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Attrition and Psychotherapy

by

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Abstract

Attrition in psychotherapy, also known as dropout, is a problem that affects clients who terminate, their families, therapists, mental health systems, and the overall community. Research on attrition is vast. However, the majority of this research has been done post hoc, relied on quantitative methods, and looked primarily at client demographic variables as the predictors of attrition. This has resulted in inconsistent findings, offers little to no useful information about attrition, and appears to blame clients for failed therapy. There has been little research on attrition from the perspective of clients who terminate. This study was designed to answer the question, why do clients choose to terminate therapy prematurely? Qualitative methods were used. Twelve participants engaged in in-depth one-on-one interviews. The interviews were transcribed and analyzed using Constructivist Grounded Theory methodology. In-session and out-of-session behaviors by therapists were found to be the key reasons participants chose to end therapy. Experiencing invalidation (rejection of a person's experiences, emotions, thoughts, and perceptions), invalidation of identity (rejections based on a person's sexual identity), invalidation of culture (rejections based on a person's culture), problems not being solved, and not feeling valued by the therapist were key factors in participants' decisions to terminate therapy. Immediate and long-term consequences of these experiences, including questioning sanity, feeling anger, feeling like a burden, increased pain and despair, prolonging of suffering, and experiencing the loss of an important opportunity are also addressed. Implications and recommendations for theory, research, education, practice, and social work are discussed.

Dedication

This dissertation is dedicated to all the participants I interviewed. Your openness about your experiences was invaluable to this dissertation, as well as the entire field. I am grateful to you all.

Acknowledgments

I am extremely grateful to my chair, Maria Talbott, and to my entire committee for all of your help and guidance throughout this process. I am also grateful to my cohort, Carolina, Molly, Miriam, and Jared. It has been an honor knowing you all and going on this journey with you. I would also like to thank Andy and Linda Homan, Ethan and Kristina Machel, Claire and Peter Underhill, Sandy Ngyuen, and Linda Hasson: each of you has been there with me throughout this, and your love, patience, and support have been invaluable. I would finally like to thank Strummer for being my companion and sitting on me while I did this work and Al, who took the spot on my lap when Strummer had to move on.

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Chapter I. Introduction

Mental illnesses are common in the United States. According to the National Institutes of Health (NIH) approximately 17.9% of adults in the U.S. have a diagnosed mental illness. This statistic does not include the percentages of people with alcohol and drug problems. The NIH estimates that 46.3% of adolescents (ages 13-18) in the U.S. have a mental illness, excluding drug and alcohol problems (NIH, 2017).

According to the NIH, the annual cost of mental illness in the US is 317.6 billion dollars. This includes direct (costs of mental health care, clinical care) and indirect costs (disability support, loss of employment). Missing from this financial analysis is the cost of loss of productivity due to premature death, hospitalization, homelessness, and incarceration of people with mental illnesses. It is estimated that 22% of people incarcerated in the US have a mental illness, and that 33% of homeless adults have a serious mental illness (Harwood, Ameen, Denmead, Englert, Fountaine, & Livermore, 2000; James & Glaze, 2006). None of these estimates include the emotional costs of mental illnesses on the individuals who have the mental illness and their families (Insel, 2008).

Research has found that the stigma of mental illness affects both people with mental illness, and the family members of people with mental illnesses. The stigma for people with mental illness includes discrimination in the work place, housing options, and in society (people without mental illnesses not wanting to socialize with people with mental illnesses) (Link, Cullen, Frank, & Wozniak, 1987; Penn et al., 1994; Martin, Pescosolido, & Tuch, 2000). Other research has found that the stigma associated with

being the family member of a person with mental illness negatively impacts relationships

with extended family and friends (Wahl & Harmon, 1989; Shibre, Negash, Kullgren,

Kebede, Alem, & Fekadu 2001; Struening, Perlick, Link, Hellman, Herman, & Sirey,

2001; Ostman & Kjellin, 2002). Often, parents, siblings, and spouses are blamed for

causing or contributing to a person's mental illness and for failing to keep the person with

the mental illness in treatment or to prevent relapse (Corrigan & Miller, 2004).

Psychotherapy Attrition

Given the prevalence of mental illness in the US, the negative impacts of

mental illness on individuals, families, communities, and society at large, it is critical

that mental health treatment is available and utilized. Systematic reviews of

research papers on psychotherapies have found several psychotherapies for many

major mental illnesses and high risk behaviors including depression, generalized

anxiety disorder, self- harm, and suicidal behaviors to be effective (Shinohara,

Honayahiki, Imai, Hunot, Caldwell, Davies, Moore, Furukawa, & Churchill, 2013;

Hunot, Churchill, Teixera, & Silva de Lima, 2007 Hawton, Witt, Taylor, Arensman,

Gunnell, Hazell, Townsend, & van Heeringen, 2016; Calati & Raffaella, 2016). The

efficacy of these treatments is usually based on clients completing the treatment. A

major problem affecting psychotherapies is premature discontinuation of treatment.

Rates of dropout are inconsistent across studies. There have been two major

meta analyses of therapy attrition in the past three decades. Wierzbicki and Pekarkik

(1993) report that between 35.9 % and 48% of clients terminated therapy prematurely,

while Swift and Greenberg (2012) report that dropout rates ranged from 0% to 74.23%

across the 669 studies. Swift and Greenberg (2012) report the weighted dropout rate as 19.7%. Both sets of authors report that how dropout is defined (covered in detail in the next chapter) greatly affects the reported rates of dropouts in studies. For example, studies in which dropout was defined as being based on therapist judgment had the highest dropout rates of 37.6% (Wierzbicki & Pekarkik, 1993) and 48.43% (Swift & Greenberg, 2012). Swift and Greenberg (2012) report that studies in which dropout was defined as either the failure to attend a set number of sessions or failure to complete a treatment protocol had the lowest attrition rates of 18.3% and 18.4% respectively. Wierzbicki and Pekarkik (1993) report that studies in which dropout was defined as failure to attend a scheduled session or failure to complete a set number of sessions had dropout rates of 35.87%, and 48.23% respectively.

Premature termination of mental health treatment is a serious problem that negatively impacts the lives of clients who drop out, the clinicians who are working with them, mental health clinics, and society (Swift & Greenberg, 2012). Numerous researchers have found that clients who terminate therapy prematurely have worse treatment outcomes (Cahill, Markham, Hardy, Rees, Shapiro, Stiles, and Macaskill, 2003; Herman, Blumenthal, Babyak, Khatri, Craighead, Krishnana, and Doraiswamy, 2002; Killapsy, Banerjee, King, and Lloyd, 2000; Lampropolous, 2010; Schindler, Hiller, and Witthoft, 2013). Barrett, Chua, Crits-Christoph, Gibbons, and Thompson (2008) report that client attrition negatively affects clinicians' utilization of time and creates a loss of revenue. Others report that attrition often leaves clinicians feeling bewildered, angry, and likely to label themselves and their clients as failures (DuBrin & Zastowny, 1988). Some

researchers have reported that therapy attrition can have negative consequences for

society due to the costs of untreated mental illness (Barrett et.al, 2008). Therapy attrition

may also confuse treatment efficacy findings by either under or over emphasizing

treatment outcomes, and impacting the external validity of randomized controlled trials

(RCT) (Hoffman & Suvak, 2006). Given the negative consequences, having a thorough

and accurate understanding of attrition is critical so that solutions to the problem can be

generated.

Of course, not all attrition is negative. Attrition may occur as a result of clients

moving, clients improving, or clients ending a process that is not working. This

dissertation is concerned with the factors that contribute to attrition in which the

outcomes are likely detrimental for clients as their mental health has not improved.

Understanding the various factors that contribute to attrition is important, given the

negative consequences of premature discontinuation of psychotherapy.

There is an extensive amount of research literature about attrition from

psychotherapy. However, even with the vast amount of research on attrition there is still

little understanding about the causes of attrition (Berghofer et al, 2002; Edlund et al.,

2002; Swift & Greenberg 2012; Wierzbicki & Pekarkik, 1993). The lack of

understanding of attrition is due in large part to the inconsistent findings regarding both

frequency and predictors of dropout (Berghofer et al, 2002; Edlund et al., 2002; Swift &

Greenberg 2012; Wierzbicki & Pekarkik, 1993). These inconsistent findings may be a

result of how the research on attrition has been historically conducted. The majority of

this research appears to have utilized data that were gathered during studies in which

attrition was not the specific focus of the study, and the available data about clients were analyzed post hoc. Research on attrition has primarily focused on client demographic variables, and occasionally provider and treatment variables as predictors of attrition. The previous research has also been constrained by small sample sizes and homogenous sample groups (Edlund et al., 2002). This has resulted in findings that are inconsistent and appear to have no external validity.

Another problem in the research on therapy attrition is the lack of a theory about attrition. No paper on attrition offers a theory that guides the research. The closest thing to a theory of attrition is a model of attrition presented by Swift and Greenberg (2012). Their model states that there are three contributing factors to attrition: client variables, provider variables, and research study/design variables. They offer no theory as to how these variables contribute to attrition.

The purpose of this study is to conduct research on attrition in a way that is different from how it has been historically studied. Qualitative methods were used to interview people who ended psychotherapy prematurely in order to begin building a theory of why some clients choose to end psychotherapy early. To develop a comprehensive theory of attrition, it will be necessary to include data gathered from interviews with psychotherapy clients and psychotherapists, as well as contextual data about where the psychotherapy is being conducted and what resources are available to both clients and clinicians from the clinic. In this study, I focus solely on clients who have ended treatment early. Specifically, I answer the question, from their own point-of-

view, why clients choose to terminate therapy prematurely? I hope that later this work can be combined with other efforts to provide a comprehensive theory of drop out.

In order to answer this question, I conducted qualitative interviews with 12 participants who ended psychotherapy prematurely. Questions were focused on what experiences, in-session and/or out-of-session, contributed to the decision to end treatment early. The recordings of the interviews were transcribed and analyzed using constructivist grounded theory methodology.

This study provides valuable information on the causes of attrition from the perspectives of people who have chose to end treatment. There is very little information about these perspectives available. The beginning of a theory of attrition is discussed. It is my hope that this study will also influence future attrition research, and that future researchers will study attrition in a manner that is a priori instead of post hoc, as well as changing the focus from pre-existing demographic variables of clients who drop out to assessing other factors that cause attrition.

In chapter 2 I begin by reviewing the literature on psychotherapy attrition and then discuss why this research is not effective at identifying the causes of attrition and/or contributing information that would be helpful to decrease rates of attrition. After the review of the literature and the discussion, I will present the methodology for the present study in chapter 3. The findings from this study are presented in chapter 4. In chapter 5, I discuss the findings and link them to other research, review two theories and a model that discuss similar processes, and present recommendations for research, practice, education, and social work.

Chapter 2. Therapy Attrition

In this chapter I begin by discussing some of the common problems in the field of attrition research, followed by a review of the research literature on attrition. The literature review of attrition reads and was conducted in a manner consistent with quantitative research, even though this dissertation is a qualitative study. This was done purposely for two reasons. The first reason is that the vast majority of research on attrition has been conducted using quantitative methods. The second reason is that conducting the review is this manner is helpful to highlight the inconsistent findings from research attrition studies and to justify my stance that in order to eventually solve the problem of attrition, it must be understood first, and a theory of attrition must be developed. The review of attrition research is broken down into sections on attrition from psychotherapy in general (no specific mental illness as the focus of the research), followed by two sections that are focused on attrition from psychotherapy for specific mental health diagnoses (Anxiety Disorders, Depressive Disorders). The reason for the focus on these diagnoses is that they are both common in the US. According to the National Institute of Mental Health (NIMH) Anxiety Disorders and Major Depressive Disorder affect approximately 18.1% and 6.7% of adults in the US annually. Major Depressive Disorder is the leading cause of disability in the US for peoples aged 15 to 55 (NIMH, 2017).   I will then review the findings about therapy engagement. It is important to understand all of the relevant factors that interfere with people receiving the treatments they require. To understand this fully, it is necessary to look at factors that interfere with people engaging in treatment as well as factors that interfere with completing treatment,

as there may be important overlap. Following these reviews is a summary of the current state of knowledge and theory about therapy attrition. Finally, I provide a rationale for this study.

Articles were searched for using Psych Info and Google Scholar. Search terms used were "psychotherapy attrition; psychotherapy dropout; dropout from psychotherapy; depression and dropout from psychotherapy; depression and psychotherapy attrition; anxiety and dropout from psychotherapy; anxiety and psychotherapy attrition." Inclusion criteria for articles were the main focus of the article being about attrition/dropout from psychotherapy and the researchers looking at causes and/or rationale for why people drop out of therapy. Articles were excluded if the primary intervention was not talk-based psychotherapy. This was mostly an issue in the research on depression. There are many studies about depression and dropout from exercise and psychopharmacological interventions.

Problems in Therapy Attrition Research

Researchers who have investigated psychotherapy attrition frequently report inconsistent findings on causes and predictors of attrition (Berghofer et al, 2002; Edlund et al., 2002; Swift & Greenberg 2012; Wierzbicki & Pekarkik, 1993). This may be due the small study samples that are limited to a single diagnosis and/or a restricted treatment setting in much of the research (Edlund et al., 2002). Another issue may be the way in which researchers define dropout (Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993).

Inconsistent Definitions of Attrition

Wierzbicki and Pekarkik (1993) were the first researchers to look at how the definition of dropout affected attrition statistics. They conducted a meta-analysis of 125 studies and found that investigators who defined dropout as being the failure of a client to attend a scheduled session reported lower dropout than investigators who defined dropout based on therapist judgment (Wierzbicki & Pekarkik 1993). Dropout based on therapist judgment means that if a client ends treatment for any reason (including the client thinks they are better and no longer need treatment) and the therapist does not think treatment is complete, the person has dropped out (Wierzbicki & Pekarkik 1993). Swift and Greenberg (2012) conducted a meta-analysis of 669 studies. They added three possibilities to the two identified by Wierzbicki & Pekarkik (1993), identifying five ways to operationalize therapy dropout: attending less than a specified number of sessions, failure to complete a treatment protocol, failure to attend a scheduled session, therapist judgment, and terminating treatment before experiencing a clinically significant change.

Each of these five definitions contains strengths and weaknesses. Failure to attend a scheduled session means that a person is considered to dropout out of therapy if they miss a scheduled session and do not reschedule the appointment (Swift & Greenberg, 2012). This method has high face validity and is easy to calculate. However, it is biased against the client as it doesn't take into account discrepancies between the therapist and client on how much therapy is needed or treatments that aren't working.

Defining dropout via therapist judgment has long been held as the standard (Pekarkik, 1985; Swift & Greenberg, 2012; Wierzbicki & Pekarkik 1993). In addition to having face validity, authors state that the therapist has an in-depth knowledge and

understanding of the client and the progress and changes that occur during treatment (Pekarkik, 1985: Swift & Greenberg, 2012, Wierzbicki & Pekarkik, 1993). The reliability of therapist judgment may be low as different therapists may define dropout differently (Wierzbicki & Pekarkik, 1993). Other researchers have found that therapist judgment can be erroneous and that there can be discrepancies between the therapist and client on how much therapy is needed (Garb, 2005; Garfield, 1994, Grove, Zald, Lebow, Snitz, & Nelson, 2000; Swift & Greenberg, 2012).

Defining dropout based on clinically significant change as rated by formal assessments more objectively operationalizes dropout than some of the other methods. However, this method may miss some of the nuances of psychotherapy that are noticed by the therapist and the client (Swift & Greenberg, 2012). Defining attrition in this manner may also make it impossible by definition for treatment to fail and could lead to long and ineffective treatments.

When dropout is defined as being either the completion of a specific length of treatment or the completion of a protocol, it is reliable and easily calculated (Swift & Greenberg, 2012; Wierzbicki & Pekarkik, 1993). These ways of operationalizing dropout do not account for aforementioned discrepancies between client and therapist on appropriate length of treatment, clients who improve rapidly, and clients who do not improve with an intervention (Swift & Greenberg, 2012).

Of the 669 studies included in the Swift and Greenberg (2012) meta-analysis, 314 defined dropout as failure to complete a treatment protocol, 131 defined dropout as attending less than a given number of sessions, and 63 defined dropout as therapist

judgment. Wierzbicki and Pekarkik (1993) report that of the 125 studies they included in their meta-analysis, 23 defined dropout as a failure to attend a scheduled session, 29 defined dropout according to therapist judgment, and 69 defined dropout based on number of sessions attended.

Lack of consistent definition of dropout is still a problem in attrition research. The studies that are reviewed in this dissertation do not have consistent definitions for dropout. The lack of consistent definitions of what constitutes dropout makes it difficult to compare findings between studies. Another problem in attrition research is that there is validity in each definition, and no definition encompasses all of the factors. For this study I will be including all of the above definitions for dropout. When participants are selected for the study they will be asked if they ended treatment prior to completing a treatment protocol, against their therapists' judgment, prior to an agreed-upon number of sessions, prior to a clinically significant change, prior to getting their needs met, and/or did not attend a scheduled session and never returned (see Appendix A for the full screening questionnaire).

Research Findings from Studies on General Psychotherapy Attrition

As stated previously, research on attrition tends to yield inconsistent findings, partly due to problems with small sample sizes, samples being limited to one diagnosis, limited research settings, and the way in which dropout is defined (Edlund et al., 2002; Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993). I will now review the findings about psychotherapy attrition in general and then attrition specifically related to anxiety disorders and depressive disorders, which are the focus of this dissertation.

Researchers who have studied attrition from psychotherapy in general report mixed and conflicting findings. In the majority of the research on attrition, researchers tend to look primarily at demographic variables of clients/research participants to identify which variables predict dropout. Some of the most common client/participant variables studied in the research on attrition are gender, race/ethnicity, age, education level, socio-economic status (SES), married/partnered, level of employment, and mental health diagnosis. However, as is evident in the review below, the inclusion of variables into research models varies greatly across studies, making findings somewhat difficult to compare and generalize. Of the 11 articles reviewed for this section, three found that there were no identifiable variables that differentiated treatment completers from those who dropped out (DuBrin & Zastowny, 1988; Killaspy, Banerjee, King, & Lloyd, 2000; Olfson, Mojtabai, Sampson, Hwang, Druss, Wang, Wells, Pincus, and Kessler, 2009). Gender of clients/participants is frequently included in the research models on attrition. In addition to the authors who found that no variables predicted attrition, five authors found that there were no gender differences between completers and those who dropped out (Bados, Balaguer, & Saldaña, 2007; Berghofer, Schmidl, Rudas, Steiner, & Schmitz, 2002; Edlund et al., 2002; Garcia & Weisz, 2002; Wang, 2007). Some researchers have found that race and ethnicity do not impact attrition (Edlund et al., 2002; Garcia & Weisz, 2002), while other researchers have found that being non-white increases the probability of dropout (Greenspan & Kulish, 1985; Wang, 2007). Being younger has been found by multiple researchers to increase the probability of dropout (Berghofer et al., 2002; Edlund et al., 2002; Greenspan & Kulish, 1985; Roseborough, McLeod, and Wright , 2016).

However, several researchers have found that age does not predict dropout (Bados et al, 2007; Dubrin & Zastowny, 1988; Killaspy et al, 2000; Olfson et al, 2009; Wang, 2007). There were no findings that being older predicted dropout. Roseborough et al (2016) found that having less education predicted dropout, while others found that level of education didn't influence dropout (Berghofer et al., 2002; Wang, 2007). The findings on socioeconomic status as a predictor for dropout were similarly mixed with some researchers finding having a lower SES predicted dropout (Edlund et al., 2002; Garcia & Weisz, 2002), and Wang (2007) finding that SES had no influence on dropout. Two variables, employment and marital/partnered status, were included in only a few studies. When these variables were included, they were found not to predict attrition (Bados et al, 2002; Berghofer et al., 2002; Greenspan & Kulish, 1985; Wang, 2007). There were three findings that diagnosis influenced dropout (Berghofer et al., 2002; Greenspan & Kulish, 1985; Wang, 2007) with mood and substance use disorders (SUD) being the most common diagnoses found to predict dropout (Berghofer et al., 2002; Wang, 2007). Other researchers found that diagnosis had no effect on dropout (Edlund et al., 2002; Killapsy et al., 2000).

Only one study reviewed here used qualitative methods to assess dropout from treatment. This study appears to be the only one (or one of a very few studies) that was not a post hoc analysis of existing data, but was conducted for the main purpose of obtaining a better understanding of drop out. Also, this study is one of the very few that did not focus exclusively on client variables. This study provided the most in-depth understanding of factors that contribute to dropout. Because of the different approach this

study took to studying dropout, and the similarity in methodology to this dissertation, it will be reviewed in depth.

Barnicott, Couldrey, Sandhu, and Priebe (2015) conducted a qualitative study to identify differences between people completed Dialectical Behavior Therapy (DBT) and those who dropped out. Two themes (difficulties learning the DBT skills and difficulties putting the skills into practice) had negative associations with continuing the treatment. For the first theme, clients with high anxiety during the groups were less able to learn the skills (Barnicott, Couldrey, Sandhu, and Priebe, 2015). The authors also found that many people did not like the way the skills were presented. People reported that the skills were taught too quickly, and/or the use of DBT jargon was confusing and was hard to remember (Barnicott, Couldrey, Sandhu, and Priebe, 2015).

The second theme, difficulty putting the skills into practice due to overwhelming emotions, also had sub themes. One sub-theme was losing control (Barnicott, Couldrey, Sandhu, and Priebe, 2015). Participants described experiences where their emotions were so strong they perceived a loss of control of their thoughts and behaviors. Participants stated that it was very difficult to remember to use the skills in these moments. The second sub-theme identified was participants having negative thoughts about the skills (Barnicott, Couldrey, Sandhu, and Priebe, 2015). Participants reported that they would think they didn't want to use the skills, using them was too difficult, and that they would not work. Some participants reported that attempting to use the skills while in difficult situations was exhausting, others reported wanting to rebel and not use the skills, and others reported that trying to use the skills created such high anxiety they would rather

use their maladaptive ways of coping to avoid the anxiety (Barnicott, Couldrey, Sandhu, and Priebe, 2015).

Barnicott and colleagues found two themes, personal journey to a new way of life and having an environment that supports change, were positively associated with continuing the treatment (Barnicott, Couldrey, Sandhu, and Priebe, 2015). Three sub-themes were identified for a personal journey for a new way of life: a commitment to keep working towards change, making the skills their own, and using the skills becoming automatic. The main point in this theme was that participants who continually practiced skills, even when they didn't understand them or want to use them, began to incorporate the ones that worked for them into their lives to the point that skills use became automatic (Barnicott, Couldrey, Sandhu, and Priebe, 2015).

The authors identified three sub-themes for the theme of an environment that supports change: skills group, individual therapist, and friends and family (Barnicott, Couldrey, Sandhu, and Priebe, 2015). Some participants found the group to be a supportive environment in which they could learn from others and receive encouragement and coaching to help improve their skills use. Participants stated that groups that were run in a fun and light-hearted way and incorporated multiple formats to teach the skills were the most effective. Participants also stated that it was helpful when their individual therapist answered their questions about what they had learned in group and helped them implement the skills via phone coaching and in-session role plays. A minority of participants stated that they had received encouragement from their friends and family (Barnicott, Couldrey, Sandhu, and Priebe, 2015).

The study from Barnicott et al. (2015) suggested that participants who dropped out were more likely to have experienced anxiety during the skills group that was a barrier to learning; less likely to report a commitment to consistently work towards change; less likely to have personalized their skills use; unable to make the skills use automatic; and less likely to report the skills group, their individual therapist, or the friends and family as being supportive.

The summaries above of the different variables studied in attrition research highlight the inconsistencies of the findings about attrition. What is consistent in the research reviewed above is that the majority of the variables entered into the research models are client demographic variables.

Conclusions from the findings of this section and the three subsequent sections will be presented after reviewing attrition and specific diagnoses. I will now review some of the literature on attrition as it relates to anxiety, depressive, and personality disorders.

Therapy Attrition and Anxiety Disorders

Researchers studying attrition and anxiety disorders report similar problems to researchers who study attrition across other diagnoses. Taylor, Abromowitz, & McKay (2012) report that there is insufficient research on attrition from anxiety disorders to identify predictors of outcome across treatments. Reviews of the findings of 11 studies of attrition and anxiety disorders follow.

As with other research on attrition, the majority of researchers studying attrition from psychotherapies for anxiety disorders include primarily client/participant

demographic variables in their research model. Of the research reviewed here, the vast

majority of the authors found that no client/participant demographic variables influenced

dropout (Eskildsen, Hougaard, & Rosenberg, 2010; Johnson, Price, Mehta, & Anderson,

2014; Hofmann & Suvak, 2006; Hoyer, Wiltink, Hiller, Miller, Salzer, Sarnowsky,

Stangier, Strauss, Willutzki, & Leibing, 2016; Erwin, Heimberg, Schneller, & Leibowitz,

2003; Wiltink, Hoyer, Beutel, Ruckes, Herpertz, Joraschky, Koranyl, Michal, Nolting,

Pohlmann, Salzer, Strauss, Leibnig, & Leichsenring, 2016).

There is conflicting evidence about the effect of type and severity of anxiety on

dropout. Issakidis & Andrews (2004) found that those with agoraphobia were most likely

to drop out, followed by generalized anxiety disorder, social anxiety disorder, and panic

disorder. Wiltink et al., (2016) found that as the severity of social anxiety at baseline

increased so did the probability of dropout. There was also evidence that type and

severity of anxiety did not affect dropout (Erwin, Heimberg, Schneier, Liebowitz, 2003;

Keijsers, Kampman, & Hoodguin, 2001; Hoyer, Wiltink, Hiller, Miller, Salzer,

Sarnowsky, Stangier, Strauss, Wiiutzki, & Leibing, 2014).

In addition to the findings about type and severity of anxiety disorders predicting

dropout, there was some evidence that presence of other mental health diagnoses and

problems interfered with psychotherapy. Issakidis & Andrews (2004) found that people

with co-morbid depressive disorders were more likely to dropout. Erwin, Heimberg,

Schneller, and Leibowitz (2003) found that elevated baseline levels of anger predicted

dropout. These variables were not studied by others.

The most consistent findings were from studies that incorporated motivation for treatment or belief in treatment as variables in their model. Some researchers looked specifically at the motivation levels of clients/participants and found that those with lower levels of motivation for treatment were most likely to drop out (Keijsers, Kamman, & Hoodguin, 2001; Taylor, Abramowitz, & McKay, 2012). Other researchers looked at clients'/participants' attitudes towards/belief in treatment and found that those who had negative attitudes towards treatment and/or did not believe in the efficacy of treatment were likely to drop out (Grilo, Money, Barlow, Goddard, Gorman, Hofmann, Papp, Shear, & Woods, 1998; Hofmann and Suvak, 2006). Al-Asadi, Klein, and Meyer (2014) found that people who were not concerned about their mental health problems were the most likely to drop out from an online-based treatment for anxiety.

Summary of Review on Therapy Attrition and Anxiety Disorders

Thus, the overwhelming majority of research findings are that demographic variables do not predict dropout for people with anxiety disorders. The studies that included motivation for treatment and/or people's beliefs and attitudes about treatment as variables found that low motivation and negative beliefs about treatment predicted dropout. The evidence about the effects of type or severity of mental health problem is conflicting with some studies finding that type and severity of anxiety predicted dropout, while others found that type and severity of anxiety did not predict dropout.

Therapy Attrition and Depressive Disorders

Over the past two decades there has been an increase in the number of randomized controlled trials that have tested interventions for depressive disorders

(Cooper & Conklin, 2015). Despite the high rates of the studies testing interventions, there have been comparatively few studies about attrition from treatments for depressive disorders (Cooper & Conklin, 2015). Similar to the research literature reviewed thus far, the majority of the research focusing on attrition from therapy for depressive disorders is on clients.

