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Premature termination in couple therapy as a part of therapeutic process. Cross case analysis

Joannna Jurek, Bernadetta Janusz, Martyna Chwal, Bogdan de Barbaro

Summary

Aim of the study: The paper presents the qualitative study of premature termination in couple therapy. The aim of the research was to answer why couples drop-out from couple therapy at the early stage of treatment.
Subject: To understand the complexity of this event the researchers decided to examine the phenomenon of early drop-out from three different perspectives, that is: from therapists and both spouses point of view.
Methods: The therapists and couples that ended the therapy prematurely were interviewed. Among examined drop-out cases, there were selected three which fulfilled the criteria for early drop–out. Data were analyzed according to the method of cross-case analysis.
Results. As a result common categories were singled out which were characteristic for those three cases of drop-out.
Discussion: The distinguished categories of 'the split of the working alliance' and 'the split of the therapeutic bond' show that the conflict which the couple brought to the therapy was reflected in their experience of the therapy and the therapist.
Conclusions: Premature termination in couple therapy is a part of therapeutic process.

couple therapy / drop-out / qualitative research / therapeutic process

INTRODUCTION

The problem of dropping out of therapy in the case of family therapy seems to be all the more important because – as shown by research – approx. 30% of families stop the therapy during the first three sessions [1]. The primary therapeutic approach used by surveyed therapists and researchers is a systemic approach that emphasizes the mutual feedback between all participants in the process [2, 3]. According to dialogical approach family and couple therapy is understood as an interaction of many participants who stay in constant dialogue [4–8]. Therefore, the study adopted the perspective of every participant of therapy - that is, family members and the therapist - assuming that the mutual interaction between those affected not only the course of therapy sessions, but also constituted the drop-out process. Drop out from therapy also has been defined using a pre-determined length of treatment [9]. This may occur if the therapeutic contract states that a family will attend sessions for a certain number of weeks or months, and fails to meet the agreement. However drop out has also occurred when clients terminate treatment without fulfilling their therapeutic goals, regardless of number of sessions or time spent in therapy [9-10], it does not distinguish between clients who have been in therapy for months without seeing improvement and those who failed to return after the first session.

Joannna Jurek, Bernadetta Janusz, Martyna Chwal, Bogdan de Barbaro: Family Therapy Department, Chair of Psychiatry, Jagiellonian University. **Correspondence address**: joanajurek@wp.pl

There exist a number of studies which show the connection of premature termination in couple and family therapy with the therapeutic process like: the importance of a constant therapeutic setting [11] or the role of therapeutic alliance from the first sessions [12]. In other studies of this kind, the drop-out is connected with the therapist's conviction about errors in the therapy [13–15] or about the lack of possibility of helping [16].

In presented study it was important to verify how therapeutic processes, as remembered by therapists, are perceived by them and by individual persons of the couple. In this analysis, drop-out is defined as a couple's failure to arrive at a previously scheduled session, and possibly the following ones. Investigating the phenomenon from the perspective of both: therapists and individuals gave an opportunity to describe the drop out cases from three distinct perspective.

MATERIAL AND METHOD

Study design

The aim of the research was to understand why couple drop out prematurely in particular therapeutic center. The main research questions were connected with the perceiving the reasons of premature termination of the therapy from both perspectives: the therapist's and members of the couple. Those reasons should be connected with therapeutic process.

According to this leading idea of the research those questions are:

1. How the couple therapist and both partners perceive the therapeutic process?
2. How the couple therapist and both partners perceive the therapeutic relationship?
3. How the couple therapist and both partners perceive the causes of drop-out?
4. In what way those perspectives relate to each other?

Firstly, the therapists pointed to the drop-out cases for which they were able to recall the basic elements of the therapeutic process, and then identified couples were asked to consent to participate in the study. Secondly the research procedure involved establishing contacts with families, whose therapeutic processes were remembered by the therapists, to obtain their consent to take part in the study. The first attempt involved sending a letter to each of the 7 families identified by the therapists. The letters contained a request to take part in a meeting with a researcher who was not part of the therapeutic team. Anonymity and full freedom regarding the place and date of the meeting were ensured. None of the families replied to the proposal to take part in the research sent by mail. The following stage of the study involved direct contact with the family by phone and making an appointment.

