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AN EXPLORATORY STUDY OF THE TERMINATION PROCESS
IN MARRIAGE AND FAMILY THERAPY

by

Jennifer H. Childers

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Family and Human Development

Approved:

UTAH STATE UNIVERSITY
Logan, Utah

1998

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ABSTRACT

An Exploratory Study of the Termination Process
in Marriage and Family Therapy

by

Jennifer H. Childers, Master of Science

Utah State University, 1998

Major Professor: Dr. Scot Allgood
Department: Family and Human Development

The purpose of this study was to explore and better understand termination in the field of marriage and family therapy, as well as to generate a working model of termination. Data were obtained from a total of 40 marriage and family therapists (MFTs) licensed in the state of Utah. Two research questions were posed about termination and how client type and treatment progress may influence the termination process: (1) Given that MFTs see individuals, couples, and families, are there differences and similarities across client types in regard to how therapy is terminated?, and (2) Does termination differ in regard to treatment progress (i.e., clients have been completely or partially successful in meeting the specified treatment objectives)?

Data examined from these therapists suggested that marriage and family therapists terminate individuals, couples, and families in a similar, but not sequential, manner using

six main steps: (1) plan for future problems, (2) review goals, (3) summarize treatment, (4) orientation to termination, (5) review skills and resources, and (6) empower clients. This model was compared to and analyzed against a four-step model conceptualized by Epstein and Bishop. The results not only produced a similar termination model to that of Epstein and Bishop, but added greater depth and clarification to the steps outlined in the model. The data also supported the idea that treatment progress may influence termination for couples and families, but did not support it for termination with individuals.

(64 pages)

ACKNOWLEDGMENTS

I would first like to thank Dr. Scot Allgood for serving as my major professor and advisor throughout this project. I would also like to thank Dr. Brent Miller and Dr. Shelley Lindauer for their direction and support as members of my committee. Thanks also to Scot, Rana, and Kim in the Marriage and Family Therapy program for their guidance and direction in the development of my clinical skills throughout the program.

My graduate work would never have been possible without the help of my wonderful parents whom I am extremely grateful for and love very much. I am thankful for all of my family who have supported me and given me the encouragement to succeed. I want to especially express my love and appreciation to my husband, Christopher, for his constant support, love, and confidence in my graduate work and training to become a marriage and family therapist. Finally, I wish to thank my Heavenly Father and my Savior, Jesus Christ, for making all things possible.

Jennifer H. Childers

CONTENTS

	Page
ABSTRACT	iii
ACKNOWLEDGMENTS	v
LIST OF TABLES	viii
CHAPTER	
I. INTRODUCTION	1
Nominal Definitions	2
Conceptual Framework	2
Problem Statement	4
II. REVIEW OF LITERATURE	5
Marriage and Family Therapy as a Source of Mental Health Treatment	5
Types of Clients and Problems Treated by Marriage and Family Therapists	7
Termination	8
Termination and Treatment Progress	11
Client Motivation and Impact on Treatment Progress	12
Termination Models	14
Research Questions	17
III. METHOD	19
Design	19
Sample	19
Instrument	20
Procedure	22
Coding Procedure and Data Examination	24
Ethical Considerations	25

IV. RESULTS	26
Differences and Similarities in Termination with Different Client Types	26
Plan for Future Problems	30
Review Goals	30
Summarize Treatment	31
Orientation to Termination	31
Review Skills/Resources	32
Empower Clients	33
Termination and Treatment Progress	33
Individual Successful and Individual Partially Successful	33
Couple Successful and Couple Partially Successful	34
Family Successful and Family Partially Successful	35
V. DISCUSSION	37
Conclusions	37
Research Question 1	37
Termination Model	38
Research Question 2	41
Implications and Limitations	43
Recommendations for Future Research	45
REFERENCES	46
APPENDICES	50
Appendix A. Sample Questionnaire	51
Appendix B. IRB Approval Letter	56

LIST OF TABLES

Table	Page
1 Demographic Summary of the Sample ($n = 40$)	21
2 Mean Percentage of Time Used per Therapy Model	22
3 Frequencies of Identified Steps in Terminating by Percentage of Cases for Individual Models	27
4 Frequencies of Identified Steps in Terminating by Percentage of Cases for Couple Models	28
5 Frequencies of Identified Steps in Terminating by Percentage of Cases for Family Models	29

CHAPTER I

INTRODUCTION

Since family therapy has emerged as a discipline in the mental health field and increased in popularity and maturity, great advancements have been made in family therapy research (Nichols & Schwartz, 1995). Numerous studies have been published that focus on outcome research in marriage and family therapy (Gurman & Kniskern, 1991; Nichols & Schwartz, 1995). Outcome research is concerned with what happens after therapy has been completed, for example, the number of clients achieving the goals of treatment or the effects of treatment on family functioning (Nichols & Schwartz, 1995). While there has been an increase in research that focuses on what happens after therapy, there has been little research done on what happens during therapy, including the specifics of the therapy process.

Termination is the concluding phase of therapy that is included in all the major schools of family therapy (Gurman & Kniskern, 1991). Few, if any, studies have examined the termination process of family therapy, more specifically, what is discussed in those last sessions and the possible effects termination may have on a client's future well-being. Treacher (1989) referred to termination as "a topic...almost missing from the family therapy literature" (p. 136). In the literature on termination, Epstein and Bishop (1981) offered the most cited conceptualization of the termination process (e.g., Barker, 1992; Gladding, 1995; Treacher, 1989). They recommended four steps in the termination or closure process: (1) orientation, (2) summary of treatment, (3) long-term goals, and (4)

follow-up. They make no differentiation of whether this process is for individuals, couples, or families. This conceptualization is based on a long-term behavioral model with a focus on change over time. With managed care becoming more predominant, however, therapists are encouraged to practice brief therapy ("The Marriage and Family Therapy Profession," 1998). Models of brief therapy, however, may not adhere very closely to the termination process conceptualized by Epstein and Bishop (1981). Therefore, there is a need to understand how termination is handled by therapists, many of whom practice in a managed care environment.

Nominal Definitions

For the purposes of this study, client(s) will be defined as *individuals, couples, or families* who are seeking therapy and will not be differentiated when talking about the client or clients. Termination can be broadly defined as the process of ending therapy, or more formally as "the process of relinquishing the relationship between the therapist and the family [or individual or couple] in a manner that encourages the family to maintain constructive changes and allows the family members to increase their ability to solve problems in the future" (Tomm & Wright, 1979, p. 228).

