

Spring 5-16-2011

# Beginnings and Endings: An Inquiry into the Attachment Orientations and Termination Approaches among Clinical Social Workers

Katherine C. Ledwith
*University of Pennsylvania*, kledwith@mail.med.upenn.edu

# Beginnings and Endings: An Inquiry into the Attachment Orientations and Termination Approaches among Clinical Social Workers

**Abstract**
All therapeutic relationships must come to an end. Although there is ample social work literature on the impact of termination on clients, there is a dearth of scholarship on the experiences of clinicians during this phase. This study explored the links between the levels of attachment orientation of a purposive sample (N=49) of clinical social workers and their subjective approaches to termination. The Adult Attachment Questionnaire (AAQ) and the Termination Approaches Questionnaire (TAQ) (created for this study) were instruments used in this online survey design. The results suggested a statistically significant relationship between attachment orientation of clinical social workers and their approaches to termination. Participants with lower scores on the AAQ had higher scores on the engagement subscale of the TAQ indicating that those with higher attachment security were more likely engaging in the process of termination. Likewise, results suggested that the higher the AAQ scores the higher the scores on the avoidance subscale of the TAQ indicating that those with less secure attachment orientation were more likely avoiding the termination process. Qualitative results highlighted the emotional ambivalence, the opportunities, and the need for education about the termination phase. The worker's role and the therapeutic relationship emerged as key factors in termination approaches. By bringing increased attention to termination and to clinician attachment in this phase of the work, this study strengthens the potential of clinical social workers engaged in outpatient psychotherapy practice to minimize unfavorable effects of termination on clients and on themselves.

**Degree Type**
Dissertation

**Degree Name**
Doctor of Social Work (DSW)

**First Advisor**
Jeffrey Applegate, PhD

**Second Advisor**
Joretha Bourjolly, PhD

**Third Advisor**
Lani Nelson-Zlupko, PhD

**Keywords**
attachment, termination, clinicial social work, psychotherapy, endings

**Subject Categories**
Clinical Psychology | Counseling Psychology | Social Work

# BEGINNINGS AND ENDINGS: AN INQUIRY INTO THE ATTACHMENT ORIENTATIONS AND TERMINATION APPROACHES AMONG CLINICAL SOCIAL WORKERS

Katherine C. Ledwith

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2010

_____

Jeffrey Applegate, Ph.D.

Supervisor of Dissertation

_____

Richard J. Gelles, Ph.D.

Dean, School of Social Policy and Practice

Dissertation Committee

Joretha Bourjoly, Ph.D.

Lani Nelson-Zlupko, Ph.D.

Dedication

This dissertation is dedicated to my clients and teachers – past, present, and future. A special dedication is reserved for Joe McBride, who nurtured me in my early days as a therapist, taught me how to be a clinical social worker, and whose supportive wisdom and humor sustained me. I will always remember him.

# BEGINNINGS AND ENDINGS: AN INQUIRY INTO THE ATTACHMENT ORIENTATION AND TERMINATION APPROACHES AMONG CLINICAL SOCIAL WORKERS

Katherine C. Ledwith

Jeffrey Applegate, dissertation chair

All therapeutic relationships must come to an end. Although there is ample social work literature on the impact of termination on clients, there is a dearth of scholarship on the experiences of clinicians during this phase. This study explored the links between the levels of attachment orientation of a purposive sample (N=49) of clinical social workers and their subjective approaches to termination. The Adult Attachment Questionnaire (AAQ) and the Termination Approaches Questionnaire (TAQ) (created for this study) were instruments used in this online survey design. The results suggested a statistically significant relationship between attachment orientation of clinical social workers and their approaches to termination. Participants with lower scores on the AAQ had higher scores on the engagement subscale of the TAQ indicating that those with higher attachment security were more likely engaging in the process of termination. Likewise, results suggested that the higher the AAQ scores the higher the scores on the avoidance subscale of the TAQ indicating that those with less secure attachment orientation were more likely avoiding the termination process. Qualitative results highlighted the emotional ambivalence, the opportunities, and the need for education about the termination phase. The worker's role and the therapeutic relationship emerged as key factors in termination approaches. By bringing increased attention to termination and to clinician attachment in this phase of the work, this study strengthens the potential of clinical social workers engaged in outpatient psychotherapy practice to minimize unfavorable effects of termination on clients and on themselves.

# Table of Contents

**Table of Contents (continued)**

**Table of Contents (continued)**

# List of Tables

# List of Figures

# CHAPTER 1: INTRODUCTION

## Problem Statement

According to the Bureau of Labor Statistics, in 2006, there were close to 600,000 practicing social workers in the United States. Approximately 20% of all social workers were providing mental health or substance abuse services in that year. This number is expected to increase approximately 30% over the next decade (Bureau of Labor, 2008). These figures indicate a need to explore all phases of the clinical process. Much of the literature and research on clinical social work practice focuses on creating relationships with clients, with less attention given to termination (Gutheil, 1993).

Termination is a critical aspect in the social work Code of Ethics. The code mandates awareness of a client's best interest when approaching client transfer or termination. Termination, according to the Code of Ethics, should occur when services are no longer required or needed. Social workers are to avoid abandoning clients, and take careful steps to minimize adverse effects to termination (Code of Ethics of NASW, 2008, p. 14). This can be done through increased clinical competency, and through the exploration of termination. Termination occurs in all types of clinical social work practice.

The agency settings, roles, and goals of social workers are quite varied, but the experience of termination is common among this range (Gutheil, 1993). Termination is a critical phase of the treatment process (Boyer & Hoffman, 1993; Fortune, 1987; Gutheil, 1993). Fortune (1987) defines termination as the phase in treatment when the client and

therapist reach an understanding that the contract between them will end. Gutheil (1993) describes termination as the end of a working relationship, and the beginning of life without the professional helping person. For this study, termination is defined as the end phase of the therapeutic relationship.

Attachment is a developmental theory with numerous clinical implications. Bowlby and Ainsworth proposed that internal working models of attachment, formed in early life, determine interpersonal expectations and behaviors later in life. These internal working models provide a blueprint of adult interpersonal relationships (Shilkret & Shilkret, 2008). Adult attachment styles are categorized as the following: secure/autonomous, dismissing, preoccupied, and unresolved/disorganized (Seigel, 1999). Attachment theory suggests that the attachment style of each person in the dyad is key in understanding client-counselor match (Bernier & Dozier, 2002).

## Purpose of Study

A gap in the literature exists in understanding the link of termination and therapist attachment. This study attempted to provide empirical data to begin addressing the gap and to test the instrument created for the study. This quantitative inquiry into attachment and termination provides useful information to the field of clinical social work practice. Quantitative methods allowed for comprehensive exploration of these two factors (termination and attachment) and their possible relationship to each other. Qualitative questions elicited anecdotal data from the participants. This inquiry sought to explore the following question: *Is there an association between attachment orientations and*

*termination approaches among clinical social workers working in outpatient mental health settings?*

## Attachment theory and clinical social work practice

Attachment types can be seen as an outcome of biological predispositions and of early caregiver relationships within a specific social environment, thus supporting a nature and nurture position (Shore & Shore, 2008). Clinical social work approaches tend to take all of these factors into account in assessing and intervening with clients. Although the roots of attachment theory are in developmental psychology, the link between attachment and clinical social work practice can be invaluable to the field. McMillan (1992) describes attachment theory as providing a "theoretical bridge" (p. 205) between early childhood development research and clinical social work practice.

This current study uses attachment theory as a bridge to bring to light the importance of termination as a phase of work. Termination is currently a seemingly underrepresented segment of clinical work that, if done well, may provide ongoing positive outcomes for client, worker, and the field as a whole. The universality of the presence of attachment orientation in adults, as well as the common experience of some type of termination in a helping relationship, were the building blocks for this project. Attention to both attachment and termination in a clinical encounter may emerge as a pioneering factor in modern day clinical social work practice.

Bowlby (1988) outlines specific tasks for a therapist using attachment theory to work on with clients. A therapist is to provide a secure base from which the client can

explore various aspects of their life, and to assist a client in looking for patterns in his or her relationships. A therapist should assist the client in exploring the relationship between client and himself or herself, and to consider past and present expectations and perceptions, where they may be rooted, and how they impact the client's life. Lastly, the therapist is to assist the client in recognizing models of himself or herself and others. This allows the therapist and client to address the accuracy of perceptions, the origins of these perceptions, and to shift unconscious expectations and imagine less painful alternatives (Bowlby, 1988).

These tasks are familiar in the teachings of clinical social work practice. Shulman (1999) describes three core elements of the interactional model of social work practice. Assumptions of the interactional model are the symbiotic relationship between a client and his or her social surroundings, the presence of obstacles for individuals to engage with the environment, and the strength to change. This interactional model is broad based, and can encompass specific approaches to practice. Thus it provides a useful example (Shulman, 1999).

The synthesis emerges between the attachment lens for psychotherapy, and the interactional model of social work practice. The idea of the secure base is part of the client's environment, and thus the secure base is the beginning of a symbiotic relationship for the client and his or her environment. Obstacles of engagement exist, and exploring patterns in relationships is an attempt to look at obstacles. Social work practitioners often believe that the strength to change is innate, as is the desire to attach and to have a strong caregiver bond. Part of this strength is likely fostered in the treatment relationship.

Clinical interventions in social work practice are frequently rooted in dynamic relational processes that are informed by attachment. The creation of an attachment relationship while respecting the individual is a frequent goal. A clinician's eye toward the inter-subjectivity of the work, and specifically tuning in to even small attachment communications, allows for regulations of previously disregulated affective states (Shore & Shore, 2008).

Bowlby's tasks for psychotherapy do not address an important issue in the therapeutic alliance – that therapists also have attachment orientations. A therapist's awareness of his or her reactions in the relationship may be linked to one's own attachment orientation. This plays a role in the alliance, and is also an important part of the work. This project uses a lens toward the attachment orientation of clinical social workers, with the idea that their own orientation may influence their experiences of termination and how they navigate termination.

Loss has been considered in the attachment research (Leiper & Casares, 2000) as well as in the termination research (Boyer & Hoffman, 1993), but attachment and termination have yet to be looked at together. Current research has focused on therapist's (from varying professional disciplines) and client's termination behaviors and experiences, and therapists' and/or clients' attachment styles or orientations. There is no current literature or empirical studies, outside the current study, linking clinical social workers' attachment orientations and termination behaviors.

Attachment theory is also significant in clinical social work practice areas outside of psychotherapy practice. Much of the use of attachment theory within clinical social work is in the areas of loss and child welfare. Child welfare and attachment are integrated

in early development and responses to deprivation and separation. Research has looked at the impact of child abuse and its impact on attachment, as well as the need for attachment repair in children of foster care (McMillen, 1992). Social and emotional development of children can be characterized by disrupted, disregulated or traumatic experiences that may impact children's abilities to reflect or regulate their responses within the social environment (Applegate & Shapiro, 2005).

Attachment theory and clinical social work share a lens toward cultural competency. The NASW Code of Ethics mandates that social workers understand the function of culture, demonstrate competence in delivering culturally sensitive services, and comprehend the nature of diversity and oppression (NASW, 2008). Much of social work education curricula emphasize socio-cultural theories as a fundamental way to understand and apply culturally competent practice (Simpson, Williams & Segall, 2007).

Whether cultural competency was an intended outcome in the early stages of attachment theory development and research is unknown. Regardless, it has become a clear result. The beginnings of attachment research were done in Uganda and Baltimore, so the inception of the research was culturally diverse. Both the Uganda study and the Baltimore study showed that quality of time spent with attachment figures was a prime determinant of attachment styles. The quantity of time was less important. The Uganda study children lived in an extended family context, where they were exposed to numerous adult caretakers. The Baltimore families, on the other hand, lived in nuclear family contexts. Despite the cultural and behavioral differences in children and mothers, attachment styles appeared to mirror each other. The Uganda study opened the door and invited interest in cross-cultural studies on attachment. Many further studies confirmed a

universal need for an attachment figure and a secure base, and also saw cultural differences in behaviors related to attachments (Brandell & Ringel, 2007). Since the Uganda and Baltimore studies, replication studies of the Strange Situation (Ainsworth's laboratory experiment with infants and caregivers) across other cultures, and with other attachment figures (fathers, for example), in different family types (two parent working families) are widespread, and have lead to increased knowledge about attachment and development, as well as validity of Ainsworth's original project (Bretherton & Main, 2000).

The "theoretical bridge" as described by McMillan (1992) extends to many arenas of social work practice and attachment theory. A look at practice theories and research indicates ways in which attachment theory and clinical social work are mutually supportive of each other. It is the task of practitioners and research to make use of this mutual support in order to inform best practices. This project attempts to inform best practices related to termination of treatment through a greater understanding of the influence of attachment on this phase.

## CHAPTER 2: REVIEW OF THE LITERATURE

### Termination Conceptualized

#### Characteristics of Termination

There is little debate about what termination is, although what termination looks like, what happens during termination, and how it is experienced is greatly influenced by the client, therapist, and the agency. Several characteristics of termination are described in this section.

Hoyt (1979) refers to the work of psychotherapy as a "prologue" to the termination. Because time is linear, psychotherapy moves in the direction towards ending, even from its inception. It is a goal-directed activity, and time needs to be kept in mind even if a time limit does not exist (Schlesinger, 2005). A guiding principle of termination includes being mindful of endings occurring from the beginning (Hoyt, 1979; Schlesinger, 2005; Shulman, 1999).

Termination should be dictated by patient needs and vary among patients (Palombo, 1982). Schlesinger (2005) believes it is a mistake to view termination as a uniform process, thus looking at patterns of endings rather than prescriptions of endings is critical. Without using "termination" in her language, Gomberg (1948) described the separation of client and worker in a chapter of *Family Casework and Counseling: A functional approach*, an early social work textbook. In this text, Gomberg reports that there will always be a reaction to leaving the helping experience. Although individual reactions will be different, universal elements exist. Desire to hold onto an important relationship and fear can cause people to re-experience earlier problems. The emotional

content and process that is involved with clients initiating, working through, and terminating help must be used and understood by the worker. Gomberg says it is a necessary skill to allow clients movement toward independence and to make this a productive experience (Gomberg, 1948). Gomberg's remarks provide a look at the early theoretical conception of termination but do not represent empirical data.

Practitioners have long held that the way termination is conducted is critical to the outcome, and to the maintenance of gains made in the treatment setting. Thus, a discussion of termination may evoke repetition of topics that were explored in treatment (Levinson, 1977). In psychoanalytic approaches, a processing of the transference responses can also be essential to termination processes and the outcomes (DeWald, 1978; Garcia-Lawson & Lane, 1997; Palombo, 1982). Mann (1973) proposes that processing termination must occur, and the struggle is mainly routed in a separation reaction. According to Novick (1997), a close look at case and theoretical history shows that a lack of knowledge of the intricacies and complexities of termination can lead to wasted time and effort by worker and client, and could even result in significant damage.

Although reviewing the major developments of the work is part of termination (Shulman, 1999), termination is more than that. Properly addressing termination could help individuals work through their experiences of termination or possibly present parallels in their lives. There are specific signals, including anger, sadness, and guilt, that indicate reactivation of losses, fears or other conflicts that emerge during termination (Hoyt, 1979). At times, termination is characterized by missed appointments or by increase in symptom presentation (Shulman, 1999). This phase can also be characterized by regression, acting out, and avoidance (Walsh, 2007; Zilberstein, 2008). Other initial

reactions to termination, regardless of reason for the termination, include flight, withdrawal, denial, projection and splitting, resignation and apathy (Schlesinger, 2005).

Therapists must be aware of their own affective and emotional responses throughout the termination process, many of which can mirror those of the client (Shulman, 1999). Goodyear (1981) maintains that the focus on client reactions to termination invokes a myth that counselors do not have reactive experiences during the process. The counselor may experience loss, guilt, or questions about competence (Fortune, 1987; Goodyear, 1981).

Fear of leaving the therapeutic relationship, and a wish to live more independently (Smalley & Bloom, 1977) provide a window into the ambivalence that characterizes endings. A sense of achievement and maturity can accompany endings (Fortune, 1987). Shulman (1999) describes the ending phase as having great potential for work, but that it is often not effective when client and worker do not address the feelings associated with this phase.

Maholick and Turner (1979) suggest that the lingering experience, often the suffering of unfinished goodbyes, is a powerful one. The exploration and expression of these intense emotions can be fruitful, and is something that our culture may be missing (Maholick & Turner, 1979). A clinician's role, and use of self in order to address goodbyes, can provide strength to the foundation of the work. Endings inevitably include the opportunity for new beginnings (Fortune, 1987; Shulman, 1999). Regardless of the positive, negative, or neutral response to endings, the responses are all intrinsic and useful (Fortune, 1987). The remaining missing piece in the literature is how to best deal

with responses to endings by both parties in the helping relationship, and what interpersonal qualities in each party impact these responses.

**Missing Elements**

In the psychotherapy literature, there is much less attention to the significance of endings than the attention to joining and beginnings (Levinson, 1977; Maholick & Turner, 1979; Smalley & Bloom, 1977). Fox, Nelson, and Bolman (1969) identified the deficiency in the attention to termination in the literature as mirroring a deficiency in social work and mental health attention to endings as a whole. Fox et al. ascertained that termination was missing from much of the master's level social work curricula, thus leaving social workers in their varying roles without awareness of or skills for this phase. This gap in preparedness should be looked at as a public health problem, due to the social worker's key positioning within communities (Fox et al., 1969). Although Fox et al. made strong arguments for the importance of integrating termination learning into the social work curriculum, they do not present or cite empirical research, thus further illustrating the gap.

Levinson (1977) reports that termination is "sparsely covered" in the literature, despite varying disciplines that can and must terminate with clients. He also cites lacking attention to termination in in-services, case conferences, and supervision. The distancing or effort toward avoiding emotional responses to termination by clinicians is in contrast to the clinical need of that period (Levinson, 1977). In a review of both social work texts and group work literature, Webb (1985) did find sections devoted to termination. Webb argues that the topic of termination has not been ignored, but that the efforts to emphasize

its importance have not been applied in practice (Webb, 1985). Anthony and Pagano (1998) cite termination avoidance in practice, due to therapists' difficult reactions (guilt, for example), and speculate that this avoidance contributes to the limited literature and research on termination (Anthony & Pagano, 1998).

Freud referenced the concept of termination, but missing in his writings is any technique addressing termination. There is overall disagreement in the psychoanalytic literature about how and when to terminate (Bergmann, 1997). To note irony, there is a breadth of psychoanalytic theory on termination, whereas the social work and general psychotherapy literature appears more limited. Psychoanalysis by nature is not time limited, and a client can remain in treatment until reaching an optimal psychological place. In the social work field, termination is considered as a given and as necessary. Agency function and worker roles vary greatly, but the literature remains in need of a clearer understanding on how and when to terminate with clients.

**The Setting as a Link**

Termination is linked strongly to the treatment setting. The treatment setting can often determine when and why, and sometimes how, termination occurs. Some settings are designed to provide brief, time-limited treatment. Examples include transitional housing programs, mandated treatment, and hospital-based social work. In brief treatment models, termination is begun at the same time that treatment begins. Attention to treatment setting is especially important in the social work arena due to the multitude of settings in which social workers practice.

Reid (1990) presents an integrative model of brief treatment, one that includes psychodynamic and cognitive approaches. In brief treatment, time limits are often set in the first phase of the work, therefore termination is integrated into the process. The clinician helps the client identify next steps in dealing with ongoing or emerging problems. Modifications in the time of service can be revisited, depending on setting, but must have clinical relevance, and termination is again integrated into the treatment planning (Reid, 1990). In Mann's (1973) model of time-limited psychotherapy, limits are set at the beginning of treatment and there is no renegotiating of the time. Reid and Mann's approaches make clinical use of termination and of time.