Participants

The convenience sample of 3 couples comes from research procedure. Couples who droped-out out after the first session were excluded as well as those whose one of the partners did not agree for the interview. Clients of the Therapeutic Center were the beneficiaries of public insurance, and mostly derived from the middle class with an average economic status. All couples came to therapy on their own will. All the three cases of this therapy were carried out in systemic paradigm, including the narrative and constructionist approaches. In the center under analysis, couples do not pay directly for the therapy but it is reimbursed by the basic insurance package, hence, financial difficulties, which are considered a drop-out risk [2] cannot be taken into consideration in this case. The waiting period for the therapy is long - on average approximately one year. All therapists working at the center participated in the study, 6 persons in total. Both clients and therapists were white and heterosexual.

Data collecting and analysis

The sources of data were: interviews with therapists as well as both partners and the therapy records. All details that can lead to disclosure of the client's identity were hidden. During the meetings semi-structered interviews were conducted separately. Questions of the interviews based on the previously existing research [9–10], [11–13], that underlined the importance of the therapeutic process and the attitude of the therapist toward the couple. The researchers decided to explore what kind of factors connected with the process and therapeutic relationship are possible to differentiate. The questions

were constructed according to this research idea (ex. the participants were asked to describe the therapist (cooperation, attitude), emotions he/she had aroused, what did they like or dislike about the therapy, if they experience a particularly strong emotional moments during the therapy, how do they understand reason of having stopped treatment). The interviews were recorded using a voice recorder after obtaining the subjects' consent. After conducting interviews with the couples, the second researcher conducted interviews with family therapists.

After the transcription two separate coders coded the data initially, on basic level, the third coder categorized all data on distinguish level within particular case. After the categorization process, the data from all cases were compared by three researchers. In the process of comparative analysis the main categories were singled out. Next, the qualitative analysis of the manifestations of the aforementioned phenomena in the area of the individual cases of discontinued therapy was performed and finally, using the method of cross case analysis [1] the individual cases were compared.

DATA

Case 1

Informal relationship for 5 years. The reasons of the treatment were frequent quarrels and misunderstandings, conflicts motivated by parental control concerning the man's contacts with the woman's children from the first marriage, problems with communication and conversations about emotions and mutual control. Areas of conflict were also woman's emotional instability and man's excessive focus on small things. Both had contact with therapy earlier, during family therapy they were also undergoing individual therapy. The woman that except for the physical area they have nothing in common but she was ready to check it out. The man often came back to the common moments that were a source of happiness for him.

Separation of basic concepts – categories within the case

The wife directly identified the problems with opening up due to the partner's presence, which was categorized as 'hardship in the process of therapy'. On the other hand, the husband identified involvement in the therapeutic process, regretting its interruption progress. The perspective of a therapist was closer to wife's perspective (category: 'disbelief in the existence of couple's bond'). This experience of therapy was reflected also in the fact that both the wife and the therapist did not see a turning point in the process of therapeutic consultation. The husband was the only one who noticed such point and named it as a turn from passivity to activity (category: 'a turning point from the perspective of one partner'). Family perceived the therapist as emotionally positive (category: 'positive emotions to the therapist'), in turn, the therapist did not explicitly disclose her emotional relationship to the family, but instead she tried to make an objective description of how they function in therapy (category: 'emotional distance in the description of the family').

Both partners pointed to the wife as the person who directly decided to discontinue the therapy. Due to that the husband believed that the lack of involvement of his wife in the process of therapy led to a drop out (category: 'cause placed in a partner'). The wife pointed to emotional difficulties between her husband and herself in the course of the therapy. The couple did not explicitly place the cause of drop-out on either in the process of therapy or in the person of the therapist, nevertheless they point out that either longer sessions or more frequent meetings might have resulted in desired change (category: 'not intensive enough process of therapy').

