

**‘I sort of feel that one is meant to say  
how important endings always are...’  
Counsellors’ experiences of endings in  
primary care: an interpretative  
phenomenological analysis**

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**Thesis submitted to London  
Metropolitan University in partial  
requirement for the Award of  
Professional Doctorate in Counselling  
Psychology**

**2016**

## **Acknowledgements**

I would like to begin by acknowledging the six counsellors who so generously gave of their time to share their personal experiences of endings with me. Thank you. I hope that I have done justice to your openness and the wealth of your insights.

This research would not have been possible without support of the following individuals to whom I would like to express my sincere gratitude. I would like to thank Dr Angela Loulopoulou, my supervisor, for her wisdom, encouragement and support. I would also like to thank Dr Philip Hayton for his thoughtful reading of the final draft. I would like to thank my initial supervisor, Dr Elaine Kasket, for her inspirational guidance, clarity and input in the early stages. I would like to thank Dr Mark Donati, my Director of Studies, for being a constant source of strength throughout my training and for an invaluable discussion about the service implications of these findings. Thank you too to Dr Melinda Rees and Morris Nitzun who generously gave of their time for thought-provoking discussions about the service implications, and to Elizabeth Wilson for reading the final draft from a counsellor in primary care's perspective. And finally, I owe great debt of gratitude to Dr Andrew Eagle, my clinical supervisor during my first placement. This idea was born out of discussions in supervision about how therapists experience endings. I am indebted to his invaluable practical support and insights as my external advisor. This thesis has been greatly enriched by your input. Thank you to you all.

Lastly, I would like to thank my family, most especially my mother; my research partner, Jeanne; and my extraordinary friends, Cassie, Philip and Peter. Your infinite love, generosity and belief in me over the years have meant more to me than I can say.

This thesis is dedicated to the memory of my late therapist, Ben James, who taught me about good endings.

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## **Abstract**

Ending therapy well is widely acknowledged as crucial for therapeutic gains to be maintained over time, yet numerous authors comment on the paucity of termination research. There appears to be no extant research into counsellors' experiences of ending time-limited counselling in primary care (CPC), despite this being a rapidly-expanding area of practice, and theoretical literature suggesting elevated stress levels, ideological battles and burnout as counsellors adjust to time-limited working within Improving Access to Psychological Therapies (IAPT) services. When the 'hallmark' of a good ending is mutual agreement concerning client readiness, to what extent do traditional models of termination still hold? The aim of this research is provide some preliminary understanding of counsellors' experiences of endings within this context. A qualitative design was employed. Data were collected in semi-structured interviews with six counsellors, and analysed using interpretative phenomenological analysis (IPA). Four overarching themes emerged: 'self-experiencing', 'the quality of the therapeutic process', 'conflicting frameworks', and 'towards congruence'. These are related to wider literature and implications for counselling psychology (CoP) are discussed. Limitations and suggestions for future research are explored.

## **Reflexive Statement**

This counselling psychology thesis begins with a reflexive statement to describe the researcher's personal, ontological and epistemological positioning. Subjectivity is an inevitable part of research (Gough, 2003); however, in reflexive research, the researcher seeks to maintain awareness of personal biases and, as far as possible, to 'bracket' these to support greater rigour (Kasket, 2012). This is particularly important in qualitative research where the researcher's personhood and epistemology are implicated at the level of interpretative engagement with the data (Willig, 2008). Reflexivity improves validity, creating transparency to enable others to better evaluate trustworthiness (Finlay & Gough, 2003). It is also ethical in seeking to address power imbalances between researchers and researched (Etherington, 2004), in keeping with counselling psychology (CoP) values. CoP is distinguished from other branches of psychology by the philosophical position from which it is practiced (British Psychological Society, 2014; Duffy, 1990). It was inspired by nineteenth-century European phenomenological and existential-phenomenological traditions and North American Humanism, and it is rooted in valuing subjective worlds (Strawbridge & Woolfe, 2010). Its Humanistic origins are additionally present in its orientation towards wellbeing and empowerment (Cooper & Macleod, 2010, p.ix). These influences translate into research that is respecting of multiple subjective truths, engages with inter-subjectivity, values difference, recognises social contexts, and aspires to empower rather than control (Strawbridge & Woolfe, 2010).

### **Personal reflexivity**

This section describes my personal position in relation to the research topic. Loss was a theme of my childhood. By the age of five, I had lived in three different countries and said many goodbyes. A traumatic separation in early adolescence heralded a few difficult years in a remote Namibian town without access to therapeutic support. I believe that it was around this time that my interest in psychology began. Aged 18, I was again living in a new country, embarking on my first psychology degree. However, presented with the opportunity to pursue clinical psychology training, I felt uncomfortable with the medical model, turning instead to meditation and the arts until serendipity led me to CoP with its different philosophical underpinnings. Over the years,



the theme of loss continued in a series of bereavements, including the murder of my former long-term partner and continued friend. This final bereavement led to my beginning therapy, and soon after embarking on my new training. Towards the end of my training, I believe that I have adopted the position of a reflective scientist practitioner: to the extent that empirical research serves our clients and therapeutic practice, I wholeheartedly embrace it, while nevertheless attempting to maintain a reflective stance on its use in practice.

My interest in researching therapy endings began while practicing time-limited therapy within secondary care during my first year of training. I experienced many 'good endings', sadness saying goodbye tempered by joy in clients' growth and progress; however, where clients remained vulnerable, managing endings was often more difficult. I realised that initially this reflected my inexperience working with severe and enduring psychological difficulties; however, in time, I realised that it additionally related to the intensity of my own pain without psychological support having been available when I had needed it. Therapy was invaluable in increasing my awareness of these processes, and through therapy, supervision and experience my endings practice has matured. However, in my initial searching for literature on how other therapists managed ending time-limited therapies, I found little to support my development and so it seemed to me that this could offer a valuable contribution to CoP research.

Beginning this research, my assumptions included that caring practitioners would experience client endings with the same intensity as I have done. My previous experience of researching the relationship between adult attachment style and personality variables meant that I was receptive to the considerable empirical evidence for attachment theory. On the basis of personal experience and extensive reading, I also assumed that therapists' loss histories and attachment styles would be implicated in their experiences of endings. I was aware that these assumptions might blind me to alternatives. In order to maintain rigour, I read as widely as possible, attempting to remain open to multiple perspectives, and kept a reflexive journal throughout. I sought advice on the design of my interview schedule. I re-read an early reflexive statement prior to the interviews. I attempted to remain within participants' frames of reference both by bracketing, and by asking open questions to be guided by participants' meanings. Throughout the analysis process itself, I attempted to remain as open as possible to multiple experiences of endings, and finally, I sought to 'triangulate' my final themes with research colleagues in a 'verification step' (Kasket, 2012). I have been transparent about the potential influence of personal

experiences; nevertheless, I hope that my commitment to managing this influence has resulted in findings grounded in participants' experiences. Maintaining such balance between reflexivity and awareness of an intransitive reality functioning independently of constructions of it, is compatible with the reflective scientist practitioner stance that I have sought to adopt throughout my counselling psychology training.

### **Epistemological reflexivity**

It is incumbent upon researchers to state their epistemological stance and conduct research consistent with it (Madill, Jordan & Shirley 2009). Life experiences that have led me to value subjective 'realities' over nomothetic ideals, mean that I value qualitative research's capacity to give ideographic voice. I accept the existence of an external reality functioning independently of social constructions of it, while at the same time understanding 'knowledge' of this reality as filtered through interpretative lenses, and embedded within social contexts. I understand language as an attempt to express 'real' experience. In this way, I espouse a realist ontology with a relativist epistemology, compatible with Bhaskar's (1976) critical realism. I additionally value critical realism's aim of positively developing knowledge, over constructionism's scepticism, which potentially renders ethical views obsolete (Cruikshank, 2011; Elder-Vass, 2011). In keeping with this, I am committed to representing a faithful phenomenological account of the 'reality' of participants' experiences through triangulating findings with independent researchers, while using reflexivity to maintain awareness of how interpretation may have influenced the research.

IPA is a qualitative approach committed to exploring lived experience in depth, complexity, and detail through both phenomenological and interpretative means. It does not adopt a fixed epistemology; however, it is compatible with critical realism both in seeking knowledge of an enduring reality, and in recognising such knowledge as constructed by interpretation. I concur with Rizq (2010) that IPA's constructivist aspects are compatible with relational processes, and believed that IPA's sensitivity to a range of nuance, expression and subtleties, including emotion, would support research into ending therapeutic relationships. In its valuing of subjective experiencing and its epistemological openness, IPA is additionally fundamentally aligned with CoP and chimes with my own personal epistemology, ontology, and values.

## **Overview of the thesis**

This thesis aims to explore the following question: How do counsellors experience endings in primary care? In order to demonstrate why this stands to make a useful contribution to professional practice, the following chapter reviews salient literature. The Methodology chapter describes the research method. Results are presented without discussion in Chapter 3, and then contextualised within the broader literature in the subsequent Discussion, where their implications for professional practice and CoP are further explored. The research itself is contextualised within an additional reflexivity section in the Discussion chapter. As in the preceding section, this will make use of the first person to facilitate closer understanding of the researcher's positioning, both in evaluating the research, and in reflecting on how the process of it has changed the author as a person, practitioner and researcher.

## **CHAPTER ONE: INTRODUCTION AND CRITICAL LITERATURE REVIEW**

### **Overview**

This research explores six psychological therapists' experiences of ending counselling in primary care. Participants were qualified counselling psychologists, psychotherapists and counsellors all employed as 'counsellors' within a single primary care IAPT counselling service. The chapter will begin with an introduction to psychotherapeutic endings. In order to situate the research, it will then describe the counselling in primary care context (CPC), prior to critiquing extant theoretical and empirical termination literature, and briefly reviewing IAPT literature. It will conclude with describing the rationale for the present research, the research aims, and their relevance to counselling psychology.

### **Introduction**

Younggren and Gottlieb describe terminating therapy as "the ethically and clinically-appropriate process by which a professional relationship is ended" (2008, p.500). The term 'termination' originated in an early translation of Freud's 'Analysis Terminable and Interminable' (1937). However, contemporary psychoanalytic and psychodynamic authors consider the word to have problematic connotations when applied to ending what has ideally been a caring process (e.g., Holmes, 2010; Salberg, 2010). It was likely adopted by pioneering analysts to facilitate detachment from personal feelings at ending (Williams, 1997). In this study, the terms 'ending' and 'termination' are used interchangeably to describe the ending of the counselling process. There do not appear to be specific trans-theoretical definitions of 'good' and 'bad' endings; however, Davis (2008) suggests that it is generally accepted that a 'bad' ending involves harm to either the client, the therapist, or both. Conversely, a 'good ending' is widely considered to involve mutual agreement concerning client readiness, the therapist following the client's lead (e.g., Davis, 2008; Joyce, Piper, Ogrodniczuk & Klein, 2007; Murdin, 2000). Holmes (2010) describes the importance of supporting the client's capacity to 'mentalize' or think about the ending, the feelings it evokes, and its meanings. A therapeutic termination facilitates closure to the work, and prepares the client for life post-

termination with thoughtfulness, care, and sensitivity to the unique meaning each ending holds (Graybar & Leonard, 2008; Hoffman, 1998; Lemma, 2003). Ideally, termination is the culmination of the preceding work, connecting and reinforcing preceding interventions (Graybar & Leonard, 2008).

Ending therapy well is believed to be crucial for therapeutic gains to be maintained over time (e.g., Beck, Rush, Shaw & Emery, 1979; Bellows, 2007; Freud, 1937; Graybar & Leonard, 2008; Knox, Adrians, Everson, Hess, Hill, & Crook-Lyon 2011; Quintana & Holohan, 1992). Endings are integral to process and, where they are well-managed, they can in themselves be powerful instigators of change (Barnett, MacGlashan & Clarke, 2000; Bellows, 2007; Joyce, 2007; MacNeill, 2011; Yalom, 1975). Cognitive psychology offers robust research demonstrating initial and final impressions are most memorable (e.g., Murdock, 1962). This is borne out in literature on psychotherapy endings which suggests that endings act as filters through which therapy is viewed, shaping how it is evaluated and remembered - irrespective of gains overall (Bellows, 2007; Graybar & Leonard, 2008). However, endings have also long been understood to be complex for therapists, potentially interfering with accurate empathy (e.g., Ticho, 1972). They are the point at which risk of adverse professional action increases; most complaints to professional bodies are about mishandled terminations (Murdin, 2000; Younggren & Gottlieb, 2009). Such literature suggests that we minimise the importance of endings at our peril. Nevertheless, numerous authors comment on the paucity of empirical research (Davis, 2008; Davis & Younggren, 2009; Goldfried, 2002; Marx & Gelso, 1987; Ochoa & Muran, 2008; Quintana & Holohan, 1992; Wachtel, 2002; Roe, Dekel, Harel & Fennig, 2006). Moreover, there is scant research into therapists' experiences, despite existing empirical evidence suggesting that termination is complexly influenced by the interaction between client and therapist (Boyer & Hoffman, 1992; Craige, 2002; Quintana & Holohan, 1992). Most extant literature is theoretical, focused on clients' experiences, and more concerned with how psychotherapy ideally ends than what actually happens in practice (Roe et al., 2006).

### **The National Health Service primary care context.**

Given the context of this study, it is important to situate the research within the National Health Service (NHS) and rapidly-evolving developments in primary care. The NHS was founded by a Labour government in 1948 to provide healthcare funded by

taxation. A landmark report (Layard, Bell, Clark, Knapp, Meacher, Priebe, Turnberg, Thornicroft & Wright 2006) on the need for increased access to National Institute for Clinical Excellence (NICE) approved psychological therapies for depression and anxiety disorders, resulted in the Department of Health's (DoH) 'Improving Access to Psychological Therapies' (IAPT) programme. By 2012, 150 of England's 151 Primary Care Trusts had commissioned an IAPT service, more people were receiving psychological therapy than ever before, and IAPT had achieved most of its targets (DoH, 2012). However, consequences of IAPT's success include increased referrals, longer waiting lists, and raised targets. The evidence-based therapy chosen for the implementation of IAPT in 2009 was cognitive behavioural therapy (CBT) but more recently this has been extended to a wider range of psychological therapies, including counselling (DoH, 2011). As counselling in primary care services is now largely subsumed within the wider IAPT programme, and the research was situated within an IAPT primary care counselling service, the IAPT literature is further outlined in the critical literature review.

### **Definitions of 'counselling' and 'counsellor' in primary care.**

'Counselling' normally describes shorter-term approaches focusing on developing psychological health, rather than treating psychopathology. The British Association of Counselling and Psychotherapy defines counselling and psychotherapy as "umbrella terms, covering a range of talking therapies" (BACP, 2010, para.1). Likewise, NICE originally described counselling in primary care as a "generic term for a wide variety of approaches and interventions", excluding CBT (2004, p.155). However, more recently, distinctions have been made between protocol-driven approaches, such as Dynamic Interpersonal Therapy (DIT; Lemma, Target & Fonagy, 2011) and non-directive counselling in primary care as a specific intervention that is flexible, centred on clients' needs, and involves core person-centred activities (Brettle, Hill & Jenkins, 2008; Mason, 2012). Nevertheless, a practitioner providing psychological treatment within counselling in primary care (CPC) is commonly called a 'counsellor', whatever the type of therapy provided (Parry & Elder, 2002). This is consistent with wider psychotherapy literature where the terms 'counsellor' and 'therapist', and 'counselling', 'therapy' and 'psychotherapy' are used interchangeably; for example, Mearns and Thorne (2007). Additionally, within CPC, counsellors from a range of backgrounds invariably end up

working in very similar specific ways, reflecting the influence of the setting (Hudson-Allez, 2000; Mearns & Thorne, 1999). Consequently, in keeping with the context, the terms ‘therapy’ and ‘counselling’ will be used interchangeably; and the term ‘counsellor’ will be used to refer to counsellors, psychotherapists and counselling psychologists practising within this setting.

### **The practice of counselling in primary care.**

The NHS has been offering counselling within certain primary care settings since 1970s. Research indicates high levels of patient satisfaction (e.g., Bower & Rowland, 2006; Newton, 2002). Systematic review suggests that it is generally effective and that most patients prefer counselling to specialist psychology services, which may be experienced as stigmatising (Brettle, Hill & Jenkins, 2008). Clients enjoy their GP and counsellor sharing responsibility, experiencing the setting as safe (Hudson-Allez, 1997).

Initially, counsellors worked largely in isolation; however, policy changes in the 1990s resulted in an increase in audit culture. In 2000, David Mellor-Clark described how few other areas of psychotherapy had undergone such turbulence. Elder and Holmes (2002) describe the setting as bringing pressures to do the most in the least time, forcing therapists to draw upon all of their skills working with a vast range of presenting difficulties. Lees (1999) describes how counselling theory is transformed by primary care into a sophisticated practice quite distinct from that in other settings.

Time-limited working is a distinguishing feature of CPC; in order to shorten waiting times, six to ten sessions are the norm. Research indicates slowing improvement after initial gains (Orlinsky, Grawe & Parks, 2004). Further, historically, even when additional sessions were available, six was the mean attended (Budman, 1988; Hudson-Allez, 1997). This has led some to suggest that many primary care clients approach short-term therapy eager to complete it, preferring least intrusion into their lives (e.g., Hoyt, 1995). However, there is no theoretical model for six to ten sessions based on historical mean frequencies, and, as emphasised by Hudson-Allez, time-limited therapy requires certain skills; it is not open-ended therapy cut short. Consequently, in 2009, IAPT introduced a new ‘Four Modalities’ initiative to increase access to training in time-limited therapies; of relevance to counsellors are Dynamic Interpersonal Therapy (DIT) and Counselling for Depression (CfD). However, CfD is offered solely to counsellors whose

core training is person-centred and DIT offers 16 sessions, with a four session ending 'phase', clearly incompatible with the six to ten sessions recommended for CPC.

There appears to be no extant research into counsellors' experiences of endings in CPC; however, an informal survey into counsellors' experiences of primary care more generally (House, 1999) found strongest responses related to time-limits. Indeed, Brian Mearns, a passionate advocate of the person-centred approach, refused to run a time-limited service on ideological grounds. Theoretical literature suggests that frequent, rapid attachments and separations may increase stress levels (House, 1999), and time-limits might result in vulnerability to burnout (Coren, 2010; Noy-Sharav, 1998; Rizq, 2009). In 2012, a DoH Payment by Results (PbR) initiative was introduced. PbR weights clinical outcome; consequently, targets have been increased to a minimum of at least 50% recovery rate (DoH, 2012). However, wider NHS service constraints mean that, increasingly, clients referred for counselling experience levels of difficulty comparable to those in outpatient secondary care (Barkham, Gilbert, Connell, Marshall & Twigg, 2005; Chiesa, Fonagy & Bateman, 2007; Saxon, Ivey & Young, 2008). Additionally, research suggests correlation between session-number and improvement (Hansen, Lambert & Forman, 2002; Orlinsky et al., 2004; Roth & Fonagy, 2005). Therapies of fewer than eight sessions are unlikely to be optimally effective for most moderate to severe mental health problems (Parry & Cape, 2002). Given ever-increasing pressures for rapid turnover of increasingly complex clients within a target-driven culture, counsellors' experiences of time-limits potentially have significant implications for their experience of endings. Extant literature suggesting the importance of endings and these as complexly influenced by the therapist's state within the dyad, points to the need for further research in this area.

## **Critical review of the literature**

### **Literature review method.**

A conventional literature search was undertaken using the terms 'ending/s', 'terminations', and 'terminating', each paired with 'counselling', 'therapy', 'psychotherapy', 'counselling psychology' and 'Improving Access to Psychological Therapies' or 'IAPT'. No date-range exclusions were made. The databases searched included PsycINFO, PsycARTICLES, and EBSCO. Further relevant literature was



identified through iterative berry-picking (Bates, 1989) or snowballing (Ridley, 2008). Papers not available online were sourced from both The British Library and a local NHS Trust library service.

### **Theoretical literature.**

This review begins with a brief overview of termination theory. Despite attempting to review the theoretical literature evenly, this review inevitably reflects the preponderance of psychoanalytic and psychodynamic theory; no other approach has paid as much attention to therapy endings.

### **Terminating open-ended therapy.**

Prior to the 1980s, termination literature was almost entirely psychoanalytic, psychodynamic, and theoretical. Following ‘Mourning and Melancholia’ (Freud, 1917), the literature was dominated by a metaphor that proposed clients experience terminating as significant loss, representing all former losses. Termination was understood to be complex and challenging, resulting in an increase in affect, increased potential for disengagement, relapse, and emergence of new difficulties. However, it was also conceptualised as an opportunity for experiential-reworking of historical separations within the safety of the therapeutic relationship. Mourning was essential to the process of internalising the analyst (Freud, 1933), thus termination was fundamental to a successfully-completed analysis (Glover, 1955). It was also predicated on an assumption that psychoanalysis would have cured the patient’s core concerns: termination as “a new beginning” (Ticho, 1972, p.325). Ideally, psychoanalysts retained their professional anonymity, refrained from emotional expression, and termination was final. Post-termination contact suggested failure (Frank, 2009). However, over the years, a number of authors have commented on the dearth of termination literature; for instance: “psychoanalytic technique lacks anything like a ‘royal road’ towards termination” (Bergman, 1997, p.163). Novick (1997) suggested that psychoanalysis’s reluctance to address termination had inhibited clinical and theoretical development.

More recently, a rich vein of literature has developed within contemporary relational analysis. Traditional termination ideals such as client autonomy, therapist anonymity, and permanent cessation of contact are criticised as potentially destructive by

this school which draws upon neuroscience, infant research, and attachment theory to understand inter-dependence as adaptive (Craig, 2006; Mendenhall, 2009; Salberg, 2010). Relational processes at ending are held to influence how therapy is remembered and what is subsequently internalised; if managed sensitively, the analyst endures as a strong, positive, inner presence, preserving “feelings of loving and being loved” (Craig, 2002, p.110). Relational psychoanalysts argue instead for therapists affirming their humanity (Frank, 2009; Salberg, 2010), and ongoing contact as necessary (Craig, 2002; Frank, 2009; Mendenhall, 2009).

Contemporary relational theory has much in common with other psychotherapeutic and integrative approaches. A trans-theoretical symposium in 2002 found widespread integrative, psychodynamic, psychoanalytic, eclectic, cognitive-behavioural, person-centred, experiential and existential agreement about how endings ideally proceed. This includes: reviewing, planning for the future, expressing feelings about ending, and saying goodbye (e.g., Curtis, 2002; Greenberg, 2002; Wachtel, 2002). Trans-theoretical literature makes frequent reference to clients returning as reflecting awareness of their needs, rather than failure (Etherington & Bridges, 2011; Lemma, 2003; Mearns & Thorne, 1999; Schlesinger, 2005). Another important trans-theoretical issue is that of introducing greater balance into the relationship through increasing therapist self-disclosure and discussion of the therapeutic process to support the client’s self-efficacy (Graybar & Leonard, 2008; Quintana, 1993). From an existential perspective, Yalom (2008) suggests that terminating involves addressing the inevitability of death, and the transience of life. From an experiential perspective, Greenberg argues that endings are regarded as a choice point, rather than attainment of an absolute endpoint (2002). Although overall, in the absence of identical therapists and identical clients taking part in identical therapies, the idea of conceptually uniform endings is likely mythical (Joyce et al., 2007), generally, ‘good-enough’ endings are widely held to result from therapists’ sensitivity to the unique meanings that endings hold for clients, including sensitivity to factors such as loss history which may render the termination-as-loss paradigm more salient (Graybar & Leonard, 2008; Hoffman, 1998; Lemma, 2003). There appears to be consensus that the ‘hallmark’ of a good ending in open-ended therapy involves mutual agreement concerning readiness, the therapist following the client’s lead (e.g., Joyce et al., 2007; Murchin, 2000).

## **Terminating time-limited therapy.**

Time-limited therapy is not necessarily 'brief therapy'. Brief therapies are conceptual approaches in their own right, rather than longer-term therapy cut short (Bor, Gill, Miller & Parrott, 2004). Conversely, time-limited therapy is an umbrella-term for a range of models practised within a specific time period, usually short-term (Bryant-Jeffries, 2003). Ten is the average number of sessions within a time-limited intervention (Bor et al.). Relatively little attention has been paid to Cummings' proposal of a conceptual alternative in 'episodic' therapy; brief treatment episodes across the lifespan where endings are 'interruptions' of a developmental process, resumed when clients have further need (1990; 2001). Commonality amongst time-limited approaches lies in using time as a tool in planning, goal-setting and focusing, in service of initiating change as soon as possible (Fosha, 2004).

As described by Patel and Binder (2004), there appears little theoretical consensus on termination across the range of time-limited therapies. Quintana (1993) hypothesized that theoretical and research stagnancy resulted from discrepancy between therapists' clinical experience of endings and the theorised 'termination-as-crisis' component of Freud's 'termination-as-loss' metaphor. Quintana suggested that Freud's model additionally contained 'termination-as-development', and that this had been overlooked. Consequently, Quintana offered an alternative conceptualisation: 'termination-as-transformation': termination as a gradual developmental transition where clients consolidate growth, update their self-concept and gradually internalise the therapist. He proposed termination offers opportunity to transform the relationship to incorporate clients' growth, strengthening clients to survive post-termination.

Conversely, the limits of time itself are explicitly used in certain brief dynamic therapies. Termination as an analogue of the existential irreversibility of death is emphasised throughout Mann's (1973) approach where the patient is actively confronted with the pain of ending to facilitate working through previous separations. Mann's model reserves the final four sessions for dealing with affective reactions to termination. Likewise, Malan (1995), theorised that working through rage and grief aroused by termination is intrinsic to positive outcome. Contemporary time-limited approaches such as Cognitive Analytic Therapy (CAT; Ryle, 1995) and DIT similarly conceptualise endings as offering powerful opportunity for re-working of historical losses, and dedicate the last four (of 16) sessions to ending, including the mutual exchange of goodbye letters.

The ideal is to mourn past losses, address problematic feelings towards therapy and therapist, and consolidate gains. On the other hand, Sifneos (1987) and Davanloo's (1978; 1979) brief approaches minimally emphasise ending.

In many contemporary settings, including CPC, therapy is limited to six sessions, precluding dedicated ending phases described above. A number of authors (e.g., Coren, 2010) emphasise that clients with difficult loss histories may experience such endings as traumatic: a 'real repetition' (Casement, 1985, p.82). Similarly, Smith emphasises the importance of supporting clients in mobilising more secure post-termination environments, 'available places to land' (2002). However, although certain authors suggest that those who do not have strong feelings about ending may be defending against dependency and intimacy (Stadter, 1996), there also appears to be growing theoretical appreciation that the combination of brevity and reduced significance of the therapeutic relationship means that, for most clients, terminating time-limited therapy may not necessarily be challenging. Additionally, in many settings, time-limited therapy is increasingly intermittent, offering possibility of return. Cummings proposes that: "In brief, intermittent psychotherapy throughout the lifespan, you can (...) free yourself from the concept of cure, and you can free yourself from the bother of termination" (1990, p.173). Clients' awareness of the possibility of return poses fundamental conceptual difficulties for theoretical models based on the finality of loss.

