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Negotiating ending: A qualitative study of the process of ending psychotherapy

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Keywords: Ending psychotherapy, psychotherapy process, qualitative method, termination, therapeutic interaction

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Abstract

Objectives: When psychotherapy is open-ended, the question of termination is a matter for negotiation. A model based on both content and the process of ending may explain how "good enough" psychotherapies can be brought to "good enough" endings.

Design: Twelve processes of ending were explored through a combination of audio-recordings made during therapy sessions and post-therapy interviews with clients and therapists. Therapies had been tailored to the needs of the clients and were based on a broad spectrum of theoretical affiliations.

Methods: A procedure for systematic text condensation was used on a case-by-case basis. Issues surrounding the initiation and negotiation of ending were pointed out in each case and were then compared across cases.

Results: The initiation of ending and exchanges concerned with when and how to end therapy unfolded as a concerted process because both parties seemed to be aware that the theme of ending contained a potential challenge to the alliance. Dual affect regulation, implicit communication and a future-oriented perspective were important features. Structural elements such as schedule changes and temporary breaks served several psychological functions. Therapies seemed to reach "good enough" endings when the client and therapist joined in their efforts to resolve basic ambivalences embedded in the decision to terminate contact with the affirmation of a continuing emotional bond.

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Introduction

The question of when therapy should come to an end is a topic of negotiation in therapies in which the length of therapy has not been established at the outset and in which there are no pre-determined criteria as to when to stop. This paper explores how this process unfolds in presumptively good therapies and provides an in-depth exploration of the ending process in twelve useful cases of psychotherapy.

Ending psychotherapy primarily has been explored in the psychodynamic tradition, where it is known as termination, in reference to Freud's paper, "Analysis terminable and interminable" (1937). In the psychodynamic tradition, the many and ambiguous meanings of ending are highlighted — such as the ambivalence that exists between feelings of dependency and the possibility for increased autonomy, the awakening of infantile anxieties and feelings of abandonment, and the use of the ending phase as an opportunity to repeatedly work through old conflicts toward new, more mature resolutions (Freud, 1914; Loewald, 1988). Most of these psychodynamic contributions, however, either are discussed on a strictly theoretical level or in textbooks that focus on offering recommendations to the clinician about endings (Novick & Novick, 2006; Schlesinger, 2005; Wachtel, 2002). Even in the psychodynamic tradition, more descriptive and phenomenological investigations of actual client-therapist interactions during ending processes are rare. There have been a few empirical studies of therapy endings that have examined clients' experiences (e.g., Etherington & Bridges, 2011, Hynan, 1990), or combinations of therapists' and clients' experiences (e.g., Hunsley, Aubry, Verstervelt & Vito, 1999;), or specific aspects of ending, such as the phenomenon of drop-out (Self, Oates, Pinnock-Hamilton & Leach, 2005; Wilson &

Sperlinger, 2004). We have not been able to identify studies, however, that have explored what occurs during the actual therapy sessions held towards the end of the therapy process. Ending therapy is typically the theme of the final chapter in textbooks on psychotherapy technique, and what is written about endings is often educational and normative. Novick and Novick (2006), for instance, provide guidance on the topic, "Knowing how to end". The theme of ending has been explored in special issues of the *Journal of Psychotherapy Integration* (e.g., Curtis, 2002; Goldfried, 2002; Greenberg, 2002; Martin, 2002; Wachtel, 2002) and of *Psychoanalytic Inquiry* (e.g., Craige, 2009; Fosshage & Hershberg, 2009; Frank, 2009; Harrison, 2009; Shane, 2009). According to Wachtel (2002), who focused on the importance of ending in a way that safeguards the client's self-respect — especially in cases in which the client ends therapy prematurely — recommendations as to how to end therapy do not differ considerably across the different theoretical affiliations; this can best be done by summing up what has been achieved and trying to lead the client to realise his or her own contribution to these achievements. Wachtel also has pointed out how ending treatment entails separation as well as powerful, and sometimes negative, emotions. Schlesinger (2005) has argued that therapists often have excessively high expectations that endings should be more streamlined than is often possible. Finally, Hoffman (1998), Gabbard (2009), Salberg (2010) and Shane (2009) are all concerned with making endings "good enough", and each addresses the myth of a perfect termination.

Ending therapy often arouses feelings associated with loss and separation from people with whom we share an emotional attachment; these can potentially include feelings of abandonment, as well (Holmes, 2010; Muran, Safran & Eubanks-Carter, 2010; Salberg, 2010; Schlesinger, 2005). In addition, ending therapy can stir up the tension that exists between the needs for individuation and relatedness (Benjamin, 1990; Muran et al, 2010). Negotiating ruptures in the therapeutic alliance is considered to be at the heart of the change process

(Eubanks-Carter, Muran & Safran, 2010; Muran et al., 2010; Safran & Muran, 2000), and the termination process is from this perspective viewed as the resolution to the ultimate alliance rupture (Muran et al., 2010). To resolve such ruptures, Eubanks-Carter et al. have recommended, "[T]he use of metacommunication, in which the therapist explicitly draws the patient's attention to the interpersonal patterns that are emerging in the patient-therapist interaction" (2010, p. 81).