A significant factor on the side of the therapist seems to be lack of hope for the possibility of establishing common goals and the existence of the therapeutic process (category: 'lack of hope').

Case 2

Informal relationship, five-year probation before treatment. The woman reported couple to the therapy. As she reported - to seek outside help. She stressed that the problems are the lack of understanding and continuous partner's jealousy. Loneliness resulted in a commitment to a relationship of emotional bonds with another man. The man in turn, struggled with a sense of surveillance. Relations in the couple were difficult also because of the gentleman's accident which caused that he was bedridden for a few

weeks. There was a mutual dislike for each other and resentment concerning the amount of time spent together. The couple did not present any common areas for work, they were very distant from each other. The couple reported to the interview together, and described themselves as having a happy relationship.

Separation of basic concepts – categories within the case

There was a striking compatibility of partners in terms of a positive attitude to the therapist as well as the progress of the therapy process (categories: 'progress from the perspective of both', 'positive emotions to the therapist'). Similarly, they saw the cause of drop-out in improving relations as well as the lack of time to continue therapy (categories: 'the cause from outside the process, 'positive therapeutic effect'). The therapist saw the cause of drop-out in lack of motivation of the wife, wife's distancing, but she also saw that the pair moved away from each other during the therapy process, which seemed to do them good (categories: assigning a lack of motivation to one of the partners', 'a positive therapeutic effect').

Case 3

Pair currently divorced, the relationship for 17 years. Husband reported marriage to the therapy. He reported that the main reasons were the impact of generational families and difficulties in communication. Wife also saw problems in the functioning of the family. Her main complaint was neglecting the family by the husband for the religious community. During the therapy the other problems also came out like issues of mobbing at wife's work and the influence of her parents on family life. The subject matter, especially for the wife, was a divorce. She emphasized that they were going through the second, very serious marital crisis. Family problems affected her health – she was twice treated pharmacologically for depression. The only thing that prevented them from making a final decision on the separation were the kids, she thought that it would be unfair for them. She felt lack of hope for improvement in the relationship with her husband. In turn, the husband claimed that he failed in many areas and really wanted to make things right.

Separation of basic concepts - categories within the case.

What was striking in this case was the extremely different reception of the therapist by the wife and husband (in terms of emotions, and his or her professional skills) (category: 'pair difference in perception of the therapist'). The question arose how much it was connected with greater involvement of the husband in therapy and with wife's lack of belief that therapy could change something – (category: 'no hope of one of the partners'). The therapist had a similar perspective as to the commitment of both (category: 'assigning more motivation to one partner'). Both stressed the importance of openness during the therapy . The therapist saw the cause of drop-out in her too early intervention - confronting wife with her family of origin (category: 'premature therapist's intervention'). The husband and wife saw the same reason (other than the therapist) in the irreversibility of the decision had taken by the wife to divorce (category: 'no hope of one of the partners').

RESULTS

Analysis of how the presented above categories function in relation to particular cases with respect to individual cases, let for further modification of the categories in such way that they were directly transferred to the perception of the therapeutic process, as well as individual perception of the drop-out. According to Gregory Bateson [2] the information consists of differences that make information. In this work the source of information about relationships has become distinct narratives of individuals, which ultimately allowed modifying the analysis of the collected data and extracting the underlying phenomenon of reported cases.

Difficulties in the therapeutic process

The difficulty experienced by the clients applied to all the cases listed above ware connected with the difficulty in opening up during the therapy (category: 'difficulty in opening up'), otherwise the difficulty was connected with experiencing the therapy process as not intense enough. […] *I think that in our case, the fact that the distances between these meetings were so far between... At the time of a conflict this was a long time.*

Depending on the intensity of such a problem, it is important how often people meet, but at that time we needed such frequent contacts (case 1).