### **Terminating cognitive behavioural therapy (CBT).**

In their seminal outline of cognitive therapy for depression, Beck, Rush, Shaw and Emery (1979) advise that clients are more likely maintain therapeutic gains if the ending is handled well. However, despite increasing recognition of the importance of the therapeutic relationship in improving outcomes (e.g., Baldwin, Wampold, & Imel, 2007) and CBT's clear focus on empirically-supported interventions, there remains little empirical focus on termination within the approach. Two notable exceptions are Nelson and Politano's (1993) and Ochoa and Muran's (2008) contributions to the theoretical literature.

Nelson and Politano (1993) attribute the dearth of CBT termination literature to behavioural therapists' focus on that which is observable and operationalisable over subjective states. They suggest that endings and relationships are only relevant to the extent that they influence generalisation of change and maintenance of progress. The

overarching goal of CBT is relapse-prevention. Consequently, authors such as Judith Beck (1995) underline the importance of ‘blueprints’ prepared as a future resource. These outline key learnings, coping strategies and resources. Clients ideally learn to become their own therapists, assisted through tapering and ‘booster’ sessions as appropriate. These give clients time to consolidate gains, increase independence, and provide opportunities for addressing difficulties as they arise with the aid of the therapist. Nelson and Politano suggest that emphasising the ‘training’ nature of therapy and challenging cognitions around self-doubt are helpful in fostering self-efficacy and keeping the client focused on continued development. They also describe the relationship as having clear implications for outcome, through affecting co-operation, honesty and feedback. Combined, these influence the client’s self-efficacy, the benefits to be gained from therapy and the extent to which gains are maintained and generalised. Nelson & Politano additionally argue that increased self-efficacy will ease the client’s experience of the ending.

More recently, Ochoa and Muran (2008) noted that the manner in which relational processes influence termination in CBT remains relatively un-examined. These authors build on Safran and Muran’s 2003 framework for negotiating ruptures and strains within the alliance to propose a model of ending where mindfulness and metacommunication are employed to emphasise process over content within CBT. De-centring, becoming one’s own therapist, and resolving ruptures within the alliance are employed to support clients in evolving alternative ways of responding, and increased independence. They suggest that it is at ending that clients learn to resolve the ultimate alliance rupture, and ideally to achieve a more optimal balance between relatedness and autonomy.

### **Theory pertaining to therapists’ experiences.**

Sensitivity to clients, balancing relational processes with individuation, and termination as including all that has preceded it, mean that terminating requires more of therapists than technique (Murdin, 2000). However, despite it being axiomatic that practitioners’ states will inform ending (Holmes, 2010), therapists’ experiences receive limited theoretical attention (Baum, 2007; Boyer & Hoffman, 1993; Davis, 2008).

In keeping with the wider literature, extant theory is predominantly psychoanalytic and psychodynamic, drawing heavily upon the Freudian notion of

'countertransference' to warn of the dangers of therapists' personal issues interfering with responses to the clients. Therapists' difficulties with loss are held to adversely impact their ability to be emotionally attuned to clients' experiences (Goodyear, 1981; Joyce et al.; 2007; Lendrum, 2004; Maholick & Turner, 1979; Martin & Shurtman, 1985; Ochoa & Muran, 2008; Shefler, 2001). Termination may arouse conflicts between therapists' own individuation and desire for merger, resulting in non-therapeutic behaviour (Goodyear, 1981). There are repeated allusions to perfectionism and termination threatening therapists' self-esteem (Goodyear, 1981; Levenson, 1977; Martin & Schurtman, 1985). Identifying with clients may result in extending therapy (Levenson, 1977). Responses are theoretically heightened during 'forced terminations', dictated by external circumstances, to include: guilt, intensifying treatment to meet goals, anxiety, and avoiding affect (Bostic, Shadid & Blotcky 1996; Siebold, 1991; 2007). Additional sources of anxiety include struggling with loss of professional identity as the asymmetrical client-therapist relationship dissolves, and losing relationships that have become increasingly rewarding (Goodyear, 1981; Levenson, 1977; Martin & Schurtman, 1985). Terminating involves letting go of clients, letting go of unrelenting standards, and letting go of over-involvement and emotional reliance on clients (Davis, 2008). From an attachment theory perspective, Holmes theorises that open-ended psychotherapy endings may be 'too early' or 'too late' depending on the fit between therapists and clients' attachment styles; he emphasises the importance of therapists' awareness of their own attachment styles in support of mutative terminations (1997; 2010).

A less developed vein of theory describes therapists' anxiety and sadness at ending as understandable, suggesting that the absence of feeling is something that therapists would question in their clients (Penn, 1990). From a Jungian perspective, Williams (1997) suggests that effective therapeutic relationships require authentic, emotional commitment from therapists. She proposes that many therapists' moments of most meaningful relatedness are with their clients. Endings may be a reminder of the professional nature of these relationships.

Describing ending brief dynamic therapy, Noy-Sharav (1998) suggests that the motivation to engage in time-limited work may stem from avoiding the involvement required in longer-term therapies, or from working through personal abandonments. Others focus on the requisite resilience for the intense, frequent attachments and separations in time-limited work (Coren, 2010; House, 1999). Coren suggests that this necessitates therapists continually deal with their own separation anxiety. Conversely,

Cummings theorises that brief therapy results in less involvement, freeing therapists from concerns about terminating as they rapidly move into the next therapeutic relationship (1990). Within the wider literature, duration is indeed believed to be linked to depth of attachment, and thus the significance ending holds for clients and therapists (Marx & Gelso, 1987; Parish & Eagle, 2003). However, on the basis of clinical experience, others argue deep attachments may nevertheless be formed within brief therapy, and endings affectively-charged (Coren, 2010; Davis, 2008). Such opposing theoretical standpoints highlight the dearth of literature relevant to the CPC context. Little is known about how counsellors experience endings in practice.

To conclude, there appears to be theoretical consensus that endings have the potential to be affectively-charged for therapists. However, theory describing therapists' experiences of ending longer-term work may have minimal relevance for those working in different settings. How do therapists practising in time-limited settings experience endings? Is it possible to generalise from the affective intensity experienced ending long-term psychotherapy to the six to ten session framework employed in primary care?

## **Empirical literature**

Due to the relational nature of endings, this review will begin with a brief review of extant research into clients' experiences of endings, before exploring therapists' experiences in greater detail.

### **Clients' experiences.**

Termination had originally been conceptualised as a time of loss and crisis (e.g., Freud, 1937). However, research in recent decades suggests that clients regularly end with feelings of pride, accomplishment and wellbeing in both time-limited (e.g., Marx & Gelso, 1987; Quintana & Holohan, 1992) and longer-term therapies (e.g., Baum, 2005; Fortune, Perlingi & Rochelle, 1992; Knox et al., 2011; Roe et al., 2006). Research consistently suggests that endings are experienced positively where they are gradual; where clients have control, choice and desire to terminate; and where therapy is experienced as having been successful (Baum, 2005; Eagle, 2005; Roe et al., 2006; Quintana & Holohan, 1992; Knox et al., 2011; Fortune, Perlingi & Rochelle, 1992; Marx & Gelso, 1987). Conversely, ending is more likely to be experienced as loss where clients

have a significant loss-history and loss has been a theme of therapy (Knox et al., 2011; Marx & Gelso, 1987); where outcome is disappointing (Baum, 2005; Knox et al., 2011; Quintana & Holohan, 1992; Roe et al., 2006); and where clients experience less readiness, control, choice, and desire to end (Baum, 2005; Perren, Godfrey & Rowland, 2009). Research suggests that the more central the relationship to therapy, the stronger both positive and negative feelings at ending (Baum, 2005). Eagle (2005) found that clients valued therapists acknowledging aspects of the real relationship at ending, experiencing this as fortifying them post-termination. Marx and Gelso (1987) found a moderate but significant correlation evident between length of treatment and negative affect. Likewise, analysis and post-termination mourning intensifies with successful outcome and relationship (Craig, 2002). Of particular relevance to CoP is the centrality of the relationship, and the value that clients place on processing ending together with their therapist (Baum, 2005; Craig, 2002; Eagle, 2005; Knox et al., 2011; Marx & Gelso, 1987; Quintana & Holohan, 1992; Roe et al., 2006). Clients who feel supported in processing feelings about ending, report feeling profoundly understood; conversely, feeling unsupported leads to feelings of failure, frustration and loneliness (Knox et al., 2011; Roe et al., 2006).

There appears to be no extant research into clients' experiences of ending counselling in primary care. However, Hoyt cites a survey in two primary care settings which found that only 34% made use of the allocated six sessions. He suggests that many clients approach briefer therapy eager to complete it, preferring least intrusion into their lives (1995). Nevertheless, a qualitative study exploring 15 counsees' post-termination gains appears to support the centrality of the relationship at ending found within the wider termination literature. Perren et al. (2009) found that where ending was respectfully, mutually negotiated, clients experienced ending as a therapeutic intervention in its own right, consolidating gains, affirming their relationship and newly-acquired psychological resources. Less significant than session numbers was the manner in which ending was conducted, including flexibility around session intervals. Similarly, another qualitative study exploring former counsees' experiences of post-termination reviews, concluded that counsees valued mutually-negotiated endings (Etherington & Bridges, 2011).

Word constraints preclude detailed critique of these studies; however, the high proportion of clients who terminate prematurely (32-50%; Connell et al., 2006) suggests that clients who complete therapy may be more likely to value therapy and concomitant



termination precisely because of their investment in it (Macaskill, 1988). Lack of research into difficult endings or 'forced terminations' likely reflects sensitive ethical difficulties. Therefore, overall, extant research into clients' experiences may insufficiently represent those who feel that therapy has failed, or that endings are premature.

### **Therapists' experiences.**

Despite research suggesting that clients value processing ending together with their therapist (Baum, 2005; Eagle, 2005; Knox et al., 2011; Marx & Gelso, 1987; Quintana & Holohan, 1992; Roe et al., 2006), numerous authors comment on the lack of empirical research into therapists' experiences (Baum, 2005; Boyer & Hoffman, 1993; Frank, 2009; Martin & Schurtman, 1985; Quintana & Holohan, 1992; Roe et al., 2006). Overall, termination literature appears more concerned with theorizing how endings ideally proceed, than with how therapists actually experience endings in practice. For instance, an informal survey distributed to ten psychoanalysts found that many have "little knowledge of the experience of others and often have a sense of fumbling during the final phase" (Frank, 2009, p.146).

Practitioners' experiences of endings in primary care do not appear to have previously been explored. Therefore, the wider empirical literature is reviewed with a view to what it may offer the current study. Overall, the relevant literature falls into five broad categories: ending open-ended psychoanalytic or psychodynamic psychotherapy, psychologists of multiple orientations ending longer-term therapy, 'forced terminations', terminating social work and ending time-limited therapy.

### **Terminating psychoanalysis and psychodynamic psychotherapy.**

A qualitative study, focusing on 20 psychoanalysts' experiences of loss during termination, found wide-ranging responses (Viorst, 1982). All participants experienced some sense of loss; however, this loss experience varied greatly, from minimal difficulty to inevitably traumatic. Endings where clients had made significant progress were characterised by mixed sadness and pleasure. A number contrasted intense personal feelings with their professionalism, and personal feelings were intensified for remaining unexpressed. Viorst suggests that where personal difficulties are being resolved through patients' processes, and therapists' personal lives are impoverished, therapists might

become over-invested. She emphasises that therapists were often surprised to realise how they had used patients' termination phases to resolve personal issues (p.417). She suggests that reflecting upon responses may valuably serve continuing personal development. Her participants describe terminating as becoming easier with experience and self-knowledge.

A recent Constructivist Grounded Theory exploration of ten psychoanalytic and psychodynamic psychotherapists' experiences of termination offers a process model of termination (Fragkiadaki & Strauss, 2012). This describes termination as a process that begins prior to meeting and continues post-termination. Therapists begin as persons, influenced by loss histories, trainings, and personal therapies. The relationship that develops uniquely determines experience of termination. Participants describe "proper endings" in the context of deeply engaged relationships, and "erratic terminations" where relationships have been "unsettled" (p.342). The latter result in self-doubt, confusion, and worry about patients. Termination itself is when the ending is discussed and worked through. In keeping with Viorst (1982), termination may elicit intense, wide-ranging emotions, akin to experiencing a bereavement for some. Some therapists deliberately transform the relationship at ending through increasing self-disclosure. This is more likely within positive alliances; good endings characterised by mutuality. Additionally consistent with Viorst, the relationship is experienced as both professional and personal, and personal feelings are intensified for remaining unexpressed. Processing termination continues for months post-termination, therapists reflecting, working through, and feeling connected to patients. Experience results in increasing familiarity with endings. Fragkiadaki and Strauss offer detailed account of methodology and validity consistent with CoP values and Yardley's (2008) criteria for qualitative methodology. Nevertheless, de-limitations of sample size restrict generalisability in both studies. An additional limitation is the extent to which these findings may be relevant to differing orientations and settings. For instance, Fragkiadaki and Strauss found that duration and frequency increased relationship intensity, with consequences for experiences of ending. To what extent would a process model of terminating as taking considerable time, potentially continuing for months post-termination, be applicable to time-limited counselling in primary care?

### **Therapists of multiple orientations ending longer-term therapy.**

Research into differential management of endings according to theoretical orientation is limited. However, a questionnaire-based quantitative study sampling 92 nurses, social workers, psychologists and psychiatrists found differential management of non-analytic termination as a function of gender (Greene, 1980). Female practitioners relaxed boundaries, becoming more expressive, closer, and more available post-termination than male counterparts. Conversely, cross-gender similarity terminating psychoanalytically-informed therapies leads the author to suggest convergence of masculinity and psychoanalytic technique in emotional distance. However, these results are arguably confounded by profession: psychologists and psychiatrists were predominantly male, compared to predominantly female social workers and nurses. Additionally, changes in social attitudes towards gender over intervening decades might restrict generalisability of these findings to contemporary practice.

More recently, Boyer and Hoffman (1993) explored chartered psychologists of multiple orientations responses to ending as a function of both loss-history and perceived client sensitivity to loss. One hundred and seventeen participated in a questionnaire-based design into experiences of ending longer-term therapy (minimum 25 sessions). The authors cite Martinez (unpublished dissertation, 1986) that there is considerable loss in many therapists' lives, suggesting unresolved losses are likely to be re-experienced while terminating therapy. Limitations include that self-report measures are inevitably vulnerable to cognitive and social-desirability response biases. A low response rate suggests possible sampling skew, and identified predictors accounted for only a small proportion of the variance, suggesting the multiplicity of variables involved. Nevertheless, regression-analysis revealed variance representing convincing effect sizes (Howell, 2006). These findings suggest that past grief reactions indeed strongly predicted anxiety and depression at ending. Present grief reactions contributed solely to anxiety, therefore increased depression was associated solely with past grief. The authors hypothesise that as unprocessed grief reactions are, by definition, outside of awareness; it may take the loss of certain clients in the present to reactivate such grief. The crucial factor appeared to be the degree to which losses had been resolved, rather than loss frequency. However, loss frequency was related to the amount of time devoted to termination, suggesting these therapists' understanding of the significance of loss. Moreover, even when therapists' own loss-histories were controlled for, perceived client-

sensitivity to loss significantly predicted therapist anxiety. The authors conclude that termination is complexly influenced by interaction between client and therapist variables.

### **Forced terminations.**

The effect of increased therapist anxiety in response to clients' perceived sensitivity to loss appears supported by heightened responses to forced terminations. Theoretically, therapists are prone to powerful affect at such times (Bostic et al., 1996; Siebold, 1991; 2007). A mixed-methods experimental design exploring 52 USA psychology interns' responses found 50% experienced difficulty: sadness, guilt and wish for additional supervision (Zuckerman & Mitchell, 2004). Thematic analysis exploring 76 Israeli clinical social-workers' accounts similarly found intense personal distress, sadness, regret, doubts about competency, anger, and intense frustration about ending prior to completing work and just as trust was established (Baum, 2008). Practitioners expressed concern and guilt, heightened where clients had significant loss-histories. Limitations acknowledged by both studies are weak external validity due to small sample sizes, and low response rates. Zuckerman and Mitchell fail to report psychometric properties of quantitative questionnaires, and employ non-parametric chi-square, less powerful than parametric equivalents. However, both studies involve independent researchers to validate qualitative themes, and exhibit sensitivity to context in comprehensive literature review. They offer clinically-useful recommendations concerning the need for increased supervisor and therapist awareness of these processes in keeping with Yardley's (2008) guidelines. Overall, both studies found that concern and guilt was intensified in line with perceived client vulnerability, supporting Boyer and Hoffman's (1993) findings of termination as an interaction between client and therapist variables.

### **Terminating social work.**

Due to the dearth of empirical research into endings in primary care, the wider empirical literature is included in this review. Interestingly, this includes a strong vein of research into social workers' experiences of endings, both in the United States of America (e.g., Fortune, Pearlingi & Rochelle, 1992) and Israel (Baum, 2007; Baum, 2008). Unlike British social work, 'clinical social work' in the USA includes the practice of counselling and psychotherapy. Approaches include psychoanalysis, psychodynamic psychotherapy, cognitive behavioral therapy, interpersonal therapy and hypnotherapy

(New York State Society for Clinical Social Work, 2016). Clinical social workers in Israel are similarly trained to practice individual psychotherapy with their clients. The main psychotherapeutic orientation practiced by Israeli clinical social workers is psychodynamic (Shefler, Tishby & Wiseman, 2016). Preceding Baum's (2008) qualitative exploration of clinical social workers' experiences of 'forced terminations' described above, Baum (2007) used quantitative methodology to explore predictors of emotional responses to termination, using a sample of 140 trainee and professional Israeli social workers and variables identified within transition literature. These included: abruptness, control, centrality of relationship, choice, desire to end, treatment outcome, and source of termination. Baum does not specify her participants' specific psychotherapeutic orientations; however, given that Israeli clinical social workers' main orientation is psychodynamic (Shefler, Tishby & Wiseman), and that Baum does not suggest otherwise, it seems likely that this was the approach adopted by the majority of her participants.

As suggested by responses to 'forced termination', source of termination appears to have important implications for how endings are experienced: client-initiated terminations were particularly difficult for therapists, who experienced increased self-doubt at such times. Baum additionally examined the role of process variables (e.g., control, relationship centrality, choice) in therapists' responses. Parametric analysis revealed that the less abrupt the termination, the greater control and choice therapists exerted, the more central the relationship to the therapist, the greater the goal-attainment, and the more desired the termination, the more positive self-feelings the therapist reported. Interestingly, the more central the relationship to the therapist, the greater the likelihood of intense positive and negative affect: for instance, positive self-feelings alongside hurt, anger, and difficulty terminating. Likewise, goal-attainment and failure combined contributed to 45% of positive and negative feelings. Goal-attainment resulted in feelings of satisfaction, optimism, pride, success, hope, and happiness, underling the importance of professional achievement to therapists' feelings about themselves at ending. Baum concludes that, overall, termination is better conceptualised as transition than loss, where positive feelings may be accompanied by sadness, and feelings of loss are more bearable when change is chosen, desired, within therapists' control, and where therapists experience self-efficacy.

These findings are borne out in another quantitative study exploring 69 North American clinical social workers' responses. Fortune, Pearlingi and Rochelle (1992) found pride in professional skill and clients' progress to be the most pronounced affect

terminating longer-term psychotherapeutic work. The weakest responses were re-experiencing loss. Appropriate behaviours were strongest where clients initiated endings due to readiness, whereas externally-determined endings resulted in stronger sadness and less evaluation of progress. Practitioners experienced difficulty terminating appropriately where they had significant loss histories; where clients expressed need for further treatment; or where there was poorer outcome. Limitations to both studies include failure to report power or Confidence Intervals, self-report as vulnerable to cognitive and social-desirability biases and low response rates. Additionally, arguably there are limits to the extent to which social workers' experiences of terminating longer-term psychotherapy in Israel and North America may be generalised to the context of time-limited counselling within British NHS primary care.

### **Terminating time-limited therapy.**

While a great deal is written about how therapists ideally terminate therapy, with the exception of Fortune et al. (1992) above, the literature generally assumes that therapy has progressed well. Consequently, in the sole published research into practitioners' experiences of ending time-limited therapy, Quintana and Holohan (1992) aimed to explore whether therapeutic outcome influences termination.

Eighty-five university counsellors of multiple orientations participated in a questionnaire-based design, reporting on ending therapy averaging 12 sessions. Parametric analysis revealed that therapists failed to prepare clients for ending treatment that is perceived to be unsuccessful as completely as they did when therapy was perceived to be successful. This was manifest in fewer attempts to bring closure to the relationship, less review, and less discussion of clients' feelings. However, where outcome was disappointing, significantly higher levels of negative client affect were reported, indicating the importance of helping clients process endings *most* where this least occurred. The authors hypothesise that where relationships may be characterised by the lower levels of genuineness and empathy frequently found in unsuccessful therapy, discussions of uncomfortable feelings at ending may be particularly difficult.

An unpublished qualitative study into five clinical psychologist and client pairs' experiences of ending 12 - 26 sessions of therapy in NHS secondary care (Eagle, 2005) similarly found support for the influence of therapeutic outcome. Eagle reports considerable convergence of psychologist-client experience. Shared themes were:

'endings as a reminder of reality'; 'mixed feelings about ending - loss versus development?'; 'expectations and goals'; and 'questioning the mutuality of deciding to end – an equal partnership?'. Clients additionally experienced 'keeping it on a professional level – breaking the rules'. Where the relationship was good, they wished to know whether it was a 'real' relationship and experienced therapists' acknowledgement of aspects of this as fortifying them post-termination. Therapists additionally experienced 'sensitivity to patients' unique emotional needs', using clinical discretion to adapt endings accordingly. They experienced positive outcome as smoothing ending processes, echoing Quintana & Holohan's (1992) findings. Eagle concludes that these findings support Quintana's (1993) conceptualisation of termination-as-transformation, and suggests the need for empirical exploration of processes involved in more difficult endings.

Nevertheless, limitations to these studies include that Quintana and Holohan describe a low response-rates, possibly indicating sampling bias. Alongside restricted causal inferences to be drawn from correlational data, considerations include low generalisability from student services, where clients are normally young, privileged, and high-functioning relative to those in public healthcare. Additionally, in both studies, therapists self-selected cases to report on, and self-report is susceptible to cognitive and social-desirability response biases. Relatedly, Eagle considers the potential influence of his professional acquaintanceship with therapist participants on the findings. Finally, there may additionally be a limit to the extent to which these findings may be generalised to counselling in primary care, given suggestions of a positive correlation between duration and development of relationship (Fragkiadaki & Strauss, 2012; Marx & Gelso, 1987). Despite the time-limited framework of the secondary care service setting, Eagle reports on ending therapy of up to 26 sessions, and even Quintana and Holohan's average of 12 sessions is twice the duration of counselling in many CPC services, frequently limited to a maximum of six sessions.

### **Summary of research into therapists' experiences.**

Therapists experience intense loss ending longer-term therapy with certain clients, reflecting on both personal and professional aspects to the relationship (Fragkiadaki & Strauss, 2012; Viorst, 1982). Of particular relevance to CoP, is that the relationship appears closely related to therapists' experiences of ending across orientations (Baum, 2007; Fragkiadaki & Strauss, 2012; Viorst, 1982). The more central

the relationship, the stronger both positive and negative affect at ending (Baum, 2007). There is additionally suggestion that therapists' unresolved losses render endings more difficult (Boyer & Hoffman, 1993; Fortune et al., 1992; Viorst, 1982). Perceived client vulnerability heightens negative affect at ending (Boyer & Hoffman, 1993), particularly where endings are forced (Baum, 2008; Zuckerman & Mitchell, 2004). Outcome contributes to therapists' ease or difficulty managing terminations (Eagle, 2005; Fortune et al., 1992; Quintana & Holohan, 1992). Successful outcome (Baum, 2007; Fortune et al., 1992) and therapist control and choice to end (Baum, 2007) contribute to positive affect. Termination becomes easier with experience (Fragkiadaki & Strauss, 2012; Viorst, 1982).

However, extant research is subject to certain methodological and sampling limitations. Alongside limited causal inferences to be drawn from correlational data, there have been no randomised controlled trials. Low response rates in certain studies indicate possible sampling bias; practitioners with strong feelings more likely to have participated. Additional limitations include therapists selecting cases and self-report as vulnerable to cognitive and social-desirability response biases. Extant research may hold limited generalisability to CPC. Therapy duration appears related to depth of engagement (Fragkiadaki & Strauss, 2012; Marx & Gelso, 1987); however, research into time-limited therapy (Eagle, 2005; Quintana & Holohan, 1992) explores terminating therapy of a minimum of 12 session duration, which is twice that of the six sessions generally on offer in CPC. Further, the majority of extant psychotherapy research explores terminating in private practice or university counselling services where clients are likely higher functioning than those with public healthcare systems (Barkham et al., 2005).

### **Improving Access to Psychological Therapies (IAPT).**

As outlined in the Introduction, the Improving Access to Psychological Therapies (IAPT) programme serves to implement National Institute for Health and Clinical Excellence (NICE) guidelines for anxiety disorders and depression. Following Lord Layard's 2006 'Depression Report: A New Deal for Depression and Anxiety Disorders' describing the dearth of accessible evidence-based therapies, IAPT was introduced for adults of working age in 2009. Since 2010, it has been available to adults of all ages. Initially, cognitive behavioural therapy (CBT) was the sole evidence-based therapy available within IAPT services and this remains the dominant approach; however, in



2011, the DoH extended this to include some limited access to a wider range of time-limited therapies, including counselling within primary care. Research suggesting that IAPT will pay for itself through savings both to the NHS and the wider public sector has possibly increased impetus to fund its implementation.

The IAPT-related literature is dominated by Department of Health (DoH) reports on its progress. For instance, following IAPT's inception in 2009, one report of the first three years (DoH, 2013) described 1.134 million clients as having accessed IAPT, recovery rates exceeding 45%, and 45,000 clients moving off sick pay and benefits. In the main, IAPT-related research appears to have been conducted by involved parties. Interestingly, Beacon UK's analysis of IAPT data across England for 2011–12 reported that only 8.7% of those suffering anxiety and depression actually accessed an IAPT service, and only 25% of services achieved a 50% recovery rate (Stanton, Wheelan & Surendranathan, 2013). However, given that Beacon UK offers private healthcare as an alternative to NHS options, clearly it too may have its own interest in publishing such data. Nevertheless, following DoH research, in 2012 targets were increased to 50% recovery rates and a new 'Payment by Results' (PbR) initiative was introduced. This has resulted in concerns about services' abilities to meet targets and incentive to manipulate service protocols, as documented in a more recent (2013) report. This outlines the risks of imposing PbR, including: services excluding patients presenting with greater severity and complexity in order to focus on those more likely to achieve recovery, and premature discharge prior to psychometric indicators of recovery being rendered sustainable. A Pulse investigation (Price, 2013) echoes these concerns. Price describes IAPT services failing to achieve either recovery or waiting time targets. The government's own Health and Social Care Information Centre reports on the use of IAPT services in England between 2013 and 2014, and 2014 and 2015 (HSCIC, 2014; HSCIC, 2015) further highlight difficulties meeting targets; for instance, an average 45% recovery rate against the DoH's 50% target. They also report vast local variation in waiting times.

