse outside of your therapy sessions?

    Probe:

        - What did you think about?

        - What effect did it have on your daily life?

27. How would you describe your relationship with your therapist at the time you left therapy?

28. What other factors may have contributed to your decision to leave therapy?

29. In retrospect, would you still leave therapy?

    Probe: Did you wish you had worked it through?

30. If the impasse had been resolved, would you have left therapy?

31. Looking back at the experience, what is your understanding TODAY of what happened?

32. How do you feel NOW about the impasse?

    Probe: What have been the ongoing effects of the experience on your life?

33. Would you seek (or have you sought) further therapy? Under what circumstances?

34. Why did you choose to participate in this study?

35. Is there anything else about this experience that you would like to share?

[Thank participant, etc.]

Conclusion and follow-up procedures

As I mentioned before, I will be sending you a brief questionnaire that is part of this study.

We'll cover the postage if you could help us out by completing it and returning it as soon

as possible in the envelope we provide. Is that still okay? **[If yes, ask for mailing address.]**

It would be a great help if you could mail back the questionnaire before we talk again. It should not take more than 20 minutes to complete.

Now I'd like to schedule the follow-up interview for about 2 weeks from now. This interview will give you a chance to add anything that comes to mind between now and then, and I may have some questions to clarify what we discussed today. What would be a good day and time for you to talk again?

Okay, so I'll call you on _____ at _____.

Thank you for your time today. I'll talk to you soon.

Client Attachment to Therapist Scale

These statements refer to how you felt about your therapist before the impasse that developed between the two of you. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

____ 1. I didn't get enough emotional support from my therapist.

____ 2. My therapist was sensitive to my needs.

____ 3. I think my therapist disapproved of me.

____ 4. I yearned to be "at one" with my therapist.

____ 5. My therapist was dependable.

____ 6. Talking over my problems with my therapist made me feel ashamed or foolish.

____ 7. I wished my therapist could be with me on a daily basis.

____ 8. I felt that somehow things would work out OK with me when I was with my therapist.

____ 9. I knew I could tell my therapist anything and s/he would not reject me.

____ 10. I wanted my therapist to feel closer to me.

____ 11. My therapist wasn't giving me enough attention.

____ 12. I didn't like to share my feelings with my therapist.

____ 13. I wanted to know more about my therapist as a person.

____ 14. When I showed my feelings, my therapist responded in a helpful way.

____ 15. I felt humiliated in my counseling sessions.

____ 16. I thought about calling my therapist at home.

____ 17. I didn't know how to expect my therapist to react from session to session.

____ 18. Sometimes was afraid that if I didn't please my therapist, s/he would reject me.

____ 19. I thought about being my therapist's favorite client.

____ 20. I could tell that my therapist enjoyed working with me.

____ 21. I suspected that my therapist probably wasn't honest with me.

____ 22. I wished there were a way I could spend more time with my therapist.

____ 23. I resented having to handle problems on my own when my therapist could have been more helpful.

____ 24. My therapist wanted to know more about me than I was comfortable talking about.

____ 25. I wished I could do something for my therapist too.

____ 26. My therapist helped me to look closely at the frightening or troubling things that have happened to me.

____ 27. I felt safe with my therapist.

____ 28. I wished my therapist were not my therapist so that we could have been friends.

____ 29. My therapist was a comforting presence to me when I was upset.

____ 30. My therapist treated me more like a child than an adult.

____ 31. I often wondered about my therapist's other clients.

____ 32. I knew my therapist would understand the things that bothered me.

____ 33. It was hard for me to trust my therapist.

____ 34. I felt sure that my therapist would be there if I really need her/him.

____ 35. I was not certain that my therapist was all that concerned about me.

____ 36. When I was with my therapist, I felt that I was his/her highest priority.

APPENDIX C

Recruitment Advertisement

NEEDED: People who quit individual psychotherapy within the last year feeling angry, frustrated, disappointed, or hurt because they had reached an impasse, or roadblock, with their therapist. If you are willing to participate in a research project by talking about your experience and completing a brief questionnaire, please call David Petersen at the Department of Psychology, University of Maryland, (301) 405-5820. This is not an offer of treatment. All responses will be kept confidential.

APPENDIX D

Contact Call and Background Survey

Contact call

My name is David Petersen, and I'm calling because you responded to an ad for research participants at the University of Maryland. Do you have a few minutes to talk with me about the project? Great. First, I'd like to thank you for responding to the ad. I'm a doctoral student in psychology at Maryland and I'm doing research on people's experiences in therapy. Specifically, I am looking at situations in which clients and therapists reach a roadblock, or impasse, that eventually results in the client dropping out of therapy.

I'm calling at this point only to ask you a few general questions to help me determine if your therapy experience fits with my research interests. Then, if you choose to participate I can tell you more about the project and what you'd be doing. Would that be okay with you?

Background survey

Date:

Respondent's first name: _____

1. _____ age (must be at least 21)

2. Did you quit therapy feeling angry, disappointed, frustrated, or hurt?   Y N

3. Did you feel that you had reached an impasse or roadblock with your therapist? Y N

4. How many months ago did you leave therapy (when was your last session)? ____

5. Approximately how many months of therapy did you have? ____ (must be at least 3 months.)

6. How often did you typically meet per week? ____ (must have been at least once per week at some point)

7. Have you returned to therapy, either with the same or a different therapist?

____ Yes ____ No (must be "No.")

8. Why did you respond to the ad for this project?

[If client does NOT meet criteria for study: "Thank you very much for your time. It looks like your experience doesn't quite match up with the project. Let me assure you this has to do with the very specific requirements for this study and not whether your answers were right or wrong. By the way, I would be happy to give you a referral for a therapist if that is something you are interested in. . . Thank you again

for your time.]

[If client DOES meet criteria, continue with description of the study]

OK, I'd like to tell you some more about the project. The purpose of the study is to learn more about situations in therapy in which people like you reached an **impasse**, or a roadblock, with their therapists and felt that they were not making progress on their goals. They may have felt angry, frustrated, disappointed, or hurt about the how things were going in therapy, and they ended up leaving therapy before accomplishing their goals.

As a participant, you will be contributing information that would help us better understand how problems develop in therapy. Sharing your experience will go a long way toward identifying what causes impasses and how they can be resolved before clients leave therapy. Your participation could help other people have more successful experiences in therapy.

As a volunteer in this study, you will participate in two interviews with me over the phone and fill out a brief questionnaire that I will mail to you. The first interview will last about 45 minutes, and the follow-up interview will take no more than 30 minutes. In the interviews, I will ask for background information about you and your therapist and about your experiences in therapy. For research purposes, the interviews will be audiotaped, and after the tapes are transcribed, they will be erased. Code numbers, rather than names, will be used on the transcripts to make sure everything we discuss is confidential. Also, I will

not be asking the name of your therapist. Your participation is completely voluntary, and you may discontinue participation at any time.

Do you have any questions so far?

I will send you a brief questionnaire that you will complete and mail back to me at my expense. To maintain confidentiality, I am the only person who will contact you during this study. I'm responsible for mailing the questionnaire and receiving it when you mail it back, and I only want you to write your first name on the background form and questionnaire.

At this point, I need to ask you to summarize what you understand is the purpose of the study and what you would be doing to make sure that I've explained it clearly.

[If respondent understands, proceed. If not, clarify any misunderstandings and ask person again if s/he understands. If s/he continues to express uncertainty, thank the person for responding and explain that "it looks as if your experience doesn't quite match up with the project. Let me assure you this has to do with the very specific requirements for this study and not whether your answers were right or wrong. By the way, I would be happy to give you a referral for a therapist if that is something you are interested in. . . Thank you again for your time.]

[If respondent clearly understands procedures, continue . . .]

OK, based on what I've told you about the project and what you would be doing, are you interested in doing the interviews and questionnaire? Can you tell me a little about why you'd like to participate?

Great. First, I'd like to schedule the first interview. I'd like you to think of some times within the next couple of weeks when you would be available to do the interview. Please think of a time and place where you'll have privacy and no interruptions for up to 45 minutes.

OK, I will call you to do the first interview on _____ at _____ . May I have the telephone number where you will be at that time? (____) _____ .

Now, I'll need your address so that I can send you a letter describing the project and the questionnaire.

name _____

street _____

city/state/zip_____

After the interview we will schedule a follow-up interview.

[Thank the person for helping out, etc.]

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APPENDIX E

Informed Consent Letter

CLIENTS' PERSPECTIVES ON UNRESOLVED THERAPEUTIC IMPASSES
Project Director: David A. Petersen
University of Maryland Psychology Department
Zoology-Psychology Building
College Park, MD 20742
(301) 405-5820

Dear   :

We are very grateful that you have agreed to participate in this project on client experiences in therapy. We believe this project is very important, because we need to learn more about why problems develop in therapy.

