Therapist Retrospective Recall of Impasses in Long-Term Psychotherapy: A Qualitative Analysis

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Twelve experienced therapists completed a questionnaire, and 8 of the 12 were then interviewed, about their experiences with a therapeutic impasse that ended in the termination of therapy. Data were analyzed using a qualitative methodology. Results indicated that most of the clients were anxious and depressed with personality disorders and interpersonal problems. Therapists perceived impasses as having a profound negative impact on both clients and therapists. Variables associated with impasses in a majority of the cases were a client history of interpersonal problems, a lack of agreement between therapists and clients about the tasks and goals of therapy, interference in the therapy by others, transference, possible therapist mistakes, and therapist personal issues. Implications for training, practice, and research are provided.

An impasse is a deadlock or stalemate that causes therapy to become so difficult or complicated that progress is no longer possible and termination occurs (Atwood, Stolorow, & Trop, 1989; Elkind, 1992; Weiner, 1974). Impasses are typically accompanied by feelings of anger, disappointment, boredom, defensiveness, and failure on the part of either or both the client and therapist (Elkind, 1992; Weiner, 1974). We need to understand more about what is involved in impasses so that therapists can deal with problems effectively when they arise and thereby reduce the number of deleterious effects on both clients and therapists.

A number of factors have been proposed by clinicians (Atwood et al. 1989; Elkind, 1992; Grunebaum, 1986; Mordecai, 1991; Nathanson, 1992; Newirth, 1995; Omer, 1994; Pulver, 1992; Strupp, 1993; Taylor, 1984; Watkins, 1983; Weiner, 1974) as leading to impasses in psychotherapy: (a) client pathology, which may prevent clients from being able to profit from therapy; (b) mismatches between the therapist and the client because of differences in stage of life, personality type, theoretical orientation, or personal issues or preferences; (c) problems in the therapeutic relationship, such as an inadequate alliance, an inflexible relationship, underemphasizing the relationship, or a breach in the attachment bond; (d) a failure to establish or explain goals, or a disagreement on goals; (e) client transference or inappropriate transference gratification; (f) therapist countertransference or personal issues that interfere with therapists' ability to function adequately in therapy; (g) therapist errors, such as misdiagnosis, sticking rigidly to the contract, misunderstanding the client, problems with judgment or lack of knowledge, inappropriate interventions, pejorative communication, doing the work for the client, acting out, colluding with the client not to discuss difficult issues, or not recognizing that the client has accomplished all he or she can in therapy; (h) client shame associated with cultural prohibitions against discussing certain topics in therapy; (i) irreconcilable conflicts and power struggles; and (j) situational or external reality issues, such as moving or deaths of close relatives. These authors developed lists of factors that may contribute to impasses on the basis of their clinical experience. Unfortunately, there is minimal consistency among these lists, and none have been empirically validated, so we do not know the extent to which any of these factors are applicable to therapists other than the specific authors.

In one of the few empirical studies to address this topic, Rhodes, Hill, Thompson, and Elliott (1994) used a qualitative methodology to study clients' retrospective recall of resolved and unresolved misunderstanding events in therapy. In the subsample of five unresolved misunderstanding events that ended in termination (which is the definition we used for impasse), the following process emerged. Clients...
reported that there was a poor relationship initially but that they were productively involved in a therapeutic task just prior to the misunderstanding event. The misunderstanding event involved the therapists doing something the clients did not like or doing something that the clients wanted or needed and resulted in the clients feeling negatively about themselves and their therapists. The clients, however, did not tell their therapists that they were upset, and hence, the therapists were never aware of their clients’ dissatisfaction. The clients thought about terminating and then did so, apparently without the therapists ever being aware that they did something the clients did not like.

Limitations of the Rhodes et al. (1994) study included the small sample size, the use of only client recall, the use of limited questionnaire data rather than more extensive questionnaire and interview data, and the inclusion only of impasses that arose from misunderstanding events. Thus, the purpose of the present study was to investigate impasses within therapy from the therapist perspective using questionnaire and interview data. We thought that therapists would be able to provide insight into their own experience as well as to use their clinical acumen to inform us about what occurred in the therapy process. Specifically, we wanted to know, from the perspective of therapists, the therapist, the client, and the interaction variables that were associated with impasses, the manner in which the impasses unfolded, and the consequences of the impasses.

A qualitative approach seemed appropriate for this exploratory stage of inquiry because it allowed us to probe the experiences of therapists without determining what their responses would be. We used the qualitative methodology developed by Rhodes et al. (1994), which combined grounded theory analysis (Strauss & Corbin, 1990), comprehensive process analysis (Elliott, 1989), and McCracken’s (1988) interview approach. This method differed from traditional grounded theory approach (e.g., Glaser & Strauss, 1967). We collected all the data using a semi-structured questionnaire and interview prior to analysis, coded data initially into rationally derived domains (i.e., categories) that were modified based on the emerging data, used a primary team of three judges and a method of consensus to arrive at all decisions about domains and core ideas (i.e., the “essence” of what the person said) within domains for each case, used auditors to check the work of the primary team, and compared data across cases to determine consistency of findings within the sample. These modifications were made to provide standard data across cases, reduce the amount of bias, and increase the validity and reliability of the data.

We first asked therapists to complete a paper-and-pencil questionnaire. Then we contacted consenting therapists for telephone interviews to ask more in-depth questions about their experiences of the impasses. We approached therapists initially with a questionnaire because we thought that therapists might feel less vulnerable responding to a questionnaire about what they might perceive as failure experiences in therapy. We included the telephone interview to provide an opportunity to fill in potential gaps in the data. We also thought that following the questionnaire with a telephone interview would lead to richer data by stimulating therapists to think more about their experiences and would allow us to explore areas that needed clarification on the questionnaire.

