Psychotherapy

Repeated Terminations: Transferring Therapists in Psychotherapy
Cheri L. Marmarosh and Samuel I. Salamon

 CITATION
Repeated Terminations: Transferring Therapists in Psychotherapy

Cheri L. Marmarosh and Samuel I. Salamon
The George Washington University

Therapists engage in transfers—a specific type of termination—with clients who will be continuing treatment with new therapists after they depart. Consequently, new therapists begin treatments in the shadow of the loss of an outgoing therapist. These transfer experiences frequently occur in yearlong training settings, where therapists-in-training encounter some of their first therapy experiences and subsequently move on to other training settings or graduation. Transfers also occur in clinical settings when therapists retire, become ill, or need to end the treatment prematurely. In this article, the authors address transfer terminations using attachment theory and the literature applying attachment theory to psychotherapy. The authors incorporate relevant literature, research, and case examples that highlight how therapists can best address these losses and transitions in treatment. This article concludes by offering recommendations for supervisors of students in training settings and detailing some of the unique benefits for clients who experience multiple transfer terminations in treatment.

Clinical Impact Statement

Question: How does attachment theory guide us when working with patients and therapists who have to transfer treatment in training clinics? Findings: Theory and clinical experience have revealed that it is critical to treat the transfer experience as an ending or form of termination. Helping address this loss is important and meaningful for the patient. Meaning: To maximize treatment, therapists should explore the impact of the transfer and raise upcoming transfers early in the treatment. Next Steps: In future studies, researchers need to explore how addressing transfers impacts treatment, what individual differences moderate or mediate transfer outcomes, and how we can best train therapists to openly explore loss in psychotherapy treatment.

Keywords: termination, transfer treatment, student therapists, training clinics, attachment theory

Therapists often consider termination to be at the end of a psychotherapy treatment; however, some treatments have multiple clinicians who leave and join the process during the same treatment. This experience often occurs in training clinics when therapists are working in the clinic for 1 to 2 years or when therapists prematurely end therapy (Penn, 1990; Super, 1982; Wapner, Klein, Friedlander, & Andrasik, 1986). Examples include a yearlong internship, externship, or a period in a graduate training clinic when therapists leave the treatment, but clients remain because they want to continue therapy. Transfers also happen when therapists become ill, need to relocate, or retire. Clients experience the loss of therapists similar to a typical termination, in addition to feelings of abandonment, as they still need therapy (Clark, Cole, & Robertson 2014; Clark, Robertson, Keen, & Cole, 2011). This ending is even more complicated when clients start a new relationship with a new therapist as if the therapy treatment has continued in one longitudinal treatment.

Unfortunately, researchers report a dropout rate as high as 69% after a transfer (Tantam & Klerman, 1979; Wapner et al., 1986), suggesting that it is often challenging when clients initiate a new therapeutic relationship in the aftermath of losing a therapist. It forces us to ask the question, “Do we terminate a treatment or do we terminate a relationship with a therapist?” Researchers suggest that the therapy relationship is at the core of therapy change (Flückiger, Del Re, Wampold, & Horvath, 2018). If the therapy relationship is paramount to treatment and the therapist is leaving, then the treatment is never the same.

We argue that this repeated termination, often described as a transfer, is really the ending of a relationship and requires at least the same sensitivity and thoughtfulness as any other type of termination. We also argue that attachment theory can guide student-therapists and their supervisors in helping clients navigate these endings (Holmes, 1997; Marmarosh, 2017). Attachment theorists emphasize past relationships and how they influence how we feel about others and ourselves (Bowlby, 1980), and the theory helps therapists understand different reactions people have to loss and endings (Marmarosh, 2017). Attachment theory also offers ways of intervening that help
clients when they endure one of life’s most painful experiences—the loss of a secure base or caregiver.

The current article will apply attachment theory and current research to understand how therapists raise the topic of therapist loss at the end of therapy and post transfer. This article will also emphasize how therapists can rely on attachment theory to help clients navigate these transitions and identify clients who may struggle more with repeated transfers in a single treatment. We also explore how therapists’ attachments influence how they facilitate or avoid exploring an upcoming transfer. Derived clinical vignettes, based on transfer clients, bring the theory and research to life and maintain client confidentiality.

**Attachment Theory and Endings**

Bowlby (1980) wrote about the significance of loss and described how individuals’ histories with their early caregivers set the stage for how well they will be able to cope with future losses. He proposed a framework for conceptualizing atypical forms of mourning, chronic mourning on one extreme and prolonged absence of conscious grieving on the other (Bowlby, 1980, p. 138). According to Bowlby, adults with anxious attachment styles, those with histories of insecurity, inconsistent care, and experiences of abandonment, are more vulnerable to prolonged or chronic grief, whereas individuals who have avoidant attachment styles, those with histories of being self-reliant, are more likely to express fewer overt signs of grief.