Conceptual Framework

Epstein and Bishop's (1981) model of termination most closely fits with a behavioral family therapy framework. This is mainly due to this theoretical orientation's

emphasis on teaching skills and fostering understanding so that families will be able to solve their own problems in the future and maintain changes over time (Nichols & Schwartz, 1995). Behavioral family therapy is usually equated with specific behavior-change strategies and is concerned with facilitating such changes in the home environment (Falloon, 1991). The termination model conceptualized by Epstein and Bishop (1981) is one of four macro-stages developed by the researchers to describe and conceptualize the specifics of the therapy process. According to their model, termination (or "closure," as the researchers call it) is a distinct phase of therapy that follows the assessment, contracting, and treatment stages.

This conceptualization of the therapeutic process differs from the more current brief models of family therapy. Termination from a brief therapy standpoint is conceptualized during the first few sessions. For example, from the solution-focused model of brief family therapy, one of the purposes of any interview after the first one is "figuring out whether or not improvements have led to things being 'good enough' so that further therapy is not necessary" (de Shazer, 1994, p. 135). Therapists that practice models of brief therapy "seek to pinpoint problems and conclude therapy as soon as specific, attainable therapeutic goals are met" ("The Marriage and Family Therapy Profession," 1998, p. 6). They generally try to work with clients to bring about the most change in the shortest amount of time possible, as well as give clients the tools necessary to work through problems on their own. Thus, models of brief therapy may not adhere very closely to the termination process outlined by Epstein and Bishop (1981). Given that

therapists may be practicing more from models of brief therapy, additional clarification is needed as to what they do to terminate therapy.

Problem Statement

Termination is a topic that, although stated as important, is largely ignored in the marriage and family therapy research literature. Given that managed care has become more predominant and more marriage and family therapists are practicing brief therapy, there is a need to understand how termination occurs. The purpose of this study was to explore the topic of termination and how marriage and family therapists terminate given different client types (i.e., individuals, couples, and families) and treatment progress.

CHAPTER II

REVIEW OF LITERATURE

Marriage and family therapy is a growing discipline and viable treatment option in the mental health field ("The Marriage and Family Therapy Profession," 1998). Despite the significance of termination within the therapeutic process, relatively little has been written regarding termination in the field of marriage and family therapy (Treacher, 1989; Wilcoxon & Gladding, 1985). Much of the literature on treatment termination focuses on *why* or *when* ending therapy may be appropriate, not on *how* to end therapy. This chapter will review how marriage and family therapy has become a main discipline in the mental health field ("The Marriage and Family Therapy Profession," 1998), the types of clients and problems that are treated by marriage and family therapists, what termination is and what is known about the process, how treatment progress can impact termination, how client motivation can impact treatment progress, the model of termination that has been identified in the literature, and the research questions posed in this study.

Marriage and Family Therapy as a Source of Mental Health Treatment

Therapies used by marriage and family therapists (MFTs) are based on the assumption that individuals and their problems are best seen in context, and the most important context is the family (Becvar & Becvar, 1996; "The Marriage and Family Therapy Profession," 1998). Marriage and family therapy is one of the fastest growing

mental health disciplines and is recognized by the National Institutes of Mental Health (NIMH) as one of the five core mental health disciplines (along with psychiatry, psychology, social work, and counseling) ("The Marriage and Family Therapy Profession," 1998). Since marriage and family therapy emerged as a discipline in the mental health field, it has grown immensely in popularity and maturity. The number of MFTs has grown "from an estimated 1,800 in 1966 to 7,000 in 1979 to more than 46,000 today" ("The Marriage and Family Therapy Profession," 1998, p. 6). In addition, the number of states licensing or certifying marriage and family therapists has more than tripled in the past decade ("The Marriage and Family Therapy Profession," 1998). Recent research suggests that marriage and family therapy is an effective form of mental health treatment in addition to demonstrating clinical effectiveness for treating a wide range of disorders (Doherty & Simmons, 1996; Pinsof & Wynne, 1995; "The Marriage and Family Therapy Profession," 1998).

Although marriage and family therapists see similar clientele (i.e., individuals, couples, and families) and do similar things in treatment as other mental health practitioners, they do so differently. They are trained in family systems and therefore focus on understanding the interaction patterns with family and friends as well as their clients' symptoms that may contribute to the problems presented. "MFTs will typically ask questions about roles, patterns, rules, goals, beliefs and stages of development. The MFT then works with the individual, couple and/or family to change interaction patterns

so that the problems can be solved” (“The Marriage and Family Therapy Profession,” 1998, p. 6).

Types of Clients and Problems Treated
by Marriage and Family Therapists

In an attempt to better understand and obtain national data about the professional practice patterns of marriage and family therapists licensed under the American Association for Marriage and Family Therapist, Doherty and Simmons (1996) surveyed clinical members across fifteen state divisions and presented their results in the Journal of Marital and Family Therapy. They reported that marriage and family therapists provide a broad range of clinical services to many client types, including individual (49.4%), couple (23.1%), and family (12%) (Doherty & Simmons, 1996). Other client types consisted of groups and combinations of treatment modes (15.5%). Similar results were found by Palmer (1998), who replicated this study for Utah marriage and family therapists. Palmer (1998) reported that Utah MFTs see about the same proportions of client types reported by Doherty and Simmons (1996), including individual (52.3%), couple (25.7%), and family (16.8%). Likewise, groups and combinations of treatment modes made up the rest of the client types (5.2%).

In addition, MFTs generally practice brief and cost-effective treatment, with 12 being the average number of sessions and about 65% of all cases completed within 20 sessions (Doherty & Simmons, 1996). It also was found that therapy with couples and

families is briefer than therapy with individuals, a finding that concurred with a previous study done by the same researchers on the clinical practices of MFTs in the state of Minnesota (Simmons & Doherty, 1995).

Finally, it has been found that MFTs treat a broad range of problems of individuals, couples, and families (Doherty & Simmons, 1996; Simmons & Doherty, 1995). Doherty and Simmons (1996) found that depression was the most prevalent presenting problem (43.9%), followed by other individual psychological problems (35.1%), marital problems (30.1%), and anxiety (21.1%). In addition, child and parent-child problems were found to comprise another significant set of issues with a combined frequency of 20.6%. These problems are similar to those treated by Utah marriage and family therapists (Palmer, 1998).

Termination

When a client seeks family therapy, there are some general stages that the client will move through over the course of treatment. Most therapists, regardless of what theoretical orientation they use to guide their thinking and interventions in treatment, follow the same general course: assessment, goal setting, intervention, evaluation, and termination (Gurman & Kniskern, 1991). Assessment has been defined by Filsinger (1983) as "the careful analysis of clients so that the appropriate strategy of helping them can be undertaken" (p. 15). Gurman and Kniskern (1991) described assessment as "the methods, whether formal or informal, used to gain an understanding of a particular

marriage's or family's style or pattern of interaction, symptomatology, and adaptive resources" (p. xvii). Thus, it is the process by which marriage and family therapists view the problem within its context.