The fact that therapy will end is an implicit premise from the start, but when does this ending begin? Who initiates the process of ending? What is the reason for bringing it up? What kinds of interactions take place during the ending process? What means do therapists and clients use to achieve their ending? How do they regard their decision to end therapy in the immediate aftermath of that decision? To answer these questions we studied how endings actually unfolded and how they were experienced and reflected upon by accessing two kinds of data: 1) audio recordings allowed us to follow the on-going interactions in therapy sessions as the therapists and their clients moved toward the end of therapy and toward a decision as to when that end would occur; and 2) qualitative research interviews conducted with the clients and therapists, individually, allowed us to learn about their experiences in retrospect — specifically, how they interpreted themselves, one another and their work together.

This left us with two research questions:

- How is the decision to end treatment negotiated within the psychotherapy relationship?
- How do the two parties retrospectively experience the process of ending?

Each of these research questions, when considered individually, seems to clearly be seeking out a descriptive answer. It could further be argued that good descriptions of endings are lacking. When the two questions were considered together, in exploring the same therapy processes, they allowed for interpretations of what was at stake in the alliance between the

two parties at the point at which the ending became an issue. A third research question would therefore read as follows:

- What are the two parties trying to accomplish or to avoid in their negotiations about ending, and how do they regulate the effect the negotiations have on their relationship?

Method and design

The processes of twelve psychotherapies that had come to an end were explored in a case-by-case study design. A qualitative approach was chosen to facilitate exploratory inquiries into the process of ending in each case and the constituent features of negotiations across cases. The design relied on data triangulation (Denzin, 1989). The researchers qualitatively analysed the subjective configuration of the events in therapy and the corresponding reflections from interviews, as well as observations made of the dialogues according to the chronology of the therapy sessions from audio recordings.

Data

Twelve open-ended psychotherapies were selected from a larger research project entitled, "An intensive process-outcome study of the interpersonal aspects of psychotherapy" (Rønnestad, 2006) conducted at the University of Oslo in Norway. The project is on-going, and involves 18 experienced therapists, 40 clients and several researchers. The first and third authors of this article are active participants in the project.

All of the clients and therapists live in or near Oslo, the capital of Norway. The current study's sample is comprised of twelve clients (ten women and two men, ranging from 25 to 52 years of age) and eight therapists (five women and three men, ranging from 49 to 68 years

of age). The duration of therapy ranged from 7 to 43 months. The number of sessions ranged from 10 to 67 meetings. The sessions took place in an outpatient setting, and the clients paid a low standard fee for their consultations. The frequency of sessions was weekly at the beginning of all therapies, but varied for each client during the course of their therapy.

The therapists had been practicing as individual therapists for between 15 to 35 years, with a mean of 30 years' experience. To determine their theoretical affiliations, the therapists were asked to rate on a scale from zero (not at all) to five (very much so) the degree to which they based their therapeutic work on the following theories: psychodynamic, behavioural, cognitive, humanistic, systemic or other. All of the therapists in this sample based their work on several theories and claimed a broad spectrum of affiliations, but placed different emphases on different theories. One therapist was a medical doctor — a specialist in psychiatry — and the remaining seven were licensed clinical psychologists.

The clients were diagnosed via the SCID interview. Three clients met the criteria for personality disorders. Seven had mood disorders. Four had anxiety disorders. Two had an obsessive-compulsive disorder. One had previously been diagnosed with a form of psychosis and one with PTSD. Five clients met the criteria for several diagnoses. Two clients lacked a SCID diagnosis. The clients were asked in the qualitative interview why they had sought therapy. All twelve clients explained their reasons for seeking help in terms of some kind of life crisis. Four had recently experienced a break-up of their marriage or other long-term relationship. One had lost a teenage son to suicide. Another client reported feeling overwhelmed by memories of sexual abuse experienced during childhood. One had become a mother and wanted to gain better control of her tendencies to lose control over her temper; another had recently lost her mother to illness. Three clients pointed to their low self-esteem and social inhibition as reasons for seeking therapy. All had difficulties maintaining daily

activities and were not able to work for a period of time during the therapy process. One client was hospitalised for a short time during the course of therapy due to suicidal thoughts.

The study sample encompassed therapies that had the following characteristics: 1) they had come to an end; 2) both the clients and therapists had expressed in interviews that therapy had been helpful to the client; 3) quantitative measures from standardised scales had shown that the participants rated the alliance to be a fairly good one (WAI; Hatcher & Gillaspy, 2006; Horvath, 1994a, 1994b; Horvath & Greenberg, 1989); 4) quantitative measures from standardised scales suggested positive development in all cases (OQ64; Lambert & Burlingame, 2004 and IIP-C; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988); and 5) the sample represented a common outpatient clientele as diagnosed by the SCID interview (First, Spitzer, Gibbon, Williams, & Benjamin 1995; 1997).

All therapy sessions were audio-recorded, which afforded the researchers the opportunity to observe the dialogues in accordance with the chronology of the therapy sessions. After each session, clients and therapists separately wrote a brief note of reflection, in which they answered the following question: “What was the most important aspect of this session and why?” Following the end of the therapy process, both clients and therapists were interviewed about their experiences and their retrospective reflections concerning the therapy from beginning to end. The first and third authors are part of the group who developed the interview guides. The interview guides were organized around the therapeutic process and focused on helpful as well as challenging aspects of the treatment. The interview explicitly explored how the decision to end therapy had been made, and how this decision had been experienced by each party. The interviews were conducted by the first author and two other researchers associated with the project. All of the sessions and interviews were conducted in Norwegian and translated into English by the first author.