Although there are varying ways of presenting the ideas, the psychoanalytic literature has general agreement on when termination occurs. Termination of analysis occurs when the transference is addressed, the oedipal struggle is expressed, and ideal psychic functioning is reached (Bergmann, 1997; Garcia-Lawson & Lane, 1997; Golland, 1997). Setting is a critical piece of what termination looks like, as traditional psychoanalytic approaches are neither functional nor appropriate across all treatment settings (Schiff, 1962). It is clear that in most clinical settings, these termination goals are not possible. Generally in social work settings, a client is ready for termination when agreed upon goals are met.

In Shiff's (1962) paper on termination in outpatient psychiatry settings, he refers to settings as an obstacle to successful termination. In his observations of clinical training centers, Schiff observed some patients' awareness of the yearly turnover of psychiatry residents, thus coloring care from the outset. Often times, patients know this pattern and have preconceived views on their treatment (Schiff, 1962). Similarly, terminations of

social work students and their clients are almost always dictated by the end of the school year, a practice often referred to as "premature terminations" (Gelman, Fernandez, Hausman, Miller & Weiner, 2007).

External realities are one of the reasons that analysis ends (Bergmann, 1997). External realities are frequently the reasons that treatment ends in clinical social work settings. Because clinical social workers roles' are so varying, a call for increased attention to termination, and use of setting in termination is indicated. Using the setting, or agency function, along with time, provides a bridge to our history with the analysts, and also highlights our adaptability to circumstances and function.

Rather than using setting as an obstacle, it can be the challenge of the clinical social worker to search for opportunities for unique outcomes. A unique outcome is no longer dominated by the problem (in this case, the setting as an obstacle) (White & Epson, 1990). We are not crippled by our inability to engage in ongoing, non time-limited analysis with every client we see. Rather, making good use of time and of the termination phase regardless of when it occurs, can allow for richness in the work. Therefore, ample attention to how we end treatment with clients and what it is like for practitioners is a step toward giving termination the attention it needs.

**When to Terminate**

Social work has many modalities with different forms and functions. Ongoing outpatient psychotherapy, brief treatment, crisis intervention, and traditional casework are

just a few examples. The different treatment settings and roles, individual client goals, and logistical limitations, all dictate when termination will happen.

Endings are a process and not a fixed moment in time. Abrupt endings can be challenging to both the worker and the client, and can limit the work that is done (Shulman, 1999). The NASW Code of Ethics says that social workers are to avoid abandoning clients and withdrawing services without attention to the various factors involved. Social workers are also to plan for termination when possible, and provide opportunities for continuing care when needed (NASW, 2008). A client's recognition of unconscious patterns and defenses, and working through some of these responses could indicate time for termination of analysis.

Whereas brief treatment models begin termination in the first phase (Reid, 1990), Palombo (1982) says termination begins when mutually agreed upon goals are met, and includes the loss experience of client and therapist and a processing of the transference during the endings. Schlesinger (2005) sees the ability of a client to make strong interpersonal attachments as a defining characteristic of an ending. Palombo's (1990) and Schlesinger's (2005) models illustrate a psychodynamic approach to the idealized setting for termination.

Mann (1973) believes the lack of time limits allows ongoing psychotherapy to dribble to an end, reach chronic impasses, or terminate due to moving, scheduling, or other non-therapeutic ends. For this reason, as well a belief in the power of the conscious and unconscious interlocking of time, Mann (1973) advocates for time-limited psychotherapy. In Mann's model, psychotherapy is a 12-session encounter, with time limits set in the beginning, and termination technically starting at session nine but

sometimes earlier or later depending on the client. Mann reports that avoidance of termination processing should not be allowed in the encounter. He believes that dependence on the therapist is not fostered in this model, but clinging to the therapist may happen, representing childhood fantasies. According to Mann, adult reality is integrated with accepting the sense of time. The goal of the end phase is to undo early and unresolved ambivalent relationships that play out in present lives of clients (Mann, 1973).

The term "interruption" describes termination that occurs for reasons other than the treatment process coming to a logical end. Walsh (2007) describe three types of endings: unplanned, client-initiated endings, unplanned practitioner-initiated endings, and planned endings. Each type of ending evokes different reactions from client and practitioner (Walsh, 2007). Examples include factors such as a patient moving, therapist's leaving, or patient requiring expertise that the therapist does not have. Clients' choices to terminate treatment, either communicated or not communicated to the therapist, can also be an interruption (Palombo, 1982). This concept of treatment interruption is all too common in today's social work milieu.

As social workers, we do not always have the opportunity to reach a place of resolution with clients. Social workers can use this idea of treatment interruption to extend the termination concept. Termination does not always occur when treatment goals have been met and the process is coming to a logical ending. Creative adaptations of termination can allow for endings that are fruitful for both therapist and client, leaving the worker and the client with a beneficial story. It is possible that attachment orientation can influence the creative adaptations, or interventions, that are used by the worker. A

clinician's attachment style may also impact the timing and processing of termination. This paper now explores the conceptual roots of attachment.

## Attachment: A theoretical framework

Psychoanalysts in both Europe and North America were considering the long term impact of child institutionalization and changes in the primary caregiver in the 1930s and 1940s, long before *A Secure Base*, Bowlby's seminal book on attachment theory was published (Bowlby, 1988). The phenomenon that Freud originally termed as attention, for example love relations, separation anxiety and emotional detachment, began to make up a new paradigm called attachment (Bowlby, 1988).

Bowlby (1988) defines attachment behavior as "any behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world" (Bowlby, 1988, p. 26-27). The quality of one's attachment therefore informs attachment behavior. Attachment behavior is an observable expression of an internal motivation, thus of equal importance as other internal motivations including feeding and libido. Therefore, according to Bowlby, the treatment of a child by the mother figure is of primary importance to a child's development. A child's exploration from a secure base from which the infant explores the world is critical, and allows the child to explore the world while returning to safety and comfort (Bowlby, 1988).

Slade (2000) outlines four major assumptions of attachment theory. The infants are motivated to form and maintain relationships with their primary caregiver, mainly

because their physical and emotional survival is dependent on the caregiver. This dependency can influence the infant to act in ways to maintain the caregiver relationship and respond to caregiver needs. At times this need for survival can cause an infant to develop vulnerabilities in relating to others. A child's biologically driven adaptation to caregivers leads to patterned affect regulation and defenses in the infant. Because of this influence of the caregiver and infant the relationship, attachment theory indicates that the attachment style of the mother (or primary caregiver) has a great influence on the child's attachment representation and attachment behaviors (Slade, 2000). There is also evidence of a multi-generational transmission of attachment styles (Applegate & Shapiro, 2005).

John Bowlby formulated the basic tenets of attachment theory, while Mary Ainsworth provided much of the empirical evidence to support Bowlby's ideas and to expand some of the concepts (Bretherton, 1992). Bowlby and Ainsworth proposed that internal working models of attachment, which are formed in early life, determine interpersonal expectations and behaviors later in life. These internal working models are patterned and influence the important relationships of adults (Shilkret & Shilkret, 2008).

**Patterns of Attachment**

Attachment styles are believed to be patterned. Through research and theory development, attachment classifications have been identified. Ainsworth identified three

classifications of attachment by gathering data through the Strange Situation, a laboratory experiment of mothers and infants. In the experiment, a stranger is introduced to the situation, shortly after which the mother leaves. The stranger then leaves the room, the infant is left alone, and the stranger, then the mother, returns. All of these changes in the dynamic are brief, with the entire experiment lasting 20 minutes. Results were validated by the home visit data gathered in Ainsworth's Baltimore study (Brandell & Ringel, 2007). The Baltimore study began in 1963 in Baltimore, MD, and consisted of 26 participating families. The Baltimore study was an observational project in which 18 four-hour home visits were made with the mother-infant dyads over 54 weeks during which patterns of behavior were observed (Bretherton, 1992).

The Strange Situation, originally conducted in Baltimore has since been replicated worldwide with similar results. The Strange Situation data showed ambivalent, avoidant, and secure patterns of infant-mother attachment (Bretherton, 1992). A secure infant shows signs of distress with separation, then actively greets the parent upon return, makes contact, and then returns to play. Avoidant infants show little distress in separation and actively avoid the parent upon reunion. Resistant-ambivalent infants show preoccupation with parents, alternatively seeking and resisting parent, and do not return to exploration (Main, 1996). A fourth attachment style, disorganized attachment, was identified by Main and her colleagues (Main & Soloman, 1986), and was ultimately supported by Ainsworth (Main, Kaplan, & Cassidy, 1985). This category is characterized by disoriented or disorganized behaviors in parent's presence, including freezing, clinging while leaning away, or rising and falling at parent's entrance (Main, 1996).

The Strange Situation looks closely at the interaction between infant and caregiver. In Ainsworth's original study, secure infants were highly correlated with sensitive mothers. Insecure-avoidant infants showed little interest in the mothers, and mothers tended to be intrusive and controlling. Resistant-ambivalent infants were clingy and distressed when the mother was not around, and appeared linked to unresponsiveness or insensitivity on behalf of the mother (Bretherton, 1992).

Bowlby (1988) and Ainsworth and Bowlby (1991) present evidence that patterns of attachment persist into adulthood, and act as representational models of viewing and responding in the world. They are automatic and mostly unconscious (Sable, 1992). A look at attachment in adults is thus indicated. Four adult attachment classifications have been identified that correlate both theoretically and empirically to the infant attachment categories. These classifications include the following: secure-autonomous, dismissing, preoccupied, and unresolved-disorganized. Much of the data to support adult attachment classifications is derived from the Adult Attachment Interview (George, Kaplan, & Main, 1985), an instrument that looks closely at the discourse around attachment history rather than the content. The ability to present life history and to evaluate the experiences of the past, rather than the actual past history, is the focus of this interview (Main, 1996).

Secure-autonomous adults present a coherent and collaborative discourse while they describe and evaluate attachment-related experiences. They appear to value attachment while remaining objective about particular experiences. Dismissing adults present praising, positive experiences of parents that are unsupported or contradicted in anecdotal memories. Interviews are marked by a lack of negative experiences, and a lack of memory. Preoccupied adults present as angry, sometimes confused, fearful and

overwhelmed. Interviews at times are vague, marked with irrelevant responses. Unresolved-disorganized adults show lapses in reasoning or monitoring of the interview discourse (Main, 1996).

Since the original conception of infant and adult attachment categories, there has been much research and debate about these categories. At the core of the debate is the question of whether attachment is in fact typological or dimensional. The infant attachment types and adult attachment types are a clear effort toward the typology of attachment. This categorization assumes that with respect to attachment security, individuals differ in kind rather than degree. Alternatively, attachment types could be explored using a dimensional approach (Fraley & Waller, 1998). Ainsworth et al. (1978) did in fact present their data on a continuous rating scale characterizing two discriminant functions: anxiety and avoidance (Ainsworth et al. 1978 in Brennan, Clark, and Shaver, 1998). Much of the literature to assess attachment is geared toward two dimensions and the four types that are defined within the dimensions (Brennan, et al., 1998). Fraley and Waller (1998) cite systematic variance in identified attachment groups, as well as the many sources influencing the development of working models (such as temperament, responsiveness of caregivers, trustworthiness of romantic partners), as evidence for a dimensional approach to attachment. Attachment research is characterized by both continuity and changes, thus possible harmful consequences emerge when categorizing continuous variables (Fraley and Waller, 1998).

**Biopsychosocial basis of Attachment Theory**

Attachment theory is considered a developmental theory, but it is rooted in the biopsychosocial approach to human functioning. This section reviews the theoretical constructs related to the biopsychosocial basis of attachment theory, and is followed by the empirical data that support the theory.

The need for an attachment figure is seen as innate and instinctual (Ainsworth & Marvin, 1995; Brandell & Ringel, 2007). Environmental influences are not believed to play a role in this need (Ainsworth & Marvin, 1995), thus attachment begins as a biological need. Infants are born with a system in place that guides them to monitor the accessibility of protective others, and to move toward these figures for safety during times of stress or alarm (Main, 1996). Bowlby (1988) proposed the likelihood that secure attachment has a positive impact on social functioning, and affect regulation overall has a biophysiological base.

The biological origins of attachment have repeatedly been seen in animals, particularly mammals, where physical closeness of an infant toward a preferred adult is frequently seen. Harlow's (1956) study found that infant rhesus monkeys clung to dummies that were soft and comfortable to cling to, linking this to a survival mechanism (Harlow, in Bowlby, 1977). Hoffer's work with rodent pups expanded attachment from a survival mechanism to a mechanism of regulatory function, both physiologically and behaviorally (Hoffer, in Fonagy, 2001).

Current brain based research in humans has confirmed the biological make up of attachment needs. Interdisciplinary data have shown that right brain functions including emotion processing and affect regulation are critically influenced by attachment

communications (Schore, 1994). Right brain functioning and early preverbal right brain development has been proven to support social bonding (Shore, 2002). Zuckerman (1997, in Applegate and Shapiro, 2005) reports that neural circuits are influenced by a child's care giving experience. The number of neural connections during early years is predicted by a child's experience with their environment (Zuckerman, 1997). Research has indicated that infants learn to regulate psychophsiological states by mirroring exchanges with primary caregivers (Applegate & Shapiro, 2005).

Although infants play an active role, the attachment figure is primary, and the experiences that the figure provides for the infant are of utmost importance. The attachment figure is more cognitively developed and has an idea of the contextual relationship (Goldberg, 2000). Infants are more likely to be securely attached when they have responsive and empathetic caregivers who are attuned to both negative and positive affective and psychological states (Applegate & Shapiro, 2005). This concept can be translated to the therapeutic relationship, and the creation of Winnicott's (1965) holding environment in the therapeutic encounter as an opportunity to regenerate neural pathways during psychotherapy. Regenerating neural networks using the brain's plasticity is an unconscious process of psychotherapy (Cozolino, 2002).

Disregulation of affect is experienced and expressed in the form of psychological difficulties. The way people experience relationships, or difficulty in relationships, has been widely understood as a function of attachment styles. Both of these experiences are common triggers that move people to seek psychological treatment. The psychological experiences of the mother, or primary caretaker, also temper the experiences of the infant. Infants attempt to get their emotional needs met through the use of their caretaker. A

caretaker who is depressed, preoccupied, or otherwise unable to attend to those needs, will likely negatively impact the formation of the attachment (Brandell & Rindel, 2007). When a primary caretaker is unresponsive to a child's needs, pathology is likely to develop (McMillan, 1992). The caregiver environment influences psychological and psychosocial functioning.

Attachment theory looks at a person-in-environment. The goal of attachment, or the development of a secure base, happens within a social context (Brandell & Ringel, 2007). Once attached, infants use the attachment figure as a secure base with which to explore their environment (Bretherton, 1992). Ainsworth (and Bowlby) differed from the drive theorists in the belief that infants played an active part in forming attachments through the use of their social interactions (Goldberg, 2000). Ultimately, attachment orientations can impact people's social relationships throughout their lives.

## Attachment Research

Possibly due to Ainsworth's early emphasis on empirical data gathering, there is a broad breadth of empirical research in the attachment arena. Therefore, review of the literature requires a focused look at what has been done. For this dissertation, a review of a normative sample of psychotherapy patients (Riggs, Jacobvitz, & Hazen, 2002) and of romantic partners (Simpson, Rholes, & Phillips, 1996) provides a starting point to move toward exploring attachment as related to both clinicians and clients, and the impact on attachment organization on the therapeutic alliance (Dozier, Cue & Barnett, 1994; Black, Hardy, Turpin, & Parry, 2005; Ligiero & Gelso, 2002; Sauer, Lopez, & Gormley, 2003, Tyrrell, Dozier, Teague & Fallot, 1999). This review also explores studies of clinician

attachment and the resolution of problems in therapy (Black, Hardy, Turpin, & Parry, 2005; Rubino, Barker, Roth, & Fearon, 2000), the impact of therapists' personal characteristics on the work (Dunkle & Friedlander, 1996), and therapists' attachment and early loss (Leiper & Casares, 2000). The reviewed research is multidisciplinary, looking at clinicians from varying disciplines, to ensure that the topic is sufficiently reviewed. Studies that look at clinician attachment and the therapeutic work lay the groundwork for moving toward clinician attachment and the specific piece of therapeutic work that is a focus of this study: termination.

Qualitative methods have been used frequently in attachment research, specifically with the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985). The AAI is a semi-structured interview that looks at current perceptions of early attachment experiences (Riggs, Jacobvitz, & Hazen, 2002), and has repeatedly been shown to have reliability and validity across clinical populations, and interrater reliability across nonclinical populations (Dozier, 1990; Dozier et al. 1991). Riggs, Jacobvitz and Hazen (2002) explored internal working models of attachment and history of psychotherapy in a population of middle-class women. Participants (n=120) filled out the Mental Heath Survey (Riggs & Jacobvitz, 2002), and researchers administered the Adult Attachment Interview (AAI). Results showed that secure adults were most likely to have previous experience in therapy while dismissing adults were least likely. Limitations included the self-report administration of the instrument, particularly its use with dismissing adults. Previous research has indicated that the defensive, emotional avoidant make-up of dismissing adults may limit their self-disclosure. The sample was homogeneous; therefore it can be generalized only across middle-class women (Riggs et

al., 2002). Anecdotal evidence in the field shows that some current clinicians have had experience as clients. Some training programs and graduate programs add personal psychotherapy as a requirement. Riggs et al. (2002) highlight the attachment styles of people who choose to seek psychotherapy.

Simpson, Rholes, and Phillips (1996) did not study those seeking psychotherapy, rather a normative sample of dating partners. The study found that individuals with high ambivalent or high avoidant attachment ratings had more anxiety and stress regarding the relationship and resolving conflict within relationships. Additionally, this study used various attachment ratings and provided data for the reliability of the Adult Attachment Questionnaire (AAQ). Other than the initial development of the AAQ, this study provides insight into the influence of attachment orientation on difficult or trying moments in intimate relationships. This can be translated to therapeutic encounters in which the attachment orientation of both members of the relationship may influence the quality of the relationship. The studies reviewed below look at the attachment orientation of those who enter the profession of psychotherapy as clinicians.

Dozier, Cue and Barnett (1994) studied the relationship between clinician attachment styles and their therapeutic strategies with clients. Twenty-seven clients and 18 case managers were given the Adult Attachment Interview (AAI), and case managers participated in a 5-10 minute phone interview about interventions. The results suggested that securely attached case managers attended to the underlying needs of clients, while insecurely attached case managers responded mainly to overt needs. Securely attached case managers responded in-kind to the different attachment styles of clients. Findings were limited by the psychiatric presentation of clients, for example clients in active

psychosis, leading to the need to modify the AAI in certain cases. Specifics about the educational background and the interventions of clinicians were lacking (Dozier, et al., 1994). The study's strong correlation between clinician attachment and interventions indicates the relevance of clinician attachment in the clinical encounter, some of which includes the termination phase. More information needs to be gathered on clinician attachment and interventions as related to termination of treatment.

In an extension of Dozier et al.'s (1994) study, Tyrrell, Dozier, Teague and Fallot (1999) sought to explore client and case manager attachment states of mind and the impact of this on treatment relationships and client outcomes using the AAI, the Working Alliance Inventory (Horvath & Greenberg, 1989), and other measures. Fifty-four clients with serious psychiatric disorders and 21 case managers participated in the study. Using Koback's (1989) Q-sort of the AAI, researchers assessed the degree to which the client was deactivating or hyper activating regarding attachment. A deactivating state of mind is associated with avoidant attachment and is characterized by diverting attention to the topic and minimizing the importance of the attachment related experience. A hyper activating state of mind is associated with preoccupied attachment and is characterized by unresolved conflict with parents and more personal distress as compared to other individuals. The results supported the researchers' hypothesis, that client outcomes were better amongst client-case manager dyads that were dissimilar. The hypothesis and finding, indicates that dissimilarity in deactivation and hyper activation can provide a useful balance in the treatment relationship. Higher working alliance ratings by the client were associated with higher global ratings of client functioning by the case managers. Although this study was limited in the subjectivity of participants, there were similar

outcomes amongst client and case manager pairs. Some case managers reported on more than one client, possibly inflating the significance of the results (Tyrell et al., 1999). This study highlights the importance of the attention to attachment styles (as well as other qualities) of both participants in a therapeutic relationship and pays attention to the therapeutic dyad. As both participants (clinician and client) come together to do the work, they must also come together to end the work and a look at their qualities can help to end it well.