**Method**

**Therapy Cases**

Twelve White therapists (8 women and 4 men; 9 Ph.D. psychologists, 2 Ed.D. psychologists, and 1 social worker), ranging from 39 to 67 years of age (M = 51.50, SD = 8.67), participated in this study. Using 5-point (5 = high) scales to indicate how much they believed in and adhered to the techniques of different theoretical orientations, therapists rated themselves on average as 3.58 (SD = 1.31) on psychodynamic approaches, 3.25 (SD = 1.54) on humanistic approaches, and 3.00 (SD = 1.41) on cognitive–behavioral approaches. On the basis of self-ratings and self-descriptors, 4 therapists were analytic–humanistic, 2 were analytic, 2 were humanistic, and 4 were cognitive–behavioral in orientation. Therapists had all been clients in therapy themselves, having seen on average 3.42 (SD = 2.50) different therapists for a total of approximately 8.96 (SD = 5.52) years. In addition, therapists had all been in some form (individual, group, or peer) of supervision since receiving their degrees. According to therapists, an estimated average of 22.92 (SD = 30.07) of an average total of 1,821.25 (SD = 2,985.52) of their clients (approximately 3%) had terminated in impasse.

Each therapist reported on one client who had terminated with an impasse. All 12 (7 women and 5 men) clients were White and ranged from 20 to 62 years of age (M = 39.17, SD = 13.00). Therapists indicated that 11 of the clients had Axis I diagnoses (3 had generalized anxiety disorder, 3 had major depression, 2 had bipolar disorder, 2 had posttraumatic stress disorder, and 1 had dysthymic disorder); 10 had Axis II personality disorders (4 had mixed personality disorders, 3 had borderline personality disorder, 2 had paranoid disorder, and 1 had obsessive–compulsive disorder); 1 person had no Axis I or II diagnosis.

The setting was private practice for ten cases and outpatient clinics for two cases. Sessions were typically once per week, and all but one involved only individual therapy (one client was also in group therapy with the therapist). The duration of therapy was from 10 to 390 sessions (median = 84, M = 122.50, SD = 124.27) over 3 to 132 months (median = 18, M = 35.56, SD = 40.00). Therapists indicated that between 2 and 48 sessions (median = 5, M = 8.75, SD = 12.67) had been influenced by the impasse. Termination had occurred between 1 and 60 months (median = 2, M = 11.67, SD = 18.13) prior to participation in the present study.

**Researchers**

Five researchers participated in this study. The primary team of judges, who did all the major analyses, included one White female counseling psychologist and two White female graduate students in a counseling psychology doctoral program. The auditors were two White female psychologists (one counseling and one clinical), who were involved in the delivery of psychological services. The primary team recorded their biases or expectations about the outcomes of the study prior to collecting data. Qualitative researchers typically record their biases to ensure that they become aware of them and to try to set them aside and be objective when doing the analyses. Clara E. Hill expected that transference, countertransference, and client level of pathology (i.e., inability to form relationships) would all play major causal roles in impasses and that impasses would have a major negative impact on therapist
self-esteem. Elizabeth Nutt-Williams believed that impasses would result from poor working alliances, poor matches, therapist countertransference, client pathology, therapist inexperience, or therapist lack of experience with own personal therapy. Kristin J. Heaton thought that therapists would generally be distressed by impasses, that male therapists would report fewer impasses and would be less distressed by impasses than female therapists, and that therapists would tend to attribute responsibility for impasses to the clients rather than to themselves.

**Measure**

The Questionnaire on Impasses in Individual Therapy, a paper-and-pencil self-report measure, was developed based on the questionnaire used by Rhodes et al. (1994) and a review of the literature on impasses. After the primary team developed the questionnaire, they obtained feedback from the auditing team and another experienced psychotherapy researcher. A pilot study was then conducted in which the revised version of the questionnaire was completed by two advanced graduate students who had experienced impasses as therapists. Their feedback was used to create the final version of the questionnaire.

The final questionnaire consisted of four sections: (a) demographic data about the therapist; (b) general questions about therapists’ experiences with impasses, including approximate number and type of clients whose treatments had ended because of impasses; (c) a request for information about a recent or salient impasse (defined as a deadlock or stalemate in which the therapy has become so difficult or complicated that further progress is impossible, typically accompanied by feelings of anger, disappointment, or a sense of failure for either or both the client and therapist); and (d) demographic information about the client described in the impasse example. In the example, therapists were asked to write about how the therapy began, their assessment of the working alliance before and after the impasse, the client and therapist factors that led to the impasse, the events in therapy that preceded and occurred during the impasse, the therapeutic strategies used by the therapist to deal with or to overcome the impasse, the therapist’s perceptions of the therapist’s and client’s immediate reactions to the impasse, transference and countertransference issues, consequences of the impasse for both the client and therapist, the therapist’s understanding of why the impasse occurred, and a description of consultation therapists sought about the impasse.

The Impasse Interview was designed as a follow-up to the questionnaire. At the beginning of the interview, we reminded the therapist of the procedures for confidentiality and asked permission to audiotape. We then asked the therapist about any other thoughts they had had about the impasse since completing the questionnaire, why they chose to report the particular impasse, about the salience of the impasse, whether there were similarities between the chosen impasse and others the therapist had experienced, for clarifications of specific points from the questionnaire (particularly whether there was a specific event leading up to the impasse and whether transference and countertransference were involved), and for any other details that would help us understand the impasse more thoroughly.