Researchers

The authors are psychologists and researchers working at the Universities in Oslo (first and third authors) and Bergen (second author) in Norway, either as Professors (second and third authors) or as an associate Professor (first author). All three authors combine research with teaching psychotherapy to psychology students, and all maintain a part-time psychotherapy practice. All of the authors have an interest in qualitative studies as a means of understanding the processes of change that occur during the psychotherapeutic process. The first and second authors have an interest in relational, dynamic, emotion-focused and existential psychotherapy and in psychotherapy integration. The third author has an interest in interpersonal psychology, as well as in personal change and development.

Ethics

The study was approved by the Regional Committee for Medical and Health Research Ethics (South-East Region) and by the Norwegian Social Science Data Services (Rønnestad, 2006). The names and personal details of the participants have been changed to ensure anonymity.

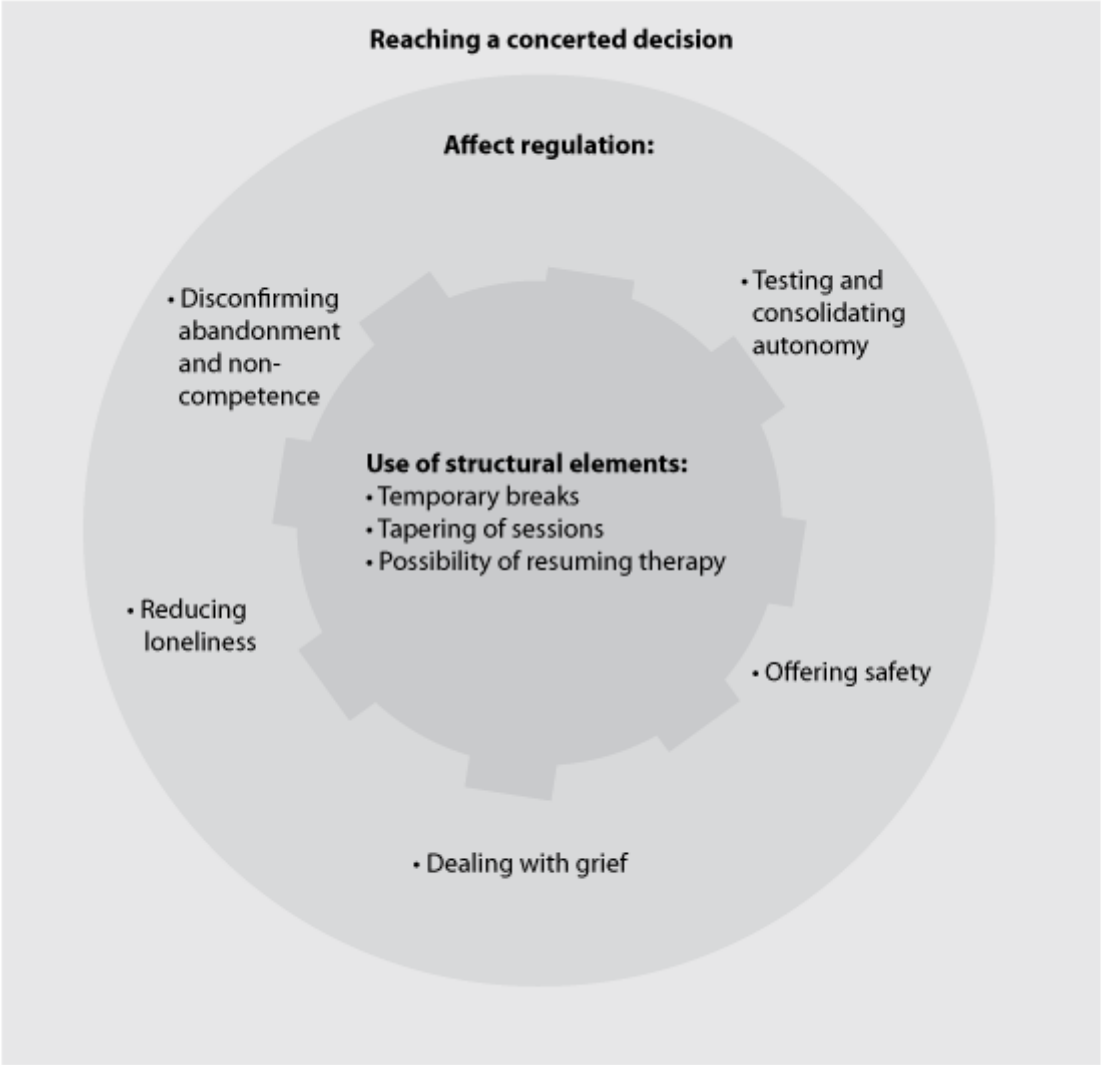
Analysing interactions and reflections

Both the selection of relevant material and the analyses were performed using a method for systematic text condensation (Malterud, 1993, 2001, 2011), with a few adjustments inspired by Braun and Clarke's (2006) thematic analysis and McLeod and Balamoutsou's (2001) qualitative narrative analysis of psychotherapy transcripts. We sought to connect the participants' experiences with what we observed in the therapy sessions. Our aim was to identify both patterns of interaction as well as how the theme of ending was introduced and discussed in the dialogue. The descriptions of the themes were formulated, generalised and supported using Safran and Muran's (2000) theory of "negotiations" in the therapeutic