In this study, you will be asked to reflect on your experience in therapy in which you and your therapist encountered a roadblock, or a "therapeutic impasse," that left you feeling frustrated, angry, disappointed, or hurt to the point that you eventually quit therapy before completing all your goals.

We have some evidence that suggests that when an impasse between a client and therapist is not resolved, the typical result is that the client drops out of therapy. Surprisingly, there has been a minimal amount of research about what causes impasses or how they can be resolved. Your participation in this study will be invaluable in helping us learn more about the experiences of clients in therapy.

What does your participation involve?

Initially, we would like you to complete the "Participation Sheet" and the "Questionnaire" and return them in the stamped envelope. Then, as arranged, you will participate in a telephone interview conducted by David Petersen, a third-year doctoral student in counseling psychology at the University of Maryland. This interview will last approximately 45 minutes. You will also be participating in a follow-up interview approximately two weeks later that will last up to 30 minutes.

Confidentiality is our highest concern, which is why we have developed several procedures to protect your privacy. First, we will maintain complete confidentiality regarding the information you provide except in cases of current suicidal thoughts, homicidal thoughts, and child abuse. Only one person, David Petersen, will be in contact with you during this study. He is responsible for mailing the Participation Sheet and Questionnaire and receiving them when you mail them back. Although there is minimal risk in mailing this

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information, you can be assured of complete confidentiality once we receive it. Please note that we do not want you to write your last name on the Participation Sheet or Questionnaire. Also, only your first name will be used during the interviews. The interviews will be audiotaped for research purposes, but the tapes will be erased immediately after transcripts of the interviews have been typed. Code numbers, not your name, will be used on the transcripts.

We recognize that the discussion of impasses might raise uncomfortable feelings. In designing this study, we tried to be sensitive to these feelings. First, the interviews are for research purposes only and are not intended as therapy. You will be asked questions designed to elicit information, not to "analyze" you or "process" your experience. You will not be asked questions intended to make you uncomfortable, and you are free to discontinue your participation at any time. Also, we encourage you to contact the principal researcher, David Petersen, at (301) 405-5820, whenever you have questions about the project.

We also recognize that some people in this study, after talking and thinking about their last therapy experience, may decide they would like to seek therapy again. At your request, we would be pleased to provide you with a referral to a local therapist.

Why should you participate in this project?

The information you provide will be extremely helpful in identifying how impasses occur and how they can be resolved before they result in a premature end to therapy. Furthermore, as we learn more about impasses through studies such as this, we may be able to prevent the most harmful impasses from occurring in the first place, and therefore help clients gain the most from therapy. We will be pleased to send you a summary of the results if you indicate this on the Participation Sheet.

Your return of the Participation Sheet and Questionnaire will serve as your informed consent to participate in this study. If you have any questions before the first interview, please do not hesitate to contact David Petersen at (301) 405-5820. Thank you again for your help.

Sincerely,

David A. Petersen   Clara E. Hill, Ph.D.
Doctoral Student   Professor
University of Maryland   University of Maryland

APPENDIX F

Informed Consent Form

CLIENTS' PERSPECTIVES ON UNRESOLVED THERAPEUTIC IMPASSES
Project Director: David A. Petersen
University of Maryland Psychology Department
Zoology-Psychology Building
College Park, MD 20742
(301) 405-5820

INFORMED CONSENT FORM

Please read and sign this form and
return it with your completed questionnaire in the postage-paid envelope.

I have read the attached project description, and I am willing to participate in the research project being conducted by David Petersen and Dr. Clara E. Hill at the Graduate School, University of Maryland College Park, Department of Psychology. I understand that the researcher hopes to learn more about how impasses develop in therapy and that the interviews conducted for this project are not designed to help me personally. I understand that my participation is voluntary, and that I may discontinue participation at any time. I understand that the information I provide is strictly confidential and that my name will not appear on interview transcripts. I also understand that following the interviews I may ask the principal researcher, David Petersen, for a referral to a local therapist and that I will not be reimbursed for the cost of treatment by any therapist. I am over 18 years of age.

_____
(Please print name)

_____
(Signature)

_____
(Date)

____ I would like to receive a summary of the results of this study.

Field Notes Form

Date:

Case #:

Time start: Time finish:

Overall tone of interview

Concerns/questions expressed by participant

Distractions/interruptions

Positive aspects of interview

Problem areas

Overall impressions of participant/interview

APPENDIX H

Follow-Up Interview

Date:

Participant's first name: _____

This is David Petersen at the University of Maryland. I'm calling to ask a few follow-up questions from our interview. Are you somewhere where you won't be disturbed for a while?

1. What additional thoughts or feelings have you had about your therapy experience?

2. Is there anything you told me last time that you would like to correct or change in any way?

3. I have a few follow-up questions:

4. **[If necessary]** Also, I just want to check and make sure you received the questionnaire we sent you and remind you to mail it back as soon as possible. Thanks again for all your help with our project, etc.

Cross-Analysis

DOMAIN 1: CLIENT BACKGROUND

1. Client Had Previous Negative Family Relationships (7 cases, typical)

3. Throughout her life, client was hurt by mother's negative attitude about client's weight, although client doesn't see herself as obese. Client had trouble in past establishing good relationship with medical doctors. Client has felt put down by other people.

4. Client saw therapist previously to work on dysfunctional family relationships. Client's father has always seemed emotionally distant and not interested in talking with her. Client's mother is verbally abusive and critical of client. Client believes her family isn't interested in knowing about her. Client is the only one in her family who addresses problems. Client has pattern of relationships in which people who are important to her do not seem interested in having her in their lives or responding when she needs someone to share things with or talk to.

9. Client was fine prior to her father's death, but at age 21 she began 3 years of therapy to deal with father's death (in coma for a year after an accident), and she attributes her relationship problems to unresolved issues with father.

11. Client and mother did not form an early attachment because of mother's inability to cope with client's life-threatening illness. Client believes her problems relate to early trauma of feeling rejected by and not bonding with her mother, exacerbated by father leaving her and later having to testify against father. Client

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feels like a throwaway child because her parents locked her out of her house when she was 17, at which time client lived on the street and developed a hostile attitude.

16. Client had unresolved issues with his deceased father, around whom client had felt that he could not be himself and express anger toward him, and whom he blamed for his mother's problems.

19. Client views herself as being overly dependent on her parents and having a low tolerance for stress and a tendency to worry a lot.

20. Client's family members tend to scream at each other rather than hold in anger. Client attributes her efforts to maintain relationships to her mother teaching her to love and accept people, but client feels that other people, in contrast, dismiss her.

2. Client Had Previous Negative Experience with Therapy (6 cases, typical)

9. Client also went to and became attracted to a male analyst she was seeing for marital problems, which made her like her husband less. Before seeing this therapist, client had been in a therapy group but didn't get enough individual attention.

16. Client previously saw a female therapist 3 or 4 times but quit because he did not feel connected to her and thought she did not pay attention to him.

18. Client previously had 4-6 months of individual therapy in law school but became uncomfortable because therapist was in the same social group and quit even though therapist wanted her to stay.

19. Client worked 10 months with a therapist in grad school even though she never felt comfortable with her. Client did not confront previous therapists when she was unhappy with them.

20. In past and current treatment, client sometimes felt that what she said or did was not acceptable. Psychiatrist whom client saw periodically over past 8-10 years and continued to see for meds while in treatment with therapist was too aggressive in prescribing medication, which client didn't like.

21. Client was previously in therapy 4 or 5 times in past 10 years but never saw a therapist longer than 1 month because she wasn't ready or willing to work on her issues. Lack of previous therapy successes might have stemmed from fact that client is an African American woman and other therapists were Caucasian women and men.

3. Client Was Previously Depressed or Suicidal (5 cases, variant)

4. Client was once hospitalized with suicide ideation and has struggled with body weight recently and lost 93 lbs.

9. Client's marital problems began when infant daughter began to need client less, and she became extremely depressed and went to therapy for 2 years.

10. Despite depression, client believed he was very productive at his work. Client had an opportunity to be hired as a journalist on a newspaper, but he lost the opportunity due to self-destructive behavior.

20. Client had struggled to cope with episodes of depression and mania.

21. Client attempted suicide in the past.

4. Client Had Previous Positive Experience with Therapy (4 cases, variant)

9. After seeing male analyst for marital therapy, client switched to a female therapist, who was helpful.

10. Previously, client had two episodes of brief therapy that were very helpful and ended well.

19. Client had previous positive 7-year therapy experience.

25. Client, who had an eating disorder since childhood, saw a nutritionist and counselor during prep school, a counselor in college, a social worker throughout med school who was very helpful, and another therapist who specialized in sexual abuse and domestic violence but was too expensive to see for more than a few sessions.