**Procedures**

A mailing list was obtained from an East Coast state psychological association in the United States. We went through the mailing list and noted all those people who were also listed in the National Register of Health Service Providers in Psychology, under the assumption that these people would probably be practicing therapists. The questionnaire was sent to 270 people randomly selected from the resulting list, as well as to 6 therapists who indicated that they might be willing to participate.

All respondents were asked to estimate how many cases they had that had ended in impasse (defined as a deadlock or stalemate in which therapy becomes so difficult or complicated that further progress is impossible and termination occurs, with accompanying feelings of anger, disappointment, and a sense of failure on the part of either or both the client and therapist). If therapists had at least one recent, salient impasse, they were asked to complete the remainder of the questionnaire. Therapists were informed that their consent was inferred if they completed and returned the questionnaire. Therapists were assured that their data would be kept confidential and anonymous. At the end of the questionnaire, therapists were asked if they would be willing to be contacted by telephone for a taped interview.

Prior to the interview, the primary team read through the therapist’s responses to the questionnaire to determine areas that needed further probing. All therapists who indicated they were willing to be interviewed were contacted by one of the primary researchers, who first reminded them that the telephone call was being audiotaped for research purposes. The Impasse Interview was then conducted with the therapists.

Questionnaires were returned by 15 therapists (13 from the mailing list and 2 from personal contacts). Three therapists declined to participate (2 could recall no impasses; 1 said the study required too much time and effort to complete). Twelve therapists completed the questionnaire, although only 8 consented to be interviewed. The data for the cases without interviews did not appear to be qualitatively different in any identifiable way from the other eight cases, so we included them in the data analyses. Thus, the data analyzed included the eight cases with both questionnaires and interviews and the four cases with just questionnaires.

**Data preparation.** All identifying information was removed from the data and each therapist was assigned a code number to maintain confidentiality. All responses to the questionnaire and telephone interview were transcribed verbatim by undergraduate assistants.

**Method of consensus coding.** Consensus is considered critical in this qualitative methodology to reduce the potential bias inherent in the use of a single judge and to produce a richer conceptualization of the phenomenon. To limit the potential distorting effects of group decision-making processes and to encourage us to work cooperatively, we strove to create a group atmosphere in which each person could express herself and the contributions of everyone were valued. We engaged in an open exchange of ideas in which we sought to understand each other’s perspectives and to examine our own perspectives. After the initial “hearing” of each other’s views, commonalities and differences were identified. Differences were examined in a spirit of compromise, with the team first agreeing on content and then agreeing on the specific wording. When an idea was brought up that not all three judges initially agreed on, we went back to the raw data and added the idea only if there was sufficient evidence for it. Hill, Nutt-Williams, and Heaton worked together on the primary coding team, discussing each decision until consensus was reached. Determining agreement levels is not appropriate in this method, but it is important to ensure that all the relevant ideas are expressed and considered. Barbara J. Thompson and Renee H. Rhodes served as auditors at each stage of the research process, giving feedback to the primary team, who then revised each decision through an additional consensus process.
Coding into domains. The three judges on the primary team independently divided the text in each questionnaire and interview into meaning units (all adjoining text on a given topic) and then assigned each meaning unit into one or more domains (topical areas). On the basis of the literature and the Rhodes et al. (1994) study, we began with 16 domains that were modified based on the data into 12 domains within three megadomains: (a) background (client diagnosis, client background, presenting problem, and initial relationship); (b) impasse stage (impasse event, contributors to the impasse, client reactions, therapist reactions, and therapist strategies); and (c) consequences (relationship at termination, method of termination, and lingering effects on therapist). Following independent coding of meaning units into domains, judges argued to consensus about how each meaning unit should be coded.

Coding core ideas. Each judge then independently read all raw data for a given case within each domain (e.g., client background) and wrote down the "core ideas" (i.e., the essence of the therapist’s thoughts in more concise and abstract terms). For example, all the therapist’s detailed descriptions from the questionnaire and interview about the client’s background might be “boiled down” into the phrase, “client threatened suicide and refused medication.” Judges then met and argued to consensus about the wording of each core idea. A consensus version for each case was developed consisting of the agreed-on core ideas and the exact quotes (all the raw data) for each of the domains.

Feedback from auditors. The auditors studied the consensus version of each case and provided comments about the appropriateness of the coding into domains as well as the wording of the core ideas. The primary team discussed each of the auditors’ comments and once again arrived at agreement for the domains and wording of the core ideas in the revised consensus version for each case.

Cross-analysis. After listing the core ideas in each domain for all 12 cases, the primary team looked for similarities in core ideas across cases for each domain. They then categorized the similar core ideas for all cases within each domain into coherent themes or categories (e.g., the domain of contributors to the impasse was divided into categories of therapist mistakes, triangulation, therapist issues, and transference, with several of the categories being broken down further into subcategories). The auditors met with the primary team to help clarify the wording of the categories. Once they had a preliminary set of categories, the primary team reviewed all the raw data to make sure that the core ideas were complete and correct. All three members of the primary team had to agree before any changes were made to the core ideas. The consensus version of the case and the cross-analysis were modified accordingly when changes were made in the core ideas.

Feedback from auditors on cross-analysis. The auditors then reviewed the cross-analysis and made suggestions. They also compared the cross-analysis with the consensus versions for each case to ensure that the cross-analysis accurately represented the raw data. On the basis of the feedback from the auditors, we revised the cross-analysis.