alliance, and Beebe and Lachmann's (1994; 2002) theory of dyadic affect regulation. The analysis was carried out using Nvivo 8 software (QSR, 2008). The data analysis proceeded through the following five steps: First, the first author listened to and transcribed the recordings of the interviews verbatim, as well as strategically selected therapy sessions. Every final session was transcribed at the start. To identify additional sessions in which ending was a theme, we used information gathered from the interviews, the notes the informants had made after each session and the previously transcribed final sessions. These additional sessions were carefully assessed, and dialogues about ending, in the broadest sense, were transcribed. Second, all of the authors read through the written material separately several times to obtain a basic sense of the meaning of the dialogues about ending that had occurred in the therapy sessions and in the interviews. Third, the first author discussed the material alternately with the second and third author and identified various structural features, such as how they used session frequency and temporary breaks, as well as substantive content concerning the meaning of the ending process, and looked for connections between what we had observed in the sessions and how it was subsequently experienced and reflected upon by the participants. Fourth, significant themes were identified from the dialogues, with the material, and between the researchers. Text material was sorted into "nodes" using NVIVO-8 in accordance with the themes for systematic organisation. The themes were then refined and condensed to the presented configuration of findings. Finally, examples and quotes were selected to illustrate the various aspects of the process of ending. We have chosen the presentation style of thick descriptions (Denzin, 1989; Geertz, 1973), which provides the reader with quotes that illustrate the meaning of our domains, and as a way to enhance the transparency of our interpretative process. Both typical and atypical examples were chosen to show the main tendencies as well as some of the diversity and ambiguity in the material.

Findings: the ideal of a concerted decision

One overarching finding was that, in the negotiations about ending therapy, therapists and clients were drawing on a set of different elements and together made these constituent elements work in a concerted manner. Ending therapy did not appear to be a straight-forward decision arrived at via the assessment of certain predefined criteria. Rather, the dyads seem to have shared an ideal means of reaching a decision to arrive at an ending through a concerted set of proposals as well as through structural arrangements. In this sense, "ending" comes up as something to explore together. When they talked about an ending in the sessions, they tended to refer to a "we" — what "we" have done or what "we" could do. In the individual interviews, both therapists and clients were mindful of the possible reactions of the other person. Looking back, they could reflect on how they had been guided and driven by an on-going awareness of any possible emotional reactions by oneself as well as by the other person. Such emotions were seldom directly addressed in the interaction, but were carefully regulated by the ways in which some experiences were shared and others were kept private. It was as if they put effort into achieving consensus by handling the theme of ending in a harmonious manner. With this as a backdrop, "ending" unfolded and was made into something that happened like a melody they had to compose, rehearse and would then play together. This is what we refer to as a concerted decision, and in the presentation of the results we will point out the elements that came into play between therapist and clients.



How does ending begin? - Initiating and establishing ending as a negotiable process

The client was typically the one who mentioned ending first; this was not always readily apparent, however, as in some cases the initiation of a dialogue about ending was so concerted that it was difficult to tell whether it was the client or the therapist who had first introduced the topic. In such instances there seemed to be a mutual implicit experience of having finished the job, owing to the fact that the client was doing much better in her/his life. As one client, Anita, said during her interview:

Anita: *I think I was the first to mention that I felt we were approaching the end. Perhaps it was her.*

In seven cases, the process of ending was highly concerted, with the client hinting about feeling better and the therapist following up on these mentions by making ending a theme. In four cases, the client wanted to end treatment but the therapist thought he/she would benefit from a longer therapy process. In one case the therapist took a clear initiative to end therapy. We have chosen one case to illustrate each of these ways of initiating ending.

"We have reached a new phase" - The client cautiously leads the way and the therapist responds in a sensitive manner

All clients were polite and cautious when first suggesting that they wanted to stop treatment. They found a way to communicate this, for instance by noting: "I am better now", and, "You have helped me". The therapist may have responded by hinting about the possibility of ending therapy.

The case of one client, David, and his therapist, John — a therapy process that lasted for fifty-five sessions — effectively illustrates the group of seven cases that culminated in a smooth and straightforward ending process. In this case, both client and therapist felt they had been the first to mention ending therapy. David used the first forty minutes of session forty-nine to talk about how well everything had been going in recent days, and how his former complaint seemed to be behind him. John responded in the following manner:

John: *It seems to me that we have reached a new phase in therapy.*

David: *Yes, I agree with you. And I wonder where we are heading? Do you feel I still have issues to work on to take me further?*

John: *That's a complicated question. One way to look at it is that you had a problem, then you worked on it, and now you are content. On the other hand, it is likely*

that continuing conversations about oneself in therapy will continue to take you further. There is no given recipe telling us when to stop.