The majority of the variables studied were client demographic variables. Multiple researchers found that being younger predicted dropout (Karyotaki, Kleiber, Mit, Turner, Pastor, Andersson, Berger, Botella, Breton, Calbring, Christensen, de Graaf, Griffiths, Donker, Farrer, Huibers, Lenden, MacKinnon, Meyer, Moritz, Spek, Vernmark, and Cuijpers (2015); Jarret, Minhajuddin, Kangas, Friedman, Callan, and Thase (2013); Cooper et al., (2016). Only one study found that age did not predict dropout (Simon & Ludman, 2010). The majority of researchers reviewed did not find differences in gender between those who completed and those who dropped out. However, one group found that men were more likely to prematurely terminate (Karyotaki, Kleiber, Mit, Turner, Pastor, Andersson, Berger, Botella, Breton, Calbring, Christensen, de Graaf, Griffiths, Donker, Farrer, Huibers, Lenden, MacKinnon, Meyer, Moritz, Spek, Vernmark, and Cuijpers (2015). Two studies found that lower education levels predicted dropout (Karyotaki, 2015; Jarret et al. 2013), but Schindler, Hiller, and Witterhöft (2013) found that level of education did not influence attrition. Two studies found that people who were not white were more likely to drop out (Cooper and Conklin, 2015; Jarret, Minhajuddin, Kangas, Friedman, Callan, and Thase, 2013), however Simon and Ludman, 2010 found that race didn't impact attrition. Jarret et al., (2013) found that people who

were not working for pay were likely to drop out. No other researchers included

employment in their models.

Numerous researchers studied the severity of depression. Jarret, et al, (2013) and

Cooper et al., (2016) found that higher ratings of depression severity at baseline predicted

dropout. This is in contrast to finding by Simon and Ludman (2010) who found that

lower ratings of depression severity at baseline predicted dropout, and Schindler, Hiller,

Witthöft (2013) who found that higher ratings of depression severity at baseline predicted

completion of treatment.

In addition to studying severity of depression, some researchers studied the effect

of co-morbid diagnoses on dropout. Two studies found that people who had a co-morbid

personality disorder were likely to drop out Cooper and Conklin (2015); Schindler,

Hiller, Witthöft (2013). Karyotaki et al., (2015) found that co-morbid anxiety predicted

dropout.

Two studies included non-demographic and non-diagnostic variables: belief in

treatment and motivation for treatment. Simon & Ludman (2010) and Schindler, Hiller,

Witthöft (2013) found that low levels of each of these predicted dropout.

Summary of Review on Therapy Attrition and Depressive Disorders

Few variables that predicted dropout were reported consistently across the

research literature on dropout from treatments for depression. There was some

consistency in the reporting that younger age and co-morbidity predicted dropout,

however, there was no information or hypotheses generated as to why. Only two studies

included motivation and belief in treatment in their research model. Both of these studies

found that low motivation and negative beliefs about treatment predicted dropout. These findings are similar to the research on attrition from anxiety, insofar as when motivation and belief in treatment are included in the research models, low levels of both predict dropout. It is also important to note that the one study that included non-client variables (Cooper et al., 2016) found that therapist adherence to the treatment manual and therapeutic alliance predicted successful completion of treatment. This is the only study of attrition and depression that researched therapist behavior in session. This finding is important to this dissertation as it suggests that therapist behavior in-session may be critical for decreasing dropout.

Treatment Seeking and Engagement

In order to have a comprehensive understanding about completion of psychotherapy, it is important to look at factors that interfere with engaging in treatment in the first place, which could be related to leaving treatment after starting it. What follows is a brief review of literature about treatment seeking and engagement. Heiy (2013) reports that treatment seeking and engagement are influenced by numerous variables including beliefs about treatment, perceived need, stigma, symptom severity, social support, and avoidance.

Ajzen's (1991) Theory of Planned Behavior posits that an individual's volitional behavior is the result of that person's belief about the behavior. Heiy (2013) states that an individual's seeking of treatment is in part dependent on that person's beliefs about seeking treatment. The belief that treatment will not work has been found to be a barrier

to seeking treatment (Green, Hunt, and Stain, 2012; Thompson, Hunt, and Issakidis,

2004; Vogel, Wester, and Larson, 2007)

For many people the stigma of having a mental illness and/or receiving treatment

interferes with seeking treatment. Multiple studies have found stigma, perceived stigma,

and self-stigma have been found to be barriers to seeking treatment (Barney, Griffiths,

Jorm, and Christensen, 2006; Masada, Anderson, and Edmonds, 2012; Thompson, Hunt,

and Issakidis, 2004). The fear of experiencing stigma was found to exist for both how

others would perceive them, as well as how they would be perceived by

counselors/therapists.

The severity of symptoms is often a barrier for treatment as people tend not to

believe they need treatment until the symptoms have become severe (Aria et al., 2011;

Green et al., 2012; Thompson et al., 2004). Green et al., 2012 found that if people did not

seek treatment within the first year of symptom onset, the mean delay for seeking

treatment was 24.41 years. They found that people with Panic Disorder, due to severity of

the symptoms, were most likely to seek treatment within the first year of symptoms.

Other research has found that the preference to handle problems on one's own interferes

with people seeking treatment (Aria et al., 2011; Thompson et al., 2004). There were no

hypotheses offered about what drives this preference.

Avoidance is another variable frequently cited for interfering with treatment

seeking (Heiy, 2013). Problems with this variable are its broad nature, and it can be

caused by many of the other variables studied such as stigma, beliefs about treatment, and

beliefs about need for treatment. Ciarrochi and Deane (2001) assessed the role of

emotion management (defined as emotion perception, ability to manage one's own

emotions and positively influence emotions of others, making others feel better when

they are down) and treatment engagement and avoidance. The authors found that those

who reported being more capable of managing their own emotions were likely to seek

help from professionals and non-professionals. The authors report that those who

reported poor emotion management skills were the least likely to seek help from

professionals and non-professionals. Similar to the role of emotion/experiential avoidance

in attrition, people who have less emotion management skills may rely predominantly on

avoidance strategies to decrease unpleasant and unwanted emotions.

Similar to the research on attrition, there was only one qualitative study found that

looked at barriers to seeking treatment, (Biddle, Donovan, Sharp, and Gunnell, 2007).

Given the similarity to the methods used in this dissertation, and their emphasis on

adding theory to treatment seeking literature the study by Biddle et al., (2007) is reviewed

in depth.

Biddle et al. (2007) completed a qualitative study with 23 people aged 16 to 24

who had mental distress. The purpose of the study was to build a theory as to why young

people with mental health problems avoided seeking treatment. The authors developed a

theory called the Cycle of Avoidance to explain the lack of treatment seeking by young

people with mental health challenges. The authors found that the young people

interviewed described that they would continually view their problems as being normal

problems and not "real" problems, which would warrant treatment. The young people

would, therefore, not seek treatment. The young people interviewed described prolonged

patterns of this behavior, which would find them normalizing increasingly severe problems until a crisis (overdose, hospitalization severe suicidal ideation) occurred. Only at these points would the young person identify their problems as being "real" and seek treatment. The young people reported that the transition from viewing their problems as normal to real was significant and negative. Many reported fear of experiencing stigma, that treatment would alter who they were, that treatments would be frightening and disruptive, and that help seeking would make their distress long term and worse.

Conclusions from Attrition and Engagement Research

Almost all the studies of therapy attrition are quantitative, and almost all appear to be post-hoc analyses, rather than studies that set out to investigate attrition. When reviewing the findings from the attrition literature together, the predominant inconsistency of the findings that predict attrition becomes clear. Most of the variables that are researched frequently do not predict attrition from psychotherapy. Besides not being helpful to identify what variables predict dropout, the majority of the research reviewed is not helpful for understanding the causes of dropout and how to solve it. Unlike the quantitative studies, the one qualitative study reviewed (Barnicott et al 2015) provided a clear understanding of a variety of problems that led to clients dropping out of treatment. The problems identified in the Barnicott et al (2015) study lend themselves to solutions. For example, the authors found that having high anxiety in session was a contributing factor to dropout (Barnicott et al, 2015). This easily translates into therapeutic practice, as therapists can use this information to increase assessment of anxiety during sessions and to teach clients ways to cope with anxiety. Compare this to

the finding that being younger predicts dropping out. This information is only helpful if there is follow up to understand this further as to why (no study reviewed followed up in that manner). Without follow up, this does not give therapists useful information about how to work effectively with younger people, besides of course, not working with them.

It is interesting to note that the large majority of the research reviewed looks primarily at client variables and their influence on attrition only. Very few studies incorporated provider, treatment, design, or interaction variables into their research. It is important to consider the message that this view of attrition sends: if psychotherapy does not work and a client drops, out it is primarily due to some factor associated with the person seeking treatment, not the people providing treatment, or the treatment itself. As stated by McMurran, Huband, and Overton (2010) "This focus upon relatively stable dispositions, traits, and disorders suggests that practitioners are seeking inherent deficits in the client as explanations for treatment non-completion rather than factors to do with the service and the client's opinions of the service." (p. 285). In essence, the research seems to be seeking to blame clients for not succeeding in therapy instead of asking what is happening in therapy that makes it successful for some and not successful for others.

Although the majority of the findings in the attrition research are inconsistent, there appear to be some consistencies. Overall, client demographic variables do not seem to have consistent effects on dropout. Every study that included internal client variables such as motivation and belief/attitude toward treatment found that low levels of these negatively impacted treatment. There were some other consistencies as well within each grouping of attrition research. Age appears to be variable that influences treatment for

depression, as young people are reported to drop out of treatment at higher rates than

older adults. It also appears that people with higher levels of pathology and people with

greater numbers of diagnostic comorbidity may be more likely to drop out of treatment

than others.

One difference that is noteworthy between engagement and attrition research is

how these are studied. The engagement research appears to be focused on how different

phenomena such as beliefs, perceptions, and behaviors impact engagement. Attrition

research tends to look primarily at demographic variables. This difference in how

research is conducted may explain why engagement research has consistent findings, and

attrition research has inconsistent findings. The research on treatment engagement mostly

focuses on the more promising client attitude and belief variables, and produces findings

that also show that these kinds of variables do predict dropout. The main factors that are

consistently reported in the engagement literature are: belief in treatment working,

stigma, symptom severity, and avoidance.

Summary of Literature Review on Attrition Research

Many attrition researchers have called for research to look at what is happening

in psychotherapy and to give up trying to find demographic and other client variables that

predict attrition (Barnicot, et. al, 2011; Barrett, et al, 2008; Berghofer, et al, 2002;

McMurrn, et al, 2010; Wiltink, er al, 2016; Wnuk et al, 2013). Despite the repeated calls

for research that investigates what is happening in psychotherapy, and/or using other

research methods such as qualitative interviews to better understand attrition, the majority

of attrition research continues to be quantitative post hoc analyses of client variables to

predict attrition. The consistent post hoc analysis of attrition fundamentally flaws the research on attrition. It is a field of research that is primarily an afterthought.

Post hoc analysis of attrition does not actually answer the question of what causes attrition in a meaningful way that would allow for problems to be clearly identified and subsequently solved. Instead, researchers have consistently looked at primarily what attributes of clients predict clients not being successful in therapy. It appears that the majority of the research of attrition is focused on asking who drops out, not why people drop out. Even if the research findings on attrition were consistent, the question of who on its own would not be very helpful. Answering this question does not answer why some people who need treatment are succeeding while others in need aren't.

Given the efficacy of so many treatments, and the necessity of treatment for so many people, it is time researchers begin to ask why some people drop out of treatment prior to being treatment being completed. The enormous body of this research suggests that the client demographic avenue of research is not fruitful. I propose changing the way in which we look at attrition. Instead of predominantly viewing attrition as being the result of pre-existing client factors, I propose to develop a theory as to why clients end treatment prematurely. This approach will be further developed in the theoretical section.

The majority of the research on attrition has been conducted using quantitative methods. These methods appear to have been used prematurely, especially given the fact that not one study reviewed in this section cited having a theory for attrition. The one qualitative study that was reviewed provided information that gave a much clearer conceptualization of the factors that lead to dropout, and therefore possible solutions.

There is a great need for more qualitative research on attrition in order to achieve a better understanding of the various factors that cause attrition, and from there to develop a theory about attrition that can be tested. The field of attrition research appears to have put the cart before the horse.

The aim of this study is to begin to develop a theoretical understanding of attrition, by using qualitative methods and grounded theory methodology. Once a theory has been developed, it can be tested. If the theory is supported, then it can be utilized to help target change in the way in which therapists are trained and supervised to help decrease dropout. I entered into this research without a hypothesis as to what causes dropout, in order to allow the theory to develop from the data instead of coercing the data to fit my hypothesis. I did, however, approach the question with an assumption, based on prior research, that the answers would not be found in client background variables. I asked more questions about the transactions and events that take place in therapy, and about the therapy provided, to explore these under-examined possibilities.

Chapter 3. Methods

This is a qualitative study in which the perspectives of clients who have dropped out of treatment were gathered to answer the question, what are the factors that occur in psychotherapy that cause clients to end treatment prematurely? Qualitative methods were used as they are best suited to answer the question of why clients end psychotherapy prematurely. According to Morgan (2013), qualitative methods are more useful than quantitative methods when the purpose of a study is inductive (theory generation and exploration of a phenomenon) rather than deductive (testing a hypothesis, identifying cause and effect). The purpose of this research is to help build a theory of therapy attrition and to explore the phenomenon of attrition.

Qualitative research methods were utilized for this study as the purpose of this dissertation is to develop a theory about psychotherapy attrition. Qualitative methods are well suited for comprehending phenomena, discovering links between behaviors and ideas, as well as development of theory (Bradley, Curry, & Devers, 2007; Glaser & Strauss, 1967; Charmaz, 2014), all of which are missing from the field of psychotherapy attrition research.

Constructivist Grounded Theory

Grounded Theory methodology was first developed by sociologists Barney Glaser and Anselm Strauss (1967). Glaser and Strauss (1967) proposed that qualitative research methods could be used to generate theory. Grounded theory was defined by the following: simultaneous data collection and analysis; creating analytic codes and categories from the data, not from preconceived hypotheses; making comparisons of the

data through each stage of the analysis; working towards theory development through each stage of the analysis; use of memo writing to elaborate categories; use of theoretical sampling; conducting the literature review after the development of an individual analysis (Charmaz, 2014).

Constructivist Grounded Theory developed by Kathy Charmaz (2000) builds upon Glaser and Straus' work and includes the inductive, comparative, open-ended, and emergent approach (Charmaz, 2014). The main difference is in the epistemology. Instead of viewing knowledge and reality as something that is discovered, Constructivists view social reality as being "multiple, processual, and constructed." (Charmaz, 2014, p 13). Given this, the researcher's position, privileges, perspective, and interactions must be taken into account. According to Charmaz (2014), grounded theorists will incorporate their background/disciplinary assumptions and perspectives in order to look for phenomena and processes in the data. Charmaz (2014) goes on to say that although grounded theorists incorporate their pre-existing beliefs into their research, they evaluate the fit between their research interests, and the emerging data, without forcing the pre-existing notions and hypotheses upon the data.

As a researcher trying to generate a theory about clients' experiences and therapy attrition, my background and discipline as a Dialectical Behavioral Therapy (DBT) therapist and trainer guides the way I initially theorized the causes of attrition. In this research my preconceived bias is that some attrition is caused by transactions between the client and the therapist that occur during the treatment that result in client losing trust and faith in the therapy and their therapist, and dropping out. The following methods were

used in the gathering and analyzing of the data in order to stay grounded in the data, and

not in my bias.

Data were collected through one-on-one interviews that were conducted over the

phone and audio recorded. The interview guideline, included as Appendix B, was only a

guideline of open-ended questions to use as a reference; this guideline was not followed

verbatim. A preconceived interview questionnaire was not used as this would have forced

the data into my preconceived beliefs about attrition, The interviews lasted approximately

one hour.

Transcription and data analysis began as soon as the first interview was complete.

Data analysis of completed interviews occurred simultaneously while interviews were

scheduled and conducted. The analysis of data influenced the questions that were asked

in subsequent interviews. For example, in the early interviews the importance of

processes that were occurring that resulted in participants not feeling valued and/or

important became clear. This information was incorporated into the subsequent

interviews and participants were asked about their feelings of being important to their

therapists. This resulted in the category, *Not Feeling Valued as a Human/Feeling*

Unimportant.

After completing transcriptions, line by line coding of the transcripts was

conducted. This is the process of defining actions and events that I saw occurring in each

line of the transcribed interviews. The process of line by line coding assists in the

researcher staying connected with the data and avoiding going off on theoretical tangents

(Charmaz, 1995). Questions to assist in line by line coding were taken from Charmaz

(1995, p.38). These questions are: "What is going on?; What are people doing?; What is the person saying?; What do these actions and statements take for granted?; How do structure and context serve to support, maintain, impede, or change these actions and statements?; What process is at issue here?; Under what conditions does this process develop? How does the participant think, feel, and act while involved in this process?; When, why, and how does the process change?; What are the consequences of the process?"

No specific final categories were identified in the line by line coding process however, important processes and experiences became clear. For example, initially many of the transcripts were marked up with the phrase "getting worse" next to lines in which participants described negative experiences as a result of therapy. During the second phase of coding the code "getting worse" became more defined as described below.

After the completion of line by line coding, focused coding was conducted. This is the process of applying codes that were developed during the line by line coding to greater amounts of data. Focused coding includes categorizing the data. The categories developed may be one of two types of categories, in vivo or theoretical. In vivo codes are codes that have been taken directly from the participant's discourse. Theoretical categories are based on what the researcher/s see happening in the data (Charmaz, 1995).

Both in vivo and theoretical coding were utilized. An example of in vivo coding came from the second interview that was conducted. That participant discussed her experience of not receiving any validation. The code *Experiencing Invalidation* came directly from her data. An example of the use theoretical coding comes from the

development of the *Consequences of the Problems in Therapy* and *Experiencing the Consequences of Failed Therapy.* Both of these categories and the sub-categories were born out of the initial code, "getting worse."

During the process of focused coding, the data that were identified as "getting worse" were looked at more closely. This first led to the development of the category *Prolonging of Suffering.* No participant explicitly said that their suffering was prolonged, but they began to talk about the negative impact failed therapy had on their lives and that it lasted years in some cases. This information gathered and coded in the early interviews also led to later participants being asked about their experiences after therapy and if they experienced a prolonging of suffering. A similar process was used for the development of all of the categories and sub-categories in this dissertation. An outside researcher who has a PhD in Sociology and who is not a DBT therapist, researcher, or trainer read through data and the codes to check the accuracy of these codes.

Memo writing occurred throughout the coding processes. Free writing techniques were used to elaborate on the condes and categories. The purpose of memo writing is to render the data, not to communicate (Charmaz, 1995). Here is an example of a memo I wrote. This memo was written after reviewing the transcripts and thinking about how important it would be to discuss the experiences of the participants prior to starting therapy.

> All of these different quotes express an excitement, openness and willingness to start therapy. Even Mike who expresses hesitation and skepticism at first expresses excitement when he gets into the office. I think these are critical to include as it lays the ground work for what is to follow. These are all people experienced a lot of pain and disruption in their lives, who are wanting help. Many don't know what to expect from therapy, and how it will work, and they all

approach it willingly and openly. They express eagerness to bring about change in their lives. This is important to communicate and I think highlights the impact of what happens in session, and how these negative experiences in therapy can be so detrimental to people. Like Daniel says, after the first experience there is now hesitation about the next experiences. He was not alone in this, others talked about this same hesitancy, and questioning if they can be helped by therapy or not.

It is important to understand people's beliefs about therapy and also that negative experiences in therapy influence the next round of therapy, if there is one. Multiple people expressed concern that there are likely people who had experiences similar to theirs and that this would lead people who need help to not seeking any more professional help.

It is also important to look at the change overtime, moving from excitement to anger and dissatisfaction, and in some cases believing that the person is unable to be helped by therapy.

The final analysis, of the data was written after the completion of memo writing, and the memos were used to guide the write up of the analysis. After the completion of the analysis the findings from this study were compared to relevant research literature.

Exclusion Criteria

Exclusion criteria were based on why participants chose to end therapy, when the therapy occurred, and the age of the person at the time of therapy. People who ended psychotherapy prior to 2009, were adolescents at the time of therapy, or left because they lost funding, moved away from the location, their therapist retired or moved, and/or stopped seeing their therapist regularly but continue to have intermittent appointments as needed were excluded from this study. None of the participants were former clients of mine or previously known to me.

Participants

A description of the participants will be given in narrative form. Given the sensitivity of the information shared, providing detailed information about the

participants and linking demographic information to their pseudonyms could make

participants identifiable to others. There was a total of 12 participants in this study.

Participants aged in range from 23 to 61 with the majority of the sample being in their

30s. Nine of the participants identified as female, three as male. Two participants

identified as queer. Seven participants identified as Caucasian, three identified as Latina,

one identified as Caucasian Latina, and one person identified as Iranian American.

　　　　Participants were recruited using purposive sampling with exclusion criteria as

well as snowball sampling. Recruitment flyers (Appendix C) were placed in one

university and in mental health clinics in the Pacific Northwest, Western States, the East

Coast, and the Midwest of the US. Participants were also recruited via snowball methods

from earlier participants in the study. Some participants learned of the study after a

picture of the recruitment flyer had been posted on Facebook by someone not involved

with this research project. All participants made the initial contact. Participants were

screened using the screening instrument (Appendix A). A total of 17 people expressed

interest in participating in the study, four were excluded due to potential dual

relationships with myself, 13 participants were screened, and interviewed. Participants

were sent informed consent documents via email or standard mail depending on the

participants preference which they signed and returned to the author. Informed consent

documents were reviewed over the phone prior to both the screening interview and the in-

depth interview. Participants were sent $25 Visa gift cards for participating in the second

interview (one participant declined the gift card). One participant was found to be

ineligible during the interview due to therapy having occurred longer than ten years ago

and while they were still a minor. This participant was still sent a $25 gift card for his time.

Participants were adults who had ended psychotherapy prematurely in the US. Participants were 18 and older, and had started psychotherapy and ended by any of the following: being unhappy with the services being provided or your therapist; not getting needs met, and/or the problems being addressed were not being solved; ended therapy although others in your life wanted you to continue; in a way that was surprising to your therapist; prior to completing an amount of time you had agreed to with your therapist or others in your life; prior to completing a therapeutic protocol (for example the completion of a therapy manual); by stopping and not letting your therapist know, and other reasons.

For the purposes of this dissertation I defined psychotherapy as being individual (not group, couples, or family) talk-based therapy that is conducted in person (not via the phone or internet) by a master's level social worker or counselor, or doctoral level psychologist, social worker, or counselor. The professions that were worked with by participants were master's level social workers and counselors, and doctoral level psychologists. Names of the therapists were not asked for. If a participant mentioned the name of their therapist during the interview the name was kept out of the transcript.

Ethical Considerations

This research was conducted in accordance with the ethical standards of the National Association of Social Workers (NASW). All methods and procedures used in this study were approved by the Institutional Review Board at Portland State University,

Portland, OR. Informed consent procedures followed the guidelines of the Institutional

Review Board at Portland State University and included a brief description of the study,

potential benefits and risks, the voluntary nature of the study and the right to withdrawal

at any point without consequences. Prior to conducting the screening interview and the

second interview, informed consent, limits of confidentiality, general procedures,

timeline of the study, and financial compensation were reviewed over the phone.

Questions that the participants had about the procedures were answered prior to the

interview. Questions that participants had about the purpose of the study were answered

after the in-depth interview was completed. During the meeting the researcher reviewed

the informed consent and answered any questions about the study. During this review the

researcher reviewed the limits to confidentiality, the approximate time for the study,

monetary compensation, and general procedures.

After the completion of the interview, the audio recording was uploaded to the I

drive at Portland State University. Once the recording was saved on the I drive, the

recording was deleted from the digital recording device. Transcriptions of the recordings

were saved in the same folder on the I drive as well as screening questionnaires and

informed consent documents. Documents that were signed and returned via mail were

scanned and uploaded. Participants were informed of the nature and purpose of the study.

Participants' rights to anonymity were respected and the data were treated confidentially.

Participants were informed that they didn't have to answer any questions they didn't want

to and that they could end the interview and choose not to participate at any time. In

order to protect confidentiality, all participants were assigned code numbers for

identification; their names and identifiable information are not included in the write up.

Reflexivity

I have been a practicing DBT clinician since 2008. Since 2008 I have received hundreds of hours of training on DBT. I worked for a DBT specific clinic in Portland, OR as a clinician, clinical supervisor, and trainer for 9 years, and now conduct DBT in my private practice. I consult and train about DBT throughout the U.S. In addition to this I work as a DBT adherence coder for Marsha Linehan's (developer of DBT) lab, the Behavioral Research and Therapy Clinics (BRTC) at the University of Washington, and as a DBT adherence coder, and DBT program evaluator for the Linehan Board of Certification (DBT-LBC).

I am a strong believer in all aspects of DBT, the theories that guide it, as well as the effectiveness of it as a therapy. I initially was interested in DBT because I wanted to work with people who were high risk for suicide. I chose DBT over other interventions because of the body of research on DBT from multiple researchers, as well as the experiencing of positive outcomes by clients that I had previously been taught were untreatable. The more I learned about DBT the more I found it fit with my values. I was specifically drawn to how seriously DBT takes treating people with dignity and respect, seeing the therapeutic relationship as one between equals, and working with people to create lives they want to live. My belief in DBT presents biases in my research. I am entering this research with the belief that attrition is likely a consequence that is the result of transactions between the client, therapist, and clinic. This belief may interfere with my ability to identify other factors that are influencing attrition. My belief is also that DBT

can help to solve the problem of attrition, but not that the treatment is immune from

problems that may influence attrition. The positive bias I have towards DBT and to

transactional theories affected my attitude towards this research as I began the research

thinking that in-session transactions affect dropout. In addition to potential biases about

attrition, my experience with and belief in DBT may also have biased how I formulated

the questionnaire I use for the interviews, as well as how I interpreted the data.

My awareness of my biases, although not sufficient on its own, will help me keep

from being automatically and unconsciously biased. In order to help ensure rigor and

protect against bias I kept a reflexive journal. I also had one other researcher read a

sample of the transcripts, selected data from all of the transcripts and check this to my

codes. The second researcher has a PhD in Sociology and is not a DBT practitioner,

researcher, or trainer. An example of how the feedback from the second researcher

benefited the study is with the *Not Feeling Valued as a Human/Feeling Unimportant*

code. The second researcher identified that there were different processes happening in

session and out of session, and that these differences were important. This resulted in me

separating this code into *Feeling Unimportant in Session* and *Feeling Unimportant*

Outside of Session.

Chapter 4. Findings

The goal of this study is to answer the question, why do some clients end therapy prematurely? In order to answer this question as thoroughly as possible, participants engaged in one on one interviews that lasted 45 minutes to an hour. Participants were asked questions about their experiences in therapy, from the beginning of therapy until they decided to stop working with a therapist. As such, the codes will be presented in roughly temporal order, that is in the order in which most clients experienced various behaviors that resulted in their wanting to stop attending. By presenting the codes in this order, the reader will also get to experience, as much as one can by reading, the experiences of the participants and how their experiences in therapy impacted them. The codes begin with participants beginning therapy. The data in this first category of Beginning Therapy do not answer the research question of this study, however, the information in this category is important to understand how the participants approached therapy, and to show that the majority of the participants were ready and willing to engage in therapy. This is followed by codes that group the different types of problems that were experienced in therapy. The answer to the research question is found in these categories. These categories are not in temporal order; they occurred at different times in therapy. These categories, problems in therapy are 1) invalidation, 2) identity invalidation, 3) cultural invalidation, 4) ineffective problem solving, and 5) feeling unimportant. Then I explore the themes of the aftermaths of the problems: the consequences of invalidation and ineffective problem solving, the consequences of failed therapy, and what the majority of participants discussed wanting from their therapists.