Despite many mental health professionals welcoming the increased resources and the greater availability of talking therapies (e.g., Davis, 2013), Price (2013) cites others questioning the extent to which the IAPT model is appropriate for all forms of mental illness, including chronic depression. This chimes with strong criticism elsewhere within the wider therapeutic community which argues that unprecedented levels of funding for IAPT, and CBT as its dominant model, have resulted in other psychotherapeutic

approaches being side-lined and cuts to these services (e.g., Leader, 2010; Rizq, 2011). Guy, Loewenthal, Thomas and Stephenson (2012) describe the impact of imposing NICE guidelines on psychological therapy within primary care, making the case for NICE instead adopting a pluralistic approach to counselling and psychotherapy evidence. They argue that the current reduction in the range of available therapies contradicts the government's own commitment to increased patient choice.

IAPT has also been criticised for failing to provide for the more vulnerable population who fail to meet criteria for referral to secondary care, yet need longer-term therapy. From a counselling psychology perspective, Rizq is an outspoken critic. She highlights referrals for short-term counselling as including increasing numbers of complex, co-morbid, severe and enduring presentations, including those potentially meeting criteria for borderline personality disorder (BPD) - despite NHS guidelines concerning BPD as best treated in specialist secondary care services (2012a). She describes the impact of this on therapists who struggle to manage a sense of failure and ethical responsibility offering short-term counselling for those with long-term needs. She advocates for improved collaboration with secondary care and specialist supervision in managing issues emerging from such work to protect against burnout. Interestingly, she describes counsellors' awareness of endings as potentially traumatic for this client group. Rizq (2011) uses psychoanalytic defence mechanisms to explore how, as IAPT emphasizes wellbeing, counsellors and psychotherapists who instead seek to contain clients' distress, may come to represent an unwanted aspect within IAPT and will need to protect themselves from responding in unhelpful ways. Relatedly, Rizq (2012b) describes conflation of economics and care within IAPT as "perversion". She describes turning a blind eye to suffering, dependence and vulnerability, and constructing a 'virtual reality' where targets, outcomes and policies are privileged as a defence against feelings of helplessness about our limitations in dealing with those in distress. At the time of writing, it is interesting that, aside from Rizq's considerable contribution, relatively little attention has thus far been paid to the practice of counselling within IAPT services. As already mentioned, as far as the author is aware, there appears to be no extant research into psychological therapists' experiences of endings within IAPT.

### **Evaluating this review.**

Any review must take into account the 'bottom-drawer phenomenon', non-significant findings failing to reach publication. However, overall, an existing strength of the literature reviewed is the diversity of research methods employed, and their different epistemological foundations. Diverse research methodologies culminating in similar conclusions substantiate empirical findings (Baumeister & Leary, 1997). The researcher attempted to protect against searching the literature according to pre-existing assumptions and confirmation biases by 'bracketing' to review the literature objectively, and reading as extensively as possible.

### **Research question, aims and rationale**

There appears to be no extant research into therapists' experiences of ending time-limited counselling in primary care, despite this being a rapidly-expanding area of practice, and theoretical literature suggesting elevated stress levels, ideological battles, and burnout as counsellors adjust traditional training models to time-limited working. When the 'hallmark' of a good ending is mutual agreement concerning client readiness, to what extent do traditional models of termination still hold in this setting?

This may be of particular relevance as service constraints mean increasingly vulnerable clients are seen in CPC (e.g., Saxon et al., 2008). Extant research consistently suggests termination is more difficult when clients are perceived to be vulnerable (Boyer & Hoffman, 1993), and endings are not within therapists' control or choice (Baum, 2007; 2008; Zuckerman & Mitchell, 2004). As budgetary and service constraints determine session limits, ethical principles guiding termination become more complicated (O'Donohue & Cucciare, 2008). Bringing the therapeutic relationship to closure is complex, potentially calling for sophisticated merging of clinical, practical and ethical factors (Davis & Younggren, 2009). Terminating where clients have ongoing needs is one of the profession's greatest dilemmas (Davis, 2008). Moreover, if therapists heal through the medium of the relationship, losing the relationship rightly becomes a focus of the process at ending (Siebold, 2007). However, very little is known about how time limits influence relational processes at ending. Therapy duration is associated with stronger attachment (Fragkiadaki & Strauss, 2012; Marx & Gelso, 1987; Parish & Eagle, 2003), and some argue that brief episodic therapy frees therapists from affective

involvement and therefore “the bother of termination” (Cummings, 2001, p.173). Conversely, others argue clinical experience teaches deep attachments may be formed within brief therapy nevertheless, and endings affectively-charged (Coren, 2010; Davis, 2008). It is precisely because the relationship is central to therapeutic success, that endings can be so difficult (Baum, 2005; 2007; Fragkiadaki & Strauss, 2012). However, how would Fragkiadaki and Strauss’s (2012) process model describing the intensity of therapists’ loss, and termination as processed over months following long-term psychotherapy and psychoanalysis, apply to counselling in primary care, characterised as it is by large caseloads, brief contracts, and high frequency of endings?

Given the dynamic interaction between client and therapist at ending, this research aims to deepen understanding of therapists’ experiences within this context. Understanding personal responses increases feelings of competence and supports self-care (Davis, 2008). Additionally, clients value processing endings with their therapist very highly (Baum, 2005; Knox et al., 2011; Marx & Gelso, 1987; Quintana & Holohan, 1992; Roe et al., 2006) therefore, theoretically, endings are profoundly shaped by therapist responses (e.g., Holmes, 2010; Martin & Schurtman, 1985). Finally, how therapists experience repeated endings potentially holds consequences for how therapists remain available for meaningful new counselling relationships in primary care. Deeper understanding may ultimately contribute towards termination guidelines within this context.

Due to the many unanswered questions, this research is exploratory in nature. It will attempt to ascertain the phenomenological nature of this empirically uncharted territory, rather than seeking to test specific hypotheses. The overarching research question is: How do counsellors experience endings in primary care?

### **Relevance to counselling psychology**

Since becoming a distinct BPS Division in 1994, counselling psychology (CoP) has become increasingly established within the NHS, highlighting primary care as offering employment possibilities (Elton-Wilson, 1994; Lenihan & Iliffe, 2000). A recent divisional survey found that almost 40% of members are employed by the NHS (DCoP, 2013). However, this potentially poses dilemmas in a paradigm clash between the medical model and target-driven environments, and CoP’s philosophical values and relational focus (Bellamy & James, 2010).

Counselling psychology's values remain grounded in the importance of relationship (Strawbridge & Woolfe, 2010). As such, CoP is very much in tune with wider contemporary literature, which has seen a blossoming of empirical evidence in support of the centrality of relational factors to outcome, and convergence between different therapeutic models in increasing emphasis upon these (e.g., Mearns & Cooper, 2005; O'Brien, 2010). However, having established the therapeutic relationship, it is surely equally crucial that we understand how to safely bring closure to the relationship, especially given findings concerning the association between relationship-centrality and negative client affect at ending (Baum, 2005; Roe et al., 2006), and the value clients place on processing endings with their therapist (Baum, 2005; Knox et al., 2011; Marx & Gelso, 1987; Quintana & Holohan, 1992; Roe et al., 2006).

A distinguishing feature of CoP is attention to therapeutic process (Fairfax, 2008), and the therapist's 'self' as an active ingredient in therapy (Rizq, 2010; Shillito-Clarke, 2003; Strawbridge & Woolfe, 2010). CoP is committed to applying psychological knowledge to therapeutic practice (Rizq, 2005; Woolf, 1996). Deeper understanding of therapists' experiences in might hold utility for CoP practice through contributing towards our understanding of processes at ending. Additionally, a broader question may be what kind of relationship can practitioners invite clients into within time-limited contexts? Brief therapy may be contra-indicated for clients with difficult attachment and loss histories; however, as described above, these clients are increasingly seen for counselling. How do we successfully negotiate this relational terrain whilst remaining true to CoP principles at ending? For many clients, endings may be straightforward, a relief (Hoyt, 1995); for others, powerfully reminiscent of prior losses. However, regardless of how any client approaches endings, it is incumbent upon the counselling psychologist to respond effectively to each client's unique needs. This requires us to examine our own relationships with endings so that in the moment of saying goodbye we can be our best selves for the client, attuned, emotionally available, and truly 'in relationship with'. Given the centrality of the relationship (Rizq, 2010), therapeutic process (Fairfax, 2008), the self of the therapist (Strawbridge & Woolfe, 2010) and practice-based evidence (Corrie, 2010), it is hoped that this research into relational processes within a common working environment will directly inform counselling psychology research, theory and practice.

## **CHAPTER TWO: METHODOLOGY AND PROCEDURES**

### **Overview**

This chapter describes the methodology and procedures employed in this research. It also outlines the epistemology underpinning the methodology and its compatibility with CoP's unique philosophical stance. Different epistemological positions hold different implications for evaluation, requiring clarification in order that research may be evaluated by its own standards of logic (Madill, Jordan & Shirley 2009). The chapter concludes with a reflexive section.

### **Research design and rationale**

A qualitative framework was employed. Qualitative approaches are appropriate for exploratory research, allowing for study of less quantifiable phenomena, and unanticipated findings (Barker, Pistrange & Elliott, 2002). Qualitative research is fundamentally compatible with CoP through shared appreciation of process, openness and non-judgmental understanding of individual perception (Coyle, 1998). Semi-structured interviews at a single time point were used and data were analysed using interpretative phenomenological analysis (IPA).

### **Interpretative Phenomenological Analysis**

IPA is a relatively new idiographic approach committed to exploring lived experience and designed for psychological research (Smith, Flowers & Larkin, 2009). It affords depth and complexity of understanding through both phenomenological and interpretative means.

Phenomenology is a philosophical approach concerned with "phenomena that appear in our consciousness as we engage with the world around us" (Willig, 2008, p.52). Phenomena vary according to perceivers' contexts and psychology, thus perception is always implicated in experiencing. Nevertheless, Husserl's 'transcendental phenomenology' seeks to identify essential features which transcend individual circumstances in order to illuminate a certain experience for others. The

'phenomenological method' sought to describe such 'pure' phenomena through minimising interpretation by 'bracketing'. Conversely, Heidegger's 'interpretative phenomenology' embraces hermeneutics, understanding interpretation as inevitable due to the impossibility of detaching from language, culture and the interpersonal nature of our engagement with the world. Heidegger describes bracketing as cyclical, requiring ongoing adjustment of pre-conceptions, consistent with reflexive practice.

IPA is a version of Husserl's phenomenological method in aspiring to express an essence in its own terms; however, it is also aligned with Heidegger in recognising this as inaccessible except through interpretative filters. IPA is additionally dually interpretative: participants attempting to make sense of experience, while the researcher attempts to make sense of the participants making sense (Smith & Osborn, 2008). Successful interpretation is rooted *within* the terms of the participant's account (Smith et al., 2009, p.37). Understanding the particular takes us closer to the universal (Warnock, 1987, cited by Smith et al., 2009). Generalisability arises from creating links within the wider literature; rather than statistical power, IPA's power lies in the insights it generates within broader contexts (Smith & Osborn, 2008).

### **IPA and epistemological positioning**

IPA does not adopt a fixed epistemology, reflecting its broad range of influences (Larkin, Watts & Clifton, 2006). Nevertheless, various authors (Larkin et al., 2006; Willig, 2008) have described its compatibility with both critical realism (Bhaskar, 1976), and 'contextualism' (Madhill et al., 2000). These occupy middle-ground between positivism, and constructionism, offering realistic ontologies with contextualised, relativist epistemologies (Larkin et al., 2006). Critical realism suggests that an objective truth exists, intransitive in functioning independently of comprehension; however, that knowledge of this is transitive and socially constructed. Contextualism is rooted in Heidegger's philosophy of persons as inevitably 'persons-in-context', and suggests perception actively constructs some reality, thus placing it closer to constructionism. In IPA's assuming correspondence between analysis and participants' experience, seeking knowledge which offers a glimpse into some enduring reality, it is aligned with critical realism. In recognising this knowledge as constructed by interpretation, embedded in context, it is aligned with contextualist constructionism. This openness to both 'real' and 'constructed' simultaneously is compatible with CoP's pluralistic philosophy and potentially

contributes to an emerging new psychology paradigm in ‘epistemological eclecticism’ (Michael, 1999).

### **Rationale for IPA and its compatibility with CoP**

IPA was considered appropriate for research into counsellors’ experiences of endings because of its stated aim of analysing in-depth “experiences and/or understandings of particular phenomena” (Smith et al., 2009, p.46). IPA is sensitive to the private, indefinable aspects of being, and to a range of expression, including emotion, cognition, and discourse (Eatough & Smith, 2008). Endings are potentially emotional experiences, and exploration of emotion is strongly represented in the IPA literature (Smith et al., 2009). The constructivist epistemology implicated in IPA is also inherent in relational processes (Rizq, 2010), and highly compatible with research into experiences of ending relationships. IPA is additionally appropriate for exploring endings through illuminating the experience of process, and facilitating closer links between theory and practice (Reid, Flowers & Larkin, 2005). IPA potentially transcends phenomenological description of insiders’ perspectives through its interpretative range which facilitates engaging with other sources of knowledge (Larkin et al., 2006). IPA holds value in engaging with participants to discover new phenomena and create new understandings (Camic, Rhodes & Yardley, 2003). Thus IPA lends itself to rich exploration of uncharted territory, holding particular utility in under-researched areas, as this one is.

IPA’s focus on subjective experiencing is fundamentally compatible with CoP research and the researcher’s own epistemological position. The exploration of participant’s experiences, understandings and perceptions (Brocki & Wearden, 2006) is consistent with CoP’s commitment to “engage with subjectivity and intersubjectivity, values and beliefs” (British Psychological Society, 2005, p.1). IPA aspires to giving voice to individual experiences, contextualising these within a psychological perspective (Larkin et al., 2006). In attempting to enter into subjective experiencing to assume an insider’s perspective and allow participants’ voices to be heard, IPA is fundamentally aligned with CoP research.

### **Alternative methods**

IPA is one of a number of closely-connected approaches seeking to explore lived experience; however, epistemological assumptions vary and choice of approach should



be determined by compatibility with the research question's epistemological positioning (Smith et al., 2009).

Discursive approaches (DA) are closely aligned with social constructionism, and were carefully considered due to their commitment to the importance of language. However, whereas IPA assumes a relationship between discourse and cognition, language as a route to understanding meaning, DA is sceptical about such relationship, conceptualising discourse as grounded in cultural contexts and a behaviour in its own right (Willig, 2008). In Foucauldian discourse analysis (FDA), discourse is understood to be a unit of knowledge, shaped by the power and social structures within which it is situated. This emphasis on context as inseparable from individual experiencing links it to IPA; however, while FDA focuses on structures themselves, IPA explores individuals' experiencing of their engaging with such contextual influences (Smith et al., 2009). It is these personal aspects of counsellors' experiences which are the subject of the current research. Narrative approaches too were considered due to their potential to offer insight into how individual narratives relate to the meanings given to endings (Murray, 2008). Narrative approaches are related to IPA, particularly where researchers incorporate aspects of phenomenology; however, in focusing on life stories, the emphasis remains broader than the rich minutia of lived experience.

Grounded Theory (GT) was also very carefully considered due to its potential for informing a process model of endings within primary care. Whereas IPA was designed for deepening understanding of individual experiencing through exploring nuance within micro-analyses, GT aims to develop commonalities arising from the data into macro-level conceptual theories (Charmaz, 2008). This frequently requires sampling on a large scale until responses fit into categories, and connections are completed. Conversely, IPA offers a contextualised interpretative account that is not exhaustive, potentially revealing underlying phenomena GT could not account for. GT may have detracted from a richer, more detailed analysis of the emotive, indefinable and private aspects of being (Eatough & Smith, 2008). IPA was employed to afford deeper understanding of the complexity of experiences, supporting therapists in finding meaning through others' accounts, rather than a process model arising from GT which might follow on from and build upon this research.

## **Procedures**

### **Participants.**

Consistent with IPA's idiographic approach, sampling was purposive (Smith & Osborn, 2003). Participants were recruited from a single primary care service. Reflecting the norm in CPC, counsellors were of heterogeneous orientation. Of these, three had participated in an IAPT training; two in DIT, and one in Behavioural Couples' Therapy. Detailed case-by-case analysis necessitates smaller samples; nevertheless, size should allow for analysis of convergence and divergence. Following guidelines for IPA and doctoral theses (Smith et al., 2009; Turpin, Barley, Beail, Scaife, Slade, Smith & Walsh, 1997), six was deemed an appropriate sample.

### **Recruitment.**

The researcher presented her research proposal at a local primary care counselling service team meeting (Appendix 1). Counsellors' supervisors also discussed the research with their supervisees. The researcher subsequently emailed an information sheet to those who had expressed an interest (Appendix 2). Finally, participants themselves referred their colleagues, on the grounds that the interview had been experienced as personally and professionally useful.

### **Participant demographics.**

Participants were qualified counsellors, counselling psychologists and psychotherapists, employed as 'counsellors' within the service. Until two weeks previously, counselling contracts were six sessions. At the time of interviews, a new initiative to increase this to ten sessions had just been introduced. However (with one exception) the endings described in the interviews related to the six session contracts. Two participants were male, and four female. Their orientations and years' post-qualification are detailed below. Pseudonyms are used throughout this thesis, in order to protect participants' anonymity.

**Table 1: Participant demographics**

<b>Participant</b>	<b>Years post-qualification</b>	<b>Years in primary care</b>	<b>Primary Orientation</b>
Andrew	20	15	Psychodynamic Psychotherapist
Jan	21	19	Integrative Psychotherapist
Jo			Psychodynamic/Relational Counselling psychologist
Layla	9	3	Psychodynamic Psychotherapist
Peter	11	3	Eclectic including person-centred Counselling psychologist
Maggie	26	18	Eclectic including person-centred Counsellor

**Interview schedule.**

The interview schedule comprised open-ended questions to ensure those areas most meaningful to participants were explored (Appendix 5). It was discussed with the researcher's academic supervisor and external advisor. The researcher learned it by heart, so as to be able to explore areas of participant interest as they arose.

**Pilot study.**

The researcher conducted three pilot interviews. The first two were with colleagues in different service lines. Minor amendments were made. The final pilot was conducted with a counsellor in primary care. Due to the quality of data, and that procedural and ethical considerations were the same as for subsequent participants, this was included in the overall analysis.

### **Interview process.**

Participants were interviewed at their workplace or a local Mental Health Centre. The researcher reviewed the information sheet and talked through an informed consent form, which participants were then asked to read and sign (Appendix 3).

Interviews lasted between 55 and 100 minutes. Although an identical semi-structured schedule was employed, question order and depth of exploration varied. Time was allocated to talk through feelings arising from the interviews and for debriefing. Participants were given a further information sheet listing support organisations and the researcher and supervisor's contact details for remaining concerns. Following each interview, the researcher made notes to assist with the analysis and personal reflexivity.

### **Ethical Considerations**

#### **Ethical approval.**

Ethical approval for the research was granted by London Metropolitan University Research Ethics Review Panel. As the research involved NHS employees, local Research and Development approval was sought and granted, to ensure the research met with the Trust's Research Governance Framework.

#### **Confidentiality and anonymity.**

Given the potentially sensitive nature of the material discussed in interviews, every attempt was made to protect anonymity and confidentiality, following 'Confidentiality: NHS Code of Practice' (2003), and the 'BPS Code of Ethics and Conduct' (2009). Pseudonyms are used throughout and participants' identities are known only to the researcher. Personal details and informed consent forms are securely stored separately to written transcriptions and audio-recordings in a locked desk under the responsibility of the researcher. Identifying information was permanently deleted from audio-recordings and transcriptions of the interviews. Data stored electronically is password-protected.

### **Informed consent.**

Participants were fully informed as to the nature, aims, rationale, methodology, design and ethical issues. Participation was entirely voluntary. Upon attending the interview, the previously-seen information letter was reviewed and participants asked to read and sign a consent form. Participants were given the opportunity to ask questions throughout. Through use of an information sheet and informed consent form, it is believed participants were cognisant of relevant information and thus able to provide informed consent.

### **Debriefing.**

Time was allocated for debriefing and talking through feelings arising from interviews, and further questions. Participants were reminded of their right to withdraw from the study following their interview. Participants were given a further information sheet, listing support organisations, as well as the researcher's and academic supervisor's contact details (Appendix 6).

### **Researcher declaration**

The researcher did not have any relationship with any of the participants involved in the research prior to commencing the study.

### **Analytic Process**

IPA may be understood as a 'stance' from which to approach data analysis, rather than a set method (Larkin et al., 2006; Smith et al., 2009). Nevertheless, Smith et al. (2009) offer broad guidelines, which the researcher attempted to adhere to. She transcribed the audio-recorded interviews verbatim, during which time participant's meanings became stronger (Smith & Dunmore, 2003). She re-read transcripts, making preliminary notes about emerging themes in the left-hand column. This resulted in identification of emerging themes, recorded in the right-hand column. Repeated readings allowed her to cluster emerging themes into superordinate themes for each participant, repeated on a case-by-case basis. A worked portion of transcript may be seen in

Appendix 7. Individual super-ordinate themes were then collapsed into a master table of themes for the group (Appendix 8), which incorporated convergences and divergences within the data in an ongoing, iterative process. Insufficiently represented themes were eliminated. In keeping with the researcher's epistemological stance, as themes developed into higher levels of abstraction, she aspired to remain sensitive to original meanings through returning to transcripts, to remain 'experience close' (Smith, 2011). The findings for the group may be seen in Table 2.

### **Assessing validity and quality**

Smith et al. (2009) advocate Yardley's (2000; 2008) criteria for evaluating qualitative research. However, more recently, Smith (2011) proposed criteria specifically for evaluating IPA. Both sets of guidelines will be used to evaluate the present study.

Yardley's (2008) first criterion is 'sensitivity to context'. The researcher attempted to adhere to this through sensitivity to researcher-researched interactions during interviews, through close engagement with data towards interpretations grounded in accounts, and through sensitivity to extant literature. 'Commitment and rigour' are attempted through close attention to participants, data-collection and analysis; and through thorough analysis, careful sampling, and interpretation beyond description, whilst aspiring to represent accounts as evenly as possible. The researcher has aspired towards 'transparency and coherence', through clear audit trail and an openly reflective stance. Coherence was sought through faithfulness to IPA's idiographic, hermeneutic and phenomenological principles, consistent with CoP research and the researcher's contextualised critical realist epistemological stance. The final criterion is 'impact and importance'. The researcher has sought to offer contextual, interpretative understanding to contribute towards CoP research on therapists' use of self and the therapeutic relationship; the primary care context; and practitioners' experiences of ending time-limited therapy, to have practical and theoretical impact and importance. The potential contribution will be presented in the final chapter.

Smith proposes four criteria for evaluating acceptable IPA research (2011). These include: adherence to phenomenological, hermeneutic and idiographic principles; transparency; coherent, plausible, interesting analysis; and demonstrable density of evidence. The first three are discussed above in relation to Yardley's criteria; however, with regards to the final criterion, the researcher has attempted to demonstrate density of

evidence both through indicating thematic prevalence and offering a minimum of three participants' data for each theme. Smith suggests that good IPA offers additionally: clear focus; high-quality data and interpretation; and engaging narrative to result in more sophisticated critique. The researcher would suggest there is evidence of high-quality data; however, attempting to evenly represent the breadth of findings relating to an un-researched topic might have reduced her clarity of focus, to limit the sophistication of the analysis.

Finally, triangulation ensures validity in qualitative research (Madhill et al., 2000), and is consistent with a critical realist epistemological stance. Confirmation of the existence of themes has been sought from the researcher's supervisor and a research colleague. Nevertheless, the researcher's perspective remains critically implicated. Her positioning and the means by which she has attempted to manage this are discussed in the following section.

### **Methodological reflexivity**

Methodological reflexivity describes how the process of implementing the method may have shaped the results (Willig, 2008).

The recruitment process itself may have shaped the data through selection bias. A number of participants described longstanding interest in endings; participants may therefore represent a unique sample of counsellors with strong feelings about endings and readiness to share these through participating in research. Additionally, remaining with the phenomenology of individual experiencing meant that different areas of the schedule were covered in varying depth, according to that which was most meaningful for participants. More personal questions were prefaced with: "Only say as much as you feel comfortable with..."; however, aware of the interface between research and therapy, and concerned that participants may regret transparency, I instinctively held back in later interviews, possibly resulting in somewhat uneven probing. More personal questions were generally asked towards the end of interviews. Depending on how detailed previous answers were, this meant there were unequal amounts of time for these questions at ending. Upon reflection, it may have been better to schedule longer interviews from the outset.

Theoretical orientation provides the language within which endings may be thought about, with consequences for meaning and how they are experienced.

Consequently, careful consideration was given to sampling counsellors of homogenous orientation. However, wide-ranging local variation in client populations and varying protocols between different services, necessitated prioritising homogeneity of service in order to recruit sufficient participants. Additionally, theoretical suggestions that the idiosyncratic primary care context itself results in increasing homogeneity of counselling practice (Hudson-Allez, 2000) meant that varying orientations were deemed more appropriate than they might otherwise have been. Heterogeneous orientation was also thought to more accurately reflect the demographic of primary care counsellors, and, as such, to potentially offer research of greater relevance, utility and impact.

Finally, IPA acknowledges insights gained through data analysis result from interpretation, thus the researcher is implicated at the level of interpretative engagement with the data (Willig, 2008). As described in my reflexive statement, I hope to add to the study's validity, rigour and trustworthiness (Etherington, 2004) through personal reflection. At different points, prior and during the research, I became aware of pre-conceptions, and attempted to bracket these as far as possible. I was reminded in supervision of the necessity of maintaining an open stance at every stage (Kasket, 2012). Drafting my interview schedule, I attempted to ensure open questions, and enquire about positive and negative experiences equally. I reviewed this schedule in supervision and with my external advisor. I drafted a reflective statement, referring to it prior to each interview. In conducting interviews, I attempted to maintain neutrality, reminding myself of the difference between therapy and research. I found it challenging to refrain from assuming a therapeutic stance, especially given the rich material around more personal aspects of ending. Hours spent transcribing further deepened my empathy with my participants' accounts. During the analysis, I attempted to remain faithful to participants' voices through frequent return to interview scripts. Having identified themes, I shared these with my supervisor and research colleague, remaining open to potential for personal biases to distort interpretation. I kept a reflective diary throughout, particularly post-interviews. I used both supervision and personal therapy to support this reflective practice, repeatedly bracketing, and re-bracketing, as I moved through the hermeneutic circle and the process of being affected by the unfolding research findings themselves.



## CHAPTER THREE: ANALYSIS

### Overview

This chapter presents the results of an interpretative phenomenological analysis of six counsellors' experiences of endings in primary care. Pseudonyms are used throughout the analysis in order to protect participants' anonymity. Themes and corresponding sub-themes are presented below. It is recognised that this analysis offers only one interpretation of many possible interpretations of the data. Themes were selected for their relevance to the research question and CoP and may not reflect all nuance of experiences. The title of this thesis "I sort of feel that one is meant to say how important endings always are" is an excerpt from Jan's interview, chosen to reflect interacting 'conflicting frames' and 'self-experiencing'. Omission of irrelevant material is indicated using brackets (...). Ellipses without brackets represent pauses. Each superordinate theme concludes with a reflexive paragraph to illuminate the double hermeneutic and increase transparency regarding the researcher's interpretative lens.