When David spoke about what was better in his life, he was introducing positive emotionality into the conversation, which the therapist then converted into a shared notion of process; they had reached a new phase. John followed up this implicit question about progress by exploring different possibilities and mentioning their options regarding when and how to end treatment. Their conversation was focused on the future and on emotional matters.

The negotiations in this case, as in 10 other cases, were not carried out as arguments and efforts at persuasion. It was instead more a matter of implicit hinting and sensibility in the interaction. What both the client and therapist alluded to during the sessions was confirmed and made specific in the interviews — the notion that it was important not to just suddenly cut off the therapy process, but to instead take care of the relationship and the gains David had to realised as a result. Both David and John seemed to be aware that this was not just about ending, but also about taking care of a positive relationship which had been helpful to the client.

"Perhaps she will come back later for another round" - When only the client wants to end therapy

In the four cases in which the client took the clear initiative to stop therapy, it seemed to be no less important that the two parties arrive at a consensus about ending. The therapists joined in and supported their clients' decisions to stop, even if she/he felt that the client would continue to benefit with a longer therapy process. In the sessions, the therapists tended to point out that the possibility of continuing remained, often voiced as an invitation, and sometimes mentioned repeatedly. In the interviews, the therapists had more to say about the

limitations or lack of motivation of the client, yet they were still of the opinion that the clients were in the best position to decide what was best for themselves.

In the example chosen, the client, Jenny, and the therapist, Ellen — engaged in a therapy that has lasted only ten sessions — we observed in the sessions that the therapist gave the client multiple chances to change her mind but the client was resolute in wanting to end treatment. At the same time, the therapist was careful to be supportive of the client's decision.

In the interview with Jenny, she spoke about the support Ellen provided and mentioned the significance of being able to end treatment:

> Jenny: *She said, "You have to do what you feel is best and I will be here if you should experience a relapse." As I see it, we were well past my problems. So I took the initiative, and she supported me. I didn't want a long duration of therapy.*

Jenny also revealed that she had sought out Ellen's affirmation. Ellen stated in her interview that she thought her client likely would return at a later date for another round of therapy:

> Ellen: *This therapy was too short. She probably will run into trouble again. Perhaps she will come back later for another round. The process of ending was short but sufficient enough. She was probably relieved when I said yes, it seems appropriate to end now. In a way I feel it was sad that we didn't continue.*

In the interview, Ellen says unequivocally that she would have preferred a longer duration of therapy. The therapists in each of these four cases spoke of the client's apparent relief when the therapist agreed that it was acceptable to stop the therapy process. The clients emphasised the meaning of the therapists' agreement and support, but they did not mention relief in either the sessions or in the interviews. In the dialogues, we observed how emotions were indirectly handled and the interviews helped us to trace the meaning of those interactions. For example, relief was not meta-communicated between the client and their

therapist. The therapist seemed to perceive it, however, and used it to navigate the showing of support for the client, even in a case such as this one, where the therapist said that she would have preferred that the therapy process continue.

"…if we agree that we are approaching the end…"- When the therapist takes the initiative to end therapy

The only case in this sample in which the therapist took a distinct initiative to end therapy was the case of Marian, the client, and Paul, the therapist, who had engaged in a therapy process that lasted forty-three sessions. Seeking out a consensus decision seemed to be important even in this case where the therapist had one-sidedly driven the process forward. When Paul took the initiative to talk about ending treatment, the client, Marian, responded by saying that she wanted to continue. Over a series of subsequent sessions, she repeatedly claimed that she was still suffering and needed therapy, as this quote from the second-to-last session illustrates:

> Marian: *I feel I am not done yet. I feel some anxiety almost constantly. When I wake up every morning, all my worries torment me. I worry about my mother, the economy, whatever. I long for safety and I need control.*
>
> Paul: *So it's far from strange that you feel you aren't finished here. There is always a great deal to worry about, if you want to spend your time that way. This safety you are seeking out in order to feel able to stop treatment, you will never find. That isn't life, it's just a notion.*

Marian disapproved of Paul's eagerness to stop treatment, and she pointed to her worries. In the sessions, Paul repeatedly stated that termination was significant in addressing Marian's main area of difficulty, her autonomy. In his view, she had to realise that she had to live with many of her difficulties and trust her ability to handle her concerns on her own. Paul

might have been willing to postpone the termination of treatment, but he stood firm in his decision despite Marian's repeated dissent. This ambiguity between the need to consider conflicting views and the need to reach a joint decision is evident across the final 13 sessions. In general, Paul adopted a two-part approach: he invited her to join in the decision-making process, and he marked out his own decision. He said, "It is important that we find a tempo that suits you", and immediately modified his statement by saying that they would be able to finish rather soon. He negotiated, too, by saying "…if we agree that we are approaching the end, we don't need to decide a date today." In this way, Paul was able to essentially divide the ending into smaller parts. In the sessions, Marian typically started out by agreeing with Paul's point of view; then she hesitated; and finally, she agreed. Some ambiguity can be attributed to the impression that Paul presented ending therapy as the final proof of Marian's improvement — so that in the end she could affirm that she had become better only by accepting that she had to end treatment.

In the interviews, both parties said that the process of ending had been a challenge, but that they had managed to find a good enough solution. Since Paul and Marian's process of ending was in many ways exceptional, it has been further elaborated on in a single-case study (Råbu & Haavind, 2012). This case demonstrates the power of the therapist in the sense that he skilfully uses the format of a mutual decision to enforce his idea of ending. When the client is aware of this but is not able to oppose the therapist, she will in the end accept ending as a proof of her improvement.