Results

Categories were considered general if they applied to all cases, typical if they applied to between 7 to 11 cases, and variant if they applied to between 3 to 6 cases. Categories that were applicable to only one or two cases were dropped from further consideration. Table 1 shows the general, typical, and variant categories that emerged for each of the 12 domains in the cross-analysis. Using the general, typical, and variant themes within each domain, we developed a narrative account of the process of impasses from the therapist perspective.

Narrative Account of Background Variables

Client background. Seven (one general, two typical, and four variant) categories emerged for client background. Therapists indicated that all clients had a background of problems with their families-of-origin (e.g., one client had mentally ill parents and intense family-of-origin conflicts, and another client had been physically abused by her mother and had a passive father). Typically, clients were involved in troubled current intimate relationships (e.g., one client had been recently rejected by her boyfriend, and another had been in a dysfunctional marriage and had intense conflict with her children) and had a history of general interpersonal issues (e.g., one client had a distrust of authority figures and felt unlovable, another was angry at men and had difficulty with intimacy, and another had fears of being abandoned and hurting others). There were four variant categories: (a) a history of abuse (e.g., childhood sexual abuse or recent rapes); (b) medication issues (e.g., one client did not respond well to antidepressant medication); (c) fragility (e.g., one client seemed about to fall apart); and (d) recent personal crises (e.g., one client’s father had recently died, and another client had just been rejected by her boyfriend and fired from her job).

Presenting problems. The typical presenting problems were anxiety or depression (e.g., one client wanted to work on stress related to his wife’s impending death, and another client had suicidal depression) and interpersonal problems (e.g., one client was interpersonally insecure, had marital problems, and was rageful to herself and others; another client had interpersonal problems stemming from having been raped).

Initial relationship. No general or typical type of initial therapeutic relationship was found. About one third of the cases initially had good relationships (e.g., good, solid relationship prior to impasse with no incidents of anger). About one third initially had limited or superficial relationships (e.g., client was superficially friendly but passive-aggressive and competitive with therapist). Finally, about one third initially had poor relationships (e.g., poor connection, with client being angry and withholding toward therapist).

Narrative Account of Impasse Stage

Impasse event. The impasse was seldom perceived by therapists as being a single major egregious event. In all of the cases, the therapists perceived that the clients disagreed with the therapists’ strategies, suggesting that there was generally a lack of agreement between therapists and clients over the tasks and goals of treatment. For example, one client was demanding but rejecting of his therapist’s suggestions. Similarly, another client wanted her therapist to
Variables associated with impasses. Therapists perceived four variables as possibly associated with the impasses: possible therapist mistakes, triangulation, therapist issues, and transference. The first variable (a general one because it applied in all cases) was possible therapist mistakes, for which there were four subcategories, the first of which was typical with the rest being variant: (a) the therapist was too pushy or unsupportive (e.g., one therapist was impatient and confronted the client prematurely by telling her that her behavior was unacceptable and by scolding her; another therapist was disapproving, too active and pushy, and expected too much of the client); (b) the therapist was too cautious or nondirective (e.g., one therapist was too cautious because she thought the client was fragile; another therapist felt that she was not authoritative or directive enough and should have helped client explore her feelings more); (c) therapist was unclear, changed techniques too much, or lost neutrality (e.g., one therapist had trouble setting limits or boundaries; another therapist thought that he may have confused the client when he shifted from active–directive interventions to a more neutral stance); and (d) the therapist may have misdiagnosed the client (e.g., one therapist underestimated the client’s pathology and ability to handle interventions; another therapist overestimated the client’s strengths, and did not recognize the depth of the client’s pain and the severity of the client’s problems).

The second (typical) variable related to impasses was triangulation, in which another person or persons intruded into the therapeutic relationship and made the client feel that he or she had to choose between the therapist and the other person(s). In one case, the client felt split between the therapist and her husband; she chose to stay with her husband and to be furious with the therapist. In a second case, the client contacted another therapist without discussing his dissatisfaction with the therapist. A third client felt that he had to choose between his therapist and his girlfriend, who felt that therapy was not working. In a fourth case, the therapist met with various family members during the client’s therapy, and the client felt pushed around by these family members. In a fifth case, the therapist felt caught between the client and the client’s wife. The therapist had allowed the wife to come into therapy with the client for a session; when the client’s wife called and spoke to the therapist in confidence, the client felt betrayed.

A third (typical) variable related to impasses was transference issues; therapists perceived that clients reacted to them as they had to their parents. In one case, the client saw the therapist as being like her disapproving mother and felt angry and disappointed with the therapist. In a second case, the client saw the therapist as being like his parent trying to make him do things he did not want to do. In a third case, the client vacillated between seeing the therapist as a good...
mother and an abuser. Finally, one client idealized her therapist as she had her father.

The final variable related to impasses, also typical, was personal issues of therapists that interfered with their performance. Four subcategories of therapist issues emerged, the first of which was typical and the rest of which were variants: (a) some therapists had difficulty dealing with strong negative affect or behavior (e.g., one therapist had difficulty in examining painful client experiences, another was uncomfortable with her client’s anger, and another was frightened and confused by the client’s dissociation and was shocked by her reported rapes); (b) the therapist’s family-of-origin issues were stimulated by the client’s issues (e.g., one therapist felt uncomfortable with extremely hostile and irrational clients who were like her mother; another had trouble working with a paranoid, complaining, help-rejecting client who was similar to his mother; and another therapist’s anger in his own marital relationship emerged when he heard about the behavior of his client’s abusive girlfriend); (c) therapists got drawn into a rescuer–fixer role (e.g., one therapist needed to rescue or take care of a passive and helpless client, and another had a rescuer fantasy about the client); and (d) concurrent life stressors were reported (e.g., a son’s serious illness may have interfered with one therapist’s ability to be emotionally available to her client; another therapist felt particularly vulnerable to criticism and attack from her clients because of health reasons).