5. Client Had Positive Self-View (3 cases, variant)

3. Client thinks of herself as a mentally healthy person without major problems.

4. Client views herself as intelligent but less functional due to mental illness.

18. Client is type of person who is nice, responsible and follows through with things.

DOMAIN 2: PRESENTING PROBLEMS OR FOCUS OF THERAPY

1. Client Presented with Intrapersonal Issues (10 cases, typical)

 3. Client sought treatment for crisis management and to deal with self-esteem

issues.

 4. Client returned to therapy with therapist when client moved back to area and

needed help managing schizoaffective disorder. Client had child abuse issues.

 9. Client's therapy ultimately focused on relationships and sex, self-esteem,

autonomy issues, self-actualization, and separateness. Before she was on lithium,

client could not make plans because she could not anticipate her mood.

 10. Client was deeply depressed, felt isolated and emotionally withdrawn, was

drinking, was a workaholic, had gained a lot of weight, and had high blood

pressure. When he began therapy client was experiencing self-hatred and self-

destruction. Client and therapist discussed use of drugs for his depression,

although therapist opposed to the idea. Although he sought therapy for

depression, therapy focused on client's childhood development and why he had not

gone through the process of maturation.

 11. Client sought therapy to address ACOA, anger, guilt, and shame issues. Prior

to seeing therapist, client attended ACOA meetings and 14 years ago had very

brief therapy that ended when client moved.

 16. Client originally saw therapist to deal with unhappiness and grief issues (related

to father's death shortly before therapy).

 18. Therapy later focused on unresolved issues related to client's mother's death 6

months previous.

20. Client thought that her life was falling apart and sought therapy for relationship problems, depression, sexual abuse, and tendency to make bad decisions. Client wanted therapist to help her stabilize and function better.

21. Client presented with issues related to rape, parents' divorce, suicide ideation following mother's death. Client started therapy as an emotionally distraught woman who had believed she was a bad person since early childhood, and she pursued therapy when she realized she could not cope alone.

25. Client was a medical student who was referred to therapist to deal with an eating disorder and depression associated with being raped. Client was emotionally vulnerable at the beginning of therapy and was so thin that her job was in jeopardy.

2. Client Presented with Relationship Issues (9 cases, typical)

3. Client has good relationship with parents but wanted to address their negativity in therapy and have a closer relationship with them. Client wanted to work out whether to get married and have children and deal with intimacy issues. Client has pattern of selecting unavailable men and wonders why she makes poor choices in men and how she can begin not to. Client sought treatment to deal with interpersonal issues. Client's boyfriend was married and interested in getting back with his wife.

4. Client worked on family, boyfriend issues.

9. Client experienced crisis over end of a relationship and was referred by this therapist (as the supervisor) to another therapist who client didn't like, so this therapist agreed to work with her as a client. Client's therapy initially addressed end of a relationship, but ultimately focused on other relationships and relationship with daughter.

11. Client sought therapy to address relationship breakup.

16. Therapy ultimately focused on client's anxiety and loss of confidence when dealing with authority figures and his relationship with his parents.

18. Client sought treatment to cope with relationship problems.

19. Initially sought help with anger in her relationships with men and her parents. Client had tendency to seek approval from others in a way that probably seemed demanding.

20. Client sought therapy for relationship problems.

21. Therapy later addressed end of relationship with husband.

3. Client Presented with Work-Related Issues (2 cases, variant)

    18. Client sought treatment to cope with work problems.

    19. Client initially sought help with career indecision.

DOMAIN 3: THERAPY BEFORE THE IMPASSE

1. Some Parts of Relationship Were Positive (11 cases, general)

    3. First impression of therapist was positive. Client selected therapist over other

therapists because therapist seemed empathic during their initial phone

conversation. Client believed therapist understood her and that therapist was

willing to make an extra effort to see her for their first session. Client thought

therapist believed client had real issues to explore. Client felt cared for and did not

have a problem speaking with therapist, although therapist was initially hard to

read.

    4. Client and therapist cared for each other. Client liked, respected, and cared for

therapist. Client trusted therapist and viewed her as honorable and hardworking.

Therapist was not critical the way client's family was.

    9. Therapist was supportive and easy to talk to. Client viewed therapist as the

good mother who could quickly analyze client in a warm and humorous way.

Client felt immediate connection to therapist and believed therapist liked her.

Client felt that therapist was helpful and empathic and that therapy was positive.

Client felt that she loved therapist and put all her affect into their relationship.

    10. Therapist liked client's vocabulary, which contributed to their good rapport.

Client thought therapist was a very good person who, despite being at the end of

her career, genuinely cared about him and was trying to help him. Client thought

therapist was a very good doctor. Client was impressed that therapist had studied

with Anna Freud. Therapist reassured client that she had helped other clients his

age. Therapist respected client's need for autonomy and self-determination

11. Client trusted therapist and believed she was competent. Therapist seemed

warm and pleasant and understood client's difficulty with trust. Client felt

comfortable talking to therapist, and therapist seemed interested in client. Client

felt good enough about the relationship that she returned to therapy each week.

Therapist seemed to like client.

16. Therapist and client had open communication. Client's comfort with therapist

allowed him to accept his fear of authority figures and to cry without fear of

therapist's criticism. Client thought it was beneficial to be interacting comfortably

with an older male in the way he should have with his father.

18. Client was comfortable with therapist because she seemed familiar to client.

Client felt good rapport with therapist, felt close to her, believed they had good

communication, and liked the combination of talk therapy and relaxation

techniques. Therapist was supportive of client's biofeedback work and reinforcing

of her change.

19. Client felt comfortable talking with therapist, who was reassuring regarding

confidentiality and privacy, and who viewed client as ready for therapy, open, and

insightful. Client and therapist had a good rapport. Therapist seemed like a good

role model, competent, a good person, and insightful.

20. Therapist gave client a safe place to be open, which she had not had in

previous therapy. Relationship felt comfortable and not too intense, except for one

instance when therapist seemed judgmental. Client thought therapist was warm,

funny, accepting, and a good human being. Client looked forward to therapy each week and viewed therapist as a good friend.

21. Client appreciated therapist's willingness to help her during the time when she was not willing to help herself. Client loved therapist and recommended her to others, including client's sister. Client respected therapist's concern that they avoid a dual relationship because they attended the same church. After 4th or 5th session client, having realized that not working in therapy was a waste of time and money, bonded with therapist.

25. Client trusted therapist and accepted her approach even though she was initially put off. Therapist had domineering and maternal personality and was directive in therapy, which client thought she needed. When therapist told client to eat, client felt obligated to do so because she was enthusiastic about therapy, believed that therapist could help her and was interested in her. Therapy felt more positive to client than in past, when therapy was painful and focused on talking through issues. Client really liked therapist and believed she had a lot of experience.

2. Therapy Was Productive (9 cases, typical)

3. Client believed that she was getting something from therapy. Client resolved her initial crisis within the first four months of therapy. Although still not comfortable with her lifestyle, client learned in therapy that she should try to accept her lifestyle, behaviors, and feelings rather than question them. Client became aware in

therapy that she tends to cover her emotions. Her main success in therapy, in the first 4 months, was dealing with a crisis. Client thought therapist helped client face reality that her married boyfriend was unavailable to her. Client believes she made gains in therapy and does not regret going to therapy, but she still is not comfortable with her lifestyle and has periods of depression. Client does not believe therapy helped her with her long-term issues and believes that in 9 months she should have made more progress on other issues. Client and therapist never resolved client's presenting issues, which was client's tendency to date men who are unavailable.

9. Client and therapist worked well together. Client feels tremendous awe and respect for all therapist did for her.

10. Therapy was occasionally fun and productive. Client believed therapist contributed to client's progress and development, especially in the early years of treatment when therapist pointed out to client the importance of emotional, over intellectual, insight. Client feels positive about impasse because it allowed him to stand up to therapist. Client attributed his improved health to the analysis. Client viewed himself as growing in therapy. Client believed that although both of them were invested in his therapy, his gains were relatively minimal.

11. Before impasse, client and therapist made progress on reducing client's hostility, which she attributed to therapist's ability to break through client's resistance. Client believes they did good work together in the group, although she believes therapist should learn about the impact of childhood trauma. Client felt let

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down by therapy and resolved her issues later.

16. Therapy helped client resolve issues related to his relationship with his father and reduce anxiety and fear when dealing with other male authority figures. Client experienced a profound change in the way he viewed some things, such as issues related to his father, but he did not feel differently about his mother.

18. After sessions, client usually felt pretty good, exposed from opening up so much to therapist. Working with therapist allowed client to finally leave her job and gain an appreciation of thinking introspectively.

19. Client learned that in relationships she sought approval and emotional support from others in a way that appeared demanding. Client learned that she could not control others' reactions to her. Client made positive steps related to her career and in choosing men.

20. Client was progressing well and found therapist supportive during a time when several of client's relationships were ending.