Following assessment, the therapist and client move to goal setting, where "the nature of therapeutic goals and the process by which they are established" are formulated (Gurman & Kniskern, 1991, p. xviii). The intervention phase of therapy can be described as the phase where therapists utilize different techniques and strategies to bring about desired changes. Over time, the therapist evaluates how the client is progressing in therapy and whether they are making progress in the goals they set at the beginning.

Progress in family therapy moves in a circular direction. The potential for reaching new goals depends on the growth that has occurred previously. If one understands systems to be open and changing, it is hard to define the conclusion of family therapy simply in terms of accomplished goals, for the goals themselves may change over the course of therapy. (Nichols & Everett, 1986, p. 266)

Nevertheless, there comes a point when it is time to end therapy, and the process of doing so is called *termination*.

Termination has been defined as "the process of relinquishing the relationship between the therapist and the family in a manner that encourages the family to maintain constructive changes and allows the family members to increase their ability to solve problems in the future" (Tomm & Wright, 1979, p. 228). Although termination is part of

every therapeutic experience, whether planned or unplanned, little is known about this phase of therapy (Treacher, 1989; Wilcoxon & Gladding, 1985). Much of the literature on treatment termination focuses on why or when ending therapy may be appropriate and on unplanned termination.

The termination of therapy may be initiated by the therapist, the client, or by a mutual agreement between them. In some cases clients decide to terminate treatment on their own initiative. Sometimes the client discusses this option with his/her therapist, whereupon the therapist and client must determine if that is the best option. More often, however, the client initiates termination by failing to attend sessions or by not returning. This often results in "unplanned" or "premature" termination (Barker, 1992; Hanna & Brown, 1995; Nichols & Everett, 1986). Clients who prematurely terminate therapy or who "drop out" are described by Acosta (1980) as "those who leave therapy without informing the therapist or who fail to return without the therapist's consent or advice" (p. 435). It has been estimated that over 50% of clients who receive marital and family therapy have unplanned terminations (Allgood, Parham, Salts, & Smith, 1995; Talmon, 1990). In these instances, the therapist often believes that the family may not have attained the outcome goals of better and more effective functioning. In addition, clients with unplanned therapy terminations usually do not improve their relationships (Allgood, et al., 1995). Clients who prematurely leave therapy have traditionally been regarded by therapists as treatment failures and as having shown little or no improvement (Acosta, 1980). A sizable portion of clients do drop out, and because there are no outcome studies

of them, dropouts are generally considered treatment failures.

Talmon (1990), on the other hand, has argued that those who never return for subsequent sessions following an initial session may have already gotten out of therapy what they came for. He discussed the importance of single-session therapy, which he defines as "one face-to-face meeting between a therapist and a patient with no previous or subsequent sessions within one year" (p. xv). These single therapeutic encounters, Talmon (1990) has claimed, may be suitable for the client: "Regardless of the determined purpose of the first session or the therapist's expectations as to the necessary length of therapy, patients take something out of the first session and often decide that it is sufficient for them at that time" (p. 17). Thus, although therapists may consider unplanned termination to be unsuccessful because of only partial success in meeting treatment goals, Talmon (1990) has suggested it may be that clients have sufficiently met their goals at that time.

Termination and Treatment Progress

The therapist may wish to terminate treatment for a number of reasons. One reason is that the client's goals have been met (Barker, 1992; Hanna & Brown, 1995; Nichols & Everett, 1986; Todd, 1986; Tomm & Wright, 1979). When client goals have been met, usually the changes that were sought through treatment have occurred. Achieved change may take the form of maintaining learned behaviors, or developing and using new skills, often relating to communication, problem-solving, or conflict management.

A second reason the therapist may wish to terminate therapy is that the client has moved to a point where functioning has improved and additional therapy will not be a significant benefit, even if the objectives originally specified have not been met (Barker, 1992; Nichols & Everett, 1986). This implies that outside help is no longer needed and that the client is now able to deal with the problems he/she faces with his/her own resources. Finally, the therapist may wish to terminate treatment when therapy proves ineffective or continuing may not be worth the time and effort of the therapist or client (Barker, 1992; Nichols & Everett, 1986).

However therapy is terminated, there are indications that a planned termination, where it is handled in a systematic and negotiated way, is the ideal, although there is no empirical support (Gladding, 1995; Nichols & Everett, 1986). Tomm and Wright (1979) discussed the importance of concluding treatment constructively in stating that the therapist should "realize that the impact of the therapist will continue after termination and that family members will be more receptive to future professional intervention, should it end constructively" (p. 249). By concluding in such a manner, it is hoped that termination will provide for continued positive change on the part of the family. Little, however, is known about the specifics of the termination process of therapy and whether treatment progress influences how clients are terminated.

Client Motivation and Impact on Treatment Progress

An important factor when considering treatment progress is what type of client-

therapist relationship exists, as well as the degree of cooperation and motivation of the clients. Motivation has been defined by Miller and Rollnick (1991) as “a state of readiness or eagerness to change, which may fluctuate from one time or situation to another” (p. 14). The solution-focused approach of family therapy conceptualizes the therapeutic relationship into three types based on the nature of the interaction between therapist and client: customer-type (high motivation and ready for change), complainant-type (low motivation and complaints about problems with no indication of readiness for change), and visitor-type (low motivation and no awareness of problem) (Berg & Miller, 1992).

These authors suggested that it is best to have a *customer-type* relationship, which exists “when either during or at the end of a treatment session, a complaint or goal for treatment has been identified jointly by the client and therapist,” as well as “when the client indicates that he/she sees himself/herself as part of the solution and is willing to do something about the problem” (p. 22). This is consistent with the client being motivated and ready to take action, or as Prochaska, DiClemente, and Norcross (1992) stated, “[when clients are ready to] modify their behavior, experiences, or environment in order to overcome their problems” (p. 1104). Thus, an important factor when considering treatment progress and the subsequent influence on termination is the degree of cooperation and motivation that exists on the part of the clients and in the therapeutic relationship in achieving treatment objectives.

Termination Models

Treacher (1989), noting that there is little about termination in the literature, especially in the literature on the structural model of family therapy, has proposed that, at the point of termination, the following questions should be asked by the structural therapist:

- (1) What has happened to the presenting problem? Has it disappeared, or reduced to a level which is now considered acceptable, or been reframed so that it is no longer seen as a problem?
- (2) What structural changes have taken place, i.e., have family relationships changed in demonstrable ways?
- (3) What changes have taken place in individual and family beliefs, particularly those concerned with the problems discussed in therapy? (p. 142).

Treacher (1989) also described a way of operationalizing these questions. A problem area is first explored in detail to establish what changes have occurred. The family (client) is then asked what they will do if a similar problem occurs, for example with a different family member.