Client reactions. All therapists reported that clients reacted negatively toward the therapist in response to the impasse. Therapists said that their clients felt angry, impatient, vulnerable, contemptuous, upset, blamed, abandoned, horrified, confused, criticized, and uncomfortable. A variant response was that some clients felt demoralized (e.g., felt worse about themselves, were discouraged or self-blaming about lack of progress, or felt an overall sense of disappointment or hopelessness).

Therapist reactions. As a result of the impasse, several therapists reported that they felt frustrated, angry, disappointed, or hurt by their clients. Several felt confused or anxious about the impasse. In addition, several reported having negative thoughts about their own self-efficacy. A few also reported feeling surprised by the impasse because they had neither anticipated it nor been prepared for it.

Therapist strategies. Therapists used two main strategies to deal with impasses with their clients. First, all but one therapist tried to discuss the impasse with the client. For example, one therapist tried to discuss the impasse with the client, interpreting the similarity of the impasse to past and present relationship difficulties. Another therapist discussed the process and the relationship with the client, trying to reengage the client in the therapy. A third therapist discussed the triangulation with the client. Thus, these therapists attempted to help their clients explore what had happened, to reengage them, to help them gain some insight into what occurred, to help them understand the impasse in light of past and present relationships or transference issues, or to reconceptualize the problem. A few of the therapists also used a variant strategy, which was to become more active and directive and advise the client about what to do (e.g., one therapist stressed the importance of self-protection to the client).

Therapists also used two different strategies for coping with their feelings about the impasses. All but one therapist consulted either with colleagues or supervisors, with a few therapists indicating that they wished they had sought consultation earlier. A few therapists engaged in positive self-talk, saying things to forgive themselves or to reframe the incident (e.g., “I did all I could.” “Everyone makes mistakes,” “I have to accept my limitations,” “Use mistakes as opportunities,” “Don’t take it so personally,” and “These things happen”).

Narrative Account of Consequences

Relationship at termination. Typically, the relationship at the end of therapy had deteriorated, although in a few cases, therapists were uncertain about the status of the relationship.

Method of termination. Typically, the clients unilaterally and abruptly terminated from therapy. From the therapist accounts, clients either called to terminate or came in and told the therapist that they were stopping treatment. These announcements typically caught therapists off guard because they had not been aware that things were going so badly in therapy. Indeed, most therapists seemed to develop an understanding of the impasse by thinking about the case after the impasse and trying to figure out what went wrong.

Lingering effects on therapists. The impasses typically had lingering effects on the therapists, who ruminated about the impasses and tried to figure out what went wrong. Some therapists commented that they participated in the research as a way to help them understand what happened in the case. Some therapists continued to have self-doubts about their own abilities as therapists. A few therapists changed strategies with other clients as a result of their experiences. Finally, a few therapists continued to worry about their clients and some maintained contact with the clients despite the termination of the official therapy.

Case Example: “An Indecisive Man”

Dr. K was an experienced, 44-year-old, White, female psychoanalytic psychologist in private practice. The client was a 42-year-old White man diagnosed with depression and mixed personality disorder. They had met for 300 weekly sessions over a 7-year period, ending a year before the therapist participated in this study. The initial therapeutic relationship was described as “stormy,” and at times the therapist felt “helpless.” The client was an Ivy League graduate but was doing manual labor for minimal pay when he entered therapy. Initially therapy helped him, enabling him to go to graduate school and get married. However, therapy later stalled when his wife left him. The client tended to become involved with women who were critical, resentful, and controlling like his mother, and he would experience push–pull struggles with these women. He was continually trying to please women but resisted being dom-
rather than as involving a single egregious event. Therapists

Discussion

To provide a context for understanding the results of this study, we should note that the cases typically involved individual, weekly, long-term (median of 84 sessions over 18 months) therapy conducted in private practice. We remind the readers that we studied only the therapist perspective, and not the client perspective, of impasses. We also remind the reader that we studied a retrospective recall of the events rather than studying the impasses while they were taking place. Finally, we should note that the sample of therapists was small and probably not representative of therapists or impasses in general, so results may not be generalizable beyond this particular sample.

In general, the 12 therapists indicated that, at least as far as they were aware, impasses had occurred infrequently (in approximately 3% of cases) in their practices. Of course, therapists may not have been aware of some impasses if clients quit without informing them of their dissatisfaction.

Description of Impasses

The impasses were characterized by therapists as involving an ongoing general disagreement between therapists and clients about the way in which therapy was conducted, rather than as involving a single egregious event. Therapists generally first became aware of the impasses when the clients abruptly and unilaterally terminated. A few of the therapists were surprised when they learned about the impasse because they had not been aware that the clients were feeling so negatively about the therapy.

Impasses were charged with negative emotion. Therapists reported that clients felt very negatively toward them as a result of the impasse, using words such as angry, impatient, contemptuous, upset, horrified, confused, and uncomfortable. They also indicated that clients often felt blamed, abandoned, and criticized by the therapist; disappointed, hopeless, and discouraged or self-blaming about the lack of progress; and worse about themselves. Similarly, therapists felt frustrated, disappointed, angry, hurt, confused, and less self-efficacious.