21. Therapist initially put client on medication, but after breakthrough session client quit using the meds and began to work. Therapy taught client how to make changes, and she believes therapist prevented her from killing herself by helping her come to terms with her mother's death.

3. Client and Therapist Did Not Formalize Therapeutic Goals (5 cases, variant)

4. Client and therapist did not agree on specific goals, but client told therapist what she wanted to work on.

10. Client and therapist did not set specific goals for analysis, although they agreed that his success was a goal.

11. Client and therapist did not discuss and agree on therapeutic goals. 16. Client and therapist did not discuss goals, but in the first 2 sessions they talked about what client wanted. Client believes therapist had goals but did not make them explicit.

21. Client and therapist did not discuss goals because client was suicidal and needed immediate crisis intervention.

25. Client and therapist talked about but didn't agree on what client's goals should be.

4. Client and Therapist Had Similar Interests and Beliefs (4 cases, variant)

3. At first client felt that she and therapist had similar beliefs and interests such as hobbies and feminist issues.

16. Client felt connected to therapist because they had similar personality profiles and because therapist seemed interested in discussing such things as client's existential concerns, which did not interest his friends.

18. Good relationship may have been due to similar backgrounds and experiences.

21. Therapeutic relationship was good because client and therapist were both African American Christians, and therapist helped client reconnect with her spirituality.

5. Client and Therapist Discussed Goals (4 cases, variant)

    3. After client and therapist resolved the crisis in client's life, she brought up other therapeutic goals, which therapist agreed were good issues to address.

    9. Therapist and client agreed on client's goals for a successful career, wealth, marriage, and autonomy.

    19. Client and therapist spent the first 2 or 3 sessions discussing client's goals for therapy.

    20. In the beginning, client was too ill to set goals, but once her medication took effect she felt better, and she and therapist discussed goals.

DOMAIN 4: DESCRIPTION OF THE IMPASSE

1. Progress in Therapy Seemed to Stop/Plateau (11 cases, general)

    3. Client thought that she basically discussed the same topic for 9 months.

    4. Impasse emerged after 3 months when client thought they weren't making progress.

    9. Client believed she wasn't getting anywhere with her issues and that she had given up during last 4 years of treatment. In addition to her envy of therapist, client's quitting was influenced by her realization that medication could help her feel better.

    10. Client thought minimal progress was being made. Client believed he had to quit because of lack of progress. Client realized that therapy was non-productive and that they were at an impasse when therapist was in the hospital for an extended

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time and client decided he liked not being in therapy. Client thought therapy had run its course even though therapist thought there was more to do.

11. In last 1.5-2 years of treatment, progress lost momentum. Progress in therapy plateaued after client resolved her hostility issue, and she had sense that nothing was happening.

16. Therapist's directiveness led client to avoid topic, which put a halt to progress.

18. Client realized that she had been spinning her wheels for a while and that therapy probably was a waste of time.

19. When therapy reached a plateau, therapist pushed client to work harder because client was resistant. Client finally quit because she was not making progress and thought it would take too long to resolve the impasse.

20. After receiving therapist's diagnosis, client thought that therapy was at a standstill because she knew borderlines do not get better.

21. After about 10 months client began to agree with therapist that she had accomplished her objectives, and she felt ready to end therapy, but by now therapist had started a private practice and wanted client to continue working with her.

25. Client felt upset that she wasn't getting anywhere.

2. Client Questioned the Benefit of Therapy (8 cases, typical)

3. Client wondered what she was getting from therapy and if therapy was a waste of time. Client felt that discussing her issues with girlfriends was more fulfilling

than the work she was doing with therapist, and wondered, therefore, why she was paying therapist. Client's sense of therapy as a chance to get away from the world gave way to frustration and a sense that the expense and effort of therapy was a burden.

4. Client wondered why she was staying in therapy and quit when she finally acknowledged her dissatisfaction.

9. Client began weighing the cost of therapy against the benefits when she had to switch to an insurance plan that paid less for therapy.

10. Client began to feel frustrated and thought that sessions felt like a waste of time. Client thought he could not justify spending $17k/year on analysis even though he regarded therapist as a good doctor and a good person.

11. Client felt that therapy was a waste of time and money and that something was wrong.

16. During impasse, client believed therapy was a waste of money, although he previously thought it was beneficial and effective.

18. Client viewed therapy as limited and not able to provide the alternative ways of changing that interested her.

21. Client was grateful to therapist but began to question the need for further therapy.

3. Relationship Felt Distant (6 cases, typical)

    3. Client thought therapist didn't connect with her either. Client and therapist did

not communicate well, and client thought it wasn't worth her effort to try and change this. There was not enough give-and-take and feedback in client and therapist's discussions.

4. Although therapist was warm and nurturing, relationship felt superficial so that client and therapist didn't connect and the problem between them was not evident.

10. Client and therapist's use of last names symbolized formality of relationship, which also lack emotional openness.

16. When client began to feel that therapist's approach was uniform across clients, client felt less connected to therapist and that therapist didn't care about him.

20. During the impasse client felt therapist did not trust her, so she could not trust therapist.

25. In contrast to the beginning of therapy, relationship felt strained but cordial.

DOMAIN 5: CLIENT FACTORS ASSOCIATED WITH THE IMPASSE

1. Client Had Difficulty Expressing Dissatisfaction to Therapist (8 cases, typical)

3. Client was not good at confrontation and felt intimidated by therapist's authority. Client was hesitant to be too pushy, too personal, or ask questions because she felt uncomfortable.

4. Client has a hard time confronting others. Client does not express her needs or feelings when she is uncomfortable, so she was reluctant to express her dissatisfaction with therapy. Client did not speak up enough about what she needed and preferred to write these things down. Client might have misinterpreted

therapist but did not speak up and ask for clarification. Client did not confront therapist about her repeated questions regarding client's sexual activity with boyfriend. Client's reluctance to express dissatisfaction might have stemmed from previous experience with therapist in which therapist was non-responsive to client's expression of discomfort with the style of therapy.

11. Client could not communicate her dissatisfaction with lack of progress because she was in awe of therapist. Client felt that the focus on eliciting anger toward father was misdirected, although she didn't have the self-esteem to speak up.

16. Client did not believe that he should express anger toward his therapist.

18. Client didn't feel comfortable enough to confront therapist about what she didn't like about her behavior. Client thought she should have defended herself more. Client was taught to submit to authority and not be confrontational and argumentative, which may have caused her to stay in treatment too long. Client did not feel confident enough to change the therapeutic relationship in which therapist was dominant and client was submissive. Client did not raise concerns with therapist out of respect for her because she did not think she could change therapist.

19. Client expressed her anger toward her therapist through her demeanor rather than telling therapist directly.

21. Client did not question or confront therapist because she respected her and wanted to protect therapist's feelings.

25. Although she was disappointed with therapy, client wanted to please therapist

and wanted her to see that she had made progress.

2. Client Had Difficulty Addressing Certain Issues in Therapy (7 cases, typical)

   3. Client was nervous about exposing her emotions and saying the wrong thing.

   10. Client was distrustful of relationship and withheld emotions in therapy. Client's withdrawal, defensiveness, and desire to be more in command of himself may have contributed to the impasse.

   11. Client was afraid to deal with the loss of her father, so she resisted working on it in therapy.

   16. Client was unwilling to be open and face his issues. Client felt drained of energy and physically tired from cathartic work with therapist about father and from school, and therefore was not up to discussing his mother in therapy. Client was closed-minded and fearful about what he might discover if he confronted difficult issues. Client didn't want to feel that his mother was bad. Client had close relationship and fewer unresolved issues with his mother, so he was reluctant in therapy to say anything mean about her. Client was not ready to work through the impasse. Although catharsis was beneficial, it was an emotionally draining experience that client did not want to repeat, and in retrospect, client acknowledged he was afraid to deal with some of his issues.

   18. Client might have shut down in therapy because she was coping with stress in her daily life that included problems at work and an emotionally draining boyfriend.

   19. Client was resistant to accepting her faults and taking responsibility for her

problems, and she reacted childishly to therapist confronting her about being late. Client was fearful of exploring possible sexual abuse, and couldn't bear the idea of talking about it with her parents. Client's denial about her parents' role in her problems limited what therapist could understand about client's family dynamics. Client could only discuss vague symptoms of possible past sexual abuse, but had no concrete memories to explore. Client might have stopped working in therapy because she just didn't have it in her to explore her problems further.

20. Client would not give in and accept therapist's diagnosis of BPD.

3. Client Had Possible Transference Reactions to Therapist (7 cases, typical)

3. Client was very sensitive to criticism by therapist because her mother was critical of her. Therapist responded negatively toward client in the same way that client's parents did.

4. Client saw a similarity between therapist and co-workers' thinking that her interests are strange and scary. Therapist discounted client's interests the way her family did.