We can see these patterns in the psychotherapy relationship (Mallinckrodt, 2010). Clients with more anxious attachments tend to struggle with letting go and accepting a loss because they have trouble relying on a secure internal representation of someone who comforts them. They continue to struggle with the loss, and this interferes with grief (Maccallum & Bryant, 2008). These more anxious clients tend to be inclined to engage in strategies that elicit caregiving in therapy, struggle to tolerate separations and being alone, and continue to seek out the attachment figure years after they are gone (Mallinckrodt, 2010). Clients with more avoidant attachments, on the other hand, tend to struggle with depending on therapists and are more inclined to detach during times of loss. They often have histories where they were neglected and alone during times of distress (Bowlby, 1980). Attachment-based clinicians describe how these attachment styles are likely to be activated in both clients and therapists during endings, and this offers significant opportunities for growth (Bowlby, 1980; Holmes, 1997; Marmarosh, 2017; Wallin, 2007).

Therapists have the unique opportunity to help clients internalize their therapy relationship and rely on internal representations of the therapist when they are struggling (Mallinckrodt, 2010; Wallin, 2007). To function as a secure base for clients, therapists need to be comfortable raising the topic of loss before and after the transfer and help the client tolerate whatever feelings or previous losses emerge. Marmarosh (2017) described the importance of the therapist acting as a secure base during termination and during transfers as well. To be a secure base, the outgoing therapist and incoming therapist should openly communicate to the client that he/she/they will not be complicit in the denial of loss and that the new therapeutic relationship is one that can become safe and stable enough for the resumption of therapy.

This is important, as researchers have shown that it is beneficial to process termination. For instance, Joyce, Piper, Ogrodniczuk, and Klien (2007) suggested that the outcomes of the termination phase differ from overall treatment outcomes. They argued that there appears to be value in the therapist exploring client satisfaction with and the therapeutic work during the termination phase. The same is true of a termination leading to a transfer. Clients can gain an enormous amount of therapeutic growth during this transition.

**Research on Attachment and Loss**

Unfortunately, there is no empirical research linking attachment style and transferring therapists, so we must rely on the research linking attachment to grief, loss, and termination. When it comes to grief, Fraley and Bonanno (2004) studied how attachment styles relate to different grief patterns for individuals experiencing bereavement. They found that more avoidant individuals revealed less grief initially and even later on. Fraley and Shaver (1997) argued that these individuals did not allow themselves to become as attached in relationships to begin with and that that is why they experience less grief when relationships end. Bowlby (1980) described defensive exclusion, a process in which dismissing adults automatically redirect attention away from experiences that may threaten their sense of independence or self-worth. They disengage. More anxiously attached individuals, on the other hand, are at greater risk of complicated mourning and struggling to move on after the loss of a loved one (Fraley & Bonanno, 2004). Individuals with more attachment anxiety demonstrate overall increases in anxiety, depression, and unresolved grief (Maccallum & Bryant, 2008) as well as poorer mental and physical health after a loss (LeRoy et al., 2020).

Holmes (1997) argued that we should expect that clients will react differently to endings in therapy based on their different attachment styles and histories of interpersonal loss. For some, the transfer is a major rupture in the treatment, whereas for others, the ending is less impactful. Marmarosh (2017) argued that despite different client reactions to endings, therapy can facilitate movement toward more secure attachments and that termination can be an important part of the treatment (Fonagy et al., 1996; McBride, Atkinson, Quilty, & Bagby, 2006).

Research has shown that certain interventions are also more helpful than others. For example, avoidant clients benefited the most from emotionally charged experiences with their therapists (Janzen, Fitzpatrick, & Drapeau, 2008). These moments facilitated the alliance and their sense that therapy is helping them. Aiding more avoidant clients in experiencing their emotions, especially grief, is helpful for them. At the same time, however, we must also be careful not to overwhelm more avoidant clients with feelings that are intolerable or uncomfortable. Many clients will want to disengage to tolerate the ending of therapy. We can apply these findings to the transfer experience as well.

**Clinical Example: Client Avoidance and the Upcoming Transfer**

The following case example describes how a therapist raises the date of the transfer months in advance and how the client, with a more avoidant attachment, splits off any memory of the transfer,
feelings of attachment to the therapist, and feelings related to ending the relationship.

Therapist: I wanted to raise the ending of our therapy in a few months and the option for you to continue after I leave the clinic. I know losses are not easy for you given the loss of your father. (Therapist raises the eventual transfer.)

Client: At the end of the year? I thought we would be able to continue until I graduate in 2 years. Am I missing something?

Therapist: I am pretty sure that I mentioned at the beginning of our work that I would be leaving at the end of the academic year and you can choose to stay on in the clinic. I recall that you seemed okay with the news, which stood out to me. Do you remember this conversation? (being curious about her denial of the timing of the ending)

Client: I think so. I am not sure.

Therapist: That’s okay. You look surprised. How are you feeling? (Therapist labels the feeling of shock and then asks the client about feelings.)

Client: I do not know. (looking away) I’m fine.

Therapist: I see. You say this is “fine.” Like this will be okay and not a big deal.

Client: I guess. (looks up) That is what I tend to do . . . like we talked about.

Therapist: You push a lot away and then do not have to deal with it? (Exploring the client’s pattern of avoidance)

Client: We talked about that. (pauses) I cannot imagine starting over with a new therapist so soon.