Important constituent elements of ending therapy seemed to be shared across the twelve cases. We will now look more closely at these shared elements. The examples are drawn from across the twelve cases, since such elements seem to be independent of who took the initiative in first deciding to discuss ending.

The active use of structural realities – Turning ending into an experiential issue

The questions of what it will be like to end therapy, and what the possible consequences of doing so are for the client's functioning, can be difficult to explore as hypotheticals. Structural matters such as vacations and other temporary breaks, as well as a reduction in the frequency of sessions, were used as contributions to the process of ending therapy. This seems to turn ending into a concrete experiential issue.

"That's how you can use this summer" - Temporary breaks

Both therapists and clients mentioned summer vacation and other breaks as a way of testing out whether they had arrived at an appropriate time to end therapy or if the client felt safe ending the therapeutic relationship. These events could make the question of ending a topic for an experiential and emotionally anchored exploration. The most recent summer vacation is frequently used as a final test of whether it is time to discontinue therapy. The following illustration with the case of a client, Anne, and her therapist, Peter, illustrates a typical example. This therapy had lasted thirty-five sessions; the quote is from the thirty-fourth session, the final session before Anne's summer vacation:

Anne: *This therapy has been really helpful. I want to use the summer to think over whether I still have anything to discuss with you.*

Peter: *Yes? That's how you can use this summer. I guess you have a couple of other things to do as well.*

Anne: *With regard to the big issues, I think I am finished here.*

Peter: *So we will make an appointment after the summer and then it's up to the experiences you gather.*

The tone in the above dialogue is cheerful. When the two met again following Anne's vacation, Anne had concluded that she was ready to stop, and they concluded the therapy.

"If I feel a strong need" - Utilizing the possibility of resuming therapy

How does the dyad prepare clients for the post-therapy challenges both of maintaining the outcomes of therapy and — when life goals and therapy goals intersect — continuing to work toward their therapeutic goals after therapy has ended? Are there interventions and agreements that can facilitate clients' inner experiences of relational support and enable them to continue a kind of therapeutic work after therapy has terminated? It seems that the possibility of future contact and the use of imagination in making this possibility specific and graspable were used as a means to this end. Clients seemed to use the imaginative elaboration of a possible future meeting in present time to regulate their potential feelings of being unsafe and alone. All of the dyads spoke during the sessions of the possibility of further contact after the end of therapy. Eleven clients mentioned in their interview that the knowledge that they could contact their therapist again — for instance, if they were to experience a new crisis — allowed them a sense of safety. There are several possible meanings of the use of the possibility of future contact, and the potential functions discussed in the following sections seem to overlap. The quote below, by a client, Anita, conveys both the safety she felt in thinking that she would be able to contact her therapist at a later time and the sadness she felt about stopping even though it felt correct to do so:

Anita: *I asked her if it is okay, if I feel a strong need, that I can call her. And she said it was okay. It makes me feel very safe to know that in a way I still have her. I felt ready to stop, but at the same time afraid to let go. It is sad to stop, but at the same time okay. In a way I am bringing her with me.*

Being sensitive about the other's feelings and reactions - Dyadic affect regulation

How do the therapist and client care for their emotional relationship toward the end of therapy? The search for consensus seemed to be an important constituent element in the process of ending. The road to consensus consisted of affective exchanges and affective regulation. Both parties tended to be careful, considerate and sensitive about the other's feelings and reactions.

"It was important that he agreed with me" - Using consensus as a means of dispelling feelings of abandonment and a lack of competence

Why was it so important to the participants that there be a consensus about ending therapy? Regulation of affect seemed to be related to a hypothetical alternative that was not explicitly addressed during the sessions but which could be reflected on during interviews conducted after the fact. Across all cases, the clients seemed to consider it a negative if the therapist had wanted to stop before the client felt ready to do so — as one client, Joel, noted in his interview when he observed that he was the one who had decided to end his therapy process, which had lasted for forty-four sessions with his therapist, Nina:

> Joel: *It would have been terrible if the therapist had said, "Now I think it is time to end." If I hadn't felt the same, I would have felt like I was thrown out.*

It would be difficult for the client to feel as though they had been rejected and abandoned. Joel's therapist, Nina, revealed her feelings of being rejected and not competent in her interview:

> Nina: *It was hard because I felt I was not allowed to help. I wasn't able to confront that deadlock I sensed he was in. I felt like I was no good.*

As the above quote illustrates, the therapists' regulation of their own emotions also may be part of negotiating the end of the therapy process. The possibility of being left feeling as though they have failed is an emotional possibility for the therapist, as well.