9. Therapist seemed like client's envied brother and sister combined. Therapist reminded client of client's mother in that both were not validating of client and made her feel invisible.

10. Client may have reacted to therapist in a manner that paralleled client's non-communicative relationship with his mother in her final years.

11. When therapy was in limbo, client's life in general was also in limbo. Client may

have unconsciously believed that therapist wanted to tarnish client's positive view of her father and thus spoil her relationship with him as her mother did. Client might have become less invested in therapy when she found out that therapist had cancer and feared she might die.

19. Therapist's reaction to incident with client's sister reminded client of her father, in that therapist was not diplomatic, nurturing, or reassuring. Therapist's lack of empathy for client's childhood struggle with learning math reminded client of her father.

25. Therapist reminded client of her domineering aunt.

4. Client's Personality Style, Issues, or Behavior Impeded Progress

(6 cases, typical)

3. Client thought that her personality characteristics and need for goal-setting and evaluating contributed to the impasse. Client is talkative, felt pressure to talk, and planned what she would talk about before sessions, which might have kept therapist from asking questions.

9. Client was enormously jealous of therapist, her kids, wealth, and successful practice. Client's envy of therapist was at the core of the impasse. Client wanted to quit when she felt that she lost her only advantage over therapist when therapist lost weight and became thinner than client. Client was angry that her financial and relationship goals had not been realized and that therapist was making money in the stock market. Client loved therapist, wanted to fuse with her and wished they

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were sisters. Client had strong feelings for therapist, wanted to "swallow her" and have her for her own, and finally decided that her envy was so strong that she had to quit. Client stayed as long as she did because she felt dependent on and idealized therapist.

16. Client was a difficult client who wanted to be the center of attention.

18. Client's sensitivity and insecurity may have caused her to take therapist's opinions too personally and not handle problems with therapy very well. Client was having problems in relationships with her boss and with her boyfriend when relationship with therapist was weakening. Client wondered if feeling lost and not having a clear sense of who she was had a negative impact on the therapeutic relationship.

19. Client's tendency to try too hard might have impeded progress.

20. Client asked for discussion with a physician in the clinic and thought he was conspiring against her when he suggested that getting upset was evidence that supported the diagnosis. Client is very intense and expressed her anger readily, and she realizes that it frightens people and that this might have made therapist and the clinic think she was crazy and obsessed with therapist. In the middle of therapy, client told therapist she had a fantasy about killing herself in front of therapist, and client thinks hearing this fantasy made therapist think client was borderline and obsessed with therapist. Client's enjoyment of S&M and her long and destructive relationship with a man could have been interpreted as characteristic of someone with BPD.

5. Client Did Not Have Clear Therapeutic Goals (2 cases, variant)

> 3. Client was vague about her issues. Client never understood what were realistic expectations of therapy and what was acceptable and not acceptable in the therapeutic relationship. Client did not begin therapy with high outcome expectations because she believed people who are successful in therapy have more tangible, serious issues than her.

> 10. Prior to beginning analysis, client did not have clear goals for therapy and was ignorant of the process. Lack of therapeutic goals contributed to client's frustration with therapy because client has always been a goal-oriented person.

DOMAIN 6: THERAPIST FACTORS ASSOCIATED WITH THE IMPASSE

1. Therapist seemed unempathic or did not listen to client (11 cases, general)

> 3. Therapist seemed unempathic when she advised client to try meeting men through personal ads rather than examine client's discomfort with dating and seemed to want client to start dating so that she would have something to talk about in therapy. Therapist used interventions that seemed irrelevant to client. Therapist watched the clock a lot and sometimes cut client off in mid-sentence at the end of a session. Therapist's non-verbal behavior suggested that therapist was not listening to client.

> 4. Therapist's constant questions about client's sexual activity with her boyfriend made client angry because she thought therapist wasn't listening to her answers. Therapist seemed conservative and seemed not to listen seriously when client

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spoke about her interest in the arts.

9. Therapist did not value client's seeking validation in a therapy group. Therapist seemed to disregard client's money concerns.

10. Therapist opposed client's independent exploration of his childhood, but client did it anyway. Impasse was created by series of complete verbal disengagements that indicated to client that therapist was not listening. Because she was very conservative and didn't like journalism, therapist suggested that client should be glad he didn't get a writing job he wanted. Therapist never connected with client's way of expressing himself. Therapist's responses seemed irrelevant, which suggested to client that therapist was not listening. Therapist was unable to relate to client.

11. Therapist did not seem to hear client's perspective. Therapist wanted client to express anger that client didn't feel.

16. While focusing on his relationship with father was cathartic, client felt guilty and was offended by therapist's suggestion that his mother might be blamed for some of his problems. Therapist seemed closed-minded and similar to other people client had relationships with who were not interested in the things client wanted to discuss.

18. Toward the end of treatment, client felt like a guinea pig regarding the biofeedback therapist had her do. Therapist tried to get client to stay in therapy by calling and leaving messages and she suggested that they could negotiate the fee, but client thought it was too late for that and that therapist was only being

responsive because client had forced the issue. Therapist was not understanding about client's reluctance to leave boyfriend.

19. Therapist suggested that client's boyfriend was not right for her, but client wasn't ready to end the relationship. Client got angry after therapist didn't read the journal she kept. Client had a negative reaction to therapist's reaction to client's disagreement with her sister.

20. Once client was stabilized with medication, therapist presented client with a diagnosis of borderline personality disorder with which client disagreed. Therapist minimized the importance of the diagnosis and of client's concerns about it and would not discuss it with client.

21. Therapist left client's church and called client repeatedly to go with her to the new church, and she became angry whenever client would not go, which made client feel guilty (client did go with therapist to church several times after therapist called). Therapist gave client's telephone number to a male church member, who repeatedly called client about joining the church. The last straw was when therapist called client 6 times in 2 hours after not seeing her for 2 weeks to get her back to church. Therapist also began to call client to chat about therapist's life and check up on client. Near end of therapy, therapist was talking more about her own boyfriend than about client's issues.

25. Client felt hurt that therapist minimized her weight gain and did not understand that she wanted to gain gradually. Client wished therapist could have recognized her success in gaining weight. Client was repulsed by therapist's suggestion to be

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fed intravenously at night, which did not address client's bad eating behaviors. Therapist lacked empathy. Therapist did not recognize the importance to client of being comfortable with men, given her eating disorder and rape, and made client feel "slutty" for wanting intimacy.

2. Therapist's Business Management or Motives Bothered Client (8 cases, typical)

   4. Therapist treated client like a commodity that therapist didn't want to lose.

   9. Client disliked therapist's referral of patients to husband for medication.

   10. Therapist announced fee increases unexpectedly rather than discuss them with client in advance.

   11. Client and therapist frequently clashed over client's ability to pay for treatment.

   16. Therapist seemed to be prolonging therapy just to get more money.

   18. Therapist's fee structure was rigid and high, especially when client was out of a job. In last 4 to 6 weeks of treatment, client and therapist had conflict regarding fees, and client found therapist callous and coldly professional when she insisted client pay for missed session. Client wanted a low-maintenance relationship and did not want to argue about money.

   19. Therapist suggested that client would feel more self-sufficient if she used her parent's financial gift to begin paying full fee, but doing so only created conflict for client because the fee was still beyond her means and she felt guilty because her parents criticized her for telling therapist about the gift and using it for therapy. Issues over money marked the beginning of client's dissatisfaction because she

began to distrust therapist.

21. Therapist seemed to try to manipulate client into staying because she needed the business. Therapist had recently started a private practice and needed income.

3. Therapist was Critical or Dismissive of Client (7 cases, typical)

3. Therapist seemed very condescending about client's lifestyle, much like her mother, friends, and colleagues. Therapist seemed to discount client's concerns by suggesting she should be fulfilled with her present life. When client would suggest a topic to explore, therapist would seem agreeable but not pursue it. Therapist seemed uninterested in client as an individual. Client's dissatisfaction with therapy peaked when she let down her usual defenses and became emotional and felt put down by therapist, who remarked that client typically spoke of silly things instead of deeper issues; therapist's condescending remark reminded client of similar negative experiences with other people in her life. Therapist never discussed her approach to therapy, inquired about client's comfort, or asked if client thought she was making progress.

4. Therapist didn't seem to take client's dreams and ambitions seriously. In previous work with client, therapist implied that client should accept therapist's style whether she liked it or not.

9. Therapist dismissed client's concern about her weight and criticized her for getting plastic surgery, but then therapist became thin and said she was considering plastic surgery for herself. Therapist had a hostile and arrogant way of dismissing

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client's interests in other forms of therapy and her accomplishments, such as her weight loss.

10. Therapist made it clear that their non-communication was client's failure. Therapist criticized client's ability to free-associate. Therapist dismissed as impossible client's 50-page erotic fantasy about himself, which left client feeling crushed. Therapist rejected client's desire to read Freud because client could not read German.