Although the data in these final sections do not answer the research question, they are important to understanding the impact the problems in therapy had on the participants. A table of all of the categories and sub-categories can be found in table 1.

Beginning the Process of Therapy

The start of therapy is a critical time in the therapeutic process. Both the client and the therapist are getting to know each other, establishing the relationship, and getting clarity on what the goals for treatment are and how therapy will proceed. For the participants the start of the therapy process was a time that for many brought hope. Hope that their lives would change, that pain and suffering would decrease, and that happiness would increase. For some, starting therapy brought fear and trepidation. This included the fear of being vulnerable and the potential to be hurt by another human, and for some it was fear that therapy would not work. These expectations and early experiences set the backdrop for what is to come, and how their later experiences in therapy impacted the participants. Many participants describe experiences of beginning the process that fit in multiple sub codes, such as feeling trepidation and/or feeling excited and optimistic.

Reasons for going to therapy. As previously stated, people choose to attend therapy for a variety of different reasons. Whatever the reasons are, a common denominator in the decision was that something was happening or had occurred in the person's life which the person wanted help addressing. The issues that participants were addressing included death of loved ones, relationship dissatisfaction, uncontrollable drinking, suicidal thoughts and actions, unhappiness in life, anxiety, depression, body

image issues, and trauma. Here a couple of participants describe what was happening in their lives and why they started therapy when they did.

> Sarah: I felt like it was really important when I started going. I, my dad had just passed away…I was just really struggling with my drinking. And it was to the point, I would not say that I was suicidal, but it was becoming in the realm of possibility that I felt like I was going to become suicidal and I just did not know what else to do. And it felt like, I don't know, it felt very important.

> Sally: I was hoping to get out of it some happiness in my life. My life wasn't really going the way I guess I had thought it would and a lot of it was unhappiness and I finally realized that I couldn't take care of it myself, I had to find professional help, 'cause I mean you only have one go around you know, you don't want to go around in sadness the whole time. And when there are people around you that are happy and seem well adjusted and you don't, so yeah, it's important.

Both Sarah and Sally stated that it felt important for them to attend therapy and that they were clear that they were not happy with what was occurring in their lives. The experience of being concerned about what was happening in their lives and wanting help to making changes in order to increase happiness was shared by many of the participants.

Feeling trepidation. For some of the participants the experience of starting therapy was a mixed experience. The importance of going to therapy and wanting to make changes was present, as was a sense of fear and trepidation. The causes of the fear differed. A few of the participants shared their experiences of not knowing what to expect, as their primary reference of therapy came from TV shows and movies. Some discussed being concerned that therapy wouldn't work for them, that it would just be a session of active listening with no real help occurring. Mike described his fear as being based off of his experiences with a friend of his.

Table 1

Process Categories and Sub-Categories

Beginning the Process of Therapy

Reasons for going to therapy
Feeling trepidation
Feeling excited and optimistic

Problems in Therapy

Experiencing Invalidation
        Not feeling understood and heard
        Being dismissed and rejected
        Feeling judged
Identity and Cultural Invalidation
        Identity Invalidation
        Cultural Invalidation
Life's Problems Not Being Solved
        Having life's problems and solutions oversimplified
        Discontinuity prohibiting change
        Therapist discomfort inhibiting change
        Experiencing validation and no guidance for change
Not Feeling Valued as a Human/Feeling Unimportant
        Feeling Unimportant in Session
        Feeling Unimportant Outside of Session
Summary of Findings about Problems in Therapy That Led to the Participants Ending Therapy

Consequences of the Problems in Therapy

Immediate and Emotional Consequences of Therapist Invalidation, Inadequate Problem Solving, and not Feeling Valued as a Human by the Therapist
        Questioning sanity
        Feeling like a burden
        Feeling anger
        Increasing pain and despair
Experiencing the Consequences of Failed Therapy
        Prolonging of suffering
        Experiencing the loss of an important opportunity
Searching for Understanding
        Blaming self
        Seeing systemic problems
        Feeling like a trigger to the therapist
        Feeling blamed by the therapist for therapy not working
Recommendations from the Participants: Transparency and Genuineness

> Mike: I would say that I was somewhat skeptical. Like I had examples from a couple friends, one or two of my friends that sought out therapy at some point. One of them …. didn't seem like she was getting anything helpful out of it. She was the type who went regularly to therapy. It was a long-term kind of thing. But then again, I wasn't really clued into what kind of baggage she had in her life. I wasn't judging on that part, other than, she seemed pretty square, and I didn't understand what the benefit she was getting out of that. So that left me a little skeptical about that.

Working with a therapist requires a person to open themselves up and be vulnerable with the therapist. Opening one's self up to another human is an experience that can result in tremendous closeness. It can also result in tremendous pain. Sarah, who talked about knowing it was important for her to go, also stated that she was afraid to go. Amy described her fear about therapy in the following way:

> Amy: At that point I was so fearful of everything and everyone. It didn't necessarily matter if you had any alphabet soup after your name, I was going to be horrified of you just because you were a human who had emotions and independent thought, you could think about me and judge me, even though usually they weren't. I would say there was some fear, my fear wasn't even towards them. My fear was that it would make it back to my parents. I didn't want my parents to be more disappointed in me, I didn't want them to worry about me.

Feeling judged and rejected is an extremely painful experience for humans. Amy's description of her fear about therapy describes part of what is requisite for therapy to be effective: people must allow themselves to be vulnerable and open with the therapist if therapy is to work. Making this even more difficult is that often the topics addressed in therapy are personal and/or painful, which can make them even harder to talk openly about. It is a key part of the job of the therapist to help address this fear and to foster a relationship where open and honest communication can occur. The experience of opening up and the responses from the therapist are a critical aspect of why some of the participants chose to end therapy and will be discussed in detail later.

Feeling excited and optimistic. Knowing that difficult, problematic, and/or

painful issues would be addressed understandably caused fear and trepidation for some of

the participants. Other participants reported that they felt excitement at the prospect of

entering therapy. For them, there was a sense of eagerness and relief to address issues

that had been happening in their lives. The excitement and relief resulted in multiple

participants being open and vulnerable early on in therapy. This was expressed in

different ways. Some discussed sharing the story of their lives, their successes, failures,

traumas, and transgressions at the beginning of therapy. Others talked about this

occurring both in session and in the completion of clinical questionnaires and

assessments. The participants who spoke about this described it as a way of jumping into

therapy with both feet. A couple of participants described their experiences in this way:

> Ellie: What I remember from that first session is just thinking that there is so much that I want to cover, and so much that I wanted to take care of, and, and I wish this was a two hour session, or I wish I could just lock this door and tell you everything that I have to tell you.

> Mike: That initial walking in there, I really was extra optimistic, I was like ah, excellent, this is exactly what I thought it would be type of thing. So when she leads me in there and basically sits me down. And so it isn't necessarily a why are you here type of thing, but she was like alright what did you want to talk about or something. I kind of laid down my earlier failures, discussed my lack of motivation in other things and where I screwed up. I was basically, I was eager to lay down my life's story. I wasn't really holding back. I was like this is a professional, this is exactly what she is here to do. So I was laying on all the details so to speak. Without any real sort of reservation. 'Cause like in ways I wouldn't be with my parents or with my friends and family and stuff. It's like, that's what they're (therapist) there for. That's actually their station to hear you be honest, not, you don't bs someone like, I don't know. That's just like my own view, but I was really layin' it down in terms of my teenage years, my habits, like that procrastination was nothing new. Anyways I was just laying down my life story, I just had to lay a basis for what I felt was going on. And I mean, that took the whole hour, and I was only halfway done or something. And she was like I'm going to have to stop you there, time's up. I already had that in my head from you

know, fictional portrayals, it's kind of like a joke, or not a joke, or a meme that therapists are staring at the clock and that once the hour's up its up, and they'll hustle you out. But that didn't really hit me in any negative way. I was like, hey I'm not the only client, they gotta keep the schedule you know, so see you next week kind of thing. So that was the first session. I really dove into it. She did a lot of smiling and nodding and writing it down. It really felt the part, so like ahh excellent, let's see where this goes.

Amanda: Because when I started with the first therapist I basically went in thinking like, I want to solve all my problems, I wanna win therapy, I'm gonna be the best at it, so just dove in right away, um, and also it was, there was an expectation of that, filling out the forms and talking about trauma on the first day. I was like oh, this is my first experience, this is what therapy is.

The early sessions in therapy are a critical time. It is the time in which the therapeutic relationship is built, when therapist and client agree upon goals for therapy and the work they will do together. It is also the time in which the therapist can address the client's fears and concerns about therapy so as to help alleviate these. The participants in this study had different experiences with starting. Some felt wary and/ or afraid, others felt excitement and relief. All talked about how it was important to them to seek help and to make changes in their lives. The data reviewed in this category does not answer the research question of this study. However, this data is critical as the beginning is important to help understand the context of the participants' lives and their subsequent experiences as therapy progressed. This data also shows that the majority of the participants were willing and ready for therapy.

I will now review the categories related to the primary research question of this dissertation. The data presented in the following section, Problems in Therapy, is where the answers to the research question are found. The breakdown of the categories is in table 1.

Problems in Therapy

The experiences that the participants had in therapy were both different and similar to each other. For some, therapy did not go well almost immediately, resulting in people ending within the first few sessions. For others, there were things that happened in the sessions that caused some hesitation and concern but were not egregious enough to result in the person ending immediately. Others had experiences that occurred after working with their therapist for a longer period of time that caused them to end therapy then. For some, therapy went on for months and years, and the decision to end was based on a cumulative effect of not making changes and/or progress in their lives. The themes in this section are invalidation, cultural and identity invalidation, inadequate problem solving, and not feeling valued by the therapist. These categories are not presented in order of time, severity, or importance. I have separated them for clarity.

Experiencing Invalidation

Participants shared numerous examples of attending therapy and having their thoughts, perceptions, experiences, and emotions, invalidated, rejected, go unseen/unheard, criticized, and judged by their therapist. For some, it was not experiencing the therapist as having empathy. For others, it was an experience of not having the therapist try to understand the participant's experience. For others, the behavior of the therapist was dismissive, judgmental, and/or cruel.

The effect that this had on the participants depended on the intensity and frequency of the invalidating behavior by the therapist. Another factor in the effect of therapist invalidation was participant level of disclosure. Participants who shared more,

were more open and more vulnerable with their therapists were more negatively impacted by the invalidations of the therapists than participants who were more guarded and closed off to their therapists. The experience of being invalidated in some way was present in the majority of the participant's experiences.

The sub-categories in this section offer examples of the various ways in which the participants experienced invalidation. The structuring of the information in this way is in order to help with information organization and clarity. It will become clear that all types of invalidation expressed here caused pain and had negative impacts on the participants' experiences in therapy, and impacts on their lives

Not feeling understood and heard. There were multiple ways in which participants experienced being invalidated. There were numerous examples of the therapists engaging in behavior that was the opposite of paying attention, actively listening, and articulating understanding. Numerous participants stated that they had experiences of their therapists making assumptions about them without listening.

The experience of not feeling heard and not having the therapist articulate understanding of the participants and the participant's experiences was common. Mike gave an example in which he had shared his life's story with his therapist, and when he finished, her response was to give him an assessment packet. Daniel discussed having therapists look at what he was doing in life and not attend to what he was communicating to them about his difficulties. He stated that he felt dismissed by them because they only saw how well he was doing, and they did not hear and understand what he was saying to them about the difficulties that he experienced. Ana mentioned that one of her problems

in life was not being validated and supported and that she found the exact same

experience in therapy. Both Amy and Sarah stated that they felt one of the key problems

that they were experiencing with their therapists was that their therapists could not

understand their experiences with alcohol and not being able to stop drinking.

> Ellie: I feel this and I feel that, and this is what I wish would happen. And he was like, nope nope, nope, no, that stuff is not right or this is not going to happen. So I came back to the second time, OK let me explain why the things I told you last session are still right to me, because I have an explanation for everything. At that point is when I felt like a child arguing with the adult. And then he was very much like nope, nope, but can I explain this, you know there is this connection here, there is this connection over there. And in that second session was just like, I'm not a kid, I don't need to convince you, I just need you to listen to me. I'm like working harder than you are right now trying to convince you that I am sick, that I need help, that um, you know. I am here telling you a story and if you just listened to me, there would be, it would make sense right, if you just let me tell you from the beginning it will make sense…The first session was very much like I'm the child I'm coming up with an excuse and the parents keep telling me, no no no. The second session, which was the one I was really angry by the time I left, because he called me whatever, called me dumb and said get out of my face type of thing. I feel like at that point I try and I try a little bit more, and maybe half way through the session it's just like I'm not going to convince this man, and he just broke me into pieces, and I just left really angry…. I just vomited all my insecurities, all my issues, all my problems, he didn't validate any of them. Right? And then on top of it, he was like oh you're a dreamer, go get busy. You know he was just like, you know it's funny, 'cause like I said I have clips I remember, like I watched a movie. I remember that, I remember leaving there really angry.

There are multiple aspects to Ellie's quotation that are important. First, there is

the obvious experience she is communicating of the therapist not listening to her. Ellie

also describes the effort she put in to trying to be heard, "I am here trying to tell you a

story" and "if you just let me tell you from the beginning." This quotation also captures

how vulnerable Ellie felt, "I just vomited all of my insecurities, all my issues, all my

problems." There is also a lot being communicated in this quote in addition to what the

actual words state. Ellie is trying to convince her therapist that she makes sense, her story

makes sense, what is happening in her life makes sense. What she is being met with is
someone not listening to or understanding her. There is a desperation that comes across in
this quotation from Ellie, wanting the therapist to stop what he is doing, open his mind
and to listen to her so that he sees her as a person who is valid and makes sense. Ellie
describes feeling like a child and that her therapist is like an un-listening parent. This
description highlights how small she felt at times with him, and the power differential
between her and the therapist. She goes on to state that she kept trying to convince him
and that his responses felt like he was disgusted with her, "get out of my face type of
thing." Although not outrightly said, Ellie seems to describe an experience of feeling
humiliated by her therapist, "he just broke me into pieces." This subsequently resulted in
her feeling intense anger. Ellie goes on to state that she is not a kid, and that it is not her
responsibility to convince him. It is his responsibility to listen to her. The lack of
validation from this therapist resulted in Ellie not going back to see him after two
sessions.

Not all experiences of not feeling heard and understood were as egregious as
Ellie's experience. Mike shared the following about the response from his therapist after
he had told her about his life and what had been happening:

> I'm like excellent, I'm in therapy now or something, the week passes and I think
> about stuff, I think about what I'm going to include in my story, and I show up the
> next time, and it's like, let's continue where you left off or something. I'm able to
> complete a narrative so to speak, about how I got to where I am at that time. What
> my misgivings were. I mean I gave her, not like a dossier, but I gave her where I
> was, what I was thinking, laid it all at her feet kind of thing. I kind of like waited
> expectantly for her to you know, bestow some kind of wisdom, or say something
> other than you know, like, more generic kind of interactions that I got over the
> course of telling like, mmhmmm, alright, or what did you think about…. You
> know fairly generic, like I'm giving the story you know so I don't need that much

from her so to speak, but after I lay it all down, I was just waiting for her to you know tell me something, she was like hmm, alright, alright I'm gonna have you fill out a couple of these questionnaires or something. She pulls out a couple of these packets, they were like four or five page packets. They were like a bunch strongly agree or disagree type questions. Like how do you feel in this situation, or if this happened to you how would you? And I mean this was almost like the first yellow flag or something. 'Cause I'm like all right, a questionnaire, like fair enough, but I'm just like, like I'm running through it and it seems like mundane, this is like, this is not the sorts of stuff I feel like I'm revealing on the questionnaire, not part of the problem, or doesn't feel like it's relevant to what I'm trying to discuss. It just feels painfully generic or something. So I fill it out or whatever, I'm trying to remember if I filled it out then and there or if she gave it to me to take home and bring back. But like, but uh, it like we ran out of time at that session.

Mike's description of his experience also highlights the vulnerability of being a

client in therapy. He states that he "laid it all at her feet" when describing how he

disclosed his life's story to his therapist. This phrase means to give the responsibility of

something to someone. In this case Mike, is giving the responsibility of his story to the

therapist. In turn, he described, "waiting expectantly for her to, you know, bestow some

kind of wisdom." His description of this again highlights the power differential inherit in

therapy. One person turns to another person for help and guidance, doing this requires

openness and trust. He states that the therapist had engaged somewhat with his story,

although he describes it as being generic uses of, "mmhmmmm," "alright." He reports

that he was waiting for more interaction from the therapist, more wisdom and guidance

but that what he was given was questionnaires that he did not find applicable to his life.

Although he did not go into detail about the effect that this had on him, he describes it as

being the first yellow flag, meaning the first real warning that something was not going

well or was not right.

Not feeling heard and understood is a key component of feeling invalidated. Participants described numerous examples in which they experienced their therapists as not understanding them and not hearing them. This type of invalidation was common for the participants and will be present in the following codes as well, although other aspects of invalidation will be highlighted. It is separated out here in order to provide some examples of this type of invalidation and how this impacted some of the participants.

Being dismissed and rejected. There were many instances in which the participants felt like they were not being heard, listened to, and understood by their therapists. Some of the participants shared examples in which their therapists dismissed and rejected their (participants') experiences and perspectives. In essence this had the effect of the participant feeling like the therapist was telling them that they were wrong in what they perceived and experienced. This is the opposite of normalizing an experience and communicating understanding.

An example of being dismissed and rejected comes from Amanda. This example comes from her description of meeting with her second therapist. Amanda's first experience in therapy ended after Amanda experienced multiple invalidations of her identity and instances of egregious behavior on the part of her therapist (more about this below). After six months of not being in therapy Amanda decided to return. She stated that with her second therapist she was more on guard and did not fully open up with her in the same way that she had with her first therapist. She did talk to her second therapist about what had happened with her first therapist and how painful this was. Amanda stated the following:

> And that was one of the first indications that I didn't want to, that I probably wouldn't stay with her long term, because I came in wanting to talk about what happened with my first therapist, and wanting, not to, I don't know, it's interesting that I even worry about my word choice here, I think that was the effect of the 2nd therapist. I wasn't trying to shit talk her [first therapist], I just wanted validation about that experience, I wanted to hear a therapist tell me that wasn't right. But when I told her about what happened her response, even though she didn't know the other therapist, I didn't mention her by name, she didn't have any personal ties that I could tell, she became defensive for the other therapist. And it was basically this closing of the ranks, of like, well, you know, that's probably not really what she [first therapist] meant, maybe you didn't understand what happened, and this is a really hard job, all these things, all these excuses as to why her behavior might have been ok. And I was just like WHAT?! Like it's literally your, not that it's not your job to be on my side, but it's your job to try and see things from my perspective, that's why I'm in therapy!

When Amanda shared with her second therapist about what happened, her second therapist responded in defense of the first therapist. The second therapist did not communicate understanding and acceptance of Amanda. The second therapist instead directly questioned Amanda's experience, perceptions, and perspective in a way that communicated Amanda's experience and perspective were wrong and/or inaccurate. She did this by saying to Amanda, "that probably wasn't what she meant," "maybe you didn't understand what happened," and "this is a really hard job." As Amanda states, the therapist began listing reasons why what the first therapist did was not a problem instead of normalizing how painful that experience would be for anyone and how people would not want to work with a therapist if that was their experience. This invalidation was one of the first indications for Amanda that she would likely not want to work with the second therapist for very long.

Being invalidated can result in a person feeling unheard, unseen, as well as being rejected and dismissed. Invalidating behaviors can also result in a person feeling like they

are being judged and/or pathologized. Some of the participants had these experiences with their therapists.

Feeling judged. Judgments are shorthand descriptions of specifics. They are used by most people on most days. Judging a person is the opposite of being open, curious, accepting, and understanding. Judgements can be communicated in a variety of ways. They can be communicated with words, for example, telling someone what they should do. The "should" is a value judgment and often is not used a manner that articulates what is happening. Other judgements are telling people they are bad or they are good. In both cases, the words "bad" and "good" are short-hand for describing a person's behaviors and the consequences of behaviors. A problem with this is this language is global and nonspecific. It communicates that the entirety of the person is bad or good instead of specifically stating that doing a certain behavior causes a negative consequence or a positive consequence. Judgments can also be communicated with tone of voice, as well as non-verbal behaviors such as looks and facial expressions. Negative judgments often result in the person who is being judged feeling shame/humiliation and/or anger. Multiple participants described experiences of feeling negatively judged and that these experiences changed how they experienced themselves in the eyes of their therapist. Four examples of experiencing judgments from therapists will be reviewed.

> Natalie: I spoke with her, when I brought it up, she said, "You know, you seem snooty and dismissive (inaudible)," and then she said, "You don't have to come back here if you don't like me (inaudible)". I said, "I don't dislike you, but I think you are missing the mark, the issues I came here for you are not helping me with. "She said, "Well thank you for the constructive criticism we can change this from here, I'm getting DBT training we can try that out next time." She would set it up, she would say, "OK I'll take that advice and move on from here," but it never got any better…It was kind of funny, are you really a therapist calling me this? If

that's the internal thought you are having don't tell me you think that about me. And then to I'm like are you kidding me, because I'm telling her that my main concern is my body image. I really want to feel better, to have more friends and have more relationships, and do better in life. And she's telling me people perceive me as snooty and dismissive. It was weird to hear from a professional, but it was also, was wait, I thought my biggest concern in life was my body image was bad, but I guess my personality sucks too. And then we never worked on fixing my horrible snooty and dismissiveness, so people are never going to like me now. Like I know that's not true, but that is how it felt in the moment. Like if my therapist is telling me that I am snooty and dismissive I must be really bad.

Natalie describes how her therapist calling her snooty and dismissive was shocking and that she was in disbelief when her therapist said this to her. The therapist did not give specific feedback of what she was noticing and/or assess what Natalie was experiencing internally. The therapist stated to Natalie, "people find you snooty and dismissive." The therapist did not say to Natalie what it was about her behavior that people found snooty and dismissive. Another issue with this statement is that it is unclear how the therapist is coming to this conclusion. One possibility is that other people had gone to the therapist and said that they found Natalie to be snooty and dismissive. If this was the case being direct about this with Natalie would be important, as well as telling her why people perceived that. Another possibility is that the therapist judged Natalie to be snooty and dismissive. This could be the case given that after calling Natalie snooty and dismissive the therapist said "you don't have to come back here if you don't like me." As will be discussed later, after hearing this Natalie took this to mean that her therapist found her (Natalie) to be snooty and dismissive and thought her therapist didn't like her. If the therapist did judge Natalie to be snooty and dismissive, telling Natalie this without telling Natalie what she did that caused the therapist to think that does not give Natalie any information that would help her change her behavior. The indirect

communication creates even more problems for Natalie as this language overgeneralized

the problem from being one that occurred between the therapist and Natalie to being a

problem that the world has with Natalie. Consider what Natalie said about this, *"I

thought my biggest concern in life was my body image was bad, but I guess my

personality sucks too. And then we never worked on fixing my horrible snooty and

dismissiveness, so people are never going to like me now."* This use of judgmental

language increased Natalie's sense of anxiety and concern about her problems in life. It

also resulted in Natalie thinking that her therapist did not like her.

> Sam: I remember there was another session early on where um, I recall not
> exactly the details, I don't know if I was stepping over her while were talking, and
> she felt offended, and she felt the need to correct me, almost to discipline me, like
> the way a teacher disciplines their pupil. Allows me to finish talking, then in a
> very stern way to put me into my place. I thought that was out of whack too. She
> is dealing with someone who isn't feeling well, and it wasn't my intention to step
> over her, I think she could have addressed it in a different way. But she did that
> and then what happened was I had rage building up in me the rest of the week by
> what she said, and me not getting to express my side of it. Then when I brought it
> up, she was taken a little bit back like that how much that had affected me.

Similar to the experiences described by two participants above in the being

dismissed and rejected section, Sam's description of one of his experiences was that of

feeling like a child in the presence of an adult, in this case a teacher. Sam reports that he

felt judged by the way in which the therapist responded towards him. Her response

appears to have caused him to feel ashamed in the moment in session. The imagery of

being a disciplined pupil evokes that of someone being told they have done something

wrong. He reports that her response to him was distressing as was her not listening

to/inquiring about his perspective and what was happening for him in that moment. Sam

states that rage built throughout the week which communicates how painful this

experience was for him. His statement that his therapist seemed surprised by the effect

her behavior had on him highlights potentially one of the problems occurring in therapy,

therapists not being aware of what is happening internally for their clients.

> Eileen: At the end of each session he would say to me call me if something comes
> up. I usually never called him. One time something did come up and I called him.
> I told him it was me and what was happening. He began yelling at me on the
> phone, "We talked about this in session! You just need to do this." I felt so
> humiliated. I told him right then that there would be no more sessions.

Both Eileen and Natalie experienced cruelty from their therapists in the delivery

of the judgmental statements. Unlike Natalie's experience, there were no specific

judgmental words that the therapist used towards Eileen. That does not mean that

judgment was not communicated. It is important to note that Eileen was following the

advice of the therapist to call him and that when she did as he said, his response was to

yell at her. The statement "We talked about this in session" although not calling her a

judgmental word like "dumb" or "stupid" outright certainly seems to communicate this

sentiment, especially when it is yelled at a person in anger. The statement, "You just need

to do this" is consistent with the oversimplification of problem solving which will be

discussed further below. Eileen reports that she felt humiliated by this and that she

immediately ended therapy with this therapist by telling him that there would be no

further sessions.

> Nadia: Yes, so going back June/ July and uh-- and then from the beginning I
> thought I was there a lot going on with me and I knew this. But in one of my
> sessions during the second wave of session, I actually had the therapist tell me, "It
> seems like there's something always going on with you." and she said, "Maybe
> you should write a book." And I was like, ok. I have thought about that, there is
> always something happening to me, but I did not expect to hear that from my
> therapist. It was what triggered me not wanting to go back.

Nadia stated that after her therapist helped her to navigate her divorce, she was hoping to address other issues in her life. For Nadia, therapy was seen as an opportunity for her to grow and to focus on herself and that she was excited about this. Similarly to Eileen, the judgment communicated was more subtle than what was said to Natalie. As will be discussed further on in the case of micro-aggressions and micro-invalidations, just because something is subtle or unintentional does not mean that it does not cause pain and harm. In this example, it is easy to understand how Nadia felt shocked and judged by her therapist. The statement, "it seems like there is always something going on with you" could easily be interpreted as "what is wrong with you?" This, in fact, is one of the main problems of judgmental and indirect communication; it leaves a lot of room for interpretation by the receiver. Another interpretation of this could be that the therapist is feeling tired of Nadia and her unrelenting issues. Again, it isn't clear. This statement was followed immediately with, "Maybe you should write a book." This could easily be interpreted as thinly veiled disgust or frustration on the part of the therapist. It could also be interpreted as being dismissive. Nadia states that she had thought this, too, and was struck by the fact that something seemed to always be happening to her. The phrasing and the manner in which the therapist communicated this to Nadia that was the issue.

Both Eileen and Nadia stated that the judgmental statements of their therapists were the factor that resulted in their ending therapy. Eileen ended with the therapist immediately on the phone. Nadia continued with her therapist for a short period of time after this experience, in which she had more negative experiences (described in another

section below). This experience of being judged, however, was the first moment when she began thinking she did not want to continue to work with this therapist.

The experiences of invalidation so far have covered participants' experiences of their emotions, perceptions, thoughts, behaviors, and/or life stories being dismissed, judged, rejected, and/or go unheard. These experiences created pain, confusion, and anger (more on this later). For some of the participants, the invalidation they experienced was directed towards their sexual identity and/or their culture.