**Table 2: Summary of superordinate themes and sub-themes**

Superordinate themes	Subordinate themes	Relevant quote
<b>Self-experiencing</b> <i>What comes into the room...</i> Jo (5.32)	<b>Attachment and loss</b>	<b>Relevant quote</b> it always touches my...old, painful places (Layla: 10.58)
	<b>Bi-directional personal and professional development</b>	<b>Relevant quote</b> I can be quite <i>there</i> with an ending (Andrew: 8.56)
<b>The quality of the therapeutic process - connecting</b>	<b>'Was it good work?'</b> <b>(Jan: 3.33)</b>	<b>Relevant quote</b> I got the sense that ...it was worthwhile to her. So that feels really good (Maggie:3.13)

	<b>Relational depth</b>	<b>Relevant quote</b> it was the being...and the connecting that was so important (Jo:10.18)
<b>Conflicting frameworks</b> <b>‘it would have been cruel’</b> (Maggie: 3.18)	<b>Psychoanalytic theory versus time-limited counselling</b>	<b>Relevant quote</b> I sort of feel one is meant to say how important endings always are (Jan:4.26)
	<b>Ethical frameworks versus ending</b>	<b>Relevant quote</b> I was left with this kind of sense of betrayal (Andrew:5.45)
	<b>Autonomy versus omnipresent system</b>	<b>Relevant quote</b> They can see (Maggie: 3.30)
<b>Towards congruence</b> <b>‘walking alongside for a bit’</b> (Jo: 10.29)	<b>Adjusting the frame</b>	<b>Relevant quote</b> a good ‘carry-on’ piece of work (Layla:6.19)
	<b>Detaching and accepting</b>	<b>Relevant quote</b> a very radical acceptance (Peter:8.47)
	<b>Metaphors of ending - journeying</b>	<b>Relevant quote</b> she had somebody walking alongside her for a bit (Jo: 10.29)

### **Superordinate theme one: Self-experiencing – what comes into the room**

This first super-ordinate theme presents an account of how counsellors experience their personal selves during professional endings. The ‘self’ may be defined as a subjectively-experienced psychological structure affording continuity to experience (Kohut, 1977); however, Epstein (1973) emphasises that this structure develops through experience. In keeping with the wider termination literature (e.g., Fragkiadaki & Strauss, 2012), this theme reflects the influence of therapists’ loss histories. It also reflects bi-directional personal and professional development explored within the wider psychotherapy literature (e.g., Skovholt & Ronnestad, 1995). In this way, it links to the

final subtheme ‘Metaphors of ending - *Journeying*’ – that which enters the room with counsellors at this stage of their journey.

### **Attachment and loss.**

Five counsellors reflect on the influence of formative relationships and losses upon their experiences of professional endings. Although it is important to note that there was no formal assessment of participants’ attachment style, Rizq and Target (2010) suggest that Slade’s (1999) conceptualisation of attachment style as a guide to affect-regulation and the meanings made of early experiences is not incompatible with a constructivist account of mind and CoP. In the present study, early attachment experiences are entwined in accounts of formative loss. These appear to mediate experiences of endings through different affect-regulation styles and degree of comfort with interpersonal closeness or distance to account for convergence and divergence within the data. Likewise, the extent to which therapists’ losses have been resolved appears crucial. Participants who describe losses as worked through are eloquent about being able to remain emotionally available to clients through the ending process, in contrast to participants who describe continuing to process or avoid affect related to unresolved personal losses. For example, Layla describes unsettled early attachments, compounded by the traumatic loss of her husband:

My mother (...) left me, a kind of separation for all my life. Never feel secure that they will stay. My father (...) a stranger when he comes back. I *never* get my head around that. Then it happened again when I get married. My late husband (...) was killed there (7.43).

Although English is not Layla’s first language, her repetition of the word “never”, and use of the present tense; e.g., “feel” and “get”, suggest that this sense of attachment insecurity continues. Her tone changes when she talks about her husband’s murder; the words “late” and “was killed” placing this loss firmly in the past. She reflects on the impact of these traumatic losses upon her experiences of saying goodbye in her personal life:

So you know, when you've been through all those endings that you never say goodbye (...) I could never say goodbye (8.50).

At this point in the interview, Layla grows tearful about never having said goodbye to those she has lost. This mirrors my own experience and, although I remain silent, I empathise and my eyes too fill with tears. She resolves to continue, reflecting on the impact on professional endings:

a lot of endings I feel very attached and passionate about patients who been through endless endings without goodbyes... I take them onboard (...) I work hard for that last session of goodbye between us (...) Work hard for not losing them (...) where they abandon me (...) when a client doesn't turn up the final session, it always touches my...old, painful places. What *happened* to them...? What *happened* to them...? (...) I work at not taking as so bad and personal when people didn't turn up and they abandon me, but for me, letting *them* down, is not going to happen (*laughs*). Is *not* going to happen. (10.53)

Layla's repetition of 'What *happened* to them?' vividly evokes an image of searching; suggesting that the loss of clients in the present possibly re-activates historical losses and related hyper-activating affect-regulation strategies to minimise interpersonal distance. She works hard to ensure that clients that do not feel abandoned as she herself had done. Layla's laughter also communicates a sense of relief and release following earlier highly-charged affect. Another interpretation might be that she experiences a sense of resolution and personal healing through offering clients the secure endings that she herself had needed. Nevertheless, the phrases "upheaval internally" and needing to "keep grounded" (3.10), suggest that certain endings continue to be experienced as traumatic. Interestingly, Jo's account converges with Layla's in this. Like Layla, Jo similarly continues to experience the influence of traumatic losses, similarly communicating high levels of affect and seeking to remain 'grounded' during certain endings:

something I've had to develop is *grounding* myself (...) I can get swept along and kind of lose myself(...)and I kind of have to wrap my foot round the chair leg and just kind of feel that foot on the ground, keep myself away from that emotion. (6.42)

However, whereas Layla seeks to minimise interpersonal distance at ending, wishing to “take them onboard” (10.54), Jo describes a more avoidant affect-regulation style. She seeks to maximize interpersonal distance and independence during endings:

to get so close to death at such a young age had a really profound effect ... a defence mechanism already in place perhaps activated to a bigger level (... ) protecting myself from feeling (5.18)  
anxiety about getting close(...) keep a distance (2.18)

Consequently, Jo describes experiencing herself as “a cold bitch” (6.40) during certain endings, ending with “executioner chop” (15.19). She reflects on how her early personal experiences affect experience of professional endings through shaping:

who I am as a therapist, and as a person. What comes into the room... (5.32).

Like Jo and Layla, Jan too links her experiences to an early bereavement. Without having been helped to process this as a child, she describes learning to “buffer” herself to “just get on with endings” (8.26).

I'm thinking about an early bereavement (...) it was never dealt with; I never dealt with it... I *wasn't* actually helped, you know, I was young... I wasn't helped to deal with it, it was kind of (...) moved over... other people's needs were taking priority, so maybe there is some deep pattern in me around (...) not giving these things enough time... (*pauses*) (8.58).

As opposed to Layla, who names the ending in every session, even in final sessions Jan “rarely talk(s) about endings as such” (3.13). Jan pauses, reflecting upon the parallel between personal and professional. Despite marked commitment to high quality practice and her clients’ best care throughout her interview, here Jan wonders aloud whether she is “skimming” (8.50) over endings, which she later reflects “doesn’t feel very good” (14.36). In these reflections, Jan appears to be gaining new insights into the relationship between her personal history and professional practice. The impact of such reflective practice is explored further in the following theme.

## Bi-directional personal and professional development.

All six counsellors experience personal development as supporting professional termination practice. This is particularly well-illustrated in Andrew's account. Andrew describes how experiencing a personal journey through a series of bereavements has supported his remaining emotionally present and available to clients through endings. He describes initially not wanting "to go there" (8.40), but having 'been there' through the first bereavement, subsequently, he "got there as quick as I could", travelling 'there' to be with loved ones. He reflects: "before then, I don't think I was very good" (8.25). However, he believes that he is now "quite good" (9.1), which he attributes to familiarity with these processes. Andrew uses the word 'there' to describe being emotionally present during his clients' endings, in an interesting parallel to 'being there' in person through the dying process.

I can encourage them to go there...to endings...and stay with it...(...) I can stay with that... I can be quite *there* with an ending (Andrew: 8.56)

Some counsellors experience reflective termination practice as reciprocally stimulating personal development. Peter describes reflective practice as an ongoing process: "a lifetime's work" (8.34). As described in relation to Jan above, this reflective practice occurs in parallel process throughout the interviews. For instance, Jo describes "giving myself insights" (5.34) reflecting aloud on attempts to disentangle whether sadness during an ending was her client's or her own:

- I think I scooped up my sadness and called it his, but really there was a sadness for *me* of what the ending was... (4.32)

She relates mistaking her own sadness for the client's to her avoidance; the word "brutal" echoing descriptions of ending with "executioner chop" to avoid ongoing connection.

I, I suppose I'm wondering why I didn't, I didn't offer him any follow-up sessions...uhhh.... And whether that felt quite...sort of... *brutal*...ummm.....when I have offered follow-ups to other people....ummm..... (7.54)

Jo's pauses, hesitations and "ummm"s are particularly notable in the context of the fluent eloquence of her wider account. One possible interpretation of this marked change of pace and rhythm is that she is experiencing new insights regarding a defensive 'blindspot' which may have motivated a cognitive bias towards avoiding further connection during this ending.

Four participants relate personal and professional growth to their own therapy, in keeping with wider literature (e.g., Bellows, 2007). However, Maggie and Jan describe little benefit, and least influence upon their practice. Both dedicate final sessions to ensuring clients achieve the good outcomes that they themselves feel that they failed to receive. However, whereas Maggie appears phlegmatic, Jan communicates distress about mostly "unsatisfying" personal therapy. She offers a poignant account of one ending:

I said to him (...) ...that I felt sad, you know, I hadn't got...(...) about what I hadn't got, and what I'd needed that I hadn't got, and he answered in some way, I can't remember what he said now...um....and I remember saying it was a loss for me (...) I'd been with him five years and I'd (*laughs*) I'd, you know - having, being, able to say that - it still didn't feel like a good ending... (...)...You know, it was an awful lot...I should never have gone on with it as long as I did...

Jan's repetition of the phrase "I hadn't got" above poignantly mirrors her description of unmet needs during her childhood bereavement. While it is important to note that there are obvious limits to any interpretations made on the basis of one interview, one possible interpretation might be that in the same way that Jan "buffered" herself to "just get on with it" as a child, enduring internal models mean that she sets up similar caregiving and therapeutic relationships in adulthood, meaning that her emotional needs continue not to be met. Rizq and Target (2008; 2010a; 2010b) and Rizq (2011) observed parallels between therapists' attachment style and transcripts of personal therapy, positing interplay between early attachment experiences, the use of personal therapy and its influence upon professional practice. These authors reported that participants without a secure attachment style were more likely to experience difficulties resolving negative feelings towards their therapist, and consequently profound disappointment with therapy, as described by Jan. Her laughter is at odds with palpable distress, suggesting its potential use as a defence.

Conversely, Layla, Andrew, Peter and Jo describe positive experiences of personal therapy, even emulating therapists' termination practice. Jo describes learning to lower avoidant defences described above to allow her current therapist to become important to her, simultaneously becoming more empathic to clients' attachment to herself and their experiences of ending.

I've been learning that a therapist can be a very important part of somebody's life... (15.43).

In contrast to entrenched "anxiety about really connecting with people" (6.10); she is experimenting with emulating her therapist with clients:

I'm connecting with a real person and it's something I'm trying to (...) emulate (3.23).

Peter too describes mutative long-term personal therapy, and his therapist's professional influence over endings. His ending left him understanding that ultimately it is the client who is responsible for change, which he experiences as supporting endings in time-limited frameworks. Conversely, Layla, who worked through an ending over twelve months, questions time-limits which preclude offering clients a similar process. Nevertheless, she too is eloquent about reflective professional practice resulting in personal growth, as she processes losses in supervision, therapy and reflective practice. Despite markedly different timeframes, she seeks to offer clients the benefits she had experienced with her own therapist, and that which she feels she herself had historically needed in a chance to say goodbye:

*Still* you can make a good ending. *Still* I am here, saying goodbye to you, not abandoning you like everyone else. At least, I am owning, facing, my goodbye (3.18)

Layla's repetition and strong emphasis upon the word "still" evokes her determined stoicism in the face of these endings. Through repeatedly facing clients' endings this way, she reflects that she herself is repeatedly: "facing the ending, the *ending*, and uncertainty of life" (10.17).



...going through that emotion again, and again, and again... it get kind of settled and accepted from the time I'm starting to where I am now (6.46).

Layla's repetition of the word "again" suggests the frequency of endings in primary care, and, over time and multiple endings, she experiences her personal emotions as increasingly resolved through such reflective termination practice; reflective professional practice supporting personal growth.

### **Reflexivity**

In hindsight, it is startling that this analysis begins with an account of loss that mirrors my own. I worked hard to 'bracket' assumptions concerning the influence of participants' prior attachment and loss experiences to enter participants' lifeworlds during interviews and analysis. Ironically, I was then surprised at the consistency of such responses. This may reflect the nature of participants drawn to research into endings. However, equally, my 'self' may have been more transparent than I was aware, implicated in relational style, empathy and the manner in which I was able to facilitate exploration of these experiences. However, such data possibly additionally highlights epistemological limitations inherent in IPA's reliance upon language; participants' own interpretations possibly influenced by reading, training and supervision that is informed by theoretical literature regarding loss, attachment and endings. I drew upon attachment theory in interpreting this data further, employing a 'questioning' hermeneutic (Smith et al., 2009) in going beyond what is stated relating to affect-regulation strategies and comfort with interpersonal distance, but, nevertheless, hopefully grounded in participants' own terms. Drawing on attachment theory this way has been uncomfortable at times, reminiscent of the power imbalance between researcher and researched. However, following repeated return to transcripts and triangulation with colleagues, I believed that this theme was intrinsic to a faithful account of the data.

Bi-directional personal and professional development too chimed with my own experience, including having used my own therapist as a role-model for my own termination practice. Awareness of this necessitated frequent return to participants' accounts to ensure validity. I was concerned that in adopting a 'hermeneutic of empathy' (Ricoeur, 1970) and in remaining so close to the terms of participants' descriptions, overall 'self-experiencing' may be insufficiently interpretative as a theme. However, I was

also aware that participants had reported deeper understandings of their own personal processes through their reflections, and so I hoped that this theme could be helpful to other practitioners in its present form.

### **Superordinate theme two: The quality of the therapeutic process - connecting**

Counsellors describe preceding relational and therapeutic processes as inseparable from their experiences of ending. Whereas 'self-experiencing' involves counsellors' personal processes, this theme involves responding to clients' experiencing. There additionally appears to be a strong evaluative thread through this theme.

#### **Was it good work?**

Counsellors' experiences of endings appear inseparable from their evaluations of the preceding counselling, in keeping with wider literature. However, IPA offers more subtlety to evaluation, suggesting dimensions of helpfulness, depth, and completion. Jan is particularly eloquent about the quality of the work affecting her experience of the quality of the ending:

I like to feel the person is going away feeling they've *got* something...but that's not really about the ending...it's more about...what was done all the way through (...) I find it hard to separate (..) the ending from the rest of it; in terms of whether it's a good ending or a bad ending: was it good work or was it bad work? (3.33).

Jan's emphasis on "good" or "bad" is interesting in the context of her lifeworld and subjective concerns. Threaded through her interview is a concern to offer her clients counselling of the highest standard. Another possible interpretation would be that Jan's belief that the quality of therapy determines the quality of ending is strengthened by her own painful experiences of ending unhelpful personal therapy. However, there is very strong convergence around this theme throughout accounts: perceiving the work to have been helpful to clients positively affects five participants' experiences. For example, Maggie describes one good ending:

I got the sense that...it was worthwhile to her. So that feels really good  
(Maggie:5.41)

Counsellors describe professional satisfaction realising that clients have benefited from the work:

feelings of satisfaction that she had seen it through (...) found a space that felt different for her and there may be something reparative in that (Peter: 2.47)

when there's feelings that work has been done and progress has been made and you have been helpful (Jo: 2.59)

There is additionally strong convergence in five accounts of tailoring endings to individual processes; for example:

try and tune into that individual person's psychology....(Peter: 7.7)

thinking about (..) what the ending is like for them, focusing on...what they might want (Jo:14.52)

Juxtaposed against this is the influence of the timeframe. Jo, Jan, Maggie and Peter all emphasise that they are cautious about the level at which they work, and that it is the supportive rather than the challenging aspects clients value most within the timeframe. Jo describes a client protecting herself from deeper exploration.

we knew there were chasms, a volcano lying underneath and we didn't go there and that was okay, we recognised why we weren't doing that (...) I think that felt like a good enough ending (...) when it was so - I was going to say nothing - it's not nothing but it was so...not doing, it was very much being (...) working in a brief setting, you have to be careful at the level that you kind of work (10.27).

However, whereas this ending was experienced as “good enough” due to mutual recognition of the rationale, where work remains superficial due to lack of engagement from either therapist or client, endings are experienced as unsatisfying:

- he did a bit of work, but it was very superficial. Ending with him felt...unsatisfying (Maggie: 9.23).

Conversely, although participants describe ending with a sense of completion as rare, they experience profound satisfaction when it does happen.

she just felt more complete as a person (...) so we ended feeling “I don't need to see you anymore, you don't need to see me anymore...that's great!”. And often there's a bit of humour about that (...)...it's a nice feeling...(Maggie: 6.40).

when a good bit of work is done it makes the ending easier for me, because I feel that we have done something (...) it's very rare but it's got the brackets either side and there it is (...) you do the bow on the top and that's it – done! (Jo: 9.15).

The humour and joy in these descriptions of such good endings is notable in the context of the wider interviews, and relates to experiences of relational depth described below.

### **Relational depth.**

Five counsellors describe experiencing a sense of connection to clients during good endings that are characterised by the attunement to individual processes described above. Descriptions echo Mearns and Cooper's (2005) 'relational depth'. These authors define relational depth as “a state of profound contact and engagement” (p.x11). They emphasise the 'two-person' nature of the experience, relational depth transcending the synergy between core conditions to involve the client's responsiveness to this level of relating. Research into the nature of relational depth converges in suggesting that the 'other' is experienced as very genuine at such times (Cooper, 2013). Counsellors in the present study relate their experience of relational depth to clients' engagement; for example:

the warm therapeutic atmosphere you experience with someone who is engaged (Peter: 6: 17)

very fond of her...because I felt her...sort of blossom...and open up...(Maggie: 5.40)

Maggie's use of the phrase "very fond" chimes with research which suggests that counsellors experience feelings of closeness, intimacy and even love at such times (Cooper, 2013). Likewise Knox (2008; 2011) includes the 'atmosphere' referred to by Peter in conceptualising domains involved in experiencing a moment of relational depth. Conversely, where clients are not engaged, or are disingenuous within the relationship, endings are experienced as "surface level" (Jan:7.48 ), "phoney" (Maggie: 9.18) or a "relief" for Jo (9.14), who feels: "Thank god I only work 6 sessions and that's the end - *goodbye!*" (13.56). Meeting at relational depth involves experiencing the core conditions "to a high degree and in mutually-enhancing interaction" (Mearns & Cooper, 2005, p.36). Most participants reflect upon their own genuineness as being integral to experiencing relational depth at ending. Peter and Maggie consciously aspire towards congruence within their relationships:

it's back to congruence; if it's congruent I might (...) just mirror and disclose a little bit about what I'm feeling at the ending, that it's been a special time being with them (...) sharing and the feeling of privilege actually, because it's a very privileged position to be in... (Maggie:12.43)

A feeling of privilege at engaging at this level is described elsewhere in the relational depth research (Cooper, 2005; Macleod, 2009). Like Maggie, Peter communicates a sense of reverence in the experience of such depth of contact. He pauses as he searches for the right words to convey his sense of this intimacy at ending:

you're actually touching upon what it is like to... be alongside someone in the human - in *their* human journey... (8.20)

His correction of the word "the" human journey for "their" human journey suggests his sensitivity to the uniquely personal nature of each journey. All counsellors describe such intimate mutuality during good endings, emphasizing the 'real' relationship at ending. For instance, Jo describes how:

it just kind of felt, less like the, the therapeutic... it kind of felt like two people (10.38)

Jo describes a sense of the therapeutic cloak not being "there" as much, in an interesting parallel with Mearns (1997c) describing that at this level of relating the therapist has done away with 'lace curtains' and 'safety screens' used to defend against the genuine encounter (cited in Mearns & Cooper, 2005, p.38). When the core conditions are met and the client is open to such engagement, counsellors describe the profound contact intrinsic to relational depth. Five counsellors use the word "connection" to describe this contact; for example:

there is a sense of....great satisfaction, of having made a connection with someone...to the point that it touches you personally that you're not going to see them again... (Peter:7:52).

you've made a relational connection. You've meant something (...) you're meaningful to them (Jo:2.60).

I love when you get to that 'higher gear' in the therapy – and you know, you just *know*, it's been...a real, true engagement and a really good connection...(...) It's a lovely...and they move on, and you move on – and it's very emotional. You feel poignant, because you feel a little sad it's not going to continue – sometimes you voice that (Maggie:12.16).

Maggie use of the phrase "higher gear" echoes accounts within the literature that suggests the spiritual, numinous and transpersonal nature of these experiences of relational depth (e.g., Rowan, 2013, p.208). Jan similarly reaches for the right words to describe her experience of such engagement at relational depth: "I felt peaceful" (6.21). Andrew describes the depth of his affect during one such ending: "very joyful for me and terribly moving" (7:25). He relates this depth of contact to his object relations training:

"The time we've spent together can never be taken away from you. Nobody can take it, you, you have this time that we've spent together and you can, can continue...and I will be there in your head." (Andrew: 11:15)

There is strong convergence in the intensity of participants' affect as they describe such moments at ending, again in keeping with Cooper (2013). As opposed to the frustrations,

compromises and loss experiences described elsewhere in the data, participants communicate a sense of reverence and joy at such closeness, 'being with' the client in such states of connection. This is exemplified in Jo's account below:

so it wasn't (...) reaching the goal, it wasn't finishing something but it was this kind of being... Two people being ... (...) I was just there with her as another human being... (...) ... just being with her and...I, I think it was the being...and the connecting that was so important (Jo:10:18).

Jo repeats the word "being" five times in her musing on this ending, highlighting the importance of the relational, even where depth of exploration and 'doing' is curtailed. Peter too is keen to emphasise during his interview that even within short-term work that limits the "developing and deepening of the relationship over time" (10.3), "very powerful connections" remain possible (10.5).

### **Reflexivity**

Despite valuing relational depth very highly in my own practice, I had not anticipated 'relational depth' as a theme and was surprised that the first consistency I noticed during the interviews themselves was descriptions of such moments of "connection" during good endings. I attempted to bracket this observation to remain open to all nuance as I moved through the final interviews. However, through the analytic process my understanding evolved and relational depth appeared particularly relevant to CoP research. Conversely, therapists evaluating therapy at ending in 'was it good work?' is well-documented in the wider literature and was unsurprising. Overall, as in 'attachment and loss', 'the quality of the therapeutic process' remains close to participants' descriptions and the phenomenological within a hermeneutic of empathy; however, I hoped that it may be useful to other readers due to the paucity of extant CPC termination literature and the themes' relevance to CoP.

### **Superordinate theme three: Conflicting frameworks – it would've been cruel**

All of the counsellors describe experiencing conflicting theoretical, systemic and time-related frameworks during certain endings. These conflicts appear to raise questions

about their identities as therapists versus NHS employees; at times, eliciting intense, negative affect ranging from helplessness, frustration and anger, to self-doubt, guilt and ongoing concern about clients. For one, these feelings had endured from an ending eight years previously. Another consequence of these conflicts appears to be counsellors doubting the value of their work at ending.

### **Psychoanalytic termination theory versus time-limited counselling.**

Theoretical constructs provide the terms within which endings may be thought about. However, at times, such constructs also appear to frustrate experience. Although psychoanalytic concepts such as ‘boundaries’ and ‘containment’ are used by all, five question application of psychoanalytic termination theory to CPC, referring to it as ill-fitting clinical experience. Participants describe being uncomfortable about assuming their importance to clients, and suggest that endings may be more significant for therapists than for clients, describing discrepancy between theorised client grief reactions and experience. They question the depth of attachment possible within six sessions - and consequently, the significance endings hold.

if someone comes in and says: “This is been a good experience.... thank you”  
(...) I don't *assume* that they're burying some horrendous agony around  
separating from me after six sessions (*laughs*) (Jan:4.7)

Maggie goes further, suggesting that some clients may be pleased to be ending.

short-term work isn't always (...) such a big deal the ending – in fact they're rather pleased because from their point of view: “I'm okay if I'm ending - and I'm not okay if I'm in treatment!” A lot of people hate being in counselling and I think that has to be honoured and understood... - it's all very well our worrying about saying goodbye, but they think: “That's good, I don't need to come anymore!” (11.22)

A sense of insufficient time threads through accounts. Counsellors describe the sheer volume of endings as resulting in endings experienced as superficial, ‘skimming’ the surface, or ‘paddling through’. This was underscored during the interview process itself



when many participants initially battled to remember any individual endings for discussion.

It's a momentary thing, I have to be, be honest. I can feel quite moved (...) that I'm not going to see them again, but it passes fairly quickly (Andrew:11.47).

I'm aware that I sort of feel that one is meant to say how important endings always are, but (...) I'm not conscious of feeling a lot of grief or distress (Jan:4.26).

Nevertheless, despite this, counsellors appear to experience doubts about their own competence for failing to adhere to psychoanalytic guidelines. Jan's use of the phrase "meant to" highlights conflict between theory and experience. Likewise, Andrew's use of the phrase "I have to be, be honest" is suggestive of a confession. Layla describes endings as an art form, requiring time for process, and struggling to achieve this; and Jo describes 'paddling through' endings, and, consequently, questioning her work:

I think "Did anything really happen? Or was it just a nice chat and that's why it feels okay in the end, or...?" (9.24)

These individual musings have a sense of guilt woven through them. This is exemplified by Jan, who criticises herself for selling her clients short by 'skimming' over endings. Jan occasionally allows for the possibility of post-termination contact, as do Maggie and Jo. However, Jan describes acute awareness of this as conflicting with psychoanalytic theory and consequently experiences internalised critical voices:

saying I'm not able to deal with endings or something like that(...)I should be realising endings are much more significant than I'm making them out to be(...)acknowledging more of the impact (...)I shouldn't leave my boundaries so unblurred(...)I'm avoiding the end (...) I'm feeling a bit rebellious actually...  
(Laughs)... Yes...

I: Yes... (laughs) ... And what is the rebelliousness about, do you think?

R: Umm...What is the rebelliousness about?... (*Sighs*)... Something about rules or...? (...) the word 'pragmatism' comes into mind...umm.... (...)...the psychodynamic voice is getting the better at the moment, it's kind of...you know I feel like it, somehow I'm some kind of... I'm, I'm, my view is immature, or not somehow quite as sophisticated or something but nevertheless. There it is.