The alternative of *not* ending therapy when the client feels they are ready to do so also may have negative emotional consequences for the client. As one client, David, said in his interview:

> David: *If the therapist had been of the opinion that I wasn't finished when I thought I was it would have been disheartening. It was important that he agreed with me.*

The therapists are less explicit in discussing the importance of reaching consensus, but they do show an awareness of its importance to the client in their sensitive reactions to clients showing the initiative to end. The therapists seem to adjust willingly to the individual client. One therapist, Ingrid, during her interview reflected on the importance of letting the client lead the process of ending:

> Ingrid: *I think it was really good for her to be allowed to take her time and lead the process of ending. Perhaps it wasn't absolutely necessary, but I think it was for the best to go along with her in a way I felt was constructive. Her way of ending was a tool in the consolidating of the therapy process as a meaningful whole.*

The therapeutic dyads seemed to avoid difficult feelings (e.g., rejection) by evoking other feelings, such as being caring, polite and sensitive toward one another. The fact that they took care of themselves and of one another in multiple ways was not openly meta-communicated in the relationship.

The possibility of future contact also may be used in some cases to regulate the client's or the therapist's feelings of having been rejected when therapy ends. In some cases

the possibility of meeting again seems to be used as an argument to end treatment. The following quote, taken from the final session between Joel and his therapist, Nina, revealed their experiences of the difficult feelings of rejection and incompetence:

Joel: *I want to come neither weekly nor monthly. Till so long.*

Nina: *No. So, what do you want, if you should come up with a model that suits you?*

Joel: *Ah, something I perhaps wish for, if I could be allowed to, if it is possible, to eventually contact you? … Say, if half a year passes and I feel I really want to talk to Nina, if I could get permission to contact you and ask if I could get an appointment?*

To ask if it is possible to come back later may be an ingredient in a polite farewell — for instance, in the four cases in which the client preferred to end therapy whereas the therapist felt the client would benefit from continuing the therapeutic process. This might also constitute momentum, as in the case of Marian and Paul, where Paul perhaps used the possibility of resuming contact as a tool for coming to an end. He seems to communicate to Marian that: *We can stop now because you eventually can contact me again.*

"It's hard to definitively let go" - Exploring autonomy and reducing loneliness

All clients mentioned the significance of being in control; some very clearly underlined this point. Session frequency reduction was frequently used as a way to test autonomy. Ending treatment by definition entails a separation, as well as a range of powerful and often negative emotions. Some of the pain associated with the process of ending is conveyed in this quote from the interview with a client, Susan:

Susan: *It's hard to definitively let go. We have reduced frequency very, very, gradually. I've always wanted to have "just one more session." In the end, we had eight weeks between the sessions. The appointments have been like an*

anchor. It would have been more difficult if I went there every week and then suddenly should stop. Then I would have felt lonesome.

Susan imagined the future, and she wanted to imagine ending treatment as something that did not create too much anxiety or cause her to feel excessively lonely. She examined her feelings and imagined loneliness as one she wanted to avoid.

Anita reported in her interview how important it was for her not to think of her relationship with her therapist as having definitively ended:

Anita: *I asked her if it is okay, if I feel a strong need, that I can call her. I think she thought we could have stopped earlier, but I found it hard to break up. It felt safe to stay. I don't know. I've always found goodbyes hard and unpleasant. To conclude something, I don't know how to explain. But it passed without any drama. I'm glad the end wasn't that abrupt. If it had been, then it would have been very hard, actually. So it's important to have the possibility to contact her again. Not that I fear so much to get all my problems back, but it's still important that I don't have to put a definite end to it.*

Not thinking of therapy as being concluded once and forever seems to be important for Anita's ability to regulate her emotions after therapy.

"I exist and live in this city and work here" - Constructive use of the memory of the relationship

All of the dyads assumed, whether implicitly or explicitly, that the image and memories of a useful therapeutic relationship may be something that the client can use constructively after the therapy has ended. According to a quote from Anita's interview, presented above, she benefited from feeling as though she still had access to her therapist. It

seems as though talking about the possibility of meeting again might have contributed to Anita creating a more vivid image of the therapist and of their relationship.

Kristin, a therapist, said in her interview that, upon stopping therapy, she says to her clients that:

> Kristin: *Now we stop, and good luck, and if you later feel you need to contact me again, of course you are welcome. If it is in a couple of months or after eight years, I will remember you, and you are welcome to come back.*

The promise of being remembered probably adds to both the client's feelings of safety and the likelihood of the client using the image or memory of the therapist when they are on their own.

Paul is one of the few therapists who expanded on his thoughts on this topic in his interview, noting that:

> Paul: *An important part of the work takes place after therapy is finished, when the client can continue the relationship without the therapist interfering. Sometimes I say to clients that even if we are not going to have any more sessions, I exist and live in this city and work here. It is possible to call me. Perhaps the mere thought of being able to call is enough?*

Paul underscored the significance of not necessarily resuming therapy, but keeping the possibility of doing so open. Knowing that the therapist still exists might be enough to keep the relationship real in the mind of the client.

Discussion

Psychotherapy is both a collaborative and a problem-solving relationship and at the same time often involves the creation and fostering of a close emotional bond. As has been pointed out in the psychodynamic tradition, it is the potential of the therapeutic dyad to establish a new

object relationship that makes it tolerable for the patient to again face old anxieties and conflicts (Mitchell, 1993). When this relationship is going to end, the possibility that feelings of abandonment will arise would seem to be a real threat, and one that will need to be addressed by both parties.