Identity and Cultural Invalidation

This category is different from the other invalidation categories, as it is specifically related to the experience of invalidation based on culture, race, ethnicity, gender, sexual orientation and identity. This category represents bias, lack of cultural competence, and lack of cultural humility on the part of the therapist. Although ineffective problem solving is a section that follows this section, ineffective solutions that are examples of cultural invalidation will be included in this section.

Identity invalidation. Amanda shared that when she chose her first therapist that she was under the impression that all therapists would have the training and the skills to work with all people and that they would understand love is love regardless of who is loving whom. She reports that still she chose a therapist who advertised as being LGBTQ competent. Therapy started off well, and Amanda talked about how she learned a lot that

helped her to understand her life and experiences. She stated that she started to notice

problems when she began discussing her relationships and her queer identity.

> Amanda: At first it was just these small things, um, like I would refer to myself and my community as gay or queer, and whenever she repeated it back she would always say "homosexual," and I would just cringe. But I didn't have the skills at the time to say, that word sounds really pathologizing especially in a clinical setting, if you, like what would help me is if you could mirror my language back to me. That's what I could say now, but at the time, it was just like it just felt like some old school Freudian shit where she was diagnosing my condition. And I also, like, she's older, it seems like she works with, like all the people I had ever seen in appointments before and after me, were, I would project as straight white women, a lot of them older, so like I don't really fit her market, so I, and I was still holding on to these early sessions where I felt like I had gotten a lot out of it. It started with these little indications that she wasn't really on board anymore, like she didn't quite understand. And also, watching her body language, when I would start talking about relationships and any kind of queer issues, she would kind of tense, and it looks like she was afraid she wasn't going to know what to do or what to say. She looked uncomfortable. Um, and I mean. I was probably also, I had a heightened awareness of that, because my upbringing was extremely homophobic, and here I am sitting across from this white woman old enough to be my mother who can't say the word gay and looks away when I talk about my relationships, and so I just started noticing those things. And the last session that we had, I shared a story um, when I was assaulted by a girlfriend, and she laughed, like not out of humor, but out of disbelief, like I tell her this story, and I'm like, shaking and on the verge of tears, cause I've not really talked to anyone about it. And she goes "HA! You just don't think about that!" And I was like, "What?!" And she goes: "You just don't think about that happening between two women." I was, stunned into silence. I was stunned into silence. And finally I was like, I do think about that because it happened, like I just, and that was our last session. And I wrote her an email, letting her, first just letting her know I don't think this is the right therapeutic relationship. I tried to leave it at that. Like I don't think this is quite the right fit, I'm going to seek services elsewhere, bye forever. And she responded pretty escalated, like it was in email, but she was like this just isn't right, if you want to end you should do it in person, I really need you to come into another session, this is inappropriate. I was like, I'm the client, and I'm not coming in to see you again. That's not your choice. And she's like well I just, it would really help me to understand what changed and what happened. I was honestly trying to find the email (to share for this research) 'cause I can't remember all of the things, but the major things were not feeling comfortable with queer people and queer relationships. So she asked me and I explicitly told her what I noticed in session and what I felt, and also she responded when I told her about that sexual assault, cause I was like, yeah, you should know this 'cause you

shouldn't be practicing with queer people until you get more training. And I didn't say that, that's something I would say now, but I didn't at the time. And she responded to the email, point by point defending herself and her behavior. Like arguing with me about everything and my experience, which I'm like, you're the person who told me about the invalidating environment I grew up in and now you're telling me that my experience isn't true. So I just left. It I was like I'm not going to keep fighting with you, this isn't, I knew at that point, even though it was my first therapist, that this isn't how it's supposed to be, this is damaging, this is hurtful, this hurts people. And even at that point I was like not unlucky that it was me, but just thinking about how many people would have that experience and never go back to therapy and never get help that they needed, because of one person, doing that. And especially, the entire sequence of events, like trying to not let me leave, and tell me what I experienced wasn't real. But yeah, it was horrible.

This quotation from Amanda encompasses a significant amount of invalidation that Amanda experienced based on her identity. Her experience of these invalidations were also invalidated through dismissal and rejection by her second therapist when Amanda attempted to communicate with her about what had happened. The invalidations she experienced based on her identity begin with the therapist not mirroring her language, instead using the word "homosexual." For Amanda this had the effect of feeling like she was being pathologized and diagnosed each time the therapist used this language. She also noticed how her therapist would become tense when Amanda discussed her relationships and how she looked away when she said the words queer or gay. These are examples of the types of subtle behaviors that encompass micro-aggressions. Amanda talked about how painful this experience was for her and that she stayed for a while because she thought the therapist could help her in other ways even if she was causing her pain. She stated that this mirrored her experience growing up where "you get the love where you can even if the person is hurting you."

Amanda also discussed the vulnerability that is part of being a client in therapy. As she noted, this was not a story that she shared with many people, and while telling her therapist about it, Amanda trembled and was on the verge of tears. The therapist's response speaks to multiple layers of invalidation. First, the therapist appears not to be attending to Amanda's in session behavior of trembling and being on the verge of tears. There was no aligning with or normalizing the pain and that trauma that is experienced by survivors of domestic violence. It is hard to imagine such a callous response from a therapist who is attuned to the pain of the person sitting directly in front of them. Secondly, her disbelief that abuse could happen in a relationship between two women communicates her bias and ignorance and is an example of a micro-invalidation which will be discussed later. To make this experience even worse for Amanda, the therapist rejected and dismissed Amanda's experiences and argued with her when Amanda informed her as to why she was quitting.

Amanda chose to end therapy after her therapist laughed in disbelief and said, "You just don't think about that happening between two women" after Amanda disclosed previous abuse. The therapist's bias, ignorance, and invalidation were shocking and excruciating. Amanda described being "stunned into silence."

Cultural invalidation. Natalie and Ana both experienced multiple types of micro-aggressions and cultural invalidation in therapy.   In the following quotations, Natalie expresses the invalidations that she experienced by her therapist. Her therapist did not ask about and did not understand the differences between her experiences in life and the experiences of Natalie. The therapist continually took a 'this worked for me and it can

work for you,' approach to solutions. In doing this, the therapist self -discloses in ways

that are not relevant to Natalie, and result in Natalie feeling like the roles of therapist and

client have been reversed. On top of this, the therapist blames Natalie for being difficult,

stubborn, snooty and dismissive because she pushes back against the solutions. The

solutions offered by the therapist highlight the therapist's lack of cultural awareness,

competency, and humility.

> Natalie: So in the beginning um she told me that she is in an actress and that she
> has been in movies before. One of my issues that I came from my parent's
> divorce, I was having self-esteem issues, and I wanted to get my self-esteem back.
> She told me that she was a model and that she loved working out and the being
> confident that comes out of that. It seemed, it didn't make sense for my life. I was
> telling her the way my body works, (inaudible) and I was also telling her I was a
> social work intern and I can't afford to do more. She told me she helped finance
> her education when she was in school she was waitressing, and other things she
> did. What she didn't understand was that my mom was a housekeeper, she is an
> immigrant. My parents couldn't help me finance my education the way her
> parents did. Her attitude was I did it and you can too. And anytime I would bring
> up it's not culturally competent 'cause your parents aren't labor immigrant
> workers, she would say, it seems like you are setting up boundaries for yourself, it
> seems like you are turning down every solution I try to help you with. Which I
> wasn't, just the solutions.

In this quotation Natalie shares her experience of her therapist basing her

suggestions and solutions for Natalie off of what worked for her (therapist). As Natalie

stated, these suggestions and solutions did not make sense for her life. The responses

from the therapist highlight the therapist's lack of cultural competency and humility. As

Natalie states, the solutions made sense for the therapist and for her life, but the therapist

failed to understand that the circumstances of Natalie's life were very different. Adding

to the experience of invalidation, when Natalie explained the differences between her life

and the therapist's, the therapist accused her of putting up boundaries for herself and

turning down the solutions.

Natalie went on to state how her therapist had an approach that communicated

that she (therapist) already knew about Natalie's life and her experiences as the daughter

of immigrants. Here Natalie talks about how her therapist did not inquire about Natalie's

culture or the culture of her parents:

> She would compare it (Natalie's life experiences) to her other clients, instead of
> saying how has your mother's experiences as an immigrant and house keeper
> impacted you or what does that look like, what does a house keeper's schedule
> look like. Didn't ever ask me questions about what my culture is like, or what my
> parent's culture was like. She was like, my parents worked very hard too, but I'm
> like, it is very different for your parents and my parents, and she wasn't curious to
> know, I think she thought that she knew from her experience.

This is another example of cultural invalidation. The therapist did not ask Natalie

about her culture, her parent's culture, or anything about her experience. Instead, the

therapist viewed Natalie and Natalie's life and experiences through the lens of her

(therapist) own life and the life of her other clients. This lack of awareness and type of

invalidation not only caused intense pain (more on this below) for Natalie, but it also

interfered with the generation of solutions that might have been helpful for Natalie.

Natalie went on to say the following:

> I went to my last meeting with her and she said "I've been thinking about your
> financial stress and I think the solution would be to move into the city where you
> go to school, you would save on that train that you complain about constantly." I
> said, "That's a great idea but I can't afford to move out of my parent's home, and
> my parents are immigrants who don't speak English, and my mom is having
> financial stress because she is going to have surgery, so it doesn't make sense for
> me to even start thinking about leaving my house." And then she said, "When I
> was in grad school my father died, and I had to leave, and my sister was mentally
> ill, and I still did it. It was hard and I still did it, and you have to stop turning
> down every solution I give you. Take out a loan and move into the city, share a

place with a bunch of people. I have other clients who have done it, you will pay really cheap rent." I said, "Yeah that's a great idea, that's what most of my friends have done, but I can't do that right now. Maybe when I finish school I can do that, but right now I can't even begin to think of leaving my house, and taking out a loan and moving in with strangers."… But that was not what I was in session for. I was in session for wanting help terminating with my clients, I'm a social work intern, and I have to end with my clients, and I need some help of dealing with the sadness and anxiety of terminating with these clients that I have been with for a year. And it turned into her telling me how I should move out and move to the city 'cause it would save me money. My things I wanted to talk about were body image and poverty. If she had told me that she was in grad school that she had issues with her body image, and that she got a job and somehow it helped her graduate, I don't know, that would have been relatable, and I've never shared that I have mentally ill sisters, so her sharing that with me was irrelevant, that didn't benefit my therapy at all, it was like we switched roles, like I went from being her client to being her therapist in that moment. There was nothing relevant there. You know. Her father dying, and that causing financial stress for her, wasn't really relevant for me. My financial stress because my parents are immigrants, because of intergenerational trauma, because of racism, hers was because of a death in the family, it wasn't really relevant to my care. It didn't really help me. It was kind of second hand embarrassment, and I thought, I can't wait to leave here, cause I'm not getting reimbursed for the therapy I'm providing right now.

In this quotation Natalie describes her last session with this therapist. She did not

schedule an appointment with her therapist at the end of this session. Natalie never

rescheduled, and her therapist did not reach out to her to schedule. Again, there are many

examples of different types of invalidation that occurred in this session. The therapist

continued to engage in behavior that shows a lack of cultural competence and humility.

The therapist continued to suggest solutions that do not fit for Natalie and her life, and

then blamed Natalie for not following her solutions, "You have to stop turning down

every solution I give you." The therapist seems to communicate without saying it directly

that Natalie's experiences life as a daughter of immigrants and as a woman of color are

really no different than her (therapist's) own. This attitude discounts the effects of racism

and intergenerational trauma and in essence communicates that the therapist doesn't

believe in and/ or understand the effects of these on people. In what appears to be an

attempt to communicate to Natalie that the therapist understands the difficulties she faces,

and to motivate Natalie to engage in some of the solutions, the therapist uses self-

disclosure. Instead of being a validating experience, this self-disclosure had the opposite

effect. The self-disclosure seemed to communicate that the therapist had no real

understanding of Natalie and Natalie's life. As Natalie said, the experiences that the

therapist disclosed had not happened to her (Natalie) and were not relevant to her life.

Natalie reports feeling like she was placed in the role of being the therapist, and that it

was extremely uncomfortable and caused her embarrassment. Natalie said this about the

final session, "It (therapist self-disclosure) made me want to run out of the room. But I sat

there because I felt like it would have been rude for me to excuse myself when she was

telling me her most intimate life story."

In the following quotations, Ana discusses her experiences with different

therapists not understanding her experience as a woman of color and as an immigrant.

She discusses her hesitancy and doubt at the start of therapy, about the therapist being

able to understand her and her experiences. Similar to Amanda, Ana expresses hope that

the education of the therapist would help overcome racial and cultural differences. Also

similar to Amanda, this was not the case. Ana gives a variety of examples in which

therapists did not inquire about her experiences or acknowledge that her experiences

would be different than those of the therapist. She discusses not receiving any feedback

from therapists as she is talking about her life other than silent head nodding. She also

discusses the impact of being in the waiting room and not seeing anything that represents

her culture and the impact that this has.

> Ana: I come from an immigrant family, a migrant family, immigrated to the United States. I was 2 years old when I was brought here. My first language is Spanish. Being an immigrant, being a person who speaks Spanish, and a woman, growing up with different types of abuse, living in a country that is not accepting of who I am and being discriminated against. There were just so many things I grew up with and trying to explain those things to a white person who doesn't understand what an immigrant, what it feels like being an immigrant, what it feels like to be discriminated against because you're a different color, you speak different, you eat different, you dress different, you look different. Do you, like it's hard for me to say, do you understand what I'm saying, to that person. And feeling like I'm being understood is just like, I feel like I was getting nowhere, nothing was being accomplished, um, it was like why do I even come here, I don't think this person understands what I'm saying. It's just really hard to feel validated or feel those feelings of um disconnection. I have nothing in common with you, not with you (Jesse), but with the person who was my therapist, I have nothing in common with them. About validation, feelings like, do you know? I was always thinking I don't think this person really knows what my feelings are, and what it's like to be an immigrant and grow up in a country where my expectations of my family were different than the culture I was being raised in. It was awful, it was hard, it is hard.

In this quote Ana shares how difficult it is for her to feel understood, accepted,

and validated by therapists who are from the dominant culture and do not communicate

their understanding of Ana and the complexity of all of her experiences to her. This lack

of validation was not only extremely painful, it also added more barriers to treatment.

Ana goes on to say the following:

> It didn't feel like there was a click or a connection. I always felt that way because of my culture, being a person of color, seeing a female therapist who was not from my culture, I don't feel connected right from the beginning. I feel like, maybe this person is going to help me because they're a therapist, they have the license, the schooling. I didn't feel like it was the right fit, because of who I am, and my identity, my culture, being a person of color. Yes, it happened with different therapists. It's hard to find a therapist who is from my culture who speaks Spanish, who understands my culture, who understands that part of it… I go in there to for treatment or to get help with depression or issues, but on top of

that there is a whole 'nother layer, a new challenge, a new barrier for me. It's like, is this person understanding what I'm saying or I'm feeling? Because I'm from a different culture, some of the things we go through are a little bit different, our beliefs, it's just hard for me to even know if that person was understanding what I was dealing with. It was difficult….one of the therapists, I feel like it was even giving me more work, 'cause I would just go in there and share and talk a lot. I didn't feel validated, or that my culture was identified, taken into consideration, the issues that I was going through, because of my identity, or any interest of, well, tell me more about what that's like, or what's the norm for that, or why is that done, or interest in wanting to know who I am and my culture and to better understand the issues I was going through.

Ana stated that the majority of the responses from her therapists would be to nod their heads and not say anything. This lack of articulating an in depth understanding of her experiences resulted in emotional pain, distress, and doubting that the therapists understood her experiences and what life had been like for her. Ana reports a similar experience to Natalie, in which the therapists asked no questions about what it is like to be her, no questions about how she was impacted, no questions about her culture. Not only did this lack of questioning contribute to Ana's experience that they didn't understand her, but it also communicated to Ana that the therapists had no interest in knowing. Ana also discussed how hard it is for her to find a therapist who is from her culture and speaks Spanish. Ana stated that this was important to her because if she could find a therapist from her culture who spoke Spanish, she knew that therapist would be able to understand the cultural aspects of Ana's life.

In addition to her experiences of cultural invalidation in session, Ana also talked about other experiences of cultural invalidation and not feeling included and accepted while waiting in the waiting room:

And then in the waiting room, even in the waiting room I wouldn't see anybody that resembled myself. There was um, no one of my culture, it was all white

people, nobody speaks my language, nobody that I could identify with… I couldn't identify with anything at the office. Right when I went in, I mean I don't expect them to have a Mexican flag-- hahahahahaha --or anything like that, but it was just, I was always looking for something that I could identify with so I could feel comfortable and accepted. Nothing, even the patients waiting in the waiting room, the person working at the front window, I just felt out of place, this is not for me, this is something that the white culture does, but not the Mexican culture.

Ana stated that she attended therapy for multiple reasons, including experiencing a lack of validation in her daily life. Arriving at the clinic for therapy Ana's experience of invalidation, feeling excluded and unaccepted continued in the waiting room. Only seeing white people, hearing only English, and not seeing anything that represented her culture made her feel out of place and communicated to her that therapy is not intended for her. It is something for white people, not for her and other Mexican people.

The stories shared in this section show how Amanda, Natalie, and Ana were not accepted. The (presumably) unconscious biases, heterosexism, and racism inherent in their therapists and in the administration of the mental health clinic, created contexts that were not therapeutic but instead harmful and retraumatizing. The behaviors of the therapists and the clinic resulted in participants feeling rejected and like they do not belong, pain, hopelessness, anger, shame, and being re-traumatized. Each of these participants also stated that after these experiences, their criteria for subsequent therapists would include finding someone who was more similar to them. Each also described difficulties in finding therapists who could meet this criterion.

I will move now from focusing on experiences of invalidation to focus on the lack of problem solving participants' experiences. The focus of the next section is the ways in which participants did not receive any help that promoted change in their lives.

Life's Problems Not Being Solved

All of the participants stated that their reasons for attending therapy were to make changes in their lives. Helping people make changes in their lives is one of the key components of therapy. The problems that the participants wanted to address were varied. There were relationship issues, problems with substance abuse and addiction, relationship losses, problems with emotion regulation, depression, anxiety, life dissatisfaction, and life-threatening issues, to name a few. Almost all of the participants shared examples of not receiving help to make changes in their lives. In the majority of cases, this was not because the therapist didn't try to generate solutions. The bulk of experiences that are discussed are ones in which the therapist offered solutions; however, the solutions offered were too simple, did not fit with the person and their life, or were unpalatable to the participant. The lack of understanding the participants and their lives is a critical component of the solutions failing.

Having life's problems and solutions oversimplified. One common experience was having therapists generate solutions that were too simple. The oversimplification of problem solving occurs when the solution offered does not address the difficulty and/or complexity of what is causing the problem in the first place. An example of this would be telling a person who is upset to calm down. This rarely, if ever, works. One problem with this type of solution it doesn't take into account that if it was truly just that easy to calm down that the person would have. Most people do not enjoy the experience of being upset and/or dysregulated. Secondly the solution tells the person what to do without teaching the person how to do this. The oversimplification of problems and problem solving took

on many forms. Natalie had her therapist tell her to go on dating apps because if a

romantic partner told her she was attractive she would believe it. Natalie described this as

being "ridiculous." Ana and Sally discussed feeling that medications were pushed very

heavily and in a way that didn't take their lives into account. Ana stated she found this

"useless."

The experience of having life's problems and solutions oversimplified is painful.

Not only do the solutions tend not to work, people may blame themselves for the solution

not working and/or have the experience of further invalidation as the solutions proffered

highlights the therapist's lack of understanding of them and their lives.

> Nadia: I would say during my struggle with um, deciding whether to get a
> divorce or not, she was very helpful, I felt like she understood me and she
> understood what I was going through, and I didn't have to go through that, in
> terms of accepting sorts of behaviors I shouldn't and such I didn't want to. But
> after, after that, was almost like um she didn't she didn't know how to handle it,
> Right? Like ok you've been through this, now how are you going to handle your
> emotions? I'm like I don't know, I mean that's what I need help with, and uh, it
> turns out it wasn't, it was like treating the symptoms but not the disease.

Nadia describes her experience of finding her therapist helpful in one instance and

unhelpful in another. She states that when there was a clear problem, (relationship

discord and divorce), her therapist was very helpful in helping Nadia navigate the

problem. When the problem moved away from the relationship, the therapist became less

helpful. The question "how are you going to handle your emotions?" seems to imply that

the therapist's expectation was for Nadia to be able to handle her emotions. Nadia stated

that she did not know how she was and that was what she wanted help with learning. She

was not taught by that therapist how to regulate/manage her emotions.

Amy shared how her therapist's lack of understanding about how she was unable to

control her drinking resulted in solutions that did not work:

> Amy: No matter what degrees they had, or who they were, I believe they were coming from a genuine space and trying to help, but at the same time, it was just not relatable cause they didn't know the situation I was in. They would say really nice things like try drinking less, or the therapist would tell me to take a walk outside, or breathing techniques. None of those worked, I still drank, I was still high all the time, I still destroyed my life, I still hurt my family members.

The solutions offered to Amy were insufficient to help with problems of

addiction. Amy described that her experience taught her that a person who is able to stop

drinking at any point they want to is not able to understand the experience of a person

who is unable to stop drinking. Therefore, the tips and solutions they offered her to help

her were too simple and ineffective.

Ellie described an experience with a previous therapist she had as an adolescent

who was helpful in giving her cognitive tools to use when she became afraid. She stated

that these tools were easy to use and helped her decrease the anxiety she was

experiencing at that time. She went on to say the following about her more recent

therapist:

> Ellie: I didn't feel like he ever um, he ever like gave me any tools um to work with, you know…. His solution was to go get a job. "Go get a job." And I was like, I don't want to leave my kids, and I cannot make enough money to um pay for my child's- you know- care. "Oh go volunteer then, go get busy, go get busy, go do something with your life, go to school, go do something… ." That's what he said to me. And here I am I have two infants, you know young kids, my life is chaotic. I volunteer at the school, I volunteer at this, I just want my husband to come home and give me five minutes of attention. And I'm like you don't know what you're talking about, listen to me! I don't have too much time on my hands, this is not what the problem is, he just doesn't want to listen to me. No matter what explanation I had to give it was never valid, it was like no, you know what I mean.

This example from Ellie illustrates clearly how the lack of listening and understanding on the part of the therapist resulted in solutions that were too simple. His belief that Ellie had too much free time was not accurate. As Ellie states, she has two small children, she volunteers at her children's school and in other activities of theirs, she does not have spare time. His belief about the problem also does not incorporate an understanding of the cost of child-care and how much money Ellie could make. As with the previous quotes from Ellie, her desperation at wanting to be listened to, seen, and understood comes across clearly, "Listen to me!" She also states that no matter what she said her therapist did not see it as valid. The repetitive invalidations from the therapist, his insistence on his belief as to what the problem was and his oversimplification of problem solving resulted in Ellie ending therapy with him after the second session. In the following quotation Mike continues to discuss his experience with his therapist and what happened that resulted in him not going back to therapy:

> So I wasn't too cowed by filling out a questionnaire and going through my life's story. But I'm like, I'm waiting, I didn't get anything from the second session. I was like what gives, where's the therapy part? I show up for the third time, and she asks me a couple more questions, verbal questions, not a questionnaire. She asks about my procrastination, about some other stuff and I kind of just like answer the questions, what's your point, kind of a thing? And she leans forward, and is like, you know what, I think you have ADHD. And I was like, I was uh, I was not really uh, like receptive to that idea, 'cause I felt like, like, I poured out my life story, I filled out that questionnaire, I did all that stuff and that's what you got from me!? It really was just like a heel-face turn in terms of my trust, or like what I thought I would get out of this. 'Cause then she was like, I can get a prescription for you right now, for Ritalin, or whatever it was. And I was just like immediately, not hostile, cause I'm a nice guy, so I didn't flip, I'm not like that kind of a person to just get livid like that. But I was like WOW! This is what you got from me? You're not going to talk about anything, you're just gonna immediately prescribe me…like I wasn't tryin' to dismiss the very idea of having ADHD, but I was like WOW! Given what I said that's the conclusion you got to. I'm just tryin' to say it really made me feel like I wasn't dealing with a therapist

anymore. I had gone there expecting some talking or really, I felt like more than anything that's what I needed. Was to talk over my entire life with someone that didn't have the sort of social consequences that talking it over with my parents or my friends otherwise would, and able to, you know, give me some advice or perspective on how or where to go from like, where I was. And that's like, I was just waiting for that, just waiting for some advice or something. Instead it went to drugs in my opinion, that kind of thing, ah we'll chemically altar your state of mind.

Mike saw his therapist for three sessions before quitting. In the first two sessions he was very open with his therapist about his life's story and what his concerns were. He shared how his first experience of a yellow flag occurred in the second session after he had finished recounting his story to his therapist. Her response was to give him a clinical questionnaire. In the third session, Mike returned, still optimistic about getting help even though he states he did not get anything from the second session. In the third session, Mike answered a few more questions from the therapist, who then "leans forward, and is like, 'you know what, I think you have ADHD.'" Receiving the diagnosis in that manner in addition to the therapist pushing medications as the solution resulted in Mike ending therapy. Mike did not recall receiving any real feedback from his therapist. He described her as not interacting with his story apart from some head nodding and saying things like "uh huh." In this case there appears to be very little validation on any level. The therapist did not communicate understanding of Mike or normalize his experiences and/or his concerns. Instead, after him sharing his life's story, she gave him a diagnosis. For Mike, that moment of receiving the diagnosis and being told that her solution was going to be to get him a prescription for medication was the turning point in therapy and what caused him to not go back. He states that his trust was negatively impacted and that this was opposite of what he thought he would get out of therapy. This experience was so

upsetting and painful that it led Mike to feel like he was not dealing with an actual

therapist.

Again, the theme of rejection by lack of validation continues. In this case, Mike

experienced the invalidation of not being heard and understood. He also had his life and

his problems boiled down into a diagnosis. Instead of being validated and having his

experiences normalized, Mike is summed up as being a diagnosis, which is

pathologizing. What is interesting about this experience is captured in the following line

from Mike, "like I wasn't tryin' to dismiss the very idea of having ADHD, but I was like

WOW!*"* Mike is saying here that his mind wasn't closed off to the idea that he might

have ADHD and that this is a factor complicating his life. It was the manner in which this

diagnosis and the solution were delivered to Mike that was the problem. Mike reported

that he went to therapy hoping to have someone he could talk to who was independent

from his family and friends, a person who could offer him perspective on what was

happening in his life, and to work with him to help him make changes that would help

him reach his goals, and to be more successful in school. Instead, the solution proffered

was to chemically altar the state of his mind.

All of the quotations in this section are examples of the various ways in which the

participants found the solutions offered by their therapists not to be helpful. For some of

the participants the solutions that were offered were more than unhelpful; they were

shocking, painful, infuriating, and/or upsetting. There were a variety of ways in which

therapists oversimplified problem solving. For some, like Ellie, it was a direct result of

the therapist not listening to what she saying was happening in her life and what she

wanted. For others, the solutions offered were the result of the therapist oversimplifying the complexity/difficulty of the person's problems and therefore generating solutions that were too simple. Some participants experienced their therapists proposing solutions that were not acceptable to them (participants).

Some of the participants shared how discontinuity in therapy inhibited and blocked progress.

Discontinuity prohibiting change. Most people do not make changes in life in one giant step. Although this may happen occasionally, it is more common for people to make small steps in the direction they want to go with some steps in directions they do not want to go. People also tend to build off prior success and learn what to do differently from failures. In order for this process to work, it is helpful to have continuity. Some participants had the experience that there was no continuity between sessions. An issue would come up one week and there would be no follow through on the part of the therapist at the following session. This resulted in participants feeling like they were not going anywhere and that no change was happening.