As described above, Jan's high standards for her practice are woven through her interview. She describes feeling inadequate in response to internalised critical psychodynamic voices that appear to conflict with her strong commitment to helping her clients within pragmatic constraints. In contrast to her laughter in relation to the description of ending personal therapy, Jan's laughter here is warm and spontaneous. One possible interpretation might be that she sees the humour in a sense of herself as an experienced, respected psychotherapist, as rebellious adolescent in relation to such psychoanalytic discipline. I mirror Jan's laughter, concerned not to appear judgmental, but also on some level identifying with these difficulties with termination theory in time-limited working. Jan's phrase: "I shouldn't be leaving my boundaries so unblurred", ironically possibly indicates a 'Freudian slip' in that she regards these 'blurred' boundaries as appropriate for the setting. Finally, her sigh suggests a weariness of such rules. Her determination to adhere to pragmatism is underlined by the finality of her conclusion: "There it is."

### **Ethical frameworks versus endings.**

Beauchamp and Childress's (2001) 'Four Principles' framework underpins CoP ethics (Shillette-Clark, 2003). This describes principles of beneficence, non-maleficence, autonomy and justice. Counsellors describe the majority of their clients as presenting with complex difficulties unsuited to the timeframe. However, for five participants, endings where clients are perceived to be vulnerable result in intense affect, suggesting violation of core values and principles, notably beneficence and non-maleficence. All participants situate endings within clients' wider lives and ethical conflicts appear heightened where clients have historically experienced rejection and abandonments, or lack post-termination material, emotional and social resources. Andrew and Maggie describe

such endings as potentially harmful, implying violation of the principle of non-maleficence:

too anxious and too alone really to be left (...) The only person he speaks to all week is me; ending will be a huge loss (...) I find that hard because he's so, so vulnerable (Andrew:1.36)

(she was) really distraught and I thought (...) I can't, I can't just end...I *can't* just end (Maggie:4.26)

Maggie's repetition of the words "I can't" suggests the intensity of the conflict this sets up for her. Likewise, Andrew's repetition of "so" in relation to his client's vulnerability. Counsellors additionally experience certain endings as inhibiting client development, implying violation of the principle of beneficence, again articulated by Andrew:

there are still issues that really need to be addressed and they're very actively in therapy and then... it's very hard sometimes to know then that you've got to really stop them opening any more up, and say "we don't have time to deal with that"(1.28)

Counsellors describe understanding systemic constraints as reflecting limited NHS resources, implicitly acknowledging the principle of 'justice' in fairness to other clients' needs, alongside non-maleficence and beneficence. Nevertheless, they experience intensely negative affect ending where they perceive clients to be vulnerable, experiencing these endings as abandoning, rejecting, letting clients down, or "cruel" (Maggie: 3.18). Andrew describes being "left in this space" (7:54):

I felt guilty, I promised him that it would be okay (...) I was left with this kind of sense of betrayal (Andrew: 5.45).

Layla, who, like Andrew, seeks to protect her clients as far as possible, and whose own experiences of difficult endings have left her invested in offering good endings, too

experiences guilt at letting clients down; the intensity of the conflict this sets up for her captured in her repetition of “feeling” below:

Feeling, *feeling* for her. Feeling that I let her down. *Feeling* I am, feeling I am another person who *abandons* her with her own world (4:33).

### **Autonomy versus omnipresent system.**

Five counsellors describe a sense of the wider system impinging upon their experience of endings, confronting them with discrepancy between clients’ needs and systemic constraints. Closely related concern for clients’ wellbeing is anger at the system which places them in this position. Layla challenges this: “Why? Why shouldn’t they have a bit more...? She describes feeling “Angry with the system. *Why* it has to be that way?” (4.50). She compares client endings with ending personal therapy, describing this as her ‘own’ because she paid privately, whereas CPC endings ‘belong’ to the system:

I had a choice (...) Will my client have that choice? No (...) Because it was my own therapy. It was my own payment (...) neither me nor my clients have a choice (10.32).

Experiencing a lack of choice and control is woven through this theme, resulting in helplessness, anger and frustration. Counsellors imply conflict between their identities as autonomous therapists and employees within the system. Andrew describes a client’s anxiety being mishandled by another team:

it was going to be a good ending (...) and they handled his fear really badly (...) he disappeared and I don't know what happened (...) Endings where it hasn't worked out how you'd hoped, and it's outside your control, are very difficult (5.19)

The strength of Andrew’s feelings in relation to the system appear closely related to the intensity of ethical conflicts he experiences, described above. He describes battling to keep his idealism under control: “the idealistic part of me which I try - I *have to try* -

to keep under control...”(8.4). His emphasis on “*have to*” evokes his sense of lacking autonomy. He describes intense frustration:

I let him down, and that's outside my control that that happened (...) I've not been allowed to do my *job* (7.50).

Jo similarly experiences intense frustration, experiencing systemic constraints at ending as preventing her from giving more to clients:

the frustration of working with people and spending time just trying to signpost them elsewhere.. I feel like I've had all this training and I have so much to *give* - as a human being as well as a therapist as well as a psychologist as well as all these different things; I feel like I have so much to *give* - and then reaching a point with somebody where I'm passing them on (Jo:3.36).

For five counsellors, including Jo and Andrew, systemically-determined endings preventing progress results in questioning the value of their work:

I question myself a lot....You know, what is it we're doing? Is it just a load of old rubbish...? You know, what *are* we doing? Does it help at all? Because so many endings are kind of like – it's not quite *there* - it doesn't quite get to where the patient wanted to get to (Jo:9.27).

You have no sense of, of anyone, getting any better; all you have is... 'Aaargh' (...) It can be a bit 'day tripping in hell' (...) that they don't always get better... (...) that can be hard to manage (Andrew:3.16).

Counsellors additionally experience conflict between professional autonomy and the system in relation to administrative demands, psychometrics and IAPTUS, IAPT's electronic database, which monitors performance. Four describe systemic pressures intruding upon time for reflection and an increasing sense of urgency at ending:

it's very tight (...) that tightness is an anxiety between both of you...the ending is here, the ending is here, the ending is here... (Layla:13.44).

I constantly feel rushed (...) I'd like to have much more time to reflect and ground myself, focused on the quality of the work rather than filling in forms (Jan:5.25).

Counsellors describe feeling judged on psychometric scores at ending. Andrew further challenges the system in challenging psychometric scores' validity: "they just give the powers-that-be numbers... as a true representation, they're rubbish" (10.2). Maggie too describes feeling judged by the system; her own experience of endings significantly affected by data-categorisation. She experiences the system as omnipresent:

you're very much observed because you're working on this remote, remote system and they can see.. (3.30).

However, unlike Andrew who challenges these categories and expresses anger towards the system, Maggie communicates a sense of passive unease about being watched by 'them' through her use of the phrases "very much observed", repetition of "remote" and "they".

### **Reflexivity**

The concept of 'frames' possibly afforded 'conflicting frameworks' greater interpretative power than preceding themes. It chimes with my own exploration of different frameworks between placements, as well as experiences of ethical dilemmas ending with vulnerable secondary care clients, so I worked hard to bracket my own assumptions throughout my engagement with this data. The intensity of participant affect in relation to these conflicting frames reassured me as to its validity. Triangulating this finding also resulted in greater confidence. Elaine was enthusiastic, recommending frame theory to other researchers. At the time of analysis, I had no experience of IAPT, so 'omnipresent system' emerging from accounts was a revelation.

#### **Superordinate theme four: Towards congruence – walking alongside for a bit**

‘Conflicting frames’ describes theoretical, ethical and systemic dissonance experienced at ending by counsellors who describe time-limits as insufficient for most of their clients. Despite these conflicts, however, five counsellors describe the vast majority of endings as unproblematic; for example: “I’d say sixty - maybe seventy - percent of the time it's not a problem” (Maggie: 2.30). This suggests processes mediating to reduce dissonance, especially given the importance counsellors place on genuineness within the relationship. ‘Congruence’ is defined by the Oxford English Dictionary as: “the psychological state of being congruent”, “in accord”, or “coinciding exactly when an external structure is superimposed” (1982, p.198). The ‘congruence’ of this title is an attempt to capture something of a psychological state more at ease ending within this setting, while referencing the person-centred values alluded to by counsellors throughout. Therapists describe cognitive, affective and behavioural coping strategies in adjusting to super-imposed frames. These include using metaphors to re-conceptualise endings, emotional distancing and practice-based strategies designed to adjust the therapeutic process to the frame and the frame to the therapeutic process, to maintain varying degrees of internal consistency and congruence. ‘Congruence’ in the Rogerian sense may be defined as outward responses to clients consistently matching therapists’ inner experiencing (Mearns & Thorne, 2007). When practice-based strategies at ending have been adjusted to ‘fit’ the superimposed frame, and therapists have evolved a personal philosophy within which to conceptualise endings within this framework, they describe greater congruence. Jo’s phrase ‘walking alongside for a bit’ may capture some of the ‘being with’ quality of these more congruent endings.

#### **Adjusting the frame.**

The therapeutic frame is a psychodynamic concept, involving boundaries of time, place and confidentiality (Langs, 1976). However, the current study suggests that counsellors adjust ending processes to the wider primary care frame and this primary care frame to clients’ processes, to maintain varying degrees of congruence within the setting. This appears to be achieved through onward referral, balancing securely holding to the frame by ending from the beginning, and tailoring the frame to individual needs.

Woven through accounts is an awareness of clients' post-termination resources; consequently, counsellors adjust the frame to include onward referrals. Five are explicit about experiencing these as ameliorating a sense of abandoning clients. Referrals appear particularly important for Layla and Andrew who describe intense ethical and systemic conflicts, and communicate a strong sense of ongoing responsibility for their clients' care:

it's very important for me to not leave him with feeling... you know, I'm just leaving, just saying: "That's it - bye..." (Andrew: 1.54).

working on your feet to find a safe place for her (...) where maybe...always the sun shines... (Layla:3.3).

The strength of Layla's wish for her clients to be well-cared for post-termination is evoked in the phrase 'always the sun shines'. Layla's homeland is renowned for sunshine; this image may communicate a wish for vulnerable clients to be offered a home. An alternative interpretation might be wishing this for herself. Layla experiences successful referrals as reducing guilt through offering opportunity for a "good carry-on piece of work" (6.19); however, where clients are not willing to accept referrals, she describes: "Banging your head... You need help and they're not accepting" (6:6). One possible interpretation of this confusion of personal pronouns could be that Layla's identification with clients and investment in their wellbeing is towards healing her own traumatic experiences. Conversely, Jan and Peter describe offering clients information regarding further therapy, rather than assuming responsibility for this, in keeping with their perceptions of clients as autonomous adults. Jo, who reflects upon her avoidance at ending, experiences referrals as "closing the connection" (13.34). These divergent experiences suggest the possibility that therapists' 'self-experiencing' interacts with their manner of referral.

Counsellors also appear to experience the manner in which therapy began during endings. Consequently, the frame is adjusted to include working towards ending from the beginning, through clarity regarding contracts and therapeutic focus:

you haven't opened up as many strands, there aren't as many loose ends... You know there isn't that sense that "there's all this other stuff..." - I mean you know



very well that there *is* all this other stuff and, and you, you know that, umm, but ahhh...that's all you can do (Andrew: 10.20)

Psychodynamically-trained Andrew and Layla describe repeatedly reminding themselves of the timeframe:

I keep in mind, I'm offering a brief therapy... (...) I have to be grounded to that every moment... it keeps the framework...it keeps it, it keeps it in mind (Layla:7.1)

Layla's repetition of "keep" evokes holding onto this structure. "Grounded" is a reminder of how endings may be experienced as traumatic; however, here working towards ending from the beginning appears to function as an anchor.

Four counsellors describe adjusting the frame to individual needs over rigid adherence to termination theory, learning to trust their sensitivity to individuals:

I just pushed all the books out the window (Jo: 10.24)

It didn't go well from the conventional model of how therapy should end but (...) I'm ok with how it ended (...) because I was trying to go with the client's experience (Peter: 6.6).

They describe ameliorating tensions between conflicting frameworks through expanding the timeframe to accommodate client needs where appropriate, describing rigidity as un-therapeutic in certain circumstances.

I said: "Well, given what's happened, we could have one or two more sessions...just to give you time..." (Maggie: 4.26)

Maggie, Jo and Andrew describe such flexibility as facilitating optimal endings, despite Andrew and Maggie's awareness that these expansions of the frame will be noticed by IAPTUS. Additionally, four counsellors expand the frame at ending where appropriate to include post-termination contact; for example, Jo offers to remain available to one vulnerable client.

I said “You can phone at any time; it doesn't matter that we're not seeing each other...I'm here to support you...” (9.14).

Jan similarly invites clients to contact her post-termination if they require information about alternative support. Like Layla, she reflects that this protects against feeling she is abandoning clients; however, as described above, she both criticises herself and elects to rebel against psychoanalytic voices in service of clients' needs. Maggie similarly expresses a sense of rebellion around post-termination contact, concluding however, that congruence and doing “the right thing” are more important:

I don't think a lot of people in the service would do that. Then what they would do...? I don't really care! I know in my heart of hearts that was the right thing to do (...) if (...) I'm not congruent, I won't do it (6.32).

Counsellors describe experiencing the ‘real’, person-to-person (Gelso, 2009) relationship at ending. Maggie considers: “the therapy is ended - I'm very clear about that, but the relationship...?”(7.51). Counsellors stress its egalitarian nature; for instance: “we're two equals” (Jan: 6.53), and “still two humans” (Jo: 4.28). It may be that such relationships are another way in which the frame is adjusted. For instance, Andrew describes a client bringing her infant into the surgery to meet him post-termination suggesting the idiosyncratic nature of CPC boundaries (House, 1999). Peter and Maggie describe experiencing person-centred trainings as supporting straddling professional boundaries and personal congruence within these person-to-person relationships.

### **Detaching and accepting.**

Counsellors additionally describe arriving at acceptance and, in some cases, detaching in order to lessen tensions at ending. Peter describes deliberately cultivating such acceptance:

what I've tried to do over the years, as a way of managing one's own emotional stress when you're working with very distressed people, is to try and cultivate a kind of mindful attitude...a mindfulness in the work, which is an acceptance,

sometimes a very radical acceptance...of where somebody is...as a way of trying to manage...the tendency at times to be over-affected (8.47).

The confusion of personal pronouns above possibly suggests Peter's own struggle in adjusting to such acceptance working with high levels of client distress, and the development of an internal supervisory voice (Casement, 1985) protecting him through a more detached perspective. He relates this to a clear personal philosophy:

philosophically, I have a very clear view about what therapy can and cannot do...Ultimately I believe it's a universal human truth that the only person we can change is ourselves (...) which I believe most people are quite capable of doing given the right emotional atmosphere so...because of that view, endings now seem more (*laughs*) straightforward... rather than one's own personal ego and investment...(*laughs*) being in there too much...rather, recognising that, from the beginning, it's not really the therapy or even the therapeutic relationship, that will ultimately change that person.. It's them - it's what they can do for themselves (4.29).

Peter's perspective likely relates to his own positive experience of personal therapy, where he concluded at termination that ultimately responsibility for change lay with himself. Peter was relatively reserved about personal experiences; however, his laughter here is interesting. Throughout the interview, he was keen to emphasise that he now experiences endings as "straightforward". Thus, one potential interpretation of his laughter is that it relates to embarrassment acknowledging his own former investments in endings. This is supported by the way laughter punctuates other references in the interview to his own or clients' "issues" or "unconscious aspects". However, it may equally have been that, in parallel process, he is being interviewed by myself, an earnest trainee, who, by the very nature of the research question, communicates that she does not necessarily regard endings as straightforward.

For Peter, former tensions are ameliorated through re-appraising therapist responsibility by recognising that, ultimately, change lies with the client:

the ending is, you know, part of that process of recognising what belongs to me, what belongs to them, and where, if you like, the power lies ultimately...(4.48)

The word choice and rhythm inherent in: “what belongs to me, what belongs to them” vividly evokes separation of ownership. The separation out of what the therapist is responsible for in relation to what the client is responsible for, appears to help Peter in detaching from being too invested in endings. He underscores this by describing his belief that “It's what they're doing outside of the therapy that's most important”. Both Peter and Jo use the phrase ‘50 minutes’ to contextualise therapy ending within the broader contexts of clients’ lives. However, even Layla and Andrew, whose accounts suggest assuming high levels of responsibility for protecting clients’ care, and consequently intense theoretical, ethical and systemic conflicts, describe increasing levels of acceptance:

you did your best. You did whatever you could do (Layla: 5.19).

Layla’s use of the pronoun “you” above suggests that she too is learning to internalise a supervisory voice to support soothing the conflicts she experiences at ending. Conversely, reflecting his idealism, Andrew leans towards the principal of justice here to help “counteract” the conflicts that he experiences.

one of the things I try to counteract that is, I think: “Well, they've had six sessions (...) at least they've had *something*” (Andrew:8.7)

Andrew, Jan and Jo also reflect that briefer timeframes and large caseloads in themselves encourage detachment:

You don’t get so attached. You can hold it a bit more ‘*out there*’ (Andrew:2.21 )

Jan describes experiencing so many endings that she is “numbed” to them (4.11). While reflecting on the nature of personal material drawing her to short-term work which also encourages “skimming” over endings, she simultaneously describes such detachment as self-preservation: “otherwise I'd be on the floor by now” (Jan:4.35). Jo similarly relates detachment simultaneously to both her avoidance, and to working within a system which encourages detachment:

I can be there in the moment and then afterwards I kind of 'click' (...) close the file..."that's it, done" (...) I'm not carrying it anymore and I get the next patient booked in (...) a high caseload maintains my defence strategy (...) I paddle through quite quickly (6.52).

Like Jan above, Jo is adamant about detachment as self-preservation:

you've *got* to - because if you've got 25 clients in a week (...) if you can't detach from that that would...(pause) sap your *life* energies (Jo:13.41).

Jo pauses here as she searches for the right phrase to communicate the consequences of failing to detach within the setting: "life energies" suggests that consequences might include burnout or, in an extreme interpretation, even death.

### **Metaphors of ending – journeying.**

Throughout, participants use metaphors to convey their experiences of endings. Four describe ending as pausing, experiencing the possibility of episodic return within primary care as containing anxieties at ending. Maggie describes this as engendering a sense of "not *really* ending":

So, what is an ending? It could be a pause. In my mind it's a proper pause, if not an end - you don't know if it's going to be a pause or not - it *is* an end. But we all say: "You can re-apply in six months' time", a lot of people say that. So they're not *really* ending. I think that's a very important contextual factor built into the system - I think most of us have trouble with ending, to a greater or lesser extent, so we probably use that...(Maggie:8.16).

Jo likewise experiences this as helpful to counsellors and clients:

"a way of managing mine and the patient's anxiety around ending... (...) it does act as a way of...managing and containing it - the context (13.1).

Participants describe the possibility of return as supporting ongoing development within a safe setting. For instance, Jo embraces episodic return as allowing for developing “layers” upon previous therapies (9.10), and, reflecting his object relations training, Andrew experiences this as supporting clients internalising him:

you can say to patients “I’m not going anywhere, if you do need to see me in the future, you can do” (...) as a way for them to hold me in their head (Andrew:6:24)

Maggie too embraces ending-as-pausing, relating it to a personal philosophy which supports ending in a state of personal congruence:

I think we need work and reflection, or pause - and possibly end. I think that's important, I just think that's a good rhythm of life, to have – in whatever you're doing (1.60).

Such a “rhythm of life” appears to relate to counsellors conceptualising endings within the context of clients’ life journeys. Journeying metaphors weave through counsellors’ narratives. Counselling itself is conceptualised as a journey, and, where concern about clients is ongoing, journeying metaphors appear to aid counsellors through reducing dissonance by contextualising ending within broader perspectives on clients’ lives. For example, Peter describes how ending “touches upon what it is like to be alongside someone in their human journey” (8.23), and Layla describes wishing to take her clients “onboard” (10.54). Maggie describes the counselling journey running parallel to the client’s life journey:

I didn't want to let go of this journey because the ending point in her life journey kept extending (2.45).

Jo vividly describes experiencing a moment of adjustment to working in primary care where she re-appraises ending as part of the client’s ongoing journey, rather than arrival at a destination in goal-attainment. She describes a moment of insight into her former urgency:

the urgency was wanting to ‘get to a place’, rather than recognising therapy as part of the journey, that he would then continue alone (4.46).

This moment possibly offers an example of the adjustment to values and goals in cognitive coping strategies described by Folkman and Lazarus (1984). Jo describes relinquishing goal-attainment as helpful. In relation to another ending, she describes accepting the value of just ‘being with’ a client at ending, accepting that, despite much unexplored territory, the client had had “somebody walking alongside her for a bit” (10.29). Extending the metaphor still further, counsellors describe referrals and community linking as ‘signposting’. Therapy endings are experienced as beginnings of new, sometimes exciting, journeys for clients. The next stages of clients’ journeys influence how counsellors experience ending the counselling journey, and appear closely related to post-termination resources. Journeying metaphors capture the shared therapeutic enterprise as a shared client and therapist journey within clients’ lives. However, there is another journey in parallel: therapists’ learning about ending within the setting through experience, and ongoing personal development, fuelled by reflective professional development through client encounters. In this way, this final theme links back to the first theme of ‘self-experiencing’.

### **Reflexivity**

Having interpreted the possibility of a relationship between frames, congruence, and coping strategies, in many ways the super-ordinate theme of ‘towards congruence’ wrote itself. Prioritising clients’ needs in ‘adjusting the frame’ chimed with my own experience, but, overall, ‘towards congruence’ involved new understandings. However, that these were new understandings means that I may not fully have facilitated exploration of their meaning during interviews, my own limitations circumscribing the available data. For instance, when it came to the analysis, I regretted failing to explore Peter’s experiences of “mindfulness in the work” and “radical acceptance” further.

Throughout the analytic process, I was aware that my inexperience with IPA meant that I occasionally found it easier to empathise with my participants, grounding myself in the terms of their descriptions, lacking the confidence to use a more questioning hermeneutic to interpret themes to higher levels. I used triangulation, supervision and personal therapy to support reflective practice relating to interpretation,

bracketing and re-bracketing as I moved around the hermeneutic circle. Beginning, my assumptions included that caring practitioners would experience endings with the same intensity as I have done. Concluding the analysis, I experienced far deeper appreciation and understanding of the complexity of endings within the setting, and the importance of coping strategies in managing the tensions implicit in the range of conflicting frames towards maintaining personal and professional congruence.



## CHAPTER FOUR: DISCUSSION

### Overview

This study sought to explore counsellors' experiences of endings in primary care. Pseudonyms are used throughout to protect participants' anonymity. The rationale for this investigation was that there appears to be a lack of research into therapists' experiences of endings within this rapidly-expanding area of practice, despite wider research suggesting that the dynamic interaction between therapist and client during the ending has consequences for maintenance of treatment gains. The discussion will consider what the findings add to extant termination literature, as well as what may be unique to endings within this setting. Possible implications for therapeutic practice, training, service provision and CoP will then be outlined. Limitations of the study and any conclusions which may be drawn from it will be detailed prior to suggestions for potential avenues for future research, and the researcher's final conclusions.

### Summary of findings and their relation to extant research

Wide-ranging variety in participants' responses supports the multiplicity of variables described in existing literature. Most therapists experience sadness ending the relationship in longer-term therapy (Fortune, 1987; Fragkiadaki & Strauss, 2012; Viorst, 1982). Within the current study, where relationships are engaged, counsellors experience some loss in keeping with wider research. However, all participants were keen to emphasise that time-limited relationships lack the depth of attachment that develops in open-ended timeframes, and none described the intensity of loss associated with longer-term therapy.

Therapists experience their own personal processes; however, these interact with clients' responses to ending. Where clients have progressed and a connection has been made, therapists experience endings positively; where clients are perceived to be in need of further support, endings are more challenging. Counsellors experience conflicting theoretical, ethical and systemic timeframes, and the ways in which they have adjusted to these within the setting. The results of this analysis suggests that, overall, termination research conducted in longer-term therapy remains relevant, reflected in 'self-experiencing' and 'the quality of the therapeutic process'. The influence of the primary

care setting itself is apparent in ‘conflicting frameworks’ and ‘towards congruence’, potentially offering an original contribution to the literature.

### **Self-experiencing**

This superordinate theme is resonant of CoP literature on the centrality of the therapist’s ‘self’ and how this is implicated in counsellors’ experiences of endings. It involves attachment and loss experiences, and bi-directional personal and professional development. It chimes strongly with Fragkiadaki and Strauss’s (2012) ‘therapist as a person’, which is described as involving personal history, particularly loss history; training; attitudes and assumptions; and termination of personal therapies. However, Epstein (1973) suggests that the self develops with experience, and these findings possibly reflect a more mutable quality within the data in practitioners’ sense of their ‘selves’ in flux, as they reflect on and in action (Schon, 1983), along personal and professional developmental trajectories.

Extant termination literature suggests the presence of therapists’ personal loss histories in their experiences of professional endings (e.g., Boyer & Hoffman, 1993). The current findings echo such research, suggesting that this remains relevant even within brief frameworks. Also in keeping with extant research is that the extent to which therapists’ losses have been resolved appears crucial: participants who describe having worked through losses are eloquent about feeling able to remain emotionally available to clients through the ending process, in contrast to participants who describe continuing to either process or avoid affect related to unresolved personal losses. Additionally, formative attachment experiences are entwined in accounts of loss. Although in the absence of formal assessment these findings must remain tentative, accounts suggest that these possibly mediate experiences of endings through different affect-regulation styles. This chimes with wider research (e.g., Mikulincer, Shaver & Pereg, 2003) which suggests that individuals who report high levels of attachment anxiety employ hyper-activating affect-regulation strategies, seeking to minimise interpersonal distance and failing to detach from emotional pain; conversely, those who report attachment avoidance maximize distance, and avoid interdependence and emotional pain through de-activating affect. Many practitioners have suffered early losses and abandonments with varying degrees of resolution (Slade, 1999); however, there is no extant research into therapist attachment style and therapy endings, despite theoretical suggestions that these uniquely

determine the form endings take (Holmes, 1997, 2010; Shilkret, 2005). These findings additionally chime with contemporary bereavement research where attachment style has been found to powerfully mediate the influence of loss history and coping (Stroebe, Schut & Stroebe, 2005). Holmes describes the importance of therapists understanding their own attachment styles in order to abstract these from co-constructed client-therapist experience (2010, p.70). Such self-reflexivity may partially be constructed on the basis of a successful personal therapy (Rizq & Target, 2010).

Previous research suggests that personal and professional development are closely related, and that personal growth stimulated by therapy enhances professional practice (e.g., Bellows, 2007; Geller, Norcross, & Orlinsky, 2005; Rake & Paley, 2009). Bellows found that the highest level of influence by personal therapy was reported by those who experienced the most benefit. This was borne out with regards to termination practice in the current study. Counsellors describe emulating personal therapists, and certain accounts additionally chime with research suggesting that personal therapy engenders greater capacity for distinguishing between clients' and personal issues, and therefore more accurate empathy for clients' experiences at ending (Rizq & Target, 2010).

Viorst (1982) found that personal material may be resolved through a patient's termination phase. Although the reparative potential of reflective termination practice has received scant subsequent empirical attention, participants in the current study allude to reflective practice as offering opportunities for resolution of material related to loss and interpersonal anxieties and avoidance. For instance, one counsellor reflects upon increasingly being able to differentiate between her own avoidance and her clients' needs for closeness at ending, and developing to dare to allow herself to mean more to others within the safety of professional boundaries. Another describes working through, "facing" the feelings multiple CPC endings evoke in her, in personal therapy, supervision and reflective practice, resulting in these feelings becoming increasingly "settled".