Therapist: Yes, it does feel like it is too soon. And to have to start all over . . . (exploring transfer and loss)

Client: I guess. It was hard to come in here and start to tell you everything. Then we need to end? (sounding frustrated)

Therapist: I wonder if you feel frustrated by all this? It has been really hard to do this, and now I have to leave. (empathizing with frustration of the transfer)

Client: I do not know, really. I guess I do not like to deal with that . . . (avoidance)

Therapist: Hmm? (acting as a secure base and exploring anger at the therapist for leaving)

Client: I just do not like it.

Therapist: You have always had difficulty getting mad at people who hurt or disappoint you. You tend to go it alone. You came in for therapy saying you were unhappy with relationships and feeling lonely. (Linking the current loss, avoidance of dependency, and issue bringing the client to therapy)

Client: I know. I know. I avoid all of this. (laughs) This is why . . . I hate this.

Therapist: Hate what, exactly? (therapist encouraging the client to express reactions and empathizing with feelings)

Client: This . . . talking about saying goodbye. Talking about myself: . . .

Therapist: It is so very hard to get close and start opening up to me and then have to end. I think what is happening between you and me is something that happens outside with other relationships, and it is important. We can spend time focusing on this before I have to leave. (Identifying the pattern of ambivalence to getting close in relationships)

Client: You may be right, but I do not like to deal with my feelings . . . I would rather this all go away. It is like an instinct to pull back. It is what feels right. You know when we talked about the problem I was having at work with my boss? I just want to get away. I want to move on and feel better. (explaining automatic avoidance to cope with and regulate emotions)

In this example, we see how a more avoidant client reacts to the upcoming transfer. The therapist gently explores the frustration that the client expressed, and the client is not ready to talk about those feelings. The therapist, acting as a secure base, creates the environment where the client can begin to wonder about the desire to flee and escape painful interpersonal interactions. The therapist tries to help the client express what feelings come up and then shifts to helping the client articulate the desire to move away from those feelings and the desire to be independent. The therapist also tries to link the pattern in the session to the client’s goals for treatment, specifically, his/her/their relationship difficulties. The transfer process creates the opportunity for the client and therapist to explore the client’s relationship pattern of avoidance to regulate painful emotions.

Clinical Example: Client Anxiety and the Upcoming Transfer

The next example is a client with more attachment anxiety who came to therapy after a relational breakup. She has never been in therapy or experienced a transfer before. The client has been in therapy for 6 weeks, and the therapist will leave for an externship in another 6 weeks. The following excerpt is from the seventh session, which is when the therapist reminds the client of the upcoming transfer. Note the client’s initial reaction to avoid the ending and then the painful self-blame that follows.

Therapist: I want to remind you of our transfer. Our last day together will be June 14th.

Client: What?
Client: (silence) I do not know what to say. Obviously, I noticed how painful this relationship with him was for you. Are you ok?

Therapist: I am fine (looks back up). I just forgot (pauses). So, I was going to tell you about my ex and what happened this weekend. He called and I was not sure if I should talk to him. I did end up seeing him and we hooked up. I know I should not have done that. (Client goes on about her ex-boyfriend and the challenges of ending the relationship in a tone that is detached but filled with content of how he disappoints her and she struggles to say goodbye to him. After listening, the therapist brings up the transfer again.)

Therapist: I noticed how painful this relationship with him has been for you. You still feel so hurt and sad about the relationship ending. You want to keep him in your life. It made me wonder if we should talk a little more about us ending too? You looked away when I brought it up. (therapist raising the ending again and noting the nonverbal behavior)

Client: (silence) I do not know what to say. Obviously, I know you need to leave. It is your job. This always happens to me anyway. For some reason, people keep leaving me. I have learned to expect that. (client revealing some sadness in her face but denies feelings)

Therapist: You talk about this as though you are used to it? You expect people to abandon you? You expected me to abandon you?

Client: (looking sadder) People have left me . . . look, I'm sitting here talking about my ex who cheated on me and I still love him. I'm sure he is laughing at me. (tears up)

Therapist: Laughing at you? How awful.

Client: I'm sure he does not care like I do. I am the one who always gets hurt.

Therapist: I imagine you wonder if this is something I care about as well? (inviting client to explore the pattern of feeling abandoned)

Client: (looks away)

Therapist: Sasha (she looks back), I do care about our relationship and am very sad we have to say goodbye. I can also say that my leaving is not your fault or a result of anything you have done. It does not have to do with anything about you. I have to leave because I am leaving the clinic. (Therapist discloses sadness about ending and clarifies the reason for the ending.)

Client: (tears in her eyes) I know that up here (points to head). Then why does this always happen to me? (starts crying)

Therapist: It has been very painful for you to feel so alone and not know why relationships do not work out. You know it intellectually that it is not you, but it triggers something painful inside. The loss triggers you to turn on yourself. (focus on self-blame)

Client: (sighs) I do blame myself.

Therapist: You go right to self-blame. You feel the pain and then blame yourself. It is very very hard to sit with those feelings and not be responsible. (Therapist disentangles loss and self-blame.)