Sally described her experiences with her therapist as being inconsistent and unfocused. She said the following:

> I never felt like we were getting anywhere. There wasn't any type of plan, 'cause we were always, the sessions seemed to be all over the map. We never picked up from the last session, like with my therapist now. And sometimes I almost thought that I was therapist giving him assistance. Just like some of the comments he made. So it was just very disheartening that I didn't like, um, I guess kept going and hoping that something would change. But I just didn't feel like anything was changing… I would walk out of the sessions, a lot of the sessions, towards the end like what just happened, or why am I doing this? But I guess I just kept going back 'cause I thought something going to happen, something's going to click, but nothing ever did.

For Sally, the discontinuity and lack of follow through from session to session

resulted in her not experiencing any change and wondering why she continued to go

back. She also felt at times that she was providing solutions for the therapist in his life

instead of the other way around. She stated that after each session she would be

questioning what happened in that session and that it was disheartening. The hope that

the next session would prove fruitful kept her returning.

Sam discussed a similar experience to Sally, where a lack of follow through

interfered with progress. He said the following:

> Sam: I mentioned around month 10 or 11, I had noticed I wasn't getting better so
> I was starting to get frustrated. Before that I was giving it a little more time to see
> how things would develop. I genuinely tried to put in as much of an effort as I
> could, you know, given my circumstances, and um, I think I mentioned to you
> once about how I kind of held myself back from getting angry about a particular
> situation, and then she gave me a high five. Other than that, you know like, it was
> basically me checking in with her, and she would go over my reports card, the
> little journal thing we fill out every night. I don't remember exactly what it's
> called.
> Jesse: Yeah, the diary card
> Sam: Yeah, yeah, she would go over that and we would talk about it. And um, I'll
> be honest, it was just it seemed more like a check in, it didn't seem like we were
> you know, it didn't seem like I would talk about something one week, and we
> would go back and talk about it the following week. It wasn't like we continued
> our touch points. I would talk about my week, then the hour would pass, and I
> would go to my skills group. And the skills group was kind of difficult in its own
> right, you know, for different reasons. So it just yeah, it didn't feel, it didn't feel
> personable.

For Sam sessions seemed to be simply a review of his week. He would hand his

diary card (tracking card used in Dialectical Behavior Therapy) to his therapist and then

they would talk about his week and what was on the cards. The way Sam describes this

communicated that the discussion led by the therapist was not helpful and did not include

assessment of behaviors, and/or solution generation and practice. His description also communicates a lack of consistency week to week.

Natalie's experiences of lack of follow through and discontinuity were similar to Sam's and Sally's:

> Natalie: There was no follow through ever. We would have a session, and she would give me homework, and in the next session she would never bring it up, we wouldn't touch on that again. There was no continuity, me giving her feedback never improved what she was saying, and the homework was never brought up again. She would do one good thing and then never follow through on that again.

Natalie states that homework and topics from one week were not addressed in the following session. Natalie seemed to communicate exasperation and frustration with this when she said, "She would do one good thing and then never follow through on that again."

Making progress towards a goal is considerably difficult without continuity and follow through. All three participants described experiences in which their therapists would not follow through with them on topics, assignments, and goals week to week. The result of this was the participants wondering where therapy was going, not experiencing any progress towards their goals, and feeling frustrated by the lack of progress.

Therapist discomfort inhibiting change. Another factor that impeded progress and resulted in one participant ending with the therapist was the therapist's discomfort. Daniel described an experience of talking to his therapist about what he wanted to work on. The therapist agreed to work on this with him and then did not take the lead in addressing those issues.

> Daniel: I wanted to go into some, just some, like some childhood trauma stuff. She just, I think it was like, I want to talk about this, I've never been able to talk

about this in therapy and I need help. And she was like, OK. But then she just didn't come back to it. And I kind asked a couple of times, and at one point she said something like, uh you know, I don't want to replicate trauma by like me being the one who's driving this, even though I specifically had been like, I need you to drive this. So ultimately she was like helpful, in getting out of that relationship, but once I wanted to actually kind of like dive into some past stuff, it was quickly, my feeling was like you're not comfortable talking about this, so I'm not going to see you anymore.

In some ways Daniel described an experience similar to Nadia. Both Daniel and Nadia found their therapists to be helpful when addressing a present-day relationship issue. Once their relationship issues resolved, both found the helpfulness of their therapists disappeared. Here Daniel described how he asked for help to address childhood trauma, the therapist agreed to this, and then did not follow through. Although she expressed her hesitation to him, her discomfort in the topic eventually came through more clearly, which resulted in Daniel ending with her.

Experiencing verbal validation and no guidance for change. One of the most predominant experiences of the participants in this study was experiencing invalidation from their therapists. For multiple participants, the experience of invalidation resulted in them choosing to end therapy with the invalidating therapist. In contrast, some participants found their therapists to be validating and warm; however, they offered no guidance for change. In the experience of these participants, validation and warmth on their own were insufficient in bringing about change.

In the first example Daniel talked about his experience with a therapist he worked with for a brief period of time. He also referenced similar experiences with previous therapists. Daniel's example is followed by similar examples from Nadia and Eileen.

Daniel: I don't know, I just had this sense that they, didn't want to go there, yeah. I'm not trying to say I'm so skilled that you have to be amazing to work with me, like you, I don't know, you just have to do more than active listening and unconditional positive regard. This woman was really, really nice, hahahahaha, like she was a very, very nice lady. I mean my main take away from her was her constantly her saying that sounds really hard, and I was like yeah, that's why I'm here, what else you got? I have experienced validation from a couple of those people, but I thought for a while, that it was like, validation and support and feeling seen are great, but it's like, I'm here 'cause I want to actually do something about it and I don't know what to do. I think it was a lot more about the lack of direction or solutions.

Nadia: I told her that, that I might need some sort of uh tasks or little exercises that could help me exercise whatever we talked about, or whatever concept we needed to get to, but that was not really how it worked. There was never really a conclusion, there was never really enlightenment during session, it was mostly me talking about what had happened, she would sometimes talk about something some other story or something, um not necessarily personal, but I mean, some sort of story that illustrates that illustrates what I was saying, and then that would be kind of it.

Eileen: I saw a lady for a period of time. She was so nice. She just kept agreeing with my perspective. I was wanting someone to challenge me and help me make progress. I made no progress with her.

Daniel highlighted how frustrating validation with no movements for change can be. He identified how great it feels to be seen and receive verbal support, but in the absence of solutions and change, validation and support are not that helpful. Nadia and Eileen shared similar examples in which they wanted practical solutions and help changing their lives. Instead they were met with only understanding and validation. These descriptions conjure up images of people who are being seen clearly by their therapists to be suffering and in pain. The therapists acknowledge and aligns with their pain and suffering so that the people know the therapist understands what is happening to them. Then, the therapist does nothing to help that person alleviate their pain and suffering.

Wanting help in bringing about a change in life was the one of the main reasons each participant chose to start going to therapy. Each participant shared an example of how this did not happen. For some, their time in therapy was brief. For others, it was much longer. Each person described feeling very frustrated that they did not get the help that they were looking for. The lack of helpfulness of therapy was caused by various forms of invalidation and lack of problem solving. In addition to these experiences, numerous participants shared examples of not feeling valued by their therapists.

Not Feeling Valued as a Human/Feeling Unimportant

Many of the participants shared examples of feeling that who they are as a person was not important to the therapist. In some cases, participants described "feeling like a paycheck," or being important to the business of the therapist as they (participants) were the source of income. In some cases, participants talked about being just another person that the therapist has to see during the grind of the therapist's week. This theme also encompasses the sense of lack of connection. Without feeling connected, it would be hard to feel important and valued. This section is broken down into two sub-sections, feeling unimportant in session, and feeling unimportant outside of session. In each sub section participants discuss how the behavior of their therapists in either context left them questioning their value to the therapist.

Feeling unimportant in session. Several participants shared stories about their experiences in session in which they felt unimportant to the therapist. More than one brought up questioning if their importance to the therapist was as a human or as a "paycheck." Other participants shared different examples of the ways in which they did

not feel valued to their therapists. As such the quotations from the participants will be

presented and discussion will occur at the end.

> Nadia: I remember telling my friends at some point that I thought she was asleep
> one day in one of my sessions, and I'm like, am I that boring? I remember I
> changed my regular times like I would never come right after lunch or too early in
> the morning, cause I always thought she was going to be sleeping. Yeah. So that
> did not make me feel special.

> Ellie: At the same time, I was like no I'm never going to come back to this place.
> Because he's done nothing for me and he didn't seem interested in learning more
> to be able to help me.

> Natalie: I don't think I felt important to her, from the beginning when she said to
> me that I was being snooty and dismissive to her, I didn't actually believe that I
> was being snooty and dismissive towards her, I actually did like her and did
> recommend her to people.

> Sarah: I started to feel like he was getting bored with it (working with Sarah).
> Frustrated is kind of a strong word. It seemed like he was getting kind of bored. It
> started to seem like it was the same thing every week, like we were having the
> same conversation verbatim, it was the same issue that was happening. And I
> remember I would wait in the waiting room and he would come get me. He
> started coming to get me late, and end it early. And he would yawn during it. And
> it was like, this is not helpful anymore. Looking back on it I think it was a gradual
> thing. It felt kind of sudden at the time. I think I just, well yeah, it was like he
> came late to pick me up once, and then it happened two weeks in a row and then it
> was a thing. Then it was like, ok, we're gonna start late every time.

> Sally: I really did feel like they were, maybe this is callous, but maybe they were
> just wanting to get their money from the insurance company, or the drug
> company, or whatever.

> Sam: So when I was seeing her in the morning, I was the first patient for her, she
> was just waking up too. This is a pet peeve of mine, therapist are human, not a
> machine you know, but when you're spilling your soul to someone, or generally
> trusting someone to care for you or help you get better, when it comes to mental
> health, and you see them yawning when you're talking to them about your
> problems that's a little off putting, and she did that once. And I don't recall if I
> called her out about it then, or if I called her about it the next time I saw her, you
> know, the following week. But it was definitely something where I was like, how
> much do you really give a shit or is this another paycheck for you?

There were a variety of different ways that the participants talked about feeling unimportant and not valued as a human by their therapists. Sarah and Sam discussed how they saw their therapists yawned while they (Sarah and Sam) were talking during session. Sarah stated that this was occurring within the context of her therapist showing up late and ending sessions early, which also had a negative impact on her feeling valued by her therapist. Nadia discussed how she tried to take control of scheduling so that she could schedule times when she thought it would be easier for her therapist to stay awake. Sally believed that she was only being seen so the therapists could get paid. Ellie described how her experience of invalidation from her therapists and his unwillingness to listen to her resulted in her belief that it was not important to him to know and understand her. Natalie discussed how after being called snooty and dismissive she didn't feel important or liked by her therapist. Some of the behaviors described in this category are more egregious than others. It is also important to consider that these experiences were happening in the context of therapy that was not going well and where in many cases the participants were not experiencing validation and not making progress towards their goals. It is unclear if some of the same behaviors, such as yawning, would have had as great an impact on the participants if therapy had been going better.

Feeling unimportant after/outside of session. Some of the participants shared examples of how outside of session contact or lack of contact caused them to not feel valued as a human to their therapists. A lot of these experiences are focused on if there was contact outside of session (or after the last session), who was making the contact, and how the contact went. There are multiple examples about lack of contact and never

hearing again from the therapist. This lack of communication often resulted in the

participants questioning their importance, as well as anger. At other times, there was

contact, and the way in which the therapist communicated to the person left the person

feeling that the communication occurred more because the therapist was concerned about

their income, rather than the well-being of the client. In one instance a person talked

about the experience where it was the front desk employee communicating via email and

the effects that this had on their sense of importance.

> Mike: Like should I continue scheduling you? Like that in itself kind of not the response I wanted kind of thing. Like, oh it's just 'cause I'm not showing up that you care about or something? Like that that didn't seem like a personal outreach, it was more like a bureaucratic outreach I guess… I mean maybe if it had like an aw, man, I'm sorry if something about what I did was off putting or aw, man, if anything went wrong in that session, I would love to talk about it, … But there wasn't really anything like that type of thing… I mean maybe that second part that I meant was that maybe the only part that was important to her, like, I'm trying to figure out a way to put this. Like she was merely checking in my rescheduling, because that's important to her business model or something. Like, oh if he's not going to show up, I should be filling that slot or something. So that's kinda connected to what I meant when I said bureaucratic, but I mean it was like she was just covering her own stuff, like, oh, if he doesn't want to show up we're all good or something…. yeah, like fulfilling some sort of quota I guess. Like more concerned for that.

> Nadia: There was something happening then with the cancellations I felt, like it was either like it was two in a row, and for somebody who's coming in every month it was a big hit for me, like I'm counting on this. And she never really said what it was, like it was one time I think they said she was sick and the other time it was a family thing, but it's like you can't see me, and that's ok cause you're a human but then I would expect at least for her to reschedule, or for her to find a way, you know since considering it's been two months since we've seen each other and I needed help she did her job getting me through divorce and not failing school, so now she was setting me aside. I was no longer a priority…, no rescheduling, no call back,… yes, yeah, there wasn't even a call, there was an email.
> So it was either a good thing that she was OK with that or she really didn't care, which I mean, I don't think she didn't care. Umm. I think she, yeah, I mean, how much can she care really? Right? Like when it's somebody you don't know, then,

that is getting paid to help you go through whatever struggle you're going through, how personal can they get? How much can they care? I mean I'm not at a suicidal state or anything like that, you know, there's no fearing for my life, so I don't think they care that much.

Natalie: I think also I didn't like that if I cancelled a session, I never did skype sessions with her, but she was like if I don't have a session, I could have scheduled someone else, so do you want to do a skype session, I can't bill if you weren't here. So it was really like I was the thing that made her money, it was like she would say I'll stay later if you can come in. it didn't feel like she was offering to stay later to help me it was like I needed to show up because she wasn't going to get the payment from my insurance company.

Ana: I felt like sometimes they were just doing their jobs, like I'm another patient of theirs. I was important to them as a patient, to their job maybe, not as a human being. Because when I stopped going to see them, I never got a phone call. I know it's up to the patient to continue the therapy. I don't know if I had felt important to them if I would have continued or not.

Sam: So I think the week, during that week before my last session, I had a situation I think where I got really depressed. Actually I know I got depressed. … I had one of those episodes where I got suicidal…. Little did I know that I was tempting fate. I found out later on that it only takes a couple of pounds of pressure and just a few seconds for you to do that and you're going to go unconscious, you're going to black out, and once you black out, your body is going to drag you down, and commence the asphyxiation, and you'll die. A lot of people I think die that way, not realizing how little effort it takes to kill yourself. …. So in a moment of clarity, when I thought therapy wasn't working out, and it seemed like a waste of time, I grabbed the jump rope and I bundled it up and put it into my back pack, cause I was going to go to class afterwards that day. And I brought it in with me. Um, and I was talking with her, we were having a regular discussion. I said, "Listen, I came to the conclusion that this therapy is not working out. I've been coming to you for better part of a year, and my symptoms are not getting better, I gave it an effort. I don't know if it's 'cause my lack of ability, with my schedule and what not, I thank you for taking me on as a patient, but I think I'm gonna have to stop here." … I pulled out the jump rope and I gave it to her. And I mentioned to her before that I had tried to kill myself with that jump rope. So she knew what I was talking about, it was kind of like a gesture, if I keep this I'm going to kill myself. She kind of looked very you know frozen in her tracks, her eyes were not blinking, she was staring straight, not directly at me, but towards my direction, …, I gave her the jump ropes and I walked away. I think I had asked her if she knew any place else that I could possibly go try. Some place that could give me one on one therapy. She said she would send me an email, but she never did. That was the last I heard from them.

Checking in with someone is one of the ways in which we communicate to others that they are important to us and that we value them. The most common experience shared by participants in this sub-category is the lack of outreach by the therapist. It is easy to understand how a person would not feel important to a therapist if a session was cancelled and the therapist never reached out again. Nadia mentioned how outreach happened, but it was by the front desk and via email, thus impersonal. The lack of outreach by her therapist in combination with the previously reviewed invalidation resulted in Nadia ending with her therapist.

Although unstated directly in this section, there is the sense that for the participants, their therapists were so much more important to them than they were to the therapist. What communicated to Sam that he was unimportant to her was the therapist not addressing his communicated suicidality in the jump rope gift and the lack of follow through with referrals that she had agreed to give him. Natalie, Ana, and Mike all described how the way in which the therapists reached out, or in the case of Ana did not reach out, communicated that their (participants') importance to their therapists was solely as a source of income. Ana also stated that she was not sure that if she would have stayed had she felt like she was important to the therapist. This suggests that despite all the other experiences of invalidation and barriers, had she felt valued by the therapist as a human she might have stayed.

The therapeutic relationship is unlike other social relationships. One person meets with another person and openly discusses one's life, their various problems, and the therapist works to help them make change. Being a client in therapy is a vulnerable

experience that requires the client trusting that the therapist has the client's best interest at heart. As such it seems to be critical that the client has the experience of being cared for and valued as a person by the therapist. The majority of the participants in this study did not have this experience with their therapists. Several of the participants described feeling like their real importance to their therapists was primarily as a source of income. The behaviors the participants encountered were: falling asleep in session, yawning while the participants talked, starting late and ending early, being judgmental of the participant, not rescheduling appointments that the therapist cancelled, not calling to schedule next appointments, calling and communicating that it is important to their income to schedule a session, not responding in session to communication of increased suicidality, and not following through with referrals (in one case not following through with referrals for a person who was at increased risk of engaging in suicidal behavior). When reviewing this list, it is understandable that Nadia communicated her loss of faith in therapy and stated, "I don't think they (therapists) care that much."

Summary of Findings about Problems in Therapy That Led to the Participants

   Ending Therapy

The research question asked in this study is what happens in therapy that results in some clients wanting to end therapy. The participants in this study quit for a variety of reasons, and for many there was more than one specific cause that resulted in them choosing to end therapy. Invalidation in a variety of forms played a major factor in the decision of participants to quit. The participants recounted their stories of not being listened to by their therapists despite their (participants') best efforts. Others shared

examples of being judged by their therapists, others spoke of having their experiences, emotions, perceptions. dismissed and rejected by their therapists. Some participants had all of these experiences with their therapists. One participant experienced microaggressions and invalidation of her sexual identity by her therapist. Two participants experienced microaggressions and invalidation based on their culture. Two of the three of these participants mentioned hoping and believing at first that the training therapists receive would be enough to insulate them from homophobia, heterosexism, and racism. They learned in a painful way that this was not the case.

Some of the participants chose to end therapy because there was no progress made towards their goals and/or no change in their lives. Multiple participants gave examples of how the invalidation of the therapists resulted in the therapist oversimplifying the problems faced by the participants, and therefore generating solutions that were too simple and/or unrealistic for the participant's life. Others shared how the lack of continuity and follow through between sessions resulted in therapy that went on for prolonged periods and went nowhere. Others spoke about their experiences of being seen and feeling validated and understood by their therapists but how there was no movement by the therapist to help solve the problems that were causing pain and suffering. One participant gave an example of his therapist's fear and hesitation interfering with addressing a topic that was of importance and they had agreed to address. Similar to the experiences of invalidation, multiple participants had experienced behaviors in multiple categories.

Although no participant said that their experience of not feeling valued was the only cause of their choosing to end therapy, multiple participants stated that the experience of feeling unimportant and not valued contributed to their decision to end and not return. These experiences occurred both in and out of session. One of the most common experiences between participants was their therapists not reaching out to them after missed/cancelled session and therapists not following through with referrals. Some of the participants stated that the way in which the therapist communicated with them during the outreach led the participants to believe that their value to the therapist was as a source of revenue, not as someone whose wellbeing the therapist truly cared about. In-session behaviors of the therapists also communicated to the participants that they were not valued. Examples were shared of therapists falling asleep, therapists starting sessions late and ending early, yawning while the participants were talking, not asking questions or inquiring about the participants' experiences.

I turn now to the consequences of the problems of invalidation, lack of problem solving, and not feeling valued as a human. The information shared in the following sections highlights what happened for these participants after therapy failed. Although this information does not answer the research question of this study it is critical for understanding why therapy not working is a major problem that needs to be addressed.

Consequences of the Problems in Therapy

The variety of painful events in therapy that the participants experienced resulted in a multitude of different consequences. Some of the consequences were immediate, others were prolonged. The sections below have been separated into the immediate and

emotional consequences and the consequences of failed therapy. The categories are based

on the experiences of the participants and are not arranged in order of significance

Immediate and Emotional Consequences of Invalidation, Inadequate Problem

Solving, and Not Feeling Valued as a Human by the Therapist

All of the problems listed and reviewed above caused various negative

consequences for the participants. This category captures the emotional experience of the

participants as therapy progressed and they experienced more invalidation and less help.

Multiple participants shared examples of how their experiences in therapy negatively

impacted them. The sub-categories in this section capture these experiences: questioning

their sanity, feeling like a burden, increasing anger, and increasing pain and despair.

Questioning sanity. Sarah and Ellie discussed how the repeated invalidation from

the therapists began to impact their (participants') perception of reality, including

questioning their sanity.

> Ellie: But that is exactly how I felt at that time, like am I that crazy, I am here
> telling you a story and if you just listened to me, there would be, it would make
> sense right, if you just let me tell you from the beginning it will make sense. To
> me it was just like, oh, I guess I'm delusional. That's the word, I guess I'm
> delusional.

> Sarah: And it [not making progress in therapy, and the therapist's reactions] made
> me feel kind of stupid too. Like am I making too big of a deal of this? Or am I
> imagining all of this? I just started to feel a little crazy.

Ellie and Sarah describe how the mismatch between their experiences and how

their therapists responded to them resulted in them questioning their reality and feeling

delusional and crazy. Neither Ellie or Sarah said that they believed that they were crazy

or delusional; however, at that time this was one of ways they felt. If a person

experiences life in one way and has an understanding of what is happening, having

another person respond in a manner that is invalidating negates the person's experience.

The internal experiences are at direct odds with what the external person (in this case

therapist) is saying. The lack of congruity between the two can result in a person not

knowing what to believe and what is accurate.

      Feeling like a burden. Sarah and Natalie began to feel like a burden to others

while in therapy.

> Sarah: Um it started to feel like I was bothering him, which, I guess it affected me
> on a few levels. Like on one hand I was frustrated, like this is your job. You're
> getting paid to do this. Whether you're frustrated about it or not, I feel like there
> should be a level of professionalism there.
>
> Natalie: And I felt like a burden to my friends. Because every time I left therapy, I
> would call one of them and say, wow this is terrible, I feel really bad right now, I
> feel sad, I feel angry, I feel misunderstood. But I think it gave me, it made me feel
> bad for my friends for having to tell them all of this, because the point of having a
> therapist is not telling my friends all of my issues.

      For Sarah and Natalie attending sessions caused more pain. Due to the

interactions with her therapist Sarah felt like a burden to the person whose profession it is

to help her solve problems. This leads into what Sarah said below about the development

of hopelessness. For Natalie, the experience of going to the therapy was so painful that

she called her friends after sessions in order to get support. This resulted in more pain as

she felt like a burden to her friends.

      Feeling anger. One of the most common emotional experiences shared by the

participants was that of anger. Multiple participants described feeling angry at their

therapists for what they had done or not done in session. The frustration and anger

experienced by the participants is evident in the quotations discussed thus far. Two

examples are included here.

> Mike: I think I didn't show up to the next one. And later when she was like, oh my gosh, she was like, are you going to keep showing up? I was like, no. I didn't necessarily inform her why I stopped. 'Cause I was kind of like, I don't want to say that it was revenge, but sometimes someone might not turn in their two week notice because they weren't satisfied with their employer.

> Natalie: I definitely felt anger, I felt um, just angry with my financial situation, angry the way insurance is set up, angry that I have to keep going back to this person, my options were limited.

Mike's experiences with his therapist resulted in him ending therapy and not

informing his therapist. When she called to ask if he was returning, he said no and gave

no explanation. His analogy about a dissatisfied employee walking off a job without

giving notice highlights how upsetting Mike's experience in therapy was. Mike went on

to talk about finding help in other places and that he was pleased with where he was now

at in life. When discussing this he stated, "And that had nothing to do with her the

psychotherapist, it wasn't her who led to any of that."

Natalie was limited to seeing a person who was on her insurance, close to public

transit, and who had a flexible schedule. For Natalie, there was not only anger that she

experienced towards her therapist but also an increase in anger that she felt towards

aspects of her life and the mental health and insurance systems, as she felt stuck with

having to see this therapist.

Increasing pain and despair. Attending therapy is supposed to help people

decrease the amount of pain and suffering they have in life. Instead of decreasing pain,

multiple participants discussed feeling increased pain and hopelessness as time went on.

The experiences discussed in this sub-category occurred while the person was still in

therapy.

> Sarah: And then, I don't know, it started to make me feel a bit more hopeless about my situation. Because it's like I'm seeing a professional for this specific issue that I can't figure out how to fix, and he has clearly has given me everything he's got and that hasn't fixed it either. So it felt like a dead end on a lot of levels… There was also this worry, like if I start feeling like the way I had been feeling again, then I really don't know what to do. 'Cause this was the only thing I could think of, and it clearly didn't really work.

> Natalie: Yeah, it made me really angry, it made me really sad. I think it was a reminder, I was coming into sessions and saying, "I have no money I am still trying to figure out bus tickets to school because I can't afford it," and I think every time I went to the sessions I was thinking, oh my god, I'm back at this shitty therapist because I can't afford a good therapist. I would get anxious, like I'm never going to get out of the cycle of poverty, and the person who is supposed to be helping me is not good, she is a shitty therapist that my insurance will pay for. Over time she became a trigger for how poor I am.

> Amanda: It was hard because I, I had such low, low skills around emotional awareness and communication at that point, that I was going into the sessions very mistrustful, like I wasn't sure how she was going to respond to things, but also, because I wanted therapy and I wanted help, I was telling myself like, well, just because she doesn't know the language doesn't mean she can't help me in other ways, you know, like kind of trying to make the most of it and trying to make the best of it. And like really listening to my own intuition and my own feelings, 'cause that's what I was there to learn, and I didn't know how to do that yet. And at this point in my life if I sat across from the table from a professional and they flinched when I said the word "gay," I would be like, I gotta go. But at that point in the work that I was doing I was just like, I'll take what I can get, you know. If she can, if she can help me in certain ways then I'm willing to put up with some discomfort and some-- I'm trying to think of a good word for it-- it was definitely damaging, and that's how I was raised too: you get the love where you can even if the person is hurting you at the same time. So again it seems like another relationship that was reinforcing some of that earlier stuff, and because I still hadn't learned how to listen to myself, I was listening to her and she was telling me how things were supposed to be, and what things were supposed to be like, and if she hadn't reacted so inappropriately to my sharing that really hard story I mean I might have stayed a lot longer. It was something that was so heightened that was so intense, that I was like, I cannot stand this. Like, this is not OK, I had enough of a response, it was a breaking point, like this actually isn't ok, and a lot of her behaviors leading up to that weren't ok either. It's like micro

aggressions where I know this is bad but it's not that bad and I'm kind of used to it.