However, while counsellors who experience the most benefit from therapy report the greatest influence on their practice, counsellors who describe the least benefit, report little influence, dedicating final sessions to focusing on therapeutic outcome over ending the counselling relationship. It is possible that these counsellors are attempting to ensure that their clients receive the outcomes that they themselves feel they failed to receive from therapy (*cf* the 'wounded healer' literature, Samuels, 1986). Therefore, a convergence in the present data is therapists seeking to offer their own clients what they

themselves historically needed: for Maggie and Jan a focus on therapeutic outcome, and for Layla a chance to remain with the ending and to say goodbye. This highlights the importance of therapist reflection in order that such influence may be used in service of clients' needs (Rizq & Target, 2010). Given the potential potency of personal therapy as a professional model, this theme additionally suggests the potential utility of therapists practising within brief timeframes themselves experiencing brief therapies (and associated endings) to support continuing professional development.

### **The quality of the therapeutic process – connecting**

Consistent with extant research (e.g., Baum, 2007; Fragkiadaki & Strauss, 2012; Viorst, 1982), counsellors in the present study experience endings as inseparable from preceding processes. If the first super-ordinate theme involves counsellors' self-experiencing, this theme incorporates responding to clients' experiencing. However, it additionally comprises counsellors evaluating the quality of their work at ending, in keeping with a particularly robust finding in the extant termination literature concerning the centrality of outcome to therapists' experiences (Baum, 2007; Eagle, 2005; Fortune et al., 1992; Quintana & Holohan, 1992). IPA afforded more nuance than quantitative methodologies have previously allowed. Counsellors appeared to evaluate therapy according to its perceived helpfulness to clients, its depth, and a sense of completion. Positive affect, self-worth and professional satisfaction appear closely related to these outcomes.

In the present study, descriptions of therapeutic process during 'good endings' are powerfully resonant of Mearns and Coopers' descriptions of 'relational depth' (2005). Relational depth is defined as a "state of profound contact and engagement between two people" (p.xii). Mearns and Cooper use the term to refer both to the quality of the therapeutic relationship overall and to heightened moments of contact within it. These moments of contact are likened to Stern's (2004) 'moments of meeting'. Nevertheless, Knox, Wiggins, Murphy and Cooper (2013) suggest that there is a need to distinguish between these two aspects of relational depth. However, although to date most research has concentrated on moments of encounter, these authors suggest that such moments are more likely where relationship is a focus of therapy and deeply engaged.

Mearns and Cooper posit that the process of the client "being real in relation to a therapist being real is the crux of the healing process" involved in relational depth (2005,

p.9). Counsellors in the present study likewise describe such moments of ‘realness’; for example: “it felt like ‘two people’” (Jo, 10.38). In this way, ‘relational depth’ links to the real person-to-person relationship in ‘adjusting the frame’. However, such moments of “in-depth connection” appear to go beyond the person-to-person relationship in involving high levels of congruence, acceptance and empathy towards counsellors’ selves as well as towards the client: the therapist bringing herself fully into the mutual encounter as a genuine human being, similar to the genuineness described by Greenson (1967) and Gelso (2009). The counsellor’s part in creating relational depth is to extend the core conditions to such a high degree that each interacts synergistically to enhance the other; however, relational depth also involves the client’s responsiveness to this level of relating (Mearns & Thorne, 2007). Murphy (2013) proposes that such mutuality is the core process involved in ‘relational depth’. Interestingly, Fragkiadaki and Strauss (2012) too found that ‘proper endings’ of long-term psychodynamic psychotherapy, were characterised by a sense of mutuality.

In his review of recent research into relational depth, Cooper (2013) concludes that therapists experience relational depth as arising spontaneously, while clients see themselves in control of the level of relating. Cooper suggests that, although counsellors cannot create relational depth without the client’s responsiveness to it, they can nevertheless prepare themselves for engaging at this level of connection should it be what the client is open to. In this way, ‘relational depth’ links to ‘bi-directional personal and professional development’; counsellors’ personal and professional developmental journeys engendering capacity to relate at such depth.

However, extending the core conditions requires of the counsellor that he or she is able to be fully congruent within herself at ending. Intrinsic to this is the therapists’ congruence with ending within the setting - despite the multiple tensions described in ‘conflicting frameworks’. Thus ‘relational depth’ also links to ‘towards congruence’.

Mearns and Cooper describe moments of relational depth as typically accompanied by feelings of satisfaction: 'something far more, kind of, satisfying about that than, kind of working at a ... "doggy paddle" kind of depth'. There are strong echoes of this in the current study. Counsellors describe experiencing connection, honesty, positive affect, professional identity and profound satisfaction at such moments; ending in a state of relational depth experienced as optimal practice. Mearns and Cooper note similarities with Csikszentmihalyi’s state of ‘flow’ (2002), involving ‘optimal experiencing’, satisfaction, pleasure, changes in perception of time, heightened

awareness, and complete unself-conscious immersion. They compare their participants' experiences to those of Geller and Greenberg (2002), who likewise describe absorption, timelessness and a strong feeling of 'being with' clients. Again, these descriptors are paralleled in the current study where descriptors include: "peaceful", "entering into that higher gear", and: "just being with her...it was the being...and the connecting that was so important". Mearns and Cooper suggested in 2005 that such similarities indicate a distinctive therapeutic occurrence, worthy of further empirical exploration. Research since suggests that relational depth remains a phenomenon across multiple orientations (e.g., Leung, 2008, cited in Cooper, 2013). The current study potentially contributes to this research supporting the existence of such occurrence; counsellors using strikingly similar descriptors to those noted in other studies of relational depth. However, the current study suggests moreover that such experiencing may remain 'an empirical phenomenon' across timeframes. To return to Knox et al.'s (2013) suggestion that moments of relational depth are most likely where the relationship is deeply engaged and the focus of therapy, the current findings suggest that, even where brief working limits relational depth as a quality of deep attachments and enduring therapeutic relationships, profound 'moments' of relational depth nevertheless remain possible, are experienced very positively by practitioners of multiple orientations, and are important to their experience of endings within the setting. Mearns and Cooper too emphasise that these moments are profoundly rewarding, sustaining involvement with even the most difficult of clients (2005, p.50). It is possible that in the face of multiple other demands and tensions, experiencing such relational depth during endings in primary care may be prophylactic against cynicism and burnout.

### **Conflicting frames – It would've been cruel...**

All of the counsellors describe experiencing conflicting theoretical, ethical and systemic frameworks during certain endings within the setting. At times, such conflicts evoke intense affect ranging from helplessness, frustration and anger, to self-doubt, guilt, and ongoing concern about clients.

Within the present study, particularly when viewed from the perspective of certain theoretical positions, such as that assumed by classical psychoanalytical termination theory, extant models of endings are described as ill-fitting the setting. Originally a psychodynamic concept, the notion of the therapeutic 'frame' (Lang, 1976) is

accepted as fundamental across multiple modalities, involving the basic contractual and interpersonal conditions between therapist and client (Spinelli, 1994). The security of a consistent, predictable frame serves to contain anxiety (Gray, 1994), offering a ‘secure base’ (Holmes, 2001) that facilitates exploration of personal material. For instance, D.L. Smith (1991) describes therapists setting the date for termination as a violation of the security of such a therapeutic frame. Psychoanalytic termination theory evolved within such a framework, where clients mourn their therapists prior to internalising them, while practitioners maintain their professional anonymity and abstinence. Termination is final, involving cessation of contact. Counsellors are keen to emphasise discrepancy between such termination theory and clinical experience within the CPC frame; for example, questioning the depth of attachment possible over six sessions and consequently, the significance of endings. This appears to relate to wider debates about the psychoanalytic termination model (Novick, 1997; Quintana, 1993, Wachtel, 2002). Wachtel describes violating termination ‘rules’ as only a problem if one assumes that they are inviolable to begin with. Nevertheless, three counsellors experience doubt about professional competency when not adhering to these rules, expressing varying levels of apology, guilt, dismissal, rebellion and conflict. From a theoretical perspective, Frank (2009) notes that, despite recognising the value of contemporary ideas in theory, many psychoanalytically and psychodynamically-trained practitioners struggle to free themselves from the classical model’s ideals in practice. The present study raises the question of whether, particularly in the case of vulnerable clients, existing termination theory is of sufficient use to clinicians.

Source of termination has implications for therapists’ experiencing; in general, the more choice and control therapists have over endings, the more positive their experience (Baum, 2007). This study potentially contributes nuance to such quantitative research and its relevance to IAPT. Certain endings appear to confront participants with discrepancy between clients’ needs and systemic constraints, resulting in ethical dilemmas, and conflicts between their identities as professional therapists and employees. Beauchamp and Childress’s (2001) ‘Four Principles’ model underpins CoP ethical frameworks, describing ‘autonomy’, ‘beneficence’, ‘non-maleficence’ and ‘justice’. Counsellors draw upon the principle of ‘justice’ in reflecting upon the reality of limited resources. Nevertheless, some experience intense conflict with ‘the system’, anger at their lack of control, and negative affect where they perceive clients to have been harmed by

endings dictated by systemic constraints that violate principles of non-maleficence and beneficence.

Extant termination literature describes heightened therapist anxiety ending where clients have significant loss histories (Boyer & Hoffman, 1993). However, where clients are perceived to be vulnerable in the current study, affective responses include: anger, frustration, concern, sadness and guilt due to experiencing themselves as betraying and abandoning clients. This range of affect more closely resembles that described within the 'forced termination' literature (Baum, 2008; Zuckerman & Mitchell, 2004). Consistent with such literature, negative affect increases with perceived client vulnerability. Interestingly, research on primary care counsellors' experiences of working with clients potentially meeting criteria for Borderline Personality Disorder (BPD) overlaps with this theme. Rizq (2012a) found participants experienced ethical dilemmas and intense guilt about the brevity of the work where clients were experienced as needing more therapy.

Counsellors also experience high levels of frustration when they experience endings as preventing the beneficent therapeutic practice that they are trained for, in their identities as professional therapists versus employees. Whereas good outcome lends meaning, resulting in positive affect and increased engagement in keeping with the wider literature (e.g., Quintana & Holohan, 1992), counsellors question the value of work perceived as unfinished, echoing theoretical suggestions that time-limits amplify self-doubt (Noy-Sharav, 1998).

Rizq (2012b) suggests that IAPT services have resulted in a 'perversion of care', turning a blind eye to suffering in focusing on targets and outcomes. The emphasis on targets means that therapists are regularly evaluated according to outcomes, increasing demands and additionally potentially increasing vulnerability to burnout. Counsellors in the present study describe experiencing these systemic pressures as omnipresent at ending, intruding upon time needed for reflection and process, and heightening anxiety about evaluations of their client data at ending.

In summary, this theme suggests counsellors experience conflicting theoretical, ethical and systemic frameworks with certain clients and the need for a new model of endings within the framework. As pressures on NHS services increase, and funding cuts elsewhere mean vulnerable clients are increasingly seen in CPC (e.g., Saxon et al., 2008), findings concerning such conflicting frames are likely to gain increasing salience.



## **Towards congruence – walking alongside for a bit**

Despite conflicting frameworks, five counsellors describe the vast majority of endings as unproblematic. This suggests processes mediating to reduce dissonance, especially given the importance counsellors place on genuineness within the relationship. The ‘congruence’ of this title is an attempt to capture something of a psychological state more at ease ending within this setting; “in accord”, “when an external structure is superimposed” (O.E.D., 1982, p.198). Therapists describe using cognitive, affective, and behavioural coping strategies to adjust the therapeutic process to the frame and the frame to the therapeutic process, to maintain varying degrees of internal consistency and congruence at ending. ‘Congruence’ in the Rogerian sense may be defined as outward responses to clients consistently matching therapists’ inner experiencing (Mearns & Thorne, 2007). When practice-based strategies at ending have been adjusted to ‘fit’ the superimposed frame, and therapists have evolved a personal philosophy within which to conceptualise endings within this framework, they describe greater congruence. These practice-based and cognitive responses may additionally be conceptualised as problem-focused and appraisal-focused coping strategies. Lazarus and Folkman (1984) define problem-focused coping as adaptive coping behaviour aimed at reducing a stressor, whereas appraisal-focused coping involves adjustments to cognitions regarding stressors. These may involve distancing from the stressor, or adjusting values and goals, such as valuing ‘pausing’ or re-conceptualising endings as being within clients’ ongoing life journeys, rather than endings involving arriving at complete cure. Although person-centred training is described as helpful, all participants refer to learning about endings within the setting through experience. The results of this analysis potentially offer some limited practice-based findings towards a new paradigm of ending within primary care.

### **Adjusting the frame.**

Where clients are perceived to be vulnerable, endings result in negative affect resonant of ‘forced terminations’ (Baum, 2008; Zuckerman & Mitchell, 2004). This chimes with research that suggests the less choice and control therapists experience, the more difficult endings may be (Baum, 2007). Within the current study, counsellors appear to minimise conflicts through adjusting the CPC frame to the therapeutic process, and the therapeutic process to the CPC frame. Examples of counsellors adapting the

frame to individuals' needs include leaving the door open to post-termination contact, or increasing session numbers or intervals where deemed appropriate at ending. These adjustments may be conceptualised as problem-focused coping. Such flexibility is experienced as resulting in improved outcomes and optimal endings.

Counsellors additionally refer to the 'real', person-to-person relationship at ending in this setting. The 'real' is the 'personal relationship' between therapist and client, comprising accurate (as opposed to transference-countertransference) representations, and 'genuineness' in authenticity and non-phonicity (Gelso, 2009). Counsellors describe person-centred training as supporting ending such 'real' relationships in a state of congruence and genuineness. This may relate to wider termination literature regarding therapists seeking to reduce the transference at ending (e.g., Fragkiadaki & Strauss, 2012). However, exploring clinical psychologist and client pairs' experiences of ending 12-26 sessions of time-limited therapy in NHS secondary care, Eagle (2005) found that clients valued the real relationship at ending very highly. Likewise, a study of relational processes in brief therapy found that the real relationship matters considerably to clients from the beginning, and is important for therapists to foster (Gullo, Lo Coco & Gelso, 2012). Therefore, five participants' descriptions of such relationships may additionally reflect the more 'real', nature of relationships developed throughout the counselling process within this time-limited setting.

These findings appear to relate to wider literature concerning CPC boundaries. Theoreticians (Hoag, 1992; House, 1999; Smith, 1999) describe the setting as complex, suggesting the impossibility of adhering to an inviolable therapeutic frame, and arguing for the need for flexibility to establish containment within the setting. House suggests that ontological assumptions concerning the necessity for the traditional therapeutic frame normally remain unexamined, and that rigid adherence may in fact say more about counsellors' needs for security than clients' needs. House concludes that it is ultimately both more humane and more productive to adopt a flexible approach, citing Brown that universal psychotherapy frameworks are mythical, and appropriate boundaries are instead "a reflection of the specific and unique relational matrix" (1994, p.30).

In keeping with this CPC literature, participants explicitly refer to valuing managerial trust in their managing endings with some flexibility within systemic limits. This chimes with Eagle's (2005) finding of clinical psychologists' using their discretion to adjust endings to patients' unique emotional needs. It likewise appears to echo a qualitative study which explored counsellors' experiences of counselling clients with

BPD in primary care. Extending contracts or increasing session intervals to reduce as far as possible the emotional disruption of ending, increased counsellors' sense of efficacy and decreased their guilt (Rizq, 2012a). These findings imply that even where counsellors have little control over systemic constraints, having some control to tailor the frame to the client's needs at ending affords a sense of efficacy which therapists relate to positive experiences of endings within the setting.

Theoreticians of all persuasions emphasise the importance of sensitivity to the client over technique at ending (e.g., Graybar & Leonard, 2008; Hoffman 1998; Lemma, 2003; Mendenhall, 2009; Ochoa & Muran, 2008; Pinkerton & Rockwell, 1990). Counsellors tailoring endings in response to individual needs within the present study is therefore consistent with contemporary theory. However, five participants' keenness to emphasise their understanding of the clinical importance of such flexibility over rigid adherence to theoretical frameworks, suggests the powerful hold traditional analytic protocols regarding abstinence, neutrality, and permanent cessation of contact continue to exert over therapists' imaginations. It is possible that contemporary literature described above has remained academic, rather than filtering through into therapeutic trainings as a whole, which continue to be dominated by the analytic termination paradigm and appear to pay relatively little attention to endings. For instance, Valerie Garrett's book on counselling in primary care (2010) does not make a single reference to endings within the setting. In the current study, the consequences of adapting the therapeutic frame to the CPC setting are varying levels of apology, guilt, dismissal, rebellion and conflict, alongside doubts about therapeutic competency. Ultimately, such self-doubt may be ironic, as the limited research into counselees' post-termination experiences of endings in primary care suggests such flexibility is in fact helpful to clients. Two qualitative studies found that session quantity was less significant than the manner in which ending was conducted. Where ending was mutually-negotiated, clients experienced this as affirming the therapeutic relationship and newly-acquired psychological resources, to become an intervention in itself (Etherington & Bridges, 2011; Perren, et al., 2009). These studies support counsellors in the present study's perception of the value of some autonomy in adjusting the frame to respond to clients' individual processes at ending.

Within the present study, endings are experienced as inseparable from the therapeutic process. Counsellors experience the way counselling has begun during its ending, and emphasise the importance of working towards ending from the beginning

through establishing a therapeutic focus and clarity regarding session numbers within the timeframe. Counsellors additionally adjust to the frame through their involvement in onward referral. Success in brief therapy is unsustainable where systemic elements are unhelpful, necessitating post-termination support (Gustafson, 1986; 1995; Holmes, 2010; Smith, 2002). Clients' post-termination resources strongly affect counsellors' experiences of endings; referral ameliorates concern and guilt. It additionally appears to offer counsellors a means of conceptualising the work as continuing along the client's journey.

### **Detaching and accepting.**

Within the wider CPC literature, large caseloads; rapid, frequent attachments and separations within time-limited working; and an audit culture are described as stressful for counsellors (Coren, 2010; House, 1999). In the present study, counsellors describe high volumes of endings to meet targets as encouraging detachment, 'numbing'. Rizq described IAPT as 'a perversion of care' which disavows the realities of suffering by privileging targets to defend against unbearable feelings of helplessness in the face of limitations to deal with client needs (2012b). She suggests that this requires adopting a number of different Freudian defences mechanisms against caring too deeply for clients. Some psychodynamically-trained participants relate their detachment to avoidance and defence mechanisms, in keeping with Rizq's contention. However, although Folkman and Lazarus (1984) acknowledge conceptual overlap with Freudian defence mechanisms, Weiten and Lloyd (2008) describe how such 'detached coping' may in fact be adaptive in the face of a stressor that one feels helpless to change. Strategies are not in themselves necessarily adaptive; rather 'adaptive' refers to their effectiveness in improving outcomes (Lazarus, 1993). This appears to be the experience of counsellors in the present study. Counsellors explicitly describe detachment as self-preservation. They additionally describe arriving at acceptance of systemic limits over time. One possible interpretation might be that, faced with the choice to remain within IAPT or to leave the NHS altogether, those who elect to remain seek to reduce cognitive dissonance arising from experiencing systemic requirements as compromising deeply-held ethical and professional values. Festinger defined cognitive dissonance as the psychological discomfort experienced by an individual who simultaneously holds contradictory beliefs or values (1957). He proposed that individuals strive for internal consistency through reducing this dissonance. In keeping with Festinger's suggestion that one means of

reducing dissonance is to focus on consonant beliefs to outweigh conflicting ones, counsellors describe focusing instead on what clients *have* received, and how they themselves have done their best in the circumstances. Alternatively, counsellors may seek to change dissonant beliefs to become more consonant; for example, regarding therapy as only one aspect of the client's life and believing that ultimately it is the client who is responsible for change. They describe learning to relinquish responsibility for that which they cannot change; as Layla puts it: "it is what it is; it's not your fault", reducing dissonance this way. For some, this involves a "radical acceptance" of where the client is at ending. Such acceptance is likened to mindfulness, implying emotion-focused coping beyond cognitive coping strategies. However, while counsellors experience such detached coping as adaptive, literature suggesting that clients value processing endings with their therapists very highly (e.g., Roe et al., 2006) raises the question of what the consequences of such detachment are for clients' experiences, particularly as counsellors are most likely to require this strategy where clients are most vulnerable and therefore most dissonance is experienced.

### **Metaphors of ending – journeying.**

Metaphors facilitate communicating multiple simultaneous meanings (Fainsilber & Ortony, 1987). They capture both experiential and meaning-making and are therefore compatible with both IPA's phenomenological and hermeneutic underpinnings (Eatough & Smith, 2008). Journeying metaphors are woven through counsellors' accounts. The counselling process itself is conceptualised as a journey, and the next stage of clients' life journeys hold implications for counsellors' experiences of endings. In parallel are therapists' own journeys as they acquire familiarity with endings through personal and professional development and experience, consistent with wider termination literature (Fragkiadaki & Strauss, 2012; Viorst, 1982). In this, journeying metaphors are linked to 'self-experiencing'; that which comes into the room at this stage of counsellors' journeys.

Interestingly, a Norwegian study (Rabu, Haavind & Binder, 2013), published since the analysis, found therapist-client dyads shared multiple metaphors, including a 'travel' metaphor, preparing for ending 'good-enough' longer-term psychotherapy (7-43 months). Travel clearly parallels 'journeying', facilitating conceptualising distance covered, future obstacles, and ending time-limited joint process. The extent to which counsellors in the present study share journeying metaphors with clients is unclear. They

appear most frequently in relation to conceptualising endings within over-arching life journeys. Counsellors appear to use these metaphors to support adjusting to the imperfect nature of endings where work is experienced as incomplete. Jo vividly describes a moment of adjustment with an insight into her own urgency towards ending as reflecting wishing to reach a 'destination', rather than recognising counselling as one part of a larger journey the client would continue alone. She describes relinquishing traditional termination criteria, accepting instead the value of: 'somebody walking alongside for a bit'. In adjusting values and goals related to ending, this appears to demonstrate the reappraisal strategies described by Folkman and Lazarus (1984). However, this may equally illustrate another strategy to reduce cognitive dissonance, through reducing the salience of dissonant beliefs about ending where clients remain vulnerable, and work incomplete. In illuminating certain aspects of a phenomenon, metaphors throw shadows over others, lending themselves to becoming strategies to effect detachment and avoidance of certain feelings (Shinebourne & Smith, 2010).

However, metaphors additionally potentially transform conventional representations and meanings, offering new models to change our perception of phenomena (Kilmayer, 1992; Ricœur, 1978). Schon refers to generative metaphors as "a process by which new perspectives on the world come into existence" (1993, p.137). It may be that repeated use of journeying metaphors indicate that, as opposed to traditional conceptualisations of readiness and goal-attainment, 'journeying' is intrinsic to a new model of endings within the setting.

Another way in which counsellors appear to reduce incongruent frames is through focusing on the possibility of clients' return: ending as 'pausing'. Counsellors describe pausing metaphors as containing anxiety at ending through facilitating ongoing connection; as Andrew puts it to his clients: "I'm not going anywhere". Counsellors reduce incongruence through focusing on the supportive aspects of such 'pauses'; for example, as part of "a good rhythm of life" which allows for reflection between episodes and the possibility of developing layers upon previous work. Such invitations to return are described as valuably supporting ongoing development, through offering clients the possibility of continuing counselling within a familiar setting. In re-conceptualising endings thus, counsellors appear to be embracing the primary care setting as offering "an attachment from the cradle to the grave" (Bowlby, 1988, cited by Garrett, 2010).

This re-conceptualisation is compatible with Cumming's Budyne model of episodic therapy. Cummings suggests that leaving the door open for repeated episodes

frees therapists from feeling they have to cure clients; instead, therapists learn to trust that developmental processes set in motion during therapy will continue until clients need to return. Coren (2010) suggests that the ‘ripple effect’ may be helpful to psychoanalytically-trained practitioners adjusting to time-limited working, supporting an understanding of how therapy may be incomplete, yet nevertheless beneficial. Journeying and pausing metaphors may be compatible with ‘ripple effect’ metaphors, which allude to the effect of insights gained in therapy continuing in ever-expanding insights and growth post-termination.

These metaphors may also be compatible with Prochaska and Norcross’s (2003) conceptualisation of change as cyclical; moving through phases and interacting with numerous influences, one of which may be counselling. Prochaska and Prochaska suggest that their model offers value through conceptualising change as a process which typically begins prior to therapy, continues following it, and involves progression through distinct stages. They suggest that this approach may support therapists and clients be realistic about what may be accomplished within time-limited therapy, accepting that important stages of change may follow (2008).

Overall, counsellors’ re-appraisal strategies are consistent with such contemporary literature, despite these strategies being described as acquired through experience, rather than training. However, that four counsellors continue to negotiate tensions with traditional psychoanalytic termination models indicates the potential value in training which incorporates such contemporary theory, potentially offering conceptually-compatible paradigms to support endings within this setting. It is notable that the two counsellors who identify themselves as ‘eclectic’ describe least conflict and have the most developed personal philosophies for ending. They describe drawing on person-centred theory, and ending in a state of personal congruence and relational genuineness. For instance, Peter indirectly alludes to Prochaska and Prochaska’s model, describing the client’s responsibility for change within their own life journey. Maggie conceptualises endings as pausing between episodes, understanding these as helpfully allowing for reflection and a ‘good rhythm of life’, compatible with Cummings’ episodic paradigm. In conclusion, counsellors who develop personal philosophies concerning ending brief therapy appear to find these support ending in a state of congruence with the superimposed frame. In the absence of these philosophies, or where these philosophies fail in the face of cognitive dissonance and conflicting ethical, theoretical

and systemic frameworks, counsellors use detached coping, explicitly describing this as 'self-preservation'.

## **Implications**

This research sought to offer some preliminary understanding of counsellors' experiences of endings in primary care. While recognizing the extent to which small sample size and an ideographic approach limit generalisability, this analysis may nevertheless possibly illuminate certain considerations for practice, training, service provision and CoP.

### **Implications for practice.**

Counsellors in the present study appear to experience resolving personal losses as supporting their remaining with their clients' experiences. The results of the analysis also appear to suggest the potential value of reflecting upon varying responses to endings as these may offer opportunities for addressing personal material. The findings additionally suggest that considering the ways in which personal attachment style may impact ending processes may provide a valuable area for self-reflective practice. Personal therapy is experienced as an important influence on termination practice within the present findings, therefore another possible implication is the importance of therapist reflection on such influence, in order that it may be used consciously to support clients' needs. A related implication may be that therapists practising time-limited therapy themselves experience time-limited therapy and associated endings as part of their continuing professional development.