This example demonstrates how a more anxious client initially avoids vulnerable feelings in the therapy session and focuses on details of previous abandonments and rejections by a former partner. The therapist looks for an opportunity to bring up the loss and ending of the therapy later in the session and tries to help the client be more honest about her reactions toward the therapist. The therapist addresses the self-blame that is often a coping mechanism for clients who have felt abandoned earlier by caregivers (Marmarosh & Tasca, 2013). The therapist tries to help the client experience some feelings of loss without being flooded by them, disentangle feelings of sadness and then self-blame related to abandonment, and continue to identify the therapeutic goal to focus on before the transfer.

Therapist Attachment and Preparing for Transfer

Just as the client’s attachment influences the transfer, the therapist’s attachment also influences the transfer because the therapist is leaving and has a responsibility to help the client confront the loss (Marmarosh, 2017). Similar to clients, therapists with insecure attachments may be more inclined to either avoid painful feelings (more avoidant) or become overwhelmed by them (more anxious; Wallin, 2007). Researchers have found that therapist attachment insecurity was related to poorer client-rated working alliances (Dinger, Strack, Sachsse, & Schauenburg, 2009), less observer-rated empathy after a rupture (Rubino, Barker, Roth, & Fearing, 2000), and increased therapist-rated ruptures after starting treatment with a transfer client (Marmarosh et al., 2015).

Research on Therapist Attachment and Endings in Treatment

Although there have been many studies examining therapist attachment and psychotherapy, few studies have examined how therapist attachment relates to termination and endings in therapy. Boyer and Hoffman (1993) found a link between a therapist’s history of loss and anxiety during termination. Specifically, therapists’ histories of loss predicted their anxiety and depression during the termination phase of treatments. Endings with their clients stirred up their own experiences of loss and influenced their sense of well-being during termination. Shulman and Gold (1999) found that therapists who were more securely attached experienced significantly less anxiety, depression, and dysphoria during termi-
nation. Therapists with a more anxious attachment style engaged more actively in summarizing the therapy and reviewing the attainment of goals during termination. They also focused less on the here-and-now experience in the session compared with more secure therapists.

Clinical Example: Therapist Attachment Anxiety and Transfer

The following are two clinical examples of how a therapist initially avoids saying goodbye to a transfer client but then, after supervision, is able to engage in a useful conversation about the transfer during the last session. We see how a more anxious therapist who struggled to tolerate the loss or client’s grief/anger tells the client that she will be back someday after an internship, which could prevent the client from fully mourning the loss of the therapist and attaching to the new therapist. Although the therapist does not intend to interfere with the new therapy, this intervention will nonetheless likely hinder the alliance with the new therapist.

Before supervision.

Client: I am really going to miss you. You have been the best therapist I have seen in this clinic.

Therapist: I have also enjoyed working with you. (disclosing value of the therapy but avoiding the “miss you”) 

Client: (tearful) I wish you did not have to leave. I do not want to start over with a new therapist.

Therapist: Well, the good news is that I hope to move back here after graduation. (avoiding the loss and difficulty of the upcoming transfer)

Client: (smile through tears) Really? You will be back?

Therapist: Well, I will not be back in this clinic, but I will be back and hope to start my own practice. I will give you my cell number, and I will call you when I am back in town after my internship. (focusing on the hope of reuniting and avoiding the present loss and transfer)

Client: I am so relieved. I thought I would not see you again. I hate goodbyes. I will definitely see you in your practice when you get back. (Client shifts from sadness and frustration about the transfer to the uncertain hope of reuniting in the future.)

After supervision.

Therapist: I know this is our last session and I wanted to talk to you about something that we talked about last week.

Client: Ok . . .

Therapist: Well, I am very aware of how well we have worked together and how hard it is to end our work together now. Last week, I focused on working together in the future, which we can do, but it avoided saying goodbye today. (therapist owning avoidance of loss)

Client: Yes, I feel so much better knowing we can work together in the future.

Therapist: I know. Me too (smiles). I have a hard time saying goodbye as well. But I have realized that even if that is true, and we can work together someday, there is always a chance that something may happen, and we will not be able to work together again. You or I may move or you may decide not to continue therapy at that point. There is no guarantee that we will definitely see each other again. This could be the last time I see you. I want to make sure that, if this is the last time, we see each other, we say goodbye. (focusing on the ending and loss)

Client: (tears up) I’m sure I will call you after you graduate and set up a practice. (continues to avoid ending)

Therapist: I know. I hope you do and we work together again, but I would hate to lose this opportunity to share my thoughts and feelings with you if we do not. No regrets. I see you are tearing up. (Therapist continues to explore loss.)

Client: (tears) Yes, I do not like saying goodbye. I do not know why we have to.