A more popular and much more cited termination process in the literature appears to be the process described by Epstein and Bishop (Barker, 1992; Epstein & Bishop, 1981; Gladding, 1995; Treacher, 1989). They recommended four steps in the termination or closure process: (1) orientation, (2) summary of treatment, (3) long-term goals, and (4)

follow-up, with no distinction of whether this process was conceptualized for a particular clientele (i.e., individuals, couples, or families). In the first step, orientation, the therapist brings up the subject of termination. This may be because the family expectations with which therapy was started have been met, or because the contracted number of sessions will soon be reached. Hanna and Brown (1995) stated the importance of planning for termination in advance by saying that "the therapist should be careful not to withdraw abruptly, because in such cases the problem behavior returns to pretreatment level" (p. 223). It is also advised to gradually withdraw therapy, especially if clients are unsure that they can maintain the changes they have made. Todd (1986) discussed this withdrawal process as follows:

As therapy begins to be successful in achieving the agreed-upon goals, the sessions are usually spaced at wider time intervals, such as moving to alternate weeks and progressing to once a month. This allows the spouses [clients] to do more of the work themselves and helps ensure that they can maintain the changes without the therapist. (p. 81)

Thus it is important that the therapist go through this gradual orientation step of termination.

After the client has become oriented to the fact that therapy will be ending, the client and therapist review what has happened during treatment. This is the second step, summary of treatment, in the termination process. The therapist can be the chief spokesperson during this review, or both the therapist and client can take equal

responsibility for summarizing what has occurred during treatment. This is indicative of the expert position versus the coach/facilitator role of the therapist. Barker (1992) pointed out that termination is often better accomplished if the client is able to see the extent of the changes that have occurred, as well as the effort they have put forth to make those changes. In addition, it is suggested that if clients believe that they have been responsible for the changes they have made over the course of treatment, they are likely to be more confident in their ability to handle problems in the future (Barker, 1992; Hanna & Brown, 1995; O'Hanlon & Weiner-Davis, 1989).

The third step is the discussion of long-term goals. The discussion of long-term goals provides a process through which families can be helped during termination to avoid, anticipate, or modify potentially distressing situations (Barker, 1992; Epstein & Bishop, 1981; Gladding, 1995). Clients are also able to identify how they will recognize if things are going well or badly and what they will do if the latter occurs. It may also be helpful during this stage to do some relapse prevention by helping the client decide when they may need to return to therapy by asking such questions as, "What would each of you have to do to bring the problem back?" (Tomm & Wright, 1979) and "What would be the first sign that you can no longer handle this problem?" (Hanna & Brown, 1995). By raising these questions, the therapist and client are able to explore and identify strengths and resources the family may have and which might be helpful to the client in the future.

The final stage in the termination process outlined by Epstein and Bishop (1981) is follow-up. This stage is optional, but it gives the idea that therapy is a never-ending

process, an assertion Nichols and Everett (1986) describe as being "open-ended."

A popular and alternate way to view termination is advocated by therapists practicing brief therapy. They suggest that termination begins as early as the first few sessions and that if things are better and "good enough," termination can occur (de Shazer, 1994).

Thus, although termination is part of every therapeutic experience, whether planned or unplanned, little is known about this phase of therapy. Much of the literature on treatment termination focuses on why or when ending therapy may be appropriate, such as family goals have been met, that therapy is not working, or that continuing it is not worth the time and effort of the family or therapist. There is little written, however, on the actual specifics of the termination process. Although not empirically based, Epstein and Bishop's (1981) four stage model of the termination process is the closest that there is in the literature to identifying the specifics of termination. However, they give no indication of whether this process was conceptualized for a particular clientele (i.e., individuals, couples, or families). There is a need to better understand the termination process and how therapists terminate when practicing in an age of managed care.

Research Questions

Given that there is little known about the termination process in the field of marriage and family therapy, this study attempted to break new ground by better understanding the topic of termination. In addition, this study attempted to determine if

the termination model conceptualized by Epstein and Bishop (1981) is used in today's predominant context of brief therapy, or if there is a need to identify a new model of termination. This study posed the following research questions:

1. Given that MFTs see individuals, couples and families, are there differences and similarities across client types in regard to how therapy is terminated?
2. Does termination differ in regard to treatment progress (i.e., clients have been completely or partially successful in meeting the specified treatment objectives)?

CHAPTER III

METHOD

Design

This research was exploratory in nature. Miller (1986) suggested that "the purpose of exploratory research is to generate ideas about, and insights into, a relatively little understood issue" (p. 31). Therefore, the study was exploratory in that it was an attempt to better understand, develop, and organize a conceptualization of the termination process, which is lacking in the field of marriage and family therapy.

Sample

The sample for this study consisted of single-licensed marriage and family therapists ($n = 40$) in the state of Utah who belonged to UAMFT (the Utah Association for Marriage and Family Therapy), the professional association for the field of marriage and family therapy in Utah. In order to distinguish between those who identify themselves solely as marriage and family therapists and those who identify themselves as some other mental health practitioner, only those who were single-licensed and professionally identified as marriage and family therapists were included in the sample. This eliminated those who were "grand-fathered" into the MFT field and who may practice marriage and family therapy, but who may also be licensed in another field, such as psychology or social work.

The majority of the participants identified themselves as Caucasian males with Ph.D.s who work in private practices (see Table 1). The mean age was 49.26 years ($SD = 7.89$), while the mean number of years practicing MFT was 14.56 ($SD = 8.36$). The majority of participants identified the solution-focused and cognitive-behavioral models most often used in their practice (see Table 2). Models from Table 2 that are considered models of brief therapy in the marriage and family therapy field include solution-focused, strategic, and narrative, constituting about 42% of the therapies used (see Table 2). Thus, it appears that therapists are practicing brief therapy over 40% of the time.

Instrument

Inasmuch as marriage and family therapists provide services to many client types, (i.e., individuals, couples, and families), and given that client progress may influence termination, a questionnaire was designed which asked the participants to identify, as closely as possible, the steps they would follow to terminate six scenarios that differed in client type and treatment progress. They were asked how they terminate given a client type and whether the client had been completely successful or only partially successful in meeting specified treatment objectives. The question structure was open-ended, which is defined by Dillman (1978) as "...questions [that] have no answer choices from which respondents select their response. Instead, the respondents must 'create' their own answers and state them in their own words" (p. 86). Open-ended questions are

Table 1

Demographic Summary of the Sample (n = 40)

Variable	Number	Percentage
Gender		
Male	28	70.0
Female	12	30.0
Ethnicity		
Caucasian	40	100.0
Degree		
Ph.D.	22	55.0
M. A.	7	17.5
M. S.	6	15.0
Ed.D.	2	5.0
D. S. W.	2	5.0
M. Ed.	1	2.5
Work setting		
Private practice	22	56.4
Mental health	7	17.9
Education	6	15.4
Other	3	7.7
Inpatient Tx center	1	2.6
Missing	1	2.5

Table 2

Mean Percentage of Time Used per Therapy Model

Model	M	SD	n
Solution-focused	25.94	25.27	40
Cognitive-behavioral	23.90	24.45	40
Other	11.38	28.89	40
Strategic	11.05	14.55	40
Experiential	9.10	15.36	40
Structural	8.30	11.86	40
Narrative	5.48	11.29	40
Intergenerational	5.11	7.54	40

“indispensable for exploratory studies in which the researcher’s main purpose is to find the most salient aspects of a topic...” (Dillman, 1978, p. 87). Thus, open-ended questions were the preferred choice for the instrument.