Sauer, Lopez, and Gormley (2003) collected survey data as part of treatment-as-usual with graduate level training therapists and their clients in an effort to explore the temporal relationship between attachment orientation and the working alliance. Participants filled out self-report questionnaires on attachment (Adult Attachment Inventory, AAI; Simpson, 1990; Simpson, Rholes & Nelligan, 1992) and the working alliance (Working Alliance Inventory, WAI; Horvath & Greenberg, 1989) before and during treatment. Sauer et al. found that therapist attachment anxiety was positively related to the development of the early working alliance. High therapist attachment anxiety predicted decreasing working alliance ratings over time. The small sample size, participant attrition, and the ability to generalize were limits to the study. The attachment scale demonstrated only marginal reliability (Sauer et al., 2003). This study contributes to the field with its naturalistic design and the study of process rather than outcome measures. The attention to and measurement of time as a function of treatment is an indicator of the value in the use of time, and gives strength to Mann's (1973) argument that "all significant human behavior is linked with time" (pp. 3). Time is a critical aspect

of termination and is typically given different levels of therapeutic attention depending on clinician therapeutic orientation.

Black, Hardy, Turpin, and Parry (2005) explored the extent to which attachment styles of therapists and therapeutic orientation were related to the general alliance and reported problems in therapy. Therapists (n=491) returned self-report questionnaires about attachment (Attachment Style Questionnaire, ASQ; Feeney, et al., 1994), therapeutic alliance (Agnew Relationship Measure, ARM; Agnew-Davies et al., 1998), problems in therapy (Therapist Problem Checklist, PCL; Shroder, personal communication, 1999), and general personality features (Brief Eysenck Personality Questionnaire, EPQ; Eysenck & Eysenck, 1969). Results showed that therapists with insecure attachment reported poorer therapeutic relationships, and that securely attached clinicians were best able to create interventions that produced client change. Need for approval, one of the insecure attachment scales on the ASQ, was associated with therapist reported problems in therapy. Psychodynamically oriented clinicians reported more problems in therapy, likely due to the nature of the varying approaches. This study was limited by the low response rate (36%), the population of highly trained psychotherapists, and the self-report measures (Black et al., 2005). Despite the limitations, this research provides data related to therapeutic relationship and attachment, as well as the differences among therapeutic orientations.

Rubino, Barker, Roth, Fearon (2000) conducted an analogue study of the relationships between therapists' resolution of the therapeutic alliance ruptures and their attachment styles. Researchers rated student therapists' responses to video-taped role-plays displaying four different attachment styles on the basis of empathy and depth of

interpretation, and assessed the students' attachment using the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994). Results suggested that more anxious therapists responded less empathetically to the tapes than less anxious therapists. There was also evidence that the attachment avoidant dimension may be less pertinent than the attachment anxiety dimension in the patient therapist interactions. Depth of interpretation was related to attachment styles. Rubino et al. cite the weak correspondence between the measure of attachment they used and other measures, as well as the isolated response to one case vignette as limitations to the study. The importance of clinicians' self-awareness is highlighted in this study. Replication of these results in a naturalistic study could further the knowledge base of the occurrence of disruptions (Rubino, et al., 2000). Furthering insight on disruptions may allow for termination before disruption occurs, something that may continue the value of the work beyond the treatment relationship.

In contrast to Black's et al. (2005) and Rubino's et al. (2000) findings, Ligiero and Gelso (2002) found no relationship between therapist attachment styles and the working alliance as indicated by 50 therapists in training and their supervisors. Participants filled out self-report questionnaires including the Working Alliance Inventory for Therapists (WAI-Therapist; Tracey & Kokotovic, 1989), the Relationship Questionnaire (Bartholomew & Horowitz, 1991), the Countertransference Index (CT; Hayes, Riker, & Ingram, 1997), and the ICB, a counter transference behavior measure (Friedman & Gelso, 2000). In looking at the finding that proved the null hypothesis true, researchers speculate that this result may be due to the unlikelihood that the client becomes a significant attachment figure to the therapist, therefore that therapists'

attachment style may not be particularly active in the therapeutic relationship (2002). The notion that the therapeutic relationship is not significant and doesn't have attachment qualities for psychotherapists is refuted in other theory (Shilkret & Shilkret, 2008, Zilberstein, 2008) and research (Black, Hardy, Turpin, and Parry, 2005; Dozier, Cue & Barnett, 1994; Tyrrell, Dozier, Teague & Fallot, 1999). Attachment styles are reflective of early connections and interactions with authority figures, thus it is reasonable to expect attachment styles to appear within the therapeutic relationship, particularly in the transference (Shilkret, 2005).

Psychotherapists bring themselves into the therapeutic relationship, as do clients. Dunkle and Friedlander (1996) studied therapists' personal and professional characteristics, and their impact on the therapeutic alliance. Findings indicated quality of the therapist's social network predicted the extent and the bond component of the therapeutic alliance. Clients were more likely to report a strong emotional bond early in treatment when therapists reported less hostility, more social support, and greater comfort with closeness. Outcomes of treatment (goal and task components) were not predicted by therapists' personal experience (Dunkle & Friedlander, 1996). This study suggests that social network is closely related to interpersonal qualities, which is indicated by attachment styles; and that comfort with closeness is likely indicated by secure attachment.

Leiper and Casares (2000) studied British psychologists, using measures on adult attachment and early loss. A relationship between attachment style and early loss was established. They found that therapists with insecure attachments had more professional problems. Although results showed that therapists rated themselves as securely attached

at a greater rate than the general population, no data was collected on the non-responders to the questionnaires (Leiper & Casares, 2000). Loss, or personal loss experience, is a factor often believed to operate in termination of therapy (Boyer & Hoffman, 1993; Fortune, 1987; Goodyear, 1981; Hoyt, 1979).

Zilberstein (2008) provides an integrated theoretical look at attachment, loss, and termination in the therapeutic process, but does not present empirical data. Therapists are among the many figures in adulthood that may become primary or secondary attachment figures. Further exploration of clients' attachment styles can provide clinical information about how and when to carry out termination (Zilberstein, 2008).

The exploration into the attachment of clinical social workers and their experiences of termination in the proposed study can lead to further clinical theory and practice on this topic. This study will provide a stepping stone to elevate termination as a usable and valuable part of the clinical process.

## Termination Research

As compared to the theoretical breadth of literature on attachment, the amount of attention devoted to the concept of termination is more limited. This review of the literature again looks at multidisciplinary studies of those who provide psychotherapy. The termination literature includes empirical studies looking at clinician experiences of termination (Baum, 2007; Boyer & Hoffman, 1993; Fortune, 1987; Green, 1980; Gelman, Fernandez, Hausman, Miller & Weiner, 2007; Roe, Dekel, Harel, & Fenning, 2006;), at

client responses to termination (Marx & Gelso, 1987) and at clinician perceptions of client responses (Fortune, 1987; Quintana & Holahan, 1992).

Greene (1980) used a survey design to look at effects of therapists' gender, clinical experience, and theoretical orientation on five dimensions (role shift, denial, depression, anxiety, and task satisfaction) related to termination as measured by a scale created for the study (Therapist termination questionnaire). Less than 50% of the sample, ninety-two therapists, responded to the questionnaires. Results showed sex-role differences in affective responses to termination, specifically in non-analytically oriented therapists. Females reported more anxiety and willingness to conform to clients' needs. Analytic techniques of neutrality and emotional restraint appeared to aspire to culturally dictated male norms during termination. The findings were consistent among therapists in training and those who were more experienced, indicating that training does not eliminate sex-role bias (Greene, 1980). An effort to further educate clinicians on the experience of termination could allow for a better use of this phase so it does not fall prey to gender role stereotypes. Awareness of the emergence of unconscious processes could allow therapists to make better use of them.

Marx and Gelso (1987) explored clients' experiences of termination using survey design and a sample of former university counseling center clients. They created the Termination Behavior Checklist, used the Multiple Affect Adjective Check List, (Zuckerman & Lubin, 1965) and used two individual Likert assessments. Results suggested that exploration of termination was important to clients, with only 12% responding that reviewing reactions to ending counseling with counselors was *unimportant* or *very unimportant* to them. Clients reported positive responses to treatment

termination by choosing significantly fewer negative than positive adjectives describing their feelings about ending counseling. Although the results cannot be generalized outside of the time-limited university counseling center model, they do indicate the significance of the termination phase for clients (Marx & Gelso, 1987).

Quintana and Holahan (1992) explored counselors' reports of clients' termination experiences in university counseling centers by expanding the survey design of Marx and Gelso (1987). Results suggested more positive than negative affective experiences during termination. Termination activities concerning the therapeutic relationship, including therapist self-disclosure, were more often present in the termination of perceived successful treatment relationships. The study was able to be generalized only to university counseling centers and short-term treatment. The self-report measures and choice of cases were other limitations, although authors sought to reduce those limitations through pilot testing and test-retest analysis (Quintana & Holahan, 1992). Quintana and Holahan (1992) and Marx and Gelso (1987) provide evidence that counters the perception that termination is always a difficult experience. A closer look at termination as a part of the therapeutic experience, and as a phase that is impacted by the therapeutic alliance, may provide data leading to greater clinical expertise.

Boyer and Hoffman (1993) collected data from 117 counselors who responded to mail-in questionnaires about work with a client they had seen for at least 25 sessions and included a termination phase. The Therapist termination questionnaire (TTQ) (Greene, 1980) was used to measure therapist anxiety, depression, and task satisfaction, and the Texas Revised Inventory of Grief (TRIG*)* (Faschingbauer, DeVaul, & Zisock, 1977) was used to measure therapists' past and present grief responses. The study found that both

counselor loss history and perceived client reactions to loss were related to counselor experience during the termination phase. Results showed that past counselor losses were more indicative of anxiety and depression than current counselor losses. Counselor perception of client sensitivity to loss was somewhat indicated. Task satisfaction was not found to be impacted by counselor loss or perceived client loss. Factor analysis on the Task Satisfaction subscale was not robust in a five factor solution (both anxiety and depression were robust), leading to questions about the TTQ scale. Bias in self-report measures and counselor self selection of the case to report on are other limitations of this study (Boyer & Hoffman, 1993). Nonetheless, Boyer and Hoffman's (1993) study provides valuable groundwork for linking termination and loss, as well as the importance of attention to counselor experiences. Counselor experiences of relationships, part of their attachment orientation, may also be very important.

In a move away from self-report scales and survey designs, Fortune (1987) used structured, 60-90 minute interviews of MSW practitioners to examine both practitioner reactions to termination and practitioner perceptions of client reactions. Participants also responded to how often they had certain experiences during termination. Findings showed more frequent positive than negative affective responses to termination from both the practitioner and client. Practitioners reported pride in a clients' success as well as in their own therapeutic skill as central themes for themselves during termination. There was little report of a re-experiencing of loss from clients, as reported by the clinicians. Clinicians also reported limited re-experiencing of their own loss experiences during termination, and at times noted incompleteness related to wondering what happened to a client later. The interview method may have created socially desirable responses to

questions, and there is a limitation in gathering clients' experiences from the practitioners (Fortune, 1987).

Fortune, Pearlingi, and Rochelle (1992) conducted a similar study, using the same structured interview, and yielded similar results. Pride and accomplishment were the most common practitioner responses, with loss and sadness at the midpoint of the scale. Results indicated that the reasons for termination, the outcome of treatment, and the difficultly in termination were important factors in the termination experiences (Fortune, et. al, 1992). These structured interviews provided concrete data about positive responses to termination, as well as details about the experience of MSW practitioners.

A mixed methods approach by Roe et al. (2006) explored clients' feelings during termination of psychotherapy, and how these feelings were related to satisfaction with the therapy. Eighty-four former clients of psychodynamic psychotherapy answered three open-ended written response questions and completed self-report scales. Results suggested that clients had positive termination experiences when the therapist supported termination, and when it was experienced as a practice of independence. Negative termination experiences were related to the loss of the relationship, premature termination, and inadequately processed termination. The length and extent of written responses varied greatly (Roe et al., 2006). This study highlights the importance of adequately processed termination as an important factor in satisfaction with therapy.

Baum (2007) studied 92 master's level social work (MSW) student therapists' and 48 MSW therapists' experiences of treatment termination using a survey design. Participants reported moderately difficult experiences of termination, and moderate

emotional valence. Negative emotional valence, low positive self-feelings, and higher self-doubt were suggested when the client initiated termination. Therapists reported more difficulty with termination when the relationship was significant to them. Limitations of this study included significant differences in the sample subgroups, the possible bias in self-report measures, and the participants' choice of one termination to report on. This study provides evidence of termination as a transition (Baum, 2007). The significance of the relationship and the reason for termination provide possible links to the attachment orientation of those in the therapeutic relationship.

Case studies provide a valuable window into the work that happens in the therapeutic experience. Gelman, Fernandez, Hausman, Miller and Weiner (2007) present clinical case studies on forced termination with MSW students and their clients. One student described being transferred a case in which termination was never processed with the original therapist and client. This set up a therapeutic relationship characterized by splitting, and a supervisor/supervisee relationship that quickly became damaged. Both client and MSW student experienced parallel negative transference toward the supervisor. The student described a resurgence of symptoms for the client when the next termination occurred and reported being unaware of this as a consequence of termination, therefore feeling guilty. Another student expressed guilt of abandonment while terminating with a client with serious mental illness and getting superficial supervision. In an additional example, a student described getting active supervision about his separation and loss experience, allowing for a powerful therapeutic process with clients (Gelman et al., 2007).

The vignettes provided by Gelman et al. (2007) offer evidence of the importance of learning termination, of further development of termination techniques related to management and preparedness, and the significance of quality supervision through the student practicum experience. Baum's (2007) study also had a significant focus on MSW students. Two of the other studies reviewed (Marx & Gelso, 1987; Quintana & Holahan, 1992) were conduced with university counseling center clients and workers. This population has a built in time limit, and university counseling centers are at times responsible for training social work students. Because the MSW practicum experience is by nature time-limited, attention to time and termination is all the more essential.

This review of the theoretical and empirical research as related to attachment and termination leads to two primary conclusions: that these two constructs of the clinical encounter in social work practice are likely related, and that a further understanding of attachment and termination, and the extent of their relationship, is indicated. Gaining this further understanding through empirical research can help inform theory and practice development as related to termination, a phase of the work that currently gets limited attention. Because we sometimes carry with us our last moments or memories of any significant experience, considering the terminations in clinical work practice can allow for social work clients and clinicians to carry with them the valuable insights of the termination and overall experience. This project is a first step towards better conceptualizing termination by looking at clinicians' experiences of termination as related to their attachment orientation.

## CHAPTER 3: METHODS

This study sought to explore the relationship between attachment orientations and termination approaches among clinical social workers in outpatient mental health settings. It was an exploratory pilot study with a survey design. Data were collected through an online survey tool called PsychData. All study methods were approved by the Institutional Review Board at the University of Pennsylvania.

### Instruments

For this study, the Adult Attachment Questionnaire (AAQ: Simpson, Rholes, & Phillips, 1996) was used to measure adult attachment. This scale is well researched and its psychometrics have been extensively tested. The development of the AAQ included comparison statistical analysis with the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) and Hazen and Shaver's (1987) initial self report adult attachment measure which consists of typological vignettes and was created out of Ainsworth's research.

The AAQ scale is a 17-item 7-point Likert scale that asks participants to respond to statements about their feelings toward romantic partners in general. For the purposes of this study, "romantic partners" was changed to "close relationships." Jeffrey Simpson, first author of the scale, approved this alteration. Although previous studies exist where the AAQ was used to measure attachment as related to constructs outside of the romantic relationship, there are no current studies where the instructions were changed. Participants responded from "I strongly disagree" to "I strongly agree." Factor analysis of this scale revealed two dimensions – avoidance and ambivalence. Avoidance on the AAQ

reflects the extent to which the participant has negative views of others and avoids or withdraws from closeness or intimacy in relationships. Internal consistency of the avoidance dimension was .70 for men and .74 for women, as measured by Cronbach's alpha. The ambivalence subscale reflects the extent of individuals' negative self-views regarding relationships, and preoccupation with abandonment loss, or partner's commitment level. Internal consistency of the ambivalence dimension was .72 for men and .76 for women, as measured by Cronbach's alpha. Low overall scores on the AAQ indicate secure attachment orientation, as the respondent is not indicating high levels of avoidance or ambivalence. The AAQ allowed for a dimensional look at attachment orientations of the clinical social workers who participated in this study.

To measure termination approaches, the Termination Approaches Questionnaire was created for this study. The TAQ is a 36-item self-report measure designed to assess the emotional reactions, perceptions and techniques during termination. Items were included to evaluate the scale and training associated with termination. It is a Likert scale with a range from 1 to 7 (never to always). Participants are asked to report on their overall experience of termination, not limited to a particular client. The instrument also included 4 open-ended questions designed to elicit responses in the words of the participants. There are no known psychometric properties as this instrument was piloted during this study.

The development of the TAQ occurred in three phases. The first phase included reviewing all of the relevant literature on termination, and gathering anecdotal clinical experience from the author and her social work colleagues with varying amounts of outpatient therapy experiences. The first draft of the TAQ was then created. After

creation of the draft, colleagues (N=6) in the field were asked to review the scale to check for bias, clarity and other possible problems. Specific questions asked of reviewers included: What are your reactions to the questions? Are they reasonable? Would you be comfortable answering the questions? What do you think the scale is assessing?

All feedback was accepted and taken into consideration. The major adjustment was to the instructions. The instructions were expanded to clarify the intentions of the scale and to attempt to limit participant bias toward social desirability. Feedback during the pilot phase indicated clinicians' awareness about the socially desirable responses to the questions. Therefore, an overall disclosure at the beginning of the scale was included. Generally clinicians reported that they would feel comfortable answering the questions, and that they felt the scale was clear. Some suggested minor changes to wording. Feedback also questioned the inclusion of the qualitative questions, and if people would take the time to answer them. This pilot feedback was considered and the decision was made to include the qualitative questions. Because of the lack of statistical analysis on the scale, the qualitative questions presented an opportunity to generate more from the research if the data generated from the scale proved weak.

After the initial phase of creating the TAQ, the next version was piloted to 10 clinical social workers who currently work as outpatient therapists. Participants were asked to complete both measurement tools, the TAQ and the AAQ. Results were carefully reviewed to ensure clarity of questions. The careful creation of the scale was an attempt to ensure face validity of the tool.

In addition to the TAQ and the AAQ, selective demographic information was gathered from study participants to describe the sample. Demographic information

included the following: time in the field, licensure level, current job role, the theoretical orientation of the participants, gender, age, the common reasons for termination and general population served.

The complete tool for this project, including the two scales and demographic questions, is attached in Appendix A.

**Variables**

The independent variable of this study is “attachment orientation” and was measured by the AAQ. Participants were measured on a dimensional scale of high to low anxious and high to low avoidant orientations. Participants who scored low on both the anxious and avoidant subscales were considered securely attached. Those who scored high on one or both of the subscales showed insecure attachment (Simpson et al., 1996). The dimensional scale assessed the type of attachment as well as the extent of the attachment orientation.

The dependent variable of this study is "termination approach." For the purposes of this study, a participant’s termination approach was measured dimensionally. Scores on the engagement and avoidance subscales were calculated independently. Questions on the TAQ were designed to assess a clinician's level of engagement in or avoidance of the termination process. As such, participants' score on each TAQ dimension served as an indicator of the dependent variable.

The open-ended questions provided anecdotal data to this project.