Counsellors in the present study describe experiencing the discrepancy between their clients' needs and time-limited working at ending, and high levels of negative affect resulting from conflicting therapeutic, ethical and systemic frameworks, intensified where clients are perceived as particularly vulnerable. Participants also describe intense frustration at being prevented from practicing the beneficent therapeutic art they are trained for. Another possible implication therefore is the importance of supervisory sensitivity to these processes, to normalise such affect for counsellors. However, IAPT is a relatively new initiative; what are the longer-term consequences of enduring such stressors for counsellors? And what is the impact upon practice? How do therapists



manage ambivalence without communicating to their clients that what they have received is not enough? A number of counsellors experience degrees of detachment or ‘numbing’, described as emotional and physical self-preservation. While such detached coping may be psychologically adaptive for counsellors, what are the consequences for clients’ experiences, particularly in light of research indicating that clients value processing endings together with their therapist very highly? Consequently, one recommendation might be that counsellors remain mindful of the possible impact of detachment on clients.

Nevertheless, during ‘good endings’, counsellors describe experiences that are powerfully reminiscent of ‘relational depth’ (Mearns & Cooper, 2005). The present research amplifies the existence of relational depth as an empirical phenomenon, suggesting moreover that it occurs across timeframes. Even where brief work limits therapeutic reach and attachment, it appears that relational depth remains possible and is very important to practitioners’ experience of endings. Mearns and Cooper describe working at relational depth as profoundly rewarding, sustaining involvement with even the most difficult of clients. This is echoed in the present study, where counsellors experience such moments as optimal practice and profoundly satisfying. The implications of this are that, in the face of multiple other stressors at ending, experiencing such relational depth may be prophylactic for counsellors against cynicism and burnout and, as such, is potentially another important aspect of CPC practice to foster and develop.

### **Implications for training.**

The findings of this study suggest a number of possible implications for training. All of the counsellors within the present study describe learning about CPC endings through experience. As described in the literature review, the dominant theoretical model of termination is psychoanalytic. This originated in a very different timeframe and is based on notions of cure and termination as final; however, counsellors experience conflict, rebellion, and self-doubt for failing to adhere to psychoanalytic guidelines within the setting. An unexpected postscript is that during the writing up of this study, the three psychoanalytically or psychodynamically-orientated practitioners left the counselling in primary care service. Although there are likely multiple reasons for this, that psychoanalytically and psychodynamically-trained participants experience tensions with traditional termination models potentially suggests the value of training on ending time-

limited therapy. Consequently, one implication may be support for a recent IAPT initiative of Counselling for Depression (CfD) being more widely-available. CfD is specifically designed to equip counsellors to work within the 6-10 session framework.

Evolving a personal metaphor for endings may support counsellors ending in a state of congruence with the superimposed frame. Achieving good outcome and a sense of having helped clients is important to counsellors at ending, as is a sense of completion. However, a sense of completion is described as rare in CPC, and consequently it appears valuable to counsellors to re-conceptualise endings using metaphors, such as journeying, or pausing while the work of therapy continues through reflection between episodes. Cummings' episodic model (1990; 2001) and Prochaska and colleagues' (2003; 2008) 'phases of change' potentially offer conceptually-compatible paradigms; counsellors appear to implicitly draw on these models in adjusting values and circumscribed goals for ending within this context. A further implication is the potential value of training in person-centred approaches for ending within this setting; in the present study, person-centred training is experienced as supporting ending in a state of personal congruence. Such training may be particularly relevant given the value psychological therapists place on experiencing relational depth at ending.

A final recommendation based on these participants' experiences may be that training addresses incorporating the idiosyncratic primary care frame. Theoreticians propose that it is more productive to adopt a flexible approach within the CPC setting (House, 1999; Smith, 1999). Counsellors in the present study describe experiencing endings more positively when they permit themselves some flexibility to tailor endings to clients' needs. Extant research suggests that counselees too experience such flexibility as therapeutic, affirming the therapeutic relationship and newly-acquired psychological resources to become an intervention in itself (Etherington & Bridges, 2011; Perren et al., 2009).

### **Implications for services.**

These findings potentially additionally hold implications for services. In the present study, participants appear to experience an increase in tensions when there are narrow doorways to options for ongoing therapy, whereas being able to trust that the work will continue appears to support these counsellors ending well. Therefore, one implication may be the importance of services cultivating strong referral pathways for

ongoing therapeutic support. Further, given the intensified conflicting frameworks experienced by participants during endings with particularly vulnerable clients, another recommendation may be greater pragmatism about referral criteria at the assessment stage.

Participants in the present study repeatedly referred to their valuing highly managerial trust in their ability to manage endings flexibly within systemic limits. Therefore, another implication may be that, even where there is little control over session numbers, some autonomy to tailor the frame to clients' needs at ending may afford practitioners some sense of creativity, choice and control within the setting.

The present findings additionally suggest the importance of supervisory sensitivity to counsellors being particularly affected by certain clients' endings as part of their ongoing personal and professional development. A related implication may be the importance of service provision for regular reflective practice groups to allow time for counsellor reflection, process and support. The emotional demands of high volumes of endings experienced by counsellors in the present study suggest that while managers attempt to maintain service viability in the face of commissioners' financial imperatives, protecting the wellbeing of counsellors also needs to be factored into the constant struggle to meet minimum service standards (Mark Donati, pers.comm, July, 2014). Although the language of commissioners may be hard to reconcile with psychotherapeutic considerations, the experience of this small sample of counsellors implies that attempts should nevertheless be made. The way a service manages endings may offer a litmus test of its values (Morris Nitzun, pers.comm, May, 2014).

### **Implications for counselling psychology.**

There are a number of clear implications for CoP arising from the results of this study. The BPS emphasises that CoP practice requires "a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context" (2009). Counsellors of multiple orientations appear to be describing fundamental CoP tenets in the centrality of the therapist's 'self' as therapeutic instrument, underlining the importance of reflective practice and personal therapy. Counsellors additionally experience the primacy of the relationship at ending. CoP's emphasis upon the therapeutic relationship transcends 'schools' (Clarkson, 2000), offering a 'way of being' which is easily incorporated into therapeutic encounters

independent of orientation (Cooper, 2007; Strawbridge & Woolf, 2003). Ashley (2010) describes how focusing on the healing potential of the relationship offers the client a quality of relating that may be missing elsewhere. Paying particular attention to the experience of therapeutic processes is a fundamental aspect of CoP (Strawbridge & Woolfe, 2003). It conceptualises practice as fundamentally relational, 'being with', rather than 'doing to'; when the timeframe restricts what can be 'done', the current findings suggest that 'being with' remains fundamental to counsellors' experiences of endings within the setting. CoP training which emphasises tolerance of uncertainty within a fellow-travelling relationship with the client (du Plock, 2010) may well support the types of experiences reported by practitioners practising and ending within the setting in the present study.

As evidence-based practitioners, counselling psychologists have been encouraged to be at the forefront of developing effective healthcare within CPC for well over a decade (e.g., Lenihan & Illiffe, 2000). The current findings support previous suggestions that CoP has much to offer within the setting. Ethics lie at the very heart of CoP theory and practice (Olsen, 2010), and, as argued by Simon du Plock (2010), CoP's identification with Humanism potentially safeguards valuing the human being in primary care, despite the multiple systemic constraints and tensions reflected upon throughout this study.

### **Limitations of the current study**

IPA resulted in rich in-depth account of counsellors' experiences of endings. IPA is idiographic, concerned with in-depth understanding of individual experience in context, and was employed to illuminate and make explicit implicit processes, consistent with the research aims. In this way, the present study may offer a valuable contribution to a currently limited knowledge base. However, qualitative methodology has inherent limitations. The findings are based on my own interpretations and others may have identified salience in different themes. I have attempted to ensure rigour and validity through transparency, reflexivity and an audit trail; however, personal experience and extensive reading have inevitably have shaped my interpretative lens. Additionally, small sample size means that the study cannot make claims to generalisability. Further, as outlined in 'Methodological reflexivity', the recruitment process itself may have shaped the data through selection bias: those counsellors with strong feelings about endings most likely to have participated. It may be that such counsellors have experienced

unusually high levels of loss in their own lives, therefore the data itself may be biased due to these participants' areas of interest and responses which may not reflect those of other CPC counsellors. Additionally, counsellors were aware of the nature of the study. Self-report is inevitably vulnerable to social desirability sensitivities, selective recall, denial and other cognitive biases. Therefore, potential implications outlined above are suggestions, rather than directives to be applied in a prescriptive manner.

A final consideration is that the majority of participants were not counselling psychologists, a clear limitation within CoP research. However, counselling psychologists themselves are trained in a range of different modalities, therefore it could be argued that counsellors subscribing to Humanistic values are not dissimilar to counselling psychologists. Moreover, recent years have seen considerable convergence between different therapeutic models in increasing emphasis upon the relational dimension (O'Brien, 2010). CoP's emphasis on the relationship arguably means that differences between modalities may ultimately be less important than what the practitioner brings to the relationship developed with each client (Strawbridge & Woolfe, 2003).

### **Epistemological reflexivity**

Epistemological considerations include limitations inherent in the research question and method. I have attempted to sensitively represent counsellors' experiences through IPA which has supported exploration of the more emotive, personal aspects of data; however, the method itself limits theory-level development, development of a model or explanation, which may have been offered by GT. A further epistemological limitation is IPA's dependence upon the representational validity of language (Willig, 2008). IPA assumes correspondence between language and experience, whereas it may be argued that in fact language actively constructs meaning, and therefore that such constructions are context-dependent. Additionally, individual ability to articulate nuance is implicated in the quality of data. For instance, despite my best attempts to represent accounts evenly, Jan and Jo's accounts are particularly well-represented in the analysis due to their succinctness, openness and eloquence. In this way, the method has to some extent 'constructed' the findings. Using a different method or methodology may have resulted in different emphasis.

## Suggestions for future research

This research possibly illuminates a number of avenues for further exploration. The reparative potential of reflective termination practice has been obliquely referred to in previous theoretical (Frank, 2009; Noy-Sharav, 1998), and empirical (Viorst, 1982) literature; however, it does not appear to have received focused empirical attention. Given the importance of the therapist's self in CoP, the current findings suggest that future research could usefully explore this reparative potential further. Relatedly, despite theoretical suggestions that therapists' attachment styles influence the form co-constructed client and therapist endings take (Holmes, 1997, 2010; Shilkret, 2005), this does not appear to have been empirically explored. The present study supports the potential utility of such research. Given the value that counsellors place on relational depth at ending, it could equally be beneficial to deepen our understanding of how to develop and sustain such depth through the ending process. Additionally, it could be valuable to replicate this study exploring counsees' experiences of endings, or perhaps a comparative study of counselee and counsellor experiences. Such findings could valuably inform clinical practice. Further, replicating this study solely with counselling psychologists could increase its relevance to the profession.

Within the current study, sampling sought to be purposive, small and homogenous to one CPC service, limiting generalisability to time-limited therapy more widely. Future qualitative research might usefully investigate differences and commonalities in the experience of ending time-limited therapy across a variety of settings, including private practice. From themes identified this way, it may be possible to move from the particular closer to the universal (Eatough & Smith, 2008; Smith, 2004). Relatedly, Cummings' episodic model (1990; 2001) potentially offers widespread conceptual utility in 'ending-as-pausing'. Given episodic therapy's likely future within a range of settings, this too may be an area for further research, beyond the questions it raises for endings. Overall, these practice-based findings strongly suggest the value of a GT analysis towards a process model of endings within the setting. Further, given the richness of a number of individual accounts, future termination research might include interviews with an individual practitioner in a single case-study design. Finally, in keeping with CoP's pluralistic underpinnings, quantitative methodology could usefully add to our understanding of the area. A pluralistic epistemology which makes use of varying methodologies supports more confident understandings (Ashley, 2010; Cooper, 2008).

## Final reflections

Walsh (1996) suggests that researchers who employ qualitative research methods might learn as much about themselves as their participants. A sense of the analysis as inevitably influenced by my own limited conceptualisations and language, has resulted in greater appreciation of the impossibility of separating knowledge from the knower (Steenberg, 1991), and, consequently, an epistemological move towards the constructionism end of the realist – constructionist spectrum. I was initially cautious about developing description into higher levels of interpretation, seeking faithfulness to a hermeneutic of empathy and phenomenological principles. Through this research process, I have learned to trust myself a little more.

At times, I have been surprised at how emotional it has been. I have continued processing my own losses, including that of my own therapist. Ben and I had worked through a good ending together prior to an agreed break. When I attempted to resume contact, I was informed that he had died. The memory of the nature of our ending, and the knowledge of his care for me, sustained me through an uncomplicated grieving process. I was also unexpectedly saddened reading Williams' (1997) suggestion that some therapists' moments of most meaningful relatedness are in the consulting room, intensifying sadness at ending. Although I would consider the depth of the therapeutic relationships that I develop with clients to be one of my strengths as a practitioner, this paper too stimulated much personal reflection.

Finally, I have grown more aware of my vulnerability at ending to identification with clients who cannot afford ongoing therapy. Applying the wisdom of my participants' experience has helped. Awaiting thesis feedback following completion of my analysis, finance necessitated beginning a fulltime IAPT CBT role. Despite CBT's markedly different approach to counselling, at times I have nevertheless found myself experiencing my analysis 'in action'. This has been validating, offering much food for thought. I experience greater acceptance of limited NHS resources, embracing the principal of justice in fairness to those on waiting lists, alongside beneficence and non-maleficence. However, interestingly, alongside many intensely rewarding moments of relational depth, I also occasionally feel vulnerable to numbing at ending, detaching and accepting, just as my participants described. I wonder whether, ironically, I was better placed to conduct this research *prior* to working in IAPT. My interest was fuelled by my reading, ending longer-term secondary care contracts, and ending my own personal

therapy. I wonder whether, had I been working in IAPT at the time, I would have had the emotional energy to reflect on endings in the same way.

Overall, I feel that my ability to manage endings has developed in parallel with this research. I understand better what my own processes are, which buttons may be being pushed, and where I personally may need time for reflection. My endings practice has at times been constrained by my researcher-self observing my personal- and therapist-selves, intruding upon my ability to remain with clients' experiencing at ending; however, this has ultimately confirmed to me the importance of simply 'being with' the client, and my commitment to CoP values, theory and practice. When I embarked on this process, I hoped to understand my experiences more deeply. Nearing ending, despite the limitations to generalisability outlined above, my hope is that this study may to some extent normalise and illuminate others' experiences of endings in primary care.

## **Conclusions**

It is hoped that this study has made a useful contribution to termination research, to research into counselling in primary care, and to CoP more generally. The use of IPA has afforded a rich, in-depth account that both chimes with existing literature and has allowed for the emergence of novel understandings and interpretations. Four super-ordinate themes emerged: 'self-experiencing', 'the quality of the therapeutic process', 'conflicting frames', and 'towards congruence'.

On the whole, counsellors appear to respond to endings within primary care time limits with lower levels of affect than that described in different timeframes, attributed to counsellors and clients being less attached than within longer-term therapies. The exception to this is where clients are perceived as vulnerable, which results in intensely negative affect as a result of conflicting systemic, theoretical and ethical frameworks. Counsellors' own developmental histories and personal and professional developmental journeys, including personal therapies, appear to influence their experiences of ending. Where counsellors perceive the work as having been helpful to clients, endings are easier. Conversely, counsellors experience intense frustration at being prevented by time limits from doing the psychotherapeutic work they feel that clients would benefit from and that they have been trained to provide. Overall, there is a theme of psychoanalytic termination theory ill-fitting the timeframe, and the importance of tailoring termination practice to each client. Those who have been able to develop a personal philosophy or



metaphor for ending within the setting appear to be able to adopt adaptive cognitive coping strategies through adjusting values and goals in order to achieve greater congruence with the timeframe. This appears to be supported by person-centred training, which additionally potentially supports the more ‘real relationships’ experienced within the setting. Even within the timeframe, it appears that it remains possible to experience relational depth. This is experienced as optimal practice and as profoundly rewarding, and may be protective against cynicism and burnout in the setting.

Close attention to the experience of therapeutic process, including the relationship, is a fundamental aspect of counselling psychology (Fairfax, 2008; Strawbridge & Woolfe, 2010). Given the importance of endings as therapeutic interventions, and the light shone on the necessity for reflective practice in the present study, one hope is that this research may deepen practitioners’ understanding of such processes within primary care, lending meaning to these and normalising them to support counsellors through the ending process. In this way, it is hoped that, as well as contributing to termination and CPC literature, this research additionally contributes to the practice of counselling psychology within CPC. Counselling psychology’s identification with Humanism potentially safeguards valuing the human being in primary care (du Plock, 2010), despite the multiple systemic constraints and tensions reflected upon throughout this study. NICE guidelines will continue to evolve in response to new research, therefore there is a continuing need for an evidence base to ensure that counselling psychology plays a role in contributing to the practice of developing the authentic relationships which lie at the heart of our mission, and to the process of ending these safely and well in primary care. As expressed by Jo, “it was the being... and the connecting that was so important”.

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## **Appendices**

Appendix 1 – Research Proposal sent to service manager prior to recruitment presentation at counselling team meeting

Appendix 2 – Participant Information Sheet

Appendix 3 – Participant Consent Form

Appendix 4 – Distress Protocol

Appendix 5 – Semi-Structured Interview Schedule

Appendix 6 – Debriefing Information Form

Appendix 7 – Sample of annotated participant transcript – Jan

Appendix 8 – Master Table of Themes for the Group



## Appendix 1

**Research Proposal sent to service manager prior to recruitment presentation to primary care counselling team**

### **Counsellors' experiences of endings in primary care**

**Research Team:** Satara Lester, Dr Elaine Kasket, Dr Andrew Eagle

**Contact:** Satara Lester

#### **Aims**

The principal objective of this research is to explore counsellors' experiences of adjusting to ending therapy within a time-limited framework in primary care, using qualitative methodology to reach deeper understanding of underlying processes. Ultimately, the purpose of attaining this understanding is to inform clinical guidelines for managing the ending process most effectively for optimal client benefit, and long-term treatment gain.

Evidence-based guidelines for ending well in time-limited therapy hold particular relevance within current healthcare contexts, as practitioners accustomed to working within a client-centred model are required to make considerable adjustments to practice. When historically the hallmark of a 'good ending' in psychotherapy has been mutual agreement concerning readiness, a secondary aim of this study is to explore the extent to which traditional models of termination hold within time-limited therapy. Given the centrality to Counselling Psychology of the therapeutic relationship (British Psychological Society, 2011), and the dynamic interaction between therapist and client variables and experience while ending the therapeutic relationship, it is hoped too this research will inform Counselling Psychology theory and practice.

#### **Background and scientific justification**

Ending well is believed to be crucial for therapeutic gains to be maintained over time (Freud, 1937; Beck, Rush, Shaw & Emery, 1979; Frank, 2009; Ochoa & Muran, 2008). However, numerous authors comment on the paucity of the termination literature (Davis, 2008; Davis & Younggren, 2009; Goldfried, 2002; Marx & Gelso, 1987; Ochoa & Muran, 2008; Quintana & Holohan, 1992; Roe, Dekel, Harel & Fennig, 2006; Wachtel, 2002). Additionally, the majority of the extant literature is theoretical, open-ended psychodynamic and focused on clients' experiences.

Research into therapists' experiences is limited, despite existing evidence suggesting termination is complexly influenced by the interaction between client and therapist variables. If therapists work through the medium of the relationship, losing the relationship rightly becomes the focus of the process at terminating therapy (Siebold, 2007). A repeated theme within the extant empirical literature is the value clients place on affectively processing ending together with their therapist (Baum, 2005; Marx & Gelso, 1987, Quintana & Holohan, 1992). However, therapists' own difficulties ending significantly impact their ability to be emotionally attuned to clients within this process (Martin & Schurtman, 1985). Clients with significant loss histories are more likely to be sensitive to termination as loss (Marx & Gelso, 1987), and although therapist anxiety is

predicted by perceived client-sensitivity to ending (Boyer and Hoffman, 1993; Baum, 2008), therapists' anxiety and depression is additionally predicted by their own loss histories (Boyer & Hoffman, 1993).

Theoreticians have proposed therapeutic guidelines for terminating therapy: planning, reviewing the course of therapy, discussing feelings and bringing closure to the relationship. Although therapists largely adhere to these where outcome is positive, they have difficulty following these where treatment is felt to be unsuccessful (Quintana & Holohan, 1992), experiencing feelings of failure, self-doubt and sorrow terminating with poor outcome (Baum, 2007). However, clients too experience higher levels of distress where outcome is disappointing (Roe et al, 2006; Quintana & Holohan, 1992), and where there is less control, readiness and desire to end (Baum, 2005) - strongly indicating the importance of therapists helping clients affectively process endings *most* where this least occurs (Quintana & Holohan, 1992). Additional limitations in the existing literature are that extant research has limited external validity in an era of time-limited therapy, due to primarily making use of samples (private practice, or university counselling services), where there are invitations to return as necessary and/or the luxury of terminating according to readiness. When the 'hallmark' of a good ending in open-ended therapy is mutual agreement concerning readiness, to what extent do traditional models of termination still hold in time-limited therapy? As NICE guidelines dictate increasingly brief contracts, to what extent may this research may be generalised to time-limited counselling as it is practised within Primary Care? For counsellors who have traditionally worked within a client-centred model, adjusting to working and ending within this framework may pose significant challenges. Finally, scientific justification for the research arises from the complexity involved in bringing the therapeutic relationship to closure, requiring a sophisticated merging of clinical, practical and ethical factors. As public and private healthcare constraints increasingly influence contemporary therapeutic practice, ethical principles guiding therapeutic practice become more complicated (Davis & Younggren, 2009). Terminating therapy is the point at which risk of adverse action professionally is greatly increased (Murdin, 2000; Davis & Younggren, 2009).

In conclusion, given the complex dynamic interaction between client and practitioner at ending, there is a growing need to explore the underlying practitioner processes ending time-limited therapy. Ultimately, the hope is deeper understanding of the dynamics involved as counsellors make adjustments to ending within this framework will inform therapeutic guidelines for managing endings within Primary Care most effectively, for optimal client benefit and long-term treatment gain.

## **Design and Methodology**

A qualitative framework will be used. Qualitative methodology seeks deeper understanding of individuals' subjective experiences, and is closely related to Counselling Psychology through shared appreciation of process, openness, and non-judgemental understanding of subjective experiences (Coyle, 1998).

Semi-structured interviews at a single time point will be employed to facilitate exploration of practitioners' experiences of endings within a time-limited framework. In semi-structured interviews participants are facilitated in expressing their own interests and the interviewer responds by exploring these more deeply as they arise. Data will be analysed using Interpretative Phenomenological Analysis (IPA). Due to the exploratory nature of the research there are neither null nor alternative hypotheses to be tested.

### **Participants**

Participants will consist of six to eight counsellors, psychotherapists and counselling psychologists practising time-limited counselling. The sample size was

decided upon in collaboration with the chief investigator's supervisors as appropriate for the methodology and analysis chosen for the research. Data will be analysed using Interpretative Phenomenological Analysis (IPA). IPA aims to acquire deeper understanding of individuals' subjective experiences. However, although commitment to in-depth analysis necessitates smaller sample sizes for pragmatic reasons, sample size should nevertheless be large enough to allow for insights afforded by analysis of convergence and divergence within cases selected. A sample size of six to eight is also in line with sample sizes proposed by Turpin, Barley, Beail, Scaife, Smith and Walsh (1997) in setting standards for psychology doctoral research using qualitative methodology. A limited number of interviews will be conducted for purposes of a pilot study, to establish whether any changes to the schedules are needed. Should no changes be necessary following the pilot, these interviews may be included in the final study.

### **Recruitment**

Potential participants will be approached via a recruitment letter/information sheet (see Appendices). It is possible the chief investigator may also present the idea to a team meeting of the counsellors.

### **Procedure**

Practitioners interested in volunteering will be invited to make contact with the chief investigator and an interview will be scheduled at a mutually convenient time. It is anticipated the semi-structured interview will last approximately an hour, with time allowed at beginning and ending for discussion, signing informed consent, completing a very brief demographic questionnaire, and debriefing. It is expected that the total time committed will not exceed ninety minutes.

### **Analysis**

IPA has been chosen as the method of analysis as it affords detail, depth and complexity of understanding. IPA is concerned with the meaning individuals give to personal experience rather than revealing objective 'facts' for empirical generalisability. Generalisability may instead come from theoretical generalisability – making links between theory and wider literature. Its power is assessed through the insights it affords within broader contexts (Smith & Osborn, 2008). IPA lends itself to rich exploration of unexplored territory, thus holding particular utility in under-researched areas, as this one is.

### **Validity**

Due to the interpretative nature of the analysis, every attempt will be made to ensure rigour is maintained, guarding as far as possible against "researcher effects" and "researcher bias". This will be through commitment to triangulation, and adhering to Yardley's (2008) guidelines for validity in qualitative research: sensitivity to context, importance, transparency, coherence, and reflexivity. An openly reflective stance on the way in which any bias may unintentionally be influencing interpretation of data and outcome will be maintained throughout. Triangulation, which allows for comparison between two or more views of the same data, is recommended as a means of ensuring quality control and validity in qualitative research. The chief investigator will seek confirmation of the existence of themes in the data and conclusions drawn from the interpretation of transcripts, from Dr Andrew Eagle, regarded as an expert in the area of endings.

### **Benefits**

Ending therapy well is believed to be crucial for therapeutic gains to be maintained over time. If therapists work through the medium of the relationship, losing the relationship rightly becomes the focus of the process at terminating therapy (Siebold, 2007). A repeated theme within the existing literature is the value clients place on

affectively processing ending together with their therapist (Baum, 2005; Marz & Gelso, 1987, Quintana & Holohan, 1992).

Bringing the therapeutic relationship to closure involves a sophisticated merging of clinical, practical and ethical factors (Davis & Younggren, 2009). However, therapists' own difficulties ending significantly impact their ability to be emotionally attuned to clients within this process (Martin & Schurtman, 1985). Therapists' anxiety and depression during the ending process are predicted by their own loss histories (Boyer & Hoffman, 1993). Therapists additionally have difficulty following termination guidelines where treatment is felt to be unsuccessful, despite the increased importance of helping clients affectively process endings in such circumstances (Quintana & Holohan, 1992).

Ethical principles guiding therapeutic practice become more complicated as public healthcare budgetary constraints increasingly influence contemporary therapeutic practice, and terminating therapy is the point at which risk of adverse action professionally is greatly increased (Davis & Younggren, 2009). Given the dynamic interaction between client and practitioner at ending, the hope is deeper understanding of complex underlying practitioner processes will assist counsellors and inform guidelines for best clinical practice in bringing the therapeutic relationship to closure for longterm client benefit and optimal treatment gain. Evidence-based guidelines for ending well in time-limited therapy hold particular relevance within contemporary Primary Care settings, as practitioners accustomed to working within a client-centred model are required to make considerable adjustments to traditional practice.

#### **Costs**

Costs for the research are expected to be minimal and incurred in stationary. These will be covered by the Chief Investigator's budget as part of her training.

#### **Review**

This research proposal has been reviewed by the chief investigator's supervisory team: Dr Andrew Eagle, widely regarded as an expert on endings in therapy, and Dr Elaine Kasket and Dr Mark Donati, the Counselling Psychology supervisory team at London Metropolitan University who are experienced in supervising academic projects at this level. It has also been reviewed by The Psychology Department's Research and Ethics Review Panel (RERP) and the Research Student Progress Group (RSPG) which reports to the Research Degrees Committee (RDC) at London Metropolitan University (the chief investigator's institution).

#### **Dissemination**

The study will be written up as part of the Chief Investigator Satara Lester's Counselling Psychology doctorate. A paper may be prepared and submitted to relevant journals following completion, and findings shared with peers in internal reports, and at relevant conferences and seminars.