Ana: I felt like sometimes I just wanted the hour to pass by fast, so I could just maybe even leave because I felt like, it was just uncomfortable to be there in that situation like that. And not knowing what I should be doing, or what my actions or my reactions would be. And I felt a lot of uncomfortable, like maybe I don't need to come back, or maybe I need to find somebody different. Or maybe even, what is it I'm doing wrong? What is it I'm supposed to do, or not do? What do I need to do to be understood? Just a bunch of different questions of what was going on at that time

The participants shared their experiences of how being in therapy caused an increase in pain, despair, and in some cases hopelessness. Ana's experiences in some sessions were so uncomfortable that she could not wait to leave. Amanda talked about how her experiences in therapy reinforced painful and problematic experiences from her past, and although she was experiencing pain, she kept returning in order to get the benefits of the parts that helped. Sarah and Natalie talked about their increased hopelessness that their lives would ever change as a result of therapy. For Sarah, the experience of being given all the tools the therapist had to help her and having those not work resulted in her feeling hopeless about being able to change. In addition to this she also felt like a burden to her therapist. Having the tools provided not work and feeling like a burden to the person whose profession it is to help people make changes would make many people feel hopeless. Natalie's experience increased her fear that she would never be able to break the cycle of poverty. Getting help through therapy was a critical part of breaking this cycle for her. She knew that the therapist she was seeing was not helping and causing her more pain. She saw no other options at that time of a therapist to see. She described this as being "soul sucking."

The experiences shared in this category describe the experiences the participants had as a result of all the various problems in therapy that were reviewed above. These experiences are the opposite of what people choose to attend therapy for. The participants in this study attended therapy to bring about positive changes in their lives. The experiences described here show that instead of increasing positivity, the problems in therapy increased the pain and negativity in their lives while they were working with these therapists. For some, this resulted in them questioning their perspective and their sanity. For others, there was a lot of anger at their experience, for others therapy became triggering, and for another therapy re-enacted a painful pattern from earlier in life.

The following three sections show consequences of failed therapy and why it is important to understand. The information shared in these sections is based on experiences that happened after the participants left therapy.

Experiencing the Consequences of Failed Therapy

For the majority of participants, the negative experiences they encountered in therapy continued well past its ending. Many reported that the negative experiences impacted and delayed their seeking out a different therapist. This category focuses on these experiences and the two main themes that were described by participants.

Prolonging of suffering. Some participants reported the problems in their lives continued for months to years after therapy failed. For some, the negative experiences they had with their therapists delayed them looking for a new therapist. This resulted in the problems they had been experiencing to continue. Others spoke about the loss of time and opportunity in their lives due to not receiving help.

Amy: I felt like I would always be broken. No matter what combo with therapy I tried, nothing seemed to fix what was happening internally. So at that point I didn't have any beliefs that anything would happen. Mostly because of my past experiences, nothing really changed, like I learned some things, but at the same time, it wasn't sufficient to actually to produce any results in my life, if that makes sense.

Ellie: And ten years later, I have a full time job, I'm busy, so haven't really thought of those of things, but they're very real and they're very present. Then I realized that he was wrong, get me a job and get me busy was not going to take care of the problem. And the shit hits the fan, and then we finally address it, and I'm like, gosh I just wish we had done this ten years ago. So, yeah, we went through so much pain for ten years because we didn't find somebody to help us figure it out.

Sarah: I think it kept me from going to AA for a while. I don't want to place blame, I think I got to AA when I needed to. But I think on some level I had in the back of my mind, AA is kind of I don't know, it felt sort of condescending, the way he would talk about AA. I kind of had this thing in my mind, I guess it's something, but it's not real. This other thing is more concrete. So I think of it did sort of postpone, my arrival in AA I guess.

Sally: There was frustration and sadness. I felt like I wasted a lot of time, trying to resolve my issues, and not really feeling like they were, as far as talk therapy, maybe I was, I felt like I was all talked out… but I felt frustration, because I think if I had a decent time with them, I would have stuck it out and maybe I wouldn't be doing therapy again.

Amanda: I have a different experience about it looking back than I think I had at the time, because at the time, like I said I just, I was a baby learning, learning my own emotions at that point, and so, I thought that at that time, was that like I knew that when she had that response I was like clearly this is on her, right, and of course it impacted me emotionally, but I think that at that point it was too vulnerable and too painful to feel what I felt, so instead I intellectualized it by saying that clearly she is not fit to provide care to queer people or possibly anyone, and this is on her, and also trying to hold the pieces from our sessions that I did find valuable, and so the story that I told myself was I, you know, I need some time to digest what I learned and maybe I just don't need more therapy, like actually that was my first response, you know. I saw her for a few months, I got some stuff out of it, maybe I just, maybe I'm good, maybe I'm good, and so, I, and I wasn't able to sit with my feelings at that point, but I think looking back the way that I responded was that it was too painful to sit in those feelings, so I told myself that I didn't have them, so maybe I got what I needed to get from therapy, I'm probably better now, right? And it was really an excuse for me, to not keep

going, and to not keep trying, and to not make myself vulnerable again, and to not have to do the work. Someone just gave me a get out of jail free card, and now I just didn't have to worry about it, and I kept that up for a few months, maybe even 6 months, and kind of just fell back on dissociating from things, and just pretending things were ok.

Natalie: I think maybe my requirements for my next therapist were so much greater than the ones I had for her. My first requirements were I want somebody who takes my insurance and who is a woman, and then it was I want someone who is a woman of color because I am a woman of color, I want someone who speaks Spanish because they might understand the immigrant side, I want someone who is close to transportation, who takes my insurance, and that limits my options by so much more, it's impossible to find someone who fits that criteria. But she, I think I would have been more open to maybe a white person who doesn't speak Spanish who maybe is (inaudible), but she made me think I'm not making any more excuses, I'm raising my standards, because I don't want to trust somebody all over again. I think it did extend my suffering, it prolonged it, because every time I went it was like, which side of her will be showing up today? Is she going to be understanding or is she going to be a whack-a-doodle at times? It didn't feel good.

Daniel: I think one more thing that could be important, this wasn't a steady stream of clinicians, this was spread out over 8 years. The initial clinician was (omitted), after that I didn't try to go back to therapy for a couple of years. After having that super validating lady, I got this feeling like this is not helpful, and I didn't try again for a couple of years [referencing that he did not attempt therapy for a couple of years after working briefly with a therapist who was very validating and didn't help solve problems.] Like I struggle with depression, and getting to go to a therapist, is such an effort, and then getting there, and having it be shitty is super defeating, and in a lot of those things it's like, ok, I just did all of these things and I got the message that this isn't going to be helpful and I shouldn't be here. I think it delayed finding someone who could actually help me get to a point where I'm not just seeing a therapist when I'm depressed, but actually seeing someone when I'm doing well, and how to prevent myself from getting back into a major depressive episode. I feel like that was another thing, even…With my training and knowledge, depression is a beast, and it's hard having that invalidation and messaging that therapy can be helpful for everyone except for you.

Nadia: I actually ended up on a good two weeks of not wanting to see anyone, and just like being really in bad shape …. I had this uh, mmm, this idea that it was better to keep myself away from people instead of trying, and this is definitely not me. And this is the reason I was looking for help, 'cause I was like, this is not who I am. I am a people person. And I didn't want to talk or see or do anything.

The pain caused by failed therapy continued for periods of time that ranged from weeks to years after therapy ended. Multiple participants talked about how their negative experiences in therapy resulted in them delaying searching for new therapists. Ellie mentions how the problems she had gone to therapy for were swept under the rug for almost a decade until they all came to a head. Amanda shared her experience of returning to being dissociated for a period of months after ending with her first therapist. For Natalie going to therapy increased her fears about making changes in her life. Similarly, to Ana, one of the impacts on Natalie was to narrow her criteria of who she would work with, thus making it harder to find someone that met her criteria. As a therapist, Daniel had the knowledge that therapy can be and is helpful. The repeated failures of therapy for him resulted in the painful belief that therapy could be helpful for others but not him. The experience of therapy not being helpful and his resulting belief that he was not someone therapy could be helpful for resulted in long periods of time in which Daniel did not search for a therapist.

Experiencing the loss of an important opportunity. Some of the participants described the experiences as missed opportunities for personal change and growth to occur. They expressed being excited about therapy and looking forward to making the changes they wanted to only to have the behavior of the therapist block this from occurring.

> Sarah: You know that would have been probably been a good thing to talk about, 'cause when he brought that up, and he made that comment, he kind of made it, [the therapist made a comment about how Sarah communicated] I think he was trying to make it in an offhand way, it was sort of pointed, it put my relationships with virtually everybody kind of in a new light. And I thought wow, that's how I

am with everybody. That's kind of a big thing that we should have maybe addressed, maybe sooner than two weeks before graduation from school].

Nadia: I was pretty sad. I mean I thought this was the time she was supposed to do something, so the first, the first time was like I was going through something and then needed support to go through it. Now that I was done, I was actually working on myself, you know trying to be better, and stronger, and finding all these things uhh that I need to know. It's literally, I needed treatment, you know. So this is when I expected her to say you know what, I am glad you're trying to be you know your better self blah blah blah, let's do this. And just you know, really embrace it, 'cause that's what, as a professional person I would think that when you see the results, that's when you see an actual product of your work, not just let's get you through the divorce. I could have done that on my own, I mean I'm not saying she didn't help. She did, I'm sure. But it's like going through it is just going to be going through it. And now would be the time that this is how we come back with you know, something special and better you know a product of rediscovery or whatever it means, and it didn't.

Sarah and Nadia described their experiences of recognizing the lost opportunity

for change and growth. For Sarah it was having a pattern of behavior that she engaged in

being brought to her attention just before she graduated from school and her recognition

that she engaged in this pattern with most people. Also present is the recognition that the

therapist knew about and saw this pattern of behavior and had not said anything to her

about it previously. Nadia discussed her experience of being excited to focus on herself in

therapy and changes she wanted to make. After dealing with her divorce Nadia saw

therapy as an opportunity for personal discovery and growth that would result in her

being a better person. She was excited about this opportunity. Nadia expressed sadness at

the loss of this opportunity and confusion that her therapist was seemingly not interested

in doing this work with her.

This sub-category captures how the participants' lives were impacted by therapy

not succeeding, the loss of time, delaying finding a different therapist, the continuation of

pain, and the loss of opportunities. The next section focuses on participants' attempts to understand what went wrong in therapy and why it went the way it did.

Searching for Understanding

For the participants, the failure of therapy had many negative effects including the prolonging of suffering, increased hopelessness, pain, anger, and despair. Many participants wanted to understand why therapy did not work. Many expressed that they had spent time searching for understanding the reasons for what went wrong.   There seemed to be a propensity for the participants to blame themselves. There were also examples of participants feeling like their therapists blamed them (participants) for not being successful. Some said not knowing why therapy did not work was one of the most difficult aspects, especially when they came to believe that therapy is not something that can work for them.

Blaming self. Many participants shouldered at least part of the blame for therapy not working. Some expressed that they believed the problem was that they did not clearly communicate to the therapist, others expressed that they thought they just were not the type of person therapy would work for, and others described that they didn't try hard enough due to the structure of their lives.

> Nadia: Maybe she's just not, it's not her specialty I guess, I don't know. Maybe I was not clear on like my goals, to me it felt like either she wasn't prepared to deal with me, or she didn't want to. I don't think she understood that as something I wanted or needed, I don't know if it was my mistake, not saying it in a way that she knew.

> Ellie: It's my fault partially too 'cause I should have gone to somebody else you know the minute it didn't work. Not just like, ok whatever, he doesn't see my side, there's not a problem, I must be crazy.

Sam: There's a flip side to that and it's something I'm willing to admit in retrospect, I wasn't willing to admit it back then. I think partly the lack of progress I experienced, even though I kind of you know, was looking at from my perspective, this treatment I'm going to is being ineffective. A part of it had to do with my lack of effort. There were a couple of reasons for that. I was spreading myself way too thin. Having to deal with work, with school, and still wanting to fit this thing in. Because with DBT, it's not just like going for an hour and talking. It's like learn these skills, and spend time, get good at them, especially when you're not feeling bad, so when you are feeling bad you have them. I never was really able to fully involve myself in these skills, and then even with other therapies, CBT therapies, usually involve in my experience, to go over a certain type of skills. I want you to work on this this week and let me know how it goes. Even though I didn't have that much distraction, the therapist I saw (omitted) would recommend a book to read, and I wouldn't always invest the time to do what was instructed. So as much as I tried to follow through, like to do the nightly journals so I could turn them in to my therapist, I feel like I did an effort but at the same time I was spread thin. I partly want to take accountability for that. I don't know if that's factual or not, my intuition is it is. I just want to look at it constructively as possible…'Cause at that time I wanted to put the blame on myself, I'm being difficult for them to handle, and I'm making it harder for myself. But in retrospect when I look at it, and I take accountability, I think they could only help me as much as they could, because they had other people that they had to tend to…. I got the sense that they were kind of, possibly like I was the one causing the issues or the trouble.

Amanda: I know underneath the waves that I was responding, with a lot of pain and a lot of shame, and this idea that I wasn't the kind of person that could get help. And that fell in line with AA and sobriety, because for me, going to AA and hearing people talk about god and powerlessness like made me want to drink more than anything in the entire world, and I always knew, like I can't go to AA, it's not for me, I need to look for other opportunities, and now I was at this point where I was like I can't go to therapy because I'm not the right kind of person for therapy. You know it's so vulnerable, and you never know who you're sitting across the table from. It was definitely this feeling that I'm not the right kind of person to be able to access care, I think that's what I came away from it with.

Amy: I can only imagine how hard it was for anyone that came into contact with me and felt like they weren't getting anywhere. But that's because I was not willing or capable to be honest, um, and I think for me it's like a weird, it's like some super cheesy, it's not you, it's me, type of thing. I don't think that think there is anything they could have done until I was prepared to be honest with my drinking. And I don't think that there is any therapist in the world that I would have been willing to be honest with my drinking.

The participants described the ways in which they viewed the failure in therapy to be partially their responsibility. For some, the assessment was balanced, addressing how various factors such as the day to day structure of life, and/or addiction contributed to therapy not succeeding. Others described viewing themselves as being the problem, their communication was not clear enough, their emotions were too strong, they did not leave sooner, they were not the right type of person for therapy. What is interesting is that all the reasons described in this section are reasons people choose to attend therapy. People attend therapy to help learn to regulate emotions, or deal with addiction, and communicate more effectively. It can be considered a failure of therapy when the person who ends blames themselves for the reasons driving them to therapy.

Seeing systemic problems. One participant described seeing their therapist as human and viewing his experience as the result of a failed system.

> Sam: I try to be a little more realistic about it. I try to realize that I may have a hand in the difficulty of that experience, that it doesn't fall just on them. But I remember, for a long time after that, me just wishing that there was some sort of reformation about how mental health care is implemented in this country. I realize that you know, therapist burn out is a very real thing. It's in literature I read. You guys are only human, you're having to constantly deal with all kinds of people, but maybe you know, just like the way things are implemented, if there is some way to accommodate certain aspects of this process, on the patient end, and on the provider end. To make things more manageable, to make things a little more streamlined. Even something as simple as billing, which could be one less thing to worry about.

Continuing on from above, Sam viewed his unsuccessful therapy being the culmination of factors that interfered with him and factors that interfered with his therapist. Sam spoke more about his views that a major problem of therapy is the sheer number of clients most therapists have to see in order to make a living. For him, the

failure was a symptom of a diseased mental health and insurance system in the United

States

Feeling like a trigger to the therapist. Two participants described wondering if

there was something about them that triggered the therapist and if that was the cause for

the therapist to behave in the manner they did.

> Amanda: Yeah, just the invalidation and the shut down, and really with the second person, at this point it's easy for me to recognize how much she was projecting a lot of insecurity onto me, because I was questioning a therapist that I had seen I think that she was afraid that she would be questioned, or something along those lines, because those were all the examples of why this isn't a good space. Because I would share things and then she would respond sort of defensively from her own perspective. Like I just briefly mentioned being vegan one day, and she said, "I'm not vegan and that doesn't make me a bad person." And I was like, I didn't say anything about good or bad, I didn't say anything about you, I literally don't care what you do or don't eat! Just these strange defensive responses to things, and it felt like she was using the session to kind of work out, I don't know, just work out her own stuff, or she couldn't hold my stuff because it all felt like she saw me as a threat, or something, and again it's not my job to identify what she was doing…or I can't remember if I called her or emailed her, and I said, I just don't know if I think this is a good fit, I don't think this is the right therapeutic relationship for me, and she was like, I agree, and I was like, ok fine. So it was very simple, but also there was this weird mean girls feel with her, and again I just got the sense that she felt threatened and I didn't know why, because I am here as the client in such a vulnerable position looking to you for care and your literally in an office called (omitted) hahahahahahaha, what are you, don't do this high school mean girls stuff to me, this is so uncomfortable.

> Natalie: I'm really proud of my academic achievement and she kind of shared that her academics weren't great and that she had to redo a year of her schooling. I got the impression that maybe I was a reminder, like a trigger for her about, like I'm academically doing ok, and she did not do well. I feel like maybe she was hurt by my academic success. It sounds silly but I think the way she thinks is silly. I think maybe she saw it as a competition or something, which is ridiculous, but I think maybe that's what she thought.

Both Amanda and Natalie had therapists who provided irrelevant information

about their own lives and compared themselves to their clients in a manner that harmed

the relationship. Both discussed their hypothesis as to what it was that they had

mentioned that might have triggered their therapists. After talking to her second therapist

about her painful experiences with her first therapist, Amanda found her second therapist

to be defensive and almost combative. Natalie had a multitude of problems with her

therapist. She wondered if her sharing about her academic success activated her

therapist's insecurities about her own academics.

Feeling blamed by the therapists for therapy not working. After the

participants had tried the various solutions that were offered by the therapist and did not

find them helpful, several reported feeling blamed by their therapists for the failures.

Instead of experiencing reinforcement for trying the solutions, and assessment from the

therapist as to what was not working, the message received by the participant from the

therapist was that they weren't doing it properly. None of the participants who described

these types of experiences provided examples where the therapist coached them on how

to increase the effectiveness of the solutions.

> Sarah: I got the sense that there was um, like he knew, somehow he knew a clear
> solution to my drinking problem, and that the fact that I continued to drink, was a
> result of me somehow not following his solutions. You know, rather than, 'cause I
> felt like I was trying the stuff he was suggesting and it just wasn't working. And it
> seemed like his impression was that I was doing it incorrectly or wasn't doing
> enough. So if he had said, you know, I can see that you are doing this and it isn't
> working, it would have felt like, I don't know, I guess more genuine, instead of
> like well this is what you should do.

> Amanda: I have this feeling that this is what they believed, but I wouldn't say that
> they explicitly said that to me. I think it needs to be with the first one, especially
> around the way things ended and the fact that she is telling me, we should have
> some closing sessions and we needed to talk in person and, like it was definitely
> this feeling that I was doing it wrong. Basically, I was leaving wrong, not only
> was I doing therapy wrong I was also leaving wrong. She was literally telling me
> that. And there was a part of me that felt like, you know, if I had the tools and the

skills I could have this conversation in person, and I could, and I felt like I should, because here is this person that is telling me that I should, and I was like maybe she's right, maybe I should. And the other part of me was like I'm not going to go in and pay her to sit in her office for an hour to make her feel better too. She definitely told me that I was leaving therapy wrong, and um, and the second person, it felt like she blamed me, for the last one not working because when I tried to explain to her what happened with my first therapist, it definitely felt like she was being like, she didn't do anything wrong, it must have been you kind of vibe. And but again, like we didn't have that complication with ending our relationship, but the way that she treated me and her body language around me, and when she said, "Yeah, you're right", when I said I don't think this is the right fit, she said, "Yeah you're right," it just felt like I don't know, I wasn't the right person, like maybe I wasn't doing therapy right, like if I could be different then it could be different. So, I think from their perspective for sure it was me, um, but they didn't like explicitly say that.

Natalie: I was being blamed for being too difficult and not getting a waitressing job, not moving out, not advocating for myself better at my internship to get paid, if I just did these steps that she did my life would be so much better, and since I'm not doing it I'm doing something wrong.

Sam: In the end she kind of argued the point that maybe I was in such a volatile state that maybe they needed to get me a little more under control in terms of my emotions in order for the DBT to be more effective.

It is important to consider the previous information shared by these participants when reviewing this category. Each participant had experienced an array of different types of invalidations, as well as not getting solutions that were helpful, and not feeling valued as a human by their therapists. Amanda quit therapy when her therapist laughed in disbelief when Amanda told her about a prior abusive relationship. This therapist then argued over email with Amanda about why Amanda was leaving, informing her that her perspective and experience about what had happened was inaccurate. She then told Amanda that this was not the right way to leave therapy. Natalie had experienced multiple micro aggressions and cultural invalidations from her therapist. Her therapist repeatedly offered solutions that did not fit for Natalie's life and then blamed Natalie for

not using the solutions. Sarah talked about trying the solutions that were offered by her therapist to help her not drink. These solutions did not work. The therapist did not reinforce her for trying the solutions or assess what happened as to why they did not work. The message Sarah received was that she was not implementing the solutions correctly. No information was given to her on how to implement the solutions correctly. Sam felt blamed for having emotions that were too strong and too volatile. This is another example of blaming a person for therapy failing for the reasons the person is seeking therapy. What adds to this is that DBT is a therapy known for its effectiveness in helping people with problems of pervasive emotion dysregulation learn how to regulate their emotions, and Sam was being told his emotions are too strong for DBT.

The category, Searching for Understanding, covers the reasons that participants had identified as to why therapy went the way it did. When people are not clear as to why something does not work, especially when pain is involved, they will often search for understanding and the causes. Multiple participants blamed themselves, and several felt blamed by their therapists for therapy not working. Two people viewed things they had brought up in session as triggering their therapists. One person viewed his experience as being partially caused by failures of the mental health system. The following section explores what the participants said about what they wanted from therapy that they did not get.

Recommendations from the Participants: Transparency and Genuineness

Before the interviews ended, the participants were asked what they would recommend to therapists in order to help decrease clients quitting therapy. There were a

variety of responses given, and in general the responses directly tied to the experiences that the person had in therapy. Sally, Eileen, Nadia, and Ellie all spoke about the importance of homework, follow through, and having clear action items that would be worked on. Sally also spoke about the importance of therapists taking notes. Natalie, Amanda, and Ana spoke about the importance of cultural competence and cultural humility. Ana also spoke about how important it was for therapists to spend time and interact with people of the various cultures they worked with and that this lived experience on the part of the therapist would help open the minds of the therapist and decrease the cultural barriers in therapy.

The vast majority of participants expressed directly or indirectly how lack of therapist genuineness had a negative impact. Participants believed that their experiences would not have been as painful if they had experienced their therapists as being as open, transparent, and vulnerable in sessions. This category appears in the majority of the transcripts in various forms. When transparency is there it is helpful, and people are not left searching for why therapy failed. The genuineness and openness that participants desired from their therapists was categorically different than the therapist self-disclosure some participants experienced that was unhelpful and painful.

> Amanda:[responding to being asked what they would have liked to have happened] I think also just teaching more, just like being more explicit, I think part of it is trusting your client to be able to understand the process so that you can say it explicitly, I think that is something that would have really helped me. I think if that second therapist had named that I don't know, maybe named her that she was projecting things, maybe saying things that didn't feel like the right fit for her either, it wouldn't have meant that she was kicking me out of therapy, it just means that not everyone can do therapy with every person, instead just gritting her teeth until I named it. Or even my first therapist if she had been able to say to me, you know I haven't worked with a lot of queer clients, I think I might make

some mistakes, and I'm here for that, and I want to know from you if I can do things differently, there are learning opportunities. I think often times it comes to the power structure of the relationship, and they're so afraid of either losing power or looking like they don't know what they're doing, that they make these really painful mistakes, when for myself thinking about going into practice. I would so much rather cultivate this egalitarian sense of we're working together, and I'm not going to know everything about every identity in the world, because I only have my experience. Just being able to be a little bit more transparent. That might not work for every client. For me that would have been so helpful.

Natalie: Yeah, right from the beginning, my new therapist told me I do somatic therapy, I do CBT, I do psychotherapy, I do…I might use a combination of these things. Are you ok with that? That to me felt really good, I didn't even know what the types of therapy were, but that felt like we were being a team. Like she was asking for my consent for something she didn't need to. I didn't need to consent to doing somatic therapy, she could have done it without telling me. So she put the power back in me being the client. I had a really active role in being a client, and I could have said no, and it would have been fine. But my other therapist said, oh, I have been trained in CBT, here is a binder I paid for, let's try this out, here's one for depression. I said I don't want to do that, I'm not depressed, I'm anxious, she was still kind of like, I got trained in this so I want to do it. There was no power in me there… I mean just tell me that you don't know how to do this thing and you want to figure it out, that would be fine. It's ok if she didn't know how to do something and she wanted to practice it, it's like, ok, let's try this out. And in that session when she called me snooty and dismissive, it would have been another thing if she told me why, I still don't know what I did that made her say that, or maybe if she gave me examples of what snooty and dismissive looked like. She just placed that blame on me and never said why she found me snooty and dismissive or why she didn't like me….And my new therapist is very human with me, which I think my old therapist tried to do, but she wasn't great at it, I think that's what she tried to do when she told me all of her family issues in our last session, but my new therapist will do something silly like, I haven't peed in 4 hours cause I've been back to back is it cool if I step out to the bathroom? And it's like yes, that's totally human, go to the bathroom, you're a person and not just a blank screen therapist. There's ways of proving you're human that are not telling me your pain and suffering.

Daniel: I think for me, transparency, I mean I know that people get a sense of, especially early career with having imposter syndrome, or I've learned this stuff in school but now there's so much more to deal with. I don't know if I would have stuck with any of those people if they had been transparent about them feeling stuck or their experience. But I was left guessing, or just like, yeah, I think, I wish, that those clinicians had been able to say what was going on so I didn't have to guess. I might have still left, but at least I would have been like, at least this

person really has my best interest, or this person really wants me to get the support I need. Maybe it's them, but that's ok. It's also this sense that maybe it's being afraid at getting caught in an area you don't know. But it's like, yeah! Just own it, no one is an expert at everything. That was a big part of my frustration. 'Cause then it just leads down this trail of, ok you want me to bring my authentic self, and you want me to own my stuff, and I'm experiencing you as not bringing your authentic self and not owning this process. I understand the role is different and yea yeah. Yeah. That would have made a really big difference for me….So even on the one hand, I think it's helpful in session to be upfront when you're stuck and frame it like I'm going to work with you on this. And there is also something to be said, if you don't think you can work with the person, then don't do it. It's not helpful for them. But then again, we all, I mean they call it a practice for a reason I guess. You shouldn't have to be an expert in an area to work with someone. But if you're not willing to wade into that and learn with them versus pretending you're already an expert, then I don't think it's good to work with them.

Sam: But he's like, don't forget I'm here to create a space for you to talk. And things take time, and he reasserts how it works. It allows me to make up my own mind, he presents the facts, so I don't lose sight of what we're working on. I find that very genuine. I find that very commendable, that he at least does that. And it hasn't been just once, it's been multiple times. He is able to give that care and attention. Whereas these guys, they were like hey it's not working, alright, we'll give you whatever we can, but you can just take a hike kind of thing. Not that they told me to take a hike, but that's the impression I got.

The experiences shared in this category cover how participants longed for transparency and vulnerability on the part of the therapist. Some participants also shared examples of later finding a therapist where they experienced this type of reciprocity in the relationship and how beneficial it was. The majority of the participants who discussed this identified that they did not expect perfection from their therapists or for their therapists to know everything about all treatments, all cultures, all sub-cultures; what they wanted was honesty from their therapists that they did not know and that they were willing to learn and or work on it. Participants also wanted to hear from their therapists that they acknowledged there were problems occurring in therapy, or problems with the

relationship. The participants did not expect perfection from their therapists. Having the

problems with treatment or the relationship addressed would have been preferable to the

therapist trying to tough it out and ignore the issues. Participants also mentioned that they

still might have left that therapist to find someone better suited to help them achieve their

goals, but had their therapists been genuine with them the negative experiences post

therapy would have been very different.