**Quantitative Data Analysis**

The data from the Termination Approaches Questionnaire (TAQ) and the Adult Attachment Questionnaire (AAQ) (Simpson, Rholes Phillips, 1996) were closely examined in order to explore the relationship between attachment orientation and approaches to termination in the sample of clinical social workers. The statistical analysis for this project consisted of descriptive statistics, with some attention to correlation data. Given the provisional stage of the TAQ, data were interpreted with caution. The TAQ has not yet been tested via factor analysis and the sample size for this project was too small to indicate factor analysis. Measures of central tendency and measures of dispersion were used to look at the data of each scale and subscale. Measures of association were used to describe the relationship between the two scores on the AAQ and the TAQ.

The plan for data analysis began with categorizing, coding and cleaning the data. After that stage, SPSS version 17.0 was used to run descriptive statistics and statistical analyses. Cronbach's alpha was used to explore reliability and Pearson's coefficient was used to explore the relationship between the independent variable (attachment orientation) and the dependent variable (termination approach). This section provides a detailed description of the analyses processes, after which the results are presented.

In order to analyze the data from the TAQ, item-by -item placement in the avoidance or engagement subscale categories was identified. This process involved placing each scale item in a category, and discussing the placement with another clinical researcher. Placement was discussed in detail and the reasons for our choice of placement were reviewed in-depth for any placement on which there was disagreement. Because

there was little disagreement about categorical placement, it was apparent that there was no need for further clinical researcher input.

In addition to engagement and avoidance, three smaller categories of the TAQ emerged: training associated with termination, evaluation of scale, and feelings associated with termination. These items were purposely included in the TAQ to provide more data to the study, and were grouped together during the analysis phase. Although these categories do not directly address the engagement/avoidance spectrum of termination, they do provide a greater understanding of the topic at hand.

The categorical placement and the coding rules for the TAQ were as follows:

Table 1: Categorical Placement of TAQ items

| **Category** | **TAQ item number** |
|---|---|
| Engagement in termination<br><br>(higher numbers indicate higher engagement) | 1, 2, 3, 4, 5, 10, 15, 16, 19, 23, 26, 27, 28, 33 |
| Avoidance of termination<br><br>(higher numbers indicate higher avoidance) | 7, 13, 14, 17, 18, 20, 21, 22, 24, 25, 29, 32 |
| Feelings associated with termination<br><br>(higher numbers indicate stronger negative feelings) | 6, 8, 11, 12, 30 (reverse coded) |
| Scale assessment<br><br>(higher numbers indicate higher ratings, positive assessment of scale) | 34, 36 |
| Termination training<br><br>(higher numbers indicate more adequate training/perceived competency around termination) | 9, 35 |

During the data analysis phase, an inadvertent omission in the TAQ was discovered. The TAQ was to include a 7-point likert scale ranging from Never (1) to Always (7). The instrument that was distributed had a 6-point scale with the following categories: Never (1); Almost Never (2); Rarely (3); About half of the time (4); Almost always (5); Always (6). The "some of the time" option, which was to be option (5), between "About half of the time" and "Almost always," was inadvertantly omitted from the instrument. Thus, this omission gives the data a negative skew, as participants had more options of answering below the midpoint (4) than above the midpoint. The last three quantitative questions of the TAQ (TAQ 34, 35, 36) were measured on a 7-point likert scale with different ranges. Ranges included: not well at all to quite well, not adequately at all to quite adequately, and not accurately at all to quite accurately. The items with the 7-point likert range measured termination training and scale assessment. Therefore, the subscales of the TAQ, engagement and avoidance, all used the same 6-point likert scale. This negative skew of the majority of the data will be mentioned throughout the analyses. It will also be shown that the data remain valuable despite the omission.

Data analysis methods for the AAQ followed the instructions set forth by Simpson, Rholes, and Phillips (1996). These instructions included reverse keying items 1, 3, 4, 12, 14, 16, and 17.

Table 2: Categorical Placement of AAQ items

| **Category** | **AAQ item number** |
|---|---|

| | |
|---|---|
| Avoidance subscale | 1, 2, 3, 5, 6, 7, 8, 9 |
| Ambivalence subscale | 4, 10, 11, 12, 13, 14, 15, 16, 17 |

**Qualitative Data Analysis**

Participants were asked about their overall experience of termination, and to describe both a memorable termination and a typical termination. These were open-ended questions in which the researcher could hear from the participants in their own words. The responses to each individual question were grouped together and an initial read through was done in order to get familiar with the data. Charmaz (2006) describes a clear data analysis plan to allow themes to emerge from the data. The procedures for this project were developed from Charmaz (2006). After the initial read of the data, responses to the questions were analyzed using open coding, and then focused coding. Open coding (in this case, line by line) was an attempt to stay close to the data and allowed themes to emerge from the ground up. The focused coding stage was characterized by collapsing the initial codes into larger codes from which themes could emerge. Ultimately, categories were formed to represent themes that emerged from the data. After the categories were identified, the focused codes were reviewed to ensure that the focused codes were well represented by the categories.

Participants were also asked to make a list of feelings that came up for them when thinking of termination. Content analysis strategies were used to quantify the findings and analyze frequencies of answers. All feelings were identified, counted and categorized into negative and positive feelings categories.

Throughout the data analysis process, memos about the process were kept to stay in tune with researcher reflexivity. Reflexivity is the ability to examine one's self and the impact that self may have on the research (Padgett, 2008). Smith (2006) describes monitoring reflexivity as essential in that it welcomes and explores the subjectivity of the researcher. Reflexivity impacts one's meaning making of the data (Smith, 2006). Analysis of the qualitative data included researcher awareness of the presence of reflexivity.

**Hypotheses**

This research explored the following question: *Is there an association between attachment orientations and termination approaches among clinical social workers working in outpatient mental health settings?*

The overall research hypothesis was that there is an association between attachment orientations and termination approaches. A level of significance of .05 or higher was used to established an association. Because of the lack of data on the TAQ instrument, specific hypotheses were not indicated. That said, the following was a probable trend in the data:

- High scores on the AAQ, indicating insecure attachment, will be correlated with high scores on the avoidance category of the TAQ, and low scores on the engagement category of the TAQ. The reverse, low scores on the AAQ, will be correlated with low scores on the avoidance category of the TAQ and high scores on the engagement category of the TAQ.

In addition to association between attachment orientations and termination approaches, results of this project show the strength of the newly developed tool.

**Recruitment**

This project had two approaches for recruitment, both of which were outlined in the Institutional Review Board application. Initially, participants for the study were solicited through the membership roles of the Pennsylvania Society of Clinical Social Work (PSCSW). This is a professional organization of clinical social workers practicing in a variety of settings focused on direct clinical work. PSCSW has an active email listserve through which members communicate with one and other and the group as a whole. Permission was gained to use the listserve as a venue for recruitment after making contact with the Society President and discussing the research. To gather the data, three outreaches were sent to the listserve, and a thank you email was sent that also reminded potential participants that they could still participate.

Because the initial recruitment strategy did not generate a large enough sample size, a snowball sampling strategy was used to recruit additional potential participants in the community. This strategy included calling on some group practices known to the researcher as well as other social work colleagues. In both recruitment strategies, the letter of invitation included a reminder that recipients of the letter were free to forward the email on to other potential prospects.

To meet study inclusion criteria, prospective subjects were required to be clinical social workers who had worked in outpatient mental health settings for at least 2 years.

This time frame was chosen to ensure that participants had had the opportunity in their clinical practice to engage in termination.

A link to the survey was sent via email, and participants filled out the survey online. When recipients of the email chose to participate, they clicked on the link to the survey and were routed to a password protected website, and then directly to the study instruments. This allowed for participant confidentiality and anonymity.

Because the study involved no more than minimal risk to subjects, choosing to participate after reading the invitation to participate and clicking the next screen served as consent. This did not constitute a physical consent form, but was in accordance with IRB standards. A sample of the invitation to participate is attached in Appendix B.

This study sought at least 50 participants. Data collection was closed when over three weeks passed without an additional participant. When data collection was closed, the online survey tool indicated 69 participants. Not until looking at the data was it apparent that some of these participants could not be included in the study due to missing data or ineligibility (see Chapter 4: Results).

Although the research participants in this study did not represent a vulnerable population, ethical guidelines for research with human subjects were carefully considered. This project was submitted to the Institutional Review Board before any data were collected. Participants' confidentiality and anonymity were preserved, as only the researcher saw their responses and had no way to identify the results with the participant. The researcher did not know who participated in the study and collected no identifying information.

# CHAPTER 4: RESULTS

## Quantitative Results

### Sample Descriptive Statistics

When data collection ended, the sample included 69 participants. Of that, 5 participants were eliminated from the data analysis due to lack of full inclusion criteria. Another 15 participants, either purposefully or inadvertently, did not begin (or complete) the AAQ. The AAQ was placed after the TAQ, following the TAQ open-ended questions. This scale placement may have caused this result. Regardless, because the study seeks to explore the relationship between termination and attachment, these 15 participants were eliminated from data analysis due to the lack of attachment data (these participants were included in the qualitative data analysis which will be described later). The total N for the quantitative portion of the study was 49, which was 71% if the initial sample.

The sample was largely female; 87.8% (N=43) of participants were female and 12.2% (N=6) were male. Ages were quite varied, with the youngest participant being 27 and the oldest 71. The mean age of the sample was 45.84 and the standard deviation was 12.86. The minimum time participants had been in the field as an outpatient therapist was 2 years, and the maximum was 41 years. The mean time working as and outpatient therapist was 14.54 years, and the standard deviation was 11.43. The majority (87.70%) of the sample had LCSW licenses or the state specific equivalent (i.e., LCSW-C, LICSW). Only 6.1% reported being licensed at the LSW level, and 4.1% reported their license as “MSW.” See the charts below that describe the sample.

Figure 1: Gender of participants

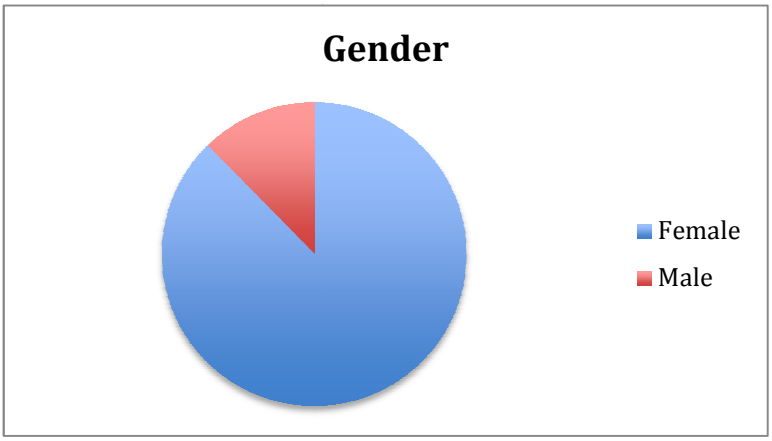



Table 3: Age and Time in the field of participants

| | **Mean** | **SD** | **Range** |
|---|---|---|---|
| **Age** | 45.84 | 12.86 | 39 years |
| **Time working as an outpatient therapist** | 14.54 | 11.43 | 33 years |

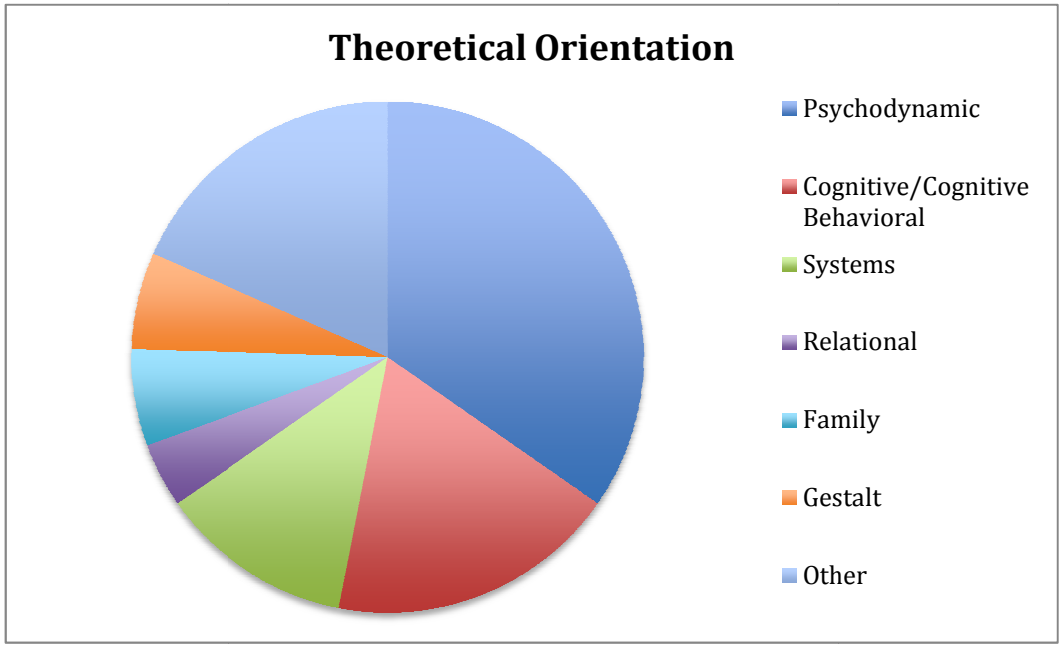
Table 4: Licensure of participants

| **LCSW or equivalent** | **LCSW** | **"MSW"** |
|---|---|---|
| 87.7% | 6.1% | 4.1% |

Participants were asked to identify their primary theoretical orientation. In order to allow for the breadth of answers, this question called for a fill in answer. Some participants chose to answer with more than one orientation. For the purposes of describing the sample, I used the first answer given by participants. Using this method, the results showed that 34.7% of the sample identified as primarily "Psychodynamic" (N=17). The "Psychodynamic" category included those who specifically identified as "Psychodynamic," as well as those who reported "Psychoanalytic" as well as "Object Relations" and "Ego Psychology." The next most common category was "Cognitive/Cognitive Behavioral," with 18.4% (N=9) of the sample identifying this as

their primary theoretical orientation. Six participants (12.2%) identified "Systems" as their primary orientation. Both "Family" therapy and "Gestalt" therapy were primary orientations for 6.1% (N=3) of the sample. "Relational" approaches were the primary orientation for 4.1% of the sample (N=2). Lastly, 18.4% (N=9) made up the "Other" category. This category is comprised of those responses that had only one participant identified with that primary theoretical orientation. Examples included "Client Centered," "Narrative," "Eclectic," and "Biopsychosocial." See the pie chart below representing primary theoretical orientations of the sample.

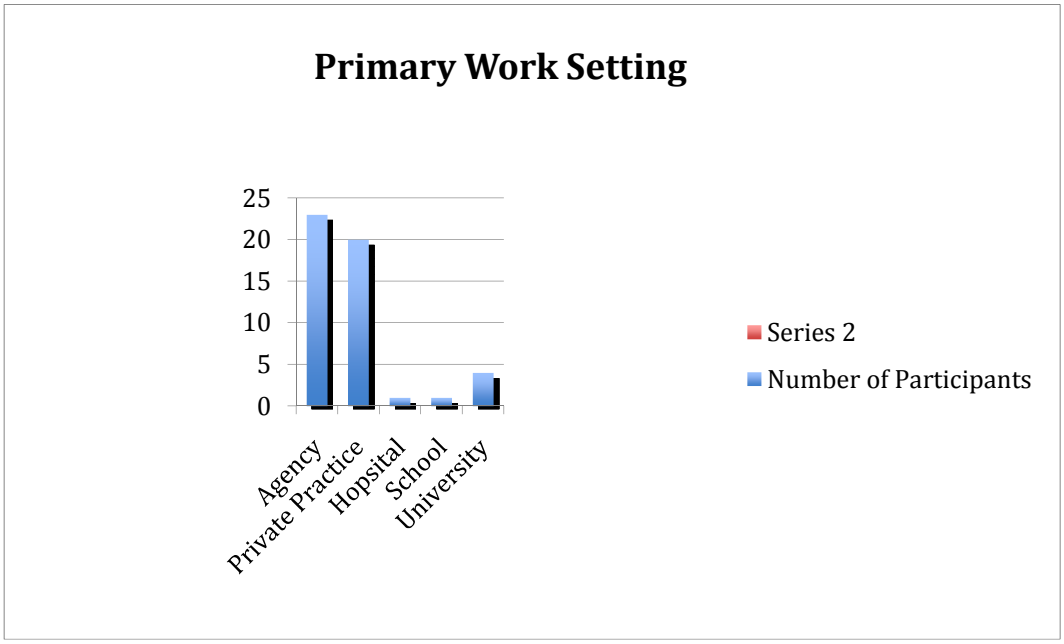
Figure 2: Theoretical orientation of participants




Participants were also asked to fill in their primary work setting. Primary was described as "more than half time" in the question. Again, the first answer was used for categorizing, but few participants reported more than one. Some participants named their specific setting. Settings were coded based on the specific setting mentioned. For example, if a participant reported a specific hospital, the data was coded for "hospital." Not surprisingly, the primary work settings were agency (46.9%; N=23) or private

practice (40.8%; N=20). One participant (2.0%) reported working in a hospital setting, one (2.0%) reported working in a school setting, and four (8.2%) reported working in a university setting. Some of the university setting responses included "university counseling center," and were combined with those that read "university" to make up the broader "university" category. The bar graph below shows demonstrating the primary work settings of the participants.

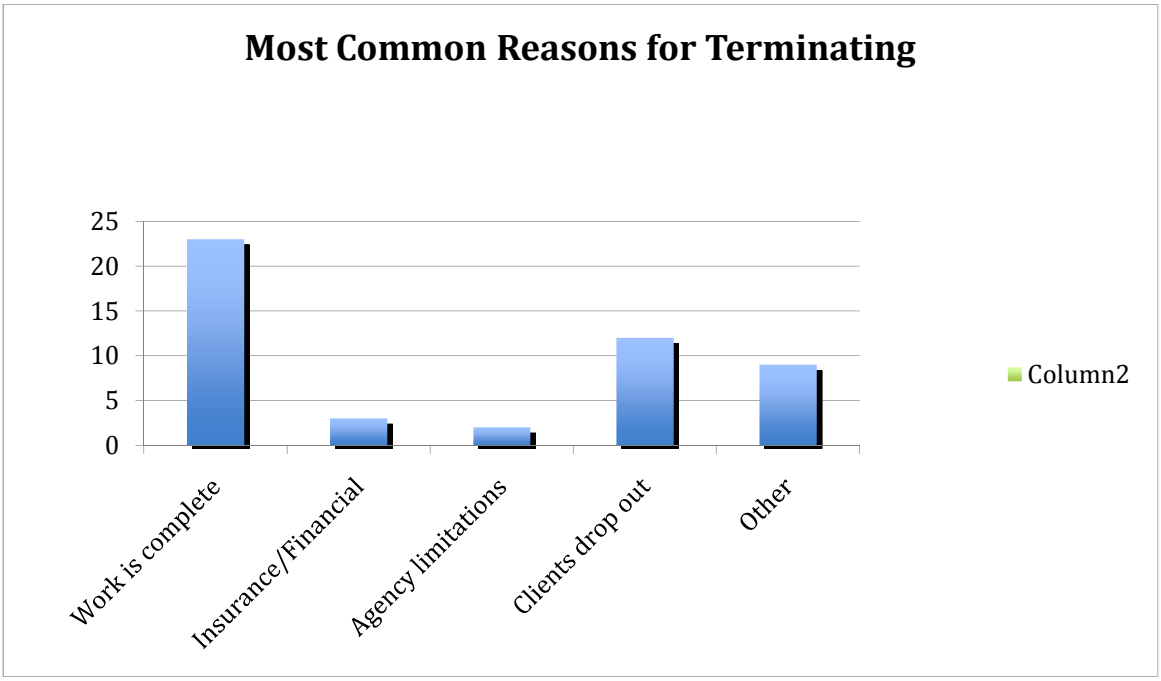
Figure 3: Primary work setting of participants




In addition to identifying their primary practice setting, participants were asked to identify the most common reason for terminating with clients. Close to half, 46.9% of participants, indicated "the work is complete" as their most common reason for terminating with clients. This was the most common identified reason for terminating. A client dropping out of treatment was the next most common reason for terminating, with 24.5% of participants endorsing that answer. Other answers included insurance or financial reasons (6.1%) and agency limitations (4.1%). "Other" was an answer choice

given to participants to choose on this question. For those that chose other, 18.4% of the sample, some identified their own choices to move or to change jobs as a common termination reason. See the bar graph below that represents this data.