Clients mentioned the therapy was too difficult to bear. The therapists remembered the feeling of hostility in the couple and the deadlock but neither of them realized that the therapy itself could have been an unbearable effort for the family (Case 1). Similar perception of the therapy process as a difficulty and great emotional burden affecting the results of the therapy was described by Campbell [17]. Therapists pinpointed their own mistakes in the therapeutic process as directly connected with the drop-out. On this basis the category of 'recognizing one's own mistake by the therapist' was identified. Moreover, they indicated their therapeutic actions as ones which could have caused the drop-out, such as a premature intervention or an intervention closer to the expectations of one of the partners (Case 3).

T: *My intervention was too early. Perhaps if it had happened during the third or fourth session, it would have been different. I think it was my mistake, I mean, a mistake in the sense that I did not appreciate the importance of her [the wife's] dependence on the parents*. The category of 'recognizing one's own mistake by the therapist' is consistent with the research which shows that the factors connected with the therapist's interventions such as: problem definition not fitting the family map [13] structuring the therapy in an unskillful manner [14] as well as lack of joining, understood as joining the family [15] lead to a drop-out. These factors quoted in the literature are regarded as connected with the drop-out.

Experiencing the therapeutic process: 'split working alliance' and 'split therapeutic bond'.

The identified categories of 'split working alliance' and 'split therapeutic bond' refer to the notion of "split alliance" which is present in the literature [18-21]. This applies to significant differences in the perception of the therapeutic process by its individual participants. These differences pertain to both the objectives and tasks of the therapy and the experience of an emotional bond with the therapist.

The 'split working alliance' category additionally refers to the notion of "working alliance" [22-24]. This notion refers to the mutual involvement in the therapeutic system and the couple's involvement in the fulfillment of their mutual objectives. A good working alliance exists when both partners are involved in the therapeutic process in an active manner and perceive it as a tool for solving their problems.

Split working alliance.

The 'split working alliance' does not only pertain to differences within the alliance between individual members of the family and the therapist but also to the lack of alliance between all participants of the therapeutic process - partners as regards their experience of various aspects of the therapeutic process. The following subcategories have been distinguished within this notion: 'attributing the lack of motivation to change to one partner', 'attributing the reason for the failure of the therapy to just one partner', 'attributing the motivation for therapy only to oneself' and not to the partner, and also the fact that only one of the partners hoped for a change or considered the change to be the effect of the therapeutic process. In case no. 1, one person - the husband indicated a good direction of the therapeutic process "*the therapy was going in a very good direction, but, unfortunately, it was ended by my wife*." The wife reported that she was not able to "enter" the therapeutic process "*because of my partner's presence I found it difficult to open to the therapy despite my efforts*. Interestingly, from the therapist's perspective, the alliance with the couple was not possible; "*It was not possible to make an alliance with them, there was no partnership between them, they came here to create a family*". The first case shows there was no correspondence between the reports of these three persons as far as the objectives and progress of the therapeutic work was concerned. Just like in case no. 2 the wife described the therapeutic process as "reliving the problems", while her husband reported: I had a very positive perception of the therapy, I have a feeling that it "worked". In this case, the therapist had an impression that the couple moved further away from each other during the therapy. In case no. 3, the wife said: "the therapy allowed me to speak freely", while her husband said: I had a feeling that my wife took part in the therapy because I wanted her to." In this case, the therapist thought that the wife felt a lot of anxiety and she (the therapist) did not judge it properly and confronted her (the wife) too early.

(During the first session, the therapist commented that the door to the wife's parents should be walled up). This case also illustrates a different perception of progress and possibilities of the therapeutic process by the three persons quoted above. Therapeutic alliance is commonly considered as one of the most important factors - regardless of modality - determining the therapy's success [25]. The lack of cooperation in the therapy of one person is a significant factor decreasing the involvement in the therapy [26]. As a larger number of patients/clients are involved in family therapy or couple therapy than during individual therapy, it can be concluded that the lack of involvement in the therapy on the part of one person also contributes to a larger number of drop-outs in family and couple therapy [27–28]. However, the involvement and motivation for therapy should not be treated as the same factor for the therapy, as research shows [24] it is important to understand internal alliances and splitting which occur between the individual persons in a family and a couple.