#### **Planned timeline**

From the point at which Research and Development clearance has been obtained, the recruitment and data collection stages will begin simultaneously. After sufficient data has been collected, analysis and write-up will begin.

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## Appendix 2 – Participant Information Sheet

### PARTICIPANT INFORMATION SHEET

**Study title:** Counsellors' experiences of endings in primary care

**Research Team:** Satara Lester, Dr Elaine Kasket, Dr Andrew Eagle

**Contact:** Satara Lester      **Tel:**      **Email:**

**We would like to invite you to take part in a research study. Before you decide to take part, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. You may discuss it further with the researcher Satara Lester if you wish. Do not hesitate to ask if there is anything that is not clear, or if you would like more information. Please take time to decide whether or not you wish to take part. Thank you for reading this.**

#### What is the purpose of the study?

Ending well is believed to be crucial for therapeutic gains to be maintained over time. However, surprisingly little research exists into this phase of therapy. Most of the existing literature is theoretical and focused on clients' experiences. However, extant research suggests endings are complexly affected by the interaction between client and therapist. If therapists work through the medium of the relationship, losing the relationship inevitably becomes the focus of the process at ending, and a repeated theme within the literature is the value clients place on processing ending together with their therapist. As NICE guidelines dictate increasingly time-limited contracts, therapists are having to make considerable adjustments to practice. Given the dynamic interaction between client and therapist variables in mutually experienced endings, deepening our understanding of therapists' experiences may be more important than ever. The aim of this project is to inform therapeutic guidelines for best clinical practice, with the intention of helping therapists manage endings most effectively for optimal client benefit and long-term treatment gain.

#### Why have I been invited?

You have been invited to participate in this study as a Counsellor, Psychotherapist or Counselling Psychologist practising time-limited counselling in primary care.

#### Do I have to take part?

**No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw within two weeks of participating, without giving a reason. Your decision whether or not to take part will in no way affect your role within the service.**

### **What will happen to me if I take part?**

You will be interviewed by the researcher Satara Lester in a private setting. Before the interview, you will be given the opportunity to ask any additional questions about the study, and to discuss and sign an informed consent form and a very brief demographic questionnaire. The interview will last for about 60 minutes and will be audio recorded. It is semi-structured to obtain deeper understanding of your experiences of endings in a time-limited framework. Following the interview, you will be allowed as much time as you would like to talk through any feelings arising from the interview, and ask any further questions. You will also be given another information sheet with Satara Lester's contact details, in the event you wish to talk through anything further arising from the interview, or you wish to withdraw from the study.

### **What are the benefits of taking part?**

The information from the study may help in understanding counsellors' experiences of endings within this framework. You may find it helpful to discuss your experiences with the knowledge the study may be used to inform clinical practice and outcome for clients receiving counselling within a time-limited framework, and thus indirectly to help counsellors.

### **What are the possible disadvantages of taking part?**

You may possibly find it upsetting to talk about your experiences of endings. However, you do not need to talk about anything that you choose not to. In addition, the researcher is a trainee Counselling Psychologist experienced in discussing sensitive, personal and/or upsetting material and you will have every opportunity to talk about any distress you experience as a result of the interview. The researcher's contact details are provided should you feel the need to talk further following the interview.

### **What if there is a problem?**

If you have a concern about any aspect of the study, you should ask to speak to the researcher and interviewer who will do her best to answer your questions. The academic supervisor, Dr Elaine Kasket's contact details will additionally be provided should you wish to express dissatisfaction with any aspect of the interview process. The Research and Development team's details will be provided for independent general advice. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

### **Will my taking part in this study be kept confidential?**

All information will be handled in strictest confidence. Anonymity will be maintained by coding tapes with pseudonyms, deleting identifying information from the recordings and storing names and contact details securely, and separately away the data. All recordings will be stored securely and permanently destroyed five years after the project is completed. Digital voice recordings and any other typed information will be stored securely on password-protected computers and hard copies of transcribed interviews will be kept in locked drawers under the care of the researcher. Data will be coded and anonymised from the outset.



### **What will happen if I don't want to carry on with the study?**

You are free to withdraw from the study for up to two weeks after the interview without any need for explanation, and the information collected about you will not be included in the study.

### **What will happen to the results of the research study?**

The results will form the basis of a Counselling Psychology doctoral research thesis and it is possible that these may be published, or be written up in an internal report. You will be asked if you would like to see a summary of the results of the study, and if so, it will be sent to you upon completion.

### **Who is conducting and organising the research?**

This research is part of Satara Lester's Counselling Psychology doctorate at London Metropolitan University. She is the main researcher. However, Dr Andrew Eagle and Dr Elaine Kasket will closely monitor the quality and conduct of the research throughout.

### **Who has reviewed the study?**

This study has been given a favourable opinion by The Psychology Department's Research and Ethics Review Panel (RERP) and the Research Student Progress Group (RSPG) which reports to the Research Degrees Committee (RDC) at London Metropolitan University. It has also been given NHS Research and Development approval.

### **Contact for Further Information**

Please contact researcher Satara Lester for further information, details at the top of the first page.

## Appendix 3 – Participant Consent Form

### CONSENT FORM

**Title of Project: Counsellors' experiences of endings in primary care**

**Name of Researcher: Satara Lester**

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information and ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time within the next two weeks, without need to give any reason, and without my role within the service being affected.
3. I consent to my interview being digitally audio recorded. I understand recordings will be assigned a pseudonym and personally identifying details will be deleted prior to transcription.
4. I understand anonymous, pseudonymous written transcriptions will be used for the research.
5. I consent to being quoted (anonymously) in the writing up of the study.
6. I agree to take part in the above study.

\_\_\_\_\_  
**Name of Participant**                      **Date**                      **Signature**

I, the principal investigator, have explained the project to the participant and have answered all the questions honestly and fully.

\_\_\_\_\_  
**Name of person taking consent**                      **Date**                      **Signature**

## Appendix 4: Distress protocol

### Distress Protocol

Given that participants are experienced psychological therapists, it is believed that it is unlikely that participants will experience severe distress during the interview. Nevertheless, the nature of the topic may potentially evoke strong feelings. Therefore, this protocol has been devised to deal with the possibility that some participants may become distressed during their participation in my study. I will monitor and manage situations where distress occurs in the following ways. It is hoped that extreme distress will not occur, and that the relevant action will not become necessary. However, it is included in the protocol and in case of emergencies where immediate support is unavailable.

#### **Mild distress:**

Potential signs: 1) Tearfulness 2) Voice choked with emotion/difficulty speaking 3) Participant becomes distracted/restless

Action plan: 1) Ask participant if they are ok to continue 2) Offer them time to have a break 3) Remind them gently that they can stop at any time

#### **Severe distress:**

Potential signs: 1) Uncontrolled crying 2) Panic attack - e.g. hyperventilation, shaking, sweating 3) Inability to talk coherently

Action plan: 1) The researcher will intervene to terminate the interview 2) The debrief will begin immediately 3) Relaxation techniques will be suggested to regulate breathing/reduce agitation 4) The researcher will recognise the participant's distress, accept and validate these 5) Details of counselling/therapeutic services available will be offered to participants, although it is expected they may already be familiar with these.

## Appendix 5 – Semi-structured interview schedule

Title of Project: **Counsellors' experiences of endings in primary care**

Name of Researcher: **Satara Lester**

### **Semi-structured Interview Schedule**

*As you know, this research is into counsellors' experiences of ending time-limited therapy. There are no right or wrong answers; I'm just really interested in your own experiences of these. Most of these questions are about professional experiences, and a couple about more personal ones. Before we begin, are you comfortable? Is there anything else you would like to ask me?*

- 1. Just a few very brief questions to start with. How would you describe your primary theoretical orientation?**
- 2. I wonder if you could say a little about the service you're working in, and the nature of your role within this service?**
- 3. What is your understanding of the number of sessions you're able to offer your clients? How does that work?**
- 4. In general, how would you describe your experience of endings within this setting?**
- 5. Could you tell me a story about an ending with a client in this setting?**  
*Asking prompts depends on answers given; these may be altered or not asked if already answered elsewhere.*  
Maybe an ending which comes to mind, or is memorable within this setting?
- 6. On the flip side, where you found it harder/ felt it had gone well (depending on previous response...)**
- 7. Generally, what would you say you personally try to bear in mind with regard to endings in this setting?**  
*Asking prompts depends on answers given; these may be altered or not asked if already answered elsewhere.*  
What are the main differences between a good ending and a bad ending in this setting, do you think?
- 8. Generally, how would you say you experience endings in your own life?**
- 9. I wonder if you could juxtapose, or put alongside what you were saying about endings in your personal life, with ending with clients?**
- 10. If you have experienced ending your own personal therapy, I wonder if you could tell me what has that been like for you?**
- 11. Thinking about what ending your own therapy was like for you, could you juxtapose/think about that alongside ending with your clients to see what comes up for you there?**

12. Could you tell me a little about how the relationships you have with your clients impacts your feelings at ending?
13. I wonder if you could tell me a little about the training you've received with respect to endings?
14. Are there any suggestions you would like to make which you think might improve the current practice of ending therapy time-limited frameworks?
15. Is there anything else I've failed to ask about which you feel might be important?
16. Thank you for your time, and for taking part in this study. How have you found this interview?



## Appendix 7 – Sample of annotated participant transcript - Jan

<p>Adjusting goals to timeframe Having been helpful 'Was it good work?'</p> <p>The effect of client resources</p>	<p>R:... So I wouldn't say the work was complete but it was <u>as complete as it could be in six sessions</u>...yeah, yes...ummmm.... So I <u>felt she had received something</u>... <u>She'd, she was taking something away</u> with her... And I also felt <u>comfortable</u> that if she needed more help she would be able to access- she would find a way to access it... Often if I... I mean, this is probably a different question... But often if I have, if I have, suggested to someone that they continue... I do say that it's okay to contact me if they want to, to get some further help with <u>finding a way forward</u> so I quite often don't... I mean, you know, I certainly wouldn't say to somebody never contact me again...ummm.... It would be, you know, I mean I would say that, if it is relevant that they can get a <u>re-referral</u> to the surface if they need it, but I also say <u>if they want help with finding something they can contact me</u> so...</p>	<p>Good work within the timeframe, having been able to give something, be helpful, the client receives something felt <u>comfortable</u> that if she needed more help she would find a way to access it...the effect of clients' material, emotional, social resources on counsellors' experiences vs <u>discomfort</u>, the anxiety, guilt, anger when cs' are un-resourced Resources time-limited counselling in the stream of clients' lives</p>
<p>Journeying forward...</p> <p>Re-referral, episodic, possibility of return</p> <p>Possibility of contact</p>	<p>I: ...Yes .... And how do you think doing that influences your experience of the ending?</p> <p>R: I suppose it makes it...ummm.... Maybe, maybe it means, it means <u>I don't feel I'm abandoning somebody?</u> Ummm... I've got all sorts of <u>psychodynamic voices in my head...ummm... criticising me</u> right now... (Laughs)...</p>	<p>Finding a way forward, movement onwards again, journeying...</p> <p>Ongoing contact, primary care context – so not really an ending...altering the frame, the boundaries, ongoing contact - offering info versus setting referrals up I wonder whether she is may have been about to say "it make it "easier"? Ongoing contact so she doesn't feel she is abandoning clients at ending</p>
<p>Avoiding abandonment</p> <p>Psychodynamic training voices criticising practice</p>	<p>I: What are they saying? (laughs)</p>	<p>Feeling criticised for being unable to deal with endings, for failing to adhere to psychoanalytic theoretical guidelines IPA: ps interpreting, researcher interpreting ps interpretation, double hermeneutic - in context Reflecting on action Reflective practice</p>
<p>Feeling judged</p> <p>Reflective practice</p>	<p>R: They're saying umm...you know, I'm not able to...ummm.... <u>I'm not able to deal with endings</u> or something like that you know, or some sort of... 'A' they've been kind of, kind of going on earlier in our interview around I should be, <u>I should be realising that endings are much more significant than I'm making them out to be</u>. You know, endings are <u>always very significant</u>, and...and I should be making, you know, I should be sort of...acknowledging more of the</p>	<p>Trying to work out how significant endings actually are – they're always very significant and I should acknowledge</p>
<p>Questioning the significance of endings</p> <p>Psychoanalytic termination theory versus time-limited counselling</p>	<p>I should be, <u>I should be realising that endings are much more significant than I'm making them out to be</u>. You know, endings are <u>always very significant</u>, and...and I should be making, you know, I should be sort of...acknowledging more of the</p>	<p>Trying to work out how significant endings actually are – they're always very significant and I should acknowledge</p>

<p>Psychodynamic theory versus practice</p> <p>Blurred boundaries Avoiding ending Influence of attachment and loss? Ongoing contact Adjusting the frame</p> <p>Rebelling against the psychoanalytic rules</p> <p>Theory versus practice Rules versus pragmatism Mismatch between theory and context The 'real relationship' in CPC Egalitarian versus transference relationship Effect of relationship on boundaries Effect of boundaries on endings</p> <p>Experiencing view of endings as inadequate</p> <p>Lack of model to respond to the psychodynamic criticism with</p>	<p>impact on me and my clients... So that's one sort of psychodynamic message. And the other one is that I shouldn't, <u>I shouldn't leave my boundaries so unblurred at the end.</u> You know I should be much more, I, you know, <u>I'm avoiding the end by allowing them a possible contact...</u> with me...</p> <p>I: Yes, yes...</p> <p>R: And I'm feeling a bit rebellious actually... (Laughs)... Yes...</p> <p>I: Yes... (laughs) Yes... And what is the rebelliousness about, do you think?</p> <p>R: Umm... What is the rebelliousness about?... (Sighs)... <u>Something about rules</u> or...? I don't know I'm not sure, actually, I can't...um... I think the word '<u>pragmatism</u>' comes into mind...umm... And something about not, <u>not infantilising</u> the client... umm...I mean, ultimately <u>we're two equals really</u> in terms of our...you know, I, I see it as a 'there but for the grace of God go I' sort of thing, I, I don't ummm... But that <u>doesn't quite answer</u> the...that psychodynamic voice actually, it doesn't, doesn't, it's not quite...the <u>psychodynamic voice is getting the better</u> at the moment, it's kind of...you know <u>I feel like it, somehow I'm some kind of... I'm, I'm, my view is immature, or not somehow quite as sophisticated</u> or something but nevertheless. There it is.</p>	<p>their impact more on myself and my clients as in theory, and I shouldn't remain open to possible contact -</p> <p>Unblurred boundaries – Freudian slip? Rebellion - I <i>should</i> be leaving my boundaries so blurred? Avoiding the end – as she experienced her own early loss as avoided by primary caregivers? Attachment and loss experiences influential here too? Experiencing personal apriori influences, counsellors” self-experiencing Ongoing contact – so not ending... Rebelling against rules These rules don't work in this context? Rules versus pragmatism in context ‘There but for the grace of God...’ an equal relationship The ‘real relationship’, egalitarian, two equals versus the deeper dependency, transference she facilitates in her private practice The psychodynamic voice getting the better, winning, haven't developed a response/a model to respond to the psychodynamic voice with, feeling inadequate, immature, insecure nevertheless acceptant of this position in relation to endings in primary care. There it is. This is how I feel. Pragmatism versus theory</p>
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## Appendix 8 – Master table of themes for the group

Master table of themes for the group
<p><b>Self-experiencing</b></p> <p><b>Attachment and loss</b> it always touches my...old, painful places. What <i>happened</i> to them...? What <i>happened</i> to them...? (Layla: 10.58) kind of keep myself away from that emotion (Jo: 6.42) an early bereavement (...) was never dealt with (Jan: 8.58) the whole business of attachment and relationships.... (Peter: 7.45)</p> <p><b>Bi-directional personal and professional development</b></p> <p><b>Influence of therapist</b> I'm connecting with a real person and it's something I'm trying to (...) emulate (Jo: 3.23). a recognition that from both people that something important has taken place (Andrew:11.13) a model for me (Peter: 9.11) And that's what every day is standing in front of you, in your patient (Layla: 9.34)</p> <p><b>Personal growth influencing professional development</b> I can be quite <i>there</i> with an ending (Andrew: 8.56) Managing those darker feelings... (Peter: 7.7) <i>Still</i> I am here, saying goodbye to you (Layla:3.18) I've been learning that a therapist can be a very important part of somebody's life (Jo: 15.43)</p> <p><b>Professional development influencing personal growth</b> have to be very - which is a lifetime's work (<i>laugh</i>) - very self-aware, (Peter: 8.34). I can <i>dare</i> to sort of be, be something more for somebody (Jo: 3.6). I'd kind of got more insight both from my personal therapy and through work (Andrew: 8.29) going through that emotion again, and again, and again... it get kind of settled and accepted (Layla: 6.46)</p> <p><b>The quality of the therapeutic process – connecting</b></p>

## **Evaluating the quality of the work - Was it good work?**

..whether it's a good ending or a bad ending: was it good work or was it bad work? (Jan: 3.33)

### **Helpfulness**

I like to feel the person is going away feeling...feeling they've got something (...)

helpful ... (Jan.3.33)

people have realised something about themselves (Andrew:7.47)

feelings of satisfaction that she had seen it through (...)found a space that felt

different for her and there may be something reparative in that (Peter: 2.47)

I got the sense that...it was worthwhile to her. So that feels really good. (Maggie:5.41)

when there's feelings that work has been done and progress has been made and you

have been helpful (Jo: 2.59)

### **Depth**

The word that comes to mind is a surface level..There wasn't the depth to it (Jan:7.48)

in a brief setting (..)you have to be careful at the level that you kind of work (Jo: 2.11)

a taste of being held, listened to.... (Maggie 5.17)

- he did a bit of work, but it was very superficial. Ending with him felt...unsatisfying

(Maggie: 9.23).

the supportive aspects(..)that she most valued...someone would just listen(Peter:3.25)

### **Completion**

she just felt more complete as a person (...) so we ended feeling "I don't need to see you anymore, you don't need to see me anymore...that's great". And often there's a bit of sense of humour about that (...) a nice feeling...(Maggie: 6.40).

it was as complete as it could be in six sessions (Jan: 6.25)

when a good bit of work is done it makes the ending easier for me, because I feel that

we have done something (...) it's very rare but it's got the brackets either side and there

it is (...) you do the bow on the top and that's it – done! (Jo: 9.15).

they do what they need to do in the six sessions...in, in their own way(Andrew:9.18)

### **Tuning into the individual**

very sensitive, really listen... (Andrew: 12.31)

try and tune into that individual person's psychology....(Peter: 7.7)

it's a return to process (at the ending in a way – and )dealing with the feelings – but not being too precious – not making assumptions (Maggie: 12.7)

really focus on...(..) what they might want... (Jan: 5.42)

very much thinking about the patient, what the ending is like for them, focusing

on...what they might want (Jo:14.52)

### **Relational depth - Connecting**

a sense of...great satisfaction, a connection with someone... (Peter: 7:52)

very powerful connections (Peter: 10.5).

the connection... (Jan: 5.41)

terribly moving (Andrew: 7.25)

that 'higher gear' in the therapy – and you know, you just *know*, it's been...a real, true engagement and a really good connection... (Maggie:12.16).

it was this kind of being... Two people being ... (...) it was the being...and the connecting that was so important (Jo:10:18).

### **Conflicting frameworks – it would've been cruel**

#### **Psychoanalytic termination theory versus time-limited counselling**

I don't *assume* that they're burying some horrendous agony around separating from me after six sessions (laughs) (Jan:4.7)

on guard for how much importance *we* attach to endings... (Peter:11.4).

It's a momentary thing, I have to be, be honest. (Andrew:11.47).

I think "Did anything really happen? Or was it just a nice chat and that's why it feels okay in the end, or...?" (Jo: 9.24)

short-term work isn't always (...) such a big deal the ending – in fact they're rather pleased because from their point of view "I'm okay if I'm ending - and I'm not okay if I'm in treatment!" (...)It's all very well our worrying about saying goodbye, but for them, they think: "That's good, I don't need to come anymore" (Maggie: 11.22)

#### **Ethical frameworks versus endings**

too anxious and too alone really to be left (...) ending will be a huge loss (...) I find that hard because he's so, so vulnerable (Andrew:1.36)

Six sessions was really selling him short (Jan: 7.20)

I was really worried about her vulnerability... (Jo: 17.)

Feeling, *feeling* for her. Feeling that I let her down. *Feeling* I am, feeling I am another person who *abandons* her with her own world (Layla: 4:33).

letting them down, abandoning them (2.2) *need an absolutely immensely help and you don't have anywhere to refer them Layla 260*

(she was) really distraught and I thought, given everything else that's happened(...)I can't, I can't just end...I *can't* just end with her like that (Maggie:4.26)

### **Autonomy versus omnipresent system.**

Why? Why shouldn't they have a bit more...? Angry with the system. *Why* it has to be that way? (Layla: 4.50).

I had a choice (...) Will my client have that choice? No. (...) neither me nor my clients have a choice (10.32).

I let him down, and that's outside my control that that happened (...) I've not been allowed to do my *job* (Andrew: 7.50).

the frustration of working with people and spending time just trying to signpost them elsewhere.. I feel like I've had all this training and I have so much to *give* (Jo:3.36).

but that doesn't really feel like...that's not really what my job is....I'm not really – I mean don't really want to be an advocate....It's not really what I, umm... see myself as...(Jan: 2.39)

...it's an artificial imposition (Maggie:13.51)

### **Questioning the value of the work:**

I question myself a lot....You know, what is it we're doing? Is it just a load of old rubbish...? You know, what *are* we doing? Does it help at all? Because so many endings are kind of like – it's not quite *there* - it doesn't quite get to where the patient wanted to get to (Jo: 9.27).

So that's a kind of ending, where it didn't really begin (Maggie:10.32)

You have no sense of, of anyone, you know getting any better; all you have is...'Aaargh' (...) It can be a bit 'day tripping in hell' (...) that they don't always get better... (...) that can be hard to manage (Andrew:3.16).

often I feel it's hopelessly inadequate (Jan:1.42)

guilt ending them so quickly...there wasn't time to do good piece of work (Layla: 2.5)

### **System intruding:**

it's very tight (...) that tightness is an anxiety between both of you...the ending is here, the ending is here, the ending is here... (Layla:13.44).

I constantly feel rushed (...) I'd like to have much more time to reflect and ground myself, focused on the quality of the work rather than filling in forms (Jan:5.25). they just give the powers-that-be numbers... as a true representation, they're rubbish (Andrew: 10.3 )

you're very much observed because you're working on this remote, remote system and they can see.. (Maggie: 3.30).

## **Towards congruence – walking alongside for a bit**

### **Adjusting the frame**

#### **Referring on**

it's very important for me to not leave him with feeling... you know, I'm just leaving, just saying: "That's it - bye..." (Andrew: 1.54)

just to talk it through...and to see if she needed any...perhaps referral on...if it was a complicated issue...(Maggie:4.55)

a way of closing the case, and I think kind of... closing the connection for me...is, you know, the letter goes, and that's it (Jo: 13.33)

making the client aware um...of what the options may be available for them at the end (Peter: 1.39)

make sure they'd got information - if they wanted it - you know information about how they could ummm...find other help...(Jan: 3.25)

working on your feet to find a safe place for her (...) where maybe...always the sun shines... (Layla:3.3)

#### **Ending from the beginning:**

You have to focus on something (...) it's quite difficult at first, particularly when you're psychoanalytically trained, not to just sit back and see what happens...(Andrew 10.10)

*you haven't opened up as many strands, there aren't as many loose ends... (Andrew: 10.20)*

working towards the end from the beginning (Peter: 1.33)

I try these days very much to be very clear from the beginning (Jan:2.59)

You have to keep staying with the ending in every session...(Layla:1.49)

majority of cases...the work comes to an end, because it has been focused, it has been understood that this is what we're working on (Maggie: 2.30)

#### **Tailoring theory to individual needs**

that's the theory - I don't know that that's actually what I actually do. What do I do? I guess it very much depends on the individual... (Jan:2.56)

I just pushed all the books out the window (Jo:10.24)

I don't think you can have one way of doing it, at the end (...) pick up what it's going to be like for them (Andrew:12.32)

It didn't go well from the conventional model of how therapy should end but (...)

I'm ok with how it ended (...) because I was trying to go with the client's experience (Peter:6.6).

### **Expand the frame at ending**

I said "You can phone at any time; it doesn't matter that we're not seeing each other...I'm here to support you..." I just kind of felt that she didn't have – you know... (Jo: 9.14).

I also say they want help with finding something they can contact me so...(Jan: 6.33)

I can't, I can't just end (...) I said: "Well, given what's happened, we could have one or two more sessions...just to give you time..." (Maggie:4.26)

I tend to actually sneak in an extra session if I've been away, because I think we need a catch up - if I can get away with it! (laughs) (Andrew: 12.55)

### **Real relationship**

the therapy is ended - I'm very clear about that, but the relationship...?(Maggie: 7.51). we're two equals (Jan:6.53)

still two humans (Jo: 4.28)

she did phone me and say she'd had the baby and that she wanted to come and see me (Andrew: 7.20)

it allows me to be with my feelings on the one hand - and remembering and honouring a contract (Maggie: 7.10)

congruent about - to try, to try and be real about the ending in a way which still maintains the boundaries....(Peter: 5.46)

### **Detaching and accepting**

#### **Accepting**

to try and cultivate a kind of mindful attitude...a mindfulness in the work, which is an acceptance, sometimes a very radical acceptance...of where somebody is...as a way of trying to manage...the tendency at times to be over-affected (Peter: 8.47).

I'm just one part of this person's life, I'm '50 minute blocks' (Jo: 13.22)

you did your best. You did whatever you could do (Layla: 5.19). It is what it is (Layla:66)

one of the things I try to counteract that is, I think: “Well, they've had six sessions (...) at least they've had *something*” (Andrew:8.7)

### **Detaching**

You don't get so attached. You can hold it a bit more '*out there*' (Andrew:2.21 ) numbed” to them (4.11). detachment as self-preservation otherwise I'd be on the floor by now (Jan:4.35).

you've *got* to - because if you've got 25 clients in a week (...) if you can't detach from that that would....*(pause)* sap your *life* energies (Jo:13.41).

### **Metaphors of ending – journeying**

#### **Ending-as-pausing**

I think we need work and reflection, or pause - and possibly end. I think that's important, I just think that's a good rhythm of life, to have – in whatever you're doing (Maggie: 1.60).

you can say to patients “I'm not going anywhere, if you do need to see me in the future, you can do” (...) as a way for them to hold me in their head (Andrew:6:24)

I would say, you know “If you feel, you know this service is here for you, if you feel you would like to come back you can get a new referral from your GP...” So I do think it does act as a way of...um, managing and containing that, the context (Jo: 13.3)

you see them another time (...) sort of building a layer on something, on what you've done before(...)different...to sort of a more traditional concept (Jo: 9.10)

#### **Journeying metaphors**

ending touches upon what it is like to be alongside someone in the human – in their human journey (Peter: 8.23)

take them onboard (Layla: 10.54).

I didn't want to let go of this journey because the ending point in her life journey kept extending (Maggie: 2.45).

the urgency was wanting to 'get to a place', rather than recognising therapy as part of the journey, that he would then continue alone (Jo: 4.46).