Therapist: Either do I. I really do not like saying goodbye to you. What do you like about saying goodbye to me? (explores loss)

Client: Like you said, I do not like it. I have had a few therapists, and I really feel like you have helped me the most. (begins sharing the pain of loss)

Therapist: I get it. You and I have done important work together. We click (smiles). We have a difficult task to do together—to hold on to the possibility that we will work together again and to prepare for the possibility that we may not—saying goodbye. We also can think of what will help you start over with a new therapist in a few weeks. (summarizes the challenges of the ending)

Client: I guess I do not really want to start over even though I know I need it. I briefly met the new therapist 2 weeks ago, and she seems nice. (pauses) She is just not you. (shares desire to avoid loss and ambivalence to transfer)

Therapist: She is not me. We have worked hard to get to this place in our relationship. I have really enjoyed getting to know you.

Client: Yeah. It is just not fair. I do not want to start over even though I need to. I hate it.

Therapist: (silence) I hate it too because I am going to miss you.

Client: (looks away)
Therapist: I noticed you looked away after I said, “I am going to miss you.”

Client: (smiles) You never let anything go do you? (laughs) It feels weird to hear it, I guess. I can say I am going to miss you, but it is different to hear it coming from you.

Therapist: How so?

Client: I knew you would ask that. (smiles) I think. . . I think it feels good. I know this sounds crazy, but I feel uncomfortable with it . . . like I am not used to it . . . (tears up). I always want people to care about me, and when they do, I feel scared. Isn’t that crazy?

Therapist: No, it is not crazy. You feel scared now?


Therapist: Embarrassed? (Therapist is curious about client’s feelings.)

Client: That you will see how much that means to me. (looks down, feeling ashamed of needs and vulnerability)

Therapist: I can see how hard it is for you to share this with me. It means a lot to me to hear how much I matter to you. (Therapist tears up.) I wonder how it is for you to see me have feelings in here too.

Client: (looks up at therapist and pauses) I feel very lucky.

After supervision, we see how the therapist reengages in the previous conversation about the ending and how she works to help the client say goodbye while also exploring the ambivalence about continuing with the new therapist. The therapist tries to address the loss while also fostering hope. In the end, the therapist discloses her own feelings of sadness in an attempt to increase engagement and vulnerability (Marmarosh, 2017). Even though there is potential that they could work together again in the future, the therapist still addresses the ending of the current relationship and says goodbye. The intimacy raises discomfort in the client, but that discomfort comes from having a new experience that is more positive and vulnerable. The focus shifts to the feelings of being close and the embarrassment that emerge when having positive interactions. These are important experiences for clients who come to therapy with insecure attachments and relationship difficulties.

Initiating the Discussion of Loss Post Transfer

So far, we have focused on what happens before the transfer and how the therapist can prepare clients. Now, we will shift to what happens after the transfer, when the client starts treatment with a new therapist at the same training site or clinic. Often, incoming training therapists are novice clinicians who do not have experience with psychotherapy. In essence, we have clients who may be experiencing complicated feelings after changing therapists and therapists who are anxious and concerned about their ability to be effective clinicians. Therapist anxiety often makes it difficult for the new therapist to empathize with the new client regarding the loss of the previous therapist. Marmarosh, Thompson, Hill, Hollman, and Megivern (2017) interviewed doctoral candidates in two training clinics and found that it was difficult for new therapists to take over and replace a beloved previous therapist. They also found that therapists reported that personal insecurities, feelings of anxiety, or a negative attitude made the transfer process even more difficult and interfered with them being able to facilitate the transition. Despite these challenges, Marmarosh et al. (2017) recommended that the new therapist needs to invite the client to talk about whatever feelings emerge, such as anger, loss, relief, or the absence of feelings altogether. The transfer therapist’s engagement or lack of engagement on the topic of loss of the previous therapist signals to the client what can or cannot be tolerated by the therapist and foreshadows the dyad’s ability to effectively engage in therapy together (Marmarosh, 2017).

Research Supporting the Discussion of the Transfer

Researchers have found that previous transfer experiences influence the success of subsequent transfers (Clark et al., 2011; Wapner et al., 1986). Clients with more time in therapy and those with previous experiences with a transfer were less likely to drop out after the transfer than their less experienced counterparts. In a qualitative study, Clark et al. (2014) interviewed 11 clients about their transfer experiences. Clients indicated that they felt some anxiety, fear, sadness, and anger about the transfer. They also said that it was helpful when the new therapist helped them cope with their feelings and the clinic provided support during the transition. In essence, the research supports therapists initiating the discussion of the previous therapy and that this approach positively impacts the current treatment.

Clinical Example: Client Avoidant Attachment and the New Therapist

The following example is of a client who was in therapy with a doctoral student for a year and then was transferred to a new student-therapist when the client’s previous student-therapist left for an internship. When the new therapist called the client to set up an appointment, the client was detached (more avoidant) and did not show up for the arranged appointment. The therapist reached out again to schedule another appointment, and the client arrived 20 min late to the session. The following conversation transpired, and it demonstrates how the new therapist initiates a conversation about loss and endings with a more avoidant client, empathizes with the client’s feelings of loss (becoming a secure base for emotional exploration), and explores the struggle to tolerate previous losses during their first session.

Client: I’m sorry to be late. It took a while to park the car and there was traffic.

Therapist: I am glad you came to the session, even if you are late.