Split therapeutic bond

The category of 'split therapeutic bond' does not only include differences in the couple, in the scope of experiencing a relationship with the therapist but also the inability to experience an emotional alliance simultaneously by all therapy participants. This means that the therapist experienced an emotional relationship with the individual persons in the couple to a different extent. Differences in the scope of experiencing the alliance and the attitude towards the therapist were manifested in various ways; one of the partners attributed 'a lack of involvement of the therapist' or 'perceived the therapist as being closer to the other partner' or, generally, expressed negative emotions towards them. On the other hand, the other partner revealed positive emotions towards the therapist. In case no. 3, the wife's perception of the therapist can be considered as clearly negative "a boring lady with a learned ability to listen", "I had a sense of routine, the therapist's weariness". The husband had a very positive perception of the therapist "…very nice, friendly but firm (…) I liked it that she made matters clear." The way in which the therapist described the spouses concerned their functioning in their mutual relations. The therapist clearly appreciated the husband's contribution and involvement "motivated, with a sense of guilt and responsibility for the relationship". While talking about the wife, in turn, she emphasized her greater loyalty towards their parents and the fact that "she was not ready to undertake the topic of relations with her parents." The therapists' narration about the couples is described by two categories: 'distancing oneself' and 'revealing negative emotions'. 'Distancing oneself' means that the descriptions of the couples or the individual persons included operational facts from the course of the therapy or a description of the couple's functioning. The therapists did not reveal personal emotions connected with the relations with the couple or individual persons. While describing various elements of the therapeutic process, e.g. motivation, the therapists revealed their negative emotions. In case no. 1 the therapist described the couple in the following way: "the partners came here to ask to create family, they desire was to create a family area which was not among them. I had a strong feeling that they were two separate individuals with lack of shared issues".

Drop-out perception: factors outside the therapy

The respondents taking part in the study emphasized the fact that discontinuation of the therapy was also caused by factors other than the therapy process. In case no. 2, the lack of time was one of the factors describing the reason for the drop-out „…firstly, because it got better and secondly, things were so rushed sometimes…" In this case, the therapist indicated a lack of motivation of both partners as the reason for stopping the therapy (case 4). Interestingly, none of the therapists said that the possible cause of discontinuing the therapy lay outside the therapeutic process. There exist studies showing that drop-out can be associated with life-related conditions and situations, e.g. moving house [29].

Drop-out perception: lack of hope

The distinguished "lack of hope" category can be defined as a lack of faith in both the possibility of solving the couple's problems and the possibility of a change during the therapeutic process. The lack of hope category had its subcategories such as 'attributing the reasons for

the failure to one partner', 'lack of faith in the existence of partnership in the couple'. In case no.3, to answer the researcher's question why they stopped the therapy, the husband said: "… I think my wife either had decided in her heart that it was something that she should endure only for a while or she knew that she would not finish it". The therapist indicated the wife's dependence on her parents and her unwillingness to reflect on the conditions connected with her family (category 'lack of hope') .

The lack of hope specific for the therapist, applies to those statements in which the therapists emphasized the 'lack of faith', 'the impossibility of setting joint goals and a therapeutic process' in which no contract was established. It was also connected with the subcategory defined as a "lack of faith in the existence of clients as a couple" (Cases 1, 2). The therapist's statement (Case 1) is a good example here "I 'just thought how very different their expectations of the relationship are.... that it is not going well, all the more so as it was the third consultation. It is as if the areas did not overlap" (Case 1). The therapists' "lack of hope" was also connected with their failure to notice their client's motivation, which is exemplified by the following statement: "I had an impression that this man was less motivated and he imposed his own rules of relationship" (Case 2).