Figure 4




**Reliability of the Instruments**

The reliability statistics provide evidence for the internal consistency of the instrument. The reliability of the new instrument, the TAQ, shows promise thus far. The reliability coefficient proved to be above the social science accepted coefficient of .70. The TAQ subscales (TAQ Engagement and TAQ Avoidant) showed .908 and .839 reliability coefficients respectively, as measured by Cronbach's alpha. These data indicate that the extent to which subscales of the TAQ measured the same characteristics, namely avoidance or engagement in termination, was relatively high.

With respect to the AAQ, reliability statistics also showed high internal consistency as measured by Cronbach's alpha. The reliability coefficient of the AAQ Avoidance subscale was .858, and the reliability coefficient of the AAQ Ambivalence subscale was .780. This result suggests that the Avoidance and Ambivalent subscales of the AAQ did in fact measure the intended constructs. In all, the strong reliability scores on both instruments of this study demonstrate the reliability of the instruments, therefore suggesting that the instruments may produce consistent results over time if they are to be used again.

Reliability statistics are as follows:

Table 5: Reliability statistics of TAQ and AAQ subscales

| TAQ Engagement | TAQ Avoidance | AAQ Ambivalence | AAQ Avoidance |
|---|---|---|---|
| N of items =14 | N of items=12 | N of items = 9 | N of items = 8 |
| Cronbach's alpha: .908 | Cronbach's alpha: .839 | Cronbach's alpha: .780 | Cronbach's alpha: .858 |

**Statistics on Attachment and Termination Constructs**

The Adult Attachment Questionnaire (AAQ) generated results about the attachment orientation of the sample. The sample size of participants who completed the entire AAQ was 44. After reverse coding, the total possible score on the AAQ was 119. mean attachment score was 47.41 and the median was 45.5.

**AAQ Avoidance**

The AAQ avoidance subscale had a total of 8 items to which participants (N=46) responded on a 7-item likert scale from "I strongly disagree" to "I strongly agree." The

range in possible scores was 7 to 56. Higher scores indicated greater avoidance. The mean of the subscale was 23.15 with a standard deviation of 8.50. The item with the highest mean (4.02) is "I'm not very comfortable having to depend on other people." The item with the lowest mean (2.30) was "I'm nervous whenever anyone gets too close to me."

**AAQ Ambivalence**

The AAQ ambivalence subscale had a total of 9 items to which participants (N=45) responded on a 7-item likert scale from "I strongly disagree" to "I strongly agree." Higher scores indicated greater ambivalence, with the highest possible score of 63. The mean of the ambivalence subscale is 24.89 with a standard deviation of 8.84. The item with the highest mean (3.60) was "I'm confident others would never hurt me by suddenly ending our relationship." The item with the lowest mean 1.47 was "I often want to merge with others, and this desire sometimes scares them away."

The table below shows the average attachment orientation scores generated from each subscale of the AAQ and the AAQ in total.

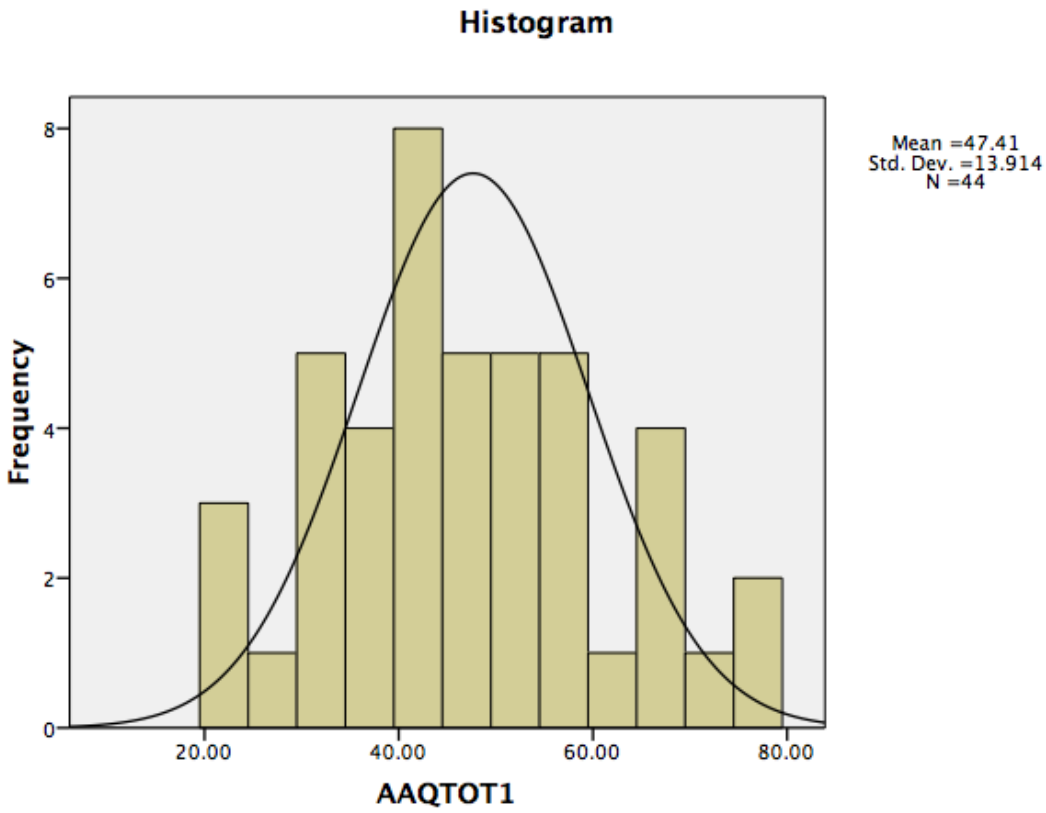
Table 6: Mean and Standard Deviations of AAQ Subscales and total

| | **Mean** | **Standard Deviation** |
|---|---|---|
| AAQ Avoidance | 23.15 | 8.50 |
| AAQ Ambivalence | 24.29 | 8.84 |
| AAQ Total | 47.41 | 12.91 |

This histogram provides a visual picture of the attachment orientation of the sample as measure by the AAQ.

Figure 5: AAQ scores histogram

## Total AAQ Scores




The Termination Approaches Questionnaire was split into two main constructs of engagement in and avoidance of termination.

### TAQ Engagement

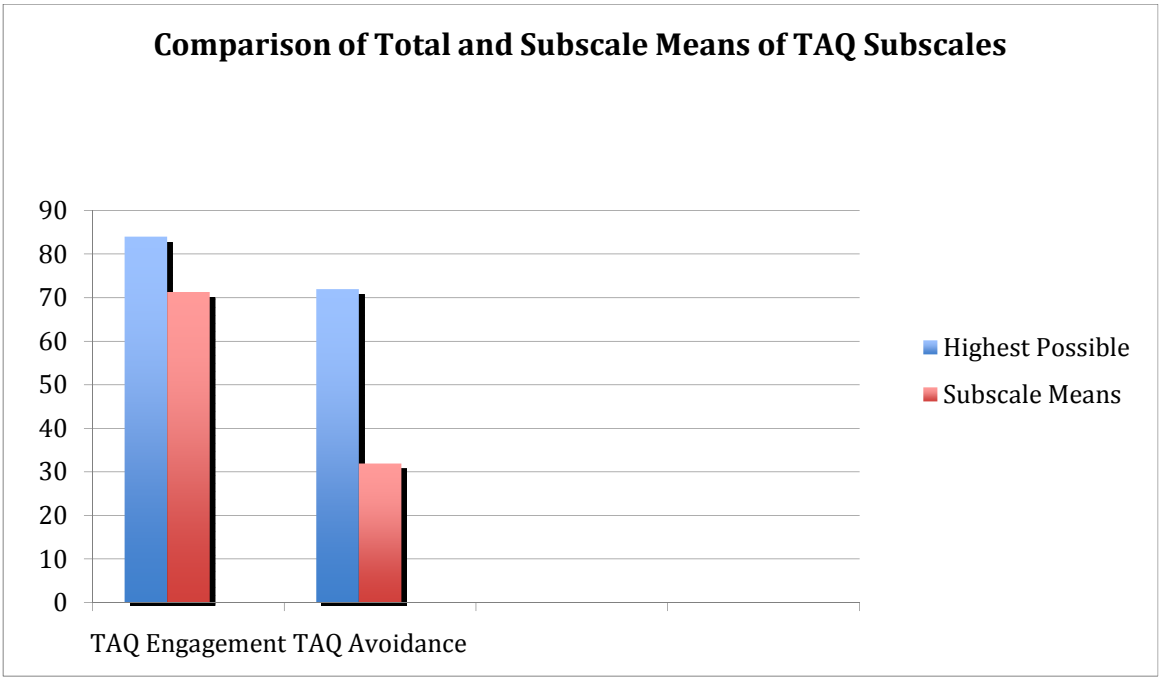
The TAQ engagement subscale had a total of 14 items to which participants (N=45) responded on a 6-item likert scale from "Never" to "Always" with a negative skew. The midpoint (4) referred to "About half of the time." The larger the number of the response indicates higher engagement, with the highest possible score of 84. The mean score of engagement in termination on this subscale was 71.33, with a standard deviation of 10.05. The item with the highest mean (5.40), was "I encourage clients to come in for

a final session instead of terminating on the phone or via email." The item with the lowest mean (4.24) was "I review my own feelings with my clients during termination."

**TAQ Avoidance**

The TAQ avoidance subscale had a total of 12 items to which participants (N=43) responded on a 6-item likert scale from "Never" to "Always" with a negative skew. The midpoint (4) referred to "About half of the time." The larger the number of the response indicates higher avoidance, with the highest possible score of 72. The mean score of avoidance of termination on this subscale was 31.97 with a standard deviation of 7.94. The item with the highest mean (3.49) was "I am satisfied with a brief goodbye when clients end treatment." The item with the lowest mean (2.14) was "I dread terminating with clients." See the figure below that represents the subscale means of the TAQ.

Figure 6




**Intrascale Correlations**

A main goal of this study was to explore whether or not there is an association between attachment orientations and termination approaches of clinical social workers working in outpatient mental health settings. Because the focus of this study is on the linear relationship between two quantitative variables, Pearson's correlation coefficient was used to explore whether or not there is a linear relationship between the variables, and to quantify the strength and direction of the relationship.

The intrascale correlation of the TAQ showed a negative correlation of -.326 with a p-value of .022. Because a result between 1 and -1 indicates a linear relationship, this result suggests that these constructs are in fact associated on a linear level and the results are significant at the alpha = .05 level. The -.326 number shows the linear relationship is there, but that the subscales may not be exact opposites, as the closer to the 1, -1 spectrum indicates stronger polarity.

The intrascale correlation of the AAQ showed a positive correlation of .270 with a p-value of .063. Although not reaching statistical significance, the constructs appear to be positively related. The larger p-value calls into question the randomness of the observed difference between the two subscales. This result may be due to the small sample size.

**Interscale correlations**

A comparison of the data from the two scales, the TAQ and the AAQ, was indicated in order to generate data about the relationship between the two variables, termination approaches and attachment orientation. The overall research hypothesis of this study was that there is an association between attachment orientations and termination approaches of clinical social workers working in outpatient mental health settings. The results regarding two probable trends in the data this study sought to test were as follows:

**H1: High scores on the AAQ, indicating insecure attachment, will be correlated with high scores on the avoidance category of the TAQ, and low scores on the engagement category of the TAQ**

Both AAQ subscales were negatively correlated with TAQ engagement subscale. The AAQ avoidance subscale had a Pearson correlation of -.291 and was significant at a .05 level, while the AAQ ambivalence subscale had a Pearson coefficient of -.100 and was also significant at the .05 level. Additionally, both AAQ subscales were positively correlated with the TAQ avoidance subscale. The AAQ avoidance subscale showed a Pearson correlation of .490 as compared to the TAQ avoidance subscale, and was significant at a .01 level. The AAQ ambivalence subscale as compared to the TAQ

avoidance subscale showed a Pearson correlation of .394 and was also significant at a .01 level.

**H2: Low scores on the AAQ, indicating secure attachment, will be correlated with high scores on the engagement category TAQ, and low scores on the avoidance category of the TAQ**

The AAQ subscales were each positively correlated with the TAQ avoidance subscale at a higher significance level than the engagement subscale. The AAQ avoidance subscale had a Pearson correlation of .490 and a p-value of .00, indicating significance at the alpha = .01 level. The AAQ ambivalence subscale had a Pearson correlation of .394 and a p-value of .006, indicating significance at an alpha = .01 level.

These results suggest that the higher the attachment insecurity, the lower the engagement in termination, and the higher the avoidance of the termination process. Thus, the results suggest rejection of the null hypotheses and support for the research hypotheses.

**Additional Findings**

Five of the items (TAQ 6, 8, 11, 12, 30) on the TAQ instrument assessed feelings associated with termination. During data analysis, these items were looked at as their own separate constructs, as they were not necessarily associated with engagement or avoidance, but still provided valuable data. The higher the scores on the feelings questions on the TAQ indicated negative feelings associated with termination (after TAQ 30 was reverse coded). Data from the feelings portion of the TAQ were significantly positively correlated ($r = .526$, p-value $< .001$) with the TAQ avoidance subscale. This

finding suggests that those with higher negative feelings associated with termination also have higher avoidance of the termination process. The TAQ engagement subscale was not correlated with the feelings items.

The AAQ avoidance subscale was found to be positively correlated with the TAQ feelings items with a Pearson correlation of .297, and at the alpha = 05 level, indicating that those with avoidant attachment tendencies reported negative feelings related to termination. The AAQ ambivalent subscale was not correlated with the feelings items.

Two of the items on the TAQ (TAQ 9, 35) assessed participants' training associated with termination. TAQ 9 asked participants to assess their competency level, and TAQ 35 asked participants to indicate their training level. These two items were grouped together during data analysis. The level of training was positively correlated to the TAQ engagement (Pearson's correlation = .422, p-value < .01) and was negatively correlated to the TAQ avoidance construct (r = -.364, p-value = .01). This indicates that participants with higher competency and training around termination may be likely to engage in the termination process, and may be less likely to avoid termination or may be more likely to get training in this area.

## QUALITATIVE RESULTS

The purpose of gathering the qualitative data was to allow full descriptions of participants' individual experiences in their own words.

In addition to responding to the open-ended questions, participants were asked to make a list of feelings that come up for them when thinking about termination. Results

included 27 feelings that were categorized as negative feelings, and 25 feelings that were categorized as positive feelings. Participants identified a total of 95 (54.6%) negative feelings and 79 (45.4%) positive. Sadness and grief and loss were the most frequently identified negative feelings (sadness, 27; grief/loss, 11). Relief, pride, hope and satisfaction were the most frequently identified positive feelings (relief, 11; pride, 9; hope, 9, satisfaction, 9). Notably, of 45 participants who answered this question, 36 identified at least one negative and one positive feeling. Thus, 80% of the sample identified variance in their experiences. The results are listed below:

Table 7: Feelings list from qualitative data

| **Negative Feeling** | **Occurrences (95)** | **Positive Feeling** | **Occurrences (79)** |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Sadness | 27 | Relieved | 11 |
| Grief/Loss | 11 | Pride | 9 |
| Anxiety | 7 | Hope | 9 |
| Worried | 4 | Satisfied | 9 |
| Rejection | 4 | Happy/glad/joyful | 7 |
| Frustration | 3 | Accomplished | 4 |
| Regret | 3 | Excited | 4 |
| Anger | 2 | Enjoyment | 3 |
| Scared/Fear | 2 | Good | 3 |
| Concern | 2 | Wonderment | 2 |
| Uncertain | 2 | Positive | 2 |
| Doubt | 2 | Completion/finality | 2 |
| Questioning | 2 | Aware | 2 |
| Disappointed | 2 | Love | 1 |
| Sorry to see it end | 1 | Connected | 1 |
| Bittersweet | 1 | Wistfulness | 1 |
| Guilt | 1 | Release | 1 |
| Confused | 1 | Success | 1 |
| Annoying | 1 | Pleased | 1 |
| Challenging | 1 | Compassion | 1 |
| Discomfort | 1 | Empathy | 1 |
| Uneasiness | 1 | Caring | 1 |
| Inadequate | 1 | Interesting | 1 |
| Uncertain | 1 | Calm | 1 |
| Difficult | 1 | Encouraged | 1 |
| Missing | 1 | | |
| Emptiness | 1 | | |
| | | | |
| 27 feelings | 95 | 25 feelings | 79 |

Participants were asked to describe their overall experience of termination and several key themes emerged from the data. A total of 46 participants responded to this question. Below are the themes along with detailed data descriptions supporting the themes.

***Termination as a "rich opportunity"***

"Rich opportunity" is an in-vivo code that emerged as a theme. The participant who coined the term referred to termination as an opportunity for innate, human communication and full emotional expression. With this, many other participants named specific opportunities that termination provides. Examples included: a chance to work through previous abandonments, to tolerate loss, to summarize and articulate progress, and an opportunity for closure. An illustration of this theme is the following response:

> "Usually it presents a nice opportunity for closure and processing of the patient's feelings about endings. It is very helpful in itself for patients."

One participant referred to the difficulty termination presents due to the need to differentiate between her own responses and the responses of the client. Although she described it as "difficult," the opportunity for growth on both the clinician's and client's part was present in this response. Another participant spoke of the chance to make something constructive, even if the circumstances were not ideal, and the manner in which this translates to the outside world. This response brings words to some of the internalized values of the social work profession. Enacting the NASW ethical principle to advocate for vulnerable and oppressed populations (Code of Ethics of NASW, 2008), often means acting within less than ideal circumstances for the good of our clients. Additionally, some respondents referenced their use of supervision and the need for supervision as a way of facing and getting through the issues surrounding termination.

***Termination as a missed opportunity***

> "I rarely have a client who wants to participate in the process of terminating and I am not very good at making it happen."

This quote describes the impact of missing the opportunity for a termination process, and that the missed opportunity impacts both client and clinician. The inherent ambivalence associated with termination was shown in the data that described both the rich–and missed- opportunities that make up termination. Although some participants spoke a great deal about how they use termination, others spoke about what is missing when a termination process is foreclosed. Many participants mentioned drop-outs, sessions running out, or rushed terminations as frequent experiences. One said, "there is no process, clients just stop coming." Another reported "I rarely get to engage in the process of termination with client as described in textbooks." Some indicated phone terminations. Others reported that they rarely have the opportunity to conduct termination as they wish. Agency functions and limitations, as well as other types of limitations (i.e., parents pull a child from treatment) were other indications of missed opportunities. One participant reported that the agency he or she works for doesn't handle it well. Another reported termination as "under-discussed and under-processed."

One participant described the following experience of termination:

> "Almost never is it a considered, deliberate process. Clients no show, then they no show more frequently, then they're not there."

Participants also noted that if they felt it was not time, or if they felt that more issues needed to be addressed, then their own experience of the termination was more difficult. Another component of the missed opportunity theme was missed opportunities regarding training, education and overall preparedness. One participant reported, "I feel I

wasn't adequately trained [to deal with termination]." This component also emerged in the following quote:

> "I wish I had more skills in probing with patients who self-terminate in order to understand why they did not feel comfortable coming back, or why they weren't engaged, or if there were practical barriers."

In all, these data suggest that clinicians have awareness of the termination process, and the opportunities that it presents are sometimes used and other times missed.