The next chapter of this dissertation will discuss these findings in more depth, tie

the data gathered in this research to the research literature, and discuss implications for

practice, supervision, and professional education.

Chapter 5. Discussion

The vast majority of research on attrition from psychotherapy has been conducted post hoc using quantitative methods. A result of this is a large amount of research that has found inconsistent results. Another issue with the existing body of research on attrition is that the primary focus is on pre-existing client variables that might contribute to attrition. There are a couple of problems with this approach. The first problem is that a useful question that could have implications for the field of psychotherapy is not being asked. The results of these studies only tell researchers and clinicians who is likely not going to complete treatment without saying why. This information could be helpful to researchers if they were to do more studies and ask why some people are not likely to complete treatments. So far, this has not been the case. Practically speaking, this information is unhelpful as it does not provide specific problems to be addressed or solutions to these problems. The second problem is that by researching attrition in this manner the blame for therapy not working is placed at the feet of the client. In essence the field of psychotherapy is blaming clients for not succeeding for reasons that are out of the client's control (e.g. gender, race, and age) and/ or by factors that cause people to attend therapy (e.g. depression, anxiety, and anger). The third issue is that client characteristics have not been found to reliably predict attrition. By continuing to research attrition by identifying factors that are not important, the actual causes of attrition are not being identified, and because of that, rates of attrition are not decreasing.

The aim of this study is to approach the problem of attrition from psychotherapy in a manner that yields information that can be useful for researchers and clinicians as

well as not blaming clients for the therapy not working. The research question of this study is: what are the factors that happen in therapy that result in clients quitting? Thirteen participants were interviewed for this study. One-on-one interviews were conducted over the phone and audio recorded. Twelve of the 13 recordings were transcribed by myself (one participant was found to be ineligible during the one on one interview, this interview was excluded from analysis). The transcriptions were coded and analyzed following the methods laid out by Charmaz (2014).

Clearly attrition is occurring for reasons other than pre-existing client variables. The main factors that contributed to the participants ending therapy were experiencing invalidation, identity and cultural invalidation, not having life's problems solved, and not feeling valued as a human by the therapist. For many of the participants there was a combination of these different experiences that resulted in them choosing to end therapy. It is important to note that although the data were separated into categories for organization and clarity, no categories existed in isolation from each other. For example, the experience of having one's life problems and solutions oversimplified also included behaviors of invalidation, as the therapists' lack of understanding the participants contributed to the therapists' overly simplistic views. Similarly, many participants discussed the ways in which they did not feel valued by their therapists and how this contributed to their decisions to end therapy. It would be hard to feel valued and important to someone who is consistently engaging in invalidating behaviors.

I will now discuss the main themes that contributed to attrition. Research from psychotherapy and other fields will be brought in to help strengthen the discussion and

connect the findings to the theoretical and research literature. The topics that will be

discussed are the therapeutic alliance, beliefs about therapy, invalidation in therapy,

discrimination in therapy, microaggressions in therapy, lack of problem solving, not

feeling valued in therapy, genuineness /authenticity, and the harmful effects of therapy.

After discussing these topics, I will briefly review two theories and a model that overlap

with the findings from this study. The theories are the Biosocial Theory of Borderline

Personality Disorder (BPD) (Linehan, 1993), A theory of Marital Dissolution and

Stability (Gottman, 1993), and a transactional model of relationship discord (Fruzzetti &

Worral, 2010). After the discussion I will discuss the implications for practice and

research as well as the limitations of this study.

The Therapeutic Alliance

One obvious consideration when reading through the quotations from the

participants is to consider the therapeutic alliance between the participants and the

therapists. It is clear that by the end of therapy there was little to no positive alliance in

the relationships described, even though some of the therapists were described as being

"really nice." Much has been written about the therapeutic alliance and how important it

is to successful therapy (Lambert & Barley, 2001). Claiming that the issues described by

participants were the result of a lack of a strong alliance, although somewhat accurate,

does not give a complete picture of the experiences described by the participants. There

are also other problems with limiting the discussion to poor therapeutic alliances. First,

this does not give specific information about the behaviors as experienced by the

participants that were unhelpful, painful, and at times harmful. Secondly, because it is

commonly accepted that therapists will not be able to develop a strong therapeutic alliance with all clients, having the discussion focused on problems of therapeutic alliance would be easy to ignore and not be concerned about. Thirdly, limiting the discussion in this way does not adequately describe exactly how painful and harmful psychotherapy can be even when no unethical behaviors are occurring.

Beliefs about Therapy

Participants were asked about their beliefs about therapy before they began (therapy), as beliefs about treatment working or not have been found to be a predictor of treatment engagement and completion (Green, Hunt, and Stain, 2012; Thompson, Hunt, and Issakidis, 2004; Heiy, 2013; Vogel, Wester, and Larson, 2007). The majority of the participants described believing in therapy, being open to therapy, and having excitement about therapy. Some of the participants expressed hesitation, skepticism, and fear about therapy. For all of the participants, regardless of what their beliefs were, what happened in therapy is what resulted in them deciding to end. Some of the participants stated that their negative experiences in therapy affected their beliefs about therapy working and had implications on how they chose their next therapist and how they started therapy with the next therapist.

I am not making the argument that client beliefs are not important and do not impact treatment engagement and outcome. Future research on beliefs, engagement, and outcomes should assess why clients have the beliefs they have. There may be a cycle occurring where a person tries therapy and has a negative experience which negatively impacts their beliefs about therapy working, which delays them seeking treatment, and/

or interferes with how they engage in therapy. Knowing that beliefs about treatment can have a positive or negative impact on treatment engagement and outcome is very useful. Understanding why some people have negative beliefs can add to the value of this research, provide useful information for the field, and help not inadvertently place the blame for failures of treatment on clients.

Invalidation in Therapy

The discussion of invalidation in this section will be on the experiences of invalidation that were not invalidation of identity and culture. A discussion of identity and cultural invalidation follows this section.

Validation is a process that results in the communication of understanding and acceptance of another person's thoughts, feelings, desires, perceptions, and experiences. Invalidation occurs when a person's responses communicate a failure to understand and accept the other person's experiences, perceptions, emotions, desires, and actions as legitimate. This negates the person's experiences and communicates to them that their experiences and/or actions are wrong, illegitimate, or invalid. (Fruzzetti & Worrall, 2010). The experience of being invalidated was common for the participants in this study. Participants shared a plethora of examples of having their therapists judge them, not listen to them, and reject and dismiss the participants' experiences, thoughts, perceptions, emotions, and/or desires.

Invalidation has many consequences. Shenk & Fruzzetti (2011) found that invalidation maintains or increases negative emotional arousal (they also found that validation decreases negative arousal). Invalidation can also result in people feeling

silenced and questioning their own experiences and perceptions, and it is also a key

component of emotional abuse (Kelly & Radford, 1990; Semple, 2001). No participant

described their experiences as abusive; however, it is important to highlight this given

how powerful the negative effects of invalidation can be.

Invalidation from the therapist was one of the key contributing factors found in

this study that led to participants quitting. Participants shared examples of trying

desperately to get their therapists to listen to and understand them, which usually resulted

in further invalidation by the therapist. Participants also described experiences of being

judged and having their emotions, perceptions, experiences, and/or thoughts dismissed

and rejected by their therapists. This resulted in the participants feeling angry, powerless,

humiliated, and/or crazy. Two participants left their therapists rather quickly, within the

first three sessions. Invalidation was a key factor in their decision to leave.

There are numerous experiences that people have day to day in which they are

invalidated. Due to this most people tend to go through life with their guards up to a

certain extent, to help protect themselves from different types of pain. The invalidation

that the participants experienced from the therapists occurred after the participants had

opened up to them about their lives, their faults, fears, traumas, and transgressions. The

experiences described by the participants give rise to an image of a person approaching

the therapists naked (vulnerable) and asking for help, only to have the therapist pour

scalding hot water on their unprotected bodies.

The invalidations that were experienced after this openness were painful,

upsetting, infuriating, and at times excruciating. The relationship between client's

openness and the pain caused by invalidation from the therapist is important. This is highlighted by one of the participants who described experiencing less pain and anger even though therapy was unsuccessful. Amy discussed openly about her experiences with addiction and how she was not honest with many of her therapists. Amy described much less pain, humiliation, and anger at the hands of her therapists than the others. It appears that being on guard with her therapists and not being as open and vulnerable as the other participants was in some ways a protective factor for Amy.

Not being open and honest with her therapist protected Amy from experiencing the same negative consequences that the other participants described. There are numerous types of psychotherapies and many different theoretical orientations about therapy. What they all have in common is the purpose to help people make changes in their lives in order to alleviate pain and suffering. In order for this to work it is imperative that clients are open and honest with themselves and their therapists about what is happening in their lives. The majority of the participants described the ways in which they were open and honest with their therapists and how this resulted in more pain. These experiences had real consequences on the lives of the participants such as returning to previously used maladaptive ways of coping, avoiding problems until they erupted, and increased hopelessness and despair. It can be considered a major problem in the field of psychotherapy that for some people being guarded and dishonest with their therapists is a protective factor.

Discrimination in Therapy

Three of the participants experienced discrimination and/or prejudice by their therapists, and one participant experienced discrimination in the treatment setting. Ana, Natalie, and Amanda all reported multiple experiences of discrimination in the form of microaggressions, specifically microinsults and micro invalidations. Micro aggressions are defined as being expressions of discrimination and/or prejudice that are brief, common, verbal, behavioral, or environmental insults that are either intentional or unintentional (Constantine & Sue, 2007; Sue et al., 2007). Microaggressions have been categorized into three types, microassaults, microinsults, and micro invalidations (Sue et al., 2007). Microassaults are conscious, deliberate expressions of discrimination and prejudice that are designed to hurt people. They are most similar to overtly discriminatory behavior (Shelton &Delgado-Romero, 2013; Sue et al., 2007). Microinsults are expressions that are demeaning and insulting and communicate a lack of sensitivity and rudeness towards marginalized people (Shelton &Delgado-Romero, 2013; Sue et al., 2007). Microinvalidations are behaviors and communication that reject, dismiss, negate, or nullify the thoughts, emotions, perceptions, and experiences of marginalized people (Shelton &Delgado-Romero, 2013; Sue et al., 2007).

Sue et al. (2007) created a taxonomy of racial microaggressions that occur in psychotherapy. This is a list of common patterns of behavior that are microaggressions, microinsults, and/or microinvalidations. Ana and Natalie each experienced microaggressions that were included in Sue et al's. (2007) taxonomy, myth of meritocracy (microinvalidation) and environmental microaggressions (microaggressions).

The myth of meritocracy and environmental microaggressions were experienced in addition to other microinvalidations.

The myth of meritocracy is communicated through statements that assert that race does not play a role in a person's life success such as in career advancement or education. This communicates to people of color that they are incompetent and/or lazy and that they need to work harder (Sue et al., 2007). Natalie's therapist repeatedly gave examples of what she (therapist) did in order to be successful and implored Natalie to take the same approach. As Natalie pointed out, her therapist was ignorant about the effects of racism and intergenerational trauma and the difference between the therapist's life and Natalie's life. Natalie informed her therapist that the proffered solutions were a problem, they weren't culturally competent, and they did not fit her life. Her therapist responded saying that Natalie was putting up barriers and that she had to stop dismissing each of her solutions. This fits with what Sue et al. (2007) refer to as the double bind that racial minority clients find themselves in in therapy. If Natalie did not challenge the solutions, the solutions would have inevitably failed for various reasons. When she did challenge the solutions, she was blamed for putting up barriers and being difficult. This is a lose - lose situation.

Environmental Microaggressions occur at the macro level when there is no representation of non-dominate cultures anywhere in the environment. This communicates to people of color that they do not belong; that what is offered in that particular environment is only for white people. Examples of this in therapy settings are having all white therapists, not having any visual representations of non-dominant

cultures, and not having literature about non-dominant cultures (Sue et al., 2007). Ana

expressed when she sat in the waiting room that she felt strongly like she didn't belong

and that therapy was something only for white people. Future research on attrition from

therapy should include environmental variables into the research design as environmental

microaggressions may be a significant factor in attrition.

Both Ana and Natalie experienced microinvalidations while in therapy. Ana

spoke at length about her therapists not knowing anything about her culture. She reports

what was invalidating and painful was that her therapists did not inquire about her culture

and/or her experiences as an immigrant. This communicated to her that they were not

interested in learning about her cultural and experiential reality. Natalie experienced

microinvalidations when she told her therapist that the solutions were not culturally

competent and her therapist said, "Thank you for that feedback, I will work on that," and

then never did. The therapist continued to give examples of what worked for her in her

own life, communicating to Natalie that her perspective and experiences should be

similar to the therapist's, when they were not.

Shelton and Delgado-Romero (2013) created a taxonomy of sexual orientation

microaggressions in psychotherapy. The types of microaggressions that Amanda

experienced were avoidance and minimizing of sexual orientation, microinsults, and

microinvalidations. Minimizing of sexual orientation occurs when a therapist avoids

using LGBTQ terminology. This communicates to the person that issues related to sexual

orientation are not important to talk about. Amanda experienced this when her therapist

refused to use Amanda's language of *gay* and *queer*. Amanda also stated that her

therapist's use of the word "homosexual" felt pathologizing. Microinsults are demeaning, insulting, or rude and communicate a lack of sensitivity. Amanda experienced these from her first therapist multiple times. When Amanda talked about her relationships, her therapist would tense up and look away. Amanda experienced microinvalidations from both of her therapists. The first example occurred when Amanda told her therapist about an abusive relationship and her therapist laughed and said, "You just don't expect that between two women." Amanda stated that she was stunned into silence. As mentioned previously, invalidations have the effect of making people feel silenced (Kelly & Radford, 1990). Amanda experienced further microinvalidations from her first and second therapists. With each of these therapists Amanda attempted to talk to them about what happened. Each responded in ways that told her she was wrong and that negated her experiences.

It is likely that the therapists in these examples were not intending to be racist, homophobic, or insensitive. This is one of the problems with microagressions. They often come from people who are well intentioned and view themselves as being non-biased (Shelton &Delgado-Romero, 2013; Sue et al., 2007). The lack of awareness of bias is arguably what makes microinsults and microinvalidations so damaging, as the person engages in behaviors that are damaging and cause tremendous pain without realizing it. Often when questioned or challenged, the person further denies what has happened, saying that was not their meaning or intention. It is as if they believe that the goodness of their intention should negate the pain that was caused. This would be like someone driving a car and accidentally hitting a pedestrian telling the pedestrian, "You're

OK, that was just an accident." That it was unintentional does not undo the harm done to the pedestrian (Ridley, 2005). This denial of the person's experience is the basis of microinvalidations. Microinvalidations are considered the most damaging as they deny the reality of -- and impose an oppressive reality on -- marginalized groups (Sue, 2010).

The experience of microaggressions in therapy is painful and harmful. The experiences of microaggressions in therapy were key contributing factors in the decisions by Ana, Natalie, and Amanda to end therapy. Experiencing microaggressions in therapy has been found to cause dropout (Constantine & Sue, 2007; Sue et al., 2007). Future research on attrition should continue to address the role of microaggressions of all types in attrition.

Lack of Problem Solving

Almost all of the participants gave examples of how the problems that they were wanting help with were not adequately addressed and solved. This happened for a variety of factors, including the oversimplification of problems and problem solving, discontinuity, therapist discomfort, and not receiving any guidance for change. The lack of problem solving was a key factor in many of the participants' decisions to end therapy.

It is an interesting juxtaposition after hearing about the effects of invalidation on participants to hear about problematic therapy that involved validation only without problem solving. Some of the participants shared their experiences of working with therapists who were validating but who were ineffective because they did not offer any information or solutions that helped move the participant in a direction the participant wanted to go. Having insight, knowledge, and understanding about the causes of behavior

may not be sufficient to change behavior (Beidas, Edmunds, Marcus, & Kendall, 2012; Carroll, Martino, & Rounsaville, 2010; Fixsen, Blase, Naoom, & Wallace, 2009). For example, many people engage in habitual behaviors they do not like such as smoking, nail biting, road rage, and placating. Understanding what caused the behavior to develop and how it is maintained is certainly helpful; however, quitting any one of the above behaviors requires much more than just knowing that it is occurring and why it is caused.

The descriptions shared by the participants about being validated and not being helped introduce a different experience of frustration and pain than has been discussed prior in this study. These participants had the experiences of knowing that their therapists understood them (participants) and saw what was happening in their lives. For some this might even be more upsetting and painful as it begs the question, if you see me, why aren't you helping me get out of here!?

Invalidation seems to be linked to some of the participants' experiences of not having their problems solved, particularly in having life's problems and solutions oversimplified and experiencing discontinuity in therapy. From the data about having life's problems and solutions oversimplified, it is clear that a lack of understanding the participants, lack of hearing what the participants were saying, and therapist judgments were present. For example, Ellie's therapist told her that she needed to stop dreaming and go get busy. The therapist was not listening to Ellie's description of her life (it was already busy) and her goals. The therapist's lack of listening and understanding resulted in a solution that did not fit Ellie's life and was too simple.

Another example of invalidation interfering with problem solving occurred with with Mike. Mike spent two sessions diving into his life's story with his therapist. During those sessions, there was little interaction with the therapist. In the third session, the therapist told Mike that she believed he had ADHD and that she could get him a prescription for medications. It appears that Mike's therapist listened to his story from a position of identifying pathology and a diagnosis. She missed his humanity entirely. Had the therapist engaged with Mike more and understood him more, she also would have likely had learned that Mike did not want to take medications. He wanted to work with someone who could help him change his perspectives and behaviors.

Discontinuity between sessions was another factor that interfered with change. The experiences of the participants included not knowing if their therapists would be helpful or not in sessions and also having the sense that each session was like starting anew. The lack of follow up on topics and critical aspects of the participants' lives resulted in participants feeling like there was no building occurring, no progress towards goals. One participant described her therapy as venting sessions, not therapy. It is apparent that the lack of continuity between sessions has two negative impacts. First, it is a significant roadblock to progress. How is progress towards goals made if each session is like starting afresh? This is like having a goal to build a sandcastle, getting the foundation built, then having a wave come and knock it down. So the person starts over on the foundation only to have another wave come and wash it away, and the process starts again and occurs over and over and over. The second aspect of this is that this behavior also subtly communicates a lack of importance to the client. How would

someone ever feel important to their therapist if at each session there is no carry over and

the therapist does not remember information from the previous session?

Not Feeling Valued as a Person

The lack of feeling valued was experienced by the majority of the participants.

There were a variety of different behaviors that the therapists engaged in that

communicated this to the participants: falling asleep in session, yawning while

participants talked, starting sessions late and ending early, not calling to reschedule,

communicating financial importance of the participant over their value as human. Many

of the participants talked about how these experiences exacerbated their anger and for

some contributed to their desire to end treatment.

Invalidation seems to be present here as well. The behaviors of the therapist

communicated to the participants that they (participants) were not important to the

therapists. Fruzzetti and Ruork (2018) describes one level of validation being when the

therapist treats the client as a person of equal status, worthy of respect, and with radical

genuineness while maintaining empathy for the client's pain, suffering, difficulties, and

challenges. It is the opposite of not paying attention to the person, treating the person

with condescension, disgust, as fragile, or someone to be feared.

A phrase that came up in multiple interviews was participants feeling like they

were just a paycheck/source of income to their therapist. One reason the relationship with

a therapist is so different from other relationships is that it is simultaneously intimate and

professional. Therapists get paid for their services. The issue brought up here by the

participants is not that they think that therapist should not be paid but that when the

therapist treats the relationship in a manner that is more weighted on the side of income it damages the relationship. For therapy to work, it is important that the client feels connected to the therapist and trusts that the therapist has their best interest at heart. If a person doesn't feel valued or important except monetarily, therapy is not likely to work. As Daniel noted, just as therapists want clients to bring their authentic selves to the relationship, clients want therapists to bring their authentic selves and to genuinely care for the client and the client's well being. When therapists do not have genuine caring for clients it is likely that clients will be attuned to this, and therapy may be negatively impacted.

Genuineness and authenticity by the therapist seem to be important in other ways besides helping the client feel valued as a person and not just a source of income. Almost all of the participants expressed wishing that their therapists would have been as genuine with the participants as the participants were with the therapists. The lack of genuineness by the therapist was a key contributing factor to the participants searching for understanding why therapy failed. Participants stated that if the therapists had told them they did not have experience working with certain types of problems, or with the LGBTQ population, or with people from different cultures, that this would have been beneficial. Some participants stated that they would have been willing to work with the therapists while the therapists were learning. Others stated that they might still have chosen to leave, but that knowing this information would have helped them not blame themselves for the failure and/or view themselves as someone for whom therapy would not work.

Therapy Causing Harm

It is well known that therapies are generally positive and help people (Parry, Crawford, & Duggan, 2016). There is a tremendous amount of research about therapies that demonstrates this. It is also relatively well documented that certain types of therapies, e.g., conversion therapy, as well as certain types of therapist behaviors, e.g., sexual relationships with clients (Berk & Parker, 2009,) are harmful. A problem is that attention to harm being caused in therapy focuses primarily on extreme and categorically unethical behaviors. It is safe to say that the vast majority of clinicians ascribe to and follow the professional codes of ethics in order to do no harm. This is also one reason why there are licensing boards, to hold therapists accountable when they violate these codes. Focusing the research on the harm caused in therapy on extremes and unethical behaviors allows therapists to think and believe that as long as they do not engage in harmful therapies and follow the code of ethics, they will not do harm.

The participants in this study gave no descriptions of unethical behaviors by the therapists. Almost all of the participants in this study experienced some form of harm from their therapists. Examples of harm caused were participants feeling increased hopelessness, despair, anger, shame, not getting better, continuing to use maladaptive coping mechanisms, prolonging of suffering, and long periods of time not seeking help. This in some ways is similar to the research on microaggressions, in that most people who engage in the behavior do not realize and do not believe they are causing harm.

The potential iatrogenic effects of psychotherapies have received attention intermittently over the past 50 years. Despite this repeated attention, and that it is estimated that at least 5% of psychotherapy clients experience harm from therapy, little

has been done to address this issue (Boisvert & Faust, 2003; Parry, Crawford, & Duggan,

2016). There are a couple of problems with this. First, there is a failure in the field to use

language that is consistent when it comes to the harmful effects of therapy, which makes

researching and understanding it difficult. Another issue is that researchers and clinicians

have failed to take the potential for harm caused by psychotherapies seriously (Parry,

Crawford, & Duggan, 2016). The data gathered in this study clearly shows that behavior

by the therapist that does not rise to the level of being unethical can still cause

tremendous harm. As Parry, Crawford, & Duggan (2016) state, it is clear that

psychotherapies cannot be simultaneously psychoactive and harmless.

Berk and Parker (2009) described that for some, problematic therapy follows the

boiled frog principle. The standard technique for cooking a frog is to put the frog in a pot

of cold water and then turn the heat up. As the water gradually warms the frog adapts to

the warming and does not jump out of the water, which results in the frog being in danger

without the frog realizing this. The end result is a cooked frog. If the frog were thrown

into boiling water, or if the water temperature were raised too quickly, the frog would

leap from the pot. This metaphor seems applicable for the stories shared in this study.

Some of the participants had very painful experiences almost immediately in therapy,

which caused them to end (leap from the pot). Others described how they stayed for

months and in some cases years as they had limited options or kept hoping that it would

get better. For them it did not, and they eventually quit. Amanda shared how her

experience (therapist laughing in disbelief about the abuse Amanda experienced) was

incredibly painful. She also stated that she was glad in some ways that it had happened, as otherwise she would have stayed with that therapist for much longer.

How the field has approached the issue of attrition has also contributed to the false belief that therapy does not cause harm. When a research protocol or therapy does not work for some, the response is to identify what are the pre-existing variables that the people who did not succeed have in common. The possibility that a person quit because the treatment was not working or what happened in session made them worse has not been much considered. The field seems to have placed the responsibility of attrition on the clients. Similar to microaggressions, even if this was not intentional, this is still the outcome. Given this, it is critical that understanding and addressing the causes and effects of attrition and harm in therapy continue to be researched.

Towards a Theory of Attrition

One of the numerous problems with the field of attrition research is a lack of theory about attrition. Without a theory, it is difficult to study attrition in a manner that is useful, as there is nothing to test. One of the aims of this study was to provide information that would be useful in the development of a theory of attrition. This has been accomplished by identifying factors that occur in therapy that result in clients deciding to end therapy. In order to develop a comprehensive theory of attrition, it will be important to conduct research with clients, therapists, micro mental health systems, and macro mental health/health care systems, as it is likely that there are factors of each that are contributing to attrition.

I will now review some existing theories and models that may be useful in guiding the study of attrition research. The first comes from a theory of the development of Borderline Personality Disorder, followed by two relationship models/theories.

The biosocial theory of borderline personality disorder. Linehan (1993), the founder of DBT, hypothesized that invalidating environments are a necessary component in the development of Borderline Personality Disorder (BPD). Linehan (1993) created the Biosocial theory of BPD. This theory posits that BPD is the result of transactions over time between a person who has a biological vulnerability to emotions and environments that are pervasively invalidating.

The invalidating environment is defined as an environment/s that responds to a person's private experiences (thoughts, emotions, and perceptions) in erratic, inappropriate, and extreme ways. This can include communicating that a person's private experiences are inaccurate, inappropriate, or wrong; denouncing and/or punishing these descriptions; not accepting the authenticity of a person's self-description/perception; pathologizing normative responses; normalizing pathological and/or maladaptive responses; associating a person's normative emotions, wants, and thoughts. to socially objectionable characteristics (laziness, lack of maturity, intent to manipulate, mental health diagnosis…) (Linehan, 1993; Fruzzetti, Shenk, & Hoffman, 2005). This type of invalidation was reported by multiple participants in this study as taking place in therapy

Invalidating environments range in intensity of behaviors engaged in by members of the environment. Invalidating environments can include environments in which sexual, physical, and/or emotional abuse occur, others are chaotic and marked with disorder and

unpredictability, others are environments of perfection in which negativity and failure are not tolerated, and many are typical normal everyday environments (Linehan, 1993). As previously stated, there were no reports of unethical behaviors by therapists. Natalie mentioned the unpredictability of her therapist's behavior and feeling anxious before sessions because she did not know if her therapist was going to be helpful or harmful. What is also important to note here is Linehan's reference to normal everyday environments being invalidating. The potential for harm in normal everyday therapy has not been adequately addressed. Identifying the "normal/everyday behaviors" that happen in therapy by therapists and cause harm will be imperative to understanding attrition.

The invalidating environment may minimize difficulties and oversimplify the ease of problem-solving. When a caregiver pervasively minimizes the difficulty of a task/problem, the caregiver is unlikely to provide the necessary supports to help the person master the task (Fruzzetti, Shenk, & Hoffman, 2005). This fits with the experiences participants had of having their life problems and solutions oversimplified. Nadia's example of being asked how she is going to manage her emotions is a good example of a minimizing the difficulty/complexity of a task (in this case emotion regulation) and the person not receiving the necessary support and help to change. This is similar to taking someone who cannot swim and is attending swimming lessons, throwing them into the deep end of the pool, and then asking them how are they going to swim?

Invalidating environments have a tendency not to respond in a helpful manner to normative emotional display, which results in extreme emotional displays being needed to generate supportive responses from the environment. Therefore, the environment

punishes normative emotional communication and intermittently reinforces extreme

emotional behaviors and outbursts (Linehan, 1993). Because the problems experienced

by the emotionally vulnerable person are often unrecognized, little effort is given by the

environment to solving them (Linehan, 1993). No participant shared clear examples of

therapists reinforcing increased emotions and behaviors in session. Sam gave an example

of being hurt and upset in session by his therapist and the following week being angry

about what had occurred. He described his therapist as being surprised at the intensity of

his emotion. It may be that Sam's therapist did not recognize the immediate shame/pain

Sam experienced and then took him seriously the following week when he was angry. If

therapists are not attending to and responding to normative displays of emotion and

communication, it is likely that a client will escalate their emotions and attempts at

communication in order to be heard and understood. If therapists reinforce the escalation

of emotion and behavior, they are likely contributing to the client's problems in life

instead of helping.