We could not investigate lingering effects of the impasses on the clients because therapists no longer had contact with clients after termination. We did find, however, that the impasses had lingering effects on the therapists. Therapists thought about the cases and tried to understand what had gone wrong, had self-doubts about their own abilities as a result of the impasses, engaged in self-talk to reassure themselves about their abilities, changed strategies with other clients to try to prevent additional impasses, and worried about the welfare of their clients. Clearly, these therapists felt badly about not having been able to provide a good therapeutic experience for their clients.

Variables Associated With Impasses

Because this was not an experimental study, determining causal relationships was not possible. However, therapists discussed several variables that they associated with the occurrence of impasses: the severity of client pathology, disagreement over tasks and goals of therapy, possible therapist mistakes, triangulation, transference, therapist issues, and the therapeutic relationship.

Severity of client pathology. Most clients had an Axis I diagnosis of anxiety or depression or an Axis II diagnosis of personality disorder, a history of problems with their families-of-origin, troubled current intimate relationships, and general interpersonal problems (e.g., anger, dependency, lack of assertiveness, and guilt). Hence, these were distressed people who had major interpersonal problems. These clients probably would have been difficult for most therapists to work with in therapy. These findings support the clinical literature (Elkind, 1992; Mordecai, 1991; Newirth, 1995; Taylor, 1984) that certain client types may be prone to impasses because of their pathology.

Disagreement over strategies. Interpersonal conflicts characterized the ongoing therapeutic relationships in these cases. All therapists reported power struggles over the tasks and goals of treatment. Therapists indicated that clients typically disagreed with their strategies or were dissatisfied with the progress they were making. These findings confirm the writings of several clinical authors (Nathanson, 1992; Pulver, 1992; Weiner, 1974), who suggested that problems around goals (failure to set goals, failure to explain goals, or disagreement over goals) were associated with impasses.
Possible therapist mistakes. All 12 therapists reported that they may have made mistakes in terms of not providing clients with what they wanted or needed in therapy. Possible mistakes included such things as being too pushy or confrontive, too supportive or not supportive enough, losing objectivity, being unclear, being inconsistent in terms of sticking to a given strategy, or being inaccurate in their diagnosis of clients. In other words, there was not a single identifiable type of technical error that therapists made. Similarly, in the clinical literature on impasses (Mordecai, 1991; Nathanson, 1992; Pulver, 1992; Strupp, 1993; Watkins, 1983; Weiner, 1974), a number of types of therapist errors have been suggested, although the lists of errors differed somewhat from ours.

We would like to highlight a therapist error that Nathanson (1992) discussed that may have been present in our data. He noted that sometimes therapists do not recognize when clients have accomplished all they can within therapy. He suggested that sometimes clients might have gained everything they can from one therapist and may need to move on to a different therapist to continue their growth. Unfortunately, there is a lack of clear criteria for when clients should terminate from long-term therapy, so clients and therapists may feel unsure about when to stop therapy. Clients may not be "finished" with their work or "cured" but may not be willing to do any more work at the time or may feel that they cannot do any more work with a particular therapist. We speculate that some of these impasses may have been initiated and carried through as a way for the clients to end therapy.

Although all therapists reported making mistakes, general therapist incompetence did not seem typically to be an issue, at least in our judgment after reviewing the cases. These therapists were highly experienced, had been in therapy themselves for an average of 9 years, had received extensive postdegree supervision, and were generally concerned about their clients and committed to conducting therapy to the best of their ability.

Triangulation. Another person (a partner, parent, or other therapist) often interfered with the therapy. In these cases, clients felt triangulated and sensed that they had to choose sides. Having to choose between a therapist who provides support for one to three hours per week and a spouse or family member who, even if abusive, is available on a daily basis for the client, is often painful. Being in situations in which they felt forced to choose between two sources of support may have recreat ed painful scenarios from the client's past. If the clients had difficulty with attachment or had not yet been able to individuate from parents, then having to choose between two people may have stimulated fears of abandonment or of being overwhelmed and dominated by the therapist. Of course, some clients may have put themselves in the triangulated position, for example by seeing two different therapists, to avoid deep involvement with either person. Interestingly, triangulation was not specifically mentioned by the previous clinical authors, perhaps because they did not attend as much to external factors that lead to impasses. More empirical attention is needed on this topic.

Transference. Transference issues, or distortions such that the client projects negative expectations from his or her parents onto therapists, were mentioned in the majority of the cases. Therapists perceived that their clients thought they would be disapproving, angry, controlling, dominating, or abusive toward them, as the clients' parents had been. Freud (1912/1958) first identified the transference phenomena and suggested that the analysis of transference is one of the major tasks of psychoanalysis. Often times when a person expects something so strongly, it is hard for him or her to see evidence to the contrary. People expect others to act in particular ways and thus behave so as to elicit these responses. For example, if a person expects others to be hostile, he or she might act aggressively and defensively to forestall attack, thus inviting others to respond in a negative manner. Hence, these findings provide support for the role of transference in impasses that has been noted in the past (Atwood et al., 1989; Elkind, 1992; Nathanson, 1992; Pulver, 1992; Weiner, 1974).