Concluding open-ended therapy is a matter of reaching an agreement through interpersonal negotiation in a unique relationship in which the participants have gotten to know one another. Some ambiguities may be addressed during this process, whereas others may go unmentioned. An overarching theme in our findings has been the shared ideal of reaching a consensus between the clients and therapists. As we have seen, the agreement seems to be based largely on an embodied, sensed affect — rather than, for instance, the use of arguments or meta-communication. Structural features of therapy seem to be important constituent elements in creating a process of ending that might serve several psychological functions, and these features fulfil their roles in both explicit and implicit ways. The working alliance seems to be at stake toward the end of the treatment process (Muran et al., 2010). The creation of a viable alliance is not just the result of the work put forth during the first phase of therapy, but continues to be something both parties care about. Maintaining a strong alliance through to the end of the therapy process might be important for preserving the gains made in therapy and for ensuring that the client retains a positive memory of the therapist and their relationship in her or his life after therapy. Analysis of the first phase of therapies from the same broader study of process and outcome in psychotherapy discussed above has demonstrated that negotiations about how to proceed are not directed at firm and explicit decisions. The creation of a viable alliance instead seems to come about in a more non-linear fashion, with invitations that underscore the need for symmetry and decisions that are not necessarily explicitly agreed upon (Oddli & Rønnestad, 2012).

All of the dyads in this study seem to relate to a standard or an ideal way of ending therapy that fits well with the clinical literature (Novick & Novick, 2006; Schlesinger, 2005). Important ingredients of this standard are that the therapist ensures that they are spending time on the process of ending by focusing on what ending means and summing up the content of therapy. Together they seem to anchor the decision to end in the progress the client has made and will make in life outside of therapy and progress in therapy, and they do so without relying on explicit assessments. In the end, when the therapist refers to successes rather than failures and the focus is on gains made and positive aspects of the therapy, it is a way of anchoring the client in the here and now while also pointing them toward the future.

By carefully comparing actual therapy dialogues and interviews with clients and therapists, we have been able to see how basic emotional needs were primarily addressed indirectly in the client-therapist relationship, and how therapists only rarely used meta-communication and the exploration of emotions and fantasies about the relationship in this process. This was a surprise to us, particularly when viewed against the background of both our own psychotherapy training and the theory on rupture and repair (Eubanks-Carter et al., 2010; Safran & Muran, 2000), which emphasises the importance of actively recognising ruptures and using meta-communication to repair disjunctions. We went a step further in the present study and explored how clients and therapists use their notions of the client's improvement — for instance by noting changes in self functioning and symptom relief — to sustain the process of ending (Råbu, Haavind & Binder, submitted). References to how a client dealt with emotions, relations and situations in significantly new ways were often cited as evidence of the clients' motivation and ability to continue to challenge themselves. Such references seemed to be both a constituent element of improvement and an outcome of treatment, and thus acted as guidance toward the end.

When an important constituent element for the ending process is the tending to the therapeutic alliance in order to preserve what is good about the relationship, it seems to strengthen the notion that this is something for the client to use in the future, for instance as a source of confidence. That led us to take a second look at why the dyads were not explicitly marking milestones and goals. Ending seems to be less about looking back to assess in detail what has happened and more about the imagined future in which there will no longer be regular sessions. Rather than discussing the results of their work they could actually celebrate their sense of being involved in this together. The simple answer to how this was done is the co-creation of metaphors (Råbu, Haavind & Binder, 2012). In all cases such metaphors came out of the interaction with a mutual sensitivity to their capacity to confirm and regulate affect toward the end. The client's careful hints about feeling better — in addition to containing a convention, cf. the hello-goodbye pattern (Hathaway, 1948) — also can be an expression of sensitivity and a constructive way of taking care of the alliance through a phase of therapy during which the relationship and what is to be gained from it are at stake. This can be either an expression of implicit relational knowing (Lyons-Ruth et al., 1999; Wachtel, 2008), or a procedural knowing about how to do things with others. Such knowing is as much affective and interactive as it is cognitive. It might be thought of in terms of Bugas and Silberschatz's (2000) theory about how clients, through implicit communication, coach their therapists to be better able to contribute to their specific developmental and relational needs. The careful hints and polite initiatives also may be seen as a way of encouraging therapists to end therapy when this is what is needed, according to the client's conscious and unconscious project to be completed with the therapy.

These results came out of an exploration of a limited sample of twelve clients, all of whom had experienced positive psychotherapy gains in outpatient treatment with highly experienced therapists in Oslo, Norway. The findings of indirect and implicit communication

may be an expression of a cultural feature. The experience of positive gains may also have led to a relative lack of need for overt communication. Since both therapists and clients were aware that they would be interviewed afterward, one can imagine that the therapists at least would tend to the process of ending in a serious and committed way. More than a study of therapies as usual, this could be ending according to the best efforts of the therapists. Exploring the process of ending in other groups of clients likely would expose variations from our findings; for instance, cases in which the dyads were working under tougher economic conditions with greater pressure to end or cases in which the risk of drop-out is relevant. The concept of a concerted decision and the detailing of all of the constituent elements that the clients' and therapists' might put to use nevertheless has theoretical significance for discussions of variations of how endings might unfold and what is at stake for those involved.

One answer to when therapy ends may be this: therapies stop when the client and the therapist find a way to resolve basic ambivalences concerning ending. Then they can reach the consensus decision that the therapy should end and the emotional bond can continue.

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