Procedure

The procedure for data collection followed that outlined by Dillman (1978). The study began by sending the questionnaire, along with a cover letter to all those single-licensed marriage and family therapists in the state of Utah ($N = 113$), who were identified from the membership records of the Utah Association of Marriage and Family Therapy.

The cover letter described the purpose of the study, why the study was important,

and asked for their participation. Three forms of the questionnaire (A, B, and C) were constructed. The first page of all the forms asked the respondents demographic information. The next three pages of the questionnaire focused on how therapists terminate with clients who are individuals, couples, and families and how treatment progress may influence the process. Form A asked about individuals first, followed by couples and families. Form B asked about couples first, followed by families and individuals. Form C asked about families first, followed by individuals and couples (see Appendix A). This was done in an attempt to counterbalance the possibility that termination would not differ among client types and the respondent only answering the first page of the questionnaire. Thirteen (32.5%) completed form A, 14 (35%) completed form B, and 13 (32.5%) completed form C. Thus, no version of the questionnaire was predominant over any other. A stamped return envelope, addressed to the researcher, was also enclosed.

Of the original 113 therapists in the sample, 13 were eliminated because they had either moved out of state or were no longer practicing marriage and family therapy. Ten responses were received before the postcard reminder was sent one week later. The postcard reminder was sent to everyone, which served "as both a thank you for those who have responded and as a friendly and courteous reminder for those who have not" (Dillman, 1978, p. 183). Between the postcard reminder and the next mailing, 24 questionnaires were received. Three weeks after the first mailing, a second and final follow-up letter and replacement questionnaire were mailed to nonrespondents. Only six

additional questionnaires came back, giving a final response rate of 40%, or 40 of the eligible 100 therapists. According to Doherty and Simmons (1996), this response rate "is typical for questionnaires sent to professionals" (p. 12).

Coding Procedure and Data Examination

Because the nature of the study was exploratory, Miller (1986) has suggested keeping it "flexible in order to pursue leads and procedures that emerge in the process of investigation" (p. 32). After the data were collected, a list was generated for each client type and progress level (e.g., individual successful and couple partially successful) from those responses given and identified by the respondents on the questionnaires. From there, each termination step was coded and entered into the SPSS statistical computer program. The data examination first consisted of running frequencies of the identified steps for each of the six scenarios: individual successful, individual partially successful, couple successful, couple partially successful, family successful, and family partially successful. However, because many of the original responses were describing the same process but using theory specific descriptions, the data were transformed and recoded, combining the responses that were similar enough to form a broader, more general category. For example, the responses "review/evaluate original treatment goals," "review/evaluate progress," "discuss goal maintenance," and "discuss any possible further concerns" all refer to reviewing and/or evaluating treatment goals. Therefore, these original responses were combined to form the more general category of "review goals." Thus, all the

original steps identified by the participants that fit together were grouped to form a new, more general step of termination that encompassed the general process of all those responses included. Frequencies were then run on the transformed data, again for each of the six different scenarios. Lastly, the data examination included looking for common patterns in an attempt to generate a working model of how termination occurs.

Ethical Considerations

This study was classified as minimal risk under the guidelines for the Protection of Human Subjects developed by the Department of Health and Human Services. Since the therapists were reporting their mode of practice, there was no element that could potentially pose any sort of threat to either the clients or the therapists. Participation in the study was completely voluntary. A research proposal was submitted, reviewed and approved by the Utah State University Internal Review Board (see Appendix B).

CHAPTER IV

RESULTS

The purpose of this study was to explore and better understand the topic of termination in the field of marriage and family therapy, as well as to generate a working model of termination applicable to those who may be practicing MFT in an era of managed care. This section will discuss the major findings of the study based on the two research questions presented earlier.

Differences and Similarities in Termination with Different Client Types

The intent of the first research question was to determine if marriage and family therapists differ in terminating individuals, couples, and families. It appears from looking at Tables 3 through 5 that, for the most part, therapists generally terminate individuals, couples, and families in a similar manner. The six main points for termination, regardless of client type, were found to be: (1) plan for future problems, (2) review goals, (3) summarize treatment, (4) orientation to termination, (5) review skills and resources, and (6) empower clients. In addition, a few therapists either administer or review some sort of standardized test across the client types that reflects change. Whereas these main categories were found to make up the termination process, they are not necessarily sequential in order. Although these six main categories are present in the termination

Table 3

Frequencies of Identified Steps in Terminating by Percentage of Cases for
Individual Models

Identified steps	Individual	
	Successful	Partially successful
Plan for future problems	73.7	78.9
Goal review	68.4	61.5
Summarize	60.5	44.7
Orientation (Process readiness for termination)	55.3	47.4
Skills/resources	42.1	34.2
Empower/congratulate/ celebrate progress	26.3	26.3
Standardized tests	13.2	7.9
Assess suicide	5.3	5.3
Review/assess for possibility of medication	5.3	7.9
Accuracy of assessment	0.0	2.6
Assess for hospitalization	0.0	2.6

Table 4

Frequencies of Identified Steps in Terminating by Percentage of Cases for
Couple Models

Identified steps	Couple	
	Successful	Partially successful
Plan for future problems	76.3	86.8
Goal review	68.4	39.5
Summarize	68.4	44.7
Orientation (Process readiness for termination)	50.0	31.6
Skills/resources	34.2	36.8
Empower/congratulate/ celebrate progress	31.6	26.3
Standardized tests	7.9	7.9
Process change	0.0	55.3
Share how they have affected me	5.3	0.0
Stress accountability	2.5	7.9
Assess for individual issues	0.0	2.6

Table 5

Frequencies of Identified Steps in Terminating by Percentage of Cases for
Family Models

Identified steps	Family	
	Successful	Partially successful
Plan for future problems	72.2	77.8
Goal review	69.4	39.5
Summarize	63.9	42.1
Orientation (Process readiness for termination)	41.7	28.9
Skills/resources	41.7	28.9
Empower/congratulate/ celebrate progress	25.0	21.1
Standardized tests	5.0	5.3
Process change	0.0	55.3
Share how they have affected me	2.9	0.0
Stress accountability	0.0	5.3
Inform referral source	2.9	2.6

process regardless of client type, a few differences were found in the original responses that were combined to form these categories.