***Meaning making of termination***

When asked to describe their overall experience of termination, responses generated a theme of meaning making. Participants reported termination is a "positive sign the client is moving on," as valuable and beneficial and as representing success. "Success" and "positive" were common words that emerged regarding meaning making. Participants referred to the changes clients have made, and the significance of their moving on having made changes. One participant noted termination is "necessary and natural." Another participant indicated:

> "Treatment should not go on forever, and clients need to look back on their process and recognize their successes and their hard work."

When indicating many phone terminations accompanied by clients' apologies, one participant indicated "I think it's ridiculous to read too much into this given today's society." Clearly individuals' meaning making can vary greatly.

One participant had these thoughts on this issue:

> "While I believe termination can be handled poorly or well, I find it self-serving to treat it like a good experience for the client, at least in the short term it is almost always a loss and often a rewounding of someone who is already seeking help for a wound."

These responses show that the meanings clinicians make about termination can be quite different, but they are meanings nonetheless. The presence of meaning can provide seeds to inform and expand the education and supervision process regarding termination.

***Termination as "emotionally charged" and with conflicted emotions***

One participant described termination as "sadness mixed with pleasure," a statement that seems to mirror many of the responses and again supports the emotional ambivalence of the experience of termination. Satisfying, positive, fulfilling, happy, and rewarding were all words used to describe termination. Additional descriptors included: frustrating, sadness, anxious making, fear-inducing, loss, and a mourning process.

These responses are supported by another qualitative question asking for a list of feelings associated with termination. Notably, the majority of participants listed both negative and positive feelings. This is illustrated by the following responses:

> "I always have mixed feelings. I am happy that the client has achieved his/her goals and feels strengthened and ready to move on; but I am sad to lose the relationship because I enjoy working with my clients."
>
> "It is challenging but when I can focus and do it well, not shrink away from the mix of feelings it is very rewarding."

***Termination "respects the therapeutic relationship"***

The therapeutic relationship, its quality and how it plays out during termination, emerged as a theme in the data. Somewhat expectedly, many participants said things like

"it depends on the client" or "it depends on the circumstance." Others indicated that length of time in treatment and quality of the relationship was paramount to their termination experiences. When loss was indicated on the clinicians' part, it was often about loss of the relationship. Participants frequently spoke of themselves and clients when answering this question, indicating the mutuality of the termination experience and the relationships within which it occurs. The following responses demonstrate mutuality and the therapeutic relationship:

> "When it is done appropriately, termination can be done well and benefit the client and respect the therapeutic relationship."
>
> "A time for gains when reviewing the treatment and the therapy relationship."

Participants were asked to describe a "typical termination." A total of 44 participants responded to this request. One participant had this to say:

> "None is typical…each has its own trajectory in terms of timing, texture and intensity of emotions and length of time."

Although the point this participant made is well taken, themes emerged from the data that helped provide some form to what happens during termination.

***Termination is client driven and (mainly) clinician led***

The theme of termination as being clinician led applies to circumstances where there was a planned termination. Drop-outs, or clients who stop coming do not describe

clinician led termination, but are in fact client driven. One participant described "Most discharge paperwork is checked with a 'patient was non-compliant with treatment' notation."

Many participants reported that termination is often raised by the client or by the clients' behaviors either in or outside of sessions. It was common in the data to find clinicians approaching the subject of termination with the client due to what was happening in session. The following are some excerpts from the data:

> "Usually conversations die down and sessions become less intense and more casual."
>
> "The client stops coming in with emotional material."
>
> "Client has less to say – sometimes then we relook at goals and they realize that they feel satisfied and complete."

These are examples of the client driving what is happening in session, and in turn the clinician is leading the move toward looking at termination. Other participants reported bringing up termination when they begin noticing no shows or cancellations. Missed sessions emerged as a clue to approaching termination. Illustrations of this theme are:

> "Sometimes the client no shows or cancels a few times and then I bring (up) that we may be done."
>
> "Client will call, cancel an existing appointment, say they are stopping therapy. More often than not, the message is left in a voice mail. This happens whether they are long term clients or have come for just a few sessions. If they are long term clients, then I encourage a session for termination. Short-term, I just let go."
>
> "Sometimes starting to miss sessions and we talk about that leading to discussion about readiness to end."
>
> "Client stops coming, there is some effort to reschedule them, but it's usually unsuccessful."

Two participants provided examples on the divergent opinions on who drives termination as well as when it should occur.

On this topic one participant said:

> "Essentially never do a client and I come to the agreement that they're well enough to terminate."

While another reported:

> "I let them make the call."

***Time is widely and thoughtfully used during termination***

"Ready to use the time for something else!"

When termination occurs it is sometimes planned and sometimes not. Participants demonstrated their clinical stance when speaking of "when" termination occurs. As was shown in the theme discussed above, it was common in the data to find clinicians approaching the subject of termination with the client. Clinicians reported approaching termination when session content changed or when the regularity of sessions changed. It was commonly reported in the termination process that clinicians were consciously titrating sessions. Participants described sessions as becoming less frequent, going from weekly to twice monthly, sometimes to monthly.

Many participants referred to the actual number of sessions allotted for terminations. Participants indicated that they spent from 1 to 8 sessions on the termination process. The most common number of sessions that was noted was 2-3. Some participants referred to quick terminations due to funding losses or due to the short-term

treatment model. Participants spoke of setting a termination date and then reviewing termination goals to meet as that date approaches.

> "The typical termination process spans two to three sessions. I often find that clients can not tolerate more than that (and sometimes can't tolerate more than one)."

***Content of termination sessions***

There were many similarities in the descriptions about what happens during termination sessions. Reviewing the treatment goals, reviewing the achievements, reflecting on the course of treatment, plans for ongoing symptom remission were commonalities that emerged about what happens during termination sessions. One participant described the following process:

> "We speak about what they have gained from the therapy, feedback they have for me, what they need to continue working on, etc. I work to give them feedback about my feelings towards them and the work, and am honest if they are people who I am having a particularly hard time ending with."

The data suggest that termination sessions have a feeling of invitation to them. Many participants spoke of the openness of the sessions, or about their requests for feedback and search for what may have been missed. One participant referred to the termination process as "sharing what has been unsaid" and another said, "I invite feedback." Other examples include:

> "I ask them to tell me what was most helpful in our work and what was least helpful. I also ask what they think should have been different."

> "We will talk about how they are feeling about ending and how I am feeling about ending."

### *Rituals*

A theme emerged about rituals that clinicians engage in during termination. This theme was not overwhelmingly present in the data (N=3), but present enough to mention and review. Sometimes these rituals were oriented around treatment with children or families, but other times it was for adults. Examples of rituals include:

> "We have a celebration cookie or cupcakes to mark and important life passage for the family."
>
> "We literally do draw, using art therapy materials, what they want to leave with me, what they want to take with them."
>
> "Often I will hug clients on the way out, or shake hands."

Some (N=2) participants described ritual-like actions by terminating clients.

> "Sometimes I will get cards or emails from someone letting me know how they are doing."
>
> "I usually receive thank you cards, sometimes holiday cards over the course of the year from former clients."

### *Open door policy*

A recurring theme in the data on typical terminations was the expression by clinicians of their ongoing availability should clients wish to return. The following are illustrations of this theme.

> "I explain that I have been in the same agency for a long time and am open to having someone come back for a tune up."

> "Door was left open, figuratively speaking, for him to come back at any time."
>
> "Reminder of availability in the future."

The qualitative data mirror the quantitative data on the same topic. Participants were asked to respond to the statement "I leave the option open for clients to return." The majority of participants responded that they do this frequently. The mean of the data from this item was 5.25, with a standard deviation of 1.06 and a range of 5. A possible reason for the high range, and that at least one participant answered "never" to this question, is the agency's role and function.

Although this theme may call into question the permanency of termination, it describes termination nonetheless. Clinicians are engaging in termination despite the fact that clients may return, and with the awareness that they may not return.

This end quote sums up the tone of much of the responses about a typical termination:

> "Usually termination is a celebration of the client feeling better."

Participants were asked to describe a termination that was memorable to them. A total of 41 participants responded to this request. One participant used this statement to describe his or her response to a memorable termination:

> "This is why it has been so useful to have a structured and extended process of termination, so that the client has an opportunity to express the anger and move towards acceptance of the change in clinician before saying goodbye. Terminations which have been truncated due to no-shows or attendance issues have been more difficult because this process is limited."

There were two dichotomous themes that emerged from these data. Participants described terminations that were either memorable because of their satisfaction with the work, or were memorable due to mistakes.

***Clinicians left with mutual goals realized***

Terminations with mutual goals realized were frequently described in these data. The participants described detailed feelings and experiences of terminations. Evident in the data was the growth and progress that clinicians can realize from this phase, and therefore the overall mutuality of this phase. One participant, after working with a dying woman for many years, expressed "She had given me so much, and I experienced much spiritual and professional growth while caring for her." Another participant described a poignant ending with a college student:

> "…in our last session (she) shyly asked if I would miss her. I told her I would miss her greatly (which was true) and we sat in silence with the mutual acknowledgement of caring for each other."

Below are other excerpts from the data demonstrating mutuality in the termination process:

> "There were painful feelings of loss for both of us but more predominant were feelings of joy that she felt ready to enter this new chapter of her life with confidence. "
>
> "It felt great to end this way and the client seemed to know I cared about him and his process, our relationship."
>
> "When the grandmother ended, there was a sense of completion for the whole family, and for me in having accompanied them through a very difficult time in their lives."

***Clinicians left with unfinished business***

At the other end of the spectrum from mutually experienced goals, the experience of clinicians left with unfinished business. Again, the data show the ambivalence of the termination experience, and its potential for both gains and for being left unfinished. Unfinished business can occur for various reasons. For one participant it was based on his or her mistake. This participant reported:

> "I called the client and apologized for my insensitive statement and suggested that she come back in so we could discuss what I had said (what I said was true, but insensitive). She didn't come back and I felt horribly guilty."

Another participant was left with unfinished business because of a suicide.

> "I had a client who committed suicide because he had a temporary lapse in insurance…I was left with feelings of frustration because this client truly depended on his meds and because he didn't have them he is no longer here. It was the worst termination thus far."

The other instances of unfinished business from the data demonstrate not only what the clinicians are left with, but also their lingering feelings about it and a strong sense of responsibility. Illustrations from the data include:

> "I often think about what I could have done differently."
>
> "I still think of her and considered trying to reach her when I retired but decided not to because it may be an impingement."
>
> "I've often wished we could have processed these feelings."

The purpose of this section was to present the results from this study. Data supporting rejection of the null hypotheses were presented, as were responses generated from the open-ended questions. Both the quantitative and qualitative data provided results that encourage discussion about the conclusions and implications of this study. The

following section will review the results in more detail and introduce the implications that the results generate.

# CHAPTER 5: DISCUSSION

## Limitations

The previous chapters reviewed the background, methods, and results of this research. Because limitations are inherent and are expected in human services research, this section provides a review of the limitations specific to this study. The purpose of this section is to review the limitations of the current study while demonstrating the value of the research despite the limitations.

The current study is limited by its small sample size. The N=49 sample proved robust enough to inform results, but not enough to generalize outside the sample population. Because of the snowball sampling strategy, there is no way to tell the percentage of those who received letters of invitation who chose not to participate. The limited sample size also restricted the ability to conduct factor analyses or other more in-depth psychometrics on the newly developed scale (Termination Approaches Questionnaire; TAQ).

The TAQ was a limitation to this research because it was developed for the study and, therefore, no pre-existing data were available on the reliability and validity of the tool. Despite the TAQ being evaluated by other researchers and piloted before the study began, the chance for researcher bias in the tool remained. Furthermore, self-report instruments, including the TAQ and AAQ are subject to participant bias and may generate socially desirable responses.

With respect to the TAQ, given that participants were trained clinicians who were ostensibly aware that they should be engaging in, rather than avoiding, termination, social

desirability was a real threat to this study. That said, the online survey administration was more anonymous than some other possible methods (i.e., in-person interviews), perhaps minimizing the social desirability bias. Other attempts to mediate the limitation included clarity in the instructions and the inclusion of qualitative data. In addition to social desirability, clinician awareness may have impacted responses to the TAQ. A clinician who has less awareness of his or her reactions during termination may not be as able to track accurately their responses as one with more awareness. Short of videotaping or observing the clinician-patient interactions, there is no simple way to control for this potential problem.

As mentioned throughout the study, the intended TAQ that was to be presented to participants had a major omission. The omission of the fifth descriptor in the likert scale ("some of the time") negatively skewed the data and changed the intended 7-point likert scale to a 6-point likert scale. Although the use of the TAQ was methodologically sound, human error induced a limitation. This limitation was mitigated by openness about the mistake, and the data were interpreted with the skew.

Due to the newness of the TAQ and the unknown psychometrics, a small qualitative piece was included as part of the TAQ. The qualitative data were limited in that they only generated data about termination, and no overt data were collected about attachment in the qualitative piece of the research. The attachment data gathered were only quantitative. The reasons for this decision are many, including the unconscious aspects of attachment and the time and logistical limitations in using another type of attachment tool (i.e., Adult Attachment Interview), but it remains a limitation

nonetheless. This limitation speaks to the choices that social science researchers must make along the way.

Although the AAQ is a well-researched tool, it was originally created for use in assessing adult attachment as related to or impacted by romantic relationships. The therapeutic relationship is one that has an element of intimacy but is also far from romantic. The instructions for this tool were changed in kind, but the tool was not used in its originally intended form. Again, this limitation is a result of researcher choices and arose out of a desire to use a strong and previously researched tool to counterbalance the newness of the TAQ.

Another conscious choice that is also a limitation was the decision to use only clinical social workers working in outpatient psychotherapy settings. Clinical social work is a broad based field. It was necessary to narrow the field for this study to begin research into this topic with participants more likely to have experienced "textbook" terminations. This study was conducted with awareness that the participants make up only a portion of clinical social workers in this country. Therefore, the current study does not attempt to extend findings beyond the population represented by study participants. The study is limited in its direct application to clinical social workers in other settings, but connections to both termination approaches and attachment orientations may indicate directions for future research.

The methodology of this study used newly developed technology for survey methods. In this case, a product developed by PsychData to create, manage, and hold the results of the questionnaire was used. Although PsychData was user friendly in many

ways, the newness of this approach unveiled previously unknown pitfalls. The placement of the instruments may have lead to participants unintentionally skipping the entire AAQ as it was placed after the TAQ open ended section. Additionally, the number of participants that appeared on the screen represented the number of people who accessed the survey, rather than those who filled it out. Therefore, the data collection phase was closed earlier than it would have been had the actual number of participants been available. Lastly, the choice of this method may have omitted those who are less "technology savvy" or are more oriented toward conversations or pen-and-pencil than computers.

This research comes with limitations and must be considered with its limitations. Careful evaluation of the limitations acknowledges that the methods and sample of this study are limiting in some ways. Despite the limitations, the conclusions and implications suggest the significance of this work for social work knowledge building and clinical practice.

## Conclusions and Implications

This project is built conceptually on the universality of the presence of attachment orientation in adults and the probable association of types of this orientation with the clinical termination experience. The results of the study suggest that there is a statistically significant relationship between attachment orientation of clinical social workers and their approaches to termination. The conclusions about the hypotheses and psychometrics on the TAQ are reviewed in detail below. Conclusions and implications about the

therapeutic relationship, the emotional ambivalence of termination, time, content, and context of termination, and the opportunities and outcomes that termination and attachment present are also reviewed in this section. A careful examination of the quantitative and qualitative data from this study reveals themes about termination and attachment and their relationship to each other in the clinical encounter. This section will use the study results to identify and explore conclusions that may be made from the data.

## Hypotheses

There are data from the study to support rejection of the null hypotheses and support for the research hypotheses. By rejecting the null and supporting the research hypotheses, the study reveals an association between attachment orientation and termination approaches for clinical social workers working in outpatient mental health settings. Participants who had lower scores on the AAQ (indicating more secure attachment) had higher scores on the engagement subscale of the TAQ indicating that those with higher attachment security were more likely to be engaging in the overall process of termination. Likewise, results suggest that the higher the AAQ scores (indicating less secure attachment), the higher the scores on the avoidance subscale of the TAQ, indicating that those with less secure attachment orientation were more likely to be avoiding the termination process.

## Termination Approaches Questionnaire

Preliminary psychometrics, namely reliability data, on the TAQ provide some data on the strength of the tool, thus indicating the TAQ for further use. Further use of the instrument, and use of the instrument in its intended form (7-point likert scale) may

provide additional data on the reliability of the instrument as well as item-by-item statistics. Use of the TAQ in other studies could serve two primary purposes: provide additional psychometrics on the TAQ, and generate further clinical data on termination approaches.

Additional data supporting further use of the TAQ come from the two questions that assessed the scale. One question asked "How well do you think this scale captured your termination experiences?" and another asked "How accurately were you able to answer the questions?" Responses to both questions ranged from 2 to 7, but each question generated mean scores above the midpoint (4.86 and 5.24 respectively on a 7-point likert scale). These data support the preliminary use of this scale and support additional standardization of the scale.

The scale means of the engagement and avoidance subscales of the TAQ indicate an important finding. Participants who reported high engagement in termination on the TAQ showed stronger engagement according to the results then the level of avoidance reported by those measuring high avoidance. This finding is promising, as it indicates that the level of avoidance that is occurring during termination is lower than the level of engagement. This spectrum of avoidance and engagement in termination may be related to the attachment orientation of the workers.

**Attachment Orientation and Termination Approaches**

The clinical social workers working in outpatient settings in this study did in fact have varying attachment organizations, as measured by the AAQ. The means of the ambivalence and avoidance subscales indicate that the AAQ was able to differentiate

attachment orientation for the participants in the study. The total range in AAQ scores in the study was 56. The means scores on both the AAQ Ambivalence and AAQ Avoidance subscales were slightly lower than the mean scores generated from the research by Simpson, Rholes, and Phillips (1996) while developing the instrument. This indicates that the sample population had slightly more secure attachment orientation than the population from the Simpson, et al., (1996) study. The varying attachment orientations of participants reinforce the need for clinicians' awareness of their role in relationships, one that is often influenced by attachment. In this study the dimensional nature of attachment is evident.

**The Therapeutic Relationship**

This study supports the idea that attachment orientation of the subjects likely influenced the therapeutic relationship and the therapeutic work as a whole. As to the importance of the attachment orientation of the worker, this study supports the findings of previous research, such as previously reviewed studies by Dozier, Cue and Barnett (1994), Tyrrell, Dozier, Teague and Fallot (1999), Sauer, Lopez, and Gormley (2003), Black, Hardy, Turpin, and Parry (2005).

The tendency for clinical social workers and others in the human services professions is to look closely at the innate and psychosocial factors of clients. This tendency was supported in the current research both quantitatively and qualitatively. The qualitative questions that asked for clinicians' experiences of termination frequently generated data mostly about clients. Some participants presented their experiences in the qualitative results; notably some did not. Additionally, when responding to the statement

"My feelings during termination are important," the scale yielded a mean of 4.78 with a standard deviation of 1.35. With 4 indicating "more than half the time" and the negative skew of the scale, this points out the attention that participants give to their own experiences. According to this data, only slightly over half the time do clinicians value their own feelings during termination. This calls into question the level of self-focus and self-awareness that is occurring in the clinical encounters of the study sample. Clinical social workers are frequently taught about use of self and ourselves as "tools" of the work. Further integration of this concept into clinical social work practice could enhance the quality and longevity of our work with clients. The need for further integration of clinician self -awareness is supported by this study and previous research. Dunkle and Frieldlander (1996) found that clinicians' personality characteristics play a part in the therapeutic relationship (Dunkle & Friedlander, 1996), and the therapeutic relationship is a widely acknowledged key factor in treatment success (Luborsky, Rosenthal, Diguer, Adrusyna, Berman, Levitt et al., 2002).