19. Therapist seemed to disapprove of client.

20. Therapist seemed critical of client's tendency to joke out of nervousness when she discussed childhood sexual abuse. Therapist never asked to hear client's interpretation of her suicide fantasy. Therapist made client feel that certain things she said or did were not acceptable.

25. Therapist questioned client's choices in men. Therapist was judgmental of client. Therapist's interventions were very judgmental. Therapist minimized client's improvement and always implied there was more work to do.

4. Therapist's Own Issues Interfered with Therapy (7 cases, typical)

4. Therapist seemed intimidated by client's lists of ideas and topics for sessions because she would not discuss them.

9. Therapist's grandiosity prevented her from considering that she could be wrong about her diagnosis for client. Therapist was narcissistic about trying to restrict client to therapist's method of therapy. Therapist was manipulative, opinionated,

arrogant, demanding, draining, and controlling, though at times she was empowering. The only way impasse could have been resolved would have been for client to feel good about herself and equal to therapist, but client wondered if therapist could have allowed them to be equal.

11. Therapist might have had issues related to her own father that interfered with therapy.

18. Therapist intervened in a motherly manner that made client uncomfortable and seemed to be an overstep of the therapeutic boundaries. Therapist seemed to treat client as she treated her own children.

19. Therapist may have had issues with her own father, and she was reluctant to reveal personal information to client. Therapist missed about 4 sessions due to family problems of her own, and this was difficult for client at a time when she was questioning the value of therapy.

21. Therapist left their church and called client repeatedly to go with her to the new church, and she became angry whenever client would not go. Therapist had personal issues that interfered with sessions and caused her to lose objectivity, and by the end of therapy she was talking about her boyfriend and other issues at the expense of discussing client's issues. Therapist might have needed therapy to deal with loss of her mother.

25. Client began to view therapist as bull-headed and eccentric because she talked more about herself and the training program than about client's issues. Therapist let her own problems get in the way of client's therapy. Therapist seemed

preoccupied with food and often interrupted client to talk about food she liked.

5. Therapist's Limitations Interfered with Therapy (4 cases, variant)

9. Therapist failed to diagnose client with bipolar disorder and attention deficit disorder. Therapist lacked knowledge about how to diagnose.

10. Therapist slept a lot in session when she was taking medication and client felt responsible for keeping her awake. Therapist took a lot of notes and seemed active early in treatment, but toward the end after her illness she did not seem to be working hard. Therapist never got re-certified after her illness and client thought her awareness was limited. Therapist's age, illness, year-long separation, and diminishing energy contributed to the impasse.

18. Therapist neither knew much about the alternative therapies that interested client nor encouraged client to purse them, and client speculated that therapist was not able to see that client needed something besides talk therapy or biofeedback.

20. Therapist might have been afraid of client when client seemed obsessed with therapist and when client stubbornly demanded to talk about the diagnosis. Client speculated that therapist could not end therapy easily when she determined that client was obsessed with her, so she tried to force her to leave by giving her a diagnosis she wouldn't accept.

6. Therapist Would Not Discuss Problems in the Therapeutic Relationship

(2 cases, variant)

> 3. Therapist was not open to discussing problems in the therapeutic relationship.

> 20. Therapist absolutely refused to discuss the diagnosis she gave to client.

DOMAIN 7: RELATIONSHIP FACTORS ASSOCIATED WITH THE   IMPASSE

1. Client and Therapist Differed Over Focus or Amount of Guidance or Depth of

Sessions (9 cases, typical)

3. Therapist did not give enough directions or probe with enough depth. Therapist didn't confront client about her defenses. Client wanted more structure and would have been more comfortable if she and therapist had discussed goals in the beginning of therapy. Client expected therapist to say more and expected more exploration of her life. Client wanted therapist to lead her. Client wished therapist would have been more self-disclosing so client could know more about her as an individual. Client became frustrated with therapist's lack of initiative and probing questions.

4. Therapist's style was to absent herself and be less interactive. Therapist did not acknowledge client's needs for goals and instead encouraged her to do free association, but client wanted more focus by bringing in charts and lists related to her goals. Therapist's observing style made therapy seem controlled. Therapist did not acknowledge differences between her and client or that she was not omnipotent, and she never shared anything about herself. Client and therapist never

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discussed the ground rules of therapy. Therapist wanted sessions to be unstructured but client wanted guidance about what to discuss. Client thought that therapist was only observing her rather than guiding client in the right direction. Client believed that she had no input into what they were going to discuss. Client wanted more analysis rather than only emotional support. Therapist provided minimal feedback and seemed to have her own agenda.

9. Impasse began in last 4 years of treatment when therapist disagreed with opinions client obtained from ex-husband (a biopsychiatrist) that client was bipolar and needed medication, which made client feel caught between therapist and ex-husband, who disagreed with each other and had no regard for each other.

10. Therapist refused client's request to audiotape sessions. After her illness, therapist wanted to continue retrospective emphasis in therapy, but client found this unacceptable. Therapist did not meet client's expectations for her to be a mentor (or idealized parent) with whom he could explore life without fear and criticism. Client agreed with a therapist he saw when main therapist was ill that client should be looking ahead in therapy instead of looking back on childhood, so upon returning to main therapist client thought it was unacceptable when therapist wanted to return to retrospective work. Therapy sometimes lacked in-depth exploration. What little exploration of client's issues they did was unstructured, which client did not like. During the last year of therapy client and therapist never assessed goals or progress, and client thought treatment was free-form and useless.

11. Main impasse emerged from disagreement over significance of client's issues

with father, such as the impact on client's life of her father leaving home. Client felt that the focus on eliciting anger toward father was misdirected, although she didn't have the self-esteem to speak up. Client viewed therapist as a good clinician, but they disagreed about client's issues with her father and how they should process them, and their relationship dissolved as a result. Client disagreed with therapist's approach of challenging of client's memory of the bond with her father.

16. Therapist was gently but annoyingly persistent in trying to refocus discussion back to client's mother each time client attempted to avoid the subject. Therapist's directiveness led client to avoid topic (which put a halt to progress). Client was uncomfortable with therapist's pushy effort to relate all of client's issues to his relationship with his parents. When therapist wanted to focus on client's relationship with his mother, client changed the topic, but therapist eventually redirected the focus back to client's mother. Client thought that the connection with therapist was broken.

18. As therapist got to know client and believed client was getting stronger, she became more confrontational and aggressive. Some of therapist's insights about client did not offer anything new. Client thought relationship was not equal and that therapist had the power. Client began to think that assessing her past in therapy was limiting, because client wanted to move forward in her life. Client believed that part of her problem was that she needed to get outdoors and do something fun and that she needs deep relaxation, such as through meditation, to deeply explore her issues. Client did not have the support of friends, so she sought

therapist's help, but she also believed there were limits to how helpful talk therapy could be for her. When client and therapist began discussing client's strained relationship with her mother before she died, therapist seemed to take mother's position and dig for unresolved issues from client's past when client preferred to focus on coping with present issues. As therapy progressed, therapist moved toward exploring relationship issues that client did not want to pursue. Client became disenchanted and thought therapist was too directive, opinionated, and not knowledgeable enough about the situation when she pushed client to leave her boyfriend before she felt ready. At first client thought impasse was her fault and another one of her failures, and she hoped that therapist's directive approach was confined to a few issues, but she soon realized it was therapist's general style.

20. Client was supposed to sign that she agreed with the diagnosis or they could not continue with treatment. Client did not understand why therapist did not agree with previous diagnosis that client was bipolar, especially since client's disorganized thoughts and suicide ideation diminished on lithium. Client wanted evidence from therapist that client has BPD. Client consulted with her psychiatrist, who called therapist, which infuriated therapist.

25. Client wanted to learn to eat flexibly, but therapist wanted her to maintain a rigid diet and record everything she ate. Therapist wanted to focus solely on getting client to gain weight rather than on her feelings and cognitions. Therapist focused on weight gain for client, but client also wanted to obtain a stable weight and not care about what she ate. Treatment was behavioral and health-oriented

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rather than psychological. Client would have stayed if they had talked about her feelings associated with being raped. Client and therapist had different goals regarding client's need to gain weight.

2. Relationship Was Hampered By Cultural Differences or Dissimilar Interests and Perspectives (5 cases, variant)

3. Ethnic and cultural differences added to lack of communication and bond. Client didn't connect with or feel warmth from therapist because therapist belonged to a cultural group with which client wasn't comfortable. As time progressed client realized there were dissimilarities between her and therapist.

4. Therapist and client had differences that were never addressed. Client questioned whether therapist's style fit with her and if she needed a therapist with more similar interests.