Plan for Future Problems

The first category, plan for future problems, refers to those steps that therapists identified that apply to planning for problems that may occur later down the road. The original common steps that were combined to form this category and that were found in all the models include: (1) discuss relapse prevention, (2) establish follow-up, (3) leave with an "open-door" policy, (4) have client practice relapse and self-recovery, (5) provide psycho-education, and (6) suggest biblio-therapy. Although these were the common steps identified across each model, other unique steps in the models that were also identified as belonging to the category "plan for future problems" include the following: (1) possible referral to individual therapy, (2) have each partner practice relapse prevention, (3) refer if necessary, (4) suggest good parenting books, (5) process with them their family and extended family dynamics, (6) possible referral to inpatient facility, and (7) possible referral to a more intensive treatment. It is interesting to note that some sort of possible referral is mentioned in most of the partially successful models.

Review Goals

The second category, goal review, refers to those steps that therapists identified that apply to going over and evaluating treatment goals. The combined original common steps to form this category that were found across all the models include: (1)

review/evaluate original treatment goals, (2) review/evaluate progress, (3) discuss goal maintenance, and (4) discuss any possible further concerns. Although these were the common steps identified, additional unique steps in the models, also identified as belonging to the review goals category, include the following: (1) try to bring in significant others to review progress, (2) have couple discuss together what processes helped them meet their goals, (3) review changes that couple has made together and individually, (4) conduct individual and conjoint sessions to assess the original treatment goals, and (5) review changes the family has made together and individually.

Summarize Treatment

The third category, summarize treatment, refers to those steps that therapists identified that apply to reviewing the client's treatment. The original common steps that were combined to form this category and that were found in all the models include: (1) review/summarize what has been learned and how it was learned, and (2) ask what the client has gained from therapy.

Orientation to Termination

The fourth category, orientation to termination, refers to those steps that therapists identified that apply to planning for termination ahead of time. The original steps that were joined together to form this category and that were found in all the models include: (1) orientation (bring up ahead of time/process readiness), (2) discuss termination in first and all sessions (are we there yet?), (3) discuss/process issues around fears of

termination/therapeutic relationship, (4) at the outset, contract session number and/or ask how they will know when they are done, and (5) space sessions further apart and continue to evaluate progress. Although these were the steps identified across each model, one other unique step found in the couple models included meeting separately with each partner and processing his/her thoughts about terminating.

Review Skills/Resources

The fifth category, review skills/resources, refers to those steps that therapists identified that apply to going over those skills and resources the client may have gained during and throughout therapy. The original common steps combined to make up this category and that were found across all the models include: (1) review coping strategies, (2) review strengths/skills/tools learned, (3) plan for future with skills and resources gained through treatment, and (4) assess and/or link the client with support system. Although these were the collective steps identified in each model, additional distinguishing steps in the models that were also identified as belonging to the review skills/resources category include the following: (1) encourage client to keep a journal of "successful days" for troubling times, (2) help client with a checklist of balanced life-style traits that they can review on own, (3) encourage them to keep doing what works, (4) link with other couples, (5) encourage continuation of success, (6) ask what advice parents and adolescent would give other parents and teens, (6) link adolescent with an adult he/she trusts to provide follow-up interaction, (7) link parents with parent support group, (8) set up aftercare sessions with the family's ecclesiastical leader, and (9) give written lists of

problem-solving steps as a reminder of how they (family) did it.

Empower Clients

Finally, the sixth category, empower clients, refers to those steps that therapists identified that apply to helping their clients recognize the progress they have made as well as increase their confidence to deal with future problems. The combined original steps that form this category and that were found in all the models include: (1) celebrate progress, and (2) empower clients/express confidence/applaud/congratulate. Although these two steps were identified across each model, other interesting steps in the models that were also identified as belonging to the empower clients category include the following: (1) give teen credit for attending therapy, (2) celebration ritual for achievement, and (3) applaud family change.

Termination and Treatment Progress

The intent of the second research question was to determine if termination differed with how well the client met the specified treatment objectives, that is, whether the client was completely successful or only partially successful.

Individual Successful and Individual Partially Successful

As seen in Table 3, there appears to be little difference in how individuals are terminated with regard to treatment progress. Tables 3 and 4 are virtually identical, the only difference being one therapist in the partially successful model checking the accuracy

of his/her assessment and assessing for the possible need to hospitalize his/her client. Thus, the idea that treatment progress may influence termination was not supported in the case of individual clientele.

Couple Successful and Couple Partially Successful

As seen in Table 4, it seems that couples, like individuals, are terminated similarly regardless of treatment progress with the exception that in the partially successful model, 55% of the therapists include a step labeled "process change" (see Table 6). Included in this category were the following original identified steps: (1) go over goals that were successful and those only partially met, (2) process reasons for termination with only partial success, (3) reevaluate goals and determine reasons for lack of progress, (4) ask to recommit on problem areas or settle for partial success, (5) discuss a plan for increasing progress in areas of need, (6) validate the work done and suggest that relationship change is ongoing, (7) assess the accuracy of assessment, (8) have clients identify factors that contribute to partial success and impede full achievement, (9) be respectful of clients' wish to terminate now, (10) challenge clients to return to treatment "when ready," (11) discuss consequences for terminating treatment at this time, (12) look at and/or process areas of resistance, and (13) discuss the difficulty of change. Other differences include, in the successful model, one therapist sharing with the clients how they have affected him/her as a therapist, while in the partially successful model, one therapist assessing for individual issues. Thus, for couple clientele, it appears that the idea that treatment progress may

influence termination is supported from these results. According to the results presented, termination does differ with those that are completely successful and those that are only partially successful in meeting the specified treatment objectives. For those with only partial success, marriage and family therapists appear to add the important dimension of processing change to termination.

Family Successful and Family Partially Successful

As seen in Table 5, it seems that families, like individuals and couples, are terminated similarly regardless of treatment progress, with one exception. As with couples, 55% of the therapists include a step labeled "process change" in the termination process with families only partially successful in goal completion (see Table 8). Included in this category were the following original steps: (1) go over goals that were successful and those only partially met, (2) use circular questioning to assess/evaluate progress, (3) reassess joining and the therapeutic relationship, (4) reassess treatment goals to make sure you are dealing with the right person's goals, (5) discuss a plan for increasing progress in areas of need, (6) assess the accuracy of assessment, (7) have clients identify factors that contribute to partial success and impede full achievement, (8) be respectful of clients' wish to terminate now, (9) challenge clients to return to treatment "when ready," (10) discuss consequences for terminating treatment at this time, and (11) discuss the difficulty of change. Other differences include, in the successful model, two therapists stressing accountability to each, while in the partially successful model, one therapist sharing with

the couple how the family has affected him/her as a therapist. Thus, like couples, it appears that termination does differ with those that are completely successful and those that are only partially successful in meeting the specified treatment objectives, supporting the idea that treatment progress may influence termination. Again, for those families with only partial success, marriage and family therapists appear to add the important dimension of processing change to termination.