Client: (silent for a few minutes)

Therapist: I know it can be hard to get here, and I want to acknowledge that you had been working with
Mike for quite a while. We are starting together with that loss in mind. (Therapist brings up loss of the previous therapist and avoids challenging client with regard to missed sessions at this time.)

Client: Hmmn. (silent)
Therapist: How does it feel to be here?
Client: Fine. It is fine.
Therapist: Fine. But you look like you have more you could say? You can elaborate on . . . whatever it is.
Client: (pauses) Honestly, (smiles) I was not sure I wanted to come today.
Therapist: I appreciate your honesty. You’re not sure about doing this again. (empathizes with ambivalence)
Client: I have so much going on in my life right now.
Therapist: It has been hard not to have him here for you now, when you need him. (empathizing with the client’s dependency on the previous therapist and causes a rupture)
Client: (looking away) I wouldn’t say I needed him. (client defensive of needing the previous therapist—a rupture)
Therapist: You may not have needed him, but I can see you are not sure about continuing. (staying with avoidance and trying to repair the rupture)
Client: (making eye contact) I hate dealing with this. . . . It always happens when you let yourself depend on someone. (reveals a pattern of avoidance of dependency to avoid vulnerability—a more insecure attachment strategy)
Therapist: Can you say more?
Client: Like I said, I was not sure if I wanted to do this again. (sounding defensive and shifting to avoidance)
Therapist: I know you may not feel like it is worth it. I also know that I cannot just pick up and replace Mike. You seem like someone who does it on your own, and for good reason. It is a big deal for you to come here. (empathizing with the desire for self-sufficiency)
Client: Exactly. I am a lone wolf. I prefer it that way. Although, Mike always said I needed to work on that. It is how I like it . . . but not great for other people. (smiles) He even wanted me to try group therapy. But, I said, “No way!” I just do not wear my heart on my sleeve, and I am not about to start doing that now. (defensive about being in therapy)
Therapist: Sounds good to me. How about we start with what you want to do in therapy and what you want to get out of it?

In this example, we see a client with a more avoidant attachment, express ambivalence to attaching to the new therapist. The client cancels sessions and comes late to therapy. The therapist raises the transfer. At first, the client denies feelings about the transfer, and the therapist empathizes with the challenges of starting over with a new therapist. The therapist makes a rupture by using the word “depended,” which the client immediately rejects. The therapist attempts to repair the rupture by carefully listening to what the client says and emphasizing the importance of self-reliance (Marmarosh, 2017; Safran, Muran, & Eubanks-Carter, 2011). The therapist is careful not to pull for more emotions when the client is clearly unsure about trusting the new relationship. The client is clearly ambivalent about continuing after the transfer. The therapist does not delve into the loss or past and steers clear from exposing more client vulnerability during this initial session. Instead, the therapist invites the client to talk more about what he wants to get out of therapy. The main technique is listening and empathizing to the client’s overt experience rather than being problem-focused, probing for more painful underlying affect, or using directive techniques (Marmarosh, 2017).

Clinical Example: Client Disorganized Attachment and the New Therapist

Transfer is often most upsetting for clients who have experienced trauma, especially early relational trauma. The following example is of a client who was sexually abused by her stepfather for many years while her mother suffered from chronic health issues and was emotionally unavailable. The client said she never felt loved or taken care of by others. She was incredibly intelligent and earned a scholarship at a top college. Although successful academically, she found herself in abusive relationships and said she felt “taken advantage of” by others. She added that she struggled with alcohol use, as it “numbed the pain.” The client came to the counseling center a few weeks before the end of the fall semester owing to difficulty concentrating and increased use of alcohol to cope with final exams. The counseling center she visited had a 12-session limit, and it was clear that this client would need more treatment. The focus of the brief therapy, with a therapist we will call Shelley, was getting her through the end of the semester. Her diagnosis when she started treatment was major depressive disorder, but as she elaborated on her symptoms, it became clear that she had chronic anxiety and trauma-related symptoms, including a mistrust of others, flashbacks to sexual encounters, fears of sleeping with the lights off, and nightmares. Her history and symptoms match those people with a disorganized attachment, who have elevated anxiety and avoidance. Researchers have linked disorganized attachment in children to adult substance use, relationship difficulties, and depression (Sroufe, Egeland, Carlson, & Collins, 2009).

After 12 sessions in the counseling center were over, this client was referred to someone in independent practice, a new therapist outside the counseling center, where there was no session limit. The client struggled during the transition and alternated between feeling a desire to take care of the new therapist, as she did with her mother, and protecting herself from abuse and neglect.
Beginning of the First Session

Client: (smiles) Thank you for seeing me. I really appreciate your being flexible with the time. I love your office. (Client being very “nice” and “care taking.”)

Therapist: I am really glad we could find a time that works.

Client: (looking away) I am glad finals are over. How are you doing? You look tired. I imagine it is not easy to listen to people’s problems all day long. (expresses not knowing what to talk about and then shifts away from herself to focus on the therapist, possibly evaluating what type of caregiver the therapist is, for instance, someone who is exhausted and possibly unavailable)

Therapist: I am doing ok, thank you. That is very thoughtful. Can you tell me what made you decide to continue therapy? (Therapist refocuses on the client and invites the client into saying more about her desire for treatment.)