9. Client felt conflicted about being Jewish because therapist rejected Judaism for herself.

10. Client's liberal views differed from therapist's conservative views, which contributed to a lack of connection between them. Client thought impasse related to their being mismatched.

25. Client speculates that the age difference between her and therapist played a part in the impasse.

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3. Boundary Between Professional and Personal Relationship Became Blurred

(5 cases, variant)

3. Client was uncomfortable talking about problems she had with co-workers because therapist knew them socially.

9. Since her yearning for a relationship was fulfilled in therapy, client did not consider leaving; this prevented her from seeking other relationships and made her wonder if she had borderline personality disorder. As client's depression deepened, she attributed her lack of affect and inability to interact with others to therapist. Therapist didn't have good professional boundaries, was too stimulating and intrusive, and wanted to keep client in therapy for her own needs. Client felt like she was therapist's sounding board about other clients and believed that therapist's breaches of confidentiality were rubbing off on client in her own practice.

18. Therapist intervened in a motherly manner that made client uncomfortable and seemed to be an overstep of the therapeutic boundaries. Therapist seemed to treat client as she treated her own children.

21. Relationship was confusing and awkward to client because it had the feeling of friendship yet therapist limited her self-disclosure. Therapist began to call client to chat about therapist's life and check up on client, which blurred the boundaries of therapy and friendship. Therapist left their church and called client repeatedly to go with her to the new church, and she became angry whenever client would not go, which made client feel guilty (client did go with therapist to church several times after therapist called). Therapist gave client's telephone number to a male

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church member, who repeatedly called client about joining the church. The last straw was when therapist called client 6 times in 2 hours after not seeing her for 2 weeks to get her back to church.

25. Therapist treated client as a colleague and daughter rather than as a client. Therapist began relating to client as if they were colleagues and discussed other patients' problems, which made client uncomfortable talking about her own eating problems and resentful that her time in therapy was being used to discuss other patients (even though she was not paying). Client was upset that therapist was gossiping about client's training program to dissuade her from becoming a psychiatrist and suggesting that her reasons for choosing psychiatry as a career were wrong. When client decided to take a year off from training, therapist told her she would see her for free even though it was unethical because client would not be a resident. Therapist viewed client as a daughter and became too involved in her personal life. Therapist seemed to abandon her professional role, perhaps because client reminded her of the daughters she missed. Therapist seemed overly invested in client's treatment and once offered to pay her cab fare to therapy. Therapist shared confidential information about client with other people on 2 occasions. Therapist spent most of the sessions talking about her personal life in sessions. Mother-daughter aspect of relationship prevented client from being natural and disclosing certain behaviors that she thought therapist would disapprove of or judge.

DOMAIN 8: OUTSIDE FACTORS ASSOCIATED WITH THE IMPASSE

1. Other People Influenced Client's Perspective on the Impasse (8 cases, typical)

3. Although client's friends were supportive of client being in therapy, they also validated her negative feelings about therapy.

9. Several of client's friends and her ex-husband did not like therapist and questioned her competence. Friends told client she was not getting better in therapy, and one friend suggested that therapist's own issues got in her way as a therapist. Client's friends confirmed her belief that therapist was extremely grandiose.

10. Although client's friend, who had also experienced an impasse, did not push him to quit, she may have served as a role model who let him know he did not have to stay in therapy if he was not happy. Client's increasing social activities made him feel that he was growing, and he began seeing many opportunities for personal growth beyond what he was getting in analysis.

11. Client's boyfriend questioned therapist's hypothesis that client's father did not care for her. Client's boyfriend urged her to consider that her insomnia was physical rather than psychological.

19. People in client's life, including her boyfriend and father, told client that therapy wasn't necessary for change.

20. Client's boyfriend supported therapist and told client she was sick and should accept the diagnosis, which made client angry. Client was told by her massage client, a therapist, that everybody has some borderline and narcissistic traits.

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Client's mother was sympathetic to client's situation.

21. Client's husband did not want her to go to therapy because he believed therapy was for crazy people, and he questioned why she continued during the impasse.

25. Client discussed impasse with her mother, who urged her to find a new therapist. Client's parents noticed client's improvement, which confirmed for client that she should stop seeing therapist. Internist agreed that therapist's goals for clients were unrealistic. Client's boyfriend sided with therapist's approach to therapy.

2. Cost Influenced Client's Decision to Quit (3 cases, variant)

3. Cost and inconvenience became issues when client began to think that she wasn't getting anything out of therapy. The expense of therapy when client was poor and needed to move to a new apartment had an influence on when she quit.

11. Client's decision to end therapy might have been influenced by her running low on money due to insomnia that prevented her from working full-time.

21. Lack of money influenced client's decision to quit, although not having money would have mattered less if therapy was more satisfying.

DOMAIN 9: HOW CLIENT ADDRESSED THE IMPASSE

1. Client Withdrew in Session or Cut Back on Frequency of Sessions

(9 cases, typical)

4. Rather than address the impasse with therapist, client spent sessions chit-

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chatting and repressing her negative feelings about therapist because she believed that therapist was trying to help.

9. When client decided to leave she did so gradually, giving excuses from week to week.

10. By the last year of therapy, client used buzz words to keep therapist talking at a surface level and get through the hour (client viewed this strategy as a time-waster, but he knew it helped to avoid silence). Client reduced the number of weekly sessions from four to one. After therapist's illness and year-long separation, impasse was more obvious and client did not want to do anything.

11. Client, whose life also was in limbo at the time, only went through the motions of therapy. Client stopped and started therapy several times during final year. Client kept her feelings about the impasse to herself, because she viewed therapist as right and god-like for helping her so much. Client did not discuss impasse with therapist or other group members. Client coped with anger by leaving therapy.

16. Therapy began to feel too predictable, and client felt less like participating.

18. As impasse developed, client disclosed less to therapist and questioned the affordability of therapy.

19. Client eventually began coming to sessions less often. Client began to be careful about what she revealed about herself to therapist.

21. Client and therapist had fewer individual sessions due to pressure to join the church that was spilling over into their sessions, client's growing sense of strength, and their schedules.

25. Client began cancelling appointments or coming late to sessions because she did not want to see therapist and felt sick when she thought of going.

2. Client Tried to Give Therapy a Chance (6 cases, typical)

3. Client stayed in therapy for as long as she did because people advised her that it takes time to build rapport. After some sessions, client told herself that relationship with therapist just needed time to develop or that it had not been an especially good session.

9. Client stayed in therapy (after telling therapist she was not making progress) when therapist praised client's accomplishments and urged her not to give up.

10. Client got over his anger when he accepted responsibility for the decision to be in therapy. Client tried to make relationship work even though colleagues encouraged him to seek another therapist. Client's tenaciousness kept him from quitting despite detriment to his interests. Client had been aware of impasse for a year before therapist's illness provided client an opportunity to quit.

18. Client thought that if she just trusted therapist and went along with her agenda they could resolve the impasse. Client sensed there was an impasse but she ignored her intuition that therapist was not right for her because she believed convention dictated that she trust her doctor. Client remained in therapy because therapist was easy to talk to. Although her departure might have seemed abrupt to therapist, client spent last 4 to 5 months evaluating therapy and deciding whether to quit.

19. Client coped with the impasse by trying harder. It took client 5 months to decide to quit because she didn't want to give up, respected therapist's opinion, and thought she needed therapy.

21. Client did not bring up impasse with therapist because she believed she had more work to do and because she felt obligated to support therapist's new private practice.

3. Client Talked with Others About the Impasse or Sought Information or Help Outside Therapy (6 cases, typical)

9. Client read about bipolar disorder when therapist did not address it with her in session. Client temporarily stopped seeing therapist while she sought medication from a psychiatrist, whose prescription for Ritalin helped, but client returned to therapist. Client sought validation in a therapy group because she did not receive it from therapist, and it changed her life;

10. Client talked with colleagues. Client used sources outside of therapy to enrich himself when therapy failed to provide this, including reading Freud, working with a charitable foundation, and re-establishing contact with relatives.

11. Client talked about impasse with her boyfriend and friends.

19. Client coped with impasse by talking with a friend. (Client resisted the suggestion of a friend and the therapist to try anti-depressants.)

20. Client turned to her sister and mother for support. Client consulted with her psychiatrist, who suggested she had some borderline personality characteristics and

reassured her that she was not a borderline. Client read about borderline

personality disorder.

25. Client asked her internist to write to therapist in support of client's progress in

gaining weight.

4. Client Thought About or Reflected on the Impasse (6 cases, typical)

4. Client thought some about impasse outside therapy session but did not dwell on

it and instead focused on other things she was doing in her life.

9. Client spent a lot of time thinking about impasse outside of sessions.

10. Client thought about impasse a lot outside of sessions.

16. Client let impasse roll off him and viewed it as typical of relationships he had

with other people.