CHAPTER V

DISCUSSION

By using data collected from marriage and family therapists in the state of Utah, this study explored the process by which marriage and family therapists terminate treatment. This section uses the results to develop a series of conclusions related to the research questions this study set out to explore. In addition, implications, limitations, and recommendations for further research are discussed.

Conclusions

Research Question 1

Because Epstein and Bishop (1981) gave no indication of whether their model of termination was conceptualized for a particular clientele (i.e., individuals, couples, or families), this study questioned whether termination was different for individuals, couples, and families. Thus, the intent of the first research question was to determine what differences and similarities exist across client types in regard to how therapy is terminated. Although not sequential, the data suggest that marriage and family therapists terminate individuals, couples, and families in a similar manner using six main steps: (1) plan for future problems, (2) review goals, (3) summarize treatment (4) orientation to termination, (5) review skills and resources, and (6) empower clients. In addition, a few therapists either administer or review some sort of applicable standardized test across the client types that reflects the measured change. Thus, there appears to be little difference in the

termination process with different client types. This may be due to the fact that marriage and family therapists have working internal models that are consistent regardless of whether they are working with an individual, couple, or family. Although the data indicate these six main categories are present in the termination process regardless of client type, a few differences were found in the original steps that were combined to form these categories as presented earlier in the results section.

Termination Model

One of the objectives of this study was to determine if the termination model conceptualized by Epstein and Bishop (1981) is used in today's predominant context of brief therapy, or if there is a need to identify a new model of termination. In the literature review presented in Chapter II, an assertion was made that models of brief therapy may not adhere closely to the termination process outlined by Epstein and Bishop (1981). Of those marriage and family therapists who responded to this study, none identified themselves as model purists (those who use only one model all the time). Rather they appear to be eclectic in their practices, using many therapies, some classified as brief and some not. The sample identified using models of brief therapy 42% of the time (see Table 2). Thus, although these therapists are practicing brief therapy at least 40% of the time, it appears that the process of termination is quite similar to the process Epstein and Bishop (1981) have outlined.

Although not empirically based, Epstein and Bishop (1981) recommend four steps in the termination process: (1) orientation, (2) summary of treatment, (3) long-term goals,

and (4) follow-up. The results of this study generated a model of termination that consisted of six steps: (1) plan for future problems, (2) review goals, (3) summarize treatment, (4) orientation to termination, (5) review skills and resources, and (6) empower clients. These six steps are very similar to those presented by Epstein and Bishop (1981); however, the findings of this study add greater clarification and depth to this already conceptualized process of termination.

The "orientation" step of this study is very similar to that recommended by Epstein and Bishop (1981). Both refer to bringing up the idea of termination in advance and planning ahead for it, as well as gradually withdrawing by spacing sessions farther apart. Further clarification is given to this step by the results of this study. It was found that in addition to just bringing up the idea of termination ahead of time, orientation consists of such things as discussing termination in the first and subsequent sessions, as well as discussing and processing with the client issues around fears of terminating and/or ending the therapeutic relationship. Lankton and Lankton (1983) have said that "the termination of a therapy session, as well as the termination of the entire therapy relationship, has special meaning to clients" (p. 345). Indeed, a significant aspect of therapy is the therapeutic relationship that is formed between therapist and client. It has even been suggested and supported with empirical evidence that the therapeutic alliance has more impact than the theoretical orientation of the therapist (Nichols & Schwartz, 1995). Thus an important part of orientation, as suggested by the results of this study, consists of discussing fears the client may have of terminating and/or of ending the therapeutic

relationship.

The "summarize treatment" step of this study is also quite similar to the second step of Epstein and Bishop's (1981) process of termination. Both consist of basically recounting what has occurred during treatment. Again, greater clarification has been gained through this study by defining some of those things that constitute "summarization." Results show that the step of "summarize treatment" includes reviewing and summarizing what has been learned, as well as how the client was able to learn it. In addition, the step of "review goals" found in this study would also fit under the "summary of treatment" step of Epstein and Bishop's (1981) process. The steps therapists identified as using in this study that constitute "review goals" are such things as, review and evaluate the original treatment goals and progress, how the client can maintain the success of their achievement, and discussing the possibility of any further goals, all of which seem to fit with Epstein and Bishop's step of summarizing treatment.

The "plan for future problems," "review skills/resources," and "empower" steps found in this study all seem to fit with Epstein and Bishop's (1981) step, "long-term goals." Again, greater clarification of this step was given through the results of this study. These steps all have to do with helping the client identify those things which may cause problems down the road, as well as reviewing and identifying strengths and resources gained throughout treatment that will help them deal with future problems, increasing their confidence to do so on their own. Empowering the clients through the use of compliments or what the solution-focused approach calls "cheerleading" or "positive blame" (Berg &

Miller, 1992) throughout the treatment process and in termination can be a powerful tool. Barker (1992) believes that "it is important to affirm families as treatment is terminated" (p. 256). He also likes to express confidence in their ability to continue to make necessary changes through statements such as "You've done well during treatment, and I believe you know what you have to do in the future, and how to set about making any further changes you want," stressing the importance that the family believes they are responsible for their progress and achievements (Barker, 1992, p. 256).

Finally, Epstein and Bishop's (1981) last step, "follow-up" can be found in this study's termination model in the step of "plan for future problems." Because a potential future problem may require the client to seek treatment again, the original step of "establish follow up" was grouped under the broader category, "plan for future problems." Thus, Epstein and Bishop's (1981) model of termination is very similar to the model generated by the results of this study. Not only did the results of this study produce a similar termination model, but also added greater depth and clarification to the seemingly vague steps outlined by Epstein and Bishop (1981).

Research Question 2

The intent of the second research question was to determine whether termination differed in regard to treatment progress (i.e., clients have been completely or partially successful in meeting the specified treatment objectives). Interestingly, examination of the data suggests that treatment progress may influence termination for couples and families, but not for individuals. It was found that, despite treatment progress, there is little

difference in how marriage and family therapists terminate individuals. For those individuals with only partial success, one therapist assesses the accuracy of the assessment and one assesses for the possibility of hospitalization.