Client: (smiles) Hmm. I am not sure, really. I saw, I forget her name, at the counseling center to help me with my classes. Now that I have done finals, I feel better. She said I needed to work on relationship issues and that I have a lot of things I struggle with due to my childhood. (Client avoids the attachment to the therapist and being vulnerable.)

Therapist: So, that is what she said. What do you think?

Client: (smiles) Well, I think she may be right. But I do not know. It’s a lot. She said she was going to call you. I signed those releases for you all. Did you talk to her?

Therapist: I did talk to her on Monday. She told me some things about your childhood and about the work you did. I can answer any questions you have about our conversation and want to hear what you think as well. I really value what your thoughts are about this since it is for you.

Client: I do not need to ask anything. (looks uncomfortable, long silence)

Therapist: Did I say anything that felt uncomfortable. I noticed you got quiet?

Client: No, it is fine. (Client avoids expressing her reaction. It is clear she has feelings about the expectation for the previous therapist and current therapist talking to each other.)

Beginning of the Second Session

(Client is 20 min late.)

Client: I am so sorry. I had to park the car, and I was late getting out of work.

Therapist: I am glad you are here.

Client: So, I am still not sure what to talk about.

Therapist: Well, we could start with how hard it may be to know where to begin since you were working with Shelley on finals and now you are starting over with me. I imagine that is not easy.

Client: Do not get me wrong, Shelley was great. I appreciated her help, but I am happy to start over with you. (Client denies any loss and tries to engage the therapist.)

Therapist: Great. What would you like to focus on today? (inviting the client to share her goals and desire for therapy)

Client: (angry) I thought you talked to Shelley?

Therapist: I did. I do want to hear from you as well.

Client: (silent and looks frustrated)

Therapist: You look frustrated. Were you hoping I would know what you need to focus on today because I spoke with her?

Client: (very angry) Well, OBVIOUSLY! Why else would you two talk? Why do I have to spell out everything for you? I have to tell you how to do your job? (The client feels angry and hurt that the therapist appears neglectful, withholding, and incompetent to help her in a manner that parallels her experiences with early caregivers.)

Therapist: I see. You are really angry because you thought I would tell you what you should focus on in here. If I knew what I was doing, then I would take the lead. I wouldn’t ask you these questions. (empathizing with the rupture and the anger)

Client: YES!!! If you knew what to do, you would tell me. You would help me. It looks like you do not even care. You are sitting there, and you ask these questions. . . . Just tell me what to do. Shelley told me what to do. (The client now shares that the directive style of Shelley prevented the client from feeling the abandonment and hurt from her early childhood. It is likely that she misses Shelley and uses anger as self-protective measure against experiencing feelings of loss. She is mistrustful of the new therapist.)

Therapist: I see. That would feel awful. You see me sitting here and not caring at all about you, like I know what we should focus on and am withholding it. That is so mean and hurtful to you. And Shelley would never do that to you. (empathizing with the hurt and loss of Shelley)

Client: It is hurtful, and it is not ok. I do not even know you. I just feel overwhelmed right now. (pauses) I have a headache, and I do not know if I should
leave. (confusion with her anger and the empathy she is receiving from her therapist)

Therapist: I hear you. This is very upsetting, and you’re not sure if it would be better to get away. I would like to try and help, if I can. Coming here, not knowing me, and not trusting my intentions feels overwhelming and even dangerous. I am okay if you really need to leave. I get it. I also really do want to help you even if you may not trust me right now.

Client: I do not know what to do. I am sorry I got angry. I just do not know what. . . . (starts to cry)

Therapist: That is ok. You got angry, and you do not know me. You have been hurt before, and it takes time to trust people, including me. You trusted Shelley, and she helped you. Then you had to stop seeing her. One thing I now know is that Shelley was more directive and that really helped you. Sitting with the uncertainty stirs a lot up, especially when you do not know me.

Client: (sighs and wipes her eyes) Yes, I think you are right. It would help me.

In this example, we see a client who initially dismisses any attachment to the previous therapist, forgets the therapist’s name, and navigates the current relationship by immediately caretaking the new therapist who “look[s] tired.” When the therapist asks her what she would like to focus on, she feels as though the therapist is intentionally withholding help. Rather than feeling genuine curiosity, she feels that her therapist’s intentions are malicious. Fonagy and Allison (2014) talked about epistemic trust that comes from secure attachments, the sense that you can trust others to help you and that allows you to take in their feedback and thoughts. For this client, who was emotionally and sexually abused by early caregivers, there is little epistemic trust in the new relationship. The openness and lack of direction stimulate previous traumas with caregivers who were either abusive or ineffective. The therapist resorts to empathizing with the client’s experience, sharing her desire to help, and providing therapeutic structure like the previous therapist. The therapist does not get defensive or overwhelmed by the feedback or attack, especially the painful comparison to the previous therapist. The new therapist tries to repair the rupture (Safran et al., 2011) and be a secure base for the client by listening, being present, and empathizing with the pain and disorganization caused by the transfer (Wallin, 2007).