When these transactions occur regularly over time, emotion dysregulation

becomes trait-like (Crowell et al., 2009). Consequences of these transactions such as

isolation, avoidance, hopelessness, shame, anger, and impulsive behaviors (which include

non- suicidal self-injurious behaviors, and suicidal behaviors), and oscillation between

inhibiting emotions and extreme emotional states tend to become fixed responses

(Crowell et al., 2009; Linehan, 1993). Sam discussed how his suicidality did not decrease

during his time in therapy, and that there was an increase in it shortly before he quit. It is

unclear if his experiences in therapy contributed to this or not. Others described the ways

in which their feelings of shame, anger, hopelessness, isolation, and avoidance increased while in therapy as well as shortly after ending therapy. Future research on attrition should include assessing the punishment of normative communication and displays of emotion and reinforcing the escalation of increased emotion and behaviors.

The purpose of reviewing this theory is not to hypothesize that clients are at risk for developing BPD due to negative experiences in therapy. I am stating that client dropout from therapy may be the result of transactions between a client and therapists/therapy environments that are invalidating. At least two of the behaviors of invalidating environments were experienced by participants, invalidation and oversimplification of problem solving. It is possible that the punishment of normative communication and emotion and the reinforcement of escalated emotion and behavior occurred. There was also overlap in the consequences of pervasive emotional invalidation and what the participants experienced in session. Looking at attrition as one of the consequences of transactions between clients and invalidating therapy environments may be a helpful way to understand attrition.

Another avenue of theory to explore is relationship theories. Although the therapeutic relationship is unlike other relationships, it is still a relationship between two people. Useful theories to explore are Fruzzetti and Worrall's (2010) transactional model for understanding individual and relationship distress, and Gottman's (1993) theory of marital dissolution and stability.

A transactional model for understanding individual and relationship distress.
Fruzzetti & Worrall (2010) present a transactional model where relationship discord is

explained by a prevalence of inaccurate expression and invalidating responses. The focus of this model is that of accurate expression and validation and inaccurate expression and invalidation. The authors of this model propose that validating responses from one partner help to decrease negative arousal of the other partner, thereby helping to prevent arousal and/or emotion dysregulation (emotional arousal that is high enough to interrupt cognition and self-management) (Fruzzetti & Worrall, 2010). Because dysregulation is avoided or decreased, the distressed partner is able to communicate with more accuracy about what they are experiencing. This in turn is more likely to elicit validating responses. Inaccurate expression occurs when a person communicates with secondary emotions, lack of clarity, or at times be demanding and attacking. These types of communications are harder to understand and elicit invalidation from the partner. The invalidation further increases emotion dysregulation and inaccurate expression, which increases the likelihood of an invalidating response. As these transactions persist, negative feelings towards self and partner increase, as does relationship dissatisfaction and discord.

This may be a promising direction to follow in the study of attrition. When participants described searching for understanding as to why therapy failed, a couple of participants discussed problems in their own communication. One possibility is that therapists have a difficult time responding in validating manners to inaccurate expressions. The lack of validating responses would result in the client maintaining or increasing negative affect (Shenk & Fruzzetti, 2011), which may elicit more invalidation from the therapist. Another possibility is that participants are communicating accurately

and the therapists are responding with invalidation. This invalidation would result in

increased arousal of the client which elicits more invalidation from the therapist.

Researching the role of these transactions in failed therapy may also offer greater

understanding of the causes of attrition.

      Theory of marital dissolution and stability. Another useful relationship theory

when addressing attrition from psychotherapy is Gottman's theory of marital dissolution

and stability (Gottman, 1993). There appear to be overlaps with Gottman's theory for

marital dissolution and stability and the experiences of the participants in this study.

Gottman identified four behaviors that predicted separation and divorce in couples,

criticism, contempt, defensiveness, and stonewalling. He describes these as *the four*

horsemen of the apocalypse (Gottman, 1993). The Gottman Institute defines stonewalling

as when a person withdraws from and refuses to participate in an interaction (Lusignan,

2016). Defensiveness is defined an any attempt to defend one's self from a perceived

attack (Brittle, 2014). Criticism is an attack on a person's character, while contempt is a

communication of disrespect for and moral superiority over the other person (Lisitsa,

2013). Gottman (1993) found that defensiveness, stonewalling, and contempt by the

husband, and defensiveness, criticism, and contempt by the wife were predictive of

divorce. Gottman (1993) described a transactional process in which criticism elicits

contempt, which elicits defensiveness, which elicits stonewalling.

      Although it cannot be said with certainty, participants described behaviors that

seem to match with Gottman's four horsemen. Multiple participants gave examples of

their therapists becoming defensive. The most obvious example of this in the case of

Amanda when her therapist became defensive and invalidated Amanda's experiences of what had happened in their sessions, including the therapist laughing in disbelief. An interesting area of study would be the role of defensiveness in invalidation and microinvalidation. There also seemed to be some descriptions of stonewalling by the participants. Natalie's description of her therapist saying, "thank you for this feedback I will work on that" and then never addressing it may fit with Gottman's definition of stonewalling. Another potential example of stonewalling may have occurred when Daniel asked his therapist to take the lead on addressing childhood trauma. She agreed to this then repeatedly did not follow through. Contempt and criticism also seemed to be present in the participant's descriptions. Eileen's experience of her therapist yelling at her over the phone seems to be an example of contempt. It will be important for future research on attrition to study the in-session behaviors of clients and therapists to see if these behaviors/transactions by both the therapist and the client take place.

Another important aspect of Gottman's work to note is the importance of listening and validation in relationship satisfaction. Gottman (1993) identified three sets of behaviors that, when overlearned by couples, decreased rates of separation and divorce. These are: non-defensive and non-provocative speaking; non-defensive listening and validation; and editing. Non defensive and non-provocative language is communicating accurately instead of speaking from a position of defending one's self and/or using language that is inflammatory (Hanson, 2018) Non-defensive listening and validation occurs when a person asks questions to help clarify the other person's position, communicates understanding, and refrains from immediately defending the listener's own

position (Hinckley, 2015). Editing occurs when a person refrains from saying every critical thought that they have (Gottman, 2017). The importance of validation in positive relationships, including therapy relationships, cannot be overrated.

These theories and model all stress the importance of transactions. Fruzzetti and Worrall (2010) and Gottman (1993) focus on the transactions between two people while Linehan (1993) has a broader view and looks at transactions between a person and their environment. Although different language is used there appear to be common factors between the three. Each emphasize the role of responses that communicate to a person that they are not being heard, understood, and validated. Each also describe how the transactions are compounding and that discord, distress, and problems get worse over time. Gottman's approach to developing his theory involved videotaping couples' interactions and coding them for specific behaviors. Reviewing video tapes of therapy sessions in which the client eventually quit therapy would be a useful approach for identifying the transactions that occur in session that result in attrition.

Using research on intimate relationships is helpful to understand what might be happening in therapy sessions that result in the client's experience of invalidation. However, it is not a fair comparison. In a therapeutic relationship one party is going to the other to receive help in improving their lives. Problems with communication are common and at least three participants in this study identified their own struggles with communication. If someone has difficulty communicating in their daily life it is not reasonable to expect them to have no issues communicating in therapy. It seems within reason to say that one of the jobs of the therapist is to help highlight the behavior and to

help the person learn to do it differently if they would like to. It is also the job of the

therapist to try and understand what the client is saying, experiencing, perceiving,

thinking, and feeling. Placing responsibility on the client in these instances would be akin

to blaming the client for not succeeding. Future research on attrition should look at

therapist skill in responding in a non-defensive and validating manner to inaccurate

expression as well as the ability of therapists to teach clients how to communicate with

greater accuracy.

　　　　None of the participants began therapy wanting to quit. It is likely that when they

began with their therapists the therapists did not want them to quit, either. And yet that

was the outcome. The findings of this study that multiple types of invalidations and

oversimplification of problem solving create negative consequences are in line with

theories set out by Linehan (1993), Gottman (1993) and a model by Fruzzetti and Worrell

(2010).

　　　　Attrition in therapy does not have seem to have one simple cause. It appears to be

the result of a process of transactions that happen in therapy. Therapist invalidation,

discrimination, ineffective problem solving, and communication of lack of value to the

client are all key factors in the processes the result in attrition. Berk and Parker's (2009)

description that problematic therapy follows the boiled frog principle appears to be

accurate as attrition can happen quickly or after a longer period of time. What seems to

be important in differentiating the two is the egregiousness of the therapist behaviors. The

more egregious the invalidating responses and/ or the solutions offered, the more likely

the client will to be to end quickly. If the invalidations and problem solving are less

egregious the person may be likely to continue for longer periods of time even though there is little progress being made or if there are repeated painful experiences in therapy. The data gathered in this research are sufficient to guide future research and insufficient to generate a comprehensive theory of attrition. A summary of recommendations for future research follows the discussion about the strengths and weaknesses of this study.

Strengths of the Study

There are many strengths of this study. A major strength of this study is viewing attrition in a manner that is not typically done. This is one of the few studies that the author is aware of that had the sole purpose of understanding attrition from the client's perspective. This has yielded information that has not been identified previously in studies on attrition. The participants in this study clearly described how behaviors of their therapists caused them to end therapy. These therapist behaviors also resulted in immediate and lasting pain. As such, it is essential that from this point forward the field of psychotherapy continue to take attrition seriously, and research attrition in a manner that reflects the seriousness of this issue.

Swift and Greenberg (2012) identify attrition as something that negatively impacts the clients who terminate treatment. Each participant talked about ending therapy that at best was not working, and in many cases caused harm. Harmful therapy negatively impacts clients. Ending harmful therapy does not negatively impact clients, it is beneficial and essential for them to do this. The field must re-conceptualize attrition and view it as a consequence of problematic therapy, not problematic clients.

That psychotherapies have the potential to cause harm has been known for at least the past five decades. Little has been done with this knowledge. When harmful effects of therapy have been studied, the main focus has been on unethical treatments and unethical behaviors of the therapist. The results of this study show that problematic therapist behaviors that do not rise to the level of being unethical still cause harm. Understanding the potential for harm in therapy is critical. Not only is this important for client informed consent, it is important for therapists to know in order to fully understand the harm they may cause their clients.

Another strength of this study is identifying specific behaviors and problems (invalidation, identity and cultural invalidation, ineffective problem solving, and communicating a lack of value/importance) that can be further researched to see if they contribute to the ending of therapy by more than the participants involved in this study. These can also be highlighted as important areas for research, training, and supervision.

There were also strengths in the methodology of this study. The study is comprised of 12 in-depth interviews with people who chose to end psychotherapy. The participants were open about their experiences, and their candor is a major strength of this study. Without their willingness to discuss their experiences openly, the data collected would not nearly have been as rich and useful.

Another methodological strength was the structured coding process that each transcript went through as well as receiving feedback from a second researcher from a different professional discipline. This researcher provided excellent feedback that helped me to clarify certain codes and strengthen others.

Limitations

The information provided in this study is enough to warrant further research on attrition; however, it is not without its limitations. Purposive sampling with exclusionary criteria and snowball sampling were used. This type of sampling is not typically done in constructivist grounded theory studies. The sample was small and by no means inclusive of the population in the United States. All interviews were conducted in English. There were no interviews with African Americans, Native Americans, or Asian American/Asian Pacific Islanders. Socio-economic diversity of the participants is not known as I did not ask about this. Representative sampling is not typically used in grounded theory studies (Charmaz, 2014); however, a larger sample size gathered using theoretical sampling would strengthen this research. Future research should aim to target participants that would be more representative of all the people living in the US who have left psychotherapy.

Another limitation of this study was the limited time for interviews (60 minutes maximum) and lack of follow up interviews. Although some of the participants were contacted after the initial interview in order to clarify a statement and to check with them about the codes and if they felt that the codes fit with their experiences, there were no follow up interviews in which themes and codes could be followed up on in depth. The short time limited how much detail could be gathered about participant's experiences. Future qualitative studies on this topic should allow for follow up interviews in order for researchers to gather more data on the codes that emerge. Prospective longitudinal

studies of new therapy clients could provide current accounts of therapy that is not

working.

Another limitation of this study is that it included only clients of psychotherapy as

participants and reflected only their perspectives. No therapists (some of the participants

worked as therapists or were therapists in training, however they were only asked about

their experiences as clients of psychotherapy), or mental health clinic administrations

were interviewed. This means that the data collected and analyzed in this study is only a

partial picture of the causes of attrition. A full theory of attrition would need to include

these important perspectives.

My background as a DBT therapist and trainer is both a strength and a weakness

of this study. A strength of this background is that I view problems as being caused by

transactions between people and their environments. Viewing attrition in this manner

appears to be fruitful as problems that can be further understood and solved have been

identified. A limitation of this is that I am biased to view behaviors and transactions

through a DBT lens, specifically seeing problems of invalidation and over-simplification

of problem solving. For example, I view behaviors of offering advice without achieving

and articulating understanding between the client and the therapist as being invalidating

(lack of communication of understanding) and as an over-simplification of problem

solving. Others may view these same behaviors in a manner that is different. It may be

that what is happening in sessions that result in attrition is more complex than this and

that defining the behaviors in this way is limiting.

Another limitation of this study was that I conducted all of the interviews, transcription, and coding. Although I followed the guidelines outlined by Charmaz (2014), there may be processes that occurred that I missed/did not attend to. Each stage of this research, except for the transcription, was vulnerable to my influence. This is a chief reason that I conducted a Contructivist Grounded Theory study. I cannot separate myself from my experience and therefore conducting a truly objective study would be impossible. Given that, I chose to take an approach in which I, along with the participants, would be constructing knowledge. It is still important to highlight my bias and how this has likely influenced the study.

Recommendations for Future Research

Future research on attrition needs to continue and optimally will include clients who have quit therapy, therapists, and mental health systems. In order to develop a comprehensive theory of attrition, it will be important for future research to continue research with people who have chosen or are choosing to end therapy. It is critical to identify if the factors found in this study happen on a larger scale and to identify other experiences clients have that result in them choosing to end.

It will also be important to study attrition from the perspective of therapists. It will be important to see if therapists view attrition and the causes of attrition in the same or similar way clients do or if therapists see the problems being in the behavior of clients or elsewhere. Questions to ask therapists that will be important to assess are if therapists are aware of the harm that can be caused in therapy by invalidation, lack of problem solving, lack of genuineness, therapist defensiveness, and microagressions. It will also be

important to ask therapists if they validate their clients, are non-judgmental towards their

clients, attempt to make their clients feel valued, are they aware when they are not being

effective at accomplishing the goals of the client. Asking therapists how they assess if

they are engaging in these behaviors or not is critical. Attention should be paid to the role

of self-assessment and self-report by therapists on these topics. There is evidence that

therapist self-report of what the therapist does in session is not an accurate representation

of what actually happens (Gunn & Pistole, 2012; Hantoot, 2000; Muslin, Thurnblad, &

Meschel, 1981). Similarly to what is written about the lack of awareness by the person

engaging in the microaggressions, it may be that well intentioned therapists are causing

harm without realizing it. If possible, using data from actual therapy sessions in which

the client dropped out would be highly useful as the transactions between the therapist

and the clients could be coded. Specific attention should be paid to the behaviors that are

present in invalidating environments as identified by Linehan (1993), as well as the role

of inaccurate expression and invalidation, and Gottman's *Four Horsemen* (1993).

It is important to note that the behaviors that the participants described that they

experienced indicated a lack of cornerstone therapy skills, active listening, validation,

empathy, problem solving. It will important for future research to understand what

interferes with therapists doing what they are trained to do.

It will also be important to look at what systemic factors contribute to attrition. To

begin this process, clients and therapists could be interviewed using the same methods as

in this study to gather information about what they have experienced from mental health

clinics and mental health systems that contribute to attrition. An example of an

environmental factors that may contribute to attrition are environmental

microaggressions, large caseloads, lack of support for training/ supervision, and limited

pay which makes training and expert supervision infeasible.

Qualitative assessment at each level could develop a theory that is holistic in

understanding how transactions at all of these levels result in failed therapy for clients.

Researching attrition in this way can also produce practical recommendations and

solutions that can be implemented and tested. Another recommendation is that future

research on psychotherapies make standard the use of qualitative methods to interview

participants who do not complete the research protocols instead of only looking that the

client demographic variables. Incorporating this research into their studies could help

improve the understanding of attrition and also help treatment developers develop

treatments that are helpful to more people.

Researching and understanding the harmful effects of psychotherapy is critical.

Understanding what behaviors of therapists cause harm, and how these impact clients is

of the utmost importance. Intermittent research on this topic is insufficient. As evident by

the data collected in this study it is possible for ethical therapy to cause severe pain and

harm to clients. Researchers and therapist must work to understand and decrease the harm

caused by psychotherapy. Clients must be made aware of the potentials for harm, how to

identify it, and how to respond to it.

In addition to these recommendations the language used to describe attrition

needs to be addressed. Currently the language of attrition tends to be dropout and quitting

treatment. These are terms that are used in our culture that often place the blame on the

person ending whatever it is that they are ending. These terms tend to have a negative

connotation about the person who has dropped out or quit. For example, "high school

and/ or college dropouts", and "don't be a quitter." There are instances when using *quit* in

the common vernacular is a positive. This occurs when the person has quit doing

something that was causing harm e.g., quit smoking, quit drinking. Because therapy is

generally accepted as helpful, there is likely not a positive association with a person who

quits therapy. I propose this language is problematic when discussing attrition in therapy.

All participants chose to stop therapy that was at best not working and in multiple cases

causing more pain and harm. Ending something that is not working or causing harm is

useful. Stating that the person quit or dropped out is another way of subtly placing blame

at the feet of the client and tends not to leave room to ask what is happening in session, or

what therapists can do to help decrease rates of attrition.

Recommendations for Practice

There are also practical recommendations that can be gained from this study.

Clinicians could use this information provided to assess their own practices and identify

if they are engaging in any of the behaviors that have been described as problematic.

Self-assessment is a start. Working with a supervisor, taping and reviewing sessions,

supervision and/or consultation groups are hugely valuable. At first glance, the cost of

these may seem prohibitive; however, there are multiple ways in which taping,

supervision, and consultation can occur in a cost-effective manner. Homan, Osborne, and

Sayrs (in press) describe cost effective measures for setting up training and supervision

systems in a variety of practice settings. Although the information provided in that

chapter is based on DBT practices, much of the information is applicable to other

therapies and mental health clinic settings.

Perhaps a larger conversation for the field is that of supervision and the reliance

on therapist self-report for supervision, training, and consultation. As previously

mentioned, therapist self-report is often inaccurate and may not be helpful (Gunn &

Pistole, 2012; Hantoot, 2000; Muslin, Thurnblad, & Meschel, 1981). Because this has

been found to be an unreliable source of information about what is happening in session,

it may be that therapists are engaging in invalidation, microaggressions, ineffective

problem solving and not communicating value to the client, without even realizing it.

Therapists being taped or having their sessions observed live is common practice

in graduate school. Having this practice end after graduate school may not be sufficient

for generalizing therapy skills into post school settings. The importance of taping

sessions as a means for demonstrating therapist skill is starting to be used in some areas

of the field. It is becoming standard practice for bodies that certify therapists in specific

therapies to require work samples (tapes of therapy sessions) in which the therapist is

coded by adherence coders to assess if the therapist is actually delivering the treatment or

not. This is currently being done by the DBT-Linehan Board of Certification and the

Neuro Affective Relational Model, and perhaps others. Standardizing the practice of

taping sessions for supervision standards for licensing and beyond may be a beneficial

way to help increase therapist skills and decrease attrition.

Another recommendation for practice is to consider the risks of ending

requirements for supervision after a clinician completes licensure. Although there are

continuing education requirements for all licensed mental health professionals, it is likely that these requirements are insufficient on their own to guarantee therapy that is beneficial and not harmful. Researchers have found that although trainings increase therapist knowledge, they do not create change in therapist attitudes, behavior, and knowledge application (Beidas, Edmunds, Marcus, & Kendall, 2012; Beidas & Kendall, 2010; Carroll, Martino, & Rounsaville, 2010; Herschell et al., 2010). Herschell et al. (2010) state that ongoing support is requisite in order for therapists to improve their skills. In support of this, some researchers have found that when therapists receive ongoing supervision and/or consultation after trainings, their skills improve and become more solidified (Beidas et al., 2012; Herschell et al., 2010). Not having ongoing supervision and/or consultation for licensed therapists may likely be contributing to attrition and harmful therapy as there is not a formal structure/requirement for therapists to assess the quality of their work and receive support in strengthening their skills.

Another recommendation for practice is for therapists, clinics, and mental health systems to have formal ways clients can give feedback about their experiences in therapy. This may be done through forms that clients fill out and submit to the supervisor or administration. Another possibility would be for exit interviews with clients as they leave. Although this may appear to be time consuming, it may help provide information that strengthens practices and decreases rates of attrition, which would benefit clients, therapist, and clinics.

Recommendations for Professional Education

There are also recommendations for professional education that come from this research. The first recommendation is for a broader discussion on what causes harm. It is a professional standard that therapists in all disciplines receive training in ethics while in school and as part of ongoing continuing education requirements. It seems imperative to start discussing and teaching therapists about the harm that can be caused by therapists, even when there is no unethical behavior occurring. Increasing therapists' knowledge and understanding about this may help motivate therapists to focus closely on what they do in session and receive ongoing supervision.

A second consideration for professional education is to over train therapists in the skills of non-defensive listening, validation, cultural competence/humility, and how to regulate their (therapist) own emotions in session under a variety of conditions. Gottman (1993) identified that when couples over learn non-defensive listening and validation, separation and divorce decrease. This could be extremely useful for therapists. Therapists also potentially face multiple difficult and high stress situations in session that require therapists to be able to regulate their own emotions while staying present to what is occurring. This can be extremely challenging. Addressing this early in the training of therapists would be helpful and may decrease harmful responses from therapists towards their clients.

A third consideration for professional education is to incorporate the latest research and information from the field of dissemination and implementation. It is well established that there is a gap between science and practice in the mental health field (Lyon et al., 2011; Wandersman et al., 2008). It is known that the current standards and

practices of education and training of therapists are based on beliefs and practices that do

not necessarily guarantee good outcomes (Koerner, 2013). Training therapists to

competency is one of the most difficult challenges identified in the field of dissemination

and implementation (Mchugh & Barlow, 2010). It is important that universities that train

therapists in all disciplines as well as training organizations that provide ongoing

continuing education take these problems seriously. Certification boards and training

programs, both universities and continuing education, may benefit by collaborating with

dissemination and implementation experts to help develop programs that are more

effective at training therapists to professional competencies. Maintaining the status quo

and not taking this problem seriously is a mistake that would negatively impact clients,

their families and communities, therapists, and the mental health field overall.

Implications for Social Work

Social workers work in research, practice, systems, and policy. Because of this,

social work is in a unique position to take the lead on research of attrition. Researching

attrition as a byproduct of different variables that are caused by transactions throughout

systems fits well with the systems perspective of social work.

Clinical social workers are in a position to greatly affect the mental health field.

According to Florida State University (2017) social workers comprise the largest body of

mental health workers of all the different mental health fields with more than 200,000

clinical social workers in the US (Social Work Statistics, 2017). There are more social

workers than psychologists, psychiatric nurses, and psychiatrists combined. Social

workers changing how they assess and address attrition could potentially positively

impact thousands of people who have not had positive experiences in therapy, increase the efficacy of clinical social work, and influence the entire mental health field.

In addition to clinical practice, social workers can also influence mental health policies to take attrition more seriously. Social workers who are involved in the development and implementation of policy are in a position to not only apply the recommendations listed above but also to make data collection from people who quit research trials and clinical work standard practice. Doing this would strengthen social work research, as well as social work education, and clinical practice.

Summary

This study sought to identify factors that happened in psychotherapy that caused clients to end therapy. The findings of this study are that invalidation, identity and cultural invalidation, life's problems not being solved, and not feeling valued as a human/ feeling unimportant to the therapist contribute to attrition from psychotherapy. The findings from this study also highlight the potential for therapy to cause harm, even if there is no unethical behavior occurring. Future research on attrition should incorporate qualitative methods and input from clients to help understand why the phenomenon of attrition occurs, and what the main contributing factors are. Future research should view attrition as a failure of therapy and a failure of mental health systems, not as a failure of the client. Viewing attrition as an outcome that is caused by a series of transactions and environments that are invalidating may be particularly useful as it is likely that there are client variables, therapist variables, mental health clinic variables, and mental health system variables that contribute.

Attrition is an important field of study that could yield significant information that can potentially help strengthen treatments, training programs, supervision, and individual therapists' practices. Additionally, understanding attrition could also help the field understand the harm that is caused by therapy. Both of these subjects are known problems in the field, and it is time that they are both addressed more rigorously.

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Appendix A. Screening Instrument

Are you over 18 years of age?

If you participate in this research study are you willing to have your interview audio recorded?

Have you ever been a client of individual psychotherapy in the United States (therapy consisting of just you and your therapist in person)?

Do you know the educational and professional background of your therapist: if your therapist was masters level social worker or counselor, or a doctoral level psychologist, social worker, or counselor (please do not state the name of your therapist/s)?

In the past five years have you ever ended psychotherapy?

If yes did you end because you lost insurance, had a change of insurance, lost other forms of funding, your therapist retires, or you or your therapist moved away?

If no did you ever end therapy because of any of the following or in any of the following manners?:

You were unhappy with the services being provided or your therapist.

You felt like you were not getting your needs met, and/or the problems you were addressing were not being solved?

Ended therapy although others in your life wanted you to continue?

In a way that was surprising to your therapist?

Prior to completing an amount of time you had agreed to with your therapist or others in your life?

Prior to completing a therapeutic protocol (for example the completion of a therapy

manual)?

By stopping and not letting your therapist know?

By stopping having regularly occurring sessions and now attend therapy with your

therapist on an as needed basis?

Other reasons?

If other, what were the reasons?

If you have ended therapy in any of the above manners have you since returned to

therapy?

If so are you seeing the same therapist as before?

Appendix B. Interview Guideline

Questions for Clients:

With only sharing information you want to share will you tell me a little about the problems that you were seeking to address in therapy?

How serious were these problems to you?

What your expectations for Treatment were when you started?

    -Were any your expectations met?

How long were you in therapy before you dropped out?

What were the key things that led to your decision to drop out?

What was your sense of therapy helping you change your life?

Was this your first time in therapy? If no, did you complete therapy or other therapy programs the other times?

    -Follow up questions about what led to dropout, or what were the differences between the experiences.

Will you tell me what your beliefs about therapy helping you when you began were?

How did your therapist address your beliefs about therapy at the beginning?

I would like to know a little bit about how you were oriented to therapy early in treatment. Were you oriented to what to expect in session and between sessions?

What was your sense of your therapist really understanding you, the problems you were/are having/ and what you want in life?

What was your sense of being a team with your therapist?

In sessions, did you ever have strong emotions (e.g. feeling ashamed, fear, or anger)?

Do you find these emotions unpleasant?

How do you typically cope with these emotions?

When strong emotions showed up in session how did your therapist respond to you?

What was your experience leaving sessions, for example did you feel ready and able to implement solutions that you and your therapist generated? Did you feel prepared for problems that arose?

What was your experience of stigma with attending therapy?

What would have had to have been different for you to stay in therapy?

What do you think would help prevent clients from dropping out of therapy?

Can you think of anything important that I missed asking about?

Do you know of anyone who might be a good fit for this study?