Therapist personal issues. Most of the therapists indicated that their own personal issues (countertransference) were implicated in the impasses. Family-of-origin issues were stimulated by the clients of some therapists. Parents of two therapists had committed suicide, which led these therapists to feel vulnerable and vigilant when clients threatened suicide. Similarly, Boyer and Hoffman (1993) found that therapists with significant loss histories were more depressed at termination than those who reported less loss in their lives. Other therapists reported having difficulty dealing with clients who were hostile, irrational, paranoid, complaining, and help-rejecting in the same way their own parents had been. Furthermore, several therapists had difficulty dealing with strong negative affect (e.g., anger) on the part of clients or dealing with clients who had especially difficult issues (e.g., rape victims or suicidal ideation). In addition, a few therapists felt a strong pull to rescue or fix their clients. Finally, a few therapists had concurrent life stressors (e.g., health or family problems) that interfered with their abilities to focus on their clients. We should note that some therapists seemed more aware of their personal issues and open to discussing them with us than did others. Therapist issues, particularly countertransference, were cited as contributors to impasses by many of the clinical authors (Elkind, 1992; Mordecai, 1991; Nathanson, 1992; Pulver, 1992; Taylor, 1984; Weiner, 1974). Hence, there seems to be wide recognition of the potential that personal issues have to cloud therapists' judgment in their work with clients. Training programs need to teach therapists to deal with their personal issues to reduce the potential damaging effects of these issues in therapy.

The therapeutic relationship. About one third of the therapists characterized the initial relationships as good, one third as limited or superficial, and one third as poor. By the end of treatment, however, relationships were typically characterized as poor and deteriorated. Thus, some of the cases seemed to be mismatches from the beginning and did not improve, whereas others seemed to deteriorate after an initially good relationship. Surprisingly, we found no differences in the sequence of events of the impasses as a
function of the initial relationship. One certainly wonders about the ability of therapists (or clients) to recall the quality of the initial relationship accurately after a length of time has passed and the therapy has ended poorly. Thus, although the role of an inadequate therapeutic relationship in impasses was mentioned by several of the previous authors (Elkind, 1992; Pulver, 1992; Strupp, 1993; Weiner, 1974), these data provided no clear evidence about the role of the therapeutic relationship in the development or lack of resolution of impasses.

**Summary of variables associated with impasses.** These findings provide support for the following variables cited in the clinical literature as being associated with impasses: the severity of client pathology, disagreement over tasks and goals, therapist mistakes (although there was some disagreement with the previous literature about the specific mistakes), transference, therapist issues, and situational issues. There was some, albeit less consistent, evidence for mismatches and power struggles. The role of the therapeutic relationship was not supported as clearly in this study as was indicated in the clinical literature. In addition, although these had not been discussed in the clinical literature, we found evidence for the role of client interpersonal issues and triangulation in impasses. Hence, these results provide empirical evidence for a preliminary list of variables associated with impasses, most of which are supported by the clinical literature.

**Therapist Strategies for Dealing With Impasses**

Once therapists became aware that their clients were terminating treatment, most tried to explore with the clients what had happened so that they could help the clients gain some insight into the situation. Some explored the present relationship difficulties in light of past and present relationships or transference issues. Exploration of the therapeutic relationship makes good therapeutic sense, according to a number of clinical authors who emphasized the importance of first recognizing the existence of the impasse and then clarifying and discussing it with the client (Atwood et al., 1989; Elkind, 1992; Pulver, 1992). Unfortunately, the exploration might have come too late in these cases. Clients might have already decided to leave and been reluctant to reconsider their decisions.

Another strategy, used by a few therapists, was to become more active and directive and advise the clients about what to do. This strategy appeared to be one of switching tactics to see if a different strategy would work and may have been motivated by feeling out of control when things went awry. This switching strategy did not seem to be very effective.

Interestingly, therapists did not tend to acknowledge or apologize to the clients for their mistakes, as did therapists in the resolved misunderstanding cases in the Rhodes et al. (1994) study and as has been recommended by Elkind (1992) and others. In general, given that clients did not tell therapists of their dissatisfaction until they abruptly and unilaterally terminated, therapists may not have had much opportunity to discuss their own feelings. Or perhaps the therapeutic relationships were not strong enough at that point for therapists to risk making themselves vulnerable. From these data, it is not clear what therapists could have done differently to prevent or address the impasse once the relationship had deteriorated to such an extent. Perhaps early recognition of interpersonal problems in therapeutic relationships is the key to resolution of such problems.

As has been recommended in the literature, therapists also engaged in extensive self-analysis and consultation with other therapists or supervisors (Elkind, 1992; Pulver, 1992; Weiner, 1974). The awareness by therapists of the need to think through the issues and seek consultation is heartening. Other recommendations that were used less seldom were seeking personal therapy and referring the client (Pulver, 1992; Weiner, 1974). Therapists reported that they had been in personal therapy in the past and may have felt that consultation was a more appropriate solution than personal therapy at this point in their lives. Referral, however, may be an option that therapists should consider more often when they feel there is an initial mismatch or when an impasse develops. Grunebaum (1986) found that 78% of the clients (who were mental health professionals) in his sample who reported having had harmful psychotherapy experiences subsequently reported that they had successful therapy experiences, indicating that they were treatable but just did not match with the particular therapist.

**Comparison to Rhodes et al. (1994)**

Comparisons to the Rhodes et al. data for just those five clients who ended therapy as a result of the misunderstanding event must be made with caution because both samples were small and probably nonrepresentative. In addition, participants in the Rhodes et al. study were clients who were themselves therapists or therapists-in-training, whereas participants in the present study were therapists whose clients were not professionally involved in counseling or clinical psychology. Finally, the clients in the present study may have been generally more disturbed, less psychologically minded, and less open about their experiences than those in the Rhodes et al. study.