Not surprisingly, the quality of the therapeutic relationship emerged as a theme throughout study. Previously reviewed literature (Sauer, Lopez, Gormley, 2003; Black, Hardy, Turpin and Parry, 2005) looked at attachment organization and the impact on the therapeutic alliance. Qualitative results included the different ways clinicians approach termination depending on the treatment length, the client and the relationship. References to the experience of terminating with difficult clients were also present. In the quantitative section, participants were asked to respond to: "Processing termination is important regardless of the quality of the therapeutic relationship." Results showed a mean of 5.36 (sd=.86). A response of "6" indicated "always." Additionally, participants

responded to: “The relationship I have with my client impacts my feelings during termination,” resulting in a mean of 5.07 (sd= .89), with a response of “6” also indicating “always.” These results show consistency between the qualitative and quantitative data, and the results are in line with the previous literature on the therapeutic relationship.

**Content of Termination Sessions**

The content of termination sessions was consistent in the data and in the theoretical literature on this phase. The content includes processing the work, reviewing treatment gains and reviewing feelings about ending. A few participants in this study also reported asking for feedback from clients. Surprisingly, study participants did not report addressing transference and countertransference responses although the majority did identify as primarily psychodynamically oriented. Content of termination sessions appears consistent, but the presence of termination sessions appears less so. Additionally, the lived experience of the termination, the confidence in doing this “work,” seems lacking. I am left wondering if the data here represent socially acceptable responses, and if clinicians reported what they felt “should be happening” during termination rather than their experience. The richness that could be a part of the termination experience appears lacking.

The data indicate that frequently terminations are left open ended, possibly leading to the termination descriptions lacking richness as described above. The invitation to return to treatment was found throughout the qualitative and quantitative data. This finding is similar to the findings of Marx and Gelso (1987) and Quintana and Holahan (1992) which showed 66.7% and 69.6% percent of clients received an invitation

to return to counseling. In the present study, clients were asked to respond on a 6-point likert scale to "I leave the option open for clients to return." The mean was 5.25 out of a possible 6.0 and the standard deviation was 1.06. The open door policy was ever present in the qualitative data and supported by the quantitative data. This finding provides an element of conjecture regarding the perceived permanency of termination. Additionally, although the door may be open in theory, what are the practical implications of that offer? Reasons for termination may be agency limitations or financial limitations. If financial or agency circumstances shift, does it benefit clients to invite them back to treatment? That said, the worker may change jobs, the private practitioner may move or close their practice, or numerous other changes may occur. This study opens up questions about the open-door invitation during termination and what could be done to prevent any possible damage from this practice, as well as what about this practice is useful to clients. It appears that even when engaging in termination including saying goodbye to the therapeutic relationship, an element of speculation remains about the possible resumption of the therapeutic relationship at a different time. Data from the study indicate that termination is less permanent than is sometimes noted in the literature.

**Termination as Emotionally Ambivalent**

The varying emotional experiences of termination were clear in both the quantitative and qualitative data. That said, naming this phenomenon and describing it clearly proved more difficult. The term "paradox" was originally used but did not accurately describe this result. "Paradox" implies contradiction, whereas the results of the research were less contradictory, but rather describing co-occurring feelings or experiences that were quite different. Careful consideration of this result eventually led to

the emergence of the term "emotionally ambivalent." This term describes the simultaneous experience of varying feelings that was present in the data.

The emotional ambivalence of the termination experience is quite visible in the data generated from asking participants to list feelings associated with termination. As noted in the previous section, 80% of participants listed at least one feeling categorized as negative, and one feeling categorized as positive. Sadness, grief, and loss, and anxiety were the most commonly identified negative feelings. This was not surprising as related to the termination experience. Previous research (Boyer & Hoffman, 1993) and practice applications (Goodyear, 1981; Shulman, 1999) have indicated the presence of these factors in the termination experiences of clinicians. Interestingly, whereas Fortune, Pearlingi, and Rochelle (1992) found "pride" and "accomplishment" as the most common practitioner responses to termination, the current study found "relief" was the most common positive feeling identified (relief was identified 11 times). Participants also frequently (9 responses) identified the feelings of satisfaction, pride, and hope. This emotional ambivalence was further supported in themes that emerged in the data asking about a typical termination. Participants used the same and similar verbs to describe their typical terminations, and included a number of overt references to the emotional ambivalence of the termination experience.

The emotional ambivalence of termination and the most frequently identified feelings illustrate the need for further education and training around the termination process. Although the feeling "relief" can be interpreted in many ways, according to the American Heritage Dictionary of the English Language (2010), the first two definitions of the word include the easing of burden or distress, such as pain or anxiety, and

something that alleviates pain or distress. Regarding termination, this implies that there may be some distress associated with the process as revealed by these data. Some other responses to the qualitative questions about termination experiences generated answers referring to the use of or need for additional training and supervision. In the quantitative data, a positive correlation was identified between level of training and engagement in termination. Increased education may help individual workers and the social work profession as a whole to capitalize on the opportunity that this phase of the work presents.

**Termination and Opportunities**

A clinician's meaning making of the termination phase will influence how he or she capitalizes on the opportunity that termination may present. Meaning making was a theme in the qualitative data, but individual participants' meanings of termination were quite varied. This finding calls attention to the need for increased dialogue on termination and what it means. Such dialogue can surface diverging opinions that can provide a space to advance knowledge and practice. Although differences may remain in the meaning making of termination, a dialogue may present another opportunity for growth around this phase.

The concept of termination as opportunity was present in the two themes that emerged of "termination as a rich opportunity" and "termination as a missed opportunity." Tuning in to the opportunity that termination presents can be valuable for the work. Because termination is inevitable, clinical social workers can make the choice to engage in termination and to do it well. It is encouraging that the data indicate workers using the termination opportunity. The awareness that was shown that termination

doesn't happen for reasons both within and beyond their control with what appears to be desire to better engage in the process is optimistic and shows an opportunity for growth. The data also indicated termination is mainly clinician-led but driven by either expressions or behaviors of the client. This indicates participants' attunement to what is going on for clients and suggests some use of the opportunity termination presents on the part of the clinical social workers in this study.

Seizing the opportunities that termination presents requires education, training, and supervision on the topic. Some participants clearly spoke about their own lack of training and supervision, while another indicated the need for more supervision if workers had strong loss responses during termination. Ongoing education can facilitate further engagement and allow social workers to meet the requirements as described by the profession's Code of Ethics and to participate in high quality practice. This finding supports the need for increased educational focus around termination and could in turn reinforce the Code of Ethics mandate that social workers minimize adverse effects of termination (Code of Ethics of NASW, 2008, p. 14).

**Favorable and Unfavorable Outcomes**

The possible adverse effects of termination impact both clients and clinicians (Novick, 1997). Notable in the qualitative data about memorable terminations were frequent references to clinician mistakes, ongoing regret, and continued thoughts of those clients and the circumstances. The current study did not access data from clients, but participants' reports of lingering unfinished business suggest concerns about the impact of this phenomenon on clients. Are former clients left with regret, anger, or other

negative feelings about outpatient therapy in general, or their therapists or clinical social workers as a professional group? Clinical social workers may have many chances with various clients to see the benefits of the work. In contrast, sometimes our clients engage in only one opportunity for treatment, and one disappointing ending may impact their viewpoint on treatment and on social workers in general. Again the theme of education, training and supervision emerges, and this study highlights this gap and the need for expansion. Including such content can limit harm to our clients, to ourselves, and respect the integrity of the profession while continuing to uphold the Code of Ethics. Additionally, this finding indicates the need to explore not only prior treatment experiences with clients but also prior termination experiences. This can address a possible client need for help resolving a prior termination.

Interestingly, when the theme of mutual realization of goals appeared, participants more frequently described a success story of their work. They described the treatment course but did not specifically describe the termination. Although the question specifically requested a description of termination, specific answers were often absent. Is this indicative of avoiding the termination experience even after the fact? We will never know if this result was from avoiding the termination, but it does indicate an important concept. Termination is something that clinicians are less used to talking about, possibly less comfortable talking about, and is overall a less familiar ground. If termination were a more "mainstream" topic in clinical social work practice, generating responses to the topic may be quite different.

When clinicians reported being left with unfinished business, it was usually around treatment mistakes. Participants described the mistakes and often described

attempting to bring the client back in order to repair mistakes. The terminations in these responses were typically over the phone, via email, or some other form of communication that did not occur within the office or while processing the ending. This result again speaks to the importance of engaging in an actual termination process (Schlesinger, 2005). It also speaks to the therapeutic relationship and the importance for both clients and clinicians to work through mistakes (Fortune, 1987; Goodyear, 1981; Shulman, 1999). A termination that includes processing the difficult feelings and including what went wrong could alleviate the "unfinished business" for both clients and clinicians (Novick, 1997). This result is in line with the results generated from Fortune's (1987) structured interviews that included themes of "incompleteness" and reactivations of clinicians' own loss experiences.

Unfinished business, at times, is represented by the feeling of loss. Loss, not surprisingly, was a theme in the data. When asked to respond to the statement "I experience termination as loss," the mean response was 3.21 (sd=1.15), which is slightly below the midpoint of 4 (with the negative skew). This result indicates that loss was present in the experience of termination for clinicians close to half of the time in this sample. As previous research indicates, loss is linked to clinician characteristics and experiences as related to termination (Boyer & Hoffman, 1993) and to clinician attachment (Leiper & Casares, 2000). Additionally, the qualitative data generated information about rituals that participants engaged in during termination. Some of the rituals mentioned were activities with children (such as picture making or cupcakes), while others included hugs or handshakes when working with adults. Termination rituals

are ways of mitigating loss and are a frequent technique in the therapy around grief and loss (Boss, 2000).

**Time**

Another way to limit unfinished business is to pay proper attention to time in treatment as a whole and session by session. Mann (1973) said that all significant human behavior is linked with time, thus his development of time-limited treatment. Participants in this study were involved in different types of clinical practice, but many referenced time when describing a typical termination. When asked to respond to the statement, "I talk about termination in sessions leading up to the final session," the data resulted in a mean of 5.04 (sd=1.00). Participants sometimes described how many sessions they use to prepare for termination. Some used just one session, others 2-3 sessions, and one used up to 8 sessions for preparation. Participants also described using time between sessions as preparation by spreading out the frequency of appointments. Clearly study participants were making use of time throughout termination.

Interestingly, popular dialogue in the social work outpatient therapist community is about managed care and session limits, as well as the financial burdens that treatment sometimes imposes on clients. Data from this study indicated that common reasons for termination were not in fact dominated by insurance or financial reasons and were more often due to completion of the work or clients dropping out. Clinical social workers can benefit from this knowledge and from ongoing tracking of the reasons their clients terminate. Such tracking can provide a more realistic picture of what is happening across

our varying treatment settings. This result begins to illuminate a possible blind spot that exists in the clinical social work community about termination of treatment.

**Attachment and Termination in Context**

Termination, like all phases of outpatient therapy, exists within a context and does not occur independently. This is also true for attachment orientation. Termination is a phase for which workers can be trained. Workers can also be trained to tune in to their own reactions. Whereas attachment organization is not something chosen, rather unconsciously built over time, how we are in relationships, how we feel in relationships, and other factors are conscious and can be valuable to clinical social workers as individuals and in their work with clients. These clinician factors were suggested as important in the treatment relationship and working alliance in previous research by Black, Hardy, Turpin, and Parry (2005) and by Rubino, Barker, Roth, Fearon (2000) and clinician attachment orientation emerged as an important treatment factor in the current study.

Attachment orientation is not thought of as completely fixed, as evidenced by ongoing neuroscience developments. Recent neuroscientific research suggests that psychotherapy can provide an environment for increased neural growth and integration and therefore help to heal previous relational trauma (Cozolino, 2002). The healing power of psychotherapy can be true for both clients and clinicians. Clinical social work has various practice iterations, all of which hold value to our profession as well as to our clients. Findings from this study support social work's longstanding emphasis on the importance of clinician self-awareness.

The purpose of this chapter was to review the conclusions and implications that arose from the results of this study. The results were evaluated with respect to the previous research on termination and attachment. Additionally, this section integrated the quantitative and qualitative data in order to synthesize the findings and to illustrate the implications of the findings. The next chapter will specifically review the implications for practice. Because clinical social work is a practice-based profession, the implications for practice that evolved from this piece of research are specifically highlighted in their own section.

## Implications for Practice

The early days of social work practice classes are often filled with attention to "joining" with the class, the school as a whole, and of course our clients. Joining can be an exciting phase for workers. It may be less exciting for clients as clients generally seek treatment or are involved in social service agencies due to difficulties in some arena. This study provides evidence in support of the emotional ambivalence inherent in the termination experience. A practice-based implication of this evidence is to embrace the ambivalence. The duality of the termination experience is not something that practitioners will undo, nor should we aim to. The ambivalence can help clinicians and their clients become familiar and more comfortable with the inevitability of mixed feelings. This familiarity may limit people's tendency to engage in all-or-nothing thinking. Termination is not all good, nor is it all bad. It is a reality that exists within a treatment relationship. Practitioners can work towards making the termination experience as positive as possible for both clinician and client, despite the reasons for termination or other factors that influence the experience.

The results of this study suggest that the clinician's role is an important factor and that clinicians' own relational behaviors impact the termination phase. Therefore, in addition to addressing the practical aspects of the termination phase in education and supervision, clinical social workers may want to consider what their own personal psychological makeup looks like and what room they may have for growth. This implication for practice includes the possibility of workers engaging in their own psychotherapy or in the other various arenas of individual self-care. Such attention to personal growth can help clinical social workers, such as those in this study, address their own attachment injuries. Overall, an increased knowledge of the importance of clinician self-awareness is a key practical implication that emerges from the current study.

Out of increased education and increased clinician self-awareness emerges the implication for increased dialogue among clinicians about termination. Dialogue can often lead to points of practice and assist in further developing the phase of termination so as to minimize missed opportunities for growth that can result when endings are not processed adequately. In the ever-changing social work field, dialogue about what clinicians are doing and could be doing can serve to advance the field.

Advancing the social work field is a process of ongoing engagement within the social work community, among our clients, and among the human services professions as a whole. The Code of Ethics will guide all advancements in the social work arena. Because the Code of Ethics mandates social workers to minimize adverse effects of termination and to be careful not to abandon clients (Code of Ethics of NASW, 2008, p. 14), the current study has practical implications related to adhering to the Code. By bringing to light increased attention to termination and to clinician attachment in this

phase of the work, this study strengthens the potential of clinical social workers engaged in outpatient psychotherapy practice to minimize unfavorable effects of termination on clients as well as on themselves.

## Recommendations for Future Clinical Social Work Research

The beginning of the limitations section in the early part of this chapter referenced the inherent limitations in human services research. Inherent in limitations is the chance for opportunities. This section will review recommendations for future research that emerged from this research. The purpose of this section is to propose future research opportunities that materialized from this study.

The scarcity of research on termination, particularly from the perspective of clinicians, is documented in the literature review for this study. Further recommendations emerging from the present study include ongoing research about the clinicians' experience of termination, what impacts this experience, and how clinicians approach their termination experience with their clients. The research examines an underrepresented phase of the work, and expands the opportunity to bring termination to the forefront alongside other phases of clinical work. The review of the literature, the lack of termination related instruments, and this study's data, all provide evidence for the need for expanded attention to termination.

Although the breadth of attachment research is broader than that of termination, this study calls attention to clinician factors and their impact on this phase of the therapeutic relationship. Because results from this study suggest the large role the

clinician's attachment style plays in the work, it gives strength to the push for clinician self awareness. Further research could continue to focus on the client clinician dyad, and on therapists' awareness of their role in the relationship. This research arena could add to some of the current research around attachment injuries and healing in psychotherapy (Cozolino, 2002).

The current study provided an opportunity to create and pilot a new instrument. Review of the previous research revealed no current tools that assess termination from the clinician's perspective. Preliminary data on the Termination Approaches Questionnaire (TAQ) indicate that it may be valuable for possible ongoing development and use in the future. Recommendations for further research include further standardization of the TAQ by employing it with larger samples of social work clinicians. Later, expanding the TAQ to use with other helping professions in order to gather data on termination approaches across disciplines could be a valuable endeavor.

If the TAQ is normed and tested, the scope of this study could be further expanded. A closer look a the TAQ Avoidance subscale and the AAQ Avoidant subscale could explore if these constructs are in fact the same, and if there are enough data to separate termination and attachment within the subscales. Each subscales has "avoidance" as a title and characteristic; whether avoidance is the same or different in the respective scales could be a useful exploration. Another iteration of this study is to pair the further developed TAQ with a semi-structured interview on attachment, like the AAI (George, Kaplan, & Main, 1985). This could provide anecdotal data from participants on both variables in the study.

The current study gathered data on theoretical orientation as well as practice setting. Although the data were useful demographically, further research could look more closely at whether or not attachment orientation impacts these factors, and whether these factors (and others) impact termination approaches. Because in theory attachment orientation comes first, it could be useful to explore attachment as an indicator of the choice of theoretical orientations or practice settings that clinicians make. Then, in turn, exploration of theoretical orientations and practice settings and their impact on termination experiences of clinicians could be useful.

Termination and attachment orientation have not been linked in previous research. That said, they are each frequently linked to another clinical topic: loss. This study excluded an extensive investigation of loss experiences in order to keep the focus on the two constructs of attachment and termination. After additional research is conducted on the relationship between attachment and termination, adding loss as a variable into the equation could prove quite fruitful for social work knowledge development and practice.

Although this study attempted to fill a small gap in the research on termination and attachment, it also unveiled further gaps and areas of interest that are deserving of investigation in the future. These gaps represent opportunities for future learning, knowledge building and research.

## Conclusion

This study addressed a missing element in the literature about the attachment orientation and termination approaches for clinical social workers working in outpatient

mental health settings. Data indicated that there is a relationship between termination approaches and attachment orientation, and that increased engagement in termination is related to more secure attachment orientation. Additionally, data highlighted a need for increased awareness of both the termination phase and clinician self-awareness. The TAQ and the study as a whole sought to address the vacuum in which termination is currently situated. In all, this study is an initial building block to expand awareness of termination in education, practice and research. In addition, it is encouraging that this study adds to the previous research on clinician factors as critical in the therapeutic relationship.

Exploratory pilot studies like this one are as they are termed-- exploratory. It takes this type of study to make an initial step to move the dialogue further by creating a thoughtfully developed tool and overall project that has not been previously attempted.

**APPENDIX A**

Thank you for participating in this study. Your participation is anonymous, and your answers to the following questions will be kept strictly confidential.

**Gender_____ Age_____ Licensure_____**

**year of MSW graduation_____**

**How long have you worked as an outpatient therapist?_____**

**What is your primary theoretical orientation?_____**

**What is your primary (more than half time) work setting? (i.e. private practice, agency)_____**

**What are the demographics of the primary type of client you serve? (socioeconomic status, age, race, gender)_____**

**What is your most common reason for terminating with clients?**

- work is complete
- insurance or financial limitations
- agency limitations
- clients drop out of treatment
- other_____

**Termination Approaches Questionnaire (TAQ)**

Thank you for agreeing to complete this survey. Therapists are taught that termination is an important part of the therapeutic process. Yet, termination remains under-emphasized in clinical seminars, research, training, and supervision. Most of us know what we should do while terminating with our clients; this survey is designed to find out what therapists actually do, feel, and experience while terminating with clients. There will likely be varying responses to the questions and there are no right or wrong answers. In order to help advance knowledge about the termination process as it is currently happening in the field, please be as honest as possible. Your answers will remain confidential.

Although your termination experiences, feelings, and actions vary from client to client, for purposes of this survey, please consider your overall experience with termination. It will take approximately 15 minutes to complete the survey.