Discussion

It is not easy to say hello to a client who does not want to start over again with someone new or to say goodbye to a client who is not ready to leave. As you can see, these are challenging situations for a seasoned clinician, but even more challenging for a new therapist who is learning to see clients for the first time. The clinical examples highlight how difficult transfers can be and how therapists’ and clients’ previous relationship histories, as seen through an attachment lens, can impact the transfer.

Given the frequency of transfers in clinical training settings, we need to shed more light on how to help therapists-in-training welcome clients to talk about these losses. Swift, Greenberg, Whipple, and Komiña (2012) described specific strategies to prevent premature treatment dropout that apply to the transfer process. They argue that therapists should be direct about the duration of treatment and what to expect regarding treatment changes over time. In essence, it is important for therapists to try to bring up the transfer process early in treatment and make sure that clients are aware of the changes that will occur during the course of their therapy.

Swift et al. (2012) also described the importance of fostering hope that the treatment will be useful to clients and recommended reviewing the progress clients are making with them during the treatment. In all of our clinical examples, the therapist emphasizes with clients’ perspectives, encourages clients to explore their emotional reactions, mirrors the clients’ strengths, and fosters a sense of hope for the future. It is especially important that therapists foster hope that the future therapist will be able to help them.

Clinicians and Transferring

Students often feel guilty about abandoning their clients, especially when they are moving on to something better for themselves (for instance, an internship or graduation), making it more challenging for them to stay with their clients’ feelings of anger, sadness, and/or rejection (Marmarosh et al., 2017). Even more seasoned clinicians are likely to feel guilty about prematurely leaving a treatment owing to illness, retirement, or life transition. It is never easy to end a therapy when the client still needs the treatment. As we can see in one of the clinical examples mentioned previously, the therapist avoids the transfer, and it is only after supervision that she is able to address the loss and help the client prepare for the next therapist.

On the other side of the coin, tolerating clients’ rejection and anger when therapists are just starting to work with posttransfer clients is challenging as well. The new therapists are taking on clients who are often grieving the loss of previous therapists and may be ambivalent about starting a new therapy relationship (Marmarosh et al., 2017). Helping therapists learn how to stay and empathize with painful feelings and raise difficult topics such as these is also important for therapist development. Supervision can help student-therapists tolerate rejection so that they can remain engaged and help the client through the process.

Future Research Directions

Although we know that the transfer process impacts therapists (Marmarosh et al., 2017) and clients (Schen, Raymond, & Notman, 2013), there is much more we have to learn. We need research that explores how transfers influence outcome, what factors influence successful transfers, and what factors—such as attachment styles—influence client dropout and success after transfers. Qualitative research that explores why clients have dropped out of treatment after a transfer could help us understand what we could do better to help clients and therapists navigate this delicate time in the therapy process. Research that examines how race, ethnicity, gender identity, religion, culture, and socioeconomic status influence the alliance after a transfer is also something that needs attention.
Frequent Transfers: Policy Changes and Resources for Clients in Need

Olson, Wang, Wall, Marcus, and Blanco (2019) found that compared with adults with less serious psychological distress, those with more distress experience greater increased use of outpatient mental health services. They also found that minorities continued to have less access to mental health care. The clients that experience the most trauma, deprivation, systemic neglect and oppression, and poverty tend to be the same ones who rely on low-fee, sliding scale community mental health clinics. These clinics do not require clients to have mental health care insurance and provide services regardless of the ability to pay. Graduate students who are learning to become psychotherapists often staff these low-fee clinics. The clients are able to receive services without having health insurance, but their therapists are graduating or moving on after a year of training. Despite chronic mental illness, trauma, and/or challenges that require more stable clinical care, they endure frequent transfers. Session limits also force some clients into transfers. For instance, clients who come to a university counseling center may only receive 10 to 15 sessions before they need to transfer to therapists in the community. Unfortunately, the most symptomatic clients are often the ones who have the most insecure attachments (Mikulincer & Shaver, 2016, for a review). The clients with the most insecure attachments—the most vulnerable to grief and loss and the ones needing the most relational stability—are the ones forced into ongoing transfers in community-based clinics.

Benefits of Transfers

Although challenging for many clients, transfer terminations may also be useful and offer opportunities to facilitate change (Marmorosh et al., 2017). Specifically, they allow clients to explore their relationships with loss in a therapeutic setting. Yalom (1980) argued that all clients are dealing with death anxiety and loss, and Bowlby (1980) agreed that loss is a significant part of early development and the process of moving toward attachment security. Transfers offer clients the opportunity to work through prior, concurrent, and/or anticipated losses that surface during the transfer process with an empathic caregiver. Different therapists also intervene with different techniques and interventions, and this can help clients learn different strategies to address their symptoms and goals for therapy. More importantly, transfers allow clients the possibility of having multiple secure attachments with different therapists who are diverse with regard to age, gender, race, or ethnicity. The experience of multiple securely attached relationships challenges maladaptive internal representations, stereotypes, and biases, and these secure bases offer hope that even when we have to say goodbye to one person, there are others we can depend on for support.

References