In the Rhodes et al. study, clients reported that the therapeutic relationship had typically been poor initially, whereas in the present study we found no consensus among therapists about the quality of the initial therapeutic relationship. There was, however, some similarity in the description of the misunderstanding or impasse: the Rhodes et al. study described misunderstandings as occurring as a result of a breach of something the client wanted or needed, whereas in the present study impasses were described, in part, as a disagreement between clients and therapists about the tasks or goals of therapy. In addition, both found that clients felt negative emotions about self and therapist at the result of the impasse.

An interesting parallel in perspectives occurred in the descriptions of events during the impasses. In the Rhodes et al. study, clients indicated that they never told the therapist about their dissatisfaction before they quit therapy. From
the description that the therapists provided of the impasses in the present study, many became aware of their clients’ dissatisfaction only after the clients abruptly and unilaterally stated that they were terminating therapy. When the therapists in the present study reconstructed the events in therapy leading up to the termination, they realized that all had not been going well and that, in fact, they themselves had also been frustrated with the process. Nevertheless, the therapists often were taken aback and surprised by the termination. In combining the results of the two studies, it seems likely that therapists were unaware of the clients’ dissatisfaction because the clients did not express it directly prior to termination. These results highlight the extent to which clients hide their dissatisfaction from therapists, as has been found in a number of other studies (Hill, Thompson, Cogar, & Denman, 1993; Hill, Thompson, & Corbett, 1992; Regan & Hill, 1992; Rennie, 1994).

Limitations

One limitation of this study is that we do not know how representative the sample is of experienced therapists. Although we sent invitations to a representative sample of therapists, our return rate was low, which is typical of field studies with experienced therapists (see Vachon et al., 1995). We do not know whether people did not respond because they were not doing therapy, did not have a good example of a recent impasse, did not have the time or motivation to participate in the research, or were not comfortable discussing a failure. Vachon et al. reported that therapists did not participate in their field study, which (unlike ours) involved audiotaping of therapy sessions, because of insufficient time and unwillingness to audiotape clients. We might speculate that therapists who chose to participate in this study had especially salient examples of impasses or were uncommonly open to allowing themselves to be vulnerable, given how difficult it is to admit to and discuss a situation in which one did not excel. Although both male and female therapists and clients and a range of therapist theoretical orientations were represented in this sample, all the therapists, clients, and researchers were White, and all the researchers were women, which again raises concerns about the generalizability of the findings.

Another limitation is that we examined only the therapist perspective, and so we do not know whether clients would have reported similar experiences. Future studies need to examine the therapist and client perspectives from the same cases. Furthermore, we studied a retrospective recall, and there is no way of knowing how accurately therapists remembered events that transpired in the therapy. In addition, we were restricted to what therapists were aware of and willing to disclose, which is of course a limitation not only of qualitative research but of all research that requires participants to reveal inner, subjective experiences. Another issue is that 4 of the 12 therapists would not allow us to interview them, so we did not have as much data on those cases. Finally, therapists may have selected unusual non-representative cases to report to us given that we asked for the most recent salient examples of impasses. We also do not know, even though we tried to reduce the biases of the judges, whether another team of qualitative researchers would come up with similar results. Hence, the results cannot be generalized beyond this particular sample of therapists and team of judges and need to be replicated.

Implications

We would suggest that future researchers study both therapist and client perspectives in the same cases. The disparity of results between this study and the Rhodes et al. (1994) study may be because therapists and clients generally view impasses very differently. Being able to compare perspectives within cases could provide some clues as to why these disparities exist.

There were several interesting findings in this study that need to be replicated and extended in future research. Specifically, the roles of triangulation, therapist mistakes, and therapist issues in the development of impasses seem particularly important to investigate. Further research also needs to be done on how misunderstandings or impasses can be resolved.

Future research might examine the process of impasse events for different types of clients. One variable that seems particularly feasible to examine is the different attachment styles of clients to their therapists (cf. Mallinckrodt, Gantt, & Coble, 1995). Avoidant clients who withdraw and distrust therapists, clients who want to merge with or become dependent on therapists, and secure clients who feel a sense of self-esteem would all probably have different experiences of misunderstanding events in therapy. Likewise, therapist attachment styles might influence how therapists respond to different types of clients.

A major implication of the results of this study for practice is that we need to train therapists to become aware of the variables associated with impasses so that they can intervene before cases end in termination. Perhaps therapists need to be aware that when they feel frustrated with clients or when things are not going well, the clients may also be dissatisfied. We would recommend that therapists check with their clients frequently regarding their feelings about therapy so that they can intervene before difficult situations reach a crisis stage. Perhaps asking clients to complete standardized assessments of their satisfaction and of their perceptions of the working alliance would be a useful way to circumvent being caught unaware by client dissatisfaction. Asking clients about their feelings or using standardized measures can give clients the message that therapists care about their reactions to the therapy process. Another recommendation made by some of the therapists in this study was to seek supervision early when feeling stuck on a case. Because some cases are very difficult and one’s own personal issues often are aroused when providing therapy, therapists may need to have supervisors readily available for consultation during their whole careers. Finally, therapists need to recognize when they have gone as far as they can go with clients and terminate or refer clients when they have reached a plateau or stalemate.
In reviewing these cases, we were struck by the apparent inevitability of misunderstandings and impasses. Even experienced therapists do not always feel successful. We hope that by discussing problem cases openly, we will begin to learn more about what does and does not work in therapy.

References


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