For couples and families, however, it was found that 55% of the marriage and family therapists add the step "process change" in the termination process for these clientele who were only partially successful in meeting the specified treatment objectives. As the results above indicate, this dimension of the termination process for partially successful couples and families includes those things that the therapist may do which challenge the client to reflect on their decision to end therapy at this time, while respecting their decision to do so.

Tomm and Wright (1979) recommend that whenever termination with only partial success is a possibility, the therapist should take certain steps. These include considering what problems remain and what goals have not been achieved, assessing why the family is inclined toward termination, and looking especially for any evidence that there is serious danger of deterioration if treatment stops at the current stage (Tomm & Wright, 1979); all of these suggestions correspond with the "process change" step of the termination model generated from the results of this study.

Thus, according to the results, therapists who participated in this study are more concerned about the possibility of couples and families ending treatment with only partial success than about individuals. It is interesting to note that even though individuals comprise the largest of Utah clientele of marriage and family therapists (Palmer, 1998),

respondents failed to identify the step of "process change" as important in the process of termination with individuals. It is possible that marriage and family therapists just have higher expectations than are realistic for couples and families to progress and exceed in therapy.

Implications and Limitations

This study is valuable in that it explores the termination process in marriage and family therapy and gives therapists a working model of how they might terminate therapy with their own clients. It is also valuable in that it may be the first study which looks at what some marriage and family therapists actually do in the termination process. Epstein and Bishop (1981) offered a conceptualization of the process, but no practical evidence that the process is indeed what therapists are following to bring treatment to an end.

In addition, the study is beneficial because of the clarification and depth that it gives to the topic of termination and to the model generated from the results. Therapists may use this information to help guide the termination process and build a termination model of their own. Finally, the study is valuable because it added the dimension of treatment progress and how that may influence the termination process. Indeed, therapists may benefit from knowing that there is an important step to the termination process for at least couples and families terminating with only partial success (see Table 4 and Table 5).

Some limitations of this study should be kept in mind. The response rate was lower than desirable (only 40%), making generalizability to the population of MFTs in Utah

problematic. Dillman (1978) claims that by following his procedure for data collection, return rates should be in the 60 to 70% range. However, according to Doherty and Simmons (1996), the response rate attained in the present study "is typical for questionnaires sent to professionals" (p. 12). The small sample size limits the certainty or conclusiveness of the results. Although the sample was made up of mostly males (70%-- see Table 1), it is only slightly higher than the percentage of male marriage and family therapists in the state of Utah (66%, Palmer, 1998). Thus while the sample is slightly overrepresented with males, it is reflective of the Utah male marriage and family therapist population.

Another limitation is that the findings technically can be generalized only to marriage and family therapists in the state of Utah, not to all licensed marriage and family therapists nationwide. Perhaps the most significant limitation of this study is that because this was an exploratory study and the questionnaire consisted of open-ended questions, responses were not limited to prearranged alternatives. This left therapists to identify the steps they use without any fixed responses from which to choose. A potential limitation could be that they may do something in the termination process, but forget to identify it as a step, or give the politically correct response. In addition, open-ended responses made the categorization, management, examination, and interpretation of the data a major task of the researcher, making the study more subjective and nonempirical in nature, which may be seen as a limitation to the study.

Recommendations for Future Research

While this study has provided a beginning exploration into the topic of termination, additional research is needed to better understand the process of termination in marriage and family therapy. One suggestion for future studies is to build a fixed choice questionnaire from the results of this study and again survey therapists for what they do in termination. By providing a previously prepared questionnaire, more therapists might participate and fill out the questionnaire because they would not have to take as much time to think of and write out what they do. Future research should also continue to identify important steps that may differ by type of clientele and treatment progress.

In addition, therapists in other states and regions should be surveyed to give a more representative picture of licensed marriage and family therapists and permit a more generalizable termination model applicable to all practicing marriage and family therapists. Finally, future research should focus on those aspects of the termination process which may affect future client well-being and encourage the continuation of success over time. For example, by using a series of controlled studies, future research should determine which components, if any, of the termination process correlate with future client satisfaction and well-being.

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APPENDICES

Appendix A. Sample Questionnaire

ID _____

DEMOGRAPHIC PROFILE

Gender: _____ Female _____ Male

Age: _____

Ethnicity: _____ Hispanic _____ Caucasian
_____ African American _____ Other (please specify) _____Highest Earned Degree(s): _____ Ph. D. _____ M.S. _____ M.A. _____ Ed.D.
_____ M.S.W. _____ Other (please specify) _____

Number of years practicing MFT since terminal degree: _____

Primary Employment Context: _____ Private Practice _____ Mental Health
_____ Inpatient Treatment Center _____ Education
_____ Other (please specify) _____**List the percentage of time you use each of the following models:**

_____ Structural	_____ Behavioral
_____ Strategic	_____ Experiential
_____ Solution-Focused	_____ Narrative
_____ Intergenerational	_____ Other (please specify) _____
	_____ Total Percentage

ID _____

You have been seeing an *individual* that initially presented with depression. Identify and list as closely as possible the steps you would follow to terminate given that the client has been *completely successful* in meeting the specified treatment objectives.

You have been seeing an *individual* that initially presented with depression. Identify and list as closely as possible the steps you would follow to terminate given that the client has been *partially successful* in meeting the specified treatment objectives.

ID _____

You have been working with a *couple* that initially presented with marital problems. Identify and list as closely as possible the steps you would follow to terminate given that the clients have been *completely successful* in meeting the specified treatment objectives.

You have been working with a *couple* that initially presented with marital problems. Identify and list as closely as possible the steps you would follow to terminate given that the clients have been *partially successful* in meeting the specified treatment objectives.

ID _____

You have been working with an *adolescent and his/her parents* who initially presented with parent-child problems. Identify and list as closely as possible the steps you would follow to terminate given that the clients have been *completely successful* in meeting the specified treatment objectives.

You have been working with an *adolescent and his/her parents* who initially presented with parent-child problems. Identify and list as closely as possible the steps you would follow to terminate given that the clients have been *partially successful* in meeting the specified treatment objectives.

Appendix B IRB Approval Letter

VICE PRESIDENT FOR RESEARCH OFFICE
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INTERNET: [pgerity@champ.usu.edu]

July 13, 1998

MEMORANDUM

TO: Scot Allgood
Jennifer Childers

FROM: True Rubal, Secretary to the IRB

GR

SUBJECT: An Exploratory Study of the Termination Process in Marriage and Family Therapy

The above referenced proposal was reviewed and approved by the IRB. You may consider this letter to be your approval for your study.

Any deviation from this protocol will need to be resubmitted to the IRB. This includes any changes in the methodology of procedures in this protocol. A study status report (stating the continuation or conclusion of this proposal) will be due in one year from the date of this letter.

Please keep the committee advised of any changes, adverse reactions or the termination of this study. I can be reached at x71180.