19. Client tried to be objective about impasse, weighed the pros and cons of

therapy, and did not believe the impasse was entirely her or therapist's fault.

25. Client spent a lot of time outside of sessions thinking about the impasse.

5. Client Brought Up Impasse With Therapist (5 cases, variant)

3. Client addressed her frustration with therapist, who merely asked client to

identify what she wanted from therapy.

9. Client told therapist she was not making progress.

10. When client brought up the impasse, therapist said it represented the client's

unresolved issues, that impasse didn't exist, and that more work together would

resolve it. When client felt that he was ready to quit, therapist urged him, during several months of sessions, to stay in therapy.

19. Client raised impasse issue a few times and she and therapist discussed client leaving.

20. Client tried to discuss the diagnosis with therapist and a physician in the clinic. Therapist acknowledged client's distress but would not change or discuss the diagnosis and wanted to move on in therapy.

DOMAIN 10: HOW THERAPIST ADDRESSED THE IMPASSE

1. Therapist Did Not Directly Acknowledge the Impasse (11 cases, general)

3. Client was not sure if therapist was aware of the impasse. Client had the impression that therapist felt client was wasting therapist's time. Therapist did not follow up when client called and left a voice mail message that she was cancelling and then just stopped coming, which confirmed for client that therapist was never invested in her.

4. Client thinks therapist must have been aware of the impasses but didn't express it.

9. Therapist was not aware of the impasse and wanted to continue analyzing client.

10. Therapist remarked that impasse didn't exist.

11. Client believes therapist was not aware of impasse.

16. Client believed therapist was very aware of the impasse because he was very tuned in to client.

18. Therapist might have been aware of client's dissatisfaction when she told client that client was emotionally distant and may have wanted to break through her defenses.

19. Therapist might have been aware that client believed she wasn't making progress, and therapist thought this could be overcome by increasing the frequency of sessions.

20. Although therapist acknowledged client's distress, therapist would not discuss the impasse.

21. Therapist might have been aware of impasse, although they did not discuss it.

25. Therapist told client she believed client lied to her about missing sessions, but therapist probably was not aware that client viewed countertransference as a major problem in therapy.

2. Therapist Encouraged Client to Return to Therapy (2 cases, variant)

4. Therapist suggested client come back to discuss the impasse.

19. Therapist did not agree with client's decision to quit but did not get angry and reassured her that she was available if client needed her again.

DOMAIN 11: CLIENT FEELINGS ASSOCIATED WITH THE IMPASSE

1. Client Had Negative Feelings Directed Toward Therapist (11 cases, general)

3. Client sometimes felt bothered and disliked therapist when therapist was condescending or confrontational. Client was frustrated by lack of progress and

because she felt that the therapist, as the professional, should have asked probing questions or provided direction. Client felt angry and annoyed. Client was disappointed that she had to do all the talking. Client was hurt that therapist seemed inattentive.

4. Client was angry that therapist did not appreciate client's interest in writing. Client felt dissatisfied and discouraged with therapy. Client was resentful when she wanted to use her list of issues in sessions and therapist told her she preferred less structure.

9. Client felt conflicted and pained about her feelings toward therapist. Client felt wounded because therapist questioned client's choice to do alternative therapy. Although she loved therapist, client felt rage and envy because she thought her life was getting worse while therapist's was getting better. Client was angry that her financial and relationship goals had not been realized and that therapist was making money in the stock market. Client felt put down, humiliated, and shamed.

10. Client was disturbed about having to keep therapist awake in their sessions. Client felt very angry with therapist and shortchanged by therapy (although sessions remained civil), and he attributed this to Freudian analysis rather than to therapist. Client felt irritated toward therapist and thought she was not understanding him in their final sessions when she tried to get him to stay in treatment. In last year of therapy, client was frustrated because therapy did not keep up with his physical and emotional gains outside of therapy. Client felt "flattened" by frustrating sessions. Client was frustrated that they couldn't

communicate effectively. Client felt crushed and shattered by therapist's non-empathic response when client told her how he ruined an opportunity to obtain a writing job he highly valued. Client felt confused and put off when therapist disapproved of his reading Freud in English.

11. Client became so mad at one of therapist's interventions that she revoked payment and later cried when therapist left telephone message that she would never work with client again. Client was angry that therapist could help her with other issues but not with impasse issue. The impasse made client feel irritated, angry, confused, very upset, and disillusioned with therapy. Client was angry when she left because therapist made her feel that she was being ungrateful.

16. Client felt frustration, anger, and dislike for therapist. Client began to dislike therapist when he pushed him in therapy. Client was offended by therapist continuously relating his problems to his mother. Client became defensive to protect himself from therapist.

18. Client tried to understand their dispute over billing from therapist's perspective, but she began to feel angry and view therapist as cold. Client was offended by therapist's presumptuous statements that insulted client's sense of independence. Toward end of treatment client felt disappointed.

19. Client felt distrustful of therapist over her suggestion to pay full fee. Client was angry when therapist was critical of her.

20. Client is still mad about the impasse and believes it should not have happened.

21. Client began to pity therapist. Client felt fed up with therapist's pressure to

join her church and with sessions that seemed non-productive. Client was angry with therapist's missing an appointment.

25. Client usually left therapy feeling amused because she realized that much of the therapy was for therapist's benefit.

2. Client Had Negative Feelings in General About the Impasse (7 cases, typical)

4. Client felt uncomfortable but continued to like therapist despite the impasse.

9. Client felt hopeless because therapist wouldn't help her with her bipolarity.

10. Impasse was somewhat irritating to client even though he never missed a session.

18. Toward the end of treatment client felt morose, despair about the therapeutic relationship, lost, confused, bewildered, and resentful.

20. Client experienced disbelief, shock, frustration, and betrayal when therapist would not discuss diagnosis. Client, afraid of borderline people, was dismayed that anyone would think she is borderline. Therapist's insistence about the diagnosis felt like a slap in the face to client.

21. Client felt empty and sad after sessions. Client felt that she lost the woman she originally went to see.

25. Client realized therapist had flaws and felt sorry for her. Client felt confused and hurt because others praised her weight gain but therapist minimized it.

3. Client Felt Guilty or Blamed Self For Not Being a Good Client

(4 cases, variant)

4. Client felt guilty because she wanted something different than what therapist was providing.

10. Client felt "drenched in guilt" that he couldn't free associate well enough for therapist.

11. Client blamed herself for not being able to feel what therapist wanted her to feel about her father.

19. Client felt upset that she wasn't progressing in therapy or living up to therapist's expectations to be a good client

25. Client felt badly that she could not meet therapist's expectations.

4. Impasse Did Not Have Big Impact on Client (4 cases, variant)

3. Since her expectations for therapy were not high, client was not bothered a lot by the impasse.

10. Impasse did not have a major impact on client's life because he was fed up with therapy.

16. Impasse did not have much impact on client's daily life.

21. Impasse did not affect client's daily life.

DOMAIN 12 - IMPACT OF IMPASSE ON CLIENT'S VIEW OF THERAPY

1. Client Might Return to Therapy But Would Do Things Differently

(8 cases, typical)

3. Client might try therapy again, but might use self-help books and talk to friends first.

4. Client would make sure that goals are discussed if she were to enter therapy again.

10. Client might go back to group or individual therapy after thinking carefully about it first, but he believes he would be good in therapy because he would work hard at it.

11. Client would return to therapist in future. Client has sought help since, although it is non-traditional therapy.

16. Client would seek further therapy as preventative treatment because he enjoyed it and found it uplifting.

18. Client would only seek further therapy (but with different therapist) if everything in her life fell apart, and she would make sure to clarify issues about billing immediately.

21. Client does not currently feel need to be in therapy, although she plans to return someday.

25. Client speculates that she might be more successful with a younger and more professional therapist. Client has plans to see another therapist when client has enough money.

2. Client Became Disenchanted with Therapy or Therapist After Impasse

(6 cases, typical)

9. Client would not seek individual therapy again for fear of becoming entrenched in long-term treatment. Client believes she should have sued therapist for misdiagnosing her.

10. Client now believes analysis is inefficient and that clients can be helped with briefer therapy.

16. Client became disappointed as his view of therapist changed from seeing him on a pedestal to seeing him as an ordinary person.

18. Before the impasse, client was more optimistic about therapy. Client became disenchanted with therapy. In the end, client and therapist liked each other and client valued therapist's insights, but there was distance, and client was wary about disclosing.

20. Client would not seek talk therapy again because she would have difficulty trusting doctors and believes they are judgmental and non-communicative at times when clients need them most, but she believes therapy can be useful for others, including her daughter. Impasse harmed client's trust of all people.

25. Client feels hesitant to return to therapy.

4. Impasse Did Not Change Client's View of Therapy (2 cases, variant)

11. Impasse did not change client's view of therapy,

21. Impasse did not change client's positive view of therapy in general.

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