1. **I review the treatment during termination with clients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

2. **I work with my client to review their feelings about the ending during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

3. **I make specific efforts to review endings.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

4. **I review my own feelings with my client during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

5. **The relationship I have with my client impacts my feelings during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

6. **I regret having to terminate with clients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**7. My treatment seems to slow to an end and eventually die out.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**8. I leave the option open for clients to return.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**9. I feel competent about how to terminate with clients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**10. I talk about termination in sessions leading up to the final session.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**11. I have a sad emotional response to termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**12. I have an anxious emotional response to termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**13. I am satisfied with a brief goodbye when clients end treatment.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**14. I tend to withdraw from the client during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**15. I encourage clients to come in for a final session instead of terminating on the phone or via email.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**16. My feelings during termination are important.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**17. I am frequently shocked when clients are ready to end treatment.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**18. I am frequently not ready to end treatment when the client is ready.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**19. I consider termination a valuable part of the work.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**20. I feel pulled to continue treatment indefinitely.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**21. I experience client initiated termination as rejection.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**22. I dread terminating with clients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**23. Processing termination is important regardless of the quality of the therapeutic relationship.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**24. Termination is the most difficult part of the work.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half | Some of | Almost | Always |

of the time the time Always

**25. When clients drop out of treatment (no show or no contact), I don't reach out to them.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**26. I review treatment gains during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**27. I invite client feedback of the treatment during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**28. I am open to discussions of limitations of the treatment during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**29. I have difficulty letting go of significant therapeutic relationships.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**30. Generally I am relieved to terminate with clients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**31. I talk about the loss of the relationship during termination.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**32. I experience termination as loss.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**33. I experience termination as a sign of client progress or moving on.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Almost never | Rarely | About half of the time | Some of the time | Almost Always | Always |

**34 How well do you think this scale captured your termination experiences?**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Not well at all | | | | | | Quite well |

**35. Indicate the level of training you've received around terminating with clients.**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Not adequate at all | | | | | | Quite adequate |

**36. How accurately were you able to answer the questions?**

| 1 | 2 7 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Not accurately at all | | | | | Quite accurately |

**If you'd like to say more about this, please use the space below:**

**Open ended questions:** Please include a few sentences responding to the questions below.

1. What is your overall experience of the process of termination?

2. Make a list of the feelings that come up for you when you think about termination.

3. Describe a termination that is significantly memorable to you.

4. Describe a typical termination in your practice.

**ADULT ATTACHMENT QUESTIONNAIRE (AAQ)**

This study explores attachments and termination. Adult attachment is often evident in adult close relationships, including romantic relationships. Please indicate how you typically feel about close relationships in general. Two questions do ask you to report specifically on romantic partners. Keep in mind that there are no right or wrong answers. Use the 7-point scale provided below. It will take approximately 5-10 minutes to complete this scale.

1 2 3 4 5 6 7

_____

I strongly I strongly

disagree agree

1. I find it relatively easy to get close to others.
2. I'm not very comfortable having to depend on other people.
3. I'm comfortable having others depend on me.
4. I rarely worry about being abandoned by others.
5. I don't like people getting too close to me.
6. I'm somewhat uncomfortable being too close to others.
7. I find it difficult to trust others completely.
8. I'm nervous whenever anyone gets too close to me.
9. Others often want me to be more intimate than I feel comfortable being.
10. Others often are reluctant to get as close as I would like.
11. I often worry that my partner(s) don't really love me.
12. I rarely worry about my partner(s) leaving me.
13. I often want to merge completely with others, and this desire sometimes scares them away.
14. I'm confident others would never hurt me by suddenly ending our relationship.
15. I usually want more closeness and intimacy than others do.
16. The thought of being left by others rarely enters my mind.
17. I'm confident that my partner(s) love me just as much as I love them.

Simpson, Rholes, & Phillips, (1996). Conflict in Close Relationships: An Attachment Perspective. *Journal of Personality and Social Psychology*. *71*(5), 899-914.

**APPENDIX B (letter of invitation)**

Dear Colleague,

I am a clinical social worker, and a doctoral candidate at the University of Pennsylvania School of Social Policy and Practice. I am studying the relationship between practitioner attachment style and termination approaches with clients. Findings present a real opportunity for growth in the field both in terms of practitioner insight development and client benefit. Results will seek to add to the literature in clinical social work, and to inform the practice of termination. The study seeks to enroll at least 50 participants who are clinical social workers providing outpatient psychotherapy. Data collection begins March 21, 2010 and will continue until ample sample size is collected. I know your time is valuable. Your participation should take approximately 25 minutes. I do hope you will agree to be part of this important study.

Participation in this study involves consenting to participate, providing some basic demographic information, and completing two brief scales.

There are no known risks associated with participating in this study. There are no right or wrong answers. All information gathered through participation will be anonymous and confidential, and participant privacy will be strongly upheld. The researchers will not be able to associate answers with particular participants, as there is no identifying information on the questionnaires. There are no costs or payment associated with participation other than the reward of knowing you have contributed to clinical research.

You are free to choose not to participate. Your participation in this research study is voluntary and you may choose not to answer all questions or discontinue the survey at any time. If you have questions about your participation in this research study or about your rights as a research participant you may contact me at anytime at 215-573-3308. You may also call the Office of Regulatory Affairs at the University of Pennsylvania at (215) 898-2614 to talk about your rights as a research subject.

Your participation is confidential and anonymous. Following the link below and using the password provided indicate your consent as a participant.

https://www.psychdata.com/s.asp?SID=134272

password: taq

Thank you in advance for your participation. Your engagement in advancing the clinical social work knowledge base is greatly appreciated.

Sincerely,

Kate Ledwith LCSW

Doctoral Candidate

University of Pennsylvania School of Social Policy and Practice

215-573-3308

kledwith@mail.med.upenn.edu

## References


Agnew-Davies, R., Stiles, W. B., Hardy, G. E., Barkham, M., & Shapiro, D. A. (1998). Alliance structure assessed by the agnew relationship measure (ARM). *British Journal of Clinical Psychology*, 37, 155 – 172.

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist*, *46*(4), 333-341.

Ainsworth, M. D. S., & Marvin, R. S. (1995). On the shaping of attachment theory and research: An interview with Mary D. S. Ainsworth (Fall 1994). *Monographs of the Society for Research in Child Development. 60*(2-3*)*, 3-21.

Anthony, S., & Pagano, G. (1998). The Therapeutic potential for growth during the termination process. *Clinical Social Work Journal*, *26*(3), 281-296.

Applegate, J. S., & Shapiro, J. R. (2005). *Neurobiology for clinical social work: Theory and practice*. New York, NY: W.W. Norton.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology. 61*(2), 226-244.

Baum, N. (2007). Therapists' responses to treatment termination: An inquiry into the variables that contribute to therapists' experiences. *Clinical Social Work Journal. 35*(2), 97-106.

Bergmann, M. S. (1997). Termination: The Achilles heel of psychoanalytic technique. *Psychoanalytic Psychology*, *14*(2), 163-174.

Bernier, A., & Dozier, M. (2002). The client-counselor match and the corrective emotional experience: Evidence from interpersonal and attachment research.

*Psychotherapy: Theory*, *39*, 32-43.

Black, S., Hardy, G., Turpin, G., & Parry, G. (2005). Self-reported attachment styles and therapeutic orientation of therapists and their relationship with reported general alliance quality and problems in therapy. *Psychology and Psychotherapy: Theory, Research, and Practice, 78*, 363-377.

Boss, P. (2000). *Ambiguous loss*. Cambridge, MA: Harvard University Press.

Bowlby, J. (1977). The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry. 130*, 201-210.

Bowlby, J. (1988). *A secure base*. New York: Basic Books.

Boyer, S. P., & Hoffman, M. A. (1993). Counselor affective reactions to termination: Impact of counselor loss history and perceived client sensitivity to loss. *Journal of Counseling Psychology.* 40*(3)*, 271-277.

Brandell, J. R. and Ringel, S. (2007). *Attachment and dynamic practice: An integrative guide for social workers and other clinicians* (p. 208). New York: Columbia University Press.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. *Attachment theory and close relationships*, 46–76.

Brennan & Shaver (1995). Dimensions of adult attachment, affect regulation, and romantic relationship functioning. *Personality and Social Psychology Bulletin*, *21*, 267-283.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary

Ainsworth. *Developmental Psychology*, *28*(5), 759-75.

Bretherton, I., & Main, M. (2000). Mary Dinsmore Salter Ainsworth (1913-1999). *American Psychologist*, *55*(10), 1148-1149.

Charmaz, K.(2006). *Constructing grounded theory*. London, Sage.

C. J. Shilkret, & R. Shilkret. (2008). Attachment theory. In J. Berzoff, L. Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (2nd ed., pp. 189-204). New York: Aronson.

Code of Ethics of the National Association of Social Workers (2008). In socialworkers.org. Retrieved December 6, 2008, from http://www.socialworkers.org/pubs/Code/code.asp

Cozolino, L. J. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain.* New York, NY, US: W. W. Norton & Co.

DeWald, P. A. (1978). The process of change in psychoanalytic psychotherapy. *Archives of General Psychiatry*, *35*(5), 535-542.

Dozier, M. (1990). Attachment organization and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology, 2,* 47-60.

Dozier, M., Cue, K., & Barnett, L. (1994). Clinicians as caregivers: role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology*, *62*(4), 793-800.

Dozier, M., Stevenson, A. L., Lee, S. W., & Velligan, D. I. (1991). Attachment organization and familial over involvement for adults with serious psychopathological disorders. *Development and Psychopathology, 3,* 475-489.

Dunkle, J., & Friedlander, M. (1996). Contribution of therapist experience and personal

characteristics to the working alliance. *Journal of Counseling Psychology*, *43*(4), 456-460.

Eysenck, S. B., & Eysenck, H. J. (1969). Scores of three personality variables as a function of age, sex, and social class. *British Journal of Social and Clinical Psychology*, *8*, 69 – 76.

Faschingbauer, T. R., DeVaul, R. A., & Zisock, S. (1977). Development of the Texas Inventory of Grief. *American Journal of Psychiatry, 134,* 696-698.

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment. In M. B. Sperling & W. H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives* (pp. 128 – 152). New York: Guilford Press.

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. Other Press, LLC.

Fortune, A. E. (1987). Grief only? Client and social worker reactions to termination. *Clinical Social Work Journal*, *15*(2), 159-171.

Fortune, A. E., Pearlingi, B., & Rochelle, C. D. (1992). Reactions to termination of individual treatment. *Social Work. 37*(2), 171-178.

Fox, E., Nelson, M., & Bolman, W. (1969). The termination process: A neglected dimension in social work. *Social Work*, *14*(4), 53-63.

Fraley, R. C., & Waller, N. G. (1998). Adult attachment patterns: A test of the typological model. In Simpson, Jeffry A.; Rholes, William Steven (1998). *Attachment theory and close relationships*. (pp. 77-114). New York, NY, US: Guilford Press.

Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social*

*Psychology. 78*(2), 350-365.

Friedman, S., & Gelso, C. (2000). The development of the inventory of countertransference behavior. *Journal of Clinical Psychology, 56,* 1221–1235.

Garcia-Lawson, K. A., & Lane, R. C. (1997). Thoughts on termination: Practical considerations. *Psychoanalytic Psychology*, *14*(2), 239-257.

Gelman, C. R., Fernandez, P., Hausman, N., Miller, S., & Weiner, M. (2007). Challenging endings: First year MSW interns' experiences with forced termination and discussion points for supervisory guidance. *Clinical Social Work Journal*, *35*(2), 79-90.

George, C., Kaplan, N., & Main, M. (1985). *Attachment interview for adults.* Unpublished manuscript, University of California, Berkeley.

Goldberg, S. (2000). *Attachment and development*. Texts in developmental psychology (p. 301). London: Arnold.

Golland, J. H. (1997). Not an endgame: Terminations in psychoanalysis. *Psychoanalytic Psychology*, *14*(2), 259-270.

Gomberg, M.R. (1948). The specific nature of family casework. In Taft, J. (Ed.) *Family Casework and Counseling A Functional Approach*. Philadelphia, PA: University of Pennsylvania Press.

Goodyear, R. K. (1981). Termination as a loss experience for the counselor. *Personnel and Guidance Journal*, *59*(6), 347-350.

Greene, L. R. (1980). On terminating psychotherapy: More evidence of sex-role related Countertransference. *Psychology of Women Quarterly, 4,* 548-557.

Griffin, D.W., and Bartholomew, K (1994). The metaphysics of measurement: the case of

adult attachment. *Personal Relationships*, 5, 17-52.

Griffin and Bartholomew (1994). Models of self and other. Fundamental dimensions underlying measures of adult attachment. *Journal of Personal and Social Psychology*, *59*, 511-524.

Gutheil, I. A. (1993). Rituals and termination procedures. *Smith College Studies in Social Work*, *63*, 163-163.

Hayes, J. A., Riker, J. R., & Ingram, K. M. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research, 7,* 145–153.

Hazen and Shaver (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, *59*, 270-280.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology. 36*(2), 223-233.

Hoyt, M. F. (1979). Aspects of termination in a time-limited brief psychotherapy. *Psychiatry*, *42*(3), 208-19.

Kobak, R.R. (1989). *The Attachment Interview Q-Set*. Unpublished manuscript.

Leiper, R., & Casares, P. (2000). An investigation of the attachment organization of clinical psychologists and its relationship to clinical practice. *British Journal of Medical Psychology*, *73*(4), 449–464.

Levinson, H. (1977). Termination of psychotherapy: Some salient issues. *Social Casework*, *58*(8), 480-489.

Ligiéro, D. P., & Gelso, C. J. (2002). Countertransference, attachment, and the working alliance: The therapist's contribution. *Psychotherapy: Theory/Research/Practice/Training,* 39, 3-11.

Luborsky, Rosenthal, Diguer, Andrusyna, Berman, Levitt, et al. (2002). The Dodo Bird verdict is alive and well – mostly. *Clinical Psychology: Science and Practice: 9*(1): 2-12.

Maholick, L. T., & Turner, D. W. (1979). Termination: that difficult farewell. *American Journal of Psychotherapy*, *33*(4), 583.

Main, M. (1996). Introduction to the special section on attachment and psychopathology: 2. Overview of the field of attachment. *Journal of Consulting and Clinical Psychology*, *64*(2), 237–243.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development. 50*(1-2), 66-104.

Main, M. & Solomon, J. *(1986),* Discovery of a new, insecure-disorganized/disoriented attachment pattern. In: T. Brazelton & M. W. Yogman (eds.), *Affective development in infancy, pp. 95-124.* Norwood, NJ: Ablex.

Mann, J. (1973). *Time-limited psychotherapy*. Cambridge, MA: Harvard University Press.

Marx, J. A., & Gelso, C. J. (1987). Termination of individual counseling in a university counseling center. *Journal of Counseling Psychology. 34*(1), 3-9.

McMillen, J. C. (1992). Attachment theory and clinical social work. *Clinical Social Work Journal.* 20*(2)*, 205-218.

Novick, J. (1997). Termination conceivable and inconceivable. *Psychoanalytic Psychology*, *14*(2), 145-162.

Palombo, J. (1982). The psychology of the self and the termination of treatment. *Clinical Social Work Journal*, *10*(1), 15-27.

Quintana, S. M. (1993). Toward an expanded and updated conceptualization of termination: Implications for short-term, individual psychotherapy. *Professional Psychology: Research and Practice. 24*(4), 426-432.

Quintana, S. M., & Holahan, W. (1992). Termination in short-term counseling: Comparison of successful and unsuccessful cases. *Journal of Counseling Psychology. 39*(3), 299-305.

Reid, W. J. (1990). An integrative model for short-term treatment. In: R. Wells and V. Giannetti (eds.) *Handbook of the brief psychotherapies*, pp. 55–77. New York, NY: Plenum Press.

Riggs, S. A., & Jacobvitz, D. (2002). Expectant parents' representations of early attachment relationships: Associations with mental health and family history. *Journal of Consulting and Clinical Psychology. 70*(1), 195-204.

Riggs, S. A., Jacobvitz, D., & Hazen, N. (2002). Adult attachment and history of psychotherapy in a normative sample. *Psychotherapy: Theory, Research, Practice, Training. 39*(4), 344-353.

Roe, D., Dekel, R., Harel, G., & Fennig, S. (2006). Clients' reasons for terminating psychotherapy: A quantitative and qualitative inquiry. *Psychology and Psychotherapy: Theory*, *Research, and Practice,* (79), 529-538.

Rubino, G., Barker, C., Roth, T., & Fearon, P. (2000). Therapist empathy and depth of

interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles. *Psychotherapy Research*, *10*(4), 408–420.

Sable, P. (1992). Attachment theory: Application to clinical practice with adults. *Clinical Social Work Journal*, *20*(3), 271–283.

Sauer, E. M., Lopez, F. G., & Gormley, B. (2003). Respective contributions of therapist and client adult attachment orientations to the development of the early working alliance: A preliminary growth modeling study. *Psychotherapy Research*, *13*(3), 371-382.

Schiff, S. K. (1962). Termination of therapy: Problems in a community psychiatric outpatient clinic. *Archives of General Psychiatry*, *6*(1), 77.

Schlesinger, H. J. (2005). *Endings and beginnings: On the technique of terminating psychotherapy and psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ, England: Lawrence Erlbaum Associates.

Schore, A. N. (2002). Advances in neuropsychoanalysis, attachment theory, and trauma research: Implications for self psychology. *Psychoanalytic Inquiry. Special Issue: Self-regulation: Issues of attention and attachment. 22*(3*)*, 433-484.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal.* 36*(1)*, 9-20.

Shilkret, C. J. (2005). Some clinical applications of attachment theory in adult psychotherapy. *Clinical Social Work Journal*, *33*(1), 55-68.

Shulman, L. (1999). *The skills of helping individuals, families, groups and communities*.

Brooks/Cole-Thomson Learning.

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY: The Guilford Press.

Simpson, J. A. (1990). Influence of attachment styles on romantic relationships. *Journal of Personality and Social Psychology*, *59*, 971–980.

Simpson, J. A., Rholes, W. R., & Nelligan, J. S. (1992). Support seeking and support giving within couples in an anxiety provoking situation: The role of attachment style. *Journal of Personality and Social Psychology*, *62*, 434–446.

Simpson, Rholes, & Phillips, 1996. Conflict in close relationships: An attachment perspective. *Journal of Personality and Social Psychology*. *71*(5), 899-914.

Simpson, G. A., Williams, J. C., & Segall, A. B. (2007). Social work education and clinical learning. *Clinical Social Work Journal*, *35*(1), 3–14.

Slade, A. (2000). The development and organization of attachment: Implications for psychoanalysis. *Journal of the American Psychoanalytic Association*, *48*(4), 1147.

Smalley, R. E., & Bloom, R. (1977). Social casework: The functional approach. In J.B. Turner (Ed.), *Encyclopedia of social work, 17th Edition* (pp. 1280-1290). Washington, D.C.: National Association of Social Workers.

The American Heritage Dictionary of the English Language 4th edition (2000). Boston, MA: Houghton Mifflin Company.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor Structure of the Working Alliance Inventory. *Psychological Assessment, 1,* 207–210

Tyrrell, C. L., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of

attachment states of mind. *Journal of Consulting and Clinical Psychology*, 67, 725–733.

U.S. Department of Labor Statistics. Occupational Handbook, 2008-2009. Retrieved October 16, 2008 from http://www.bls.gov/oco/ocos060.htm.

Walsh, J., (2007). *Endings in clinical practice: Effective closure in diverse settings.* Chicago, IL: Lyceum Books, Incorporated.

Webb, N. B. (1985). A crisis intervention perspective on the termination process. *Clinical Social Work Journal*, *13*(4), 329-340.

White, M., & Epson, D. (1990). *Narrative means to therapeutic ends*. New York, NY: W.W. Norton.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development.* Oxford, England: International Universities Press.

Zilberstein, K. (2008). Au revoir: An attachment and loss perspective on termination. *Clinical Social Work Journal. 36*(3), 301-311.

Zuckerman, M., & Lubin, B. (1965). Normative data for the Multiple Affect Adjective Check List. *Psychological Reports. 16*(2), 438.