Empirical studies also emphasize the importance of the sense of hope monitoring by the therapist; Flaskas [30] notices that the therapist's task involves efforts to find a balance between the family's hope and the lack of it. The research by Moltu et al [31] shows that the appearance of subjective feelings concerning a deadlock or difficult moments in the therapy on the part of the therapist constitutes a threat for the therapeutic process. Ward and Wampler [32] in their analysis of the phenomenon of hope in therapy find that the therapist's hope can be reflected in the clients' hope and the other way round.

Considering the fact that, the investigated therapists did not have any hope for the success of the therapy, and what is more, it was connected with the lack of hope on at least one of the clients, we consider this factor as significant in the group under analysis. The distinguished category' 'lack of hope' can be referred to research of Escudero et al. [33] that indicate that elements such as hope, shared goals or the couple's motivation for a change are of key importance for the establishment of a therapeutic alliance at each stage of the therapy.

The drop-out process: relationships between categories

The presented analysis emphasizes mutual connections between the distinguished categories: the lack of faith in the sense of the therapy causes the therapist to lose faith, which appears to lead the initially more motivated partner to lose their faith. This phenomenon is depicted by two categories: 'split of the working alliance' and 'split of the therapeutic bond'.

In this analysis, the difficulty in establishing an alliance was attributed to the "therapist-partners" system. The 'split of the therapeutic bond' is one of the key phenomena of the drop-out process: one of the partners feels more connected with the therapist than the other one who thinks more about ending the therapy. Low hopes or the lack of hope presented in retrospective studies also constitute a significant variable for the success of the therapeutic process. This process was also affected by variables connected with attributing the failure: to the therapist, to one of the partners, to therapeutic interventions, to the setting and to the factors outside the therapy.

DISCUSSION

The presented analysis depicts the complexity and processuality of the drop-out phenomenon. The distinguished categories of 'the split of the working alliance' and 'the split of the therapeutic bond' show that the conflict which the couple brought to the therapy was reflected in their experience of the therapy and the therapist. The difficulty in the therapeutic process for the couples was connected with the lack of possibility of removing the tension generated by the therapeutic process itself, especially if the couple perceived this process in a different manner. This aspect was not perceived distinctly by therapists, who conducted the session under analysis and it was not taken into account in a sufficient manner. The difference between the partners' perspectives proved to be striking - both in terms of their experience of the therapeutic process, in the existence of hope for the thera-

peutic success and in perceiving the discontinued therapy as helpful. Also the therapists, in their descriptions of the therapeutic process and their understanding of the causes of the drop-out, tended to talk rather about individual persons than about the couple as a whole. The presented analysis shows the connection between the drop-out phenomenon with elements of the therapeutic process, such as alliance or the therapeutic bond and with the conflict present in the couple. The categories and processes which were distinguished can be referred to research studies associating drop-out with a failure to conceptualize the problem [33, 34] and a failure to define mutual expectations about the method of solving this problem [13, 35, 36] as well as to studies which emphasize the importance of establishing a therapeutic alliance with at least two persons [28]. It should also be underlined that split alliances mostly appear at the beginning of therapeutic processes [21].

CONCLUSIONS

As a conclusion we want to point some significant factors, that are important in conducting couple therapy: firstly the therapist should monitor their own sense of hope for a change, because it is a significant factor determining the success of the therapeutic process. Secondly, it seems to be important to examine by the therapist one's own "counter position", especially, when it differs in relation to separate members of the couple.

The most important notion is connected with the necessity of taking into account one's emotional distance, which can not only be a response to the "lack of hope" and the "split alliance" but can be also connected with the emotional processes existing in the couple.

The limitations of this study should also be taken into account. The lack of hope reported retrospectively by the therapists is also significant for the result of the therapeutic process and it is connected with the conviction of at least one of the partners. However, the question arises whether this is not a specific projection reflecting the current situation and not necessarily the situation which existed during the session before the drop-out. Another limitation of the presented research may result from the research procedure which is based on materials collected retrospectively [34